An inclusive health agenda: meeting public health challenges in South-East Asia

Selected speeches by

Dr Poonam Khetrapal Singh
WHO Regional Director for South-East Asia

2014–2017

World Health Organization
REGIONAL OFFICE FOR South-East Asia

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Selected Speeches by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, 2014–2017.

ISBN 978-92-9022-605-5

Suggested citation. An inclusive health agenda: meeting public health challenges in South-East Asia, Selected Speeches by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, 2014–2017. New Delhi: World Health Organization, Regional Office for South-East Asia; 2017. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Preface

This volume of selected speeches by Dr Poonam Khetrapal Singh covers a period of over three years, from 1 February 2014, when she assumed office as WHO Regional Director for South-East Asia.

The speeches cover a wide range of health issues and were delivered at various national, regional and global-level meetings, workshops and conferences. The publication does not include speeches delivered at internal-level meetings nor at the governing body meetings of the South-East Asia Region. The speeches, however, cover the broad areas of WHO collaborative activities in the Region and reflect the resolve of the Regional Director to bring change and to build partnerships to meet public health challenges in the South-East Asia Region.

The speeches are broadly classified into five areas and are presented chronologically for ease of reference. The title, venue and period of the event are indicated in the footnotes.

Acceptance speech: setting the tone

This is a moment of great honour for me. I would like to thank the Member States of the South-East Asia Region and the Executive Board of WHO for trusting me to lead one of the most dynamic regions of WHO in such exigent times. I take up my new position in all humility, fully aware of the challenges that lie ahead.

I have been extremely fortunate in being able to pursue my passion for public health through both advanced educational training and my professional career. It started in 1975 when i joined the Indian Administrative Service, an institution in the Government of India responsible for the governance of one-fifth of the world's population. For over two decades I formulated policy and developed and implemented strategies for health systems, medical education, finance and human resources. It gave me the opportunity of becoming the Health Secretary of Punjab, a State with a population of 22 million and a health budget of 350 million dollars. After three years with the Health Population and Nutrition Department of the World Bank, I joined Dr Gro Harlem Brundtland's cabinet in 1998 as Executive Director, Sustainable Development and Healthy Environments in WHO Geneva and, subsequently I moved to SEARO as the Deputy Regional Director till I retired in February last year. I have since been Advisor International Health to the Ministry of Health and Family Welfare, Government of India.

I have had the honour of working with our Member States in SEAR for over a decade. Together, we have worked as a team to overcome extreme challenges and celebrated well deserved victories.

I remember the Tsunami in 2004 which was one of the worst natural disasters in the Region. From SEARO we coordinated a multi-country rapid response bringing resources

Acceptance speech at the 134th Session of the WHO Executive Board, 21 January 2014, Geneva, Switzerland

from Geneva, other Regions as well as our partners. Together we contained the health impact of the disaster and have subsequently supported the reconstruction of the health system. The following year brought reward in the form of the establishment of SEARHEF, the South-East Asia Region Health Emergency Fund, the first of its kind in WHO which has been instrumental in strengthening country response to natural disasters and emergencies. We benefited from this enhanced capacity during the Yogyakarta earthquake in Indonesia, the floods in Democratic People's Republic of Korea and cyclone Nargis in Myanmar.

Through the decade, we have learnt from Thailand's path to universal health coverage. We have also impressive lessons from Timor-Leste's post-conflict progress in reconstructing its health systems. Bangladesh and Nepal have received international acknowledgement for achievements in MDG 4 and 5. Maldives continues to be malaria free. Bhutan has garnered international support for health and wellbeing as a true measure of development and we have taken this forward from the Region in the post-2015 debate. India`s landmark achievement in becoming Polio Free is a historical milestone and the Region looks forward to the certification of Polio Eradication in March this year.

Significant health challenges in the Region however, remain and are, in fact, increasing as the essential nature of public health continues to evolve. Late last year, I had the privilege of visiting several of our Member States, meeting Ministers of Health, Presidents, Prime Ministers, Ministers of Foreign Affairs, eminent public health experts, social scientists and health economists. We agreed that the Region is undergoing unprecedented demographic, epidemiological, economic and social transition and requires a bold strategy to address the unfinished agenda of MDG 4, 5 and 6, noncommunicable diseases, health systems and emergencies, with a strong SEARO at the helm.

We are already witnessing type 2 diabetes, cardiovascular diseases, hypertension and strokes striking not just more rapidly but also disproportionately in the countries of our Region. Alarmingly, this is a trend across all income groups and more

worrisome among the young. These long term chronic problems call for a new type of care and a new type of care giver, increasing cost of care, where out-of-pocket health spending is a key driver of inequities and impoverishment. The cause and impact of NCDs encapsulate the increasingly complex influences on the health of our population, further stretching our already weak health systems.

Technology has brought us to the threshold of universal health coverage and, yet, we are a long way from achieving it. On the one hand we are able to transplant hearts and kidneys, but on the other we are still not able to persuade people to do what is necessary to prevent diseases. We thought we had TB and malaria beaten but it is now coming back and in new more complex forms of drug resistance and co-infections. We have at our disposal extraordinary vaccines to eliminate childhood diseases but we are unable to reach all the children who are so desperately in need for it. Climate-change related natural disasters and health emergencies are on the rise. The multiple and multisectoral influences underlying these challenges require us to urgently mobilize the extraordinary opportunities of new health partnerships. We need to garner and consolidate support from all health-related sectors and partners in what I believe, must and can be a new era of universal development of health.

We need to garner and consolidate support from all health-related sectors

At a time when countries need WHO most, WHO must, simultaneously, undergo wide-ranging Organization reforms. In the words of our Director General, we must build our Organization to be more effective, efficient, responsive, objective, accountable and transparent. These are critical times in the evolution of this great organization and, we must be guided, above all else by the needs of our constituents. This is our core mandate and, together with Member States, we must define and deliver on country priorities.

And, for this, it is imperative that we recognize the need to join hands within WHO across the three levels of the Organization. The South-East Asia Region has some of the best public health experts, state of the art medical facilities, frontline centres of excellence and a leading pharmaceutical industry that is already improving the health of populations within and beyond the Region. There is significant potential here to make further

contributions to global health and an important opportunity for WHO's collaboration. I am steadfast in my resolve to bring change, to explore new avenues and to build partnerships for a technically sound, committed and dynamic effort to meet each and every public health challenge in South-East Asia.

In so doing, I am cognizant of the advice of the Honourable Minister of Health, Government of India, who after my nomination reminded me that I must lead the Region without fear or favour.

During my 15 years in WHO, I have had the good fortune of working with many experts whose experiences and insights deeply enrich my professional reportoire. My sincere thanks to them, specially my predecessor Dr Samlee with the assurance that the knowledge I gained from them shall be used in addressing the numerous challenges the Region faces.

I look forward to your support to rapidly and substantially improving the health of the population of the South-East Asia Region and beyond.

Communicable Diseases

Goodwill ambassador for Hepatitis

Viral hepatitis threatens public health across our Region. Every year it infects millions of people, causing the death of around 410 000 – more than HIV and malaria combined. Across the South-East Asia Region hepatitis is driving rates of liver cancer and cirrhosis, and is a substantial contributor to premature morbidity and mortality. As some of you may be aware, India is particularly burdened, accounting for around 60% of the Region's hepatitis-related deaths.

In recent years, the resolve to tackle hepatitis – both globally and in South-East Asia – has crystallized. Hepatitis is explicitly mentioned in the Sustainable Development Goals, which highlight the need to strengthen associated programmes. Hepatitis has been focused on at the World Health Assembly, leading to the endorsement last year of the Global Health Sector Strategy. And in the South-East Asia Region, hepatitis has been a priority area of work, with a regional strategy now adopted by all Member countries.

With the right policies, preventing, controlling and treating hepatitis is possible

This is all very encouraging. We know that with the right policies, preventing, controlling and treating hepatitis is possible. Indeed, ending hepatitis as a public health threat by 2030, as per our targets, is an imperative that we can – and must – achieve.

Nevertheless, to forge the necessary progress, we must find ways to amplify the reach and efficiency of our interventions.

For example, it is estimated that just 10% of those infected with hepatitis know their status. Greater public awareness of the disease can overcome this deficit, and ensure every infected person can access the treatment they need.

Hepatitis B and C continue to be prevalent among high-risk groups such as intravenous drug users and sex workers. Greater

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Event to announce the Goodwill Ambassador for Hepatitis in South-East Asia Region, 12 May 2017, Mumbai, India

understanding and uptake of harm reduction measures can limit the spread of hepatitis, and help keep vulnerable groups safe.

And millions of newborns continue to go without the hepatitis B birth dose, at times due to lack of awareness or fear of vaccination among parents. Greater buy-in for the birth dose can ensure that, where the vaccine is available, every child can access its life-saving benefits, as well as the two to three subsequent doses needed.

In each of these areas, and indeed, in many others, public communication, outreach and engagement is a powerful tool that can multiply programme efficiency and bring change to the lives of millions of people.

With this in mind, I am pleased to announce Mr Amitabh Bachchan as the WHO South-East Asia Region's Goodwill Ambassador for Hepatitis.

As I'm sure you're aware, Mr Bachchan has long used his star power for the greater good. Mr Bachchan is already the face of India's hepatitis B vaccination campaign, and was a crucial voice in India's successful battle against polio. He has participated in campaigns related to immunization, TB and diabetes, and has been a key advocate for the drive towards a clean India.

The power of Mr Bachchan's voice is well established. WHO is excited to be partnering with him on this important public health issue. I take this opportunity to thank him for his enthusiasm and support.

Indeed, together we are committed to eliminating hepatitis as a public health threat. As I mentioned earlier, hepatitis has been one of WHO's priority areas of work, with a Region-wide strategy developed and adopted by all Member countries. We are working with countries to adapt this policy to their needs, and to find solutions to a range of pressing issues.

We are working to strengthen infant immunization in all countries, and to make the birth dose available to all, including newborns delivered outside of institutional settings. We are facilitating collaboration across programmes, and harnessing the

broadest possible expertise and action. We are supporting the scale up of testing and treatment, as well as ensuring access to affordable medicines. And we are convening and coordinating partners to ensure that our vision is consistent with our individual and collective actions.

I once again express my gratitude to Mr Bachchan for joining us on our quest to eliminate hepatitis as a public health threat. Mr Bachchan's passion and drive will enhance the effectiveness of our programmes, and will bring greater awareness to this critical public health issue.

I have invited Mr Bachchan to WHO South-East Asia Region's governing body meeting in Maldives in September where Health Ministers from our Member States would together set the health agenda for the Region. We would immensely benefit by Mr Bachchan's advocacy for hepatitis.

I look very much forward to a productive, impactful partnership, and to achieving a Region in which hepatitis no longer threatens public health, and which is healthier, happier and more productive as a result.

Elimination of neglected tropical diseases

When in the early 2000s WHO created the NTD grouping out of a string of separately managed diseases, three patterns defined the grouping's criteria.

First, each disease was driven by poverty and marginalization, whether in remote rural areas or urban shantytowns.

Second, each was suffered by communities that lacked a political voice, meaning there was little momentum to lift their burden.

And third, each was insulated from the global health agenda and its focus on highly infectious diseases. Instead, NTDs caused hidden suffering within national borders and among select communities.

By definition, NTDs are a multidimensional problem

By definition, NTDs are a multidimensional problem; the health sector alone cannot solve them. By definition, they require innovative, out-of-the-box solutions.

I am pleased we have the opportunity to share our diverse perspectives and experiences to accelerate progress towards our goal.

I am also pleased that we can build on recent momentum. As you know, WHO first published its roadmap against NTDs in 2012. Later that year a group of donors issued the London Declaration. In 2013 the World Health Assembly adopted the roadmap and recognized the Declaration.

We have seen a tremendous increase in support since, including from partners and pharmaceutical companies. This has helped ensure millions of people can enjoy the future

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Regional meeting on accelerating progress towards elimination of neglected tropical diseases in South-East Asia Region, 25–27 April 2017, Jakarta, Indonesia

they deserve – one free from the deformities, disabilities, and emotional pain NTDs bring.

WHO South-East Asia Region is committed to this goal. With your support, in 2014 we made the battle against NTDs a regional health priority and a flagship programme.

Though South-East Asia carries the second highest NTD burden globally, our progress has been significant: In the last year alone India was declared yaws-free, and Maldives and Sri Lanka were validated to have eliminated lymphatic filariasis as a public health problem. Thailand is expected to do the same later this year, while Nepal is due to undergo validation of trachoma elimination.

More generally, our Region continues to undertake the largest preventive chemotherapy campaign in the world. This is something we can be proud of.

With your continued commitment I look forward to making further gains. Indeed, we are well positioned to do so: Quite apart from our NTD-specific plans and programmes, the Sustainable Development Goals provide an effective framework for success.

This is because the SDGs emphasize the interrelated nature of health and development. As I described earlier, the biosocial components of NTDs are a key reason for their persistence. A broad, multidimensional approach to them is needed, and is something the SDGs encourage.

Importantly, the SDGs also take our commitment beyond 2020, the endpoint of the current NTD plan. As per the WHO roadmap for NTDs, lymphatic filariasis, visceral leishmaniasis, leprosy and schistosomiasis are to be eliminated by 2020. Yaws is targeted for eradication in the same timeframe.

The SDG framework ensures that our commitment to leaving no one behind outlasts these targets, and stimulates a mindset attuned to the needs of society's most vulnerable.

Such a mindset is vitally important if we are to succeed: Despite our progress, the task before us remains immense.

In each of the Region's countries at least one of the 17 NTDs is endemic.

In nine of the Region's countries lymphatic filariasis is endemic, with Bhutan and DPR Korea the only countries spared.

Visceral leishmaniasis – or kala-azar – is endemic in Bangladesh, Nepal and India with sporadic cases occurring in Bhutan and Thailand.

And a large number of leprosy cases continue to be reported: In 2015, the Region accounted for 74% of global leprosy incidence, and 75% of the world's child leprosy incidence. The number of grade 2 disability cases also remains high, indicating ongoing transmission and late detection of leprosy patients.

I appreciate your efforts to overcome these challenges. There nevertheless remains plenty of scope to enhance our operational and programmatic capacities.

In 2015, the Region accounted for 74% of global leprosy incidence

First, on lymphatic filariasis: Where mass drug administration is failing to sustain low transmission, in some settings additional resources and effort is required. This applies across the Region, but especially in parts of Indonesia and India.

Second, on yaws: Where progress is less-than-optimal, programmes should be strengthened and resolve fortified. Indonesia and Timor-Leste each have the opportunity to scale up their efforts and achieve the national target of eradicating yaws by 2020.

Third, on schistosomiasis: Multisectoral solutions – including agro-engineering – should be pursued and fresh thinking embraced. The benefits of doing so will see rapid gains accrue. These will go beyond public health, and will stimulate wider economic growth and development.

And fourth, on surveillance: Across the Region, IT infrastructure and technology should be adopted and integrated with existing systems. Programme managers and senior leadership should have real-time data at their fingertips, enabling quick and timely interventions where needed.

Together we are working towards our time-bound disease elimination targets.

We are committed. We are focused. We are ready.

Indeed, I very much appreciate your enthusiasm to accelerate progress, and your shared commitment to avoid missing even one of your targets. I also appreciate your resolve to sustain political leadership and allocate adequate financial and human resources to this cause.

As I have outlined, the pursuit of universal health coverage, poverty reduction and other Sustainable Development Goals will help us on our way. Most of the Region's countries are now lower- or upper-middle income and are expected to invest more in the health of their people. NTD elimination is one way to measure the quality and efficacy of this investment.

I am proud to reiterate WHO's full commitment to support and work with you to ensure we achieve each one of the NTD targets.

We will continue to advocate for additional resources; we will continue to provide technical support; and we will continue to coordinate with drug donors and other partners to bring innovation and new technologies to your programmes.

I must, however, be clear on this point: Leadership and ownership of national programmes is ultimately the responsibility of Member States. The final push must come from within.

With that in mind I very much appreciate your Call to Action and the commitment it speaks of. I thank each of you for your attendance and engagement at this meeting, and appreciate your desire to make the most of this opportunity.

I also want to thank donors and partners for your commitment and ongoing support. Without the millions of tablets and funding you mobilize we would not have made the progress we see today. I am confident you will continue to work with us and consider increasing the resources available to help South-East Asia become the first WHO region to achieve NTD elimination.

I wish you an engaging, informative and productive few days.

Through our shared commitment and action we can lift the NTD burden. We can assert in practice, not just in word, that NTDs have no place in today's world. And we can ensure society's poorest, most marginalized groups are at the centre of health, development and progress across our Region forever more.

Progress against malaria

Today we commemorate the tenth World Malaria Day – a day on which we come together to highlight progress against malaria and take stock of the challenges we face.

Over the past ten years, and indeed, since the turn of the millennium, the world has made significant advances in reducing malaria's deadly burden.

Between 2000 and 2015 new malaria cases fell by 37%. Malaria mortality was slashed by 60%, with the Millennium Development Goal of halting and reversing malaria incidence convincingly met.

The South-East Asia Region is part of this story. The Region reached the malaria-related MDG target, and between 2010 and 2015 cut case incidence by an estimated 54% and the malaria mortality rate by an estimated 46%.

Between 2000 and 2015 new malaria cases fell by 37%

As per the SDG Agenda, the world is now aiming to "end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases" by 2030. I am pleased to share that our Region is making solid progress.

In 2015 and 2016 respectively, Maldives and Sri Lanka were certified malaria-free – a truly stunning achievement. Bhutan is now striving for elimination by 2018 – an exciting prospect. Nepal has not reported a malaria death since 2012. Timor-Leste has sharply reduced its caseload, which is now at less than 100. India, which accounts for 89% of the Region's estimated malaria burden, is rolling out its national malaria elimination framework 2016–2030. In Indonesia, almost half of subnational malaria-endemic units are now malaria-free.

World Malaria Day event, 25 April 2017, New Delhi, India

Indeed, all countries in our Region now have national strategies in place aiming to eliminate malaria by or before 2030. Region-wide resolve to end the malaria epidemic – alongside the HIV and TB epidemics – has been abundantly clear at recent consultations, and is immensely inspiring.

Nevertheless, the road ahead is not an easy one.

Our Region has the world's second highest malaria burden. Malaria remains endemic in nine of the Region's eleven countries. Multi-drug resistance – including to artemisinin-based combination therapies – is an ever-present threat, as is resistance of malaria-transmitting mosquitoes to insecticides. Across the Region, domestic funding for malaria prevention and control has declined, even as the need for more innovative and localized solutions has increased.

Renewed focus is needed. As the theme of this year's World Malaria Day emphasizes, enhancing prevention is a critical means of closing the gap and ending malaria for good. Though policy must always respond to local needs, there are powerful strategies that can accelerate gains.

Key among them is vector control. By controlling the mosquitoes that transmit malaria we can significantly diminish the disease's burden. Two highly effective ways to do this is by ensuring affected communities have access to long-lasting insecticidal mosquito nets, and by carrying out indoor residual spraying. In 2015 alone residual spraying was estimated to protect 106 million people worldwide, including upwards of 41 million in India.

Ensuring these tools reach vulnerable groups is essential. Malaria transmission occurs primarily among hard-to-reach, often disadvantaged or neglected communities, including migrant or mobile populations. These communities must be empowered to act, and must be fully engaged in programme implementation. Nevertheless, even within these communities, special efforts must be made to protect pregnant women and children under five years of age. There are a number of strategies that can do this, and which antenatal services in high-risk areas must be in a position to deploy.

As part of a wider push, countries should invest in and harness the latest technological advances. New vector control interventions, improved diagnostics and new anti-malarial medicines all hold out the prospect of driving world-beating progress. Meeting the 2030 targets requires agile thinking and a willingness to be bold, meaning all avenues must be explored, and all effective tools embraced. This is particularly important given the threat posed by multi-drug and insecticide resistance.

Our Region has shown what it can achieve. Each of us is familiar with the significant gains South-East Asia has made in recent years, from being certified polio-free to eliminating maternal and neonatal tetanus. Achieving a malaria-free Region must be added to this impressive arc of progress. Through strong political commitment, integrated strategies aimed at reaching the unreached, and a willingness to harness the power of cutting-edge tools, malaria's centuries-long burden can be lifted. We can eliminate malaria across our Region; we can end malaria for good.

Health sector response to viral hepatitis

As we gather today we can be proud of what we've achieved in the past year.

Proud that together we have developed a regional action plan to end viral hepatitis.

Proud that together we are pushing hepatitis prevention, care and control to the fore of public health programming.

And proud that together we are taking discussions on hepatitis beyond public health, making it a key social, economic and political issue.

Our joint action is vitally important.

Hepatitis infects millions of people in the Region each year

At present hepatitis infects millions of people in the Region each year. More people die of the disease than HIV and malaria combined.

Across the Region, hepatitis is a common cause of liver cancer and cirrhosis and is a substantial contributor to premature morbidity and mortality. It also impacts economic growth and the push for inclusive development.

Though Hepatitis B and C attract much of the focus globally, our Region faces specific challenges. Inadequate access to safe water and sanitation, for example, mean transmission of hepatitis A and E is an ongoing problem, and one that requires multisectoral solutions.

So the need to take comprehensive action is clear. It is reflected in the Sustainable Development Goals, which include specific mention of strengthening efforts to combat the disease. It is also reflected in the World Health Assembly's 2016 endorsement of a Global Health Sector Strategy on Hepatitis.

Regional workshop on scaling up health sector response to viral hepatitis in SEAR, 10–12 April 2017, New Delhi, India

The Strategy calls for elimination of viral hepatitis as a public health threat by 2030 – a very ambitious goal.

I am pleased to note the Region's Member States have much experience to draw on: With GAVI's sustained and generous contributions, all countries of the Region have had hepatitis B vaccine in their national immunization programmes for more than a decade.

I am also pleased to note the Region's commitment to maintaining and strengthening these programmes while at the same time taking a comprehensive approach to address all forms of hepatitis as per the Global Strategy.

Myanmar and Timor-Leste, which are classified as high hepatitis B prevalence countries, have each developed and implemented comprehensive national strategic action plans. DPR Korea, which also has high hepatitis B prevalence, is now finalizing one.

Indonesia and Thailand, both of which have intermediate hepatitis B endemicity, have also implemented comprehensive national plans. At present, they are scaling up public sector diagnosis and treatment of hepatitis B and C in line with these plans.

Investments in surveillance are facilitating progress

While India is making efforts to develop a national strategy, Punjab and Haryana – two states with high hepatitis C burdens – have started diagnosis and treatment within the public sector. Notably, the bulk of these programmes are funded through domestic financing.

Both Nepal and Bangladesh, meanwhile, are still developing their national strategies to address all forms of hepatitis. Nevertheless, each has developed treatment guidelines that will help their country standardize treatment and management of hepatitis cases.

Across the Region, investments in surveillance are facilitating progress.

Bhutan's efforts to conduct hepatitis B sero-surveillance, for example, will be instrumental in guiding and fine-tuning

policy interventions. So too will the efforts of India's National Centre for Disease Control, which is working to scale up surveillance across the country. Indeed, effective surveillance is key to diminishing the disease's public health threat.

The efforts of our Member States are commended. I am pleased to reiterate WHO's determination to match them.

As you know, WHO has been providing normative guidance on testing, treatment, monitoring and surveillance. We appreciate the unique challenges you face, and are developing effective, evidence-based tools and strategies to overcome them.

As I mentioned earlier, with your input we have now devised a regional action plan. This plan will give shape and purpose to efforts across the Region, with each country encouraged to adapt it to their needs.

But we're also looking at more specific challenges.

As I'm sure you're aware, last year WHO released a report on how difficulties regarding access to medicine can be overcome. I understand these barriers – particularly for the treatment of hepatitis C – have inhibited progress, and that the evidence-based recommendations in the report provide a way out.

As momentum to tackle hepatitis gathers pace, I am pleased to note a wider spirit of cooperation and solidarity. The close collaboration between health and development partners, civil society and academia, is proving to be a force multiplier in our battle. It is one that I trust will continue throughout this meeting and beyond.

As you continue to develop national plans and fine-tune your interventions, there are seven points I would like to stress here as fundamental to our cause.

First is the need to generate and sustain robust political commitment matched by adequate resource allocations. A shared resolve to ending hepatitis as a public health threat, and a broad understanding that this is indeed possible, is key to

driving Region-wide progress, both in the immediate and long-term. As part of this, effective convergence and integration of health issues is needed, with hepatitis prevention, control and management being embedded in all that we do.

Second is the need for greater community awareness and understanding of hepatitis. Community awareness is essential to creating momentum at the grassroots, and will ensure greater uptake of hepatitis testing. At present, it is estimated just one in 10 people know their hepatitis status, meaning increased awareness will magnify our ability to control the disease many times over.

Third is the need to make the hepatitis B vaccine birth dose a mandatory part of early post-natal care. Despite being entirely preventable, mother-to-child transmission of hepatitis B continues to be a matter of concern. Every newborn in the Region should receive the birth dose, followed by at least two more doses during the first year of life. To this end I am excited to note the development of an Asia Pacific Framework for triple elimination of mother-to-child hepatitis, HIV and syphilis.

Fourth is the need for effective infection prevention measures. This includes ensuring safe and rational use of injections, ensuring the safety of blood transfusions and blood products, and ensuring greater safety in medical and dental procedures. Not only will these interventions protect against hepatitis, they will also protect against other blood-borne diseases such as HIV.

Fifth is the need to make point-of-care rapid diagnostics widely available. Though in recent years efforts to do so have shown results, there is still work to be done, particularly in low-resource settings. As part of this, new innovations should be harnessed and integrated with existing protocols, while efforts to expand the reach of primary health care services should be scaled up.

Sixth is the need to guarantee access to medicines. As I'm sure you know we now have effective medicines that can treat hepatitis B and cure hepatitis C. Within the Region, India, Bangladesh, Indonesia and Thailand have the capacity

to manufacture generic versions of these medicines, meaning there can be no reason for a lapse in coverage.

Finally, and above all, is the need to recognize that information is power. Not only do we require robust surveillance to understand hepatitis' prevalence and spread, but we also need it to monitor progress. Effective use of information technology is critical to making this happen, and to devising innovative and localised strategies to achieve our goals.

We are witnessing renewed vigor and momentum among Member countries for addressing pressing health issues. Last month each of the Region's health ministers signed a Call for Action promising to tackle TB. This was followed by senior officials of all 11 countries registering their desire to see HIV, TB and malaria brought under the aegis of a single, empowered national body. As part of this approach we need to include hepatitis and all other diseases mentioned under SDG 3.3. The deadlines of our time-bound targets are approaching; we have zero time to lose.

Effective use of information technology is critical

Beyond this point of interest our three day consultation will cover a lot of ground; there is much to discuss and reflect upon.

I am confident that with your engagement and input this meeting will be a success, and I look forward to the recommendations for action that come out of it.

As I know you appreciate, our opportunity to forge dramatic, path-breaking progress on this issue is unparalleled in the history of our Region.

Let us make the most of that opportunity.

Indeed, together we can end hepatitis as a public health threat, and free our Region of its onerous and costly burden. Together we can achieve a healthier, more prosperous South-East Asia Region.

Ending HIV/TB/Malaria in SEAR

We are at a unique moment in humanity's struggle against key infectious diseases, as Steve, my colleague and friend from UNAIDS, has just mentioned by highlighting the three I's – Investment, Integration and Innovation.

Whereas the best we could once hope for was to bring a measure of control to the most serious of these diseases, today we are trying to end the HIV, tuberculosis and malaria epidemics by 2030.

This reflects a journey of steady, methodical achievement.

Drawing on robust political commitment and programmatic success, the South-East Asia Region reached the Millennium Development Goal target to halt and begin to reverse these epidemics.

From 2001 to 2015, the 11 countries of South-East Asia cut new HIV infections by almost half, malaria cases by 46% and malaria deaths by nearly 90%. The TB incidence rate fell by 18% from 2000 to 2015; associated deaths declined by one-third.

Today we possess the tools needed to defeat these diseases and achieve the Sustainable Development Goal targets. Nevertheless, to make this happen, a well-calibrated and rigorously implemented strategy is needed.

Though previous public health programming has – at times – created particular disease or issue-based silos, a more integrated approach is necessary. Indeed, there are powerful reasons why we must work together to address these three diseases.

Regional consultation on accelerating progress towards ending HIV/TB/Malaria in SEAR, 28–30 March 2017, Dhaka, Bangladesh

First, HIV, TB and malaria each disproportionately affects the most vulnerable and those with the least capacity to respond. Vulnerability can be caused by economic, social or geographic factors.

Second, each is preventable and treatable.

Third, each disease is featured in the SDGs alongside clear numerical targets. The targets call not for an incremental decline, but for the end of all three epidemics.

Fourth, and finally, responses to these diseases are undermined by the same health system limitations. Health system improvements alone will not eliminate these diseases, meaning a more targeted approach within the UHC framework is needed.

By working together we can achieve greater synergy and efficiency while learning from one another. Indeed, this meeting is an important step towards doing this, and ensuring disease control programmes work together to drive progress.

An estimated 1.4 billion people in South-East Asia are at risk of malaria

Ending these epidemics will not be simple. Indeed, merely continuing current trends – favorable as they may be – will leave us short of our 2030 goal.

Of the 3.5 million people living with HIV in our Region, less than half are receiving antiretroviral therapy. HIV viral load testing, which is essential for managing HIV, is routinely available only in Thailand. HIV stigma and discrimination – especially in health care settings – too often deters the most vulnerable from accessing the prevention and treatment services they need.

An estimated 1.4 billion people in South-East Asia, meanwhile, are at risk of malaria. Though seven countries reported reductions in confirmed malaria cases of at least 75% from 2000 to 2015, malaria remains endemic in every country in the Region except the Maldives and Sri Lanka.

The malaria burden, as well as patterns of infection, varies substantially between and within countries, preventing us from using a one-size-fits-all model for malaria control. Particular efforts are needed to accelerate malaria control programmes

in India, Indonesia and Myanmar, which together account for 98% of the Region's malaria cases.

Although South-East Asia accounts for only about a quarter of the world's population, we represent nearly half the global TB burden. In 2015 more than 4.7 million people in the Region contracted TB and more than 780 000 died of the disease. The rate at which TB incidence is declining – between 1.5% and 2% per year – is too slow to reach the goal of ending TB by 2030, meaning progress must be accelerated.

As we work to face these challenges head-on, several key principles and strategic directions should guide our collaborative efforts.

First, political commitment must be sustained and converted into action. The push to end these three epidemics by 2030 – as well as to eliminate neglected tropical diseases – should be visibly and enthusiastically led by a national body empanelled by the Head of State. Doing so will enable countries to devise their own approaches to respond to specific national and sub-national needs. It will also demonstrate the urgent need for action.

We welcome important signs of political commitment to the TB response. The just-concluded meeting of health ministers issued the 'Delhi Call for Action' and declared TB a regional priority. Greater budgetary commitments for TB are being made. The new 'Bending the Curve' initiative will catalyze regional progress in TB control and promote optimal strategies towards ending TB.

Second, financial investments must be front-loaded rather than delayed. Decision-makers must understand that we can either pay for endgame strategies now or pay much, much more down the road. WHO is committed to helping countries estimate their resource needs. Indeed, recent WHO estimates show that we need three to four times more resources for TB and at least twice the present resources for HIV.

Third, communities must be empowered and engaged. Focusing on the most vulnerable will help ensure disease control

efforts are equitable and inclusive, and that they respond to community needs.

As part of this, a range of key players – from persons suffering the diseases to CBOs and NGOs – can work to raise awareness and ensure appropriate services that leave no one behind. Their efforts will also combat stigma and help address the social and structural factors that increase vulnerability.

Fourth, we must strengthen our strategic information systems. Switching to case-based surveillance, for example, is an absolute must to end HIV, TB and malaria. It is imperative that data systems are aligned with Health Management Information Systems, that they reach the local level, and that they aid the performance monitoring of local programmes.

To make the most of this information, local authorities must have a strong understanding of the disease burden and the resources needed to tackle it. They must also develop local plans and indicators. Dashboards should be available to enable ministers and other decision-makers to visualize and understand in real time the needs, situation and gaps in each locality, and to take action accordingly.

Investments in research must be maintained and scaled up

Fifth, and finally, investments in research must be maintained and scaled up. To convert new knowledge into action, impediments to early adoption of innovations must be removed. At the same time, new communications technologies must be fully leveraged to increase access and improve retention in services. WHO pledges to help national partners do this, and to promote South-to-South collaboration on key issues such as regulatory review and registration of new products.

Since the year 2000, HIV, TB and malaria have together caused millions of deaths in our Region. They have devastated communities and households, diminished the life potential of countless children, and slowed economic growth and development.

Given HIV, TB and malaria's unfortunate toll, envisioning a world in which these epidemics are no longer a threat is difficult. But taking a moment to imagine a world without them is important – and inspiring. Imagine families and communities

being able to live, grow and work without fear of these leading infectious killers. Imagine a Region that is safer, happier, more just and more prosperous.

That is what this meeting is about. That is why we do the work we do.

This meeting has the potential to serve as a watershed in our regional response to HIV, TB and malaria. In our time together, let us learn from one another and find new ways to pursue our joint mission. Let us leave this meeting more committed than ever to a time-bound, results-driven approach to eliminate these and other communicable diseases.

I reiterate WHO's full support for your efforts, and pledge WHO's ongoing commitment to achieving success.

Let us take full advantage of the opportunity before us. Let us together end the HIV, tuberculosis and malaria epidemics once and for all.

“Bending the curve” to end TB

We are gathered today to explore how we can further ‘bend the curve’ and end TB in the South-East Asia Region – a goal of critical importance to all countries of the region borne out by the presence of the Ministers from nine countries of the Region.

I fully appreciate the range of public health issues the South-East Asia Region is facing. In this real world – battered by old as well as new threats – each country has several health priorities. But my plea to you is that we make ending TB an important priority in our Region for the coming decade, particularly in the 6 to 8 countries with high rates of TB.

Among infectious diseases TB is the Region’s leading cause of death

Reaching our goal of ending TB is paramount for health and development across the Region.

I know many of you are already convinced of this. The evidence is clear. Indeed, it has come into sharper focus with the national population-based TB surveys that so many countries in the Region have recently invested in.

We now know that more than half the Region’s countries have some of the world’s highest TB burdens, and that rates of new TB cases in several of them exceed all but those in sub-Saharan Africa.

We now know that among infectious diseases TB is the Region’s leading cause of death and lost productive years in the crucial 15–49 year age group. The toll is most severe on men.

We know that in four of the Region’s countries TB is among the top two causes of mortality and lost working years in the productive age group, outstripping every non-infectious condition but ischemic heart disease.

Ministerial meeting towards ending TB in the South-East Asia Region, 15–16 March 2017, New Delhi, India

We know that TB – like HIV – disproportionately affects adults in their most productive, vital years, causing catastrophic expenses and financial losses, and even outright impoverishment of individuals and households, with massive aggregate costs to national economies.

This enormous suffering is the fundamental reason why ending TB must be a central priority for the coming decade, both in highly affected countries and the Region as a whole.

Importantly, countries with low TB burdens have already shown what is needed.

First and foremost, the full commitment and determination of political leaders, beginning with ministers of health, so that TB is handled as a key national health and development issue.

Second, adequate financing for national TB efforts, so that comprehensive programmes can be scaled up to achieve universal access, and can reach each and every individual at risk.

Third, the application of best practices in taking comprehensive TB treatment and prevention programmes to universal scale, at the same time as improving quality and making them genuinely 'people-centered'.

Fourth, the rapid adoption of advances in diagnostics and medicines, so that opportunities to accelerate progress are seized.

And last, but crucially, the political determination to tackle poverty, malnutrition, substandard health care services, poor living conditions and other socio-economic factors that fuel TB and cripple effective treatment. Within this, the need for financial support to non-affluent patients being treated with TB cannot be over-emphasized.

Indeed, there is no doubt that TB can be ended in each of the Region's countries by embarking on an urgent and extraordinary response matched by corresponding investments in TB programmes. Our technical team will detail the best roadmaps for this Region in their presentations, with a special focus on how we can strengthen systems to support TB spending, and how we can reappraise TB funding requirements.

So that WHO can fully support your efforts in this last crucial stretch, over and above the support already provided by the Regional office and the Stop-TB programme, WHO South-East Asia is now supporting and advocating for funding of three areas: aiding fast-track implementation, supporting innovation, and translating innovation to implementation. These funds will prove instrumental to the success of our joint mission.

I take this opportunity to note the fruitful deliberations you have already had this morning, and the important topics already discussed, including

(i) the scientific modelling already performed, which demonstrates how our strategies can accelerate progress,

(ii) the need to address research gaps and integrate cutting-edge innovations with national programmes. I am told there was a lot of interest from delegates and partners on this subject.

I also hear that discussions on the Call for Action were held, and that feedback from country delegations have been incorporated. I encourage further input, if any, to ensure the document truly represents your commitment.

Many of us have dedicated decades to public health. Decades in which we've seen several big breakthroughs in our field; breakthroughs that benefited millions of children and adults alike. But if we can look back a decade from now and see that we helped bring TB to an end it will be an achievement of immense pride. By meeting the Region's End TB goals we will have prevented nearly 9 million deaths and more than 50 million infections.

We have the power to make this happen.

I wish this meeting success and hope that it is remembered as a historic one – a landmark event in the Region's efforts towards ending TB, which seems a real possibility; an achievable goal rather than an optimistic slogan, and a turning point produced by your dedicated and far-sighted leadership.

Today and for the coming decade, let us make the battle against TB a central priority. Together we can – and must – end TB.

Health of migrants

This global meeting is the second of its kind. It occurs at a time when the political and social dimensions of cross-border movements are reshaping our world.

It is no coincidence that the Government of Sri Lanka, a leader in primary health care and universal health coverage, has taken a leadership role on migration and health, an issue that requires a steadfast commitment to service provision and effective usage of resources.

Indeed, migration and health's challenge looms large.

By the end of 2015 the number of international migrants was estimated to be 250 million. Most of them crossed international borders to work, study or reunite with their families. Over 21 million crossed the international borders fleeing war or persecution.

By the end of 2015 the number of international migrants was estimated to be 250 million

This reflects a steady global increase in cross-border movements. Since the year 2000 international migration has increased by 41%. Global connectedness – alongside a range of push and pull factors – has created a world that is truly mobile.

At global, regional and country level population movements create important public health challenges. Migration is, after all, a social determinant of health. Though most migrants are healthy and young, the migration process can expose them to a range of health risks. This often occurs alongside inadequate access to health services and a lack of financial protection.

Health matters associated with migration are also of vital concern. Human mobility can be a critical factor in the spread of disease, as well as a challenge in controlling it. The 2014 Ebola crisis is a powerful example of how a lack of preparedness,

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Second global consultation on health of migrants, 21–23 February 2017, Colombo, Sri Lanka

a shortage of targeted health services, and a dearth of surveillance along mobility pathways undermines disease control measures. IHR compliance must be an important part of how we think about the migration-health nexus moving forward.

As public health practitioners and advocates, then, addressing migration and health is a practical imperative. By guaranteeing migrant access to health services we ensure that more people can achieve better health. We also fortify national and global health security. These ends are core to our mission, and must be pursued with vigor and clear-headed resolve.

But taking action on migration and health is also a legal and moral imperative. WHO's founding constitution emphasizes the right to the highest attainable standard of health for all. As several international conventions and declarations underscore, this right extends to migrants and refugees. Upholding them is a professional and moral duty, and is key to achieving the Sustainable Development Goal of universal health coverage and leaving no one behind.

Despite practical, legal and moral obligations, many migrants and refugees across the world still lack access to health services.

For internal migrants, inadequate health services are often a result of inflexible or poorly designed health systems that lack capacity. Linguistic, social and cultural barriers can also make access difficult, while discrimination can make it prohibitive. Administrative hurdles, meanwhile, can be as much of a deterrent as high out-of-pocket expenditures.

Similar factors impact health and migration internationally, especially in steady state scenarios. Among migrants, a lack of information and awareness of health services is common. Difficulties of navigation and administrative hurdles are near ubiquitous. This diminishes health seeking behaviour and with it health care consumption.

In recent years large-scale population movements have provided unique humanitarian challenges. These challenges are straining health systems that are often ill-equipped to handle

the pressures faced, exposing gaps in national and international preparedness and planning.

Importantly, in an age of unparalleled human rights advocacy and awareness, these breaches also challenge notions of progress. As German-Jewish philosopher Hannah Arendt observed following the Second World War, the human rights of non-citizens are often vulnerable, however legitimate and just they may be. This is for the simple reason that rights are recognized and enforced by nation-states.

In a world in which citizenship and sovereignty still matter, Arendt's haunting question, 'who has a right to have rights?' is as applicable now as it was 70 years ago.

As global public health actors working alongside nation-states and nongovernmental organizations, we have the opportunity to give substance to the answer. Indeed, we have the opportunity to guarantee the right to the highest attainable standard of health for all, and to fine-tune and reify the political, legal and operational frameworks by which migrants and refugees can access the health services they need.

In recent years, WHO has been listening to and working with Member States and partner organizations to do just that.

In 2008, the World Health Assembly endorsed resolution WHA61.17. The resolution called for the promotion of migrants' health on the international health agenda; the inclusion of migrants' health in the development of regional and national health strategies; and dialogue and cooperation on migrants' health among all Member States involved in the migratory process. The 2008 resolution was followed by a 2010 Global Consultation on Migrant Health in Madrid, Spain, where an operational framework was created to guide the implementation of the Resolution.

In the years since, each WHO Region has made important progress. This is evident in numerous Regional Committee resolutions, from WHO-AMRO's resolution and Policy Document on Migrant Health to WHO-EURO's Strategy and Action Plan for Migrant Health. Regional progress is also evident in numerous

on-the-ground initiatives. This includes WHO-EMRO's effort to provide medicines and medical equipment for Syrian refugees across five countries. And it also includes WHO-AFRO's vital work on the impact of health worker migration on health systems.

In the South-East Asia Region, several important interventions have made an impact.

Sri Lanka's national migration and health policy, which was developed and launched in 2013, has been vital to keeping the country malaria-free, as well as creating coordinated care plans for family members left behind by out-migration. Sri Lanka became the first country of the SDG era to be validated as malaria-free, despite conflict-related population movements in the past decade, and without imposing coercive measures for migrants or travelers.

Thailand was the first country with a large-scale HIV epidemic to have achieved elimination of mother-to-child transmission of the disease. Thailand made this possible by offering PMCT services to all people, irrespective of their migrant status.

And in Bangladesh, a National Strategic Action Plan on Migration and Health is providing the means to improve the health status of all categories of migrants throughout the migration process, with a special focus on a core area of concern – migrant labor.

WHO-SEARO and WHO-WPRO's healthy border initiative for control of TB, HIV and other communicable diseases in the Mekong basin, meanwhile, has been recognized as a vital initiative, and has inspired significant Global Fund support for combatting drug-resistant malaria in the region.

We very much look forward to building on these and other developments.

Activity at the global level has also quickened in recent times. At the 69th World Health Assembly in May 2016, a technical briefing on health and migration was held. That briefing has informed and guided much of WHO's actions and

approach since. In September 2016, Member States of the UN General Assembly issued the New York Declaration for Refugees and Migrants. That Declaration reaffirmed Member States' commitment to address the specific health care needs of migrant and mobile populations and refugees. And just a few days later, a High Level Meeting on health in the context of migration and forced displacement was organized by the governments of Italy and Sri Lanka, as well as WHO, IOM and UNHCR. That summit reiterated the need for a rights-based approach to the health needs of mobile populations.

I am pleased to note that WHO has further honed its organization-wide framework on health and migration. As Director-General Dr Margaret Chan outlined earlier, WHO is now in the process of working with IOM, UNHCR and other stakeholders to develop a draft framework of priorities and guiding principles to promote the health of refugees and migrants. This will be considered by the Seventieth World Health Assembly in May 2017. WHO is also making every possible effort, in close collaboration with Member States, to ensure that health is adequately addressed in the development of the global compacts on refugees and safe, orderly and regular migration. To inform these efforts, WHO is identifying and collecting experiences and lessons learned on the health of refugees and migrants in each region. These will be reported at the Seventy-first World Health Assembly in May 2018.

During this global consultation we have had the opportunity to refine our collective understanding and approach to the issues at hand. Deliberations have focused on three thematic areas that define present global agendas, and which were discussed within a rights-based, people-centered, gender and equity framework.

This included how we can reduce the disease burden in migrants and host communities through universal health coverage. It also included how we can reduce vulnerability and enhance resilience of migrants, communities and health systems. And we also deliberated on how we can ensure the health of migrants is made an integral part of the 2030 Agenda for Sustainable Development.

Migration and health is one of the greatest challenges we face as public health practitioners

Engagement on these and other issues provided critical substance to the Colombo Statement, which I am certain will enhance our collective ability to address migrant health issues moving forward.

As I stated at the outset, migration and health is one of the greatest challenges we face as public health practitioners and advocates. It is a challenge inherent to Westphalian order, and one that requires innovative national, international and multilateral solutions.

