FROM VISION TO REALITY

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

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

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

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

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

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

As the world settles into the Sustainable Development Goal era, the need to promote public health policies and concerns remains as strong as ever. WHO South-East Asia Regional Office will continue to advocate for the highest attainable standard of health for every person in the Region, and will continue to do so at all levels of the discussion.
“My Vision: A healthier WHO South-East Asia Region; A responsive Regional Office”

Dr Poonam Khetrapal Singh’s Vision for WHO South-East Asia

I take charge as Regional Director at an important moment in the history of public health and at a critical time in the evolution of WHO. I do so in all humility, knowing full well the challenges that lie ahead.

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

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

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

Addressing the persisting and emerging epidemiological and demographic challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

**Strengthening emergency risk management**

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

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

A strong voice in the global health agenda

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

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

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

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

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

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

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

By fortifying emergency risk management, health security across the Region is being enhanced.
Honourable ministers, distinguished representatives, dignitaries, ladies and gentlemen.

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

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

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

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

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

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

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

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

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

In 1994, for example, India was isolated and shunned overnight after it reported a suspected outbreak of bubonic plague in Surat, an industrial hub in Gujarat. Despite widespread panic and confusion, authorities controlled the situation within two months. More devastating than the outbreak, however, was the international reaction to it. Cargo transshipments were suspended, exports were embargoed, flights were cancelled and travel bans were implemented. India lost an estimated 1.7 billion dollars and suffered a record trade deficit. The irrational zeal with which states isolated India compromised the foundations of health security and created disincentives to report future epidemics. Wisely, the revised IHR places transparency and trust at the top of its agenda.

“\nIn 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.”

Breakdowns in trust and cooperation in the past demonstrate the urgency with which these values must be pursued in the present.
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. In South-East Asia, as across the world, major threats to human health emerge from many places. The inappropriate use of antibiotics in the animal and agricultural sector, for example, is diminishing the effectiveness of antimicrobials in humans. To take another example, the criminal manufacturing of counterfeit drugs compromises the wellbeing of patients across the Region as well as the control of life-threatening diseases. Both issues require coordinated, multisectoral solutions, and both require the buy-in of the whole of society. The principles underwriting health security and the ‘One Health’ approach offer a way out.

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

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

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

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

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

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

Honorable ministers, ladies and gentlemen,

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

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

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

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

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

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

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

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

Thank you very much.
WHO gives emergency health kits, funds to quake-hit Nepal

Press release in the aftermath of the Nepal earthquake in April 2015

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Still, as the monsoon nears and the provision of immediate relief cedes to long-term planning and reconstruction, the challenges to providing equitable access to quality health care are acute. With approximately 2.8 million people displaced, many of whom live in remote areas, priority must be given to reaching the most vulnerable. Along with temporary health care facilities being rolled out to replace those that have been rendered unserviceable, disease surveillance is currently being conducted in the 14 most affected districts so as to enable a rapid response if an outbreak occurs. In the coming months, priority areas of concern include the continuation of maternal and child health care services; the provision of culturally appropriate, evidence-based mental health care for those that have ongoing trauma as a result of the disaster; and access to rehabilitation for the almost 17,000 people injured in the tragedy.

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

“Perhaps the greatest challenge of all will be rebuilding Nepal’s health system to ensure equitable access.”
Perhaps the greatest challenge of all, however, will be rebuilding Nepal’s health system to ensure equitable access in a country with multiple topographic zones and varying degrees of urbanization. Though it may seem trite, the opportunities that the crisis presents are significant, and must be taken advantage of.

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

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

Nepal Quake: WHO sets up field offices for unreachable survivors


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

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

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

“Health care services are being delivered in built-up areas in Gorkha and those that still can be reached by road,” said Ryo Hojo, WHO’s emergency operations manager, who was on a two-day visit to the lightly affected Jhapa district.

He said the global healthcare institution has identified seven communities in an area not easily accessible, and where there are about 6,000 people who have not been reached with services since the earthquake struck.

“Even now there was an urgent need to provide medical support to the people and treat them for injuries and infections.

“Women and others also needed to be given rapid access to care for safe deliveries and to ensure any complications of pregnancy or birth are rapidly addressed,” he said.

**DAILY TIMES**

WHO launches emergency kits, funds to quake-hit Nepal

By Lina Abdo
2:00 pm April 26, 2015, WHO


The World Health Organization has launched an emergency kit comprising of medicines and medical supplies and US dollars 1,750,000 as the first tranche of emergency health funds to meet the immediate health needs of the earthquake-affected people in Nepal.

Within hours of the quake, WHO obtained medical supplies to cover the health needs of 40,000 people. The UN也 has mobilized emergency health kits and some items are being given to hospitals in Nepal treating the injured.

WHO-South Asia Regional Director Dr Renuka Shahi said:

“WHO has also immediately made available US dollars 1,750,000 to the Ministry of Health and Population, Nepal, for the relief and recovery of South Asia Regional Emergency Funds (SAREF).”

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

Shahi said: “WHO is supporting the Ministry of Health and Population, Nepal, to continue to assess the health needs of the affected people and the damage to health facilities, besides officials from the

WHO Regional office in Kathmandu, to enforce WHO Nepal Office’s support to the Government of Nepal.

WHO has also immediately launched an appeal for additional funds under the South Asia Regional-Regional Emergency Fund (SAREF) to ensure that health care services to the most vulnerable are provided.

“WHO stands with the Government of Nepal as it strives to overcome the crisis,” Dr Shahi said.

WHO has allocated over US dollars 1,750,000 for the emergency operations in Nepal. The funds released were within 24 hours of the earthquake from the South Asia Regional Health Emergency Fund to meet immediate financial needs and fill critical gaps in the aftermath of the 25 April disaster.

WHO Emergency Committee has also been activated in the aftermath of the earthquake to assess the situation in Nepal.

**NEW EUROPE**

According to Red Cross more than 17,567 people are injured


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

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

“We are very concerned about the increased risk of communicable diseases, including diarrhoea, in areas where water, sanitation and hygiene systems are disrupted.” Dr. Shankar Singhal, WHO Regional Director for South-East Asia, said on Thursday during a visit to Nepal’s capital, Kathmandu.

“We have a four-week window to provision medical supplies in affected districts and strengthen the country’s water, sanitation and hygiene systems as so as to shield it against the threat of disease outbreaks,” Dr. Singhal continued.

“These include water borne and vector borne diseases such as dengue and malaria, along with acute respiratory infections.”

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

**OUTLOOK**

WHO: Rebuild regular services for survivors


Experts say that the survivors are vulnerable to disease outbreaks and other health risks in the coming season.

WHO committed to helping Nepal deliver health care to its citizens, says Dr Poonam Khetrapal Singh:


WHO has elicited over US dollars 1,1 million for the emergency operations in Nepal. US dollars 375,000 was released within hours of the earthquake from the South East Asia Region Health Emergency Fund to meet immediate financial needs and fill critical gaps in the aftermath of the 25 April disaster.

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

The South Asia Regional Health Emergency Fund (SAREF), which is a fast, flexible mechanism of the World Health Organization (WHO) to support countries affected by disasters, was activated.

WHO also made available US dollars 1,750,000 to the Ministry of Health and Population, Nepal, as the first tranche of the South Asia Regional Emergency Funds (SAREF), to meet immediate financial needs and fill critical gaps in the aftermath of the 25 April 2015 disaster.

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

South Asia Regional Health Emergency Fund (SAREF) is a global health security initiative of the World Health Organization (WHO) to support countries affected by natural and man-made disasters in the region.

Dr Renuka Shahi, WHO Regional Director for South Asia, said:

“WHO stands with the Government of Nepal as it strives to overcome the crisis,” Dr Shahi said.

WHO has elicited over US dollars 1,1 million for the emergency operations in Nepal. US dollars 375,000 was released within hours of the earthquake from the South East Asia Region Health Emergency Fund to meet immediate financial needs and fill critical gaps in the aftermath of the 25 April disaster.

WHO has allocated over US dollars 1,750,000 for the emergency operations in Nepal. The funds released were within 24 hours of the earthquake from the South Asia Regional Health Emergency Fund to meet immediate financial needs and fill critical gaps in the aftermath of the 25 April disaster.

WHO Emergency Committee has also been activated in the aftermath of the earthquake to assess the situation in Nepal.

**Jakarta Post**

Hospitals told to verify building safety before resuming services


The World Health Organization (WHO) on Sunday launched four emergency health kits comprising medicines and medical supplies and US$27,000 for the first tranche of emergency health funds to meet the immediate health needs of the earthquake-affected people in Nepal.

“Within hours of the tragedy, WHO mobilized medical supplies to cover the health needs of about 60,000 people for two weeks. These supplies are in the form of emergency agency emergency health kits and are being given to hospitals in Nepal treating the injured,” WHO South-East Asia Regional Director Dr Renuka Shahi said in a statement made available to The Jakarta Post on Sunday.

WHO also immediately made available US$27,000 to the Ministry of Health and Population in Nepal for the first tranche of the South-East Asia Region Health Emergency Fund (SAREF).

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

Similarly, WHO’s supporting the Ministry of Health and Population to continue to assess the health needs of the earthquake-affected people and to rebuild resilient health facilities, said the regional office.

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

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

“We are very concerned about the increased risk of communicable diseases, including diarrhoea, in areas where water, sanitation and hygiene systems are disrupted.” Dr. Shankar Singhal, WHO Regional Director for South-East Asia, said on Thursday during a visit to Nepal’s capital, Kathmandu.

“We have a four-week window to provision medical supplies in affected districts and strengthen the country’s water, sanitation and hygiene systems as so as to shield it against the threat of disease outbreaks,” Dr. Singhal continued.

“These include water borne and vector borne diseases such as dengue and malaria, along with acute respiratory infections.”

At the same time, the WHO official stressed that more must be done to protect the health of Nepal’s people including ramping up the country’s disease and response system, providing large quantities of necessary medical supplies, and supporting the recovery of the health system.
WHO IN THE MEDIA ON NEPAL EARTHQUAKE
With coverage in
BBC News
The Wall Street Journal
Reuters
Idaho Statesman
canberratimes.com.au
The South Asian Times
News.cn
Vancouver Sun
Toronto Telegraph
ABC
NDTV
IBN Live
PBS Newshour
Zimbabwe Star
ShanghaiDaily.com
China.org.cn
sjna English
Irish Sun
Jakarta Post
Heraldo
IRNA
DW
The Globe and Mail
Winnipeg Free Press
The New Indian Express
The Economic Times
The Times of India
The Hindu
Hindustan Times
Hindustan
New Kerala.com
News Informer
Kathmandu Post
The Asian Age
Kantipur
Kantipur.com
Delhi.com
The Daily Star
Relief Web
Synergy Online
Business Standard
Zee News
The Himalayan

WHO calls for rebuilding health services in Nepal

WHO has also made available 100,000 kits for the Ministry of Health and Population, Nepal, in the first phase of a $10.5 million aid package. The kits will be used to provide emergency health care and to support the relief efforts. "The situation is critical," said WHO Director-General Margaret Chan. "We are providing emergency supplies, including medical supplies, to meet the immediate needs of people affected by the earthquake. We are also providing training to health workers to help them provide emergency care."
WHO call to make food safety a priority

On this day, we call on all countries to adopt the food safety strategy (FSS) as a key intervention to improve food safety and protect public health. The FSS is a comprehensive food safety strategy that focuses on the prevention, detection, and control of foodborne diseases, as well as the promotion of a healthy diet. It includes measures to ensure the safety of food, including the production, processing, distribution, and consumption of food. The FSS is designed to be flexible and adaptable to the needs of each country, and it can be implemented at different levels of government, from national to local. The FSS also includes a set of guidelines for the implementation of food safety measures, which can be tailored to the specific needs of each country.