Through this initiative and the momentum it builds we have the opportunity to forge world-defining progress and to fasten the bonds of our common humanity. Together we have the power to bend history to our will. Together we can ensure the human right to health is secure for all, including migrants and refugees.

Prevention and treatment of HIV/AIDS

It is an honour to have the opportunity to address you on World AIDS Day, and I thank H.E. Mr J P Nadda for inviting me to do so.

Today is an opportunity to reaffirm our commitment to the cause of HIV prevention and treatment; to raise public awareness about HIV; and to remember loved ones who lost out to AIDS.

These outcomes are especially important in the current context: Having achieved the Millennium Development Goal of reversing the global AIDS epidemic we find ourselves at a historic juncture. Of course, there remains plenty more to do, including ensuring universal access to HIV treatment – one of the MDG commitments we failed to achieve.

We have now embarked on a mission to end the AIDS epidemic as a public health threat by 2030

As a means to sustain and accelerate progress we have now embarked on a mission to end the AIDS epidemic as a public health threat by 2030.

As per Sustainable Development Goal 3.3, which maps out a series of interim goals to achieve this target, by 2020 at least 90% of people living with HIV should be identified; at least 90% of those identified should be on effective treatment; and at least 90% of those on treatment should have successfully suppressed the multiplication of HIV in their bodies.

Achieving these goals will not only help people with HIV live longer and healthier, but will also interrupt transmission of the virus, thereby resulting in fewer new infections.

Though these goals are within our reach, in India – as across the South-East Asia Region – we nevertheless have our work cut out for us: when compared to other Regions, South-East Asia has the second highest number of people living with

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Address on the occasion of World AIDS Day celebration by the Government of India, 1 December 2016, Jawahar Lal Nehru Stadium, New Delhi, India

HIV. When compared to other countries, India remains home to the world's third highest number of people living with HIV.

Still, progress has been steady, and I congratulate India's health authorities on their remarkable gains. Since the turn of the millennium the annual number of new HIV infections has reduced by 66%, for example, while AIDS-related deaths have decreased by 54% since 2007. Further, of an estimated 2.1 million people living with HIV about 1.4 million are aware of their HIV status. Around one million of these are on ART.

It is exciting to note that India has recently revised its HIV testing guidelines and is optimizing HIV testing approaches to reach the unreached. India is also in the process of revising its ART guidelines as a step towards implementing the TREAT policy in a phased manner, beginning with key populations. WHO has been providing technical support to NACO, and is fully committed to ensuring high-quality, stigma-free, universal access to ART and other HIV-related activities.

It is also a pleasure to note that India has recently renewed its commitment to use all flexibilities in the TRIPS agreement to continue providing high-quality generic drugs, including ARVs, for developing countries across the world. India's ingenuity will help millions of people receive the medical products they need, and will help achieve HIV/AIDS targets in the country, the Region, and the world.

As you know, WHO has been updating information on prevention, testing, treatment and monitoring, as well as service delivery approaches. The Global Strategy on the Health Sector Response to HIV 2016–2021, endorsed by all Member States at the World Health Assembly in May 2016, provides the framework for effective and sustainable implementation of evidence-based interventions.

In coming months and years we must be innovative and strike where we can have the greatest impact. Indeed, our focus and prioritization of interventions is critical, especially in low and concentrated epidemic settings in populous countries such as India. This is all the more important as the possibility of resource scarcity looms.

Proactive action backed by political will and innovative and sustainable financing will go a long way in fast-tracking national HIV responses. It will be these responses that steer India and the Region towards an AIDS-free generation and an AIDS-free world.

The theme for this year's World Aids Day is 'Prevent, test and treat all'. Let us commit ourselves to making this happen.

Malaria elimination by Sri Lanka

We are here this morning to mark and celebrate Sri Lanka's success, your success. This is a significant moment in the global effort to eliminate malaria. Following adoption of the Sustainable Development Goals and the mission of Ending Malaria by 2030 by the Head of States at the historic UN meeting in September 2015, Sri Lanka became the second country in quick succession to Maldives in the South-East Asia Region to achieve malaria-free status. This landmark victory represents the largest lower middle income country in the malaria endemic tropic to achieve elimination. I cannot overstate the magnitude of this achievement.

It is my honour to congratulate Your Excellency, the Minister of Health, Nutrition & Indigenous Medicine, Dr Rajitha Senaratne, who led this historic success and the staff of the Department of Health and most importantly the workers in the field, the frontline workers, that made this possible and urge you to maintain your resolve.

On September 5, 2016 I already had the privilege of announcing, at the Sixty-ninth Session of the Regional Committee, that WHO has officially certified Sri Lanka as malaria free. For the first time in its two hundred-year battle against malaria, Sri Lanka documented zero transmission for three consecutive years and qualified for this certification.

It is important for us today to go into the details of the country's battle against malaria, to understand how such a unique achievement was possible in a developing nation with all its complexities and challenges.

In my view seven key factors have contributed to Sri Lanka's extraordinary success.

Address on the occasion of malaria elimination certification by the Government of Sri Lanka, 30 November 2016, Colombo

First, a strong health system. Sri Lanka has some of the best indicators of health, on par, in some cases, with developed nations. Sri Lanka's case detection in malaria accounted for around 97% of cases found and treated by the health system. This in itself is a major achievement.

Second, a focussed approach for disease elimination for malaria: Sri Lanka's experience shows that a focussed approach to disease elimination remains a key to success. The universal health care system deserves much credit, but it is not enough by itself. Indeed, when a focussed strategic approach to malaria elimination was withdrawn in the late 1960s in Sri Lanka, the disease soared back from a few cases to millions.

Third, inclusive health reaching all: Sri Lanka has demonstrated a visionary commitment to equitable access in communicable disease control. Immigrants, along with all other residents, are covered for malaria screening and treatment. Also, no region within the country, including those that were declared conflict zones, were denied malaria prevention outreach. The policy of 'leaving no one behind' in the context of malaria elimination indicates Sri Lanka's commitment to equity in health and a response grounded in human rights.

Sri Lanka has some of the best indicators of health

Fourth, conflict is not an excuse for public health: important factor in Sri Lanka's success with malaria elimination is that it has not allowed civil conflict interfere with disease elimination. Sri Lanka's achievements were made despite the challenges posed by the protracted armed conflict in the country, which began in the early 1980s. By 2000, Sri Lanka's eight conflict-affected districts accounted for the majority of malaria infections, as anti-malaria efforts and primary health services buckled from decades of conflict.

In response, integrated vector control and treatment interventions were scaled up in the conflict-affected districts by the Anti-Malaria Campaign (AMC) Directorate and the regional malaria teams, often in partnership with non-governmental organisations and the army.

Fifth, co-ordination and communication across sectors: Coordination across different sectors played a key role.

Whenever there is a risk of malaria entering the country, whether through refugees, business travellers or fisherfolk, multi stakeholders come together for testing and treating. The security forces, airport authorities, private citizens, government are all united in their determination to keep the disease from coming back. These examples of cooperation in public health have valuable lessons for regions around the world.

Sixth, effective partnership: Sri Lanka has gained a lot from transformative international partnerships – not only between the North and South but also South-South partnerships. The country has benefited from its partnerships with WHO, IOM, UNICEF, UNHCR, Roll Back Malaria, International Red Cross, Sri Lankan Red Cross, MSF and the Global Fund, and in turn has served as a best practice example for all its partners.

Seventh: evidence-based response to disease - doing basics of disease elimination right: the Sri Lankan campaign began not only with an ambitious vision, but was sustained by very concrete steps. These included surveillance and active case detection, comprising both parasitological and entomological surveillance, and using mobile malaria clinics; treatment and health education and case management; vector control with integrated vector management and widespread use of bed nets; and strong policy actions and advocacy. An involved private health sector, advocacy among medical professionals, decentralized control, and an excellent cadre of field staff and coordination at every level were essential to achieve the spectacular decline in transmission. Instead of continuing to treat at-risk groups as passive recipients of government largesse, communities were also encouraged to take ownership and get involved.

Sri Lanka's success did not come overnight:

Malaria has cast a long shadow for much of Sri Lanka's history, particularly in the late 19th and early 20th centuries. Colonial authorities transformed large swathes of the countryside to meet the needs of modern farming and infrastructure projects, causing intensification of epidemic and endemic transmission. Major epidemics occurred every few years. The 1934–1935 malaria epidemic for example, killed around 80 000 people, approximately 1.5% of the population.

Following independence in 1948, it was clear that a determined effort to end the disease was necessary. By the time the World Health Assembly launched the global malaria eradication campaign in 1955, Sri Lanka had already made some important gains: the case-load had declined and transmission was being interrupted. In keeping with Sri Lanka's commitment to further progress, the government was quick to join the global campaign and consolidate its gains.

A regional pioneer in adopting new techniques for indoor residual spraying or IRS, in combination with case detection, treatment and surveillance, Sri Lanka recorded just six cases of malaria by local transmission in 1963. Sri Lanka, it appeared, was on the brink of a historic victory. But subsequent abandonment of the eradication programme at global level and scaling back of efforts at Sri Lanka, took its toll. Low level of IRS, reduced surveillance and weakened human resources for targeted work led to the resurgence of malaria, with about 1.5 million cases in 1967–1969. Once again malaria infected whole villages and re-established itself in once-endemic areas. Sri Lanka had to struggle and live with this scourge for another 30 years.

The late 1980s ushered in the scaling up of anti-malaria efforts in the middle of some big epidemics. 1986–1987 brought more than 600 000 cases of malaria annually. A turnaround began in 1999–2000. Across the country, malaria vector control, surveillance, and treatment interventions were scaled up. Malaria incidence fell dramatically in subsequent years — more than 90% reduction in four years' time and a 99% reduction over eight years. There was a 68% reduction in 2000–01 alone. In 2008, for the first time, there were no indigenous malaria-related deaths in Sri Lanka. Then came the final success and Zero local transmission in the next few years.

Sri Lanka's success has important messages for the rest of the world.

Integrated approach:

- Lanka's Anti-Malaria Campaign (AMC) Directorate jettisoned single vector-control methods in favour of integrated vector management. This integrated approach relied on several carefully

selected interventions, including vector control in major irrigation and agriculture projects, rigorous entomological surveillance leading to targeted spraying in high-risk areas, new classes of insecticides for Indoor residual spraying, insecticide-treated nets and larval control, and strengthened parasitological surveillance for active case detection combined with rapid response compounds.

- This kind of multisectoral approach was a tectonic shift in the history of global health for developing countries, and this kind of approach is fundamental to the achievement of Sustainable Development Goals in the future.
- Thirdly, it has shown that no matter what the level of income, and no matter what the climate or geography, real and lasting change is possible with committed political leadership and proactive community involvement.
- Whether in Sub-Saharan Africa or South-East Asia, Sri Lanka's triumph over malaria has been watched and applauded. I have no doubt at all that Sri Lanka's achievement will be a source of inspiration and learning in the global battle against malaria, while the country benefits economically from being malaria-free. Research has shown that eliminating the disease improves economic prosperity.
- As we celebrate today it is also important to remember that there is no room for complacency. Zero transmission means zero time to let down our guard.
- Ensuring that the country remains malaria free and is protected from reintroduction of malarial parasites requires continued efforts of surveillance within the country and efforts to help make neighbouring countries malaria free as soon as possible. Unless we act wisely and rapidly, Sri Lanka has a high risk of re-establishment of malaria.

- Sri Lanka's situation remains a litmus test for the entire public health community. I am confident that the country will continue to remain vigilant, and I commit WHO's full support to Sri Lanka's ongoing anti-malaria campaign.
- I wish you the very best in your determination to keep Sri Lanka malaria-free. Sri Lanka's achievement is an example of how malaria control can be done right, and how countries can be freed of this burden.
- My congratulations once again to Your Excellency, Dr Rajitha Senaratne, the department of health, its staff here and across the field, and to thousands of those who have worked to see this historic day.

Tuberculosis control

As the recently released WHO Global TB Report illuminates, the severity of the world's ongoing TB epidemic is of immense concern.

In 2015 - the estimated global TB incidence was 10.4 million. Around 1.8 million people died of the disease.

In the WHO South-East Asia Region the figures are alarming:

1. 46% of global burden is from SEA Region.
2. Nearly 30% of global deaths are from this Region.
3. Six countries of this Region are among the 30 high burden countries.
4. Countries even with a low total number like Timor-Leste, are among the top ten highest incidence rate countries of the world.
5. Very slow decline of new infections.

TB is the single largest cause of death by any infectious disease

TB is the single largest cause of death by any infectious disease. It is also the top killer of persons in the 15–49 year age group.

Indeed, tuberculosis is a public health scourge responsible for premature mortality, impoverishment and development in our Region and across the world.

As you are aware, last September we moved on from the Millennium Development Goals (MDGs) and have now entered the Sustainable Development Goal (SDG) era.

While TB control advanced during the course of the MDGs our goal has now shifted from stopping TB to ending TB.

Workshop on resource needs for accelerating impact, 28 November 2016 New Delhi, India

The key targets set in the End TB Strategy include a 90% reduction in TB deaths and an 80% reduction in TB incidence by 2030.

At present the annual decline in TB incidence is 1.5% to 2%. We need to accelerate this to a 4% to 5% annual decline by 2020. If 'business as usual' persists, not a single country in the South-East Asia Region will reach the WHO End TB targets.

To bend the TB curve :

- First, we need to do more and do it fast. Available tools must be utilized more effectively; the development of newer tools must be fast-tracked; and universal health coverage – along with social protection – must be provided to all TB patients.
- Secondly, targeted measures such as active case-finding and the treatment of latent TB infection should be more vigorously pursued.
- Third, special emphasis on reaching the unreached is needed.
- Fourth, communities and partners must be more effectively engaged.
- Fifth, effective advocacy and resource mobilization will prove critical to ensuring these efforts are successful.
- To this end, WHO will shortly convene a ministerial level meeting to establish heightened Region-wide political commitment. This will be followed by country-by-country advocacy for greater resource allocation and flow of funds.
- In this broader context, the key objective of this workshop is to build the capacity of high TB and MDR-TB burden countries to identify the resources needed to accelerate progress towards reaching the End TB targets. This will also enable strategic planning to scale-up activities at the national and sub-national levels.

- I am sure discussions during this workshop will shed light on the utility of various modelling tools and techniques, and assist in developing a definite roadmap for action in your countries.
- I would personally make TB a priority under my leadership in the Region and I hope to make the Fast-Track Plan for TB an agenda item for the next session of the Regional Committee in 2017.

I wish you a successful workshop and look forward to working with you to further accelerate progress towards the goal of Ending TB.

Antimicrobial resistance in food animals

At the 71st meeting of the UN General Assembly earlier this year, antimicrobial resistance featured as a core concern of Heads of State from across the world.

This was one of the rare occasions when a special session of the General Assembly was convened to deliberate on a public health issue. Since the Assembly first began meeting in 1948, similar discussions had been held just three times – for HIV AIDS, rising rates of noncommunicable diseases, and West Africa's deadly Ebola epidemic.

As the declaration that followed the Assembly attests, combating antimicrobial resistance is now high on the agenda of national policymakers, international organizations and financial institutions, as well as the public in OECD and developing countries alike. After years of intense outreach and engagement, antimicrobial resistance has become one of the core political, social and economic issues of our time.

If present trends continue, AMR is projected to kill 10 million people annually by 2050

Each one of us here contributed to making this possible.

Indeed, it is because of these contributions that much of the public is now aware of the fact that if present trends continue, AMR is projected to kill 10 million people annually by 2050. There is now broad cognizance of the fact that AMR is already leading to the death of around 700 000 people each year, and is the cause of costly and unnecessary suffering across the world.

It is also because of these contributions that economists and policymakers are dedicating significant resources to studying AMR's economic, political and social impact. As predicted by a World Bank report released earlier this year, AMR could lead

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Workshop on national action plan on antimicrobial resistance for developing countries: focusing on resistance emanating from antibiotic use in food animals, 10–11 November 2016, New Delhi, India

to a decline in global annual GDP of between 1% and 4%, and could diminish global livestock production by between 3% and 8%. There is now widespread awareness of AMR's potential to stymie economic growth and to inhibit the development aspirations of billions of people worldwide.

But alongside efforts to drive the public discourse and illuminate these truths and ongoing hazards, important AMR-related research and policy work has been going on for many years now.

At the regional level, as early as 2011 the Hon'ble Health Ministers of the South-East Asia Region acknowledged the seriousness of AMR and adopted the Jaipur Declaration on Antimicrobial Resistance. The Jaipur Declaration recognized the irrational use of antibiotics as the key driver of AMR, and advocated for a holistic and multidisciplinary approach to its control. The Declaration was an important tool for establishing awareness of AMR at the highest levels of government, as well as catalyzing the search for effective policy solutions.

Building on this momentum, at last year's Regional Committee in Timor-Leste, Member States passed a key resolution on AMR prevention and containment. The resolution emphasized the need for steadfast political commitment and effective multisectoral coordination to combat the problem. It also called on Member States to ensure that AMR was placed at the top of their national agendas.

In 2016, a year of intense energy and drive that we have not yet concluded, two high-level ministerial meetings on AMR involving the Region's Member States have already been held. In February there was the 'Combating AMR: Public health challenge and priority' meeting organized by the Government of India in New Delhi. At this meeting a roadmap for the creation of national action plans was developed, and countries pledged to have these plans finalized by May 2017. And in April a bi-regional meeting on AMR organized by Japan, in collaboration with the WHO South-East Asia and Western Pacific Regions, was held in Tokyo. This meeting allowed Member States the opportunity to troubleshoot the development of their national action plans, and reiterated the focus needed to reverse AMR's rising tide.

These regional milestones have taken place as progress at the global level has accelerated. In addition to the discussion of AMR at the UN General Assembly which I mentioned earlier, several notable AMR-related developments have occurred. This includes WHO's Global Action Plan on Antimicrobial Resistance, which is providing guidance to countries as they endeavor to meet the May 2017 deadline for developing national plans. And it also includes the featuring of AMR as a core agenda item at consecutive G7 meetings in 2015 and 2016 in Germany and Japan respectively.

Understandably, this burst of activity is helping to bring all partners on board and to illuminate the way forward for tackling AMR. As evidenced in the Global Plan and in a number of key reports produced by WHO and other partners in recent years, the broad policy areas for action have been staked out. Indeed, the need of the hour now is to engage in the minutiae of policy development and planning, and to be decisive in the next steps we take.

With this in mind, I would like today to focus on the critical importance of the 'One Health' approach, and of operationalizing the tripartite collaboration between the World Health Organization, the Food and Agriculture Organization of the United Nations, and the World Organization for Animal Health.

As we know, the rise of antibiotic-resistant pathogens cannot be contained in the absence of close cooperation between the human health, animal health and environmental health sectors. And as we also know, while establishing this cooperation is of vital concern within countries, it is doubly so at the international level given the cross-border nature of AMR and ongoing concerns regarding emerging zoonotic diseases.

In taking the One Health approach forward WHO is focusing on developing integrated responses across sectors, and capitalizing on the comparative advantages of WHO and partners agencies such as FAO and OIE so as to create more targeted, efficient, and cost-effective responses.

Beyond advocating interventions at our respective meetings, for example, the Tripartite should aim at joint country

support to ensure participation of all relevant ministries and stakeholders. Similarly, beyond pursuing fragmented attempts at strengthening surveillance of AMR, the Tripartite should help integrate surveillance data so as to further establish the relationship between agriculture practices and their impact on human health. This strategy is well aligned with the Global Plan and will stimulate interventions that are people-centered, comprehensive, context-specific and preventive.

Fortunately, we are in an outstanding position to bring our joint expertise to bear. As many of you will know, WHO has worked for a number of years with FAO and OIE. Through this collaboration we have been providing governments a neutral platform for dialogue and negotiation, and coordinating global activities to address health risks at the animal-human-ecosystems interfaces.

It gives me great pleasure to note that this collaboration has been immensely successful. Indeed, at the global level it has led to many effective initiatives. The FAO-OIE-WHO Global Early Warning and Response System for zoonoses is one example. This system works to inform prevention and control measures related to zoonotic diseases, and to ensure rapid detection and risk assessment of health threats and events of potential concern.

WHO has worked for a number of years with FAO and OIE

WHO and FAO's INFOSAN initiative is another example. This mechanism promotes the rapid exchange of information during food safety related events; the sharing of information on important food safety related issues of global interest; the promotion of partnerships and collaboration between countries, and between networks; and helps countries strengthen their capacity to manage food safety emergencies.

At the regional level, our collaboration has primarily focused on advocacy related to the One Health approach, with a specific focus on three priority areas: food safety, avian influenza, and AMR. But despite growing awareness and recognition of the importance of the One Health approach, as well as the need for interdisciplinary and intersectoral cooperation in the control of zoonotic diseases and other emerging infectious diseases, the application of the One Health approach in practice is relatively limited. Long-standing challenges have been

recognized, including difficulties in managing multi-sectoral collaboration and coordination, insufficient decision-making based on scientific evidence, limited capacity and the absence of adequate guidance.

WHO is committed to overcoming these barriers and operationalizing the One Health approach across the South-East Asia Region. To do so we must work towards a joint understanding of risks and the joint development of activities and recommendations. The resulting synergy will better guide national authorities in their efforts to draft AMR-specific national action plans and implement One Health measures more broadly.

At the same time as focusing our efforts on informing policy at the national level, we must also work to raise awareness among NGOs and civil society more generally. 'One Health' must become part of the common lexicon, with widespread understanding of what it means and the responsibilities and action points it entails. Indeed, the One Health approach must be considered an inseparable part of achieving health security, a concept that has now entered the mainstream and which has become a core part of WHO's work.

As part of this wider push, in coming months I shall make the case for obtaining sustainable funding to implement the One Health approach. I will also be seeking external evaluations of the impact and lessons learnt from past efforts to stimulate multisectoral engagement.

As WHO South-East Asia moves this agenda forward, I take this opportunity to applaud the Centre for Science and Environment's leadership in organizing this workshop. This is the first workshop with high-level WHO, FAO and OIE officials in the Region to focus on the specific concerns of developing countries as they relate to AMR and the One Health approach.

And at the outset of this most valuable of workshops, I also take this opportunity to assure you that WHO stands committed to supporting these efforts with advocacy, capacity building and technical assistance, as well as aiding resource mobilization. WHO looks very much forward to achieving Region-wide compliance with the Global Action Plan, and welcomes the important milestone this workshop represents.

Role of WHO Collaborating Centres

It gives me great pleasure to welcome you to this Regional consultation of WHO Collaborating Centres in the South-East Asia Region. This is especially so as it is the first such event since I assumed office as Regional Director.

I strongly believe that the WHO South-East Asia Region is strengthened by our collaborating centres which work in support of WHO's mandate and priorities. The SEA Region sees the CCs as an impressive and valuable network of cutting edge health institutions, not just valuable for the country in which the CCs are located but also beyond. These are institutions that have been strong allies of WHO in its work for years, helping WHO implement its mandated work and achieve current goals. These centres are selected after going through a rigorous review process to ensure that we have the best hands supporting us.

This collaboration brings substantial benefits to both parties. WHO gains access to top institutions worldwide and the institutional capacity to support its work. Similarly, institutions designated as a WHO Collaborating Centre gain increased visibility and recognition by national authorities, and greater attention from the public for the health issues on which they work. This win-win relationship between WHO and its collaborating centres makes a difference to public health globally. WHO encourages every designated institution to benefit as much as possible from this formal relationship. The region's priorities have obviously emerged as a direct reflection of country realities and were developed in response to them. There will be ample opportunity through this regional consultation to discuss where the CCs can play a more active role with the Flagship priority areas and promoting capacity-building at the national and regional levels in these. Significant contributions by collaborating centres have been observed in

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Regional consultation of the WHO Collaborating Centres in the South-East Asia Region, 20–21 October 2016, New Delhi, India

recent successes such as the Region being certified polio-free, malaria elimination from Maldives and Sri Lanka, the elimination of mother-to-child transmission of HIV in Thailand, as well as several other instances.

I am proud that the Region today has 96 collaborating centres and I am particularly delighted that most of the centres are represented here, alongside government officials from a number of countries. The objective of having so many collaborating centres is that these provide a platform for the Region to enhance collaboration across a large gamut of disease clusters in order to strengthen WHO's work in this part of the world which bears a high burden of disease. It also brings in the diversity of various disciplines, which is much-needed.

Your participation and presence is a clear indication that, like WHO, you value the role that collaborating centres play in working to address the health challenges of our Region.

The collaboration between your centres and WHO South-East Asia is critical for moving ahead together in a more coordinated and efficient way amid an evolving health scenario. As we strive to realize the Sustainable Development Goals, as well as achieve the unfinished agenda of the Millennium Development Goals, it goes without saying that our work is laid out for us. In this regard, strengthening our collaboration and capacity is vitally important.

When I assumed this office, I was acutely aware of the public health challenges that lay ahead for the Region. To address these challenges, I proposed the "1 by 4" plan. As you may be aware, "1" refers to a more responsive WHO; and "4" refers to four strategic areas of operation. These include:

1. Addressing the persisting, emerging epidemiological and demographic challenges;
2. Promoting universal health coverage and building robust health systems;
3. Strengthening emergency risk management for sustainable development; and
4. Articulating a strong voice in the global health agenda.

Since this plan was proposed, seven Flagship priority areas were developed that you will no doubt hear more about during the meeting, particularly with reference to their deliverables. There will also be ample opportunity to discuss where the collaborating centres can play a more active role in working on these Flagship areas and promoting capacity-building at the national and regional levels.

Indeed, at this meeting you will be fully briefed on WHO South-East Asia Region's plan of work and, therefore, be able to engage with us to more productively move forward. But beyond this very important outcome, at this meeting we also have the opportunity to establish new ways of working together.

Since collaborating centres were first established in 1948 they have provided a valuable network of cutting-edge public health institutions

Since collaborating centres were first established in 1948 they have provided a valuable network of cutting-edge public health institutions, both within countries and beyond. Similarly, they have also pioneered important research, and been a source of innovative ideas, helping to advance thinking on critical public health issues in the Region. In this sense, they have functioned true to their mandate as an extended arm of WHO. We must escalate the involvement of collaborating centres in our Programmatic areas to get maximum benefit from their expertise and experiences. There should be greater participation of WHO collaborating centres in WHO meetings and other activities to facilitate the intense interplay of knowledge, research, and its implementation.

Nonetheless, one way to deepen this collaboration further is through developing a regional platform to enhance multilateral networking and joint activities among the collaborating centres themselves. I would urge all participants to put their heads together and device a functional, effective and sleek network of WHO CCs in the Region that would not only make the research more worthwhile but also more commendable and more widely and readily acceptable. Not only would this benefit collaborating centres and boost the resources that can be drawn upon, but would also benefit Member States across the Region and, of course, the Organization itself.

Under such an initiative, the value of each collaborating centre would be multiplied, thereby quickening the march

towards achieving the SDGs. Creating this platform is clearly something that is possible; similar networks already exist at the global level, providing a blueprint on how we can do it here.

I anticipate your enthusiasm for this proposal and look forward to hearing your thoughts on how we can work together to make it happen. As I said in my inaugural speech when I assumed office, I believe we in the South-East Asia Region have the possibility and opportunity to show leadership in all areas of global health. Over the coming days we have the potential to demonstrate this.

I know that during this meeting you will share your ideas and thoughts on how best to translate the Regional Priorities into meaningful action. That is exactly what we are eager to hear and discuss. A similar exercise was done for research where knowledge was translated to tangible products, practice and policy. I expect you to have a fruitful dialogue on how to make our collaboration work in innovative ways. This is what we are counting on. Your recommendations would be taken seriously and acted upon. That is at the core of this consultation.

It is only by working together that we will translate our vision into reality and make a difference right across the Region. We have the tools, the talent and the potential to achieve the goals we set for ourselves, so let us bring all of our capacities together to make the progress we envision.

Prevention and control of hepatitis

Over the past 15 years public health authorities and governments have shown admirable focus in the battle against infectious diseases such as AIDS, tuberculosis and malaria.

Remarkable progress has been made in controlling each one of these life-threatening conditions, with high-level efforts translating into broad public awareness of how to prevent, detect and treat them.

Under the Sustainable Development Goals the battle is set to continue: All three diseases are targeted for global elimination.

In the South-East Asia Region viral hepatitis kills approximately 350 000 people every year

Indeed, we are living and working in an exciting time for disease control, and we look forward to moving ahead and achieving the goals set before us.

But even as we enter the final stages of what has been an epic battle against these major killers, our progress must not come at the expense of other public health concerns. The danger of thought-silos, of tunnel vision, and of a loss of perspective is real. And as history demonstrates, it can prove inimical to public health.

I make this point, to underscore the ongoing tragedy that viral hepatitis represents, and the need – as public health advocates and practitioners – to keep it high on our agenda.

In the South-East Asia Region viral hepatitis kills approximately 350 000 people every year. It is responsible for more deaths in the Region than HIV and malaria combined, and is second only to tuberculosis as a major cause of death.

Across South-East Asia, viral hepatitis is driving rates of liver cancer and cirrhosis and is a substantial contributor to

Address at the Global Event on World Hepatitis Day, 28 July 2016, Mumbai, India

premature morbidity and mortality. As some of you may be aware, India is particularly burdened, accounting for around 60% of the Region's hepatitis-related deaths.

Evidently, viral hepatitis is not something we can afford to ignore. It is immensely encouraging, therefore, to see you gathered here to mark World Hepatitis Day.

Given that hepatitis is largely preventable, there is much that we can do to alleviate the burden.

Harm reduction programmes can halt the spread of hepatitis C and other blood-borne diseases among intravenous drug users. Safe practices related to injections, blood transfusions and other procedures can diminish the spread of hepatitis B and C among health care consumers. And the availability of hygienic and clean food and water can reduce the risk of hepatitis A and E infection among the public more generally.

Of particular note in the prevention of hepatitis B is the fact that we have at our disposal an extremely effective vaccine. By administering the vaccine within 24 hours of birth, followed by two to three doses in the first six months of life, mother-to-child transmission of the disease can be prevented.

This is very important: Children who acquire hepatitis perinatally are most likely to develop chronic Hepatitis B infection. And these chronically infected persons are also at great risk of developing cirrhosis or liver cancer.

In recent years political commitment to fight viral hepatitis has steadily crystallized. Whereas viral hepatitis was absent from the Millennium Development Goals, SDG 3.3 now includes specific mention of the need to strengthen efforts to combat the disease. In May this year the World Health Assembly approved a Global Health Sector Strategy on Hepatitis that calls for ending the problem by 2030.

The South-East Asia Region has developed its own action plan to address viral hepatitis, with countries now devising national action plans that can provide the strategies and infrastructure necessary to combat the disease effectively.

Alongside the creation and implementation of such plans, we are working on other key outcomes. These include:

First, reducing hepatitis seroprevalence among children under five to less than 1% by 2020. To do this, scaling up Hepatitis B vaccination at birth, followed by 2–3 doses of routine childhood vaccination, is essential.

Second, overcoming challenges in diagnosing hepatitis. WHO will soon issue new viral hepatitis testing guidelines that need to be rapidly adopted and implemented Region-wide.

And third, surmounting access-barriers to effective drugs such as tenofovir and the 12-week hepatitis C oral antiviral regimen. To this end, we are exceedingly fortunate to have India as a partner that we can rightly call the 'pharmacy of the developing world'.

In the face of the acute public health challenge posed by viral hepatitis we now have hope. We have the means to prevent most hepatitis cases from occurring in the first place, and we have a range of powerful tools to treat the disease. In India it is encouraging to see prominent personalities from the film world lend their voice to spread awareness and work with policymakers to address and arrest this epidemic.

We have the means to prevent most hepatitis cases

Given that effective tools and strategies for prevention and treatment are at our disposal, we cannot – and must not – accept the fact that hepatitis kills hundreds of thousands of people in our Region every year.

Indeed, let us use this World Hepatitis Day to open a new chapter in the Region-wide battle against hepatitis. I urge you all to go back to your ministries and departments; go back to your health facilities; go back to your media houses; and go back to your communities; and do your utmost to raise awareness of this ongoing tragedy and the need to take action against it.

Through commitment, determined action and the use of existing technologies, we can end hepatitis as a public health threat within the next 15 years. And we can do this at the same time as achieving other global disease control targets. In protecting and advancing public health, let our vision be grand and our horizon unlimited.

Elimination of lymphatic filariasis by Sri Lanka

It is with great pleasure and pride that I join you today to celebrate Sri Lanka's elimination of lymphatic filariasis as a public health problem.

As Sri Lanka's achievement underscores - lymphatic filariasis is a disease that should have no place in today's world.

It is a disease that disfigures and disables. And it is a disease that stigmatizes and impoverishes. Most importantly, though, it is a disease that can be prevented and eliminated.

In this regard, I congratulate Sri Lanka's health authorities for their concerted efforts in lifting the burden of lymphatic filariasis from vulnerable communities across the country, which is a true reflection of the strong commitment of the government to improve health of its people, particularly the most marginalized.

Given that Sri Lanka's campaign against lymphatic filariasis began in 1947, and was one of the first occasions that Sri Lanka and WHO worked together in the area of disease control, it is an extraordinary pleasure to be here today to mark the campaign's success. For that I am privileged.

Today's event is also of note, as it marks yet another achievement in our efforts to address Neglected Tropical Diseases across the Region.

Indeed, Sri Lanka, having eliminated lymphatic filariasis as a public health problem, becomes a beacon of hope to other countries struggling under the disease's burden.

That burden remains significant.

Award of LF Elimination Certificate to Sri Lanka, 19 July 2016, Colombo

Worldwide, 1.1 billion people in 55 countries are threatened by lymphatic filariasis and require preventive chemotherapy to stop the infection's spread. Over 120 million people are estimated to be suffering from chronic forms of lymphatic filariasis, with about 40 million of them left disfigured and incapacitated.

Sri Lanka's achievement demonstrates that the disease can be eliminated, and that the key to doing so is strong political commitment and effective deployment of evidence-based strategies.

After Sri Lanka's most recent elimination programme was launched in 2002, a number of key interventions were made. Vector control efforts were scaled up; case detection and treatment was intensified; surveillance systems were strengthened; mass drug administration campaign was rolled out; and community engagement and active participation was ensured. Each one of these measures contributed to the tremendous gains that made today's celebration possible.

Sri Lanka's achievement demonstrates that the disease can be eliminated

Sri Lanka has been consistently demonstrating its resolve to improve the health of its people.

Sri Lanka stopped poliovirus transmission way back in 1995 and has continued its effort to remain polio-free by keeping a strict vigil against poliovirus importation, and maintaining high population immunity through childhood immunization programme. The country achieved leprosy elimination target at the national level in the year 1999.

Sri Lanka has also stopped transmission of indigenous malaria in 2012 and would soon achieve malaria-free status, a major public health achievement keenly followed by many in the region and beyond. I look forward to visiting Sri Lanka yet again to share this success through WHO certification of elimination.

Sri Lanka's epidemiological profile compares well with some of the most advanced countries of the world. As most of the communicable diseases are being controlled and eliminated, it is non-communicable diseases that are becoming the rising public health challenge in the country. The health leadership

of Sri Lanka is making commendable efforts to prevent and control these diseases.

The strong political commitment of the Honourable President and the Health Minister are reflected in innovative initiatives being taken to tackle the problem.

The elimination of lymphatic filariasis demonstrates Sri Lanka's resolve to rid the country of Neglected Tropical Diseases, and this is making real change possible. It is this commitment that I believe will lead the way to make similar gains against other NTDs.

Beyond noting the importance of high-level resolve, I also wish to highlight the efforts of all those who contributed in bringing about this remarkable achievement.

I congratulate and salute the thousands of health workers who have worked tirelessly over the years towards the goal of eliminating the disease. I hope that all of us will take this opportunity to reflect on the importance of their work and their outstanding service to humanity.

This strong public health workforce and grassroot infrastructure that has won several battles against communicable diseases is now geared towards addressing prevention and treatment of non-communicable diseases. I am confident that their demonstration of successes will lead the region in facing these new and emerging challenges.

I also take this opportunity to congratulate Sri Lanka on its wider health sector achievements.

Sri Lanka's novel initiatives to improve access, quality, coverage and efficiency of the health systems to achieve Universal Health Coverage, is leading to massive gains for the health and wellbeing of all Sri Lankans.

It is indeed a pleasure to note that Sri Lanka's health system is the envy of countries, both rich and poor, across the world.

WHO continues to be immensely proud of being a credible and trusted partner of the Government and people of Sri Lanka, as part of its ongoing public health mission.

As part of this mission, though, we must remain cognizant of the unfinished agenda as well as upcoming challenges and how we can best tackle them.

In today's globalized world, we face emerging threats from outbreaks such as Zika virus, MERS corona virus and yellow fever.

To meet these and other threats it is critical that countries prioritize and invest in complying with the International Health Regulations and achieve core IHR capacities. I appreciate Sri Lanka's progress in this regard and look forward to even further growth in the future. I assure Sri Lanka of WHO's fullest support in achieving IHR compliance and enhancing the country's health security.

It is critical that countries prioritize and invest in complying with the International Health Regulations

Against this background I would like once again to reiterate my great pleasure to announce Sri Lanka as having eliminated lymphatic filariasis as a public health problem.

This is indeed a remarkable achievement not only for Sri Lanka, but for the wider South-East Asia Region and the ongoing battle against neglected tropical diseases.

Let me take this moment to once again express my heartfelt congratulations to the Honourable Health Minister and his team, and to the thousands of frontline health workers who toiled relentlessly in remote and difficult areas, and most importantly to the people of Sri Lanka for making such achievements possible.

Victory over yaws

It is a privilege to be here today to acknowledge and celebrate India's victory over yaws and its elimination of maternal and neonatal tetanus. These achievements build on a series of recent public health gains in India, including the remarkable accomplishment of being certified polio-free in 2014.

Given that India accounts for approximately one-sixth of the world's population, these victories are not only India's, but all of humanity's.

Most striking about the triumphs over yaws and maternal and neonatal tetanus is how a focus on health care access and equity made them possible.

As many of us know, yaws is a neglected tropical disease that commonly affects those who live on society's fringes, where health services are often found in short supply. As the old saying goes, 'where the road ends, yaws begins'.

Though the chronic skin disease is easily diagnosed and treated, it has remained a problem in recent decades despite first being targeted for eradication back in 1952. India's health authorities overcame it by carrying out a highly targeted education and early treatment campaign in vulnerable communities. This campaign was able to treat existing cases and disrupt onward transmission.

Significantly, India is the first country to gain yaws-free status under the 2012 WHO roadmap for the fight against neglected tropical diseases, providing important lessons for countries still struggling under the disease's burden.

Like yaws, maternal and neonatal tetanus – often referred to as the 'silent killer' – is a disease linked to health care

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Event to celebrate achievement of a yaws-free India and elimination of maternal & neonatal tetanus, 14 July 2016, New Delhi, India

inequities. It most commonly occurs among women and their newborns that have limited or no access to health care services. The only way MNT can be overcome is through increasing access to antenatal care and supervised births, as well as through expanding tetanus immunization coverage.

This is exactly what India has done in recent years, and which is responsible for eliminating the disease as a major public health problem.

But unlike yaws, tetanus will continue to be a threat as the bacteria that causes it occurs naturally in the environment. In acknowledging this, both tetanus immunization and safe delivery practices will need to be continued, taking care to ensure that marginalized communities are well-served.

The only way MNT can be overcome is through increasing access to antenatal care and supervised births

Beyond the importance of health care access and equity, I would like to draw your attention to a few other lessons that must be heeded. In this regard, I would like to make four points:

First, victories against yaws and MNT were achieved through the existing health system without establishing any vertical elimination programmes.

Second, no new groups of health workers were added to the health system; the cadre of existing staff managed it just fine. Of course, regarding the expansion of tetanus immunization we must acknowledge the contribution of the polio eradication experience and infrastructure.

Third, sustained political commitment over an extended period of time was essential to making progress against both diseases.

And finally, programmatic successes were facilitated by clear policies, unified strategies, close supervision and independent technical evaluations.

Each of these lessons must be fully comprehended, and must inform the design and implementation of future disease control programmes.

Before I conclude, I want to commend the Government of India for its foresight and vision, and sustained political and financial commitment to the battles against yaws and MNT.

I particularly commend the efforts of H.E. Mr J.P. Nadda, Honourable Health Minister, for leading his team so ably to accomplish these remarkable feats. The achievements made will not only improve the health of marginalized communities, but will also enhance their socio-economic status and contribute to India's wider development.

I also want to commend and thank the thousands of frontline health workers who, on a daily basis, toil under difficult circumstances to deliver these and other achievements. For their hard work and commitment we must all express our utmost gratitude. I take this opportunity to thank all partners, in particular UNICEF, for their support in making MNTE a reality.

I look forward to India's continued success in controlling diseases and advancing public health.

Elimination of mother-to-child transmission of HIV and syphilis by Thailand

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

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

On 7 June Thailand became the first country in Asia to be certified as having eliminated mother-to-child transmission

In Thailand today more than 95% of all pregnant women living with HIV receive antiretroviral therapy. The rate of mother-to-child HIV transmission is less than 2%.

Whereas at the turn of the millennium an estimated 1000 children in the country were newly infected with HIV, in 2015 the number of children who become infected was 85. This is a remarkable achievement in a country where an estimated 440 000 people live with the disease.

Indeed, for far too long it was assumed that only the wealthiest countries could obtain immediate access to biomedical breakthroughs, and that everyone else would have to wait years or even decades to benefit from lifesaving technologies. Beginning with AIDS, however, non-OECD countries have attempted to guarantee the same standard of care as is available among their wealthier peers.

In acknowledging Thailand's success in doing so, and in working to protect the health and wellbeing of future generations across the South-East Asia Region and the world,

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Address at the event to mark the elimination of mother-to-child transmission of HIV and syphilis by Thailand, 20 June 2016, Bangkok, Thailand

we must understand how Thailand's most recent achievement was made possible.

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

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

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

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

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

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

Indeed, Thailand has been home to some of the most important HIV clinical trials and implementation studies, including with respect to prevention of mother-to-child transmission.

Thailand's early pioneering of condom promotion for sex workers has inspired effective HIV prevention measures across the world, in both rich and developing countries alike.

And as Thailand's investments in health get the country on track to achieve the 90-90-90 target before the 2020 deadline, it is showing the entire world what it takes to fully leverage antiretroviral therapy to reduce new HIV infections and AIDS-related deaths.

Having eliminated mother-to-child HIV transmission, Thailand's efforts to end AIDs can now be focused on the MSM community, among whom the epidemic is increasing. It also has the opportunity to address HIV's continuing prevalence among drug users.

We must use this milestone as a springboard for other health gains

Given Thailand's successes and commitment, I am confident that the country will go from strength-to-strength in its battle to control the disease.

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

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

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

Prevention and control of malaria

You are well aware that we observe World Days for specific diseases of global public health importance. And the World Malaria Day is observed on this day, i.e. 25 April, to draw global attention to the achievements and the remaining challenges in the control and prevention of this age-old disease.

This year the theme of World Malaria Day is "End malaria for good," an ambitious goal indeed. The theme reflects the vision set out in the 2015 World Health Assembly resolution adopting the *Global Technical Strategy for Malaria, 2016–2030,* which sets out the ultimate vision of a world free of malaria and, for a start, the strategy aims to free at least 35 countries from malaria by 2030.

The years between 1998 and 2015 were indeed exciting for malaria control. From the launch of WHO's Roll Back Malaria initiative in 1998 till the end of the MDG era in 2015, unprecedented resources have been pumped into malaria control activities; the most significant initiative being the launch of the Global Fund to fight AIDS, Tuberculosis and Malaria, making available huge financial and technical resources to malaria endemic countries.

As a result of these intensive efforts and vast resources, since 2000, malaria mortality around the world decreased by 60%, and no fewer than 57 countries saw a 75% drop in malaria cases with an estimated saving of some 6.2 million lives. The MDG target of halting and reversing the global incidence of malaria between 2000 and 2015 was achieved. This is an outstanding achievement, a great humanitarian triumph that we can all be proud of.

During the same period, our Region also experienced a decline of about 85% in malaria mortality. And several countries are now free of malaria or on the verge of being free of

SEARO commemorative function on World Malaria Day, 25 April 2016

malaria; recently Maldives was certified as malaria-free. Similarly countries, such as, Sri Lanka and Bhutan are well on their road to eliminate malaria.

While these gains and successes are occasions for celebration, the task is far from done. Despite the good news, we must not be complacent. Over a billion people in the Region remain at risk of malaria, and over a million malaria cases are confirmed each year. Over 500 people in the Region still die annually as a result of malaria.

Why is that, you may ask?

Malaria thrives due to a complex interplay between the biology of the parasite, the evolving ecology of the vectors, human behavior and technological gaps.

Over a billion people in the Region remain at risk of malaria

The parasite's ability to evade human immune response and its ability to adapt itself to changing environment has not only led to rise of drug resistance, but also has prevented from developing an effective vaccine. Rapid urbanization and expanding human activity has produced ample breeding grounds for malaria vectors while, at the same time, population migration and economic activity have led to spread of malaria from one endemic area to another or from the forest to the urban areas. And coupled with these are emerging multi-drug resistance, insecticide resistance and the failure to develop sensitive diagnostic tools to detect malaria that continue to make malaria control more difficult than ever.