The WMO is committed to supporting countries in their efforts to improve food safety. We are working with partners to develop and implement the FSS, and we are providing technical assistance and training to help countries implement the strategy. The FSS is an important tool for improving food safety and protecting public health, and we encourage all countries to adopt it as a priority.
WHO in the Media on Emergency Risk Management, Food Safety

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

WHO calls for creating awareness on food safety

Thailand confirms MERS CoV in traveler, WHO cautions against continuation of importation

The Telegraph

Respiratory virus alert after Thailand scare

http://www.telegraphindia.com/1160125/lp/foوpnae/story...

New Delhi, Jan. 24: The World Health Organisation today issued an alert on the region's food safety situation after a traveler in Thailand was found to have been infected with the Middle-East respiratory syndrome. The 71-year-old man from Oman who arrived in Bangkok on Jan. 17 was found to be infected with the Middle East respiratory syndrome. The WHO has documented 1,672 cases of MERS-CoV since Saudi Arabia in January 2012, with 698 deaths. The virus is found in Middle East respiratory syndrome-CoV (MERS-CoV) cases. The virus causes fever, cough, pneumonia, and can be fatal. The virus is transmitted from dromedary camels to humans. The virus is also transmitted through droplets from the mouth or nose, or contact with infected people or animals. The virus can be transmitted through household items, food, and water. The virus can be transmitted through household items, food, and water.
Battling vaccine-preventable diseases with firm resolve is the only means to free the South-East Asia Region of their burden. Vaccine-preventable diseases represent a public health problem that need no longer exist and which WHO South-East Asia Region has made it a priority to address.

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

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

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

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

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

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

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

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

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

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

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

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

With concerted efforts, WHO South-East Asia Region aims at maternal and neonatal tetanus elimination this year; measles elimination and rubella and congenital rubella syndrome (CRS) control by 2020; sustaining the victory over polio until the disease is eradicated globally; and increasing immunization coverage to > 90% at the national level and to > 80% at the district level with the three doses of diphtheria-pertussis-tetanus vaccines.

Every child has the right to lead a healthy life, and vaccination is a vital step. The World Immunization Week—celebrated in the last week of April—aims at promoting the use of vaccines to protect against diseases. This year the focus is on closing the immunization gap and reaching equity in immunization levels with renewed efforts.
WHO South-East Asia Region on track for implementing polio endgame strategy

Media statement made by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, following the global polio vaccine switch in April 2016

Implementing a monumental change in vaccination that is expected to bring the world closer to eradicating all types of polio, all 11 countries in the WHO South-East Asia Region have ‘switched’ from using the traditionally used trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) that protects against the remaining wild poliovirus strains.

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

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

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

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

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

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

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

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

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

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

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

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

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

A robust and effective surveillance system is vital to tracking progress in these key areas. After all, the failure of any one of them can mean the death of a mother or newborn through tetanus infection. By closely monitoring incidences of maternal and neonatal tetanus authorities can evaluate the impact of their efforts, and, if found lacking, better calibrate them in future. In-depth knowledge of the causes of every case...
of maternal or neonatal tetanus, combined with a resolve to ensure it is not repeated, can be the only appropriate response. However great the recent achievement is, it remains unacceptable that any woman or child should suffer the devastating disease.

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

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

**Efforts to phase out oral polio vaccine**

Bangalore, August 28, 2023. Efforts to phase out oral polio vaccine (OPV) by 2026 are set to intensify in many countries as the global health community seeks to eradicate polio. The goal is to reduce the risk of transmission and ensure that the vaccine is available in areas where it is needed most.

*Source: https://www.thehindu.com/news/national/bangalore/efforts-to-phase-out-oral-polio-vaccine/article63991578.ece*

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**THE TIMES OF INDIA**

**Bangladesh: from oral drops to injections: A different shot at polio vaccine**

Kathmandu, Nepal, March 15, 2024. Bangladesh has announced plans to phase out the polio vaccine and switch to an injectable version, becoming the first country in the region to do so.

*Source: https://timesofindia.indiatimes.com/IndiasFirst/IndiasFirst/content/37866567.cms*

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**The Daily Star**

**Building on the polio success**

Dhaka, Bangladesh, April 15, 2024. Bangladesh has made significant progress in eradicating polio, with the country now classified as polio-free. The government is continue to invest in vaccination programs to ensure that all children receive the necessary doses.

*Source: https://th dailystar.com/magazine/health/building-on-the-polio-success-689592*

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**TwoCircles.net**

**22 million infants miss out on basic vaccines: WHO**

Geneva, Switzerland, April 10, 2024. The World Health Organization (WHO) has reported that 22 million infants are missing out on basic vaccines, highlighting the need for increased efforts to ensure all children have access to vaccination.

*Source: https://www.twocircles.net/22-million-infants-miss-out-on-basic-vaccines-who*

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**Sertifikat Bebas Polio Asia Tenggara**

Oleh: Poonam Khetrapal Singh


Build on Polio Success to Fight Other Diseases

Poovan Khetrapal Singh

Today, March 26, the world voices its strong support for the eradication of the WHO's disease Polio. The event marks the 50th anniversary of the World Health Organization (WHO), which has been leading the fight against Polio for over 50 years. The event is a testament to the global community's commitment to eradicating Polio and improving health outcomes for millions of children worldwide.

WHO officially declares India ‘polio-free’

NEW DELHI: The World Health Organization (WHO), on Wednesday, announced that India has been declared ‘polio-free.’ This is a significant achievement in global health and represents a major milestone in the fight against Polio.