However, these should not deter us from re-doubling our efforts to control and prevent malaria. But I must emphasize that more of the same would not do; we have to make extraordinary efforts and go the extra mile and come up to innovative strategies if we are to gain further in our fight against malaria.

I would like to emphasize four key issues as we look to future malaria control.

First, the malaria eradication era has taught us that a vertical programme with no efforts to integrate into a stronger health system can neither achieve eradication nor, even if we did, sustain such a gain. Therefore, consistent with the broader

vision of the newly launched Sustainable Development Goals or SDGs, malaria control activities must become part of a stronger health system that builds local capacity and fosters national ownership.

Second, we must take advantage of the central theme of the SDGs to "leave no one behind." No effort must be spared to ensure that malaria control efforts address the hard-to-reach and the neglected communities. Malaria is increasingly a disease of the marginalized. For example most of the malaria affected populations in India live in tribal, hilly and inaccessible areas. Therefore, renewed commitment and efforts to build stronger partnerships and involvement of local communities from concept to implementation of control activities are important considerations.

Third, renewed political commitment at the highest level to the goal of time-bound malaria elimination must translate into greater fiscal allocation and to downstream action through real flow of funds to where it is needed most.

And *finally*, I would also like to say that malaria is engendered and sustained by conflicts that displace population as well as economic activities that move people in and out of malaria endemic areas. We need to strive for effective collaboration and efficient coordination across porous borders, not only to prevent malaria, but also to ensure a more systematic effort to provide an integrated, comprehensive range of health services which also includes malaria prevention and malaria treatment for such groups of people. Further, it is important to emphasize the importance and need to foster intersectoral collaboration as well as intercountry collaboration to address issues such as multidrug resistance, including resistance against artemisinin-based combination.

On the occasion of World Malaria Day today, I would like to reiterate WHO's commitment to the goal of malaria elimination. I assure you that I will make available whatever technical and other resources needed by our Member States for their malaria control programmes.

Leprosy prevention and control

It is my pleasure to be here to launch the Global Leprosy Strategy. Through several rounds of iterative discussions, in November last year, the leprosy programme managers finalized and adopted a realistic global leprosy strategy with a clear vision of a world free of leprosy.

Of the 213 899 leprosy cases reported in 2014, 94% came from just 13 countries. These countries are Bangladesh, Brazil, Democratic Republic of Congo, Ethiopia, India, Indonesia, Madagascar, Myanmar, Nepal, Nigeria, the Philippines, Sri Lanka and Tanzania.

Of the 213 899 leprosy cases reported in 2014, 94% came from just 13 countries

It is, therefore, appropriate that we are launching this important strategy here in India because it is still the country contributing the largest number of leprosy cases. India accounts for two-thirds of the new leprosy cases detected annually. And of the six WHO Regions, South-East Asia has the highest global burden. Ten of the Region's 11 countries continue to report cases.

The numbers are daunting.

However, that should not deter us from renewed efforts to address the unfinished agenda of leprosy control and prevention. The world has made progress, tremendous progress in fact.

In 1985, 5.2 million people globally suffered the disease. By 1995 that number was reduced to 805 000. The widespread and free availability of multidrug therapy or MDT, along with effective global collaboration and steadfast commitment, meant that leprosy was eliminated as a public health problem at the global level in the year 2000.

Since then, a series of five-year plans have guided efforts to eliminate the disease in areas where it remains. The Final

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Global Leprosy Strategy launch, 20 April 2016, New Delhi, India

Push Strategy for the Elimination of Leprosy, implemented between 2000 and 2005, focused on MDT and passive case detection. The Global Strategy for Further Reducing the Leprosy Burden lasting from 2006 to 2010, consolidated the principles of timely detection and effective chemotherapy in the context of integrated services. And the Enhanced Global Strategy for Further Reducing the Disease Burden due to Leprosy, which guided efforts between 2011 and 2015, focused on reducing leprosy-related disabilities.

The new Global Leprosy Strategy, which I am honoured to launch here today, aims at lightening this burden and accelerating the progress towards our goal of a leprosy-free world.

The strategy's targets are clear and unambiguous. By 2020 it aims to achieve the following:

First, to reduce the number of children diagnosed with leprosy and physical deformities to zero. Leprosy continues to afflict children, and all-too-often leaves them with lifelong disabilities.

The strategy is guided by the principles of accountability and inclusivity

Second, to reduce the rate of newly-diagnosed leprosy cases with visible deformities to less than one per million.

And third, to ensure that all legislation that allows for discrimination on the basis of leprosy is rectified.

The strategy is guided by the principles of accountability and inclusivity. More importantly, the strategy lays out clear actions for effective implementation. A strategy can only be as good as its implementation.

Clear actions for effective implementation require developing country-specific action plans to control and prevent leprosy. Such plans must be appropriate to the local epidemiological situations, and address the social, economic and political factors that underpin the barriers that foster environment for leprosy to continue to thrive.

Ensuring accountability means strengthening monitoring and evaluation in order to measure progress and achieve targets.

The performance indicators built-in the strategy must be used by countries to closely monitor the effectiveness of their efforts and to make adjustments accordingly.

And promoting inclusion means establishing and strengthening partnerships with all stakeholders, including persons or communities affected by the disease.

Despite many decades of advocacy, leprosy patients still continue to be discriminated against. This often pushes leprosy underground and hampers efforts to identify patients and, even if identified, for continuing appropriate treatment. Several leprosy-affected countries still have legislation in place that allows discrimination against those suffering the disease. But even where discrimination is not codified, social stigma remains. Stigma, therefore, impedes leprosy's early detection, particularly in children, and thereby increases disabilities. Timely diagnosis and treatment among children is essential to halting leprosy-related disabilities.

By impeding detection and treatment, stigma also facilitates transmission among vulnerable groups, including migrant populations, displaced communities, the very poor and hard-to-reach. More often than not, these vulnerable groups also lack access to essential services, making the expansion of health coverage critical. Indeed, the clinical resources we have for treating leprosy are incredibly effective; the only barrier we have is making sure that those needing treatment can access it in time. Combatting stigma, overturning the taboo on active case-finding, and expanding access to services are all emphasized in the new strategy and I have no doubt they will prove vital to our efforts.

WHO stands committed to the cause of a world free of leprosy. Leprosy, among other neglected tropical diseases, is important for the SEA Region and, therefore, is included in my Flagship Priorities to ensure it receives the highest attention, as well as significant additional funding.

We are highly appreciative of The Nippon Foundation through the Sasakawa Memorial Health Foundation, who remains committed to continuing financial support. And the strong and unwavering support of members of the International

Federation of Anti-Leprosy Associations is not only welcome but is highly appreciated.

Most importantly, we must note the increased financial contributions by national governments, particularly in the countries with the highest burdens. These contributions and commitments are the most effective and sustainable way to support leprosy control in areas where it is most required.

I hereby launch the Global Leprosy Strategy and let us, together, reinvigorate our commitments and our efforts towards a leprosy-free world and may our quest prove a resounding success.

Uniting to end TB

As public health advocates and practitioners, we often use words and slogans to advocate for public health results.

Inevitably, after much repetition, the meaning of these catch-all statements can become diluted. What were once galvanizing words of courage and vision become mantras devoid of inspiration.

As we enter a new era in TB care and control, the word 'bold' has increasingly come to define our thoughts, words and policy prescriptions. It is a term used in WHO's Global End TB Strategy, which was endorsed by the World Health Assembly in May 2014. And it is a term used in WHO-SEARO's Regional Strategic Plan, which will come into effect this year. As we at this meeting prepare to End TB, and to align national policies with the Regional and global plans, it is worthwhile to pause and reflect on this important concept: To be Bold.

Indeed, what exactly does it mean to be bold? Moreover, how and why is it desirable and what does it look like in real terms to be bold?

As we gather here today, being bold means acknowledging that to End TB, 'business as usual' is not an option.

The numbers in the South-East Asia Region are alarming.

Our Region is home to 26% of the world's population, but accounts for 41% of the global burden of TB.

Given the high disease burden of TB in our Region, delays in progress here will also impact progress at the global level. These delays also risk increasing MDR-TB transmission, which would, in turn, result in higher mortality,

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Unite to end TB: fast-tracking access to quality diagnosis and treatment, international meeting for ending TB, 21 March 2016, New Delhi, India

Make no mistake, however. We have made progress.

The South-East Asia Region has achieved the 2015 Millennium Development Goal of halting and reversing TB incidence. It has also achieved the Stop TB Partnership's target of halving the TB mortality and prevalence rates compared to 1990 levels. Access to TB care has expanded substantially. Almost 22 million TB patients have been treated in the past 10 years.

But it is not enough. Recognizing that these gains are inadequate is essential to pursuing bold new policies to accelerate progress. Current trends clearly show that without such policies and approaches, the SEA Region, including India, will fail to meet the SDG targets to End TB by 2035. In a Region with a high TB burden and high at-risk populations, we must think out of the box to find innovative ways to tackle the problem of TB.

I suggest the following four ways to move ahead.

We must address the social determinants of TB

First, alongside providing integrated, patient-centered care and prevention, achieving Universal Health Coverage is a priority. Universal Health Coverage means unreached and marginalized populations can access TB screening, and, if infected, can receive the care they need. With approximately 1 million missing cases in the Region, increased screening and treatment will also prove critical to stopping TB transmission, particularly of the disease's drug-resistant strains. Universal Health Coverage also allows the opportunity to implement more robust regulatory frameworks for case notification, vital registration, and rational use of medicines. In essence, it is indispensable in the battle against TB.

Second, we must address the social determinants of TB. TB remains a disease of the poor and the marginalized, with a disproportionate number of TB cases found among people living with HIV, migrants, refugees and prisoners. Addressing poverty and other determinants will have a dramatic effect on the disease's burden. Policies in this regard could include increasing access to safe housing and providing viable social security among other options. TB isn't only a health problem. Therefore its solutions must also encompass the full range of multisectoral dimensions and multi-stakeholder engagement. It is

one of those diseases that require health in all policies, coupled with strengthening the full spectrum of human rights that guarantee a TB patient the right to the best treatment possible.

Third, to End TB we must reach out to and engage with communities directly. Overcoming stigma, increasing awareness, and obtaining community buy-in at the grassroots is as valuable as any assemblage of experts and policymakers. Community engagement is essential for case detection, treatment completion, and addressing out-of-pocket expenditures. Forging partnerships with civil society groups and between public and private care providers will likewise ensure that present gaps are closed, and that a society-wide movement to End TB develops.

And fourth, political commitment at the highest level, which is already strong, must be reinforced. The mission-like zeal with which polio and HIV/AIDS have been fought must be reproduced in the battle against TB, and must lead to organizational and programming shifts. TB programmes must be given a special place within the health sector; structural and operational efficiencies maximized so that a strong, efficient and effective control programme exist in every country. Our commitment to these changes and the wider mission can only be expressed and measured via real-time programme delivery. In this regard, we are all on notice.

Finally, we must not forget that along with high level commitment and a strong programme, effective resource mobilization is essential to accelerate and sustain TB control activities. The funding required for a full response to the global TB epidemic in low- and middle-income countries was estimated at 8 billion USD per year in 2015. This figure excludes research and development. Based on reporting by countries, in 2015 6.6 billion USD was available for TB prevention, diagnosis and treatment, leaving a funding gap of 1.4 billion USD. International donor funding dominates in low-income countries. To bridge the funding gap, both domestic and international funding needs to be enhanced.

We must all renew our commitments.

To this end, the opportunity this meeting provides for countries to share experiences – both positive and negative – on TB control and prevention is immensely important. As Member States strive to align their national TB policies with WHO SEARO's Regional Strategic Plan, I can assure you of WHO's unflagging support. As part of the End TB strategy, WHO is intensifying TB-related research and innovation. The discovery, development and rapid uptake of new tools, interventions and strategies will optimize the impact of the Strategy, and will thereby enhance efforts to combat the disease.

On this occasion, I would also like to congratulate the initiative of India's Ministry of Health in convening this meeting and providing us this important forum. On the eve of World TB Day, India's commitment to addressing the TB problem and to working with other high TB-burden countries in the Region to share technical knowledge and best practices is heartening. With such a strong showing of senior health ministry officials and leaders from across the Region, I am sure the sessions will prove immensely informative and will stimulate much-needed thought, discussion and action.

We must unite to end TB.

Combating antimicrobial resistance

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

As is often the case, too much of a good thing is proving to be harmful.

We are now in a world where the efficacy of antibiotics is under threat

We are now in a world where the efficacy of antibiotics is under threat. Inappropriate use, widespread abuse for commercial gains, and a host of other misuse of antibiotics have led to resistance, resulting in approximately 700 000 people dying each year from conditions that were once easily curable. Already resistance to HIV drugs is rising; more than 100 countries report extensively drug-resistant tuberculosis, resistance against artemisinin-based combination therapies for falciparum malaria is reported. Hospital acquired infections with highly resistant ineffective organisms are now becoming daily realities. If the present trends continue, by 2050, rising AMR will contribute to more than 10 million deaths worldwide. In the looming post antibiotic era, skin sores and diarrhea could be untreatable; life-saving surgeries more risky.

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

Therefore, urgent action is needed.

Countries in the South-East Asia Region have been proactive in addressing antimicrobial resistance. Since 2010,

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Meeting on combating antimicrobial resistance: public health challenges and priority, 23–25 February 2016, New Delhi, India

several Regional Committee resolutions on prevention and containment of AMR have been adopted, the last being adopted by the RC last year in Timor-Leste. That resolution emphasized that "combating antimicrobial resistance shall require political commitment, multi-sectoral coordination, sustained investment and technical assistance," and it called on Member States to put AMR as one of the top priorities on their national agendas. Further, as early as 2011, the Honourable Health Ministers of this Region recognized the seriousness of AMR and adopted the Jaipur Declaration on Antimicrobial Resistance. It was an important and foresighted step to promote, at the highest level, awareness about the problem of AMR and to stimulate concerted efforts to tackle it. The Jaipur Declaration on Antimicrobial Resistance recognized the irrational use of antibiotics as the key driver of the emergence of resistance and advocated for a holistic and multidisciplinary approach to the control and prevention of resistance to antimicrobials.

When I assumed my responsibilities as the new WHO Regional Director for South-East Asia in 2014, to highlight the urgency needed to deal with this issue, I made AMR one of my flagship priorities for the Region. Identifying flagship priorities allows us to focus our resources to achieve clear deliverables, and to support countries to develop and implement realistic work plans.

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

In May 2015, the Sixty-eighth World Health Assembly endorsed a resolution making it mandatory for Member countries to align national action plans with the global standard by May 2017. WHO published the Global Action Plan on Antimicrobial Resistance to guide Member States in the development of their national action plans. At the UN General Assembly later this year a resolution on AMR is expected to be adopted. Concurrently, the commitment by G7 countries in Berlin in 2015, to promote the AMR agenda will likely be cemented at the G7 summit later this year in Tokyo.

We know the problem. We have committed ourselves to deal with it. International attention in AMR has crystallized and

global commitment is at its highest. And now, more than ever, is the time to start taking concrete actions on the ground; to walk the talk.

In this context, I applaud India's leadership in combating AMR. This meeting on AMR-related public health challenges and priorities will contribute to the development and implementation of national action plans in the Region – plans that will assess risks associated with AMR, as well as our response capacities. Since we cannot anticipate what pathogens may evolve, and on what scale they could harm, this planning will be vital. The meeting also provides an opportunity to renew commitments to the global agenda outlined in the World Health Assembly Resolution. Vigilance, risk assessment and risk management is the key.

AMR cannot be dealt with by the health sector alone

The key strategy is to have a holistic and multisectoral "one health" strategy. AMR cannot be dealt with by the health sector alone. In addition to easy access to medicines and over prescription, antibiotics use is on the rise in the animal and agriculture sectors. Therefore one of the key strategies in the Global Action Plan is to "optimize the use of antimicrobial medicines in human and animal health." To do this, strong coordination is needed among all sectors, including veterinary medicine, agriculture, and human. Given the multisectoral nature of AMR, the presence of the Ministry of Agriculture, FAO and OIE is vital and welcomed. We are inspired by the presence of the Honourable Ministers of Bhutan and Nepal. We are encouraged to see Permanent Secretaries of Health, many experts from countries of our Region and beyond, including France, Japan, the Netherlands, the UK and the US. It is indeed an opportunity to collectively develop meaningful and practical next steps in the fight against AMR. I urge you all to work together to take forward this momentum, both at this meeting and thereafter.

The stakes are high. We must guard our health security and fight antimicrobial resistance; we can only do it together.

Malaria elimination framework

The world has reached a critical juncture in the fight against malaria. In recent years the worldwide campaign against malaria has both picked up momentum and produced impressive results. Most importantly, Target 6 of the UN Millennium Development Goals, which aimed to halt and reverse the global incidence of malaria between 2000 and 2015, has been achieved. In continuation of this momentum, global leaders at the UN General Assembly last year pledged to eliminate malaria epidemic completely by 2030 as a part of the Sustainable Development Goals. Therefore, it is critical that we redouble our efforts to achieve this goal.

It gives me immense pleasure to share with you that the WHO South-East Asia Region has done well in the global campaign against malaria. In addition to halting and reversing malaria epidemics, an 85% decline in malaria mortality rates has also been achieved as compared to the situation in 2000. India, in particular, has made tremendous progress, bringing down total deaths by 39% and burden of malaria cases by 37% during the era of the MDGs. Other countries in our Region are also making good progress with malaria control and elimination activities.

Recently, I presented the certification for malaria elimination to the President of Maldives in recognition of their efforts that have kept the island nation free of malaria for 30 years. Likewise, since 2012 Sri Lanka has also reported no locally acquired malaria cases and has remained malaria free. Although malaria continues to occur in Nepal, malaria deaths have not been reported from Nepal since 2012. And the number of indigenous cases has fallen to almost insignificant level in Bhutan with no death reported since several years. Similar

Opening address at the launch of the national malaria elimination framework, 10–11 February 2016, New Delhi, India

decline of malaria cases is also seen in Democratic Peoples' Republic of Korea.

I would like congratulate the Government of India for its progressive efforts towards the elimination of malaria. India is the first country in the Region to adopt the targets related to SDG 3 by launching this National Framework for Malaria Elimination 2016–2030. The Framework provides a realistic roadmap towards elimination with a phased strategy, enabling those states with low incidence rates to take it up first, followed by those with higher-incidence.

I would like to emphasize that this is important not only for India, but will also have a positive impact on the global efforts towards a malaria free world. Outside of Africa, India accounts for the largest number of malaria deaths and new cases annually. What happens in India here will have tremendous impact on the speed and certainty with which the world can achieve global elimination of malaria.

Further, about 44% of all malaria cases in India occur in areas located along its national frontiers. Elimination of malaria in the frontier districts would directly influence the transmission in five neighbouring countries, namely Bhutan, Bangladesh, Myanmar, Nepal and Sri Lanka. The South-East Asia Region, and especially the countries bordering India, cannot eliminate malaria without India achieving this goal first.

One significant, and tangible, impact of elimination would be the escalation in inclusive growth of the populations otherwise left behind in the development index of the country. Although US$ 1.25 billion has been spent on malaria elimination in the last one decade, there are still reports of 17 million estimated cases with 26 000 deaths annually in the country. Of these 80% are confined to populations residing in tribal, hilly and inaccessible areas.

India's gains from the elimination of malaria will also go beyond just saving countless lives, and extend to the economic realm. In 2012, it was estimated that the total economic burden of malaria in India was around US$ 1.94 billion. Similar estimates for India during the late 1990s showed that for every rupee

invested in malaria control there could be expected a direct return of Rs 19.70. This means that implementing the National Malaria Elimination Framework 2016–2030 will translate into benefits exceeding 20 times the investment and costs.

However, I would like to point out that "business as usual" will not suffice if we are to achieve these ambitious goals. The task of malaria control and subsequent elimination will be faced with many challenges. The SEA Region experienced the lowest decline in cases of new infection in this decade compared with other regions of the world. The 2015 Global report on malaria revealed a 55% gap in India's resources for malaria elimination.

A sense of urgency is a must to continue the momentum towards India's malaria elimination goal. Early diagnosis of the problems and speedy corrections are imperative, without having to wait for annual survey reports. Real-time monitoring and efficient redressal of programmatic bottlenecks are essential if elimination is to succeed.

India has a vast pool of technical expertise whose potential must be tapped to deal with the huge burden of plasmodium vivax malaria,and the rapid development and spread of mosquito resistance to insecticides, as well as multidrug resistance, including to artemisinin resistance now seen in the Greater Mekong Sub-Region.

Achieving the goal of malaria elimination would need a paradigm shift

Achieving the goal of malaria elimination would need a paradigm shift in the approach to the problem. India has never been short of innovation, technological expertise or management excellence in the past in all areas of health, and specifically in malaria. The malarial parasite was not only first discovered in India, but the first Nobel Prize for Medicine was also awarded for work carried out in this country. Chemo prophylaxis was in practice since the early 1850s and a study on the economic impact of malaria, possibly one of the first health economics studies in the world, was carried out in India in 1911.

This is a crucial moment for all of us. We have a "make or break" opportunity for the country and the Region. I pledge my full personal and WHO's support for this effort, and in particular to facilitate and enable the implementation of cross-border

programmes with Member States and with partners such as Global Fund and APLMA.

Nothing stops us from aiming for an even quicker time schedule for the elimination of malaria. Many of you are aware that a bulk of malaria resistance cases historically emerged from the Greater Mekong region and spread all over the world. Recent studies on artemesinin resistance show that the faster we achieve the targets of malaria control and elimination today, the more will we be saving our precious resources for tomorrow.

I would like to encourage India to critically examine how we can fast-track some of the operational targets in five years' time, without waiting for the threshold of 2025. The earlier we eliminate such diseases, the more we can save resources for the emerging threats of NCD as well as for building a stronger health system. Malaria elimination, though an ambitious target, is possible and achievable in this Region. We will make it a success by working together with renewed commitment.

Leprosy control efforts

This is a very important meeting for leprosy control efforts worldwide, and it is our privilege to host it in the Regional Office of WHO South-East Asia.

The strong and enduring partnership between WHO and the Sasakawa Memorial Health Foundation and The Nippon Foundation has contributed much to the global efforts to control and eliminate leprosy. As of now, most countries of the world have achieved the leprosy elimination goal at the national level, and we stand poised to make further gains as there is strong political will in the endemic countries to do whatever it takes to eliminate this dreaded disease, not only at the national level, but even at the sub-national level too. And I am confident that we can achieve that because of two very favourable circumstances; first, the continued and generous support of The Nippon Foundation through the Sasakawa Memorial Health Foundation and, second, the visionary leadership of the WHO Goodwill Ambassador for Leprosy, H.E. Yohei Sasakawa, without whose commitment and personal engagement in leprosy activities, the world would not have reached where we are today. For that, I wish to place on record our appreciation and gratitude to both the Sasakawa Memorial Health Foundation and the Nippon Foundation, and to Mr Sasakawa, in particular.

But there is still much work to be done.

Available data from Member States still show that new leprosy cases were reported by 110 countries and territories in 2014. In the same year, there were at least 213 899 new cases registered. The annual new case-detection rate remains static at around 220 000 for the past 10 years. The 2014 data indicates that about 6.6% of new cases detected were with

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Sasakawa Memorial Health Foundation (SMHF) Advisory Board Meeting on The Nippon Foundation (TNF) funding to WHO's Global Leprosy Programme, 11–12 January 2016, WHO-SEARO, New Delhi, India

visible deformities, indicating weak surveillance and consequent delayed detection. What is even more worrying is that 8.8% of the new cases were children, signifying continued transmission of infection in endemic communities.

In brief, the data suggests that there is stagnation in leprosy control; and that the bulk of the disease burden is now limited to a few countries. Early case detection, timely treatment completion and inclusion of persons affected in delivering leprosy services are critical for the elimination of the disease.

There is hope. The 2013 Bangkok Declaration reaffirmed the commitments from the highest level of 17 high leprosy endemic countries towards a leprosy-free world at the earliest. And today, in this room, are gathered the leaders of the key funder of global leprosy efforts whose support and commitment have never wavered in these years. Through several rounds of iterative discussions, the leprosy programme managers meeting of November 2015 finalized and adopted a clear and a realistic global leprosy strategy 2016–2020 leading us forward towards a world free of leprosy.

There is stagnation in leprosy control

Therefore, I believe this consultative meeting is an important opportunity to discuss the current leprosy situation, the progress achieved and what needs to be done to implement effectively the Global Leprosy Plan of Action for year 2016. The meeting comes at a most appropriate time when the global leprosy strategy for the period 2016–2020 is being readied for adoption by Member States.

The strategy calls for results-oriented action that ensures accountability in implementation and promotes the inclusion of all stakeholders in overcoming the remaining challenges on the road to elimination of leprosy. The strategy advocates three pillars of action:

- strengthen government ownership, coordination and partnerships;
- stop leprosy and its complications;
- stop discrimination and promote inclusion.

Building upon the political commitment mobilized by the Bangkok Declaration towards a leprosy-free world, the strategy will make a significant impact in overcoming the remaining challenges in eliminating leprosy as a public health problem in all countries at the national and subnational levels.

The strategy brings about a stronger focus on early case detection with targets of achieving zero disabilities among new child leprosy patients; reduction of grade-2 disabilities to less than one case per million population by 2020 and elimination of leprosy at subnational levels.

As you all well know the cost per case found and managed goes up considerably as a disease gets rarer. Therefore, more efforts and more resources will be needed to realise the goals of this revised global leprosy control strategy. And I am sure this important gathering will address adequately the resource gaps to accrue tangible results for our efforts to rid of leprosy.

I would like to thank The Nippon Foundation for the additional funds to implement the Bangkok Declaration to further reduce disease burden of leprosy in high-endemic countries. Special projects under this initiative are being implemented in seven high-burden countries.

In our effort to strengthen technical capacity in leprosy, particularly for the strengthening of monitoring of leprosy elimination, a pool of consultants, as Leprosy Programme Monitors, has been created by WHO and made available to Member States to support leprosy programme at the subnational level.

Finally, I would like to emphasize that I have given the highest focus on leprosy work in the Region by including it in the list of Flagship Priorities, and I will continue to do so. I would also like to reiterate that WHO stands ready to support countries in whatever manner necessary, and we look forward to continue the strong relations between WHO, the Sasakawa Memorial Health Foundation, and The Nippon Foundation.

Global leprosy programme

It is a great pleasure for me to welcome you to Delhi and to this global meeting of managers of national leprosy control programmes. I see that we have programme managers from the regions of Africa, America, Eastern Mediterranean, Western Pacific and, of course, South-East Asia. Further, we are fortunate that we have the rare privilege of having so many leprosy experts gathered in one room.

As early as 2000 the elimination goal of leprosy as a public health problem at the global level was achieved. Yet in 2014, 215 656 cases of leprosy worldwide were reported. Why? We should ask ourselves that question. With the galaxy of experts and programme managers gathered in this room, we must not miss this opportunity to shape a meaningful and effective strategy to change this situation. Ten years from now, we should be in a position to say that leprosy has been eliminated from every district or similar administrative units of all countries currently endemic to leprosy.

96% of leprosy cases are limited to just 15 countries

The Global Leprosy Programme, in close consultation and collaboration with many partners and through an iterative process, has drafted a strategy for the next five years to accelerate reducing the leprosy burden. Since this meeting brings together all stakeholders in leprosy control, this is your opportunity to further improve this strategy before its official launch next year. It is my hope that by the end of this three-day meeting, we will have a realistic and an effective leprosy control strategy for the next five years which everyone agrees to.

But it is not enough to have a strategy. We have to implement such a strategy and implement it with vigour. If you look at the global epidemiology of leprosy, 96% of leprosy cases are limited to just 15 countries. And because 72% of

Global meeting of national leprosy programme managers, 23–25 November 2015, New Delhi, India

leprosy cases are reported from the South-East Asia Region alone, I have put leprosy on the highest agenda in my region; leprosy is one of the flagship priorities I identified so that it gets adequate resources and support for the programme to intensify efforts to improve this situation. Other flagship areas – such as universal health coverage, aiming to provide access to a defined package of health services at an affordable cost, or addressing antimicrobial resistance – also have links with leprosy control. Synergies can thus be defined with other programmes or cutting across health system components. The Sustainable Development Goals, as adopted by the United Nations General Assembly last September, also provide an anchor to link leprosy with the wider development agenda of ending poverty, reducing inequalities, building happy communities and promoting partnerships. I believe it is important to grasp these opportunities when elaborating the five-year strategy to control leprosy.

It is clear that even in the endemic countries leprosy is not uniformly distributed and the high prevalence is usually confined to defined narrow geographic regions or in certain endemic pockets often referred to as "hotspots." The challenge for the leprosy programme is to identify these pockets and to aggressively search, treat and follow up leprosy cases till such hotspots are cleared. We know this epidemiological aspect of leprosy, we have the tools and means to detect and treat leprosy, but we are not succeeding. This meeting must think of the reasons why we are not succeeding and come up with measures that will change this situation.

I may mention that to identify correctly the hotspots for leprosy, the national programme has to have a good surveillance and reporting system in place. You need to review your information system for reporting and tracking leprosy cases so that where weaknesses exist, they are addressed appropriately. Intensified case finding coupled with effective and completed MDT treatment still remain the core tenets of leprosy control. Therefore, I urge all countries still endemic to leprosy to strengthen their systems for early case detection and complete treatment so that the burden of leprosy is reduced and visible deformity prevented.

Leprosy is not like any other disease. Age-old stigma around the disease makes it a challenge to find cases early enough and to complete treatment. And those who develop visible deformities, rehabilitation and re-integration into their own communities become a major challenge. But we must spare no efforts. Let us not forget that a leprosy patient deserves to be treated with dignity and respect, and not just as a mere statistic. Therefore, any strategy that you develop must include the social aspect of leprosy for a holistic approach to its control and prevention.

Research is a relatively neglected aspect of most disease control programmes. I would like you, the experts in this room, to think about research needs to strengthen the control programme. Apart from research on drug resistance, which is an emerging problem, we also need to identify important implementation research agenda so that knowledge gained is translated into action thus spurring further search for new knowledge to improve our future strategies to control and prevent leprosy.

With these few remarks, I would like to wish you fruitful discussions and deliberations. I have kept leprosy prominent on my own agenda. I also assure you of my commitment to push forward whatever agreed strategy you present me.

Ebola preparedness and response

It is indeed a great privilege and honour to be here at this important meeting so kindly hosted by the Royal Thai Government to share with you some of the work done in the Regions to combat emerging infectious diseases especially Ebola Virus Disease.

At the outset I wish to commend the Honourable Health Ministers for their astute leadership in rapidly enhancing the state of preparedness against Ebola Virus Disease in their respective countries. With Your Excellencies sustained efforts, we are sure that should a case of Ebola Virus Disease occur in this part of the world, our Member States shall be able to mount an effective response for swiftly containing this disease and preventing its spread amongst our communities.

In preparing to deal with emerging diseases two Regions of WHO, namely the Western Pacific and South-East Asia, have the Asia Pacific Strategy for Emerging Diseases or APSED. This bi-regional mechanism for preparedness and response against emerging and re-emerging infectious diseases was revised in 2010 to align it with the International Health Regulations - IHR (2005).

It gives me immense pleasure to report to you that joint development, implementation and sustenance of APSED has been possible because of your support and the keen desire of Dr Shin Young-soo, Regional Director, Western Pacific Region, and myself to provide comprehensive support to our Member States without any limitations of boundaries and administrative structure of WHO offices.

To address the specific needs of Greater Mekong Sub-region, which is again a special and unique geographical area

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Address at the ASEAN + 3 Health Ministers' Meeting: build up regional mechanism for Ebola preparedness and response, 15 December 2014, Bangkok, Thailand

in the context of its public health importance for emerging infectious diseases, both Dr Shin and I have strengthened and further empowered the network of WHO Representatives of these six Member States of the two Regions. This will facilitate better understanding of disease epidemiology in this area and a coordinated response.

The International Health Regulations (2005) articulated and advocated the need for sharing information in almost real-time and establishing capacity for early detection, diagnosis and control of serious events which may prove to be public health emergencies of international concern. All Member States have been working vigorously to achieve these capacities. From 11 Member States of WHO South-East Asia Region, Indonesia and Thailand - both ASEAN countries - have already declared themselves to be IHR (2005) compliant. Other countries are also targeting to attain this compliance by mid-2016. This state of preparedness and enhanced response capacity are considered to have played a critical role in having lesser mortality in 2009 influenza pandemic as compared to all previous such pandemics. WHO will continue to collaborate with all Member States in assessing the state of preparedness in responding to the threat of emerging diseases and provide them all possible technical support that will make them compliant with IHR (2005) core capacities within the next two years. We are hopeful that investments made by Member States in IHR (2005) will yield immense value to countries in the fight against Ebola.

With the commitment of national authorities at the highest level, and with technical support from WHO offices, all countries have established multisectoral committees to coordinate preparedness and response, enhance essential capacity for screening at ports of entry, designated facilities for isolation and management of cases, a mechanism to confirm laboratory diagnosis, trained health workers in infection control practices and ensured effective communication to obviate panic and fear.

The coming together of the ASEAN+3 countries to discuss Ebola, although we do not have any case in any Member State is indicative of the concern about Ebola that countries have, and also demonstrates the solidarity that underpins our desire to ensure full preparedness and, in the unlikely event of a case,

a robust response, characterized by regional collaboration and open communication, to control it. The UN Secretary General recently said that the deadly Ebola outbreak can be ended "by the middle of next year" if the world speeds up its response. However, he cautioned that "our end game is not clear. We must get to zero cases. Ebola is not a disease where you can leave a few cases and say you've done enough." Therefore, we need to do more, both in our own countries as well as to contribute to the global efforts.

In moving forward our focus must be to leverage preparedness measures to strengthen health systems so that they are able to absorb shocks or impacts of such events. ASEAN Member States are no stranger to these shocks and they have bounced back, not only from pandemics and outbreaks, but also from other devastating disasters such as tsunamis and cyclones. It is a perfect opportunity to re-invest in public health capacities with focus on IHR (2005) core capacities and see Ebola preparedness as not a one-off event but the opportunity to be strategic, so that health systems are more robust and resilient in the future.

Our focus must be to leverage preparedness measures

The outbreak is still ongoing in West Africa – and seems to continue to run ahead of all responders. Let us remember then that although we are preparing we should think of contributing to controlling the outbreak at source- we need to contribute to the ZERO CASE goal. It is with this two pronged strategy for better preparedness that contribute to zero case and investing in resilient health systems that Ebola can be halted. SEA Region has already deployed over 50 of its staff and we have several more ready to go to West Africa as and when needed.

WHO stands ready to provide whatever support is necessary to our Member States and I affirm my full commitment to ensure that we are with you in these difficult times. WHO is committed to work together with all Member States and partners through a coordinated approach between all its offices to provide the best possible support to control Ebola in West Africa. I look forward to the deliberations in this meeting and, more importantly, to Your Excellencies' guidance and leadership in dealing with this global crisis.

Ebola outbreak

As you are all aware, several countries of West Africa are in the grip of a terrible tragedy brought on by an unprecedented and largest ever outbreak of Ebola. And the whole world stands with bated breath as the disease threatens all countries. I have invited you here today to provide you an update on the status of the epidemic, risk to this Region and the steps we have taken to support our Member States in their preparedness to deal with this disease, should it strike our shores. The Ebola virus disease outbreak has created a complex emergency situation with significant social, economic, humanitarian, and political and security dimensions in Africa. I also wish to seek your support in supporting global efforts in containing this dreadful disease and preventing its occurrence in our Region.

Ebola virus disease is not a new disease

Ebola virus disease is not a new disease. It was detected for the first time in 1976 and, since then there were more than 20 outbreaks of this disease. Those were small and localized outbreaks affecting people in sparsely populated communities often living far in the interior of the affected countries. The current outbreak, which started almost a year back, is much bigger than all previous outbreaks put together and has reached crowded urban settings resulting in the eruption of the disease in multiple locations. Further, the weak health systems in these countries have further fuelled this outbreak in West Africa.

As of 30 November 17145 cases and 6070 deaths have been reported from Guinea, Liberia and Sierra Leone. Nigeria, Senegal, the United States of America, Spain and Mali have reported a limited number of cases. What is worrisome is the fact that there are few signs that the outbreaks in any of the 3 highly affected countries are coming under control. And according to a recent World Bank assessment, the total financial impact for 2014 and 2015 can be upto 32 billion USD for Africa.

Partners' meeting, 5 December 2014, WHO-SEARO, New Delhi, India

As of today, no vaccine or medicine is available against Ebola virus. This makes prevention and control of this disease far more difficult as compared to many other viral illnesses. Though scientists are working very hard to develop drugs and vaccines against Ebola, as of now these products still remain in their early phases of development. WHO has also fast tracked the mechanism of approval of these products to accelerate their availability for the people in need. We are hopeful that some of these products will become available my mid-2015.

Amidst this gloom and doom, there are rays of hope too. Senegal and Nigeria have controlled Ebola with no more new cases reported, and have now been declared as Ebola-free. The situation in Liberia seems to be stabilizing, and there has not been any further new infection outside of Africa. These successes are encouraging since they demonstrate that with the available interventions and strong multisectoral response, the disease can be contained.

The global response in West Africa is also being accelerated. It is based on a sound strategy that has 5 Objectives which go beyond the health dimension. These are: stop the outbreaks, treat the infected; ensure essential services; preserve stability; and prevent further outbreaks. The strategy is being implemented by the United Nations Mission for Ebola Emergency Response – UNMEER. The establishment of this Mission is unprecedented in the UN history and it is the result of resolutions adopted by both the United Nations General Assembly and the UN Security Council. It goes to show the urgency to deal with this public health emergency and demonstrates the global solidarity with the affected countries of West Africa in responding to this crisis.

This Mission will bring together the vast resources of the UN system to reinforce WHO's technical expertise and experience in disease outbreaks. This Mission aims to have, by January 2015, the capacity in place for the isolation of 100% of Ebola cases and the safe burial of 100% of Ebola victims.

I'm sure some of you may be wondering about the risk of Ebola for this Region.

The risk of an Ebola outbreak in the WHO South-East Asia Region exists but the risk is relatively low. The virus is not indigenously present in our Region. It can only be brought by an Ebola patient or by someone who is incubating the disease but is not clinically ill when such a person travels from affected areas to our Region. Transmission of disease from patient to other people is not very rapid. The only mode of transmission is by direct contact with a patient of Ebola. It is important to know that this virus is not transmitted through food, water or air. Prevention of contact with a patient of Ebola and, in cases of inevitable potential contact, as for health care workers and care providers, proper application of rigorous infection control measures are the only ways to prevent further spread and contain this disease.

With the basic premise of preventing entry of an infected person, early detection of such cases, followed by their quick and effective isolation in facilities with appropriate infection control measures, as well as complete contacts tracing followed by surveillance of all contacts will ensure early detection and swift control of any potential outbreak in our countries.

All countries in our Region are on high alert and Health Ministers and senior government officials are continuously engaged in enhancing preparedness against Ebola. All countries are undertaking entry screening of passengers arriving from Ebola-affected countries, they have designated containment and case management facilities where suspected patient can be isolated and provided appropriate care; they also have established diagnostic services or mechanism for shipment of infectious material to WHO Network of Ebola Diagnostic Laboratories. The countries also have strengthened their surveillance and response capacity by undertaking simulation exercises to provide insights into gaps in their preparedness. In addition, countries have been briefing media and developing communication strategy to bring on-board the communities to obviate panic amongst them.

Several countries of this Region, namely India, Sri Lanka and Thailand, have extended material support to Ebola-affected countries of Africa. Further, Research in Thailand has led to development of monoclonal antibody that can neutralize Ebola

virus. Thai workers are now closely working with US NIH to assess its efficacy and utility in patients of Ebola.

WHO is working closely with Member States to augmenting their capacity to respond to public health issues of international concern. As a matter of fact, this process started in 2007 when International Health Regulations (2005) came into effect. Primary objective of IHR (2005) has been to contain the international spread of diseases of public health importance with minimal impact on travel and trade.

I have been regularly writing to the Health Ministers of Member States in our Region, updating them on the evolution of the epidemic, advocating on enhancement of national capacity and apprising them of technical developments that can be used in their respective countries. I have also authored few Op-Eds in leading newspapers in our countries to reach out to the communities with useful information.

Our WHO Representatives in countries have been working closely and continuously with Health Ministries and providing technical assistance as needed by countries. Support from WHO in the Region is being coordinated through a Regional Task Force on Ebola that functions from this Office under the chairmanship of Director Programme management.

WHO has already disseminated as many as 34 Technical Guidelines to the countries. Technical support has been extended on various aspects. Regional meetings on communications, laboratory aspects, risk assessment etc have been done. SEARO has made special efforts in the last six months to augment national capacity for early diagnosis of suspected Ebola cases either by initial testing in BSL3 labs, wherever available, or by shipping of infectious material as per IATA and UN norms to WHO Network of Ebola Labs.

Regional Communication Officers Network in WHO Country Offices has been active in disseminating appropriate messages and information as well as responding to queries from media. Several media training/briefings are being organized. Personal Protective Equipment or PPE, and laboratory reagents worth USD 500 000 have been procured by WHO and distributed

to countries. Several of our WHO staff members have already been deployed in West Africa and more would be deployed there to contribute to global efforts to contain Ebola.

The disease in West Africa continues unabated. Global efforts will take some more time to bring it fully under control. All Member States have to maintain constant vigil and sustained state of preparedness. However, Member States alone cannot do all that are necessary to prepare well and, in the unlikely event of a case in a country, respond effectively, support from all stakeholders and development partners is necessary. I earnestly request all partners to provide whatever support is possible to the countries of this Region as well as to West Africa. Until the epicentre of disease in West Africa is effectively and totally contained, the rest of the world will continue to be at risk.

I seek your support and appeal to all of you to contribute to the global efforts in combating this public health emergency of international concern. On behalf of WHO, I assure you our full support in all endeavours to keep our Region free from Ebola.

Dengue prevention and control

Dengue has established itself as the world's fastest growing vector-borne disease. Ever since its detection in early 1950s, a 30-fold increase has been seen in its incidence. Globally, an estimated 50–100 million dengue infections occur annually in over 100 endemic countries. Almost half of the world's population is currently considered at risk of contracting dengue.

Dengue is still an emerging infection and the overall trend in the WHO South-East Asia Region is increasing. Our Region contributes to more than half of the global burden of dengue. About 52% of the global population at risk resides in this Region. The disease is endemic in 10 of the 11 Member States.

Dengue cases have been regularly reported in this Region since 2000. The Region was severely hit in 2010 with more than 350 000 cases and around 2000 deaths. 2013 surpassed even this number of cases with Member States reporting almost 400 000 cases. Five of our Member States viz. India, Indonesia, Myanmar, Sri Lanka and Thailand are among the 30 most highly endemic countries in the world. Let me share some good news now. In spite of the increasing number of cases, the deaths due to dengue have been very low in our Region. With concerted efforts by all Member States, and technical assistance from WHO, good case management capacity has been established in all countries during the past decade. The Region has been able to sustain CFR of less than 0.5% and is striving to prevent any death from dengue.

Outbreaks of dengue are now occurring with greater frequency

Outbreaks of dengue are now occurring with greater frequency. As is obvious from currently available evidence, dengue is a disease with which we have to fight a long battle.

How do we move forward?

Symposium on dengue prevention and control, 29 September 2014, New Delhi, India

In this context I wish to share four strategic directions to guide our collective efforts to mitigate the impact of this disease.

First, we need to understand and keep pace with the changing epidemiology of dengue especially the multiple ecological factors that influence spread of this disease. Being a vector-borne disease, an ever increasing numbers and varieties of mosquito breeding habitats are being created with rapid and poorly planned urbanization, globalization, consumerisms, poor solid waste and water management and increasing population movement without adequate measures to prevent vector breeding.

Climate change is also influencing ecology that benefits vectors.

The accumulation of modern non-biodegradable products such as automobile tyres, plastic containers and tin products provide a conducive environment for prolific breeding of Aedes aegypti and Aedes albopictus vectors of dengue. Most of these factors are because of actions –or inactions of sectors other than health. Hence, effective and sustainable prevention and control of dengue requires interventions that address these factors in an integrated and multisectoral approach.

Recognizing the importance of multisectoral approach and to advocate utmost need for "Health in All Policies", the Health Ministers of the South-East Asia Region, in their recent meeting held a few weeks back, have given a call in the Dhaka Declaration on Vector-borne Diseases. The Declaration encourages a "whole of government" approach against diseases such as dengue. We are very optimistic that this declaration will act as a strong catalyst to stimulate comprehensive multisectoral action against vector-borne diseases in our Region.

Second, I would like to reinforce the efficient use of WHO-recommended integrated vector management as the approach for controlling vectors of public health importance. While integrated vector management is recognized universally as the back-bone of the vector control programmes, entomologists and vector experts are either non-existent or this expertise is rapidly declining in the Region. Urgent steps are needed to maintain and augment vector control capacity in all developing countries.