India gets WHO certificate for its polio-free status

The World Health Organization (WHO) has given India a certificate confirming that the country is polio-free. This is a significant achievement and marks a major milestone in the global effort to eradicate Polio.

WHO in the Media on Polio and Immunization

With coverage in
- The Times of India
- The Economic Times
- Hindustan Times
- India Today
- Mail Today
- Business Standard
- The Statesman
- DNA
- The Indian Express
- The Pioneer
- The Asian Age
- Jakarta Globe
- Navbharat Times
- Hindustan
- Dainik Jagran
- Rashtriya Sahara
- Rajasthani Patrika
- Punjab Kesari
- Sakal
- Samana
- Sandhya Times
- Vir Arjun Shah Times
- The Health Site
- India Live Today
- Punjab Tribune
- Eenadu
- Daily World
- Sify
- Independente
- The Daily Star
- eHealth
- HT Media Syndication
- BioSpectrum
- Dawn

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- Punjab Kesari
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- Vir Arjun Shah Times
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- India Live Today
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- eHealth
- HT Media Syndication
- BioSpectrum
- Dawn
**भारत ज्युका-बच्चा टिमेस रोग से मुक्त घोषित**

14th July 2016

http://www.hindustantimes.com/india-news/india-officially-certified-maternal-and-neonatal-tetanus-free-news-headlines-8kg1y1F8eJa4Ff9t8-M.htm

हिन्दुस्तान टाइम्स

**India officially certified maternal and neonatal tetanus free**

The World Health Organization (WHO) on Thursday officially certified India free of puerperal tetanus, a bacterial infection that mainly affects skin, bone and cartilage, and maternal and neonatal tetanus that affects the nervous system.

The official statement issued by the Union health ministry said that India is the first country to be officially acknowledged as being "taste free". Also, India was validated for Maternal and Neonatal Tetanus Elimination (MNT) on April 25, 2015, much ahead of the global target date of December 2015. It is a proud moment for India to have achieved these two milestones in public health milestones," said Union health minister JP Nadda, while releasing the official citation from WHO and UNICEF on Thursday evening.

"Following the success of polio eradication programme, these achievements reflect the dedication of the country towards achievement of health equity and universal health coverage," he said.

Nadda thanked the healthcare workers across the country, saying it was possible due to the commitment and dedication of all of them and also various stakeholders and concerted efforts of planners and policymakers.

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

New Delhi: November 30 News


**BioSpectrum**

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

New Delhi: November 30 News

http://www.hindustantimes.com/india-news/india-officially-certified-maternal-and-neonatal-tetanus-free-news-headlines-8kg1y1F8eJa4Ff9t8-M.htm

World Health Organization is launching an initiative to eliminate rubella and measles, two infectious diseases that cause severe and lifelong health problems. The programme has three main objectives: to eliminate rubella and congenital rubella syndrome, to achieve high coverage with measles vaccine and to eliminate maternal and neonatal tetanus.

"WHO'S Southeast Asia region is committed to the elimination of measles and rubella," WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh, said in a press conference in New Delhi on Tuesday. "We are confident that with the support of all stakeholders, including governments, we will achieve this goal by 2020," he added.

"Rubella and congenital rubella syndrome are preventable with a single dose of measles, mumps, rubella (MMR) vaccine. However, in India, the coverage with MMR vaccine is only 36% in children aged 10-23 months. The goal is to achieve 90% coverage with MMR vaccine by 2020," Singh said.

"We are also working towards eliminating maternal and neonatal tetanus in India," he added. "This is a preventable disease, and we have set a target of achieving 90% coverage with the antenatal care dataset by 2020."
WHO: India free from maternal, neonatal tetanus

**Pioneer News Service**

NEW DELHI

The World Health Organisation (WHO) on Thursday presented India the certificate declaring elimination of maternal and neonatal tetanus (MNT).成功 in achieving MNT elimination was hailed by Dr. Poonam Katrape Singh, Regional Director, WHO South-East Asia Region in New Delhi.

*Maternal and neonatal tetanus is a preventable disease caused by Clostridium tetani, which affects women during childbirth and newborns within the first week of birth. The infection can occur in rural areas with limited access to medical care and can result in stillbirths, infant deaths, and severe disability.*

India is the third country to officially recognise its elimination of maternal and neonatal tetanus (MNT) as of 15 June 2015. This achievement is the result of a global target of 2015.

India has taken significant steps in reducing maternal and neonatal tetanus (MNT) cases. In 2015, India has seen a reduction in MNT cases by nearly 50% compared to 2010. This is due to a comprehensive national strategy that includes antenatal care, community mobilisation, and targeted interventions for pregnant women.

India has taken various steps to achieving MNT elimination.

1. *Antenatal care*: Timely antenatal care services, especially during the last trimester, have reduced the risk of tetanus.
2. *Community Mobilisation*: Community mobilisation and health education campaigns have raised awareness about the risks of MNT and preventive measures.
3. *Targeted Interventions*: Special interventions for the last trimester of pregnancy, including tetanus toxoid vaccine, have been implemented.

India is the third country to officially recognise its elimination of maternal and neonatal tetanus (MNT) as of 15 June 2015. This achievement is the result of a global target of 2015.
CHAPTER 3
REVERSING NONCOMMUNICABLE DISEASES

Reversing rising rates of non-communicable diseases such as diabetes and cancer is critical to meeting the South-East Asia Region’s emerging health needs. As economies develop and lifestyles change, the burden of non-communicable diseases across the Region is increasing rapidly, and will continue to do so for the foreseeable future.