Technical assistance from WHO and its Collaborating Centres to enhance national capacity is available and we encourage Member States to utilize it to meet their national needs.

Third, despite non-availability of any specific antiviral drugs against dengue, rational and effective case management has been extremely useful in bringing down mortality due to dengue. While these must be sustained, another pillar of prevention ie development of an efficacious, safe and affordable vaccine that provides long term protection against all serotypes of dengue virus is swiftly needed. WHO has been supporting these R & D efforts and we understand that a few candidate vaccines are now in advanced stages of clinical trials. We look forward to their early availability to public health systems in developing countries. We shall also urge the researchers and pharmaceutical industry to accelerate their efforts in developing and making available safe and efficacious vaccines to our communities.

Lastly, and perhaps most importantly, I am convinced that control of dengue can never be achieved or sustained without community empowerment and ownership. Unfortunately, there is lack of community awareness on role played by vectors and vital contributions that they can make in mitigating vector breeding to prevent dengue. Even the best of the public health systems in the world will not accomplish the desired task of containing dengue unless communities actively participate in this endeavor. We need to make special efforts to educate and galvanize communities so that their critical cooperation in anti-dengue activities is obtained and sustained.

WHO has been assiduously working through advocacy, normative functions and provision of technical support to Member States against dengue. We continue to advocate to the governments on the public health importance of vector-borne diseases, especially dengue and its control, strengthening of public health systems in Member States including capacity building and allocation of appropriate resources. Acknowledging their public health importance, the theme of 2014 World Health Day was on vector-borne diseases to raise global awareness and increase commitment on controlling these diseases.

A Dengue Strategic Plan for the Asia Pacific Region, 2008–2015 has been developed and endorsed by the Regional Committees of the South-East Asia and Western Pacific Regions. The Comprehensive Guidelines for the Prevention and Control of Dengue and Dengue Haemorrhagic Fever – a publication of WHO Regional Office for South-East Asia is being extensively used as a valuable treatise on public health and case management aspects of dengue. In addition to these a number of guidelines and technical documents have been developed by WHO, and several training activities organized. We shall continue to do so to meet the needs of our Member States to control dengue.

Let me conclude by expressing my gratitude to the organizers for giving me an opportunity to share a few of my thoughts with you all.

I am pleased to see that this symposium will address many of the strategic directions that I have enunciated just now including IVM, case management and vaccines against dengue.

Challenges in eliminating vector-borne diseases

It is my pleasure to welcome you all to this informal consultation on vector-borne diseases which coincides with the theme of World Health Day 2014. WHO celebrates World Health Day every year to focus global attention on a disease of common interest to all of us. In the context of the South-East Asia Region, this year's theme on vector-borne disease is very apt and timely.

Vector-borne diseases are an important group of diseases, killing over a million people annually and putting half the world's population at risk. These often neglected diseases account for 17% of the global estimated burden of all infectious diseases. Vector-borne diseases involve diverse group of parasites and viruses, spreading to humans through the bite of a diverse group of vectors, including mosquitoes, bugs, ticks, mites, flies and freshwater snails. These vectors are versatile creatures rapidly adapting to changing ecological and environmental conditions, thus challenging the control interventions available.

Vector-borne diseases kill over a million people annually

Malaria is endemic in all Members States of the Region, except Maldives, putting around 1.4 billion people at risk. WHO estimates 42 million cases and 27 000 deaths from malaria in the Region in 2012. Around 1.8 million people in the Region are at risk of dengue. In 2012 there were over 257 000 cases reported from the Region, which includes countries with the highest contribution to global dengue cases. Around 875 million people in the Region are at risk of lymphatic filariasis – the highest contribution to the global burden, with an estimated 60 million infected people. Kala-azar is endemic in Bangladesh, India and Nepal, with an estimated 100 000 cases annually, while sporadic cases are being reported from Bhutan and Thailand. An estimates 70 000 cases of Japanese encephalitis with 15 000 deaths are reported annually in the Region. Schistosomiasis persists in two districts of Central Sulavesi in Indonesia.

Informal expert consultation on vector-borne diseases, 7–8 April 2014, WHO-SEARO, New Delhi, India

The Region has been making progress in controlling and eliminating most of the vector-borne diseases. Malaria prevalence continues to decline, with five countries achieving more than 75% decrease in case incidence and two additional countries expected to achieve this target by 2015. Sri Lanka is in elimination phase with no locally acquired cases since November 2012, while Bhutan and the Democratic People's Republic of Korea are in the pre-elimination phase. Bhutan and the Democratic People's Republic of Korea continue to remain free from lymphatic filariasis and Maldives, Sri Lanka and Thailand are working on submitting the dossier for certification of LF elimination. Bangladesh, India, Myanmar and Nepal are making good progress in reaching the LF elimination target. Bangladesh and Nepal is making good progress in eliminating kala-azar, and India is committed to reaching the regional target.

However, there are still many challenges in eliminating these diseases as issues of public health concern. Environmental degradation and poor solid-waste management is creating more mosquito breeding grounds than ever. Global warming and climate change are pushing vectors to new locations and higher altitudes while increasing the efficiency of the mosquitoes as vectors. Dengue and chikungunya keep on increasing in the Region. The emergence of malaria parasite resistance to medicines threatens progress, while vectors developing resistance to insecticides are posing greater challenges. While countries continue to make progress in eliminating the diseases, sustaining control measures and strengthening surveillance remain an issue. National capacities to meet these challenges need to be strengthened and communities must be educated and empowered to prevent these diseases. We need better tools to reach out to the difficult-to-reach pockets in countries. While efforts to develop a dengue vaccine continue, we need to discuss how we can better understand the epidemiology and pathophysiology of the disease and sustain improvements in case management. We need better data and stronger evidence on the disease burden and its health, social and economic impacts. We need to explore creative ways of working together both within and between countries. I hope this two-day consultation will advise and guide us on some of these issues and beyond, enabling us to better focus our agenda in controlling and eliminating vector-borne diseases. We seek technical support for us from all the institutions and WHO collaborating centres.

Preventing vector-borne diseases

The focus of this year's World Health Day is on vector-borne diseases. The theme "Preventing vector-borne diseases is everyone's responsibility" highlights the duty of every individual to prevent these diseases, for which more than half of the world's population is at risk.

We cohabit with innumerable other life forms in the world. Some of these, like vectors, have been responsible for transmitting several diseases to humans. Vectors are small organisms such as mosquitoes, bugs, ticks and mites and freshwater snails that can carry diseases from person to person and place to place. Vectors may be small in size, but with a single bite, they can cause serious diseases like malaria, dengue and kala-azar, which fall under the broad term of vector-borne diseases.

Vector-borne diseases account for 17% of the estimated global burden of all infectious diseases. While diseases like malaria and lymphatic filariasis have been with us for centuries, dengue has become the world's fastest growing vector-borne disease, with a 30-fold increase in disease incidence over the last 50 years. Vector-borne diseases have significant impact on the socioeconomic status of communities and these vigorously fuel the vicious cycle of poverty. Elimination of these diseases, therefore, will contribute to the economy and facilitate bringing poor people into mainstream.

WHO South-East Asia Region, which is home to more than one-fourth of the global population, is a diverse Region with multiple health challenges. Much of the global vector-borne disease burden is contributed by this Region. The tropical climate, inefficient water management in most countries, rapid degradation of environment, low priority to health impact in development activities, unplanned urbanization and widespread

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Address on World Health Day, 7 April 2014, WHO-SEARO, New Delhi, India

poverty are some of the reasons for the high prevalence of vector-borne diseases in our Region. Social and environmental factors (including climate change) are also key aspects affecting both the transmission and control of these diseases. In recent years, there has been a growing recognition of the importance of these ecological factors in influencing vector-borne diseases. Optimizing or managing these risk factors lies at the heart of efforts to contain these diseases.

Malaria, dengue, lymphatic filariasis, kala-azar, Japanese encephalitis, schistosomiasis and chikungunya are vector-borne diseases of public health concern in our Region. In addition, vector-borne diseases like scrub typhus, Kyasanur forest disease, West Nile fever, Crimean-Congo Haemorrhagic Fever and Chandipura virus are also seen in some parts of the Region.

Malaria is endemic in 10 of the 11 Member States of the South-East Asia Region, which is inhabited by 40% of the global population at risk of malaria. Maldives is the only country that remains free of malaria since 1984. Outbreaks of dengue fever – a disease that did not exist till 1950s, have now been reported from all Member States with the solitary exception of the Democratic People's Republic of Korea.

Vectors have, and will continue to surprise us

In spite of substantial progress made by Maldives, Sri Lanka and Thailand in reducing the disease burden due to lymphatic filariasis, the South-East Asia Region has 60 million infected people and around 870 million people at risk of this infection in all countries except Bhutan and Democratic People's Republic of Korea. Kala-azar has been endemic in Bangladesh, India and Nepal with isolated cases reported from Bhutan and Thailand. Japanese encephalitis has been killing people, especially young children with alarming regularity in few established foci. The extensive and rapid spread of chikungunya a few years back is still vivid in our memories and indicative of the ingenuity of vector-borne diseases to strike without any warning.

Vectors have, and will continue to surprise us. The versatility of mosquitoes and other vectors to subvert the interventions developed by mankind is complicating the task of controlling these diseases. Acquisition of resistance to

commonly-used insecticides has been a frequent course adapted by these vectors.

The good news is that cost-effective technological tools are now available in the fight against most of these diseases. Mass drug administration as preventive chemotherapy has already yielded excellent results in controlling and eliminating diseases like lymphatic filariasis in several countries. These interventions need to be applied along with community-based ecosystem management and environment-friendly vector control interventions. Encouraged by the efficacy of these tools, the global community has already given a call of elimination of several vector-borne diseases during the next decade. At the same time, research continues to develop better and more cost-effective interventions.

It is now well recognized that prevention and control of vector-borne diseases warrant a comprehensive, multisectoral and all-encompassing response. This requires developing and implementing strategies, interventions and technologies to modify the environmental risk factors to substantially prevent and reduce the disease burden. Integrated vector management (IVM) is one such approach. IVM is a rational decision-making process for vector control. It advocates for social mobilization, collaboration with other sectors, integration of various vector control methods adapted to the local situation into other disease control programmes and building national capacity to manage IVM programmes. IVM also stresses the importance of first understanding the local vector ecology and local patterns of disease transmission, and then choosing the appropriate vector control tools, from the range of options available.

Environmental modification and its preservation should have a national approach that considers health as central to any developmental policy or plan. However, this is not easy, since most of these policy decisions are outside of the traditional domain of the health sector. This objective can be attained only through healthy policies or the application of the concept of Health in All Policies. The policies of health, environment and development must be fully aligned.

World Health Day 2014 gives us an opportunity to unite the voice of health agencies across the world in raising awareness and strengthening advocacy on controlling and eliminating vector-borne diseases. Through this campaign, WHO focuses on the public health importance of vector-borne diseases as well as on promoting rational use of available interventions, pushing health higher on the national development agenda and articulating greater engagement of empowered communities for their active participation in limiting the proliferation of vectors.

The WHO Regional Office for South-East Asia has developed a number of awareness and advocacy materials which we hope will benefit the work of our Member States in getting multisectoral support and empowering communities. Preventing and controlling vector-borne diseases is, and must be the responsibility of everyone!

Strengthening dengue prevention and control

It is my pleasure to speak to you on this crucial and timely event, on a subject that is very important to the Maldives, to WHO South-East Asia Region and beyond. As you all are aware, this year's World Health Day theme is on vector-borne diseases, giving us an opportunity to create a global platform to highlight their health, economic and social impact and strengthen our efforts in controlling them. While malaria is still the deadliest of all vector-borne diseases, dengue has been the fastest growing, with a 30-fold increase in incidence over the last 50 years.

First recognized in the 1950s in Thailand and the Philippines, dengue fever has now become endemic in more than 100 countries. Over 2.5 billion people, making more than 40% of the world's population, are currently at risk from dengue. In the South-East Asia Region, it has spread to 10 of the 11 countries, putting about 52% of the regional population at risk. Dengue outbreaks are occurring in small island communities like the Maldives, large continental countries like India and high altitude mountainous countries like Bhutan and Nepal. It is seen in urban and rural areas, infecting young and old, putting tremendous pressure on the health systems.

Dengue continues to be endemic in the Region

Despite many efforts to control, dengue continues to be endemic in the Region. Though four countries, including Maldives, showed a decreasing trend of dengue in 2012, the overall regional figure shows an increasing trend compared to 2011. With Indonesia contributing to the second highest number of cases in the world, five countries in this Region are among the 30 most highly endemic countries in the world.

National meeting on strengthening dengue prevention and control, 4 March 2014, Male, Maldives

However, the good news is that despite the large number of cases reported, by strengthening country capacity and improving case management, the Region has been able to maintain a very low case fatality rate from dengue. Nonetheless, the high morbidity and associated social and economic burden is of concern.

In 2007, the WHO South-East Asia and Western Pacific regions jointly developed a biregional strategic plan on dengue control and prevention, which was adopted by the regional committees of both regions. In 2011, the WHO Regional Office for South-East Asia published a revised and expanded edition of the Comprehensive Guidelines for Prevention and Control of Dengue and Dengue Haemorrhagic Fever, which is a very useful and popular publication on dengue management. In 2012, WHO headquarters developed a global strategy for dengue prevention and control for the period 2012–2020. We believe these are extremely useful guidelines from which we can build and develop national strategies and action plans specific to individual countries. I am happy to note that Maldives is moving ahead in this direction and embarking on the development of a national strategic plan, which I am confident, will be an important guiding document for all stakeholders, converging individual efforts towards a national objective.

Dengue is a preventable disease

Dengue is a complex disease, with four established serotypes of causative viruses, and an extremely versatile and efficient vector. Dengue vector dynamics are strongly influenced by environmental factors, population dynamics and climate change. Despite these challenges, dengue is a preventable disease. The solution lies in a united and sustained effort from all of us. Ministries of health alone cannot control dengue. A lot of factors that create favourable conditions for the spread of dengue and emergence of outbreaks lies beyond the scope and mandate of the health sector. Therefore, dengue control and prevention require a truly committed multisectoral engagement, with strong political support, where every partner takes full ownership and responsibility for their domain of work.

Vector control is the backbone of dengue prevention. Good environmental management, effective solid waste management and better management of water and water resources are key elements of vector control. No single approach could work on mosquitoes; and hence, an integrated vector management approach needs to be practised. Educating and empowering communities to take ownership of the mosquito control in their individual houses and communities is the cornerstone of a sustainable mosquito control programme.

As of now, there is no vaccine available to prevent dengue. However, there is optimism on vaccine development, with several candidate vaccines in various advanced stages of clinical trial. In the meantime, we must focus on strengthening dengue prevention and control efforts, more specifically, vector control. We must continue to sustain the gains made on reducing case fatality and continue educating and re-educating the doctors, nurses and health workers on clinical management of dengue cases. We need to strengthen the referral systems, ensuring timely referral of patients to appropriate levels of health care to ensure that no child dies of dengue.

Much needs to be learnt to improve our understanding of dengue epidemiology and its control. More research needs to be done to bridge the knowledge and data gap. We must strengthen the research capacity in Member States and generate more interest on research, including operational research. We must strive to find innovative and more effective tools and approaches for vector control.

Since it was first reported in 1979, Maldives has experienced sporadic outbreaks of dengue, till the disease became endemic in 2004 with a high incidence rate. Since then, every year, a large number of cases have been reported from every atoll of the country. Maldives has also made serious efforts to strengthen its disease surveillance, response and case-management capacity. Despite the many challenges, including the high turnover rate of doctors in the islands, and difficulty in retaining experience and expertise, Maldives has maintained a low case fatality-rate. However, much needs to be done, and I am confident that Maldives will build on the

gains made so far. This is a country whose collective efforts and strong determination have successfully eliminated malaria, and have been sustaining that remarkable achievement – the only country in this Region having achieved this goal. We suggest your reflecting on that experience and using that expertise to eliminate yet another major public health issue in this country.

I understand this meeting will discuss most of these issues and bring the stakeholders and partners together. WHO will continue supporting this process, helping the country strengthen its capacity and be better prepared in the fight against dengue.

Family Health, Gender and Life course

Universal reproductive health coverage

Strong and healthy families are the cornerstone of strong and healthy communities. They are the social unit preceding all others, and a powerful force for raising the health and wellbeing of individuals, communities and countries.

But like all social institutions, they benefit from effective planning.

As you know, family planning is a formidable tool to drive down maternal and child mortality, empower women to avoid unintended pregnancies, and advance women's social and economic autonomy.

Family planning is a formidable tool to drive down maternal and child mortality

As outlined in the Sustainable Development Goals, family planning services must be available to all women everywhere. The benefits are clear.

It is estimated that universal access to quality family planning services would decrease unintended pregnancies by 70%. Maternal deaths would drop by an estimated 67%, while newborn deaths would decline by 77%. At the same time, pregnancy and delivery-related disability among women and newborns would decrease by two-thirds.

Making this happen is central to WHO's focus and drive. This is especially so in the SDG era, where universal health coverage – including access to family planning – provides the framework for all that we do.

Though we still have some way to go, family planning has been a feature of reproductive and child health programmes in the Region for many years. Indeed, in many parts of the Region contraceptive use – much like vaccination – has become a

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Regional meeting to strengthen capacity in new WHO family planning guidelines: towards universal reproductive health coverage in the SDGs era, 17–19 April 2017, New Delhi, India

routine health behaviour. Family planning programmes can be credited for making it so.

They can also be credited for the substantial progress we've made.

Between 1990 and 2015 the Region achieved a 69% reduction in maternal mortality – the highest among WHO regions. The contraceptive prevalence rate has meanwhile improved from 46% in 2000 to 60% in 2015. At the same time, the total fertility rate in the Region dropped from three to 2.4 children per woman – the most significant change among all WHO regions.

Despite these impressive advances, progress has been uneven. The unmet need for family planning, for example, remains high, especially among adolescents and young people. And at just 60%, the Region's contraceptive prevalence rate is one of the lowest among WHO regions.

Of significant concern is the fact that in four of the Region's countries the adolescent birth rate is more than 50 per 1000 women aged 15–19 years. Around 6 million girls aged 15–19 years give birth each year in our Region, mostly within marriage. Nearly half of these pregnancies are unintended.

The Sustainable Development Agenda provides a compelling opportunity to strengthen family planning programmes.

As you know, these programmes are supported by targets under SDGs 3 and 5. The UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health has reinforced the primacy of family planning within the Agenda, and has already attracted over US$ 25 billion in commitments.

As we gather today we must capitalize on this momentum. We look forward to familiarizing each of you with the new WHO family planning guidelines, with specific attention on how they can be adapted to your needs.

Before we proceed, however, I wish to emphasize four points that are fundamental to achieving our goals.

First, we must ensure improved access to contraceptives to all women of reproductive age, including adolescents. Ongoing barriers to access – whether related to age, geography or any other factor – must be identified and remedied. As the SDGs outline, no one can be left behind.

Second, we must ensure women can access a range of contraceptive options, and that they are empowered to make evidence-based choices. Women must be provided the means to fulfill their family planning objectives, and must be able to do so with full confidence in the decisions they are making.

Third, we must ensure higher quality of family planning services. This means investing in and enhancing the skills of service providers, both technically and in terms of their approach to patients. It also means widening the scope of services available.

And fourth, we must ensure progress is monitored closely. Access to high quality information provides policymakers the means to adjust policy where necessary. And it also provides the evidence needed to pursue more targeted interventions where appropriate.

Women must be provided the means to fulfill their family planning objectives

WHO is committed to supporting your efforts.

As many of you are aware, in December 2015 I convened the SEAR-Technical Advisory Group of global and regional experts. Ever since, the Advisory Group has provided guidance to national governments, implementing partners and other stakeholders across the Region. I am glad that some Advisory Group members are in attendance today.

As many of you will also know, the Regional Summit of the H6 Partners, which includes WHO, UNICEF, UNFPA, UN WOMEN, UNAIDS and World Bank, has now operationalized its mandate, and is harmonizing technical support to the Region's Member States. I am glad that many of these partners are here to actualize our commitment to provide collective support to Member States.

Our collective vision of a Region where family planning and reproductive health services are available to all is inspiring. As

I mentioned at the outset, making this happen will strengthen communities and accelerate development. It will also advance the enjoyment of basic human rights.

But unless our vision is supported by evidence-based standards, guidelines and tools, it will be left unfulfilled.

Today I am proud to present you the latest iteration of these tools. Through our joint engagement and commitment I am certain that we will harness and apply them as efficiently as possible, and in doing so advance the health and wellbeing of women, children and adolescents across our Region.

I take this opportunity to express my sincere appreciation to WHO HQ for their support, especially with regards to the umbrella project. I also wish to reiterate my warmest welcome to you all, including representatives of Member States, UN partner agencies, professional associations, academia, experts and TAG members.

Improving quality of hospital care for maternal and newborn health

When the Millennium Development Goals were launched in 2000, ambitious goals were set for the reduction of maternal and child mortality. In the last decade significant progress was achieved in the SEA Region, where maternal mortality declined by about 64%, and a similar reduction in child mortality as well.

However, progress was insufficient for the Region as a whole to have achieved the MDG 5 target of a reduction of maternal mortality ratio (MMR) by three fourths, and under-five mortality by twothirds, between 1990 and 2015.

Nevertheless, I must commend our Member States for the tremendous efforts in pursuing these goals and the significant progress in both the areas.

As we look to the future, we must take into consideration the lessons learnt from the MDG era. It is clear that although there are a slew of evidence-based interventions, that are being implemented, such interventions have often been delivered with insufficient quality. A number of studies over the past years have reported that the quality of care provided to mothers, newborns and children was sub-optimal.

For example, some Member States have reported that, though there has been a significant increase in coverage of skilled birth attendance, maternal and newborn mortality has failed to decline to the levels expected. High coverage by skilled attendants will have an impact only when the basic clinical and life-saving procedures are performed while ensuring good quality of care. Coverage of interventions alone is not likely to yield results unless these are delivered with good quality to make coverage effective. Moreover, poor quality of health-care

Regional workshop for improving quality of hospital care for maternal and newborn health, 10–13 May 2016, New Delhi, India

services may even be harmful to the health of individuals seeking care. In addition, such quality dissuades people from utilizing health-care services, to the extent that they should, and increases out-of-pocket expenditure.

In the Sustainable Development Goals framework, universal coverage of health-care services is the centerpiece, and quality of health care has received well-deserved attention in addition to the need for expanded availability of essential services. The Global Strategy for Women's, Children's and Adolescents' Health, 2016–2030, released by the UN Secretary-General, also emphasized quality of health services as an essential and important element of the strategy.

Member States in our Region have also identified poor quality of care as a predominant threat for reproductive-maternal-newborn-child and adolescent health (RMNCAH). They have expressed the need to urgently address deficiencies in the quality of care by embarking on national quality improvement processes, and they have requested WHO and partners to provide technical support and guidance.

Member States in our Region have also identified poor quality of care as a predominant threat for RMNCAH

The South-East Asia Region is taking concrete steps in this direction. The Regional Office has prepared a Regional Framework for Improving Quality of Care for RMNCAH in consultation with Member States and in collaboration with partner agencies. The vision of the framework is that all countries of the South-East Asia Region provide universal access to quality care for every woman, newborn, child and adolescent at all levels of the health system. The Regional Framework provides guidance for Member States to develop national mechanisms for improving quality of care by establishing leadership at the national level in the ministries of health. We hope that countries will adopt the Regional Framework to their national systems to ensure an enabling and supportive environment for continuous quality improvement in line with global standards of RMNCAH care.

The Regional Framework puts the focus for Improving Quality of Care for RMNCAH at the health care facility level, and emphasizes the importance of collaborative team work of health-care providers. I understand that one of the key objectives of this meeting is to build capacity of health-care providers at health

facilities, and to ensure that the focus will be on care provided to the mother and newborn around the time of childbirth.

I believe it is a good plan to initiate quality improvement processes at the point of care by involving the potential champions from selected hospitals in the Member States. Such champions will play a key role during the national roll-out of the quality improvement process within the national framework for improving quality of care. It is vital that strong support is available from the highest level in this endeavor, and the presence of responsible persons from ministries of health at this workshop is encouraging, as it would ensure that support from the senior management in health ministries as countries roll out national plans for strengthening national health systems for quality improvement across all levels of health care system.

Whatever we do, we cannot do it alone. Partnership is vital, both at national, regional and global levels for us to succeed. And I want to acknowledge and appreciate the strong collaboration we have with several partner agencies in this endeavour. We recently had a Regional Leadership Summit of H6 agencies, including WHO, UNICEF, UNFPA, World Bank, UNAIDS and UN Women, to discuss a collaborative approach for the region and express joint support for the Global Strategy for Women's, Children's and Adolescents' Health.

We have a joint statement for ending preventable maternal, newborn and child mortality.

If not for partnership this meeting itself would not have been possible. It is through the partnership of USAID, the WHO Collaborating Centre at All India Institute of Medical Sciences, New Delhi, and the Regional Office that the package for quality improvement at the hospital level to be introduced in this meeting was developed. I have no doubt that the deliberations and the sharing of experiences among Member States would be useful in shaping our future strategies for the improvement of quality of care at health care facilities. I encourage you all to prepare country-specific action plans to improve the quality of maternal and newborn care based on the understanding reached here and keeping in mind your existing country context. We will follow the progress closely. You can count on technical support from WHO and partner agencies in moving this agenda forward.

Women's and children's health

As the phase of the Millennium Development Goals comes to an end and the world moves on to the phase of sustainable development with a new set of goals, it is time to take stock of the situation with regard to our achievements in reducing newborn, child and maternal mortality.

As we look back, we find a mixed bag. We can derive satisfaction from substantial global progress in reducing child deaths since 1990 by more than 50%. The number of under-five deaths has decreased from 12.7 million in 1990 to 5.9 million in 2015. The acceleration in decline has been much faster during 2000–2015, with an annual rate of reduction of 3.9 per cent compared with 1.8% in the previous decade - 1990–2000. However, progress remains insufficient to reach the MDG 4 target globally.

If we look at the South-East Asia Region, decline in the under-five mortality rate has been faster in the corresponding period – having declined by about 64% from 118 per 1000 live births in 1990 to 43 per 1000 live births in 2015. However, the progress has been variable among countries of the Region.

Based on the 1990 baseline, Bangladesh, Bhutan, Indonesia, Maldives, Nepal, Thailand and Timor-Leste have achieved the MDG 4 target of reduction in under-five mortality by two thirds. Sri Lanka has reached a low level of 10 under-five deaths per 1000 live births but they are yet to reach the target of 7 per 1000 live births.

However, the Democratic People's Republic of Korea, India, and Myanmar have not shown similar progress towards achieving the MDG 4 target.

First meeting of SEAR-Technical Advisory Group on Women's and Children's Health, 15–18 December 2015, New Delhi, India

Even in countries that have achieved the MDG 4 target, there are some populations in which child mortality has remained high because of social, economic and geographic factors.

In comparison, the decline in newborn mortality has been slower—declining by 55% between 1990 and 2015. Newborn mortality presently contributes to about 56% of under-five mortality in our Region compared with 44% globally. Without a rapid reduction in newborn mortality, further reduction in under-five mortality would be a challenge. The South-East Asia Region contributed to about 30% of newborn deaths that occurred in the world in 2015. About 75% of the newborn deaths in the Region occurred in India alone (700 000 in a year), owing to its large population and a high newborn mortality rate. Other countries in our Region with a high burden of newborn deaths are Bangladesh (74 000 deaths), Indonesia (74 000 deaths), Myanmar (24 000 deaths) and Nepal (12 000 deaths).

Now let us look at maternal mortality. There has also been significant progress towards reduction in maternal mortality. Globally, there has been a decline of 45% since 1990. In SEAR, there has been a decline of about 64% since 1990. However, progress is insufficient for the Region as a whole to have achieved the MDG 5 target of a reduction of maternal mortality ratio (MMR) by three fourths since 1990.

There has also been significant progress towards reduction in maternal mortality

We, in consultation with Member States, have identified ending preventable maternal, newborn and child mortality with a focus on accelerating reduction in newborn mortality as a flagship priority area in the Region. To take forward the actions under this flagship programme, we constituted a Technical Advisory Group (SEAR-TAG) comprising of 12 members who are eminent scientists. The TAG members are independent experts of very high professional standing with considerable experience in the area of reproductive, maternal, newborn child and adolescent health (RMNCAH) academics, public health and research. They have been requested to help provide technical guidance to Member States for accelerating reduction in maternal, newborn, child mortality and monitoring progress in the Region.

This is the first meeting of the SEAR-TAG for women, children and neo-natal health. I am glad all 12 TAG members are contributing to the meeting. Some of them have travelled a long way for this important meeting. I thank them for their commitment and warmly welcome them.

This meeting is taking place at an opportune time when the framework of Sustainable Development Goals (SDGs) has recently been launched by the UN Secretary-General in September 2015 along with the updated Global Strategy for Women's, Children's and Adolescents' Health. These global initiatives provide new opportunities to undertake more strident actions towards ending preventable newborn, child and maternal mortality and to empower national governments to strengthen their leadership and assume accountability for ensuring adequate resources and achieving results. We also have better understanding of evidence on interventions and approaches to prevent mortality that has been presented in the Global Every Newborn Action Plan (ENAP) Framework and Strategies for Ending Preventable Maternal Mortality (EPMM). We all know that two thirds of newborn mortality is preventable. Based on these opportunities, we all will need to work together towards achieving the new targets for a newborn mortality rate of 12 per 1000 live births, a child mortality rate of 25 per 1000 live births and a maternal mortality ratio of 70 per 100 000 live births by 2030 in each country of our Region.

As national governments assume and strengthen leadership to ensure that all mothers, newborns and children survive and thrive, and in turn transform society, partner agencies would be required to strengthen collaboration and ensure coordination to harmonize their support to Member States. I am pleased to share that on the 14th of this month, we had a very successful Summit of the Regional leadership of H4+ agencies including UNICEF, UNFPA, UNAIDS, UNWOMEN and the World Bank. Together, we express our joint commitment and support for ending preventable mortality in the Region. I welcome colleagues from sister organizations as well as colleagues from all partner agencies present today.

It is also my pleasure to welcome the national programme managers from ministries of health from all 11 Member

States and representatives from academia and professional associations. I understand that country teams will have an opportunity for close interaction with TAG members to identify country-specific high impact evidence-based approaches for accelerating reduction in newborn mortality. I am sure all of you together will be able to deliberate on critical issues and chalk out a realistic way forward.

I eagerly look forward to the outcome of this meeting and urge you to come up with effective follow-up actions in your countries for the next year to make a difference on the basis of agreed actions. Once again, I express our full support to Member States of the Region.

Launch of IPV in India

It gives me immense pleasure to be a part of this landmark moment. It is a matter of great pride for the Government of India that another significant milestone in the eradication of polio is being celebrated today. The change from live oral vaccine to the inactivated injectable polio vaccine is a necessary and critical step to further cement the gains of polio eradication. As you all know, the South-East Asia Region was declared polio free in March 2014 and the Region has continued to maintain that status. However, the world is not free of polio. And as long as polio survives anywhere in the world, there is always the risk of an importation and spread of poliovirus. Therefore, polio eradication will remain a priority until global certification of polio is achieved. I commend the Government of India for the strong commitment to ensure that polio eradication continues to be high on its health agenda.

However, the world is not free of polio

I understand that today IPV is being rolled out as part of routine immunization programme across six large states of the country simultaneously reaching 50% birth cohort of the country. And in the next five months the rest of the country will also be covered. This is an unparalleled achievement in public health considering the sheer size of India's birth cohort which exceeds 25 million children. Further, it will be the first time in the last 30 years when India introduces a new vaccine in the entire country within a short period of just five months.

I take this opportunity to congratulate the Government of India, State Governments and the thousands of health workers of India and the many partners for achieving polio-free certification and eliminating Maternal and Neonatal Tetanus from the country. These achievements have been possible only because of the inspiring leadership and effective management of India's immunization programme. They are also a testimony to

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Launch of inactivated poliovirus vaccine in India, 30 November 2015, New Delhi, India

what can be achieved when governments, civil society, technical experts and the people come together for a common cause.

All this would not have been possible without the strongest commitment and leadership of the Government of India. India's commitment is exemplified by the steady roll out of pentavalent vaccine which delivers five vaccines in one injection. What is more, in addition to IPV, India is also committed to the introduction of Rotavirus vaccine in the national immunization programme.

India's strategic efforts to strengthen routine immunization systems through '*Mission Indradhanush'* are being appreciated globally. I laud the efforts of the national and state governments to achieve the ambitious goal of 90% full immunization coverage by 2020. This will no doubt contribute to the significant reduction of deaths and diseases due to vaccine preventable diseases. Further, these efforts will also contribute to the achievement of Goal 3 of the Sustainable Development Goals which includes "ensuring healthy lives and promoting the well-being for all at all ages".

I am aware that India's polio eradication initiative has been a model for the entire world. There are many lessons to be learnt from it. First, the value and importance of partnership in public health. The collaboration between all partners- WHO, UNICEF Rotary, CDC, local civil societies, and the government- was not only complementary but truly dynamic and robust. The combined strengths of the diverse partners working together towards a common goal truly led to the success of polio eradication. Secondly, polio eradication also used research to adapt strategies as necessary to make mid-course corrections when required. The deliberate quest to gather evidence and to learn lessons from field experiences and use them to improve the programme certainly contributed much to the eventual success of the programme. And lastly, the importance of community engagement. No public health programme can aspire to succeed if we cannot get the community to be involved. The polio eradication programme made enormous efforts to engage the community leaders, religious heads, and other civil society groups at the local level to mount what is probably the world's largest information, education and communication movement.

It is good to celebrate our success. But while we do that we must look to the future to ensure that the highest coverage is ensured for all vaccines in the routine national immunization programme. It is important to also ensure that the vaccines are safe and of the highest quality possible.

I would also like to say that the vast experiences and technical expertise that polio programme has developed over the years must be useful not only to India but also to other countries. For that I am happy that almost 50 surveillance experts from the NPSP went to West Africa to assist in the Ebola effort, the largest technical contingent mobilized from any region of WHO. Further, I also understand that India has recently hosted a special Mission from Afghanistan to share polio experiences and lessons that could be applied there too to achieve polio eradication.

I would like to inform you that on 20 September 2015, the Global Commission for Certification of Eradication of Poliomyelitis declared that wild polio virus type 2 has been eradicated globally. This declaration is significant in preparing for the phased removal of oral polio vaccines under the polio endgame strategy, beginning with the switch from trivalent OPV to bivalent OPV. The introduction of IPV is one of the preparedness criteria for the switch from trivalent OPV to bivalent OPV. India's decision to introduce IPV in the national immunization programme paves the way for the switch that is scheduled to be undertaken globally and in India in April 2016.

Let me assure you that WHO is fully committed to support the national and state governments to achieve that switch. At the same time WHO is fully also committed to support countries to strengthen their immunization programmes to protect children from vaccine preventable diseases. In consonance with WHO's strategic priorities, India has been utilizing the rich polio legacy to benefit other health programmes for broader public health gains in the country.

Driving an inclusive global agenda

Fifteen years of the Millennium Development Goals have brought significant progress in reducing maternal and child mortality, both regionally and globally. Child mortality has dropped by more than half since 1990 and maternal mortality has declined by more than 50% over the same period. Despite these achievements, the South-East Asia Region will still miss the targets of MDGs 4 and 5 by December 2015.

But there is hope. As the MDGs are sunset, a new era would dawn in the shape of Sustainable Development Goals. Next month the UN will launch the 17 Sustainable Development Goals with 169 indicators which pave the road to end poverty, transform lives and protect the planet. One of the essential elements for delivering on the SDGs, 'Ensuring healthy lives, knowledge, and the inclusion of women and children' provides a clear mandate to build upon the gains of MDGs 4 and 5 within the broader universal health coverage agenda. We cannot allow the gains of the MDG era to be lost; we must build on the successes to strive towards greater achievements in the next fifteen years.

We cannot allow the gains of the MDG era to be lost

I would like to emphasize four points that this august gathering might give some thought to in their deliberations.

First, we must be cognizant that *more of the same will not do*. We have proven interventions to address maternal and child mortality. We know how to do it. But the interventions are either not taken to scale or are just simply not implemented. Therefore, we need innovative ways to deliver proven interventions to reduce equity gaps and enhance access to maternal and child health services.

We need to take advantage of technology such as mobile technology and digital infrastructure to identify clients, monitor

Third Global Call to Action Summit (for maternal and child survival), 27–28 August 2015, New Delhi, India

implementation and track progress. We must look at integrated service delivery models that provide continuum of care across the life course; for example, why can't we deliver HIV, Malaria & TB drugs together with maternal and child care services or vice-versa?

Second, there is no alternative to a strong health system in a country – a system that provides effective, safe and quality health care. Adequate health infrastructure placed strategically to match the spread of population with adequate health workforce to deliver a range of services and a logistics system that ensures regular supply of essential items are key to a functioning health care system. Governments have a role and a responsibility to ensure that the basic minimum requirements are in place for a resilient and sustainable health system. Understandably not all governments may have the resources to do so. That is where the donor community and the international partners come in to support countries.

There is no alternative to a strong health system

Third, the problems of maternal and child mortality cannot be addressed by the health sector alone. Health is a contributor to economic development; health is also a beneficiary of economic development. Good health contributes more than just wellbeing. There is interconnectedness between women and children's health to the broader socioeconomic development agenda. Therefore a conscious effort at integrated, well-coordinated, strategically targeted health interventions that engages civil society and other related sectors is critical for success. The determinant of maternal and child deaths are not amenable to technical or health specific solutions alone. They depend as much or more on the actions or non-actions of other sectors that impact on health. Therefore, collective action and partnership across all sectors, among development partners and in close tandem with the community needs are critical in making notable gains in the years to come.

And finally, the SDGs aim to eradicate poverty in all its forms and dimensions. *This is important as is good nutrition across the life course*, access to food, improved sanitation and clean water supplies which are basic needs to address the determinants of maternal ill health and child mortality.

As I said in the beginning, there is hope to do better; much better. A Global Financing Facility (GFF) has recently been established. This will no doubt greatly help those countries with the highest burden of maternal and child mortality.

It is now widely acknowledged that national leadership, ownership, commitment and accountability have been the keys to success in the MDG phase of global development. I feel reassured to see an ongoing commitment to these principles in this Summit with the presence of several ministers of health from our Region and beyond.

At WHO, we remain committed to collaborate with Member States and partners so that our joint efforts provide sustained support for result-oriented national actions, including development of comprehensive and inclusive national policies and strategies, with the full engagement of all stakeholders and the community.

Women's, children's and adolescents' health

The world has come a long way since the launch of the *Global Strategy for Women's and Children's Health* in 2010 by the UN Secretary-General, Mr Ban Ki-moon. The thrust of the Every Women, Every Child initiative was to make renewed efforts to save the lives of more than 16 million women and children by 2015. The global stakeholders pledged over US$ 40 billion in resources towards that objective. It was the global community's call to have not only "more money for health", but also "more health for the money".

The focus of the global strategy was on country leadership, comprehensive and integrated packages of essential interventions and services, health systems strengthening, health workforce capacity building and accountability at all levels.

Much has been achieved since then. But there is more to do. Therefore, it is a great opportunity for us, gathered here today, to take stock of where we are and to plan together where we wish to be in the next decade.

As we look back, there has been significant progress towards the achievement of MDGs 4 and 5 owing to the concerted global efforts towards attainment of MDGs. Towards that end, the UN Secretary-General's Strategy for Women's and Children's Health definitely provided a practical roadmap for policy actions as well as critical interventions that help improve health and save lives of women, adolescents and children through global, multi-sector collaboration.

Countries of our Region have made significant progress in many aspects of maternal and child health. While this progress is appreciable, to achieve MDGs 4 and 5 by December 2015

Consultation on updating Global Strategy for Women's, Children's and Adolescents' Health; 26–27 February 2015, New Delhi, India

remains a challenge for several countries. It is unacceptable that, in 2013, about 76 000 mothers died as a result of pregnancy and childbirth and there were an estimated 1.7 million under-five deaths including one million newborn deaths in the Region. National governments and the global community have expressed renewed commitments for MDGs 4 and 5 as reflected in the UN commissions on Information and Accountability, and Essential Life-Saving Commodities. In addition initiatives such as *Family Planning 2020, call to Action for Child Survival, Every Newborn Action Plan* and *Health of World's Adolescents* have kept the focus on maternal, newborn, child health & adolescent health agenda. But at the global level, there is "no one size fits all" solution. Every country has unique settings which call for innovative approaches appropriate for that setting to address the inequity in access to health care interventions by women, children and adolescents. The Global Strategy for Women and Children's Health in 2010 called for country-led health plans. As we look to the future, national leadership is even more crucial to make any further progress. We will build on the experience and the evidence gained from the implementation of the global strategy to support national leaderships as they look to the future.

We urgently need to expand the coverage of evidence-based life-saving interventions

As we reach lower levels of maternal and child mortality, we realize that "more of the same" may not work. We urgently need to expand the coverage of evidence-based life-saving interventions with quality and equity across the life-course continuum, with special emphasis on reaching the unreached people in most need.

And we can do it.

Polio-free certification of the WHO South-East Asia Region in 2014 demonstrates that we can achieve difficult goals by concerted action through broad-based partnerships. We should learn from the global as well as local experiences that what we do is appropriate, efficient and cost-effective, and evidence-based.

I am pleased to share with you that the WHO Regional Office for South-East Asia has made *'Ending preventable maternal and child mortality'* a Regional Flagship programme

with focus on the reduction of neonatal mortality. This will support our collaborative work with Member States and partners for the expansion of effective interventions with quality services to achieve a higher annual rate of reduction of maternal, newborn and child mortality to progress beyond 2015 levels. I strongly believe that this priority area of our work deserves the focus it is given as it is targeted at the most vulnerable, and I am confident that this would have long-term implications of sustainable gains for the health of women, children and adolescents. I may add that I have the strongest support of the Health Ministers of Member States of the Region for this Flagship programme.

In addition, in April last year WHO, UNICEF and UNFPA issued a Joint UN Statement on Women and Children, pledging our joint support and commitment to end preventable newborn, child and maternal mortality. I wish to acknowledge the strong and whole-hearted support of my colleague Regional Directors of UNICEF and UNFPA.

You are aware that the Post-2015 Agenda has identified 'Ensure healthy lives and promote well-being for all at all ages' as one of the SDGs. 'Ensuring healthy lives, knowledge, and the inclusion of women and children' being recognised as one of the six essential elements for delivering on the SDGs provides a clear mandate to build upon the gains of MDGs 4 and 5 within the broader universal health coverage agenda. We must be able to collectively progress towards reducing newborn mortality to below 7, child mortality to below 10 by 2035, and maternal mortality below 70 by 2013 as the new global targets.

At the same time, I would urge that it is important to look at issues beyond survival. The SDG framework clearly identifies the global urgency to address the health and development of 1.8 billion youth and adolescents. It is essential that young people receive crucial developmental inputs like safety, nutrition, high-quality education, life-long learning and skills, starting from early childhood development, especially during the first three years of life that are most critical for holistic development of human brain. You will agree that such an investment is extremely critical for girls and young women. This is especially needed for our Region that is home to a huge proportion of

the world's adolescent population and also has a high burden of under-nourished and stunted children who will benefit from early childhood development interventions.

The MDG phase in global development has proven that national leadership and ownership, commitment and accountability are the keys to success. As we migrate to the post-2015 phase of global development agenda let us reinvigorate this principle. It is also imperative that we recalibrate the roadmap for further progress along with a review and revision of efficient and effective approaches as well as progressively improve the monitoring and evaluation framework.

At WHO, we remain committed to multisectoral collaboration and development of cohesive and comprehensive national policies, strategies and programmes. We will continue to collaborate with Member States and Partners so that our collaborative efforts cascade into sustainable and result-oriented national efforts.

I would like to conclude by appealing to the global and national leadership, development partners and stakeholders to seize this opportune time to further build upon the achievements made thus far and, at the same time, look beyond the MDGs to further improve the survival and the lives of women, children and adolescent everywhere. I am particularly pleased that this consultation is being held in in our Region. I would like to congratulate and thank the Government of India for hosting it, and I also thank my colleague, Dr Flavia Bustreo, for the efforts she and her team put in to organize this important meeting in Delhi.

Health Systems Development

South-East Asia Regulatory Network

I warmly welcome you to the first annual meeting of the new South-East Asia Regulatory Network – or SEARN.

SEARN is a path-breaking initiative that will enhance information sharing, collaboration and convergence of regulatory practices across the Region. These are valuable outcomes.

As you know, many of the Region's regulatory authorities lack sufficient technical capacity, staff and resources to perform effectively. At the same time, even well-resourced authorities are hard-pressed to thoroughly evaluate all products and enforce existing regulations.

This provides challenges.