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

Containing non-communicable diseases means securing a healthier future for the countries of the South-East Asia Region. Given the changes the Region is undergoing, this could not be more urgent.
The tobacco epidemic continues to rage across the WHO South-East Asia Region. Nearly 246 million adults Region-wide smoke the cancer-causing agent, while just below 290 million consume it in a variety of smokeless forms. This results in approximately 1.3 million deaths across South-East Asia every year. That’s 150 deaths per hour.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Diabetes rarely makes headlines, despite its appalling impact on public health and the wider damage this causes. On World Health Day 2016, we have the potential to re-calibrate our priorities, recognize the public health threat diabetes poses, and do something about it. We can defy expectations and beat the epidemic. The battle must begin.
World Cancer Day today

COMBATTING CANCER
WHO urges urgent preventive measures to check pollution

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

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

WHO’s Southeast Asia region comprises Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Lao People’s Democratic Republic, Malaysia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. “Outdoor air pollution, meanwhile, increases the risk of cancer for us all. The region has 24 of the world’s top 20 polluted cities, making clear the need for governments to tackle the issue with urgency,” said Poornam Khetrapal Singh, WHO Regional Director for South-East Asia on the eve of World Cancer Day.

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NEW DELHI: noting that outdoor air pollution increases the risk of cancer, WHO today urged governments of Southeast Asian region to tackle the issue with “urgency” at the area has 14 of the world’s top 20 polluted cities.

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THE TIMES OF INDIA
Strong policies required to curb cancer-causing habit: WHO


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

World Cancer Day: WHO argues every one to create awareness about the disease


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

Every year across the world, 2.2 million people die from cancer. The fact that two-thirds of these deaths occur in low and middle income countries, and that more than 50% of deaths could have been prevented, is a cause for reflection and action. Dr Poonam Khetrapal Singh, regional director, WHO South-East Asia region, said in a statement.

Tobacco use - in both smoke and smokeless forms - accounts for 24% of cancer deaths globally and is a leading cause of the disease in the South-East Asia region.

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

WHO warns of onslaught of diabetes

Regional news service
Karachi, March 9

Obesity is the new silent killer in the region, with more than 11 million people affected, while 2.6 million more are at risk of developing the disease, said a report released here on Friday.

“Diabetes, rarely fatal, remains a financial and social burden on families and communities in the region,” said Dr. Dinesh Tewari, WHO regional director.

“Thus, an individual world of diabetes, we can, and must, take steps to prevent that burden by taking on the disease,” he said.

In the World Health Organization South-East Asia Region, 40% of deaths are caused by non-communicable diseases such as cardiovascular diseases, cancer, diabetes and chronic respiratory diseases. An estimated 4.9 million people in the region died from these conditions.

“A high number of deaths and disability years lost due to chronic conditions are responsible for 65% of the global burden of disease, said Dr. Tewari.

“Non-communicable diseases are responsible for 70% of global deaths, with 80% of the disease burden in the region coming from high income countries,” said Dr. Tewari.

WHO calls for stronger policies to reduce smoking and alcohol use

In the South-East Asia Region, occupational hazards and exposure to environmental substances continue to be a source of cancer and premature death.
Plain packaging a way out to curb tobacco epidemic: WHO

New Delhi

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

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

The aim is to make tobacco products unattractive and less appealing, thereby reducing their attractiveness and making it harder for users to start smoking.

The move is part of the global tobacco control efforts and is in line with the WHO Framework Convention on Tobacco Control (FCTC), which came into force in 2005.

WHO promotes plain packaging to curb tobacco epidemic


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Plain packs can save lives: WHO

No TOBACCO DAY: 150 lives lost per hour in Southeast Asian countries

Addi Tandon

NEW DELHI: With tobacco-related fatalities in Southeast Asia reaching the 150 per hour mark, the World Health Organisation (WHO) on Monday launched a tobacco control campaign urging governments of the region to make plain packaging of tobacco products mandatory to reduce their appeal and make anti-smoking products more noticeable.

Of the 1.3 million deaths, Asia witnesses annually on account of tobacco consumption, India makes up around 10 lakh. The Indian Council of Medical Research has now shown that 30 per cent of all 14.5 lakh new cancer cases in the country this year were tobacco-related. New cases would climb to 17.5 lakh by 2020 with tobacco contributing 20% children in India tobacco consumers

Killer stats

27.5 crore Indians hooked to tobacco, 8.5% are under 15

10 lakh die annually

20% children in India tobacco consumers

Outline launched

Health Minister JP Nadda on Monday launched a tobacco cessation helpdesk called Quitline.

The number is 18001125666, the first of its kind in the country.

The WHO argued for plain packaging, saying: message that tobacco kills is not getting through and plain packaging can disrupt the psychology of tobacco consumption. Some countries have adopted the policy but India is struggling to implement even the rotational anti-tobacco warnings with the industry resisting further demands.

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WHO IN THE MEDIA ON DIABETES AND TOBACCO
With coverage in
The Times of India
ET Healthworld.com
The Hindu
The Health Site
Bio Spectrum
bdnews24.com
The Samaya
New Telegraph
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New Indian Express
DNA
The Pioneer
National Duniya
Shah Times
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Business Standard
NDTV Food
India Today
ANI
Health CNN
Sify
Yahoo
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NRI Press
Indian Bloom
News Reporter
New Delhi News
Idaho Indian
The Health Site
Yuvashare
The Times of India
Mint
Absolute India
The Asian Age
Free Press Journal
Deccan Chronicle
Absolute India-Hindi
Dabang Duniya
Virat Vaibhav
Sakal Times
Free Press Journal

Yoga can ensure healthy lifestyle

The United Nations’ decision on June 21 as the International Day of Yoga is a recognition of this ancient Indian practice, which has been gaining global acceptance. The day will highlight the need for physical exercise, which is badly needed in today’s world, as sedentary lifestyle has become a leading cause of illness.

Yoga can be practiced anywhere by people of all age groups, irrespective of their socio-economic status. It fits in very well with the healthy lifestyle that WHO has been strongly advocating, right from childhood to healthy ageing.