National regulators are fundamental to ensuring access to safe, high-quality medical products

National regulators are fundamental to ensuring access to safe, high-quality medical products, medicines, diagnostics, medical devices and vaccines. Ensuring that regulatory processes are efficient and effective is therefore vital to health outcomes. By extension, it is also vital to achieving Universal Health Coverage and attaining the Sustainable Development Goals.

SEARN provides a compelling solution to today's gaps and inefficiencies – one that takes full advantage of our collective strength. I thank you for your commitment and enthusiasm for this Network.

When you met in Bangkok last year you formed an Initial Steering Group with representatives from Thailand, Maldives, India and Indonesia. They have ably steered the Network since then, shaping the agenda and suggesting priorities for the Network's activities. These will be finalized in this meeting.

First annual meeting of South-East Asia Regulatory Network (SEARN), 11–12 April 2017, New Delhi, India

In Bangkok you also emphasized the critical role Heads of Agencies will play in this Network. It is encouraging to see so many key decision-makers here today to take this initiative forward.

This first Annual Meeting is important as it defines the Network's future course in very concrete terms. The adoption of a prioritized work plan and governance structure will facilitate cooperation and ensure we learn from one another while regulating the vast number of products in our countries.

The Network's success will depend on whether it delivers tangible benefits to its members and ultimately to the general public.

What am I expecting from SEARN?

I expect that by increasing collaboration SEARN will enhance the ability of national regulatory authorities to ensure the safety and quality of medical products.

I expect that by establishing streamlined work-sharing arrangements together we will find ways to accelerate access to medical products.

And I expect that as a result of SEARN, medical products across the Region will be safer and of better quality. This will benefit the vulnerable in particular, who are often pushed into poverty when paying for low-quality or unsafe products.

Achieving these outcomes will require national regulatory authorities in the Region to make good on their commitments. I am confident this will happen.

As per your wishes, I am pleased that WHO-SEARO can act as SEARN's initial secretariat and facilitate your progress.

As you know, better access to medicines is one of my flagship priorities. I am committed to SEARN's success, and to supporting your efforts.

I trust this consultation will lead to sustained cooperation among the Region's regulators, and that the foundations for SEARN's success will be securely laid.

Public health challenges

This meeting takes place at a significant moment for public health at the national, regional and global levels. The 17 Sustainable Development Goals have set the trajectory of international development until 2030, and are guiding public health programming, advocacy and action.

This meeting's goal – moving South-East Asia Public Health Education Institutions Network (SEAPHEIN) to influence public health management, education and action – is to be commended. To address the formidable public health challenges we face, and to deliver on the immense challenge the health-related SDG targets lay out, ambition is a quality to be prized.

Given the knowledge we have, and the many positive examples we can draw on from the South-East Asia Region and beyond, we know that rapid progress is possible.

It is essential we identify who is being left behind

The central aspiration of the SDG Declaration, and one that is particularly important for public health, is captured succinctly in one phrase: 'No-one left behind'. Despite recent progress, at least 130 million people Region-wide lack access to essential health services while many more experience poor quality and ineffective care. Over 60 million people are impoverished due to out-of-pocket expenditures.

It is essential we identify who is being left behind. The poor certainly are – both urban and rural. Women in some cultures. Migrants. People who are stigmatized by society because of their ethnicity, sexual orientation, religion or health condition. And – increasingly – the growing population of older persons: Between now and 2030 the number of people over 60 will almost double. To close the service gap – both present and anticipated – health systems must be more dynamic, and tailored to the needs of these groups.

8th meeting of the South-East Asia Public Health Education Institutions Network, Jaipur, Rajasthan, India, 13 February 2017.

The SDG Declaration also emphasizes that many of the SDGs are interrelated, and that integrated, multi-sectoral approaches are required to achieve them. These approaches are especially important for three major challenges that are now a high priority in the Region: anti-microbial resistance, the emerging NCD 'tsunami', and outbreak response in a globalized world.

For progress on AMR, the health sector needs to work with the food and animal sectors. For progress on NCDs, catalyzing changes in diet, smoking, exercise and alcohol requires cross-sectoral action. And for progress on outbreak response and health security, implementing the 'One Health' approach, which demands buy-in from all sectors, is vitally important. So is a greater engagement with the Global Outbreak Alert and Response Network.

The SDG Declaration is also clear that progress on Universal Health Coverage – or UHC – is central to achieving each of the health-related SDGs. Achieving UHC means ensuring that all people everywhere can access the health care they need without incurring financial hardship.

UHC is one of my Regional priorities, with a special focus on the health workforce and access to medicines. It is a priority that underpins all that we do, and which must inform all efforts moving forward.

In each of these core areas, public health professionals – those who focus on population health and health service planning – are critical to accelerating progress.

It follows that as public health education institutions, your responsibility and ability to drive real change is significant. You are training the public health professionals of the future. These professionals need to be 'fit for purpose' so to speak – ready to tackle today's public health problems and identify and respond to tomorrow's.

To make this happen, and to deliver on the SDG health-related targets, evidence suggests we need to recalibrate how we train our health workers, as well as what we teach them. In the coming meeting we have the opportunity to discuss what is

already being done, and how this Network could add or create new value. There are a few key ideas worth considering.

Most importantly, we could first better conceptualize and define what it is newly trained public health professionals can bring to the UHC and SDG agenda. For example, we can consider how they could better work with local government to improve health and social care for the elderly, or how they can enhance NCD-related legislation. We can study how and whether multi-disciplinary training would be beneficial for combatting health security threats such as antimicrobial resistance or zoonotic diseases. Similarly, we could look also at who we train and where they go after graduating.

Second, we can think about how to create broader awareness of public health issues among all health care workers, particularly during their basic training. This could help them better understand the basics of improving population health, and where clinical care fits in. How we can make that exposure more interesting and relevant, and how we can adapt pre-service training of a range of cadres, are critical questions that need to be addressed.

Third, we can explore how to better promote the visibility of major public health issues and inspire deeper engagement with them, both among other government sectors and the public more generally. This Network has immense potential to drive the discussion and to alert its members to new recommendations and messages on major public health issues. We should think about how to amplify that potential across sectors, and to insert public health issues into public discourse wherever possible.

Fourth, we can think about how public health education institutions can share experiences – both positive and negative – as they strive to meet the demands of the SDG era. Enhancing progress demands substantial cooperation, and one of the best ways we can do that is through the cross-pollination of ideas and experiences. No mistake should be repeated, just as no success should go unnoticed.

And fifth, we can consider how Network members can stimulate better data and research on public health issues that

require a stronger evidence base. As I'm sure you appreciate, good research and data is essential to meeting the immense public health challenges we face. To do all this, we will need to think creatively about how to mobilize resources given that past funding is dwindling.

By the end of this meeting you will have a clear set of feasible actions that can be pursued by the members of the Network, and which will define the Network's trajectory moving forward.

As I have outlined, the ability for public health education institutions to have a real impact on public health in the SDG era is substantial. I trust that you will grasp this opportunity, and that together we will move towards our public health goals with clarity, poise and purpose.

Monitoring health-related Sustainable Development Goals

At last year's Regional Committee, several Member States expressed interest in holding this meeting as early as possible in 2017. We have worked to make this happen.

The SDG era is now well underway and there is much to be achieved: The goal of SDG 3, 'ensuring healthy lives and promoting wellbeing for all at all ages,' is one that we are all striving towards.

It is a mark of your commitment to the SDG vision that monitoring and evaluation of the health-related indicators has been a recurrent theme at previous meetings and consultations.

The SDG era is now well underway and there is much to be achieved

This includes the Regional Consultation on Health, the SDGs and the role of Universal Health Coverage held here in New Delhi last March. As you know, a core part of the discussion centred on the SDGs' implications for national M&E frameworks, and how measurement and accountability mechanisms can enhance progress.

This technical consultation intends to build on such discussions, and to look in greater depth at how countries within our Region and elsewhere plan to monitor the health-related SDGs. This will help identify ways to enhance national capacity to monitor progress, including through equity analysis.

In pursuing the SDGs, it is important to emphasize that no country is starting from zero, and that health-related indicators will need to be integrated into national M&E frameworks and core indicator sets. National monitoring of health policies, strategies, and plans should remain the first priority in terms of

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Technical consultation on monitoring the health-related Sustainable Development Goals (SDGs), 9–10 February 2017, New Delhi, India

tracking and reporting progress towards improving health and health outcomes.

To this end, this consultation will help align the monitoring of the health-related SDGs with existing national platforms. It will do so in a way that minimizes the burden on health workers and improves the quality, analysis, and use of the indicators for better health policy and planning.

One group of targets and indicators address the unfinished business of the MDGs. Others are new and address emerging priorities, including minimizing the increasing burden of non-communicable diseases. A third group are known as 'means of implementation' targets and include health systems indicators. There is a target for Universal Health Coverage, which will be central to achieving progress on other SDG health targets.

Though we plan to explore each of these over the next two days, we will also consider health-related targets and indicators outside of SDG 3, such as those related to poverty or the environment.

So the scope of our discussions will be broad. There are nevertheless a few key points that we will focus on, and on which we have much to learn from one another. After all, six of the Region's Member States have already held country-specific consultations on M&E in the SDG era.

First, we will clarify indicator definitions and preferred data sources.

Second, we will map out how new indicators can be integrated into existing information systems and future surveys.

Third, we will identify which targets and indicators are most and least applicable to country situations.

Fourth, we will explore means to access and use data from other sectors more effectively.

Fifth, we will review the importance and use of disaggregated data for analysing inequalities to ensure 'no one is left behind'.

And sixth, we will examine how to deal with discrepancies between nationally reported values and global health estimates.

We anticipate greater clarity on these points will help countries plan activities and initiatives, and will also help crystallize a Region-wide consensus on how to move forward together.

I trust the next two days will be productive in terms of identifying some key actions and steps that can enhance data collection, management and use in your countries. The SDG agenda is an excellent entry point for advancing national efforts and increasing technical assistance to strengthen health information systems.

As a means to inform WHO's preparedness and strengthen our own capacity to support, our staff will be noting your feedback throughout, and will be keen to follow up with you accordingly.

I am pleased to note the presence of the Asian Development Bank, UNESCAP, UNICEF, and JICA at these discussions, and trust that the coming days will be used as an opportunity to strengthen collaboration between development partners.

Sixth BRICS health ministers' meeting

The BRICS platform provides opportunities for the world's leading developing countries to raise issues of common concern, and to find solutions of common value.

In the area of public health, harnessing this opportunity is exciting, and something we must continue to work towards.

The Beijing Declaration of 2011, for example, emphasized the importance of health-related technology transfer. It also highlighted the important role of generic medicines in the realization of the right to health, and called for establishing priorities in research and development.

The push to establish the BRICS Wellness Index is praiseworthy

The Joint Delhi Communiqué of 2013 built on this momentum, and expanded BRICS' range of concerns. The Communique stressed the need to strengthen health surveillance systems, and underscored the importance of reducing NCD risk factors through health promotion among other interventions.

These initiatives are making a difference in the lives of billions of people. They are also setting a positive example for public health policy the world over.

It has been immensely encouraging to see BRICS' focus on public health continue. The theme of the most recent BRICS summit in Goa – 'Building responsive, inclusive and collective solutions' – is an expression of this commitment. Indeed, BRICS' focus on inclusivity will help make universal health coverage a reality, and ensure that no one is left behind.

As part of this, the push to establish the BRICS Wellness Index is praiseworthy. As you are acutely aware, development means so much more than GDP indices, and must instead

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Address at the Sixth BRICS Health Ministers' Meeting, 16 December 2016, New Delhi, India

embrace the full spectrum of human health and wellbeing. In this regard, BRICS' broad vision is inspiring, and has much to offer the world's people and their governments.

One area in which BRICS is well placed to have an impact is in ensuring the safety and efficacy of traditional and alternative medicines. Indeed, traditional medicine has been a part of health and wellbeing in BRICS countries for many thousands of years, and remains highly relevant to the lives of billions of people worldwide.

In WHO South-East Asia Region, where one-fourth of the world's population resides, traditional medicine is perceived as safe, accessible and affordable, and as having minimal side effects. Indeed, traditional medicine has a vital role to play in advancing health and wellbeing in this Region, in BRICS countries and across the world.

As outlined in the WHO traditional medicine strategy adopted in May 2014, when traditional medicine services are integrated with existing health systems and made easily accessible and affordable, they can enhance a health care system's performance. Importantly, they can do so in a way that promotes health-seeking behaviour and reinforces positive health care experiences.

But to make this happen, comprehensive regulations governing the safety and quality of traditional and alternative medicines must be created and enforced. Safety should be fundamental to the provision of any treatment or procedure.

Countries that produce traditional and alternative medicines have the opportunity to take a leadership role in this process. Not only will greater regulation ensure that products are safe and effective, but it will also inspire confidence among consumers. At the same time, unscrupulous producers will be barred from entering the market.

In South-East Asia, several initiatives aimed at achieving these outcomes have occurred in recent years.

In 2013 the 'International Conference on Traditional Medicine for South-East Asian Countries' was held in New Delhi.

The Conference was jointly organized by the Government of India and WHO South-East Asia, and resulted in the adoption of the Delhi Declaration. Among other things, the Delhi Declaration called for the harmonized regulation of traditional medicines.

In October 2015 WHO held a Regional meeting in DPR Korea focused on how best to monitor and evaluate the performance of traditional medicine systems. At this meeting Member States again highlighted the importance of strengthening regulatory systems for traditional medicine products, particularly with regard to developing national adverse event reporting systems.

And just last month the 9th Annual meeting of International Regulatory Cooperation for Herbal medicine was held in New Delhi, where IRCH Member States recommended strengthening international cooperation to ensure the safety and integrity of products and to guard against them being substandard or adulterated.

Similar initiatives by BRICS can help advance the visibility of traditional medicines at the global level.

While noting the importance of regulating traditional and alternative medicines, I also want to stress the opportunity we have to make this part of a wider push to enhance the quality and reach of health care services.

The BRICS cooperation agenda in health, for example, could bring together technical experts on drug discovery & development – including with regards to traditional medicine – to address the multiple epidemiological challenges BRICS countries face. Other areas of co-operation could include human resource development of young scientists, for example, or the conversion of traditional medicine knowledge into hard science through validation procedures.

Besides supporting R&D efforts, overcoming existing inefficiencies in the supply and logistical management of drugs would also help improve access to essential medicines. We have a number of existing communiques and declarations that identify emergent needs and make clear recommendations,

and I am sure that deliberations at this conference will examine them further.

In implementing such plans, BRICS countries are fortunate to have at their disposal the New Development Bank, which was formed with the stated vision of supporting and fostering infrastructure and sustainable development initiatives in emerging economies. BRICS countries, as well as countries across the South-East Asia Region, now have an excellent opportunity to fill the gaps between 'needs' and 'funding'.

WHO's support and technical expertise is at your disposal. WHO is pleased to assist in enhancing regional and global cooperation in strengthening the safety and efficacy of traditional medicines, and in enhancing health coverage more broadly. WHO South-East Asia looks forward to further joint learning opportunities.

By working closely with one another, and updating each other on our respective initiatives, we can accelerate progress and advance the health and wellbeing of billions of people across the world. In doing so, we can also create a new template for effective public health cooperation, diplomacy and action.

SDGs and universal health coverage

Welcome to this important meeting on the opportunities Punjab has to leverage the SDGs and enhance public health and development across the state.

I think everyone in this room knows by now that the 2030 Agenda for the 17 Sustainable Development Goals – or SDGs – reflects a significant change in thinking about what should be achieved and how to go about it. This applies to development in general, as well as health more specifically. Indeed, the health goal – SDG3 – builds on the significant success of the health-related MDGs. But it is also much broader in scope, calling on us to 'Ensure healthy lives and promote well-being for all at all ages'.

The SDG agenda recognizes that human health and wellbeing depend on the political, economic, social and natural environments within which people live

This breadth reflects the reality of people's health needs today: not only do the SDGs implicitly recognize the need to close-out the unfinished MDG agenda, but they also respond to new priorities such as non-communicable diseases, health security, and the health impact of migration and climate change. Achieving these goals is, obviously, of utmost importance to our Region.

In terms of how exactly to realize them, the SDG agenda recognizes that human health and wellbeing depend on the political, economic, social and natural environments within which people live. This more integrated approach marks a departure from the MDGs, and reflects the ambition of the SDG vision.

Though critics have argued that a lack of definition could inhibit progress, such a charge is mistaken. As with all policy initiatives, our ability to turn vision into reality depends on the praxis we use. With regard to the SDGs, our praxis is clear.

Keynote address at the consultation on "Sustainable Development Goals and UHC: States' perspectives" 11 November 2016, Chandigarh, India

There are six universal instruments of change that must be employed.

The first instrument is leveraging intersectoral action by multiple stakeholders. Health must feature prominently in all sectors of policymaking, with the linkages between sectors clearly understood. To give an example from India, around 9% of the population today is over 60, though projections suggest it will rise to 20% by 2050. By linking pensions and employment policy, and breaking down the institutional barriers that too often exist between medical and social care, the heath needs of older persons can be addressed.

The second instrument is health system strengthening with the aim of achieving universal health coverage. The performance of health systems and their ability to provide services to all without risk of financial hardship must be a fundamental priority. By focusing on primary health care we can accelerate the gains made under the MDGs; expand health outcomes related to challenges such as NCDs and mental health; and promote practical ways of implementing other health interventions such as routine immunization.

The third instrument is an emphasis on health equity and human rights. As history demonstrates, the human rights discourse and its associated mechanisms are immensely powerful. The right to the highest attainable standard of health must inform everything that we do, and must intersect with other human rights concerns related to gender and non-discriminatory laws, for example. Leaving no one behind must be the mantra of a new progressive universalism in which the provision of high-quality public health care is non-negotiable.

The fourth instrument is securing adequate and dependable financing. With foreign aid unlikely to increase in coming years, health authorities in low- and middle-income countries must find novel ways to finance their public health initiatives, including by pursuing public-private and sustainable international partnerships. They must also find ways to maximize value. By investing in health system strengthening rather than vertical disease control programs, for example, health authorities

can avoid the duplication of functions while advancing the reach and quality of services.

The fifth instrument is encouraging scientific research and innovation. Our narrative of change can only be realized by investing in the development of new technologies, new legal and financial instruments, and new ways of delivering health care services. This could be as simple as digitizing health services to enhance data collection or as ambitious as developing purpose built research facilities.

The final instrument – and one which informs all of the others – is implementing effective monitoring and evaluation systems. Without effective monitoring and evaluation we cannot gauge the effectiveness of interventions and adjust course if necessary. And we also cannot understand who is being left behind and why. Effective monitoring means paying attention to data – both its collection and analysis – and having the courage to revise policy as and where necessary.

Without effective monitoring and evaluation we cannot gauge the effectiveness of interventions

It is not foreseen that the health-related SDGs will be achieved overnight. Rather, the process will be one of progressive realization. An important takeaway from this year's 'Regional Consultation on Health, the SDGs and role of Universal Health Coverage' was that no country is starting from zero, and that each must therefore develop its own plan using the instruments I have just outlined.

In this regard, India's own commitment to UHC and its determination to build on recent successes is most inspiring. Given that much depends on sub-national action, it is also inspiring to see the same commitment being echoed at the state level here today. Indeed, I note with pleasure the steps the state of Punjab has made towards achieving UHC in recent years.

This includes augmenting the health workforce through recruitment of staff nurses, lab technicians and specialist doctors. It includes actions to enhance the range of services offered, from increased numbers of ambulances on the roads to more readily available cancer screening and treatment services. And it also includes improved access to medicines and increased financial protection. I here note Punjab's efforts to make essential drugs

free of cost, including medications for chronic diseases like hypertension and diabetes. As I mentioned earlier, monitoring and evaluation will be crucial to ensuring implementation is moving in the right direction and that the intended groups are benefiting.

In commending Punjab's efforts to move towards UHC in recent years, and in urging you to build on these achievements, I take this opportunity to reiterate WHO's full support for your efforts. I also take this opportunity to reiterate the Organization's ongoing role in facilitating the achievement of our shared agenda.

To this end, WHO is pleased to offer capacity building and technical support. This involves participating in consultations such as the one being held today, as well as helping health authorities fine-tune their policies and interventions, from expanding the health workforce to enhancing data collection.

WHO is energized to rally social and political will in support of the SDG agenda and the achievement of UHC. This includes through convening high-level advocacy and awareness initiatives, as well as engaging with the wider public via traditional and social media.

WHO is similarly looking forward to reporting to countries on a regular basis on global and regional progress. This requires informing countries of progress among their peers and facilitating opportunities to learn from their successes.

And WHO relishes the opportunity to represent public health interests in SDG-related deliberations at regional and international levels. This means connecting the concerns of national and sub-national health authorities to the wider agenda, as well as working to enhance cooperation and efficiency at the macro level.

I appreciate very much your commitment to harnessing the promise and power of UHC to drive health reform in the state of Punjab. Your dedication to leaving no one behind will not only advance the enjoyment of fundamental human rights, but will also drive social and economic development in your state and across India.

Herbal and traditional medicine

I would like to thank the Government of India and the Ministry of AYUSH for inviting me to address the Ninth annual meeting of International Regulatory Cooperation for Herbal Medicines. It is a great pleasure to be here today and to have the opportunity to engage with you on a subject that has such wide-ranging significance in people's lives.

Indeed, traditional medicine has been a part of health and wellbeing in the South-East Asia Region for many centuries, from Vedic India through to the present. As those of you who have travelled from afar would also know, traditional medicine has long-standing historical and cultural roots elsewhere, including in Europe, the Americas, Africa, the Middle-East and the Pacific.

But beyond its cultural resonance, traditional medicine is often perceived as a safe and affordable option in contrast to the potentially burdensome costs of standard health care treatments and procedures. Where coverage may be incomplete or out-of-pocket expenditures high, traditional medicine is a reliable go-to for many.

When traditional medicine services are integrated with existing health systems, kept safe through effective regulation and made easily accessible and affordable, they can enhance a health care system's performance. Moreover, they can do so in a way that promotes health-seeking behaviour and reinforces positive health care experiences.

As public health practitioners and advocates, it is of critical importance that we understand this. As outlined in the WHO traditional medicine strategy adopted in May 2014 at the 67th World Health Assembly, we must harness the contribution of traditional medicine to health, wellness and people-centred care.

Ninth annual meeting of International Regulatory Cooperation for Herbal Medicine, 8–10 November 2016, New Delhi, India

At the same time we must promote the safe and effective use of traditional medicine by regulating, researching and integrating traditional medicine products and practitioners with national health systems.

The interlocking nature of these aims is self-evident: Safety is fundamental to the provision of any treatment or procedure, including when we use herbal and traditional medicines alone or combined with other medicines. Effective regulatory systems are therefore crucial to ensure and maintain the safe use of herbal and traditional medicines.

Nonetheless, setting and enforcing comprehensive standards and regulations for traditional medicine products remains a significant challenge in most countries. Overcoming these challenges and improving regulatory systems is vital for a number of reasons.

First, traditional medicines are now being produced on an industrial scale, meaning effective quality assurance and control practices must be in place to ensure a consistent and reliable product. Regulators and manufacturers need to work together to strengthen the specific quality assurance practices unique to traditional medicine products.

We must promote the safe and effective use of traditional medicine

Second, traditional medicine products are no longer restricted to local markets, but are entering regional and global supply chains. Regulatory harmonization and collaboration across the globe is crucial to maintain and enforce appropriate standards of quality.

And third, as with any lucrative trade, large profits may attract unscrupulous producers that attempt to exploit the traditional medicine market, which is typically less regulated than others. Regulators must protect the public from adulterated, fake or poor quality traditional medicine products that can be harmful and may cause lasting injury or death.

Drafting and implementing effective policies depends not only on the technical capacity of regulators, but also on their ability to communicate, collaborate and rely on competent regulators in other countries and regions. It is for this reason that this meeting is of such critical importance. It is also for this reason

that your mission – to "protect and promote public health and safety through improved regulation for herbal medicines" – is commendable and should be adopted by all countries.

In saying this, I note that only four countries in the South-East Asia Region are members of IRCH. Nevertheless, I do hope that more countries will adopt good regulatory practices that have been developed by your network, and that they also consider becoming members in future. After all, strengthening Member States' regulatory systems for herbal and traditional medicines is consistent with WHO's aims, and we are most pleased to work with you on this. Of late a number of important initiatives have occurred within the Region.

During October 2015 WHO organized a Region-wide meeting in DPR Korea where we discussed how to monitor and evaluate the performance of traditional medicine systems. At this meeting Member States highlighted the importance of strengthening regulatory systems for traditional medicine products, particularly with regards to developing national adverse event reporting systems.

As a result, in 2016 WHO initiated documentation of country case studies on pharmacovigilance systems for traditional medicine products in India and Thailand. In addition, in August WHO organized a follow-up technical consultation to establish indicators that will help monitor traditional medicine system performance.

It is anticipated that this meeting will help inform these ongoing initiatives and will help enhance international regulatory cooperation for herbal medicine. I look forward to the action points that emerge from this meeting and again reiterate WHO's commitment to support you in your efforts to promote safe and effective use of traditional medicines.

Health management research

An event such as this is special to every student, because it is the culmination of a period of hard work in pursuit of a coveted degree. And this convocation is the time when you are recognized for having achieved that goal.

Congratulations to each one of you; your hard work has paid off and you can be justifiably proud. And likewise the parents who are gathered here too also should be proud. Your daughters and sons have proven themselves worthy of the degrees and diplomas they are receiving today.

It is indeed an honour for me to have the opportunity to talk to you, the bright young men and women gathered here.

You are our future.

Let me first reflect a little on the importance of this institute. The two words that strike me most are "management" and "research." Now why are they important in public health; for that matter, why are they important for health?

In today's world management is a profession by itself

In today's world management is a profession by itself. But often people have no time to get the necessary management skills before they are put into management positions. When you are a medical student, you train yourself to be a competent doctor and you think of further specialization into areas such as surgery, cardiology, oncology etc. You never think of becoming a management specialist. Yet many of you will assume that management responsibility at some stage of your life in the future. Be it as a head of a hospital, or in charge of a public health programme, you will not only need your technical knowledge but also management skills.

Address at 2nd convocation of the IIHMR University, 5 June 2016, Jaipur, India

And management skills include financial and human resources management/ policy formulation and strategic programme planning skills/knowledge of evaluation and monitoring/ and measuring outcome of your interventions. It is for imparting such skills to health professionals that institutions such as the Indian Institute of Health Management Research are born.

We are proud to have a world class institution here in Jaipur. Over the years the IIHMR has contributed much to build management capacity in a variety of areas, be it hospital management, pharmaceutical management or management at the primary health care level. The IIHMR has now become a major destination for training and capacity development in many other areas such as human resources, leadership, economics, pharmaceuticals and strategic management, among others, which Dr Gupta mentioned. I look forward very much to the MBA.

It is an invaluable resource for us and we must make full use of this world-class infrastructure and human capital available at the IIHMR.

Health landscape is changing continually; there is no one model that suits all. We have health services run solely by government, we have health services run by the private sector only, and we also have a mix of both government and private. This can be in varying proportions and complexities. With changing epidemiology of diseases and advances in technology and in the pharmaceutical arena, health care services and demand for services are also constantly evolving. Therefore, research is essential to ensure the right mix of approaches or technologies to solve today's health needs. Unfortunately, like in many other developing countries, in the countries of our Region too research is relatively neglected. Competing priorities constrain governments from making significant investment in research. Due to a relatively underdeveloped research culture and research community, ability to access international research financing is limited. Yet, for the effective and efficient management of any health system, research is a must.

Therefore, we must look to institutions such as we have here, not only to carry out its own research, but also to train young researchers so that our people can come up with quality proposals that can attract financial support. I am encouraged by the wide range of research papers published by the IIHMR; I am also encouraged to see that the institution has many training programmes on research.

With its partnership with world's leading public health institutions such as the Johns Hopkins' University I am confident that the IIHMR will grow from strength to strength. WHO has already designated IIHMR as a WHO Collaborating Centre for management training and we will continue to support this partnership so that we can strengthen health management and health research capacities in all our Member States.

The countries of our Region are making great progress in health. Over the last 15 years, development funding for health has tripled and domestic budgets have grown rapidly. The importance of public health is being recognized by professionals in every field, from economists to development experts, and from politicians to industrialists. This is making real change possible.

The countries of our Region are making great progress in health

Many diseases are on the verge of eradication, and several more are being eliminated. Our Region has remained polio free for more than five years, the epidemic of HIV/AIDs has been reversed; malarial deaths have declined tremendously. Child mortality has fallen by over 50% and maternal mortality by over 40% in the last fifteen years. The struggle against vaccine-preventable diseases is going from strength to strength; only just recently the Region declared maternal and neonatal tetanus as eliminated. As a result of many of these extraordinary achievements in health, people today are living longer and healthier lives.

But this is not to say that there are no challenges. There are.

Drug resistance is a major emerging public health crisis. Diseases such as malaria and tuberculosis which were being effectively controlled are having resurgence due to

drug resistance. Malaria resistant to artemisinin compound, tuberculosis resistant to second-line drugs are becoming major concerns today. At the rate antimicrobial resistance is emerging, if we cannot stop it in time, soon we will be back to the pre-antibiotic era.

And then there is the emergence of new diseases or spread of existing ones into areas where such diseases did not traditionally thrive. For example, dengue is rapidly spreading – even into areas where the vector mosquito did not thrive. Then we have deadly diseases such as Ebola virus which, from obscure sources in the deep jungles of Africa, suddenly becomes a major global threat. And more recently, Zika virus, which is a mild illness which suddenly attains notoriety as scientists establish its link with microcephaly.

But let me not discourage you with these stories. I want to say to you, the graduates assembled here – there is a lot to live up to; there is a world of opportunity for you to grasp.

You are all at the beginning of your careers. The choices you can make with the qualifications you have are many, and there are several pathways you could pursue. As I wish you the best in realizing your dreams and aspirations, I also invite each of you to reflect on how best you can serve the national, regional and global health causes in what is an exciting and dynamic time to be in the health sector. I urge you to familiarize yourself with the enormous strides being made in public health and to be aware of your capacity to make a positive impact in this fast-changing world.

The world has just launched the new vision for the next fifteen years. The Sustainable Development Goals or SDGs is a set of 17 Goals and 169 targets that aim to provide the platform for an integrated development relevant to all countries. The new agenda provides us with a great opportunity to accelerate progress, to make universal health coverage a reality, and to improve the lives of millions of our fellow citizens.

And it is a broad agenda. Where the MDGs saw health in isolation, the new agenda frames health as both a contributor to sustainable development as well as an important beneficiary. In

practical terms, this means that health is linked with the goal of reducing hunger and improving nutrition; to ensuring universal access to sexual and reproductive rights; to making safe water and sanitation available to all; to advancing energy efficiency; to enhancing sustainable production and consumption; and of course to the broader goal of eliminating absolute poverty.

This mandate entails significant responsibility.

As young health professionals, your mission will increasingly involve working with multiple stakeholders across sectors. In the course of your professional lives you will work alongside government, industry, NGOs, and private health care providers among others. Your role will be complex but exciting. You must always retain focus on why exactly you got into this field in the first place, which is to protect and promote the public's health.

Having successfully completed your education at this wonderful campus, I trust that you are well positioned to do this. I once again congratulate each and every one of you for the degrees and diplomas that you have earned. May the hard work and commitment to your chosen paths bear reward, and may you continue the habit of learning and growing throughout your professional careers.

I look to the IIHMR to take the leadership path more vigorously in strengthening regional capacity for health management and health research. And rest assured that WHO will support it in whatever way we can in this joint endeavor.

I would like to wish IIHMR University all the best and, at the same time, also thank you for inviting me to be part of this significant convocation. I look forward to our continued engagement as we work towards ensuring healthy lives and promoting wellbeing for all at all ages.

Sustainable Development Goals and role of Universal Health Coverage

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

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

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

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

I want to address two big questions.

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

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

Regional consultation on "Health, the SDGs and role of Universal Health Coverage: next steps in South-East Asia", 30 March-1 April 2016, New Delhi, India

So, question one: how did we get here?

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

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

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

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

The MDGs - have been an outstanding success

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

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

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

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

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

They say nothing about the role of economic growth.

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

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

And in health ...they focus on a limited set of outcomes: they overlook new priorities like noncommunicable diseases and health security; they say little about the role of health systems.

They have created silos, vertical delivery and financing systems and distorted national planning and budgeting.

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

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

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

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

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

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

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

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

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

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

The SDGs cover the three pillars of sustainable development: economic, environmental and social

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

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

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

On a more serious note, though, throughout the negotiations a veritable army of interest groups lobbied intensely

to ensure that their priorities found a place; sadly, with little concern for the coherence of the agenda as a whole.

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

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

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

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

So, a house divided.

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

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

I also want to come off the fence.

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

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

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

First of all health is in a prominent place in the new agenda. Goal 3 is broadly drafted: Ensure healthy lives and promote well-being for all at all ages. It is followed by 13 more specific targets. Several of these follow on from the unfinished MDG agenda. Indeed, much of the critique about feasibility and measurement directed at the SDGs can be easily countered when it comes to the health goal, even though the agenda is now more ambitious.

At the same time, it is important we recognize the breadth of the new agenda. Where the MDGs saw health in isolation, the new agenda frames health as both a contributor to sustainable development as well as an important beneficiary.

In practical terms, this means that health is clearly linked with the goal of reducing hunger and improving nutrition; to assuring universal access to sexual and reproductive rights; to safe water and sanitation; to energy efficiency; to climate change; to sustainable production and consumption; to civil registration and legal identity; to preventing violence; and of course to the broader goal of eliminating absolute poverty.

No one must be left behind

The second point is that at first glance, the list of targets under Goal 3 is a bit of a mixed bag. However, if we go back to the Declaration that precedes the detailed description of goals and targets, it gives us a clue as to what is required. Let me quote what it says:

"To promote physical and mental health and well-being and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind...."

Universal Health Coverage seen in this light is the target that underpins all the others and helps make the health agenda cohesive and less like a list of separate programmatic silos.

It is thus a means to an end. And, I must add, it is also a desirable end in and of itself.

The key idea of Universal Health Coverage is that all people have access to the services they need, without facing financial hardship when they fall ill. Obviously, each country comes at this target in its own way. UHC is not a fixed state - it needs to be seen as a journey where the range of services available increases progressively, as does the proportion of the population that is protected financially.

In this meeting we will begin by reflecting on 'who is still being left behind?' in terms of access to care and financial protection in our Region. Despite considerable progress on the MDGs, a recent report on Tracking Universal Health Coverage by WHO and the World Bank found that globally, 400 million people still lack access to one or more of seven essential health services. 130 million of those people are in our Region. And around 50 million people are pushed into poverty each year in our Region, because of the costs of health care.

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

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

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

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

sanitation or the health impacts of climate change are found under other goals.

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

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

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

Understanding that achieving good health outcomes can never depend on the health sector alone is not exactly new. We have known this for ages. But the SDG agenda should, if nothing else, provide new impetus and energy for putting ideas into action.

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

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

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

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

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

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

My sense is that the anxiety generated by figures like this is misplaced. Firstly, like any normative framework the aim is for progressive realization. Countries will proceed at their own pace given the availability of resources; a point that is reinforced by the emphasis on national target setting.

Second, even though estimating the costs of some of the more aspirational targets will remain highly imprecise, some goals including Goal 3 can and will be costed more accurately.

The affordability and rate of progress in implementing the SDGs is a question - in the majority of countries - for the national government, far more than it is for their development partners.

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

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

In our Region, economic growth is expected to continue. We stand well placed to pull millions more out of poverty,

though the inclusiveness of that growth will be a common challenge.

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

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

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

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

The SDG health agenda is relevant to all countries

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

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

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

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

SEAR Advisory Committee on Health Research

Research remains one of the six core functions of WHO. It includes shaping the research agenda and stimulating the generation, translation and dissemination of public health knowledge. Health research is critical to improve the quality of care and health outcomes, and helps find appropriate solutions to everyday challenges in the health-care settings.

Before I venture any further, let me first dwell on the Advisory Committee on Health Research and the important role it plays in guiding global and regional health research activities.

The ACHR helps narrow the gap between researchers and policy-makers

The ACHR is an advisory body to the Regional Director, and has a consultative mandate to support the World Health Organization in carrying out its constitutional role of promoting and coordinating research related to international health work, in cooperation with external institutions pursuing common goals and with the scientific community in general. The ACHR helps narrow the gap between researchers and policy-makers in their respective countries. The WHO South-East Asia Advisory Committee on Medical Research, or ACMR was established in 1976, and renamed SEA-ACHR in 1987 with the word "medical" replaced with the word "Health".

The SEA-ACHR has contributed towards highlighting the research needs in the Region as per changing situations and needs. I would like to briefly highlight some recent key outcomes of deliberations of the ACHR to give you an insight on the workings of this advisory committee.

- The 25th ACHR in 2000 recommended the Regional Director to review and update the terms of reference,

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The Thirty-fourth session of WHO South-East Asia Advisory Committee on Health Research, 14–15 December 2015, New Delhi, India

membership and methods of work of the newly reconstituted SEA-ACHR.

- The 30th ACHR in 2007 recommended that an interactive forum for ACHR members be established and regional advisers appointed in SEARO to facilitate and exchange views on health research in-between ACHR sessions. This aimed to help sustain interest and generate ideas and action in health research more regularly and effectively.
- The 31st ACHR in 2009 recommended that a Regional Strategy for Research for Health be developed.
- The 32nd ACHR in 2011 prepared and considered a draft of the Regional Strategy in which five priority issues and five strategic directions were identified for the purpose of the Regional Strategy.
- The 33rd ACHR in 2013 deliberated on thematic areas, including capacity-building, and more specifically for smaller Member States.
- In October 2014, an intercountry meeting on strengthening Regional framework and developing a research action plan was held. This meeting was conducted in response to the 33rd ACHR meeting. At that meeting it was observed that even with agreement on "health research priorities", the best way to finance research and development in priority areas to produce public goods for improving health is often not clear.

Recommendations and follow-up actions over the past year reveal that there is continuity and follow-up between successive ACHR meetings. The contribution of the ACHR over the years has been unquestionably valuable. However, much more needs to be done to get optimal results from heath research in a complex region such as South-East Asia where the challenges are enormous. This is accentuated by the 10/90 gap, wherein 10 per cent of the resources for research are available in parts of the world where 90% of the health problems persist. It is estimated that less than 3% of the global funding for researches go to developing countries and only 27% of all the researchers

in the world are in developing countries. There are a number of other challenges to manage health research in South-East Asia.

These include:

- Weak health systems to support health research in some countries.
- Absence of clear national policy on health research in most cases.
- Weak coordination of health research activities at both national and institutional levels.
- General weakness in the management of research information and its wide dissemination and use of results.
- Lack of capacity and facilities relating to laboratory, literature and library services and lack of modern tools for data processing and management.
- Lack of incentives to motivate and encourage researchers to improve their competencies.
- Difficulty in mobilizing funds to finance health research.

Success can only be achieved through innovations

Despite this, there have been success stories of WHO research work conducted with advice from SEA-ACHR. Areas of such research include chronic liver disease, treatment of snake bite, chronic respiratory infections, and dengue vaccine. This list looks thin and we need to do more.

We are in an era when success can only be achieved through innovations and ACHR should advice on ways of integrating innovation as a part of SEARO's core business. This is also the era of an enhanced space for SEARO Member States on the global map of health technology. I have promised to my Member States that this Region shall forge ahead. This requires strong capacity-building in all countries including areas of implementation research that can address the barriers to meeting the Sustainable Development Goals and the time bound flagship targets that I am committed to. We need your advice to help us steer forward to address these issues.

One of the changes I have proposed to my staff to help ACHR function more efficiently is that ACHR can make recommendations through virtual meetings and also hold meetings of task forces. You may please suggest how we can work more dynamically as well as with other global partners and with headquarters. We also have a session on resource mobilization, collective engagement, and challenges related to inequity in research and the means to address that.

We have among our ACHR members and our special invitees a galaxy of experts from different areas of specialization and from different Member States. We would like you to share your expertise in identifying areas where WHO SEARO can add value to. This is an era of boundless new opportunities with a new IT environment, unprecedented economic development of Member States, and expanding funding opportunities. We need to capitalize on these advantages.

WHO-Maldives partnership

Today is indeed a special day; a day to mark an important landmark of the shared journey of the people of Maldives and the World Health Organization.

It was on 25 February 1965 when WHO, became the first UN agency to open its country office in the Maldives. And since that day, the last 50 years journey has indeed been an incredible one. Therefore, it is with great pleasure and also with great pride that I have the honour to be here to celebrate the Golden Jubilee of independence of the Republic of Maldives and, also to mark the 50th Anniversary of WHO-Maldives partnership.

My special thanks to the Honourable President for gracing the occasion.

WHO's work in the Maldives precedes the actual opening of the WHO country office. It was in 1951 when WHO first fielded a mission to conduct a survey for lymphatic filariasis. Subsequently WHO's engagement expanded to address overall health needs of the country. In the decades since then, the Maldives made remarkable progress in the establishment of health services and building a health system that yielded many successes in public health. Based on the principles of Primary Health Care, Maldives has established a network of well-quipped hospitals on the islands, initiated key preventive health programmes and services, and put in place policies that strove to deliver equitable, accessible and quality health care services for all its people. The results are truly remarkable.

- Life expectancy in Maldives increased from 47 years in 1977 to 77 years in 2012;
- Infant mortality dropped from 34 per 1000 live births in 1990 to 9 per 1000 live births in 2011; and

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Address at the 50th anniversary of WHO-Maldives partnership, 6 December 2015, Malé, Maldives

- maternal mortality fell from 500 per 100 000 live births in 1990 to 56 per 100 000 in 2011.

Maldives achieved 5 out of 8 MDGs by 2008, and is well on track to achieve the other 3 Goals ahead of 2015 deadline, making it a MDG+ country. In addition, malaria and polio are eradicated, and the country is about to be declared filarial free as well. Measles and rubella have not been registered since 2010. Further, Maldives introduced the inactivated polio vaccine in 2015 and is the only country in the South-East Asia Region to do so with domestic resources. Maldives, therefore, is truly a shining example to other countries.

This would not have been possible without the wisdom and the commitment of national leadership at every step. It is with appreciation that I congratulate His Excellency, the President, and the Government for the remarkable achievements in the health sector. Coupled with overall socio-economic development, improved health has led to poverty alleviation; achievement of universal primary and secondary education, prolonged life expectancy and the overall improvement of health and well-being of the people of the Maldives.

WHO is proud to be a credible and trusted partner of the Government and the people of the Maldives. It is heartening to note the continued commitment at the highest level and, under the insightful leadership of His Excellency, the President, and with the professional execution by the Health Minister, the Maldives health sector is already undergoing further reforms to meet the emerging needs of the country. Such reforms include the introduction of General Practitioner's services, Health Insurance as Unlimited Aasandha with expanded service coverage, and the expansion of pharmacies to islands to make essential drugs and medicines available and accessible to all people.

These efforts have been matched with increasingly higher financial allocations in the national budget where I see a noteworthy spending of about 40 per cent on the social sectors. This high allocation is certainly one of the highest in the South-East Asia Region, and I commend the Government of the Maldives for its farsightedness. It is important to rejoice at the successes and strengths of the current systems. But the

country is going through rapid transition in addition to emerging health needs that already is testing sorely the systems and services currently available. While we rejoice at elimination or eradication of important communicable diseases, sedentary lifestyles, dietary habits and environmental conditions are bringing in problems of obesity, diabetes, high blood pressure, cardiovascular diseases and cancers. In addition, as people live longer, the health care needs of an ageing population place additional stress on existing systems. Further, with changing technology and evolving epidemiology of diseases, health care costs are rising fast.

The Maldives, in addition, has the unique problems faced by low-lying island countries. Rising sea level and climate change are already having visible effect on both environment and health of the population. These challenges coupled with health system issues such as human resource shortage, under-utilization of some regional health facilities, and high out-of-pocket expenditure are concerns that will need to be addressed. But I am confident that the leadership of the Maldives will rise to the challenges adequately. WHO, as always, stands ready to support the country as we move from the era of MDG to the vast landscape of the recently adopted UN Sustainable Development Goals or the SDGs.

WHO, as always, stands ready to support the country

Against the backdrop of these achievements, it is my great pleasure to certify the Maldives as Malaria Free, the first country in our Region to be certified so. I am deeply honoured to present to His Excellency, the President, the WHO Certificate declaring the Maldives as "Malaria Free". I would like to take this moment to express my heartfelt congratulations to His Excellency, the President, to the Minister of Health, and to the hundreds of health workers who toil relentlessly in far-flung and difficult areas to make such achievements possible.

My thanks to all our partners who have been working closely with us. I would also like to take this opportunity to express my appreciation of the unstinting support given by the WHO Country Office to the Ministry of Health and the hard work that they put in to make such events possible. My congratulations to you all.