WHO has been advocating physical exercise as one of the primary preventive measures against non-communicable ailments such as heart disease, diabetes and respiratory diseases, which are growing at an alarming rate. Exercise is a must for physical well-being.

The South Asia Region has a long history and rich heritage in traditional medicines and practices which contribute to health and wellness of their people. Yoga is one such traditional therapeutic system. Yoga is believed to offer means for actualization of human potential to perfection through its three-dimensional approach to health – physical, mental and spiritual.

Yoga is very much relevant even today as it is both a physical activity and an effective way of managing stress. We are fortunate that such traditional medical practices have survived over the centuries. Traditional medicines have played an important role, and continue to contribute to improving and maintaining the well-being of millions of people around the world.

WHO respects traditional health care practices and has been working for integration of best practices and good quality traditional medicines into national health systems.

WHO warns against diabetes epidemic

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

Diabetes makes people prone to heart disease, kidney failure and infections diseases like tuberculosis, malaria, and HIV/AIDS, among others. In 2014, diabetes was the main cause of death in 7.7 million people worldwide.

The Indian Diabetes Federation and WHO is focusing on ‘Healthy Living and Diabetes’ as the theme for 2014 to 2016, and the importance of prevention in diabetes.

To put the spotlight on the urgent need to act against diabetes, WHO has selected diabetes as the theme for the World Health Day since 2011.

Diabetes could rob India of demographic dividend

Durgesh Randan, JRN, IAN | Nov 11, 2014, 05:59 AM IST

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

Physicians consider diabetes the biggest challenge to India’s demographic dividend.

WHO regional director Poonam Khetrapal Singh said in a statement. She said creating easy access to

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

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

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

“Diabetes rarely makes headlines, and yet it will be the world’s seventh largest killer by 2030 unless intense and focused efforts are made by governments, communities and individuals,” said Poonam Khetrapal Singh, Regional Director, WHO South-East Asia ahead of World Health Day which falls on April 7. World Health Day this year focuses on diabetes and calls for scaling up efforts to prevent, care for and detect the disease to arrest the global epidemic which is hitting the low and middle income countries the most.

“Diabetes is of particular concern in region. More than one out of every four of the 3.7 million diabetes-related deaths globally occur in region, while its prevalence exacerbates difficulties in the control of major infectious diseases such as tuberculosis.”
Achieving universal health coverage is vital to building a healthier South-East Asia Region. Ensuring that all people everywhere have access to the services they need without facing financial hardship is the *sine qua non* of public health, and one of WHO South-East Asia Region’s core aims.

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

Achieving universal health coverage will not only contribute to public health across the Region, but will also enhance wider development efforts. It is a goal that must inform all that we do.
Distinguished participants, ladies and gentlemen,

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

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

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

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

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

I want to address two big questions.

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

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

So, question one: how did we get here?

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

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

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

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

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

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

Measurement also has a political spin off. Commitments made by national
Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia at UN headquarters with UN Secretary-General Ban Ki-moon.
leaders not only put pressure on ministries of health, but also provide a way for civil society, parliament and the media to hold health providers accountable for their performance.

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

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

They say nothing about the role of economic growth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, a house divided.

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

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

I also want to come off the fence.

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

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

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

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

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

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

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

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

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.
change are found under other goals.

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

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

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

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.

Ladies and gentlemen,

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

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

My sense is that the anxiety generated by figures like this is misplaced. First, like any normative framework the aim is for progressive realization. Countries will proceed at their own pace given the availability of resources—a point that is reinforced by the emphasis on national target setting. Second, even though estimating the costs of some of the more aspirational targets will remain highly imprecise, some goals, including Goal 3, can and will be costed more accurately.
The affordability and rate of progress in implementing the SDGs is a question—in the majority of countries—for the national government, far more than it is for their development partners.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-pocket payments for health are highest among all WHO regions and one-third of new annual poverty is health-related. The World Bank has set a goal to reach UHC by 2030, which is considered central to their objective of ending extreme poverty. India needs to step up public spending on health because the out-of-pocket expenditure in the country is one of the highest in the world, Bhutan's Health Minister said in a recent interview. The Ministry of Health and Family Welfare plans to make universal health care a priority, and the new health minister said that the government is working on a new health policy, which will focus on reducing out-of-pocket expenditure on health.

Prevent, provide timely care for birth defects

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

Prevent, provide timely care for birth defects

The birth defect of environmental origin can be addressed by prevention approaches, but legislation controlling management of toxic chemicals is needed. Current remedies for birth defects are limited to management of birth defects and their effects. The prevention, early detection, and timely treatment of birth defects can significantly reduce the suffering of affected children and their families. A supplementary approach is needed to address this issue.

World Birth Defects Day, observed on 3 March 2015, is an effort to raise awareness about the occurrence of birth defects and advocate for evidence-based prevention and implementation of early intervention programs. The World Health Organization (WHO) and the International Confederation of Obstetricians and Gynecologists (ICOG) are partnering to promote World Birth Defects Day.

The World Health Organization (WHO) has called for a global commitment to reducing the burden of birth defects by promoting prevention, early detection, and timely treatment. The organization has set a goal of reducing the number of birth defects by 50% by 2030. The birth defect of environmental origin can be addressed by prevention approaches, but legislation controlling management of toxic chemicals is needed. Current remedies for birth defects are limited to management of birth defects and their effects. The prevention, early detection, and timely treatment of birth defects can significantly reduce the suffering of affected children and their families. A supplementary approach is needed to address this issue.

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Enhancing health coverage will help reduce maternal, newborn and child deaths.

Weekly health coverage gap means the people, whether rich or poor, who live in the cities, are more likely to have access to health services. This has been identified as a major cause of the poor health care outcomes in many countries.

The Millennium Development Goals (MDGs) set the target of universal health coverage by 2015. However, progress towards this goal has been slow, and the gap in coverage remains significant.

In low-income countries, the gap is often more pronounced, with many people remaining uninsured or underinsured. This is a major challenge for countries striving to improve health outcomes and achieve economic development.

To address this issue, countries need to prioritize investments in health systems, strengthen primary health care, and ensure equitable access to essential services. This will require a commitment to universal health coverage, which is the right to the highest attainable standard of health for all.

The journey towards universal health coverage is far from easy, but the benefits are clear. Improved coverage will lead to better health outcomes, reduced health inequities, and increased economic productivity.

In conclusion, enhancing health coverage is crucial for reducing maternal, newborn and child deaths. Countries must prioritize universal health coverage as a fundamental right and invest in necessary reforms to achieve this goal.

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**Additional Information**

- **Global Health Coverage Progress:**
  - As of 2021, global health coverage is estimated to be around 60%.
  - The MDGs target of 80% coverage by 2015 was not achieved.

- **Country-Specific Data:**
  - Low-income countries generally have lower coverage rates.
  - Middle-income countries are making progress, but coverage gaps persist.

- **Challenges:**
  - Insufficient funding
  - Limited access to health facilities
  - High costs of essential medicines

- **Strategies:**
  - Investing in primary health care
  - Strengthening health systems
  - Mobilizing political will
Finishing off the task of eliminating key neglected tropical diseases demands vigorous pursuit. Lymphatic filariasis, visceral leishmaniasis, leprosy and schistomiasis are all due to be eliminated in coming years, while yaws is targeted for eradication by 2020.

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

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

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

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

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

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

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

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

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

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

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

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

The Republic of Maldives’ recent success is no surprise given that the country has long dared to dream big. Over its history Maldives has eradicated smallpox and eliminated polio and maternal and neonatal tetanus. Maldives became the first country in the region to achieve malaria-free status when WHO certified the country as such in December 2015. And with no reported cases of measles and rubella since 2010 Maldives is suitably positioned to eliminate measles by 2018—earlier than
On my way to the Maldives, I had the opportunity to read a book on the success of malaria elimination in Maldives. I was extremely impressed to see that Maldives achieved tremendous success on effective vector and malaria control while the country was still very poor, newly independent, and lacking sufficient human resources. It was also a time when the rest of the world was giving up on its efforts to eliminate malaria.

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

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

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

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

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

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

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

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

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

Lastly, I would like to thank His Excellency, the President, Vice President,
Cabinet Ministers, and especially the Honorable Health Minister for the kind invitation extended to me to be part of this august gathering.

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

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

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

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

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

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

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

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

WHO recognition

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

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

Timeline of India’s triumph over yaws

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

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

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

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

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

New tool, new thrust for global eradication

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

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

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

The same does not apply to the rest of the WHO South-East Asia Region. Lymphatic filariasis remains endemic to seven of the Region’s 11 countries, while the Region accounts for around half of the 120 million global cases of infection.

Maldives’ and Sri Lanka’s success demonstrates that the burden can be lifted.

Despite its unique geography and scattered population, Maldives was the first in the Region to be certified as having eliminated the disease as a public health problem. To do so it sustained a mass drug administration campaign that provided at-risk communities several rounds of preventive drugs annually. This occurred alongside mosquito control efforts, as well as a greater emphasis on case identification and treatment. A robust surveillance system, meanwhile, monitored progress and provided authorities the information to better target their interventions.

Commendably, Maldives also developed a plan to provide disability prevention services to ease the suffering of more than 200 people that remain chronically affected by the disease. Since 2008 not a single new case of the disease has been reported across the country’s entire archipelago of nearly 2000 islands.

Sri Lanka, too, has demonstrated how key strategies can be deployed to tackle lymphatic filariasis. After the country launched its most recent elimination program in 2002, mosquito control efforts were scaled up; case finding and treatment were intensified; surveillance was strengthened; and a mass drug administration campaign was rolled out. The combination of strategies proved remarkably successful: Surveys conducted in 2008 and 2011 among school children in endemic districts confirmed the country’s progress, culminating in the recent WHO certification of the country’s ‘filariasis-free’ status.

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

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

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

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

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

All countries must learn from Maldives’ and Sri Lanka’s achievements and fortify resolve accordingly. All countries must prove that lymphatic filariasis and other NTDs have no place in today’s South-East Asia Region.
LIVERPOOL STAR

Maldives, Sri Lanka eliminate leprosy, India yet to achieve target

http://www.liverpoolstar.com/index.php/sid/244936725

New Delhi, June 3 (IANS) India's close neighbours, Maldives and Sri Lanka have eliminated leprosy (L), a disease commonly known as elephantiasis that has been crippling the World Health Organisation's (WHO) South-East Asia Region office since a stated date.

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

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

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

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

In India, the disease is endemic in 15 States and five Union territories with approximately 2.5 to 3.5 million people affected, according to India's Health Ministry data.

Indigenous LF cases were reported from Andhra Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, Uttarakhand, Puducherry, Andaman and Nicobar Islands, Daman and Diu, Dadra and Nagar Haveli.

From these States/UTs, a total of 25 districts have been identified by the National Vector Control Programme to be endemic for filariasis.

THE HINDU

Maldives, Sri Lanka free of elephants: WHO


World body lauds the efforts of the two South Asian countries in eliminating the disease.

Sri Lanka and Maldives have eliminated elephants, also called sympatric,KN, according to the World Health Organisation (WHO).

The WHO termed LF a disease “that was crippling people for decades, forcing them to lead a life of stigma, discrimination and poverty.”

A statement issued on the website of the WHO’s regional office for South East Asia said the success in Maldives and Sri Lanka followed intensified mosquito control efforts; treatment of the infected population, disability prevention and care, strengthening of surveillance, and short-term monitoring and evaluating those efforts which together helped eliminate LF as a public health problem.