Integration of traditional medicine into national health care systems

This is an important meeting. The countries of South-East Asia have a long and rich heritage of traditional medicine. It is widely used by both rich and poor people alike. In many countries, about 45% to 85% of people use some form of traditional medicine to treat their health problems. And for some, this is their only source of health care. Dr Margaret Chan, WHO's Director-General, noted at the International Forum on Traditional Medicine that "*Modern medicine and traditional medicine make unique contributions to health*." Strengthening traditional medicine in the countries of our Region is consistent with WHO's policy to promote integrated and balanced health care systems in harmony with the country's socio-cultural environment and health needs.

Therefore, there is no place better suited to hold this meeting than here in Pyongyang. This country has a traditional medicine practice, the Koryo Traditional Medicine that goes back more than 5000 years. And the country has set up universities, specialised training institutes, pharmaceutical establishments, and research facilities to build on their rich traditional heritage and to promote and strengthen the Koryo traditional medicine practices in the country.

Likewise I am happy that other countries are here too. All our countries have rich traditions and vast experiences in providing medical care, especially traditional medical care. There is an increasing global attention and commitment to strengthen traditional medicine as an integrated and holistic part of health systems in countries to deliver on the goal of Universal Health Coverage or UHC. UHC means all people getting the care they need, without suffering financial hardship. Frontline – or primary

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Regional workshop on the appropriate integration of traditional medicine into national health care systems, 20–21 October 2015, Pyongyang, Democratic People's Republic of Korea

care – services are central to improved access to care. As I have said before, traditional medical practitioners remain the main primary health-care providers for millions of people in South-East Asia, especially in rural areas. Moreover, chronic diseases are increasingly common as our population age. Traditional medicine has a long history in the prevention and treatment of chronic disease. These developments are putting more attention on traditional medicine.

This workshop takes forward several recent political commitments. At our WHO South-East Asia Regional Committee meeting in Dhaka last year, Ministers discussed the new WHO Traditional Medicine Strategy, adopted by the World Health Assembly in May 2014. The Ministers reiterated their support for the two important goals of the Traditional Medicine Strategy, namely,

- harnessing the potential contribution of traditional medicine to health, wellness and people centred care, and
- promoting safe and effective use of TM by regulating, researching and integrating TM products and practitioners into national health systems where appropriate.

All health care must be safe, effective and affordable

In the resulting resolution adopted at the Sixty-seventh session of the Regional Committee, countries committed to implement the new WHO global traditional medicine strategy, and to continue the regional cooperation enshrined in the Delhi Declaration on Traditional Medicine of 2013. This Region is far ahead in some aspects. For example, almost all countries now have national TRM policies, which is an important element of the new global strategy.

Policy makers need timely and relevant knowledge to help them frame sound national policies and regulations, and organize and manage traditional medicine services. Moreover, all health care must be safe, effective and affordable. Traditional medicine services in our Region are organized in many ways. In some countries, traditional and modern health services are provided together at every level of health system. In others, they are more separate. There is much experience to share among

countries and there is also a lot of effort needed to document and disseminate best practices.

This means evidence is often not available to domestic decision makers, and those in other countries. There remains a real need to better document who is using TRM services and for what health conditions; how services are organised, financed and regulated, and the costs and benefits. This meeting focuses specifically on exchanging information on different approaches to the organisation, management and monitoring of TRM services, and what we know about how well they are working. The posters up around the room bear testament to your readiness for this.

We have invited both traditional and modern medicine professionals to this workshop, as each has much to offer to enrich the discussions in the next few days. I believe the workshop provides an excellent opportunity to share regional experience about appropriate integration of traditional medicine into national health care systems, and ways to strengthen monitoring and evaluation. I hope you will be able to come out with some agreed concrete and practical action plans to be taken by governments and other key stakeholders. As WHO, I reiterate our commitment to support countries in whatever manner possible to promote the use of traditional medicine and to help strengthen the systems and services for traditional medicine.

Strengthening community-based health care service

At every Regional Committee session, a technical subject is chosen for detailed discussion at the next Regional Committee (RC). And the 2014 RC agreed that the subject of this year's technical discussion would be community-based health care service delivery. It was proposed by India and supported by Bangladesh, Maldives, and Sri Lanka.

There was a technical discussion on a related topic of community health workers in 2011. This year's discussion will build on that, not repeat it. It will focus on non-facility based services, and on community based service delivery rather than community engagement more generally, though this will inevitably come in as part of discussions.

2015 marks the transition from the Millennium Development Goals or MDGs to the Sustainable Development Goals or SDGs. The targets for the SDG health goal include Universal Health Coverage, which is an important priority subject for all SEAR Member States. UHC is about increasing all people's access to care that they need, and about protecting them from being impoverished as a result of health care. It includes a fundamental concern with reducing inequities in access to care. Community-based health care services are an essential link in the service delivery chain for many health priorities.

Following the Alma-Ata Declaration on Primary Health Care in 1978, the countries of this Region have done a lot of good work on community-based health services; several countries have excellent community-based health care service programmes in place.

Strengthening Community-based Health Care Service Delivery, 15–16 June 2015, SEARO, New Delhi, India

I understand that this consultation will draw on a range of experience to analyse the 'ingredients' of successful community-based services: what has worked and not worked, and why?

I hope that this meeting will provide an opportunity to hear of the experiences from different countries and capture the lessons learnt for shaping future community-based health care service delivery in our Region. Although there are many success stories, there is very little documentation of it. I hope that this meeting will, to some extent, fill that gap.

I see that you have before you a comprehensive agenda for the next two days to discuss and share experiences from countries of our Region and beyond. Although the meeting duration is short, I am pleased that you have gathered here a host of people who bring tremendous experience and knowledge on this matter and, therefore, I have no doubt that you will come out with useful directions and guidance to help us chart our future course on community-based health services.

Importance of public health

The WHO Regional Office for South-East Asia is proud to be a co-sponsor of the 14th World Congress on Public Health. I would like to start by congratulating the organizers - the World Federation of Public Health Associations and the Indian Public Health Association. You have put together a remarkable and wide-ranging programme, attracting delegations from across the world, and you have brought together an impressive line-up of eminent speakers.

Kolkata was an inspired choice for the venue of this meeting. Public health is, indeed, coming home.

This city has a long and proud history of achievements in public health. The Calcutta School of Tropical Medicine, for example, celebrated its centenary two years ago this month.

I have no doubt that the eminent scientists who worked there - Leonard Rogers (its founder), Lt-Col Knowles, Ronald Ross, Upendra Nath Brahmachari, Ram Nath Chopra, JB Chatterjee and many others - whose efforts brought the School of Tropical Medicine to prominence in the early part of the last century - would have approved of the theme of this conference. They knew, all too well, about the link between healthy people and healthy environments from their groundbreaking work on malaria, leishmaniasis and kala-azar.

While it is important that we acknowledge the past, it is our job as public health professionals to look to the future. Healthy people - health environments is our theme this week. So when we talk about a healthy environment in 2015, what exactly do we mean? What are we actually talking about? The thematic sessions at this meeting give a good sense as to the answer.

14th World Congress on Public Health, 11 February 2015, Kolkata, India

Our horizons must be broader. No longer can we afford to focus only on the immediate environmental causes of ill-health - clean water, sanitation, clean air, safe food and shelter - vital though they remain.

Public health, if it is to be an effective force, must look beyond the immediate determinants of disease. We have to look at the social, economic and political determinants of ill health. Not just the causes, but the causes of the causes.

I would like to spend a few moments on some of the key pillars in the agenda for public health. These will form the basis of our work in the South-East Asia Region, where one-quarter of the world's population bears a disproportionate share of the global burden of disease. But they are equally relevant elsewhere.

The starting point is to recognize that health is an outcome of political choices, both within and between countries. The biggest problems we face - from the health impact of climate change to the management of severe outbreaks like Ebola - are not amenable to technical solutions alone. They require action across sectors, across governments, across societies, across countries and regions. National sovereignty is a vital concern, but to tackle the really wicked problems, requires that it be balanced by greater solidarity. We are all in this together.

Public health must look beyond the immediate determinants of disease

Public health in the 21st century requires a 21st century approach.

Let's start with health systems.

We can no longer afford to see health systems in terms of one health problem, or one population group at a time. Even with polio, finishing the job requires an environment that allows access, ensures security and sustains political support. It not just a technical issue.

More broadly, Universal Health Coverage is gaining traction globally. UHC promotes equity and is a key weapon in the fight against poverty. It is the means by which the health

sector can make real inroads on all the continuing challenges of communicable and noncommunicable diseases, as well as child, newborn and maternal health. But UHC has to be more than a public health mantra. It requires a political environment, which supports access and financial protection for all, not just those in employment, not just those who have the right citizenship papers. Universality doesn't just happen. As we have seen in some of the wealthiest countries, universal access will be a hard-fought political issue. We have to be prepared to make the case. We know our populations are ageing.

More children survive childhood, and adults - everywhere - are living longer. This change has enormous potential benefits to society, but it requires that the policy environment keep pace with demographic change. In some richer countries for example, life expectancy has increased in recent decades by 9 years. Retirement age in those countries, by contrast, has increased by less than 6 months. More important, while we know that longevity will continue to increase, there is little or no evidence to suggest that the extra years are spent in good health. Quite the opposite in fact. Health systems can help keep older people active. This is great, but little is gained if healthier older people still live in an environment which is unsafe, difficult to navigate, and in which they are cut off from the financial and social support they need.

NCDs approach like a juggernaut, threatening communities, health systems and economies if we do not act now.

One example from this country: over 60 million Indians are diabetic and this number will cross 100 million by 2030. Estimates of future economic loss in India due to NCDs and mental health run into trillions of dollars. We cannot hope to outrun NCDs without an environment that requires and stimulates action in the many sectors that impact on health: finance, trade, agriculture and education. Partnership across all sectors of society - public and private - is not an add-on in this fight. It is an absolute necessity.

Equitable access to safe, effective and affordable medicines, vaccines and diagnostic is a key pillar of our agenda.

You do not need me to remind you of the challenges of working in this highly political environment, in which the interests of many powerful stakeholders conflict. But even as we struggle to increase access to existing medicines, and to promote the development of new tools relevant to the needs of the poor, we face the equally urgent problem of preserving what we have got.

Antimicrobial resistance if not checked and soon, can return us to an era where we will be stripped of tools that today we take for granted. We have to create an environment that brings together fundamental research, better information for the public and politicians, and action at the interface between health and agriculture.

Outbreaks and disasters, man-made and natural, something to which this Region is so prone, can destroy what we have worked so hard to build.

We must not just expect the unexpected, we must have what it takes to do something about it, and fast. The outbreak of Ebola is not just a wake-up call, it is a dramatic call to arms. We have to have a health security system, globally and in each country, that works. We need clear lines of command; we need funds and people that can be mobilized at short notice; we have to have people that are trained for the job; and we need International Health Regulations with teeth. Yes, this has implications for national sovereignty, but if we cannot find the political will to support solidarity in these circumstances, then we leave our populations exposed to the next surprise that the microbial world will throw at us. This, in my view, is unacceptable.

Expectations for better health are rising

Expectations for better health are rising. Health has to be seen as a right for all, not a privilege for the few. Health equity must be a cornerstone of our policy environment: not tomorrow, but today.

This year will see decisions about the global goals that will shape our work for some years to come. This is a vital opportunity to influence the policy environment in which we work. The SDGs, if they are to fulfill the aspiration that was articulated in Rio,

need to make links - between people and the planet, between people and the resources they consume, between sectors, and between nations. Health is - genuinely - a precondition, outcome and indicator of sustainable development. It is important not to lose this vital insight in the fight to recognize each and every individual priority.

This Congress brings together in Kolkata some of the best minds in public health from around the world. As a community we can be a voice for change. Public health can make a difference. Let me end by assuring you of my support, and the support of WHO in this critical endeavour.

Health in Thailand

It is a pleasure and an honour to be with you today and to address the National Health Assembly. Let me start by sincerely expressing my gratitude to the Royal Thai Government for giving me this opportunity.

If I was asked to sum up what the world needs to know about health in Thailand it would go something like this:

Thailand is a country that is ahead of the curve. It is a country that is already putting into practice what others are only just beginning to preach. And it is a country that is getting results.

Universal health coverage, health technology assessment, health in all policies, health and foreign policy are just a few examples of how Thailand has become a leader at the forefront of policy and practice in global health.

Thailand is a country that is ahead of the curve

Take this National Health Assembly. I know of few other instances at a national level where the most important challenges facing the country are debated - with all key stakeholders present on an equal footing. Many countries talk about ownership and participation. Many people talk about the role of academia, of civil society, and the importance of engaging religious and other key communities.

We know that we need to understand the perspective of the frontline health worker and bring in colleagues from schools and workplaces if we are to promote healthy living.

But how many countries have actually done it?

Here, though, in this great venue, you are practicing what you say and doing it all for real. I congratulate you warmly.

Address at 7th National Health Assembly of Thailand, 24 December 2014, Bangkok, Thailand

May your now famous triangle continue to move the mountain.

I understand that the theme of this year's Assembly is - "Strengthening Solidarity: act together to reform for social well-being".

I see you have also narrowed down the agenda to six key items using transparent criteria so that your discussions remain focused.

I only wish we could be half as disciplined in other fora!

Let me say, though, that the theme of solidarity is particularly appropriate as we approach 2015. Next year, the nations of the world will negotiate the final transition from the unfinished agenda of the MDGs, to a new generation of sustainable development goals.

Universal health coverage promotes equity

I feel confident that health will have a prominent place in the new agenda - and I was pleased to see in the recent report of the UN Secretary-General on the post-2015 agenda, and I quote - "the agenda must address universal health care - coverage, access and affordability". UHC is seen in the report as the overarching means to achieving the wide range of health goals that are then listed in the document.

I want to stress this last point. Universal health coverage promotes equity and is a key weapon in our joint fight against poverty.

It is the means by which the health sector can make real inroads into the challenge of communicable and noncommunicable diseases; of child, newborn and maternal health; and of the challenges that all societies face as their populations age.

Support for UHC is growing; this is good news. UHC can be a game changer. It is indeed one of the most powerful concepts in public health. But it must be more than just a mantra or a slogan.

It must be a practical expression of this assembly's main theme: solidarity across society. And it is the way we deliver results.

It is a little less than a year since I became the WHO Regional Director for South-East Asia.

Ours is a diverse and dynamic Region with strong bonds of friendship and a tradition of collaboration between Member States and between Member States and WHO. We have many successes that we can proudly celebrate - not least the fact that the Region is polio-free. But we face many challenges, and they are urgent:

- NCDs approach like a juggernaut, threatening communities, health systems and economies if we do not act now. We need action not just in the health sector, but across society. Health in all policies.
- Antibiotic resistance if not checked and soon, can return us to an era where we will be stripped of tools that today we take for granted. Again, this is not just a technical issue but an issue of governance - and policy coherence between health and agriculture.
- Expectations for better health are rising. Health has to be seen as a right for all, not a privilege for the few. Health equity must be a cornerstone of our policies: not tomorrow, but today. I am happy to see that Accelerating Equity post-2015 is the theme for the Prince Mahidol Award Conference later next month.
- Disasters, man-made and natural, something to which this Region is so prone, can destroy what we have worked so hard to build. We must not just expect the unexpected, we must have what it takes to do something about it, we need be prepared and fast.

At this point, let me take a minute to talk about the continuing threat posed by Ebola.

A disease that we used to think occurred in small local outbreaks suddenly appears in countries where it is not readily

recognized. Within a short time, it reaches the crowded cities of West Africa and starts to rage uncontrolled.

This disease has already killed over 7000 people. Fear and distrust make the task of control even harder. The disruption of routine health care will claim even more victims. Education and economic activity come to a standstill. We see before our eyes the contract between states and their peoples breaking down.

We are seeing signs of progress, but the virus is still running ahead of us. Despite massive global efforts, it is proving to be extremely difficult to bring this outbreak under control.

The threat of exportation to one of the world's mega cities - in a county where health systems are weak - is ever present.

Global solidarity with West Africa is strong and I want to publicly thank the Royal Thai Government for the generous contribution to the global efforts towards containing Ebola Virus Disease I also want to thank each the Thai people who contributed to the donation campaign coordinated by Thai Red Cross and the Ministry of Public Health of the Royal Thai Government.

No country is safe from an infectious disease

The outbreak of Ebola highlights two key issues: no country is safe from an infectious disease given the global movement of people and second, no country can mount an effective response, even with outside help, if the basic health infrastructure and systems are not in place.

It is hard to talk about silver linings in a situation as devastating as that in Liberia, Sierra Leone and Guinea.

But if we could name one, it would be that the world cannot ignore the importance of robust health systems. Without basic health infrastructure and solidarity for social well-being, societies are at risk of collapse.

Working together I want us to be champions for health in our countries and in the Region.

This Region has a quarter of the world's population, but more than 40% of the global burden of disease.

Many countries invest less than 1% of their GDP in health and rely instead on high out of the pocket expenditure.

In others, costs are rising rapidly as we see in Thailand. As technology advances people's expectations grow, and the cost of health care rises putting additional strain on the budget.

As the population ages, chronic and non-communicable diseases are going to exact a heavy toll on the health care system of this and other countries in the Region. Many countries, Thailand included, have large migrant populations for whom it is a challenge to provide health care services. Other countries are affected by conflict fueled by issues of ethnicity and religion. We have to remember that universal coverage means coverage for everyone, irrespective of their civil status. We have a big agenda ahead of us.

I am committed to making WHO more focused and better equipped to work with you. Spreading our efforts too thinly wastes scarce resources. We must therefore define where our Regional and Country Offices can really add value and make a genuine difference. This is how I understand reform.

Each country has its own health challenges. You will be discussing many of them at this assembly. But also let us not forget, that each country in our Region plays a role in health outside its own borders. This may mean protecting people from the negative effects of policies in other sectors, as well as the impact of international trade and finance.

In this regard, I was happy to see that point 5 on your six point agenda is Thailand's Global Health Policy.

There is much that other countries could learn from Thailand's experience, and I look forward with great interest, not just to hearing about the outcome of the Assembly, but also to working closely with you as Thailand puts its new Global Health Policy into practice.

Human resources for health

Member States of the WHO South-East Asia Region had met in Bali in 2012 to gain commitments from key human resources for health stakeholders and agree on measures for accelerating the strengthening of HRH management. Health workforce is perhaps one of the most important components of the six building blocks of health systems, for achieving universal health coverage. We have assembled here to reaffirm our commitment and prepare an action plan to strengthen the health workforce in the South-East Asia Region.

The recent review of HRH country profiles conducted in February 2012 reveals that countries with HRH crisis continue to be in crisis; funding support for HRH development is not sufficient to bring about the desired improvement in most countries; HRH education, deployment and management as well as migration of health workforce within and outside the countries remain challenges; and mal-distribution of health workforce exists in most countries. These challenges need to be carefully addressed for the health workforce to function effectively; otherwise, it will not be possible to achieve universal health coverage.

In the quest to ensure that an appropriately trained care provider is positioned at every level of health facilities as well as in the community, focus needs to be sustained on certain key areas, namely (i) production and medical education; (ii) recruitment and deployment; (iii) training and capacity-building; (iv) retention and support practices; (v) workforce management; and (vi) human resource management information system.

These need to be an integral part of any country's policy towards strengthening health workforce. It is encouraging to note that all the 11 countries in the Region have health policies at the national level within which developing human resources for

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Regional meeting on strengthening of human resources for health in South-East Asia, 19–21 November 2014, Thimphu, Bhutan

health constitutes a key component. However, there still remains a need to mark out clear strategies to guarantee availability of adequate numbers of human resources, especially in the rural, remote and underserved areas.

The benchmark of health workforce is 22.8 per 10 000 population and the regional average stands just below at 21.2 physician, nurses and midwives per 10 000 population. However, many countries in the Region have a critical shortage of health workforce. The shortage is further accentuated by a lack of rational deployment of available health workforce, resulting in a significant urban-rural and geographical gap.

Although considerable efforts have been made to strengthen the education and training of health workforce in the country, much remains to be done to produce desirable results in most countries. Most Member States have training institutes to produce all categories of human resource for health within the country. However, more than just the numbers, it is crucial that HWF education and training be further strengthened so that health-care providers have required competencies and appropriate mix of skills to deal effectively with emerging health challenges and deliver responsive health service. The WHO Regional Office conducted comprehensive country assessments in 2013 on HWF education and training. The gaps indicated led to resolution SEA/RC67/R6 on strengthening health workforce education and training in South-East Asia, being adopted at the Sixty-seventh Session of the Regional Committee in September 2014. Countries need to define strategies to implement these recommendations.

The benchmark of health workforce is 22.8 per 10 000 population

Nevertheless, a positive aspect in all countries of the Region is that systems are in place for developing the skills and capacities of the existing health workforce. I-service training aims at increasing the skill sets of existing service providers. In the Democratic Peoples' Republic of Korea, it is mandatory to attend these courses, while in Bhutan and Indonesia, the credits from these programs and CMEs are linked to certification, licensing and re-registration. While most training in India and Sri Lanka is centered on reproductive and child health, these programmes also focus on professional development and training of trainers in Myanmar and management and leadership in Indonesia.

In Thailand, most in-service training is conducted at the work place to improve the knowledge, attitude and skills of health workforce in sync with local needs.

Other crucial areas which affect the availability of health workforce are recruitment, deployment and retention practices. Irregular and non-systematic recruitment processes often result in delays in filling vacancies and losing out to the private sector. Decentralized recruitment with a quicker turnaround time and preference being given to local residents has played a role in increasing the availability of care providers in rural areas as seen in Indonesia, Thailand and under the National Health Mission in India. Other countries ought to adopt such good practices.

An area of major concern is the fact that although large number of HWF are being produced from numerous medical schools and training institutions across countries every year in South-East Asia, it has not translated into an exponential increase in their availability in the public health system, especially in the underserved areas. A large proportion of the population living in rural and remote areas still suffer from inaccessibility to the services of trained HWF in Region.

To address the skewed urban-rural distribution of care providers, incentives have been adopted in most of the countries of the Region for attracting and retaining health workers in rural and remote health institutions. Bhutan allows provision for high-altitude and scarcity allowance and India has a bouquet of incentives for serving in remote areas, which include preferential eligibility for postgraduate courses, promotions, subsequent choice of postings, reimbursement of children's school fee, CME, regulatory bonds and non-practicing allowance.

Indonesia has financial incentives to work in underserved areas while Maldives has regulatory bonds for doctors or other professionals who obtained government financial support along with financial incentives for postings in remote islands. Nepal offers scholarships for economically marginalized students from rural areas with a bond of mandatory rural service and differential salary packages applicable for rural areas. In Thailand, health workers in rural health facilities receive institutional support, better emoluments and career advancement.

Unfortunately, implementation issues have affected the scale of effectiveness of these schemes among and within Member States. It is also important to note that for better retention of workforce, it is best that a multi-pronged approach is adopted and beneficiaries are offered the right mix of financial and non-financial incentives. To maintain a productive workforce, these incentive packages have to be complemented with robust policies related to fair postings and transfers, timely career progression and structured performance management.

Internationally, health worker migration has been increasing over the past decades, especially from lower-income countries with already fragile health systems. To address this challenge, the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by the Sixty-third World Health Assembly in 2010. I encourage Member States adopt this code in spirit and action, to establish and promote voluntary principles and practices for ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel.

Internationally, health worker migration has been increasing

While there is a crucial need to measure HRH implementation in terms of progress, issues and challenges, hardly any assessment has been conducted with appropriate tool in most countries. This is compounded by issues regarding availability, accessibility and use of data and information on HRH. An effective Human Resource Management Information System for Health (HR-MIS) that generates adequate real-time information can serve as an effective tool to overcome these issues and certainly help address larger policy and programme challenges with respect to human resources. Currently, available systems are fragmented and countries must accelerate their efforts towards creating a robust system for both immediate workforce management and long term HR policy.

I would like to bring your focus back to the specific objectives of the meeting. Over the next two days, the technical authorities will be assessing the gaps, in their countries, in policy and implementation of specifically (i) rural retention interventions; and (ii) transformation of health professional education. They will be assisted in their group work by experts

from various stakeholders. Based on the gaps identified, each country is expected to devise separate action plans based on (i) WHO's 16 rural retention policies and (ii) WHO's 11 recommendations for transforming and scaling up health professionals' education and training.

At this point, I want to stress that we are largely aware of the challenges facing us and over the years, the WHO Regional Office has formulated various strategies and recommendations, in order to support the countries' efforts to address these challenges. Nevertheless, there is a lack of clarity as to how much of these strategies/plans have been implemented and what has been their impact. Hence, during your deliberations, I request you to focus on the "how-to-dos" as much as you would on the "what-to-dos''.

I hope that this meeting will be able to come out with a comprehensive gap analysis and attainable action plans, which can be presented on the third day in front of policy-makers from each country for their views and ratification. WHO is committed to support the countries in rolling out the activities.

Strengthening health research

You would all agree that health research is critical to improve health outcomes and to find appropriate solutions to everyday challenges in health care settings. These challenges are becoming increasingly complex.

Using research optimally for solving priority health problems is not simple. It has to go through a complex, and, sometimes, difficult process: from ensuring the quality of research to disseminating the findings, and translating research data into policy and practice. Furthermore, health research is not always focused on the areas of greatest need as sometimes it can be a pursuit of individual interests while deciding on their subject of study. Solving priority health problems may not necessarily be the motivation in conducting such research.

Health research is not always focused on the areas of greatest need

As you all know well, the situation in terms of resources for research and research activities have not changed since the publication of the report on diseases of poverty and the 10/90 gap more than a decade ago. At present 10% of resources for research are available in those parts of the world where 90% of the health problems lie. It is estimated that less that 3% of the global funding for research goes to the developing countries, and less than 27% of the total researchers in the world are in developing countries.

We, as WHO and as part of the UN family, have made a commitment to deliver on Universal Health Coverage. To do that we need to accelerate research to find answers to the many unsolved questions on access to health services and financial risk protection. We need to find new technologies and we need to learn to do not only new things, but to do the old things differently if we are to make a difference. In my vision statement for the Region, I have clearly pointed out that research and innovation will be encouraged.

Intercountry meeting for strengthening the regional framework and for developing research action plan, 14–16 October 2014, New Delhi, India

We need to redouble our efforts to advocate for research so that resources, both global and national, are made available to promote research and we need to emphasize that evidence generated by research is used to frame policies that have high impact on improving quality of health of the people.

We have countries such as India, Thailand and Indonesia with great potential for research as these countries have the human capital and the institutional back-up that can support and carry out high quality research. We must make all efforts to bring together the research communities to share information on work that is ongoing in all countries and to build networks of support for research in the region. And this meeting is one such where, I hope, the best of minds will pull together a strategic framework for promoting research in the WHO South-East Asia Region.

As was highlighted at the Thirty-third meeting of ACHR-SEAR, while there is an agreement on health research priorities, the best way to finance research and development in priority areas for health improvement is still not clear. In this meeting, I invite your thoughts to further elaborate the ACHR recommendations in conjunction with the existing SEA Regional Strategy on Research for Health developed for 2012–2016 towards formulating a regional action plan.

The action plan should provide a road map and a menu of policy options for Member States and other stakeholders, to take coordinated and coherent action, at all levels – national to regional – to achieve the objectives and outputs in keeping with the global strategy and the recommendations of the ACHR.

The action plan should prioritize strategic actions, and list the activities with clear objectives and deliverables with timelines. The action plan is about providing direction, setting targets, monitoring programmes and, most importantly, producing outputs.

I hope research institutions in each Member State would update their institutional research action plans after knowing the regional research framework based on priorities developed in the action plan. WHO will continue to support this process to assist countries to strengthen their capacities and implement activities.

Health challenges in the South-East Asia Region

Maldives is one of the Member States of WHO South-East Asia Region. Although the Region has only 11 countries, it is home to more than 1.7 billion people, which is more than a quarter of the entire world's population. And if you consider diseases of public health importance, almost 40% of the burden of those diseases is borne by the South-East Asia Region alone.

Starting from 2000, WHO regularly published the most comprehensive estimates of global disease burden using DALY or the disability-adjusted life years as a measure of the burden of each of those diseases. Since then, the global disease burden estimates have been regularly updated. The latest update for the year 2011 shows that there has been virtually no change in the top five diseases or conditions of public health importance in the last one decade, which includes: infectious diseases (including respiratory infections), cardiovascular diseases, injuries, neonatal conditions, and cancers.

It is important to bear in mind that most countries in our Region are still struggling with the prevention and control of communicable diseases. At the same time, they are faced with the growing burden of noncommunicable diseases which are rapidly escalating in almost all countries, placing tremendous pressure on their national health systems.

Just to illustrate, let me give you some figures; of the estimated 5 million new cases of TB, 3.5 million occur in our Region. What is more worrying is that of an estimated 90 000 cases of incidence of multi-drug resistant TB or MDR-TB, a mere 10 000 are enrolled for treatment; and of the approximately 3.4 million new infections with HIV, anywhere from 160 000 to 360 000 arise in the South-East Asia Region. But more

Address at University of Maldives, 5 March 2014, Malé, Maldives

importantly, the burden of noncommunicable diseases is increasing rapidly. For example, of the estimated 346 million people with diabetes in 2010, it is estimated that 71 million are in the SEA Region alone; of the 8.2 million deaths from cancers worldwide, 1.2 million have occurred in this Region alone. Likewise, of the estimated 7.9 million deaths from noncommunicable diseases worldwide, 55% take place in the countries of our Region. Therefore, you can see how important the WHO's South-East Asia Region is to the overall public health concerns of the world.

I must hasten to add that this Region has seen many achievements too; leprosy is considered eliminated at the national level, although we still have relatively large number of cases in the Region. Maldives has been malaria-free for many years and yaws has been eliminated from India. There have been no cases of polio due to wild poliovirus for more than three years and the Region is on track for polio-free certification – a truly remarkable public health achievement. Although we still have work to do, particularly for MDG 4 and 5, overall, the countries of our Region have made notable progress towards the Millennium Development Goals.

The burden of noncommunicable diseases is increasing rapidly

Given the above situation, you may ask what is WHO doing about it. WHO's core mandate is to formulate evidence-based policy, set standards and norms and provide technical support to countries with a focus on capacity-building. WHO also has the mandate to monitor disease trends, and that is what the estimate for the global burden of disease is all about. For every disease or condition of public health importance, WHO brings together the best of global expertise to shape preventive policies and strategic frameworks which are discussed at great length with Member States at the World Health Assembly before they become guidelines for Member States. WHO provides technical support to Member States – both from within its own core staff strength as well as by mobilizing the best of technical expertise worldwide – to guide and shape national health policies and strategic framework, to prevent and control these diseases or conditions of importance to public health.

It is just a month since I took over as the Regional Director for the WHO South-East Asia Region. I am not totally new to

WHO and the public health concerns of the Member States, as I have worked for a decade at the highest policy levels in WHO, first at its Headquarters in Geneva and, later, in the South-East Asia Regional Office itself. Therefore, for me, it is both an honour as well as a challenge to return now as the Regional Director. My vision for WHO's role is to remain a strong partner to Member States and to contribute to joint efforts in improving the health and well-being of the population of this Region. I intend to implement this mandate through four focused strategic directions:

1. addressing the persisting, emerging epidemiological and demographic challenges;
2. promoting universal health coverage (UHC) and building robust health systems;
3. strengthening emergency risk management for sustainable development; and
4. articulating a strong voice in the global health agenda.

Let me expand and share my views with you on these four strategic directions. The first strategic direction is: addressing the persisting and emerging epidemiological and demographic challenges. The Region is on track to be certified polio-free later this month. This success must now be replicated for other public health challenges, including the elimination of other vaccine-preventable diseases such as measles. Likewise, to build on the achievements of the TB programme, the menace of drug resistance and coinfections which looms large must be addressed. In addition, there are emerging pathogens and disease outbreaks such as the avian influenza H7N9 outbreak in China, which threatens to spread beyond the Chinese borders, and the Middle-East respiratory syndrome coronavirus (MERS-CoV) infection, which is also an emerging global threat. Fortunately, Member States are currently in the process of implementing the International Health Regulations, or IHR, which WHO has already put in place. Once IHR is well in place, each country will be capable of following the standards, procedures and protocols within it that automatically stimulate specific actions when an emergency alert is sounded for a public health event of international concern.

While our fight with communicable diseases continues unabated, the mounting epidemic of noncommunicable diseases is stretching health systems of all Member States. Currently, more than half of our burden of disease is caused by four major NCDs: diabetes, cardiovascular diseases, cancers, and respiratory diseases. It is estimated that in the Maldives about 70% of deaths are due to NCDs. More importantly, the risk factors such as tobacco use, imbalanced nutrition and inactivity are quite common.

I am fully aware of the fact that primary prevention of NCDs is difficult. Many of their root causes reside in non-health sectors whose policies have, very often, adverse health effects. The health sector, we know, has negligible influence in the shaping of such policies. Therefore, I intend to redouble my efforts to articulate the need for having "health in all policies" and making health central to development in all relevant sectors.

There are three dimensions to UHC – access, affordability and quality

This takes me to the second strategic direction, which is advancing UHC and building robust health systems. Universal health coverage, or UHC is the flagship WHO umbrella programme that aims to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. This requires:

- a strong, efficient, well-run health system
- a system for financing health services
- access to essential medicines and technologies
- sufficient capacity of well-trained, motivated health workers

There are three dimensions to UHC – access, affordability and quality. Therefore, UHC is a functioning health system that has a well-defined package of essential services of quality that are accessible and can be afforded by all people. In Maldives, you are fortunate that successive governments have been trying to build a health system that ensures access to basic health services. The real challenge for you will be the affordability and sustainability of UHC, particularly as public health concerns shift from communicable to noncommunicable diseases and the long-term impact of chronic health conditions. This is particularly

relevant to our Region which has the highest out-of-pocket spending and relatively low public investment in health. These are key causes of inequities in access to health care. With burgeoning NCDs coupled with an ageing population, health-care costs are bound to spiral upwards.

I would like to touch upon one particular aspect of UHC and its relevance to this country. The South-East Asia Region has a booming pharmaceutical industry with India leading it, particularly in the production and export of generic drugs. Yet for many countries, particularly countries like the Maldives, access to essential medicines and vaccines remains a major concern. We will take a proactive role in helping our Member States by utilizing the flexibilities in international treaties as well as promoting and facilitating innovation and cost-effective procurement mechanisms, especially for countries in greatest need.

We all know that the WHO South-East Asia Region is extremely disaster-prone. Last year, our Region accounted for around 41% of global mortality from natural hazards. Every year, millions of people lose their lives, livelihood and their homes during natural calamities. During such events, the poor are the hardest hit and, therefore, suffer the most. Therefore, my third strategic direction is to strengthen emergency risk management to ensure sustainable development. We have developed excellent benchmarks for preparedness and response in emergencies, which have received global recognition. We need to promote new ways of augmenting national capacity and making disaster risk reduction an integral part of national sustainable development policy.

Finally, for the fourth strategic direction of articulating a global health agenda, it is important, in this era of interdependency and cooperation, to build and sustain alliances and partnerships. Such collaborations not only generate more resources, but also strengthen our influence to bring about positive change. While the solidarity of countries in the South-East Asia Region is respected widely, our voice in the global health agenda needs to become louder, so that we are not denied access to the global benefits that we rightfully deserve. This is possible only through stronger partnerships, both within and beyond the Region.

Now let me dwell on some of the changes in the world that we need to adapt to. WHO has never been a funding agency. However, scarce WHO resources were used in the past to provide cash-based support to countries. There was a time when this was necessary and, for some countries, it is still relevant in a limited way. But let me emphasize that WHO is not a donor agency; the resources of WHO come from the contributions of Member States. The assessed contributions are topped with what is generally referred to as voluntary contributions which are usually programme or project-specified funds entrusted to WHO by Member States or other funding agencies. The resources of WHO are intended for providing technical support required by Member States and not for defraying the cost of delivering health care services, which is rightfully the prerogative of their ministries of health. I may add that there are more donors out there today with far deeper pockets than WHO. Therefore, WHO is adapting to ensure that it has the capacity to provide leadership in health and relevant technical support to Member States. This understanding is essential to appreciating the relationship between WHO and its Member States.

WHO has never been a funding agency

I must say that this nation is a blessed one. The beautiful islands and atolls of this country epitomize the saying, "Small is beautiful". Even your population is small and, therefore, manageable. Successive governments have built an impressive network of health infrastructure in all islands, ensuring equitable access to health care services by all people, and your present government is equally committed to improving the health of its people. However, delivering health care services in all the remote islands of your country is a challenging task.

Being an island nation brings its own geophysical challenges of reaching people in remote islands; ensuring rapid referrals or, for that matter, timely distribution of essential supplies to the far-flung island health facilities. There is a serious shortage of well-trained and motivated human resources in Maldives which is expected to continue in the immediate future. Further, as the country moves towards more decentralization and popular governance, ensuring stable financing for critical services and essential public health investments will continue to pose difficulties which, if not consciously addressed, can

threaten the achievements made thus far. However, I have the utmost confidence in the leadership of this nation, and in the collective strength and wisdom of its masses to adequately and appropriately address its needs. As WHO, we stand ready and committed to support the Government in its march towards a healthy and disease-free Maldives.

Noncommunicable Diseases and Environmental Health

Autism & neurodevelopmental disorders

At the outset I would like to thank the Ministry of Health, Royal Government of Bhutan, and the Ministry of Health and Family Welfare, Government of Bangladesh, for hosting this conference in collaboration with WHO-SEARO. Your leadership is appreciated.

I also appreciate the support and effort of Shuchona Foundation, whose work in this area – particularly in low- and middle-income settings – is commendable.

Bhutan's collaboration and partnership has been similarly valuable.

Indeed, your collective drive to address autism spectrum disorders and other neurodevelopmental disorders is laudable.

As we know, autism spectrum disorder – or ASD – is an often overlooked and misunderstood public health issue, despite affecting an estimated 1 in 160 people globally.

Part of the reason is stigma. Part is fear. Part is even the diverse symptoms of the disorder itself.

But most dominant is a lack of awareness of what ASD is and how it can be managed. This applies as much to health systems and health care workers as it does to the general public.

Given ASD's impact on individuals, families and communities, positive change is needed, both socially and systemically.

ASD and other neurodevelopmental disorders – or to use another acronym, NDDs – are responsible for impairment of personal, social, academic or occupational functioning. These brain function deficits can affect a person's emotions and memory as well as their ability to learn, socialize and maintain

NDDs – are responsible for impairment of personal, social, academic or occupational functioning

International conference on autism & neurodevelopmental disorders, 19–21 April 2017, Thimphu, Bhutan

self-control. Though the range of deficits is wide, their effect on a person's wellbeing is often similar: life-long disability marked by unemployment and social isolation.

The situation is compounded in low- and middle-income countries. Poor infrastructure, shortage of trained professionals, lack of reliable data and evidence-based interventions limit the support persons suffering the disorder can access. For an autistic child this can set-up a lifetime of unnecessary suffering. And for an autistic adult it can exacerbate the disorder's social and economic effects.

As the Convention on the Rights of Persons with Disabilities outlines, states not only have an obligation to safeguard citizens from discrimination on the grounds of disability; they also have a positive obligation to empower persons with disabilities to fully participate in civil, political, economic, social and cultural life.

I am pleased to note, Excellencies, your commitment to fulfilling these obligations. Indeed, for a number of years now you have been working to increase awareness on ASD and NDDs, and to improve the support services available.

In 2011 the Government of Bangladesh hosted the International Conference on ASD and Developmental Disabilities. The Dhaka Declaration on Autism Spectrum Disorders and Developmental Disabilities was issued, and a Strategic and Convergent Action Plan on Autism and NDDs was developed.

At WHO South-East Asia's 2012 Regional Committee in Jogyakarta, Indonesia, you built on this progress. A resolution was passed promising comprehensive and coordinated efforts for the management of ADDs and developmental disabilities in the Region. You also requested my support for the South-East Asia Autism Network, which I was pleased to provide.

Finally, at the 2014 Regional Committee in Dhaka, Bangladesh, a side event was held to strengthen partnerships to address autism – a worthy and valuable pursuit. The outcome was the launch of the Global Initiative on Autism which aims to create a more inclusive and integrated global community through enhanced ASD and NDD services.

WHO is proud to support your efforts.

Apart from facilitating these initiatives, we have carried out workshops, developed screening tools and drafted training manuals. And thanks to your input and engagement at last year's consultation in New Delhi we developed the WHO South-East Asia Regional Strategy on ASD.

I am immensely proud to present it today.

Though we will discuss many aspects of ASD and NDDs in coming days, I want to focus on four strategies that are central to achieving our goals, and which will form the overarching themes of much that will be covered.

The first strategy is scaling up advocacy, leadership and governance on ASD and NDD issues. Barriers affecting persons with ASD must be identified and removed, and legal frameworks supporting the rights of persons with ASD, their families and caregivers must be developed. As part of this, involvement of persons affected by ASD and NDDs is vitally important, as is a commitment to the Convention on the Rights of Persons with Disabilities, as well as previous regional resolutions and declarations.

The second strategy involves pursuing comprehensive, integrated and responsive mental health services in community-based settings. Simple community-based mental health services provide an opportunity to screen for ASD and NDDs, and can also help link patients with emotional and social support services. Though resource limitations inhibit the possibility of specialized services, existing systems can ensure a basic level of service provision while creating referral pathways to purpose-built facilities.

The third strategy requires us to focus on ways to minimize disabilities associated with ASD and NDDs, and to promote mental, social and physical health and wellbeing among persons suffering them. This means detecting and recognizing developmental delays and comorbidities early and making appropriate interventions. It also means enhancing understanding of the secondary health risks persons with ASD

face. By extension, the mental health of parents and siblings of persons with ASD and NDDs must also be attended to.

And the fourth strategy emphasizes the importance of sound research and surveillance in delivering effective services. Pre- and post-service research can inform policy design, help policymakers make adjustments where necessary, and increase transparency and public awareness. In order to make this happen, current health information and surveillance systems must be improved and expanded, and performance indicators developed.

At this conference you have the opportunity to make these strategies your own, and tailor them to your needs. This opportunity must be grasped.

We have among us some of the world's finest researchers and academics studying ASD and NDDs. And we also have some of the world's most experienced public health practitioners and policymakers.

As demonstrated by the presence of His Excellency Tshering Tobgay, Honourable Prime Minister of Bhutan, and Her Excellency Sheikh Hasina, Honourable Prime Minister of Bangladesh, we have support from the highest levels in the Region. I thank you, Excellencies for your keen engagement.

I also thank her Royal Highness Queen Jetsun Pema for her presence and enthusiasm.

Nevertheless, we will only truly succeed if our expertise and influence is matched by a generosity of spirit and a commitment to working with and for the people that matter: individuals, families and communities living with Autism Spectrum Disorder and other Neurodevelopmental Disorders.

I thank you for your dedication in this regard. As I mentioned at the outset, your enthusiasm is palpable.

Before I close I take this opportunity to give my sincere thanks to WHO's Regional Champion for Autism, Ms Saima Wazed Hossain. We are excited to have you on board. For many

years your voice has been one of power and conviction, both in the Region and across the world.

I wish you a productive and successful conference. I look forward to hearing about your progress, and to ensuring persons suffering ASD and NDDs are no longer overlooked or misunderstood, but are provided the services they require to live happy, healthy and prosperous lives.

Mental health: depression

World Health Day is an opportune time to pursue with vigour our role as public health advocates.

Each year it provides an opportunity to engage with policymakers across sectors, and to highlight the primacy of public health within the development agenda. It also provides an opportunity to engage with the wider public – people from all walks of life – and to talk about pressing public health issues we have all invested in.

For concerned citizens, NGOs and governments, it is a day of immense importance. But as persons working for WHO, today is especially significant: As you know, World Health Day marks the birth of our Organization. I urge you to reflect on how you are advancing WHO's public health mission.

Depression is an issue that needs to be heard

I likewise urge you to be sincere in your engagement with the theme of this year's celebration. As you are aware, this year we are focusing on depression, and the need for us as individuals, communities and countries to talk about it more openly.

Understandably, this can be challenging.

For those of us who have it, or think we might at some stage suffer from it, the subject can provoke a range of fears and apprehensions. And for societies in which depression remains taboo, or is poorly understood, discussing it can mean examining deep and enduring social norms.

But depression is an issue that needs to be heard. After all, an estimated 86 million people across our Region suffer the problem. Many do so silently.

Address at World Health Day 2017, 7 April 2017, New Delhi, India

To start the conversation, it's worth examining what exactly depression is.

Depression is a condition of persistent sadness or loss of interest in things a person normally enjoys. It may express itself as disturbed sleep or loss of appetite, feelings of guilt or low self-worth, or feelings of tiredness and lethargy. It may also manifest as agitation or physical restlessness, substance abuse, reduced concentration, and suicidal thoughts or acts.

Importantly, depression is not a weakness. It is a condition that deserves our awareness, understanding and care.

If you think you have depression, there are several things you can do. Talk to someone you trust. Adopt proven coping mechanisms, from exercising regularly to staying connected with loved ones. Seek professional help.

If someone you know and care about is experiencing depression, there are ways you can help.

Let them know you are there for them. Help them with everyday tasks. Encourage them to adopt regular eating and sleeping patterns. Join them for a walk or an exercise session. If they are contemplating self-harm, seek professional medical help and stay by their side – that's when they need your love and support most.

Though we can each have a positive impact as individuals, health systems and those working in them are integral to the conversation.

Even in low- and middle-income settings there are ways that depression and other mental health services can be made more accessible.

Health care workers can be better trained to detect depression's signs and symptoms. Community health facilities can be better integrated with national mental health networks. And a greater proportion of health funds can be allocated to this often overlooked though vitally important public health issue.

I am proud to note the support we are giving to our Member States.

Indeed, we have developed depression and grief identification tools to help in early identification, referral and treatment of persons suffering depression.

We have developed the South-East Asia Regional Suicide Prevention Strategy, which is helping health systems prevent and respond to suicide and associated mental health issues across the Region.

And I am pleased to share that we are also working on guidelines for addressing depressive disorders co-occurring with other NCDs and substance use disorders.

This focus and support is driving change.

In the 2016–17 biennium, for example, five Member States – Bangladesh, Bhutan, Indonesia, Maldives and Sri Lanka – identified mental health as a top ten priority health condition. This is an increase from two Member States – Bangladesh and Sri Lanka – doing so in the previous biennium.

Eight Member States have meanwhile developed standalone mental health plans, including Bangladesh, India, Sri Lanka, Timor-Leste, Indonesia, Thailand, Myanmar and Nepal. These plans will prove vital to ensuring persons suffering depression get the care they need, at the same time as establishing greater awareness on the issue.

The momentum continues.

Just a few weeks ago, India's Parliament passed the Mental Health Care Bill. The Bill establishes a right to mental health care, and also decriminalizes suicide – an important initiative to counter stigma.

And in his monthly Mann ki Baat address to the nation, India's Prime Minister raised the issue of depression specifically, urging his countrymen and women to understand and appreciate its impact, and to work through the problem together.

As I mentioned earlier, amid today's festivities I urge you to take a moment to reflect on our public health mission, and this year's theme of depression specifically.

Each of us must be the change we seek in the world; each of us must instill that change in all we do.

I wish you an enjoyable and informative World Health Day, and express my gratitude for your attention and engagement in what must be an ongoing dialogue.

Depression is, after all, as serious as any other chronic or acute condition. It is an issue that touches us all in one way or another, and is one for which each of us can have a positive impact.

Universal eye care

It is a privilege to be here today to celebrate the golden jubilee of this august institution, which is among the finest in the world.

For 50 years the Rajendra Prasad Centre for Ophthalmic Sciences has been at the vanguard of eye health teaching, research and care.

It is an institution that has stood tall as a centre of excellence, and one that has made vital contributions to understanding the biomedical and biosocial components of eye health.

At the global level, approximately 285 million people are visually impaired

I am most pleased to count this institution among WHO's collaborating centres, and to have the opportunity to work with you on prevention of visual impairment – a most important public health issue.

Indeed, despite dramatic public health gains in recent decades, the incidence and prevalence of visual impairment remains a pressing issue.

At the global level, approximately 285 million people are visually impaired. Of these cases, around 39 million are blind. Of significant import is the fact that 80% of visual impairment is avoidable – that is, it can be prevented or cured. 90% of cases occur in developing countries.

The South-East Asia Region, which is comprised of low- and middle income-countries, is particularly affected. There are around 90 million visually impaired persons in the Region, of which 12 million are blind. Again, 80% of cases could have been

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Golden Jubilee Oration – "Towards Universal Eye Care: From strategy to results", Dr R P Centre Golden Jubilee Ophthalmology Congress, Jawaharlal Nehru Auditorium, AIIMS, 11 March 2017, New Delhi, India

prevented. As you are no doubt aware, around eight million – or two thirds – of the Region's blind persons are in India.

Across South-East Asia, and with it, India, the causes of visual impairment are relatively well known. Together cataract and uncorrected refractive errors account for more than three-quarters of visual impairment. At the same time, cataract accounts for more than 50% of blindness. The rest is primarily caused by glaucoma, trachoma and childhood blindness.

We are now, however, seeing new causes come to the fore. Eye problems related to noncommunicable diseases, including diabetic retinopathy and hypertensive retinopathy, are increasing in number as diabetes and hypertension rates climb. In similar fashion, macular disorders associated with ageing are becoming increasingly common as the Region's population grows older.

The message is clear. The need to invest in eye health and accelerate progress against visual impairment cannot be over-emphasized.

Nevertheless, accelerating progress and achieving results is a question of strategy as much as it is one of commitment and resources. As such, it is worth looking at the policy realm in which we are operating, both as it relates to eye care specifically, as well as health and development more broadly.

The Vision 2020 Global Initiative, which was launched at the turn of the millennium, has provided much of the framework through which eye health has been conceptualized and approached. The Initiative envisaged a world in which 'nobody is needlessly visually impaired', and where 'those with unavoidable vision loss can achieve their full potential'. It aimed to intensify and accelerate prevention of blindness activities so as to achieve the goal of eliminating avoidable blindness by 2020.

The Initiative's scope has been expanded and built upon. A 2006 Action Plan enlarged its mandate to include visual impairment, not just blindness. This was followed by a 2009–2013 Action Plan drafted to complement global efforts aimed at combatting noncommunicable diseases. World Health Assembly resolutions adopted in 2003, 2006, and 2009 meanwhile served

to keep eye health on the international agenda and uppermost in the minds of health ministers.

Nevertheless, as the mandate of the 2009–2013 Action Plan ended, an important evolution in the discourse on international development was occurring. In contrast to the vertical approach of the MDGs, a more holistic and integrated strategy was being promoted for a range of development issues, from energy consumption to poverty reduction. The Sustainable Development Goals, which came into effect in 2015, were the outcome of this shift in thinking. It was a shift with profound implications for public health.

Sustainable Development Goal 3, the health goal, for example, urges governments to 'Ensure healthy lives and promote wellbeing for all at all ages', and to leave no one behind in this quest. Primary health care and the attainment of universal health coverage is of fundamental importance within this approach. Indeed, it is the means by which 'wellbeing for all' can be achieved.

This renewed emphasis on primary health care has been reflected in recent eye health programming. The 2014–2019 global action plan for eye health, for example, makes clear that the goal of any effective and result-oriented programme must be the attainment of universal eye health care. To do so it urges Member States to integrate eye health into national health plans and health service delivery. The plan also recognizes the links between eye health and efforts to address noncommunicable and neglected tropical diseases.

Trachoma is among a number of neglected tropical diseases that WHO is working with Member States to eliminate by 2020. Within the Region, Myanmar and Nepal are already reported to have eliminated trachoma, and will undergo validation next year. On this note, I appreciate India's recent initiatives to tackle the problem, and I commend the RP Centre's support to these efforts.

As I have outlined, our global action plan is both well-defined and comprehensive in scope. But to go from strategy to results, and to achieve universal eye health, there are a few approaches that I wish to emphasize as being particularly useful.

The first is ensuring quality information. As with almost everything we do in public health, information remains vital to policy, strategy and outcomes. In India, as across the Region, we continue to lack high-quality data on many aspects of visual impairment. Due to the nature of the problem and its association with marginalized populations, good data will help target interventions and thereby improve results. Systems must be devised to monitor visual impairment prevalence among the population generally, and key high-prevalence groups such as older persons specifically. The effectiveness of existing eye care and rehabilitation services should likewise be monitored closely, with information integrated into national epidemiological data.

The second is developing a clear matrix of priorities based on scientific evidence and good practice. Though integrating eye health into primary health care services is essential, and must be our end-goal, we can also find other innovative ways to reach out and provide services. These must be developed into priority order, with adequate funding secured. 'Best buys' include investing in cataract surgical coverage and correcting refractive errors. Implementing school vision care programmes is another great way to reach people, and is already being pursued across the country. Wherever possible, advances in technology and IT should be harnessed to serve these and other initiatives.

Information remains vital to policy, strategy and outcomes

The third is strengthening health systems to facilitate implementation of eye health policies. This can be done by creating a national eye health or blindness committee that can guide progress. It can be done by including eye care in national lists of essential medicines, or allocating specific human resources towards eye care within national planning. And it can also be done by adopting a set of national indicators and targets to contextualize and make sense of data. The key to utilizing this approach is achieving system-wide uniformity. After all, a national policy can only be as strong as the weakest link implementing it.

The fourth – and one we must always work on – is establishing and maintaining close multisectoral partnerships. The education, finance, welfare and development sectors are all integral to tackling visual impairment and blindness. Their role in doing so should be clear, with the buy-in of all stakeholders

established. At the same time, partnerships among the NGO and INGO sectors should be aligned with national priorities, policies and programmes, ensuring synchronicity and unity of purpose. Stronger partnerships will also promote effective use of resources.

On this note, it's worth reflecting on the partnership between our respective organizations, and how best we can leverage it for further gains.

In recent times the RP centre has been remarkably active. It has been instrumental in carrying out a national blindness survey, a diabetic retinopathy survey, and a national trachoma survey. It is taking a lead role in strengthening primary eye care, and is developing models of service integration that can be rolled out nationwide. And, as I understand, it will also be at the forefront of efforts to train health care workers in eye care at primary, secondary and tertiary levels. These activities are commendable, and each one will help accelerate towards achieving universal eye coverage.

As you go about these endeavours, I want to stress WHO's ongoing support. WHO, like you, is committed to creating a world in which nobody is needlessly visually impaired, where those with unavoidable vision loss can achieve their full potential, and where there is universal access to comprehensive eye care services. Our shared history, if appropriately harnessed, can help us make further progress.

We can, for example, work alongside you to collect and analyze data. That could mean devising surveys and other epidemiological tools, collating and disseminating reports that can help inform future interventions, and assessing existing eye care services and their cost-effectiveness.

We can help develop innovative solutions to problems that may be impeding progress. That could include providing examples of best practices from other Member States, or helping to develop innovative policies that can overcome persistent barriers.

And we can engage partners and help coordinate efforts. That could mean arranging key meetings and workshops aimed

at achieving greater working efficiency, or engaging the wider development community to support and complement eye care initiatives.

We have much to do. I am nevertheless convinced that through the strength of our partnership and the clarity of our vision we can achieve our goals.

I once again congratulate the Rajendra Prasad Centre for Ophthalmic Sciences on its long and decorated history, and look very much forward to accelerating joint efforts to end preventable visual impairment, to secure access to rehabilitation services for all, and to achieve universal eye health coverage.

Prevention of blindness

Well-designed public health policies and investments drive socio-economic development.

As economic growth rates across the Region soar, and as talk of the 'Asian century' abounds, we must emphasize the public health gains that made this possible: advances in public health inspired higher growth rates, while higher growth rates provide the means to create ever-healthier populations.

One group that must be included in this cycle, and who has too often been left out, is those suffering visual impairment and blindness. Apart from its interference with daily activities, visual impairment jeopardizes access to education, opportunities for gainful employment and participation in civil, political and social life.

About one-third of the 285 million people estimated to be visually impaired worldwide are from South-East Asia

While it may be difficult to quantify visual impairment's impact in monetary terms, its socioeconomic impact and effect on quality of life is all the more unconscionable given it is largely preventable.

Within our Region the issue is of particular concern: About one-third of the 285 million people estimated to be visually impaired worldwide are from South-East Asia. This is despite impressive success in reducing trachoma and vitamin-A deficiency-associated visual impairment and blindness.

Importantly, those with lower levels of income are most affected by the problem. Refractive errors that have not been corrected are the main cause of moderate and severe visual impairment, while cataract remains the leading cause of blindness. Both of these conditions can be solved by pursuing

Regional expert group consultation – accelerating actions for prevention of blindness 13 December 2016, Hyderabad, India

available cost-effective interventions like spectacles, low vision aids and surgery for cataract.

As populations across the Region age and the prevalence of noncommunicable diseases increases, this will become vitally important: If unchecked, diabetic retinopathy and age-related macular degeneration, for example, are likely to grow. Put simply, we need to act now to prevent pain later.

As outlined in the Sustainable Development Goals, the pursuit of universal health coverage provides an excellent platform to reinvigorate public health action in a range of areas. This includes promotive, preventive, curative and rehabilitative eye care services, and the provision of assistive technology for all persons at an affordable rate.

The Sixty-sixth World Health Assembly's adoption of the global eye health action plan opened a new opportunity for Member States to accelerate their efforts to prevent visual impairment. It commits Member States to reduce the prevalence of avoidable visual impairment by 25% from the 2010 baseline by 2019. This target, though ambitious, is achievable. After all, 80% of all causes of visual impairment are either preventable or curable.

With requisite political will and coordinated action by relevant stakeholders – including ministries of health, professional bodies, and civil society organizations among others – we can achieve the targets set by the global plan and bring change to the lives of millions of people.

There are a few key interventions that can help us on our way.

First, better information on the magnitude and causes of visual impairment should be generated. Systems must be devised to monitor visual impairment prevalence, as well as the effectiveness of existing eye care and rehabilitation services. These should be integrated with national epidemiological data as part of a system-wide approach to enhancing public health.

Second, priorities should be identified and political and financial commitment secured. Amid a host of competing

policy goods, 'best buys' to address visual impairment and blindness include enhancing cataract surgical coverage and implementing school vision care programs. Research, too, is important, and requires adequate funding, while innovative strategies to strengthen services for 'last mile connectivity' need to be developed.

Third, effective multisectoral engagements and partnerships should be forged. The education, finance, welfare and development sectors must be an integral part of efforts to tackle visual impairment and blindness. Partnerships with the NGO and INGO sectors should likewise be aligned with national priorities, policies and programmes, while poverty reduction and disability inclusion programmes should be integrated.

In each one of these areas, the continued and deep involvement of affected communities themselves is crucial.

I am sure these points will form much of the discussion throughout this consultation. I am also sure that by the end of it you will be able to recommend innovative and cost-effective strategies that Member States can then implement. As we all know, business as usual is not an option.

But there is one point that I really want to stress here, and that is the importance of integrating comprehensive eye care into existing health systems.

Since there are a number of proven risk factors for visual impairment – including diabetes, smoking, premature birth and rubella – health services, especially at the primary level, have a fundamental role in preventing and managing these risk factors and avoiding complications. Strengthening primary health care is the best way to make significant inroads into the burden of visual impairment and blindness. It is something we should all strive for.

I also want to note that disease control programmes related to visual impairment will also help our cause. As I mentioned earlier, trachoma remains a major cause of visual impairment and blindness. It is among a number of neglected tropical diseases that WHO is working with Member States to eliminate by 2020. Within the Region, Myanmar and Nepal are

already reported to have eliminated trachoma, and will undergo validation next year. That would leave India as the last country in the Region where the disease is endemic.

With strong political commitment and donor support we have the power to change this, and to give a major boost to alleviating visual impairment and blindness.

Indeed, creating a world in which nobody is needlessly visually impaired, where those with unavoidable vision loss can achieve their full potential, and where there is universal access to comprehensive eye care services, is something we have the capacity to achieve. I urge you to ensure the success of this consultation, and to lay the foundations for lasting change across our Region.

Environment and health

Throughout human history the environment has played a significant role in shaping our health and wellbeing.

Weather patterns, availability of natural resources and acute natural events have all helped determine the prospect of living a healthy and productive life, while also mapping the contours of where and how we live.

But while the environmental factors affecting human health have changed in important ways, they are as pressing today as they ever have been.

Across the world, heatwaves and droughts threaten the health of the elderly and infirm, and compromise food security. Chemical spills and poisonings damage natural ecologies and debase the resources upon which communities rely. And inadequate sanitation diminishes the availability of clean and potable water, inhibiting the human rights of billions.

As I'm sure you're all aware, the environmental hazards to our health are many. Nonetheless, within the South-East Asia Region, as in many parts of the world, the single greatest cause of environmental health risk comes from one source.

That source, is air pollution.

As the global medical fraternity recognizes, among other air pollutants, fine particulate matter, also known as PM2.5, is directly responsible for a range of chronic and acute diseases. These diseases, which include lung cancer, chronic obstructive pulmonary disease, and cardiovascular diseases, are not only affecting the health and wellbeing of billions of people across Asia, but they are also impeding the economic and social development of our respective regions and countries. I urge us all to consider the fact that one in every nine deaths worldwide

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Fourth Regional Forum on Environment and Health in South-East and East Asian countries 6–8 October 2016, Manila, Philippines

is caused by ambient air pollution, and to reflect on what that means for the communities where we are from.

But the health impacts of air pollution are greater still.

As the scientific consensus illuminates, particulate matter along with climate emissions such as carbon dioxide and greenhouse gases are responsible for driving changes in the earth's climate. Apart from the direct physiological effects of heat and cold on cardiovascular mortality, these changes can hasten crop failure, intensifying dangers for persons vulnerable to malnutrition. They can amplify the frequency of extreme weather events, which have increased threefold since the 1960s. And they also have the potential to affect the distribution of disease-carrying vectors. These vectors are responsible for spreading life-threatening diseases such as falciparum malaria, dengue and chikungunya among others.

One in every nine deaths worldwide is caused by ambient air pollution

Indeed, to tackle the challenges that air pollution and other environmental health risks pose, firm resolve is needed. This is one reason I am most pleased to be here today, among leaders that are committed to taking effective action.

Another reason why I am pleased to be here is the opportunity this Forum represents. Since this Forum was first convened in 2007, it has served a critical role in bringing the health and environmental sectors together to forge a common agenda on addressing the problems we face.

As all of us here know, addressing environmental risks to public health cannot be achieved by any one sector. Rather, doing so requires a whole-of-government approach that mobilizes and engages multiple arms of government. In the coming days we have an unparalleled opportunity to map-out our strategy and activities to combat environmental health risks for the coming three years.

The Forum has already identified seven areas of priority work. Speaking from the perspective of WHO South-East Asia, three issues in particular stand-out as deserving extra attention.

The first two of these are subjects I have already discussed – tackling air pollution and addressing climate change and health. That leaves the third issue, which is the need to make health and environmental impact assessments a routine part

of development and other projects. Without doing so, we can never fully anticipate the impact to public health that changes to our environment can bring. By extension, that leaves us unable to avert or prevent such public health dangers if they do indeed arise.

In this regard, at this fourth meeting of our Forum, we are well-positioned to make progress.

As I'm sure you are all aware, the Sustainable Development Goals provide a compelling framework through which we can understand environmental risks to health, and through which we can set goals and take action.

Indeed, several of the SDGs dedicated to key environmental issues have a clear impact on health, including SDG 6, SDG 7, SDG 11, and SDG13. Respectively, these goals call for sustainable water management and sanitation for all; clean energy; making cities and settlements inclusive, safe, resilient and sustainable; and taking action to combat climate change and its impacts. In addition, target 3.9 emphasizes the need to substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

The challenge now is converting the 2030 agenda into national targets and priorities, and devising implementation strategies for doing so. To this end, I extend to all of you WHO South-East Asia Region's full support. At this Forum and beyond we look forward to finding innovative ways to tackle the problems we face together. And we look forward to an ongoing dialogue that facilitates sharing of information and collaboration at national and regional levels.

Like other issues associated with rapid economic growth, tackling air pollution and other environmental risks to our health represents a massive moral and practical challenge. But it also represents an opportunity.

Not only would overcoming them open up new ways to solve other 'problems of the commons', but it would also redefine how we approach the environment and health nexus moving forward. As countries across our respective regions develop and prosper in the 21st century, they needn't repeat the development tropes of a bygone era. We can and must write a different history.

Food safety

The international food trade is a US$ 1.5 trillion a year industry responsible for the production, marketing and transport of billions of tons of food. It is a trade that has escalated tremendously over the last decade, with the food chain today extending over thousands of kilometers and containing many steps from production to consumption.

An error by a food producer in one country can affect consumers on the other side of the planet, impacting health, international relations and trade. Harmonization of food quality and safety standards that are science-based and uniformly accepted is therefore essential.

In the South-East Asia Region food-borne diseases are of significant concern

In the South-East Asia Region food-borne diseases (FBDs) are of significant concern. Based on data from 2010, the annual burden includes more than 150 million illnesses and 175 000 deaths, making our Region the second most-affected on a per capita basis among WHO regions.

FBD surveillance and food safety – both core capacities under the International Health Regulations – is vital to obtain a clearer picture of unique local challenges and to map-out implementation strategies aimed at combating the problem.

Alongside FBD-related concerns, the misuse and overuse of antibiotics, responsible for the rise of anti-microbial resistance (AMR), demands attention. The use of antimicrobials in farm animals for disease treatment, growth promotion and to improve feed efficiency plays a major role in the emergence of antimicrobial-resistant bacteria.

AMR's public health implications are many. It is already limiting the efficacy of standard treatments, leading to the death of an estimated 700 000 people across the world each year. It is likewise threatening infectious disease control, causing

Address at the CCASIA meeting, 26–30 September 2016, New Delhi, India

the re-emergence of some pathogens and/or increasing their virulence. And it is also making medical treatments more costly.

In our efforts to overcome these and other challenges, Codex is fundamental. For more than 50 years Codex has played a key role internationally in the area of food standards, and has fulfilled its dual mandate of protecting the health of consumers and ensuring fair practices in the food trade.

As the 70th session of the Codex Executive Committee and the 38th session of Codex Alimentarius Commission agreed, FAO and WHO, together with the Codex Secretariat, will proceed to revitalize our Regional Coordinating Committees in all regions, including in Asia.

I take this opportunity to thank the Government of India for hosting the 20th meeting of the Codex Committee for Asia in New Delhi, and for facilitating this process.

National Codex Committees (NCC) in Member States continue to play an important role in promoting multisectoral coordination and collaboration for food safety, and in providing national input to the Codex standard development process at regional and global levels. It is unfortunate that some countries in the Region still have a weak National Codex structure, with the NCC failing to function as per Codex guidelines.

The diagnostic tool for assessment of the National Codex Committee, developed by the Codex Trust Fund, may help us better understand the functional status of Codex Committees and Codex activities. FAO and WHO are working together to establish a functional NCC through high-level advocacy meetings and in-country activities.

Over the next five days you will deliberate on proposed regional Codex standards and will be exposed to a range of ideas on how to deal with critical and emerging challenges in food safety and implementation of Codex standards in Asia.

World No Tobacco Day Award, 2016

It was in September last year that I was here when we had a memorable time at the Sixty-eighth Session of our Regional Committee. It is a great pleasure to be back here again.

The pleasure of this visit is enhanced greatly by the honour to be able to personally hand over to His Excellency, Dr Rui Maria de Araújo, the Prime Minister, the World No Tobacco Day Award for 2016.

Every year WHO recognizes individuals and organizations around the world for their contributions and accomplishments in tobacco control. As you all know, the WHO Framework Convention on Tobacco Control or FCTC was adopted by the World Health Assembly in May 2003 and the Convention entered into force on 27 February 2005. And, as of now 180 Member States are parties to the FCTC.

The FCTC is a landmark in public health

The FCTC is a landmark in public health. For too long the world allowed tobacco companies to profit from death. Approximately 1.3 million deaths occur every year in our Region alone. That's 150 preventable deaths per hour. Think of that.

The statistics for Timor-Leste are alarming; 70% of males and 42% of youth aged 13–15 years consume tobacco. As Honourable Prime Minister Araujo has highlighted in his messages to the nation, the health and future of this country are in grave danger.

Across the world tobacco consumption is the leading cause of preventable death. Despite many notable achievements in tobacco control, the world may be faced with around 1 billion tobacco-related deaths this century if we allow global trends of tobacco consumption to continue.

Presentation of World No Tobacco Day Award to His Excellency Dr Rui Maria de Araújo, the Prime Minister of Timor-Leste, 4 July 2016, Dili, Timor-Leste

All of us here today will agree that this is unacceptable, and that too many lives have already been lost.

His Excellency, Dr Rui Maria de Araújo's single minded commitment and far-sighted vision is praiseworthy. And this year's WHO's World No Tobacco Day Award is to acknowledge the exemplary leadership of the Prime Minister of this country.

But more than that, what this award represents foremost for Timor-Leste is change. It is a change that started when the national parliament ratified WHO's Framework Convention on Tobacco Control in December 2004, but only fully materialized in November 2015.

It was then that the Council of Ministers, under the leadership of Prime Minister Araujo, passed the Decree Law that set out the Tobacco Control Regime for Timor-Leste, which was recently promulgated by the President of the Republic, H.E. Mr Taur Matan Ruak.

This Tobacco Control legislation, recently promulgated, represents a victory on many fronts for Timor-Leste.

It is a victory for universal health coverage. If less is spent on tobacco-related health care costs in future, more of those funds can be used to ensure all Timorese have access to quality health care.

It is also a victory for the rule of public health law. For too long in Timor-Leste tobacco companies have sought to undermine and challenge the sovereign will in this area.

This legislation is not only bold; it is also visionary, and will no doubt enhance the future health and prosperity of a rising Timor-Leste.

The legislation establishes measures to reduce both demand and supply of tobacco products, including bans on smoking in all enclosed public spaces, workplaces and in public transport.

It also regulates the contents of tobacco products, introduces mandatory labelling and health warnings on packaging.

Of vital importance, given Timor-Leste's young population, is that it prohibits the sale of tobacco to people under the age of 17 years.

In times past it has been too easy and cheap for children and young people in Timor-Leste to smoke. This legislation changes that, and provides a clear message to the tobacco industry that Timor-Leste's youth will not top-up flagging profit margins as tobacco use in other countries around the world declines. In saying this though, implementing the legislation will have its own challenges. But in this regard Timor-Leste will also succeed because of the political commitment at the highest levels and the mechanisms already put in place.

There is, under the direct authority of the Prime Minister, the National Council for Tobacco Control, which will monitor the implementation of the legislation and report to the National Parliament on a regular basis. This strengthens accountability and the rule of law.

Timor-Leste has also demonstrated steadfast commitment to achieving the newly adopted Sustainable Development Goals. Not only are there efforts to make SDGs a part of government's policy framework; but Timor-Leste has also joined the High Level Champions Group for SDG's at the United Nations General Assembly.

Timor-Leste is the only country from Asia Pacific in this group alongside Brazil, Colombia, Germany, Liberia, South Africa, Sweden, Tanzania, and Tunisia. Through this group Timor-Leste will mobilize the world to ensure the 17 SDGs and the 2030 Agenda are implemented.

As we know, Goal 3 of the SDG's focusses on Good Health and Wellbeing and one of its targets is to strengthen the implementation of WHO's Framework Convention on Tobacco control.

Rolling back the consumption of tobacco is a global movement. Since taking office last year the Prime Minister demonstrated outstanding leadership and commitment towards tobacco control. He is an inspiration not only across his country but also across the Region, and has successfully demonstrated how to address the ongoing tobacco epidemic afflicting so many.

Not only did Prime Minister Araujo take full political ownership towards strengthening legislation, he has also through direct participation affected change at all levels. This commitment serves as an example for other developing countries struggling to roll back tobacco consumption and enhance public health.

Prime Minister Araujo has been instrumental in promoting anti-tobacco messages as well and driving the message home that the future prosperity of Timor-Leste rests on the good health of all its citizens.

Rolling back the consumption of tobacco is a global movement

He has set in motion a strong movement sweeping across Timor-Leste that will guarantee the saving of many Timorese lives in future; it is firm step towards a healthier Timor-Leste.

WHO, therefore, deems it an honour to give this award to His Excellency, Dr Rui Maria de Araújo, the Prime Minister of Timor-Leste. And for myself it is a personal honour to have the opportunity to be able to hand this to the Prime Minister.

WHO looks forward to work with Timor-Leste as this movement gathers momentum.

Diabetes

Wellbeing and happiness are intangibles we all desire for and, the foundation of happiness. We all must realize to have good health is well within our own control. This year's focus of World Health Day is extremely relevant for us and our Region - diabetes.

The price of progress is diseases due to excesses. Diabetes is a case in point. When in earlier times people had less rich food, lesser quantities to consume, and more physical labour to till the farms, diseases such as diabetes were rare. Now we spend much of our lives sitting, we eat far too much and, more importantly, we eat rich foods, the resultant calories which we never burn because we do not often do any physical activity.

The price of progress is diseases due to excesses

We are all fortunate to be in an Organization that champions the protection and preservation of health. But this privilege entails responsibility. Each of us must be a leader in the effort to combat the rising trend of non-communicable diseases such as diabetes, cardiovascular diseases and cancers; all of these are, to a large extent, preventable with healthier lifestyle choices.

How many of us know that 30 minutes of physical activity a day can keep diabetes and heart diseases at bay? We all know it. Yet how many of us actually achieve this goal? Very few, I'm sure. The gap between knowledge and practice is often high.

The most common excuse for not doing any physical activity is lack of time. It is well said that "he who cannot find time to be healthy, will have to find time to be sick." We must manage our daily schedule and give priority to our health. We must shift our mindsets and include physical activity, healthier diet and exercise as part of our daily priorities. Simple things such as using the stairs instead of the lift, watching our caloric intake and eating healthy foods can win half the battle against

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Address on World Health Day 2016, 7 April 2016, WHO-SEARO, New Delhi, India

lifestyle related chronic diseases. We have a badminton court and a gym on the building premises. We have weekly yoga classes. How many of us actually make use of these facilities? Several do and I commend them.

I am also encouraged by the many positive initiatives in our office to promote healthy lifestyles. But, I do believe more can be done. At SEARO, I propose to reinforce and strengthen workplace health promotion as a core business value and part of our organizational culture. Let's call it BE THE CHANGE Programme. We will focus on building a work environment that promotes healthy eating, physical and mental fitness.

BE THE CHANGE Programme comprises SIX WATCH components:

1. Watch your plate- We will promote conscious calorie intake reduction and discourage consumption of unhealthy food. We will make green leafy vegetables and fruits and more choices of salads at the cafeteria, and promote clean water as preferred substitute for sugary drinks;
2. Watch your weight and waist- We will place weighing scales, measurement tapes and BMI machines in strategic locations of the building;
3. Watch your steps- We will encourage taking the steps rather than the lifts, actively promote use of the fitness centre and badminton court, and have a monthly self-assessment of one's physical activity level;
4. Watch your stress level- We will promote yoga, introduce stress consultation and staff counseling services, and create a space for reflection and thinking
5. Watch your change- We will conduct six-monthly screening of blood sugar, blood cholesterol and blood pressure at the worksite in addition to routine medical services;
6. Watch your tobacco and alcohol consumption- All WHO premises will be tobacco free, and we encourage moving towards an environment free from the harmful effects of alcohol. Further, we will introduce self-help and group-help for those who need support for alcohol or smoking cessation efforts on a six-monthly basis

These initiatives are relatively simple, yet will have far reaching impact on the prevention of diabetes, cancers and heart diseases.

At the country level, many praiseworthy events are taking place. In Bhutan, Walk for Happiness and Wellbeing was initiated in January 2016. The Walk for Happiness and Wellbeing is a one-hour walk before lunch every Wednesday for WCO staff. The office is also discouraging use of betel quid during working hours.

The WHO Country Office (WCO) Indonesia has initiated a Wednesday yoga class and participates annually in the UN badminton competition. The Staff Association conducts a "health talk" every few months to update staff on issues related to their health and wellbeing.

Similarly, WCO Thailand promotes activities including workplace ergonomics, first aid, and screening programmes.

We encourage all WCOs to innovate healthy workplace programmes.

On 2016 World Health Day, I strongly urge our offices, Regional as well as Country, to strengthen their commitment to make our workplaces healthier. We should lead by example and encourage organizations, including government agencies and others, to adopt similar workplace practices.

To support this year's World Health Day theme and combat diabetes, we must take meaningful steps to make healthy lifestyle choices a norm for individuals, organizations, communities and societies.

Let's begin at our offices and take it to our homes, neighbourhoods and societies. Let's create a wave of health consciousness that can influence school systems, organizations and institutions to adopt healthy workplace policies.

Today, on World Health Day 2016, I call upon our staff and WCOs to be agents of change and role models for our families, neighbourhoods and communities. Let's walk the talk. Let's adopt healthier practices to live longer and healthier lives.

Prevention and control of cancer

It is a great pleasure for me to be here at the Institute of Cytology & Preventive Oncology (ICPO) and I am honoured to be invited to give the Foundation Lecture on Cancer on the occasion of the launch of the WHO-Framework Convention for Tobacco Control Global Hub. I would like to thank the ICMR and the ICPO for giving me the opportunity to be here.

The word cancer is a dreaded one. But the fear becomes real only when cancer touches oneself or those close to you.

Cancer is a major cause of mortality and morbidity

Cancer is a major cause of mortality and morbidity. Indeed it is becoming truly the "Emperor of Maladies" as aptly named by Dr Siddhartha Mukherjee in his now famous book on cancers. A recent study indicates annual burden of 14 million new cancer cases, and 8.2 million deaths every year, accounting for nearly one-sixth of the total deaths worldwide. And what is worrisome is the increasing trend of the cancer epidemic. The world is expected to see 50% increase in morbidity and 60% increase in mortality from cancers in the next 18 years. It is projected that by 2030, over 21 million people will be diagnosed with cancers annually and, of those, 13 million will die from them.

The devastating impact of cancer is felt not only by the patient, but also by the family members, co-workers and the very society in which the afflicted live. Opportunity cost on the patient and people around him, the mental stress, the high cost of care, and the overall economic loss to society are some of the collateral maladies that accompany the "emperor of maladies."

Once cancer is diagnosed the cost of treatment often is often prohibitive. Even after that a favourable outcome is not often guaranteed. The overall economic burden from cancer to Indian society for the period between 2012 and 2030 is

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The Foundation Day Lecture on "Cancer" at the inauguration of WHO-FCTC Global Hub for information on smokeless tobacco at the Institute of Cytology & Preventive Oncology (ICPO), 13 January, 2016, New Delhi, India

estimated to be in excess of US $ 250 billion, a truly significant economic burden to the country.

There are three common myths around cancers.

First, cancer is a disease of the rich. In the past, it may have been more common to see cancer patients often among the better off people, either because of their better access to diagnosis and treatment or their better knowledge about cancers. But that phenomenon is long gone. Available evidence shows that rates of cancer deaths are twice as high in the least educated as compared to the most educated in both men and women. Furthermore, evidence indicates that 60% of all new cases and 70% of cancer-related deaths will occur in low and middle income countries.

The South-East Asia Region is going through a demographic and epidemiological transition, as well as rapid urbanisation and accelerated lifestyle changes, all of which are contributing to the growing burden of noncommunicable diseases, including cancers.

Most cancers are preventable, detectable and treatable

Cancer is a major cause of mortality in the SEA Region, accounting for 1 in 10 deaths. Recent studies indicate an estimated 1.7 million new cases and 1.2 million deaths a year from cancers in the SEA Region. And India alone sees more than a million new cancer cases and an estimated 680 000 deaths due to cancers. The second myth is that cancer is a disease of the elderly. Data indicate that 72% of cancer deaths occur in those aged below 70 years, the age when most are still active and economically productive. Furthermore, the trend of cancer-at-younger-age is becoming more and more common. Therefore, the premature deaths of many breadwinners will have profound economic impact on their dependents.

And the third myth is that cancer afflicts only the unlucky people whose destiny chose for them an early exit from life. And thus people have a resigned attitude towards cancer, perceiving it to be inevitable. The reality is otherwise - most cancers are preventable, detectable and treatable.

The high morbidity and mortality from cancer in our Region reflect the high exposure to many well-known risk factors.

Two most common sites for cancer among men are lungs and oral cavity, while breast, cervical and colorectal cancers are the leading cancers in women. All of these cancers are closely associated with known risk factors and, in particular, to tobacco use.

Our Region carries the highest burden of oral cancer with over 95 000 oral cancer cases reported each year. Over half of these cases are attributable to tobacco use, according to the International Agency for Research on Cancer (IARC).

Tobacco use, both smoking and smokeless products, is the single most preventable cause of cancer worldwide. Nearly 35 % adults in the Region use tobacco in one form or another. Nearly 1 in 5 adults in the Region smoke. In addition, exposure to second hand smoke is alarmingly high; over 45% of adults in the Region are exposed to second hand smoke at home, and 35% at the work place.

SEA Region is the global hub of smokeless tobacco

SEA Region is the global hub of smokeless tobacco. 90% of the 300 million global smokeless tobacco users reside in this Region which is nearly 1 in 5 adults in the. And in India 33% of males and 18% of females use smokeless tobacco. Not only the high prevalence of smokeless tobacco use but the increasing trend of use by the youth is a serious concern; the future burden of cancers will rise as this population group begins to age. Already, research shows the increasing trend of oral cancers among the younger age groups. Unlike the male predominance for smoking tobacco products, chewing tobacco among women and men in our Region is not only a big problem but of equal proportion among the sexes.

Smokeless tobacco products come in many forms and there are a variety of consumption patterns. Apart from tobacco itself, there is strong association of use of betel quid with cancer of oral cavity or oropharynx, not to mention its association with hypertension, another major public health problem. We must find good public policy and adopt appropriate regulatory measures to discourage the use of betel quid, in particular, co-use with tobacco which can multiply harmful effects of each individual product.

Besides tobacco, our population in the Region is also exposed to many other carcinogens and risks.

Alcohol consumption increases risks of cancers of mouth, nasopharynx, oropharynx, larynx, oesophagus, liver, colon, rectum and female breast. Consumption of unprocessed red meat and a diet low in fibre have been associated with cancers. Similarly, links between physical inactivity and elevated risk for cancers of breast and colon is well established. Obesity, a result of poor dietary practices and physical inactivity, is a risk factor for breast and colorectal cancers. The increasing trend of obesity seems inevitable and this will, in turn, drive up the cancer rates.

Occupational carcinogens such as asbestos, aromatic amines, benzene, benzidine are serious chemical risk factors as high exposure to these in the communities are common. Similarly, exposure to carcinogens such as arsenic, air pollution, aflatoxin, polychlorinated biphenyls, radon, and heavy metals pose significant threat to population health in our Region.

Infectious agents such as helicobacter pylori, hepatitis B and C viruses, and human papilloma viruses (HPV) are causes for the major proportion of stomach, liver and cervical cancers. Human papillomavirus (HPV) infection is a well-established cause of cervical cancer and there is growing evidence of HPV also being a risk factor for other ano-genital cancers and cancers of head and neck.

The majority of cancers can be prevented by reducing exposure to risk factors. But to tackle the risks in isolation is not the proper solution. WHO calls for the 'total risk approach' which has been proven to be more efficient in controlling cancers and other NCDs. Risk factor reduction requires not only promotion of healthy behaviours at the individual level; even more important is the making of our physical, mental and social environment less cancer-friendly. There are many examples showing that structural changes such as fiscal policies, urban design and supportive legal environment can effectively reduce cancer risk-exposure at a collective level.

Equally crucial is investing in health systems to enable early detection and adequate continuum of care for those with the

disease. Cervical cancer screening and hepatitis B vaccination are among the most cost effective cancer control interventions. However, we need a robust health system to deliver these services.

Let me say few words on the global movement for cancer prevention and control, and what's being done in the South-East Asia Region for the same.

In September 2011, global leaders and Heads of State adopted the UN Political Declaration on NCD Prevention and Control. Two years later, the World Health Assembly and UN General Assembly, in 2013, adopted the 9 global targets for NCDs to be achieved by 2025. The key global target is a 25% relative reduction in the overall premature mortality from NCDs by 2025. The Sustainable Development Goals adopted by the UN Member States last September further mainstreams NCDs in global agenda aiming for a one-third reduction of premature mortality from NCDs by the year 2030. In consonance with global efforts, the Member States of the SEA Region are also taking important steps to reduce the burden of NCDs, including cancers, and their associated risk factors.

Last year, the Sixty-eighth Session of the WHO Regional Committee in Dili, Timor-Leste, attended by the Health Ministers from the Member States passed two important resolutions. First, the cancer prevention and control resolution reaffirmed the commitment by Member States to increase access to early detection and treatment services, and to ensure the availability of essential medicines and related technologies. Second, the Regional Committee adopted the Dili Declaration on Tobacco Control which provides fresh impetus to the implementation of the provisions of WHO's FCTC.

Most of the countries have completed or are at the final stages of developing multisectoral NCD Action Plans in which cancer control is an integral component. Majority of countries of the SEA Region already have national cancer control programmes in place. Cancer Registries are in place in most countries, either as hospital-based or more desirably as population-based registries. Global Adult Tobacco Surveys, Global Youth Tobacco Surveys, and comprehensive NCD Risk factors survey, like the WHO STEPS

survey, have been carried out in most Member States. The local data generated by these facilitate evidence-based policy formulation and strategic planning for the implementation of measures to control and prevent cancer, and to measure the impact of interventions.

Member States are making steady progress in strengthening tobacco control measures within the provisions of the WHO Framework Convention on Tobacco Control (FCTC. Ten out of 11 SEA countries, have signed and ratified the WHO FCTC, and all countries have tobacco control legislations in place. Many countries have established smoke-free public places and banned tobacco product advertisements. SEA Member States are among the global front-liners in pictorial health warnings on tobacco product packages; Nepal is the world champion with 90% of package surface covered, followed by Thailand with 85%. Several Member countries have recently increased taxes on tobacco products as there is well established evidence that high taxes reduce demand.

Member States are making steady progress in strengthening tobacco control measures

While Member States have made significant progress in cancer control, much more remains to be done.

Effective cancer control requires comprehensive national policies and programmes with adequate resource allocation for universal access to the whole continuum of services and care - from prevention, diagnosis, treatment to palliative care. I would like to highlight three major challenges in cancer prevention and control in the Region.

First, cancer control is hindered by the lack of effective policy and programmes to address carcinogens at the population level and further hampered by poor enforcement of tobacco, alcohol, and food legislations.

Second, we need to invest more to build a robust health system. At the moment, the availability of screening and diagnostic services for cancer, and competent human resources, particularly at primary health care level, is generally limited in our Region. The lack of effective preventive, early detection and treatment services result in the majority of patients unnecessarily presenting at a late stage of the disease and usually with

complications. This results in enormous suffering for the patients and their families, high cancer fatality and high financial.

Third, hospital facilities cannot match with the increase in cancer patients. Therefore, community-based and home-based care for cancer patients are important in the long run, including availability of potent pain killers for end-stage palliative care.

Given the above challenges, tackling cancer comprehensively requires addressing the underlying social determinants, risk factors and health system strengthening. Above all, continuing political commitment and multisectoral collaboration for cancer prevention and control is vital for success.

We at WHO stand ready to provide technical and other support to our Member States for the control and prevention of cancer.

WHO is playing a leadership role in fostering partnerships, coordinating intersectoral collaboration and carrying out advocacy at the highest level. Technical support of WHO at the national level is executed in close collaboration with the ministries of health through the framework of the WHO country cooperation strategies. SEARO, with assistance of WHO collaborating Centres, provides technical support in the development of national cancer policies and strategy; setting up of cancer registries and cancer surveillance, developing training manuals; capacity building of health personnel; and monitoring and evaluation of cancer control programmes.

As we look to the future, I want to underscore the need to strengthen evidence-based prevention and control of cancer and the continuum of care while implementing programmes within the resource constraints of each country. It is important to perform locally relevant research that will assess how to scale-up and evaluate proven cost-effective interventions in resource-limited settings. It is equally important to ensure that available knowledge on cancer control is applied to the underprivileged groups as well.

Building research capacity in the Region and in countries is an important way forward for cancer control. In this context, I would like to place on record our appreciation for the

excellent work of the ICPO, particularly in HPV and cervical cancer surveillance and early detection. We hope to see similar successes in the areas of smokeless tobacco as well. WHO is pleased to collaborate with ICPO in order to present a united fight against cancers and noncommunicable diseases in general. With the launch of the regional hub, ICPO is achieving an important milestone towards prevention and control of cancer, especially tobacco related cancers. I'd like to take this opportunity to wish the ICPO regional hub for information on smokeless tobacco all success.

World No Tobacco Day Award, 2015

Noncommunicable diseases are on the rise in the South-East Asia Region. Evidence shows that there are more deaths from non-communicable diseases than communicable diseases. Tobacco is one of the major risk factors of non-communicable diseases. To address this every year, WHO recognizes individuals or organizations for their accomplishments in the area of tobacco control, such as research, capacity building, promotion of policy or legislation and advocacy to enhance tobacco control measures.

It is, therefore, my great pleasure and a privilege to hand over this prestigious World No Tobacco Day Award to Hon'ble Dr Senaratne, Minister of Health, Nutrition and Indigenous Medicine. This award is a clear recognition of Sri Lanka's achievements in tobacco control and the contribution of Sri Lanka towards the advancements of the objectives of the Global Framework Convention on Tobacco Control.

The theme of this year's World No Tobacco Day is "Stop Illicit Trade." Sri Lanka, is a Party to the WHO Framework Convention on Tobacco Control. In addition, the country has shown unwavering commitment to also eliminate illicit trade in tobacco products and is actively working towards the accession to the WHO FCTC Protocol to eliminate illicit trade in tobacco products. Your Excellency, President Sririsena, under your leadership I have no doubt that Sri Lanka will be the first country in the Region to become Party to this Protocol as well.

I wish to highlight a few significant achievements in Sri Lanka in the field of tobacco control. In 2012, Ministry of Health issued a landmark public health regulation for tobacco control. It became the first country in our Region to legislate a requirement of tobacco products to have pictorial health warnings covering

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Presentation of World No Tobacco Day Award to H.E. Dr NHRH Senaratne, Minister of Health, Nutrition and Indigenous Medicine, 7 December 2015, Colombo, Sri Lanka

80% of the pack. The tobacco industry, as expected, reacted. The court approved legislation to cover 50% to 60% of the cigarette packs. However, Dr. Senaratne, on becoming Health Minister, took immediate steps to amend the tobacco control act, to make it mandatory for all tobacco products on sale to display rotating pictorial health warnings, covering 80% of the largest surface area of the pack. The new law that came into effect in June this year also required pictures to be different on different sides. No two brands from the same manufacturer could display the same warnings. This resulted in Sri Lanka being a country with one of the largest graphic health warnings in the world. This will have enormous impact as scientific evidence attests¬- the larger the warning size, the larger the impact.

The significance of this measure will go far beyond the shores of Sri Lanka. This will be an example for other countries, especially developing countries. It also goes to show how the political skill, the commitment and the undiluted zeal of Hon'ble Minister, Dr Senaratne, helped in obtaining the unanimous support of all political parties for the amendments he ushered in.

Worldwide, tobacco use kills nearly six million people annually

It is very clear that we need to fight the global tobacco epidemic if we are to make progress on prevention and control of noncommunicable diseases. Sri Lanka, over the past decades, has established a strong public health system and has achieved many notable successes in public health. Malaria elimination and polio eradication are a few outstanding examples. I see the same commitment to deal with tobacco which, I have no doubt, will have far reaching impact on the emerging burden of noncommunicable diseases.

We know that tobacco use is the leading cause of preventable deaths. Worldwide, tobacco use kills nearly six million people annually with over 600 000 deaths due to exposure to second-hand smoke. In the WHO South-East Asia Region, the toll of death is estimated to be over 1.3 million. Our Region has about 20% of global smokers and 82% global users of smokeless tobacco. The Region is one of the largest producers and users of tobacco products in the world. Many types of smoking and smokeless tobacco products are used in the Region, which poses difficulties to harmonize taxation and regulations for controlling tobacco use. I am pleased

that Hon'ble Dr Senaratne, since assuming office, has taken many progressive steps towards a comprehensive strategy for tobacco control. Under the leadership of His Excellency, the President Maithripala Sirisena, and with the untiring efforts of Dr Senaratne, Sri Lanka has successfully addressed several important aspects of tobacco control. I understand that the government is currently working towards fine tuning the current legislation to bring in amendments aimed to align all articles covered by the WHO FCTC with the National Tobacco and Alcohol Authority Act.

The World Health Organization would like to congratulate Sri Lanka for the achievement of these milestones in public health and congratulate the tireless efforts of Hon'ble Dr Senaratne, for his many achievements, I am honoured to present him this award.

While we must celebrate our success, we must also be cognizant of the challenges that lie ahead. Despite the aggressive approach towards control of tobacco use, when reviewing the Sri Lanka data for 2008 and 2015, there is no significant change in the proportion of people who smoke and, also, the proportion of those who use smokeless tobacco. This means that Sri Lanka can miss the 30 per cent reduction target for tobacco use by 2025. It also indicates that the smokeless tobacco issue needs to be addressed as aggressively as smoking.

We would like to reiterate our commitment in providing our full support to enhance tobacco control. At the Sixty-eighth Session of the Regional Committee, Member States have unanimously adopted the Dili Declaration to accelerate implementation of the WHO FCTC. I am hopeful that with the political commitment, multisectoral engagement and community involvement, Sri Lanka, will achieve the voluntary target of 30 per cent reduction in tobacco use by the year 2030. The leadership of the Honourable President, who, I am sure, has a special place for health in his heart being an erstwhile Health Minister, will go a long way in making this happen. WHO stands ready to provide whatever assistance required as we walk together towards the shared goal of a world free of tobacco.

Human health and climate change

There is now clear evidence that significant changes to the global climate system are occurring and that human actions are largely responsible for these. The Intergovernmental Panel on Climate Change released its fifth assessment report in 2014, and this confirms that current and projected rates of climate change present a fundamental threat to the environmental determinants of health, exacerbating health risks from extreme weather events, and cause an increase in vector-borne diseases and malnutrition. For Asia, the report concluded that heat waves will cause an increase in the morbidity and mortality in vulnerable groups, while transmission of infectious diseases will be affected by change in air and water temperature and altered rainfall patterns and water flows. Further, it reemphasized that the population groups most at risk from climate extremes are those living in low-lying coastal zones and flood plains.

In the South-East Asia Region, the effects of climate change are already being felt in the form of more frequent and intense cyclones, unusual rainfall patterns and floods, droughts and heat waves. As I am sure you remember, just two months ago, parts of India experienced a heat wave that was reported to have killed more than 2000 people. Recent studies indicate that in the Himalayas, some species of mosquitoes that transmit malaria, dengue and encephalitis are now found at higher altitudes than before. Nepal and Bhutan started reporting cases of dengue for the first time in 2004 and 2006 respectively. Less obvious will be the significant impact on mental health due to the consequences of extreme events, such as loss of farm incomes, displacement of people and post-traumatic stress.

A new study by WHO, which considered only a subset of health impacts from climate change while assuming continued strong economic growth, showed that climate change is

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Regional workshop on: Protecting human health for climate change, WHO-SEARO, New Delhi, 15–17 July 2015

expected to be responsible for an additional 250 000 deaths per year from 2030–2050. This estimate is conservative and in reality the figures could be much higher.

Climate change is unlikely to cause new health problems but will rather intensify existing health risks. Therefore, there is no need, at this stage, to create new public health programmes, but I would recommend strengthening existing programmes that deal with climate-sensitive diseases. In other words, it is most timely to streamline climate risks into current public health programmes.

For more than a decade, WHO has been advocating, supporting and guiding Member States to address climate change impacts on health. Health adaptation projects, including research projects on climate-sensitive diseases and climate variability are either implemented or underway in the Region. SEARO has conducted a workshop to review the work on climate change and health in 10 countries of the Region; a synthesis report will be presented by one of the experts at this workshop.

The report serves as a basis for further strengthening efforts in each country – and the Region as a whole – to adapt to changes in climate. Bhutan is one of seven countries that participated in a global climate change and health adaptation pilot project that was jointly implemented by WHO and UNDP. I understand that it was successfully implemented and Bhutan will showcase findings of the project in this workshop. The findings should present a great opportunity for participants to learn about the pilot project and explore how it can be replicated both in Bhutan and in other countries of the Region.

2015 is a defining year for climate change. In Paris this December, at the 21st Conference of the Parties to the UN Framework Convention on Climate Change (UNFCCC CoP21), countries will seek to reach a global climate change agreement to replace and update the 1997 Kyoto Protocol. Representation of health in previous CoPs has been minimal and very little discussion on health is included in the climate change negotiations. Health sector engagement in the run-up to CoP21 and during the conference is very important if health issues are to be adequately taken into account in the climate

change negotiations. We have invited UNFCCC focal points from our Member States to this workshop so that we can consult with them and jointly plan on best ways for the health sector to engage in the negotiations. WHO, in cooperation with UNFCCC and Member States, has prepared country profiles for climate change and health. These profiles will empower ministers of health and other decision-makers to engage and advocate for health in national preparations for CoP21.

While countries prioritize work on health adaptation programmes, I would also recommend increasing the focus on mitigation to climate change in terms of reducing greenhouse gas emissions. Tackling greenhouse gas emissions brings in dual benefits – it slows down climate change and reduces diseases caused by air pollutants. The health sector can lead by adopting low carbon or green services. We will see examples of these in this workshop.

I am also pleased to inform you that SEARO and WPRO have jointly developed a training package on climate change and health with technical and financial support from GIZ. The package has been developed by a group of global experts and reviewed by professionals from various WHO offices and national programme focal points, many of whom are present at this workshop. I would encourage you to please use these resources to further build capacity at your national and subnational levels.

I hope this three-day workshop will pave the way for further strengthening of research on climate change and health in the Region, provide directions for streamlining climate risks into public health programmes and result in concrete action plans for developing health national adaptation plans. Most importantly, I also hope this workshop will help ensure the active engagement of the health sector in the run-up to CoP21.

Tobacco control

The South-East Asia Region carries one of the highest tobacco burdens and continues to face a growing public health crisis. There are approximately 250 million smokers and nearly the same number of smokeless tobacco users, leading to more than 1.3 million deaths every year due to tobacco use. The widespread use of many forms of tobacco also complicates efforts to implement effective tobacco control initiatives in the Region. In addition to being a leading consumer of tobacco products, the Region is also a major tobacco producer. India and Indonesia belong to the top ten tobacco producers and consumers in the world. This not only allows for increased availability of the product, but also creates a political climate which often hinders tobacco control measures.

Implementation of tobacco control measures has been challenged

Although much progress has been made, particularly in recent years, the Region has a number of unique challenges and conditions that make controlling the tobacco epidemic in countries of the Region an extremely difficult task. The tobacco industry interferes with the adoption of policies and its implementation in Member States through litigation and various other tactics. Most recently we have seen that in Nepal, Sri Lanka and Thailand the industry sued the Ministry of Health for implementing large pictorial health warnings on tobacco products. The industry also threatens to challenge on every initiative including implementation of smoke-free public places. They have formed front groups of tobacco farmers and bidi workers in Bangladesh, India and Indonesia and used them to oppose stringent laws. Globally, we have seen that in recent times, implementation of tobacco control measures, including implementation of the WHO FCTC provisions, has been challenged under international trade and investment agreements. Tobacco has emerged as the most litigated product in the World Trade Organization during the past few

Regional consultation on Sixth session of the Conference of the Parties, 29–30 September 2014, WHO-SEARO, New Delhi, India

years. It is important that Member States develop action plans to Implement the guidelines on Article 5.3 of the WHO FCTC. The WHO Regional Office for South-East Asia has organized a regional meeting and five national workshops on countering tobacco industry interference with tobacco control and will continue to do so in the future as well.

We have been continuously supporting Member States to effectively implement tobacco control measures in line with the WHO FCTC. Increasing progress has been made in areas related to Articles 6, 8, 11 and 13 of the Convention in most Member States of the Region. However, there are gaps, particularly with regard to implementation of the guidelines of the WHO FCTC. Additionally, even when strong tobacco control legislation is implemented, many countries face challenges in enforcing the law.

As Parties to the Convention, Member States are obliged to implement the provisions of the WHO FCTC. Article 15 of the WHO FCTC recognizes the need to eliminate all forms of illicit trade and calls on all the Parties to adopt and implement effective legislative, executive, administrative or other measures to eliminate illicit trade in tobacco products. Illicit trade in tobacco and tobacco products is an issue of serious concern in the Region. Studies show that Asia is one of the key targets of global illicit trade of international brands of tobacco products due to fiscal barriers such as high import and supplementary duties, domestic sales and value-added taxes, and a ban on imports. Illicit trade of tobacco products increases the affordability and accessibility of tobacco products which increases the burden of tobacco-related diseases and deaths.

The Protocol to Eliminate Illicit Trade in Tobacco Products, the first Protocol to the Convention, was adopted on 12 November 2012 at the fifth session of the Conference of the Parties in Seoul, Republic of Korea, and is currently open for ratification, acceptance, approval or accession by the Parties to the WHO FCTC. The Protocol was developed in response to the growing international illicit trade in tobacco products, which poses a serious threat to public health. Till date, Myanmar has signed the Protocol and I would like to urge Member States to accelerate their efforts to ratify or accede to the Protocol.

About 90% of global smokeless tobacco users reside in countries of the South-East Asia Region causing over 30 000 deaths annually. There is an increasing trend in the use of smokeless tobacco by young individuals in many countries. The increasing trend in smokeless tobacco consumption in South-East Asian countries points to inadequate tobacco control policies. Although many Parties in the Region have initiated steps to regulate smokeless tobacco, they need to strengthen policies and ensure they are fully enforced. Low taxes on smokeless tobacco and the myth that it is less harmful than smoking forms led tobacco users to switch from smoking to smokeless tobacco use. Production of smokeless tobacco is increasing globally and it has become a global epidemic. I am happy to note that smokeless tobacco is an agenda in the sixth session of the Conference of the Parties and I do hope that the Conference will suggest concrete measures to stop this epidemic.

Production of smokeless tobacco is increasing globally

Now, we have a new challenge. In recent years the electronic cigarette industry has been expanding rapidly. The electronic nicotine delivery systems known as ENDS, are frequently marketed by the industry as an aid to quit smoking or as being a healthier alternative to tobacco. But, the fact is that there is very little research on ENDS and no convincing evidence that they are effective as a "quit-smoking device". ENDS contain varying levels of nicotine, many times similar to those in cigarettes, and without regulation there is no way to control this amount. Evidence shows that though likely to be less toxic than conventional cigarettes, e-cigarette use poses threats to adolescents and fetuses of pregnant mothers. According to some reports, e-cigarettes also increase the exposure of non-smokers and bystanders to nicotine and a number of toxicants. Half of the countries in developing world have no mechanism to regulate ENDs. I would like to urge the delegates to discuss this seriously and develop a regional position at the COP6.

Tobacco growing as well as bidi rolling accounts for a significant percentage of the workforce in countries such as Bangladesh, India and Indonesia. These people get paid minimum wages and suffer from hazards of handling tobacco

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Third meeting of the Global Alliance to Eliminate Lead Paint and the associated workshop on establishing legal limits on lead in paint, 22–24 September 2014, New Delhi, India

leaves and inhaling of pesticides. There are also negative effects on the environment due to deforestation and curing of tobacco. This important issue of alternative livelihood needs to be addressed seriously, since we have mega countries in our Region where an alternative livelihood for the tobacco growers and workers needs to be provided by the government.

This meeting has been organized by the WHO Regional Office for South-east Asia at the request of Member States. I would like to thank the Member States for their continued efforts towards curbing the tobacco epidemic in the Region. I hope the momentum will be enhanced within the context of prevention and control of NCDs to achieve our global voluntary target of 30% relative reduction of tobacco use by 2025.

Harmful effects of lead paint

The harmful nature of lead has been known for centuries. As far back as Roman times, it was known that lead could cause serious health problems – even madness and death. Plumbism, colica pictorum, saturnism, and painter's colic are all terms which have been used throughout the ages to describe lead poisoning.

Unlike the ancients, we know now that there is no safe exposure to lead. This evidence has continued to grow since the early part of the twentieth century, particularly in respect of low level exposures and the effects on neurobehavioural development in young children – the most vulnerable in our society. In 2010, a joint FAO/WHO Expert Committee on Food Additives concluded categorically that there was no evidence of a threshold below which the most critical effects of lead exposure would not be seen. This is a particular concern for low-level environmental exposures which are entirely preventable – including exposure of children to lead paint.

We know now that there is no safe exposure to lead

Unlike the ancients, our world is developing at an unprecedented rate. Asia is home to many of the world's mega-cities and this impacts the way we develop. The paint industry in Asia is growing fast – particularly in its decorative paint sector – due to factors such as rapid urbanization and increasing disposable income. We must act decisively to ensure that health is at the centre of the policies of all sectors.

Health for all is a major societal goal of governments and the cornerstone of sustainable development. In May 2014, the Sixty-seventh World Health Assembly adopted a significant resolution (WHA67.12) on contributing to social and economic development; sustainable action across sectors to improve health and health equity.

Through this resolution, Member States are urged to take a number of actions including addressing social, economic and

environmental determinants of health, developing, implementing and monitoring policies across sectors and engagement with relevant stakeholders such as local communities and civil society.

WHO's engagement with UNEP, governments, civil society and other UN bodies in the Global Alliance to Eliminate Lead Paint is clearly an excellent example of work in this area to promote health in all policies.

You have a full agenda ahead of you over the next three days with much experience to share.

We understand that part of your time will be spent reviewing the very positive experience from the first International Lead Poisoning Prevention Awareness Week, held almost a year ago, when over 40 countries participated. A second week of action will be held during 19–25 October 2014 – in approximately one month's time.

In case any of you believe that the elimination of lead from paint is beyond reach – take heart.

This year. we have had cause to celebrate all countries in the South-East Asia Region reaching the target of eradicating polio. The success of this campaign is testimony to the efforts of millions of health workers who have worked with governments, nongovernmental organizations, civil society and partners over many years. This shows what can be achieved with clear public health goals, clear objectives and focused actions. Please take advantage of being here in the WHO South-East Regional Office this week to discuss some of the lessons learned in polio eradication, particularly, the experience with public health communication and community engagement.

The work of civil society, particularly environmental and public interest groups in gathering information on the scope of the problem, and engaging with relevant sectors at national and regional levels has clearly been instrumental to what has been achieved by the Global Alliance to date. We welcome representatives of several of these groups here today.

It is a real pleasure to see so many governmental representatives from all regions of the world – from Africa, the

Asia-Pacific, Central and Eastern Europe, Latin America and Western Europe and other developed nations – assembled here to move the work of the Global Alliance forward to the next phase,.

The information before you shows there is still some way to go to achieve the goals and objectives of the Global Alliance and its business plan targets. I encourage you all to take every opportunity for discussion this week to share your experiences, success stories and any outstanding concerns you may have, so that the work of the Global Alliance can be completed.

Our thanks to colleagues in UNEP and the organizing group for this meeting and to the Government of Germany for providing financial support to help bring such a wide and diverse group together.

We cannot afford to wait until another century has passed to count the cost of not acting. Let us discuss all we need to do to eliminate the use of lead in paint successfully, ahead of your ultimate 2020 goal.

47th Foundation Day of Dr R.P. Centre for Ophthalmic Sciences

It gives me great happiness to be present here with you on the occasion of the 47th Foundation Day of Dr Rajendra Prasad Centre for Ophthalmic Sciences. The illustrious history and excellent contributions of this Institute during the past 47 years are a matter of great pride and satisfaction to all of us who care for, and are concerned with the health of our people. The Institute has always lived up to its apt motto of *tamaso ma jyotir gamaya* by either preventing darkness through healthy eyes or through curing eye diseases for restoring vision in the eyes and light in the lives of people.

At the outset, I wish to congratulate the entire faculty and the staff of this national institute of excellence which is also a WHO collaborating centre, for the exemplary hard work, innovative approaches, and state-of-the-art patient care that represents the highest international standards in ophthalmic sciences, which is so apparent as I took a round of the Centre and observed the new services. It is indeed a centre par excellence and I congratulate you all.

The burden of blindness is largely in developing countries

WHO estimates that around 285 million people in the world are visually impaired out of which 90.5 million of them are from the South-East Asia Region. Of the estimated 39 million blind people in the world, 90% are in developing countries; 22% in India alone. Therefore, the burden of blindness is largely in developing countries where 9 out of 10 of the world's blind live. As you are aware, cataract alone is the cause of approximately 50% of the world's blindness and the rest is caused by conditions such as glaucoma, trachoma, onchocerciasis and childhood blindness. Despite a half century of efforts to prevent blindness, the global burden of blindness is not shrinking, but growing, due to population increase coupled with an ageing world. If nothing

Inaugural address at 47th Foundation Day of Dr R.P. Centre for Ophthalmic Sciences, 10 March 2014, All India Institute of Medical Sciences, New Delhi

is done and no additional resources are mobilized urgently to deal with this, it is projected that by 2020, the global burden of blindness will double from what it is today.

'Vision 2020: the Right to Sight' was jointly launched by WHO and the International Agency for the Prevention of Blindness (IAPB) in 1999 as a global initiative. WHO organized an expert group meeting in 2007 to review progress in the countries of the Region and to further strengthen regional capacity towards the attainment of the goals of Vision 2020. Detailed country by country situation analysis was carried out in 2011 and a regional workshop to assess the implementation of the Action Plan for the Prevention of Avoidable Blindness and Visual Impairment was also held in September 2011.

Realizing that about 80% of global blindness is avoidable, and striving for a major international effort to combat avoidable blindness, WHO and a Task Force of international NGOs jointly revisited the global initiative of "VISION 2020 – The Right to Sight". The Sixty-sixth World Health Assembly held in May 2013 adopted resolution WHA66.4 'Towards universal eye health: a global action plan 2014–2019.' The vision of this global action plan is to have a world in which no one is needlessly visually impaired, where those with unavoidable vision loss can still achieve their full potential and there is universal access to comprehensive eye care services. The global action plan aims to achieve by 2019, a reduction in the prevalence of avoidable visual impairment by 25% from the baseline of 2010.

Of course, the development of a Vision 2020 agenda is one of the series of major initiatives that WHO has spearheaded since the 1950s to combat blindness starting with trachoma, followed by the Onchocerciasis Control Programme in 1974. This was then followed in 1978 by the launch the Programme for the Prevention of Blindness (PBL), aimed primarily at onchocerciasis, xerophthalmia, trachoma and cataract as preventable causes of blindness.

Some of the key WHO core mandates are to provide evidence-based policy guidance, promote research, and provide technical support to Member States to build capacity to tackle health issues efficiently and effectively. In this regard, WHO has provided and continues to provide support to Member States to formulate sound national policies, help implement such

programmes, and monitor their progress and impact. WHO does this through its own technical capacity supplemented with its wide reach of the technical resources of global institutions and international experts, and uses its convening power to bring together different stakeholders to shape global, regional and national policies and strategies for the prevention of blindness.

All of these initiatives are based on principles of universal access and equity, human rights, evidence-based practices, life-course approach and empowerment of people with visual impairment. The key strategy is to reach out to communities, empower them and ensure access of essential quality services for prevention of visual impairment within national systems of primary health care to them.

You will recognize that these principles are the same which have guided the operations of the Dr Rajendra Prasad Centre for Ophthalmic Sciences during the past 47 years.

I wish to laud the commendable contributions of this Institute to the building of national capacity to tackle eye diseases through its innumerable educational and training activities which have helped expand the health workforce in this field and strengthen the capacity of health systems to respond to the needs of the population for eye care services. The research undertaken by the experts in this Institute and its affiliated centres around the country is well-known and highly appreciated by their peers and, more importantly, such research has also helped find appropriate solutions to address issues of blindness in the country.

The key strategy is to reach out to communities

Ever since its inception, the Dr Rajendra Prasad Centre for Ophthalmic Sciences has been recognized by national policy-makers as a centre of excellence and a dependable resource for the formulation of policies and strategies for national eye health programmes. For example, there has been a substantial input from the faculty of the Institute in the framing of the Plan of Action under the Vision 2020 Initiative in India. This Plan of Action will guide the National Programme for Control of Blindness in the years to come. Further, technical support from the Institute in the implementation and monitoring of India's National Programme for Control of Blindness has been also truly laudable. An excellent example is the "National Registry of Eye

Care Infrastructure and Human Resources in India," a software developed by the Institute which will be of immense value to support Vision 2020 activities in India.

While the above are true and indeed necessary, it is for clinical services and the excellence in eye care that RP Centre is sought by the people. Not only professionals and policy-makers look forward to the guidance and support of RP Centre on all matters related to eye health, but people also find here the desired modern services of the highest standards either totally free or at just a fraction of the true cost of such services. Therefore, it is not without reason that there is an ever-growing number of people who flock to RP Centre seeking relief from their eye ailments. I understand this Institute caters to almost 1500 patients every day in its OPDs alone. The number of surgeries and other procedures performed every year also runs into thousands.

As a public health professional, I am delighted to know that this Institute has an impressive out-reach community programme, especially in the rural and remote areas which are usually underserved or not served at all by the general reach of the health system. Thus, it is a matter of great pride that world-class services are also accessible to the poorest of the poor of our country.

The R.P. Centre is actively collaborating with various national and international agencies like ICMR, WHO and others in various fields of clinical, applied and basic research. RP Centre continues to be an important WHO Collaborating Centre for Prevention of Blindness, and it is in this capacity that RP Centre contributes far beyond the borders of India, as the WHO South-East Asia Region caters to the needs of 11 Member States.

On your 47th Foundation Day, may I urge you to continue with your excellent work, expand it further to touch the lives of as many people as possible and make a difference to the lives of people all over the world by giving them the gift of light and removing darkness from their lives. On behalf of WHO, I look forward to continue our collaboration with the Institute as we strive towards a world of light and colour, a world where all avoidable blindness is prevented.

Inclusion of persons with disabilities in development processes

I am very happy that the Christoffel Blinden Mission (CBM) is holding the 'national consultation on inclusion of persons with disabilities in development processes with special focus on children, young girls and women' in our Conference Hall. According to the Global Burden of Disease, the disability prevalence rate is the second highest (in the world) for moderate and severe disability (16%) and the third highest for severe disability (2.9%).

WHO is aware of this burden and recognizes the 'right to health' of persons with disabilities. In 2011, WHO and the World Bank released the World Report on Disability which has subsequently been translated into several languages, including all the official United Nations languages and issued in a broad range of alternative formats for the widest dissemination possible. The Report highlights the issues and makes recommendations on how national governments can address them.

The Director-General of WHO was requested by Member States to prepare a comprehensive WHO action plan in line with the Convention on the Rights of Persons with Disabilities (CRPD) and the outcome document of the UN High-level Meeting on Disability and Development. In response to that, a Draft Global Disability Action Plan 2014–2021 was developed by WHO to achieve optimal health, functioning, well-being and human rights for all persons with disabilities. The WHO Executive Board has provided guidance on the draft action plan 'WHO Global Disability Action Plan 2014–2021: Better health for all people with disabilities', and encouraged Member States to engage in further consultations to finalize the draft resolution before submission to the Sixty-seventh World Health Assembly in May 2014.

National consultation on inclusion of persons with disabilities in development processes (with a special focus on children, young girls and women), 12 February 2014, WHO-SEARO, New Delhi, India

The Global Disability Action Plan has three main objectives. They are:

1. Remove barriers and improve access to health services and programmes;
2. Strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation; and
3. Enhance collection of relevant and internationally comparable data on disability and support research on disability and related services.

The Plan supports the global agreement on disabilities including the implementation of actions in 14 Articles of the CRPD (Convention on the Rights of Persons with Disabilities); actions recommended in the Report of the 2013 High-level Meeting on Disability, and the ongoing actions of the WHO Secretariat towards mainstreaming disability in the development agenda, in line with the UN General Assembly (UNGA) resolutions.

Our Regional Office, as a member of the WHO Taskforce on Disability, has raised awareness about the Convention on the Rights of Persons with Disabilities with WHO country offices and Ministry of Health and Family Welfare focal points through several seminars which led to integrating disability in their areas of work. I am glad to share here that this building is the first one to have completed the disability access audit and can be termed disabled-friendly.

Over the past 10 years, the WHO Regional Office for South-East Asia has supported numerous activities in the field of disability like organization of the First Asia-Pacific Community-Based Rehabilitation (CBR) Congress in Thailand in 2009; the First World CBR Congress in India in 2012 in collaboration with HQ; the South-East Asia Regional Workshop on Wheelchair Service Training Package in 2013; as well as the consultation on the WHO draft Global Disability Action Plan 2014–2021 in collaboration with the WHO Regional Office for the Western Pacific and WHO headquarters.

The Regional Office also launched a regional fact sheet on wheelchairs, a booklet on the Roles of the Health Sector as per CRPD as well as an information document entitled 'Disability in the South-East Asia Region'. This last document was

disseminated to Member States during the Sixty-sixth session of the WHO Regional Committee for South-East Asia in 2013 and before the UNGA high-level meeting on disability.

A disabled or we may say, a differently abled person, may be vulnerable and may need special care and attention. Women, young persons and children with disabilities may be even more vulnerable.

Women with disabilities face multiple discrimination which negatively impact their physical, mental health and wellbeing. Disabled women have reported negative stereotypical statements of concern from health-care providers who often make them feel that they are a burden to society and refrain from providing them adequate information on available healthcare services. These women feel they have not received suitable advice to meet their needs, including on sexual and reproductive health or the effects of gender-based violence.

Women are the family caretakers, and their being disabled affects the health and wellbeing of the entire family. In addition, disabled women bear a disproportionate burden of poverty, experience significant unemployment or underemployment and are often in the lowest income bracket as compared to disabled men or abled women. It is common for disabled women not to receive adequate vocational rehabilitation and gainful labour as compared to their male counterparts.

Women with disabilities face multiple discrimination

WHO will continue to work with UN agencies, partners and NGOs including CMB, India to support countries in the Region to implement their national plans for disability prevention and rehabilitation, particularly to promote gender-sensitive health services for women with disabilities to improve their accessibility to health services for better health and quality of life.

I would also like to express my appreciation to the Action Group for the production of several information products such as the compendium of benefit schemes for the disabled at the central-and state-levels, the review of 10 flagship programmes of the Government of India, and the compendium of 20 case studies of individuals challenged with different forms of disabilities. I have no doubt that these will go a long way in raising awareness about disabilities and, also, to highlight what opportunities exist for the differently abled of our countries.

WHO Health
Emergency Programme

Global health security

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

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

Since the mid-19th century, when the first set of guidelines to control the international spread of acute diseases were adopted, nation states have often dismissed health security as secondary to other strategic interests.

In the post-war era, despite legal obligations to the contrary, disease epidemics were often covered up rather than reported, leading to the punitive use of trade and travel restrictions that could decimate livelihoods and the economies on which they depend. Neither health nor 'high' politics benefitted.

Within this environment the role of international organizations in promoting and facilitating health security was, naturally, limited. The need for this to change has been clear for some time.

In recent years new diseases have emerged at unprecedented rates, while old diseases such as cholera and tuberculosis have made aggressive comebacks. Antimicrobial resistance, meanwhile, is already killing upwards of 700 000 people worldwide every year.

Transnational food production means industrial oversights can compromise the health of millions worldwide, while international trade and travel has the capacity to vastly accelerate a pathogen's spread. The 2003 SARS pandemic was, after all,

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Opening address at meeting on Advancing global health security: from commitments to actions, 27–29 June 2016, Bali, Indonesia

initiated by a single infected traveller who stayed overnight at a busy Hong Kong hotel.

Alongside these phenomena, climate change and mass urbanization have gathered pace, with significant consequences for the way each one of us lives.

For the 11 countries of the WHO South-East Asia Region, which comprise 26% of the world's population, achieving IHR compliance and enhancing health security is vitally important.

In recent years these states have faced the full range of emerging health security threats, including from SARS, MERS-CoV, pandemic influenza (including H1N1) and Zika virus. South-East Asia is also uniquely disaster-prone. Since the 2004 Indian Ocean tsunami, which killed an estimated 230 000 people, earthquakes, floods and cyclones have ravaged the Region with varying frequency.

Wisely, the revised IHR places transparency and trust at the top of its agenda

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

In 1994, for example, India was isolated and shunned overnight after it reported a suspected outbreak of bubonic plague in Surat, an industrial hub in Gujarat. Despite widespread panic and confusion, authorities controlled the situation within two months.

More devastating than the outbreak, however, was the international reaction to it. Cargo transshipments were suspended, exports were embargoed, flights were cancelled and travel bans implemented. India lost an estimated US$ 1.7 billion and suffered a record trade deficit.

The irrational zeal with which states isolated India compromised the foundations of health security and created disincentives to report future epidemics. Wisely, the revised IHR places transparency and trust at the top of its agenda.

Regulatory oversights can prove equally devastating. In 2004 South-East Asia was impacted by the H5N1 avian influenza outbreak that threatened global health and decimated core

economic interests. As legitimate fears of the highly pathogenic influenza strain mounted, mass poultry culls were carried out in affected countries in a bid to limit its zoonotic spread.

Between the start of the epidemic and 2013, 181 people in the Region succumbed to the disease, which also cost billions of dollars in lost revenue. The pathogen's cross-border transmission underscored mutual vulnerabilities in food production processes that could have been avoided with better cooperation and international regulation.

The episode provides a salient example of how weaknesses in one country can threaten all. It has also become a catalyst for greater cross-border regulation between countries in the South-East Asia and Western Pacific Regions.

Importantly, threats to health security often have little to do with health systems themselves, underscoring the need for a 'One Health' approach that promotes multisectoral awareness and action.

As global health actors we must go beyond merely setting the rules of the game, and become active participants

In South-East Asia, as across the world, major threats to human health emerge from many places. The inappropriate use of antibiotics in the animal and agricultural sector, for example, is diminishing the effectiveness of antimicrobials in humans. To take another example, the criminal manufacturing of counterfeit drugs compromises the wellbeing of patients across the Region as well as the control of life-threatening diseases.

Both issues require coordinated, multisectoral solutions, and both require the buy-in of the whole of society. The principles underwriting health security and the One Health approach offer a way out.

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

As you are aware, last year's Cape Town meeting on health security preparedness laid the groundwork for where we are today. That meeting itself was an outcome of the need for a more robust preparedness and response framework demonstrated by the Ebola outbreak in West Africa the previous year.

As we gather here today we can be proud of the fact that this constitutes the first international and global meeting organized by the new Outbreak and Health Emergencies programme that was adopted at the 69th World Health Assembly. WHO now has the mandate to move forward with the design, results framework and budget that has evolved out of the reform consultation process.

The development of the emergencies programme is the result of a thorough reform effort that is aimed at providing fast, effective and predictable responses to health emergencies. And it is also aimed at addressing the full risk management cycle of prevention, preparedness, response and early recovery.

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

The retrofitting of hospitals in Nepal, for example, meant that when last year's earthquake hit the health system was in a position to implement mass casualty management procedures and respond effectively.

In similar fashion, efforts to enhance Thailand's surveillance system enabled health authorities to identify and halt transmission of incoming cases of MERS-CoV, a highly infectious and oftentimes lethal disease.

In Maldives, Zika preparedness and response plans are ensuring the archipelago nation is ready and able to respond to any outbreak of the vector-borne pathogen.

And right across the Region, national AMR action plans will prove vital to combating the problem.

As WHO leads the push for greater health security via its new emergency programme, regional political and economic groupings are taking note. In the South-East Asia Region, ASEAN, BIMSTEC and SAARC have all, to varying extents, integrated health security concerns within their agendas.

This is also happening at the global level, as evidenced by the G-7's recent Ise Shima Vision for Global Health, which reinforces support for IHR and the commitment of G-7 countries to facilitate international compliance.

The Global Health Security Agenda, meanwhile, is leveraging the comparative expertise of developed and developing countries across the world to advance capacities in core areas of health security via the achievement of clear and measurable targets.

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

As we work towards greater health security we must take care to avoid undesirable side-effects. Although health security is concerned with preparing for and responding to fast-evolving threats, this tendency must not distort its proper conception, nor prejudice donor priorities and public health diplomacy.

Poor health infrastructure and endemic diseases such as tuberculosis, HIV-AIDS and malaria undermine health security as much as the specter of bioterrorism or the next great pandemic. Their banality must not lead to distraction. Weak health systems were foundational to the 2014 Ebola outbreak in West Africa, for example, and continue to imperil citizens of developing countries across the world. By extension, they imperil all of humanity.

As states move beyond a narrow understanding of strategy and interest, approaches to health security must be equally far-sighted. To this end, strengthening health systems and achieving

universal health coverage must occur alongside other initiatives to advance cooperation and mutual trust.

Strong health systems provide the most effective means to contain and eradicate the infectious diseases of old, and provide the first line of defense against emerging diseases of pandemic potential. They also ensure a rapid and effective response to acute public health events such as natural disasters and environmental emergencies. Stability and growth are similarly well served.

This more robust understanding of health security is something that we must all push for. Thankfully, it is gaining traction.

The Sustainable Development Goals emphasize the importance of achieving universal health coverage. The 2015 Sendai Framework makes explicit the need for strong and resilient health systems to protect against all hazards. And state-driven emergency preparedness and response frameworks are being complemented by a renewed emphasis on health system strengthening as a core part of public health diplomacy.

The health security agenda is more important now than it has ever been

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

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

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

Health sector response to Nepal earthquake

25 April 2015 was a fateful day for the people of Nepal. On that day a devastating earthquake took more than 8000 lives, and left thousands more injured.

Homes were reduced to rubble. Livelihoods were lost.

Seismologists had long warned of Nepal's next great earthquake. But there was no way to predict when it would happen. The Government of Nepal had for several years initiated plans to strengthen the country's preparedness for such an event. So too had the health sector.

Though the challenges were immense, the response was swift when disaster actually stuck.

Within hours of the earthquake, Nepal's Ministry of Health and Population successfully established command and control at the Health Emergency Operations Centre – ground zero for the health sector response.

Even before the ground stopped shaking waves of patients began to present at health facilities, many of which lay in ruins. Nevertheless, frontline health workers steadied themselves. Mass casualty management programmes were rolled out; emergency rosters took effect; and referral systems were activated.

The earthquake struck at 1156 am. By 2pm WHO's Emergency Humanitarian Action Team was mobilized and packed onto the first flights to Kathmandu. By 5pm the first tranche of emergency funding from SEARHEF was released. And by early the next day four emergency health kits – each kit able to take care of 40 000 people for three months – were deployed.

Over the following days and weeks the Ministry and WHO-led Health Cluster acted with poise to ensure the response was

Lessons learnt conference: health sector response to Nepal earthquake 2015, 21–22 April 2016, Kathmandu, Nepal

orderly, efficient, and – most importantly – met the needs of affected groups. Foreign medical teams were dispatched to match capacity with need; disease surveillance was ramped-up across the most affected districts; and health services were reinforced.

Within the cluster system specific needs were identified and sub-clusters established. Sub-clusters were created for injury management and rehabilitation, tuberculosis and reproductive health among others. These clusters proved critical to the rapid exchange of information and effective delineation of tasks and activities. With the Ministry in lead, partners from across the world worked with one another to deliver the best possible health-related outcomes.

Through it all we all had to be agile in our approach. As many of you here know, Nepal's earthquake was always projected to be an urban disaster, with Kathmandu suffering – in a worst case scenario – in excess of 100 000 fatalities. But when the earthquake did strike, it was, for the most part, a rural disaster. The heaviest casualties and greatest health system damage occurred outside of the capital.

When the earthquake did strike, it was, for the most part, a rural disaster

After initial needs were met, we needed to adapt. To ensure continuity of services WHO positioned Medical Camp Kits in strategic locations across the most affected districts. We likewise pre-positioned supplies in remote locations in case of a disease epidemic. And in order to ensure issues such as mental health and severe acute malnutrition were addressed, we trained staff at the local level to screen for symptoms and to refer patients to specialist services.

But while we succeeded in many areas, and were able to adapt – for the most part – to the challenges faced, we also had our failings and must be candid on reflection. While acknowledging what was done right, we must also identify areas where we could have done better. Disasters are, by definition, messy affairs. There is often a cleaving of policy and practice; of intention and actuality.

Indeed, did all health workers everywhere know how to triage? Were the skills and resources of foreign medical teams

utilized as effectively as possible? How could health facilities have better managed water and sanitation requirements? Were referral pathways clear and did they function as intended? And did health authorities adequately communicate the risks communities faced and how best they could be avoided?

The discussions over the coming days will prove vital to answering these and many other questions. This is our opportunity as a sector to come together and to share experiences, to learn and make ourselves better at what we do.

In anticipation of this meeting important work has been done.

Nepal's benchmarks for emergency preparedness and response readiness have been reassessed. The benchmarks are a tool to assess country capacity in these critical areas, and were developed after the 2004 Indian Ocean Tsunami. Using the benchmarks framework, a multi-sectoral group identified the capacities that were enhanced from 2011 onwards and the gaps that remained just prior to the earthquake.

The health sub-clusters, too, have conducted reviews on how they performed and where they could improve and coordinate better. This way we have more details on what was done well and where performance could have been better in the areas of stewardship, medical services and public health interventions. This will serve us well in prioritizing ongoing preparedness activities as well as guiding health sector response actions for a future event.

In addition, the Ministry has also examined various components of its own operations with an eye to enhancing future response capacities. Several departments and divisions of the Ministry of Health at central and district levels have also reviewed their response and identified critical lessons to feed into their current and future work.

The information and experiences all of us here share will provide the material for further analysis and reflection. Lessons will be learned so that if and when a similar disaster occurs – either in Nepal or anywhere else – we will not repeat the same

mistakes or oversights. These lessons will also prove important as we move ahead with the health system recovery.

On that note – and as we talk about the virtue of candid reflection and self-examination – we must acknowledge the fact that almost one year after the disaster we remain in extended response mode. The Medical Camp Kits I mentioned earlier are still in place. We are once again preparing for the monsoon's onset and assessing how it will affect vulnerable communities.

It is worth remembering that we will always live with hazards

Though the road ahead is rough and will no doubt have our share of obstacles, we must continue on our journey. And we must do so with a commitment to continue to improve ourselves. The communities we work for deserve as much.

As we meet here almost a year after Nepal's devastating 25 April earthquake, it is worth remembering that we will always live with hazards. There will always be fault-lines to break the ground on which we stand, just as there will always be oceans and rivers to flood the areas in which we live.

But we must work to reduce the risks these hazards represent. At WHO-SEARO, and as a broader health sector, we learned much from the 2004 tsunami. We must now also learn from the Nepal earthquake. I urge you to make the most of this opportunity.

I want to emphasize, before I close, that preparedness is the key to reducing the impact on the lives of affected people when disaster strikes.

Ministerial meeting on AMR

Antimicrobial resistance is a threat to global security and economic stability. It is a potential major health and economic crisis that requires both global and local solutions. Since drug resistant genes can travel, countries with higher levels of economic and social organization have a stake in the success of measures taken by less developed countries. In the fight against antimicrobial resistance we are only as strong as the weakest link.

I thank the government of Japan, which in cooperation with the WHO Western Pacific and South-East Asia Regions organized this ministerial meeting.

Antimicrobial resistance is a threat to global security and economic stability

Japan's leadership in engaging countries in the Asia Pacific builds on the momentum to combat AMR at other global and regional forums, including the United Nations, ASEAN, APEC, the G7 and the World Economic Forum amongst others.

At WHO-SEARO, combatting antimicrobial resistance has long been a priority. As early as 2011 the Honorable Health Ministers of the Region recognized the seriousness of AMR and adopted the Jaipur Declaration on Antimicrobial Resistance. The Jaipur declaration recognized the irrational use of antibiotics as the key driver of resistance to antimicrobials. It also advocated for a holistic and multidisciplinary approach to its prevention and control. Since the declaration momentum has built and initiatives have been undertaken, from development of national action plans to policy-setting and capacity initiatives in key public health areas.

Further to this, in February this year, Health Ministers from across the South-East Asia Region convened in New Delhi and charted a Roadmap for Action. The roadmap, which is aligned with the Global Plan, lays out priority areas of action, including:

Ministerial meeting on AMR, April 2016, Tokyo

First, improving awareness and understanding of AMR; second, strengthening surveillance in human health, animal health and agricultural sectors; third, strengthening infection prevention and control practices in healthcare facilities; fourth, promoting rational use of antimicrobials across sectors; and fifth, promoting investments in AMR and related research. SEAR countries are now taking steps to align their policies and work in AMR accordingly. It is critical that they do so by May 2017.

In reinforcing and building on these commitments I would like to congratulate the Hon'ble Ministers gathered here today for developing and agreeing on the Tokyo Declaration on Antimicrobial Resistance. Beyond acknowledging the challenges to combating AMR and charting the path ahead, you have underscored how AMR could jeopardize the realization of the United Nations' Sustainable Development Goals if it goes unchecked. This is a crucial advocacy step that requires to be brought to the attention of world leaders and the general public as soon as possible.

Also of note is the emphasis on the pursuit of Universal Health Coverage as a means to combat AMR. This is a welcome development that again complements WHO-SEARO's flagship priorities. Ensuring access to the benefits of antimicrobials, while at the same time preserving their efficacy, can best be achieved by pursuing Universal Health Coverage. The progressive realization of Universal Health Coverage also ensures that efforts to combat AMR are sustainable, and can outlive the threat we face. I congratulate you on making this a key part of your efforts.

I'm also very pleased to see the presence of ministers of agriculture and high-level representatives of animal and agriculture sectors from across our regions. This is a true reflection of the commitment of all sectors to combat AMR together. Your Excellencies, we are honored and thank you for your commitment. AMR containment cannot, and will not, be achieved without your involvement.

Let us not forget that today's meeting follows a two-day technical session involving high-level officials, technical leaders, international and regional experts in infectious disease, public health, and animal health. In the preceding days you

have listened to informative presentations on the relationship between AMR, UHC and the SDGs. You have heard of the need to build robust national frameworks based on multi-sectoral plans with accountability and governance mechanisms to oversee and monitor implementation. And you have engaged in inspired and animated discussions that will allow each of you to better develop and implement your national action plans.

As you go about this task, let me assure you that WHO-SEARO stands committed to supporting Member countries with advocacy, capacity building and technical assistance, as well as aiding resource mobilization. WHO SEARO will similarly fulfil its obligation to the World Health Assembly on reporting on the development, implementation, monitoring and evaluation of the national action plans, and looks forward to achieving region-wide compliance with the Global Action Plan.

To this end, I welcome the important milestone the Tokyo Declaration on Antimicrobial Resistance represents.

This volume of selected speeches by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, covers the period from February 2014 when she assumed office, till June 2017. The speeches cover broad areas of WHO collaborative activities in the Region and would be of interest to those following health development in the South-East Asia Region.

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ISBN 978-92-9022-605-5