Shrines' resolve

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

"Eliminating NTDs is also critical to sustainable development goals which emphasise on "no one being left behind," the WHO release added.

THE ECONOMIC TIMES

Maldives eliminate lymphatic filariasis, India yet to achieve feat


NEW DELHI: World Health Organisation today said Maldives and Sri Lanka in the South-East Asian region have eliminated lymphatic filariasis, a disease that was crippling people for decades, though India is yet to achieve this feat.

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

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

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

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

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

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

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

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

Lymphatic Filariasis Successfully eradicated in Maldives and Sri Lanka: WHO


In the South-East Asia Region, the World Health Organisation has been focusing on eradicating neglected tropical diseases (NTD) for the last one and a half century and is now back to much earlier in Sri Lanka, with the mosquitoes transmitting the bug found in abundance across the two countries.

LF, commonly known as lymphatic filariasis, is caused by parasitic worms transmitted to humans through mosquito bites.

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

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

"The effective elimination of the disease in Maldives and Sri Lanka was due to intensified mosquito control efforts, effective treatment of the infected population, strengthening of surveillance and close monitoring of infected people and treatment for control measures.

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

"Lymphatic filariasis elimination as a public health problem in Sri Lanka is a major public health success which has been possible with our strong commitment, dedication of our health workforce and active participation and support of the community," said Dr. Raffaela Serrarese, Minister of Health, Sri Lanka.
**India behind Maldives, Lanka in filariasis elimination: WHO**

http://www.adaderana.lk/news.php?id=3853

World Health Organisation today said Maldives and Sri Lanka in the South-East Asian region have eliminated lymphatic filariasis, a disease that was crippling people for decades... The success in Maldives and Sri Lanka shows the resolve of these countries and the region as a whole to eliminate all neglected tropical diseases, which have no reason to continue and mar the lives of people," Dr. Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, said.

Eliminating NTDs is also critical to sustainable development goals which emphasises on ‘no one being left behind’,” the WHO release added.

**Nigeria News**

Sri Lanka: Maldives and Sri Lanka eliminate lymphatic filariasis

http://www.nigeria.chinapress.com/EN/93/29/26/0025

New Delhi: 3 June 2016 - In a significant progress against neglected tropical diseases in WHO South-East Asia Region, Maldives and Sri Lanka have eliminated lymphatic filariasis, a disease that was crippling people for decades, forcing them to lead a life of stigma, discrimination and poverty.

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

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

ColomboPage

Maldives and Sri Lanka eliminate lymphatic filariasis


New Delhi: 3 June 2016 - In a significant progress against neglected tropical diseases in WHO South-East Asia Region, Maldives and Sri Lanka have eliminated lymphatic filariasis, a disease that was crippling people for decades, forcing them to lead a life of stigma, discrimination and poverty, World Health Organisation (WHO) said in a statement on Friday.

However, India is still far from achieving the target of total elimination, with an estimated two million people still suffering from the disease, spread through monsoon rains.

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

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

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

In India, the disease was endemic in 15 States and Union Territories with approximately 600 million population at risk, according to India’s Health Ministry data.

Indian LF cases were reported from Andhra Pradesh, Assam, Bihar, Chattisgarh, Goa, Gujarat, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharastra, Orissa, Tamil Nadu, Uttar Pradesh, West Bengal, Puducherry, Andaman and Nicobar Islands, Daman and Diu, Dadra and Nagar Haveli and Lakshadweep.

From 2002-2012, a total of 230 districts have been identified by the National Vector Borne Disease Control Programme to be endemic for filariasis.

The WHO has targeted LF elimination by 2020.

"The success in Maldives and Sri Lanka follows intensified mosquito control efforts; treatment of the infected population; disability prevention and control; strengthening of surveillance; and closely monitoring and evaluating these efforts which together helped eliminate LF as a public health problem," the WHO release added.
Leprosy needs renewed efforts, greater push

By: Dr Poonam Khetrapal Singh,
Regional Director, WHO South-East Asia Region

WHO launches new strategy to end leprosy

The World Health Organization (WHO) has launched a new global strategy for leprosy control, calling for stronger commitment and accelerated efforts to stop leprosy transmission and end associated discrimination and stigma.

The strategy aims to, by 2050, reduce to zero the number of children diagnosed with leprosy and related physical deformities; reduce the rate of newly diagnosed leprosy patients with visible deformities to less than one per million; and ensure that all legislation that allows for discrimination on the basis of leprosy is overturned.

“WHO has developed, in consultation with national programmes, technical guidelines and a 2050 vision for leprosy elimination, which adequately addresses the setbacks seen in recent years,” said Dr. Poonam Khetrapal Singh, Regional Director for WHO South-East Asia Region.

WHO believes that leprosy can be eliminated, an ambitious goal for the Global Action Plan for Leprosy and Elimination of Leprosy (GAP) launched in 2003.

The strategy launches a new global strategy to end leprosy

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

WHO launched an efficient treatment protocol in the early 1980s. There is no reason why a person should suffer the deformities and stigma of leprosy today.

WHO introduced an efficient treatment protocol in the early 1980s. There is no reason why people should suffer the deformities and stigma of leprosy today. The strategy focuses on equity and universal health coverage, which will contribute to reducing the incidence of leprosy in the longer term.

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

WHO launches new strategy to end leprosy by 2020

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WHO aims for ‘world free of leprosy’ by 2020

New Delhi: The World Health Organization (WHO) aims to eliminate leprosy as a public health problem by 2020. This was announced by WHO’s Director-General, Dr. Margaret Chan, during the 67th World Health Assembly in Geneva. The elimination goal is to reduce the number of new cases by 95% and reduce the disability caused by leprosy.

WHO launches global strategy toward leprosy elimination

WHO’s new strategy focuses on strengthening health systems and integrating leprosy services into primary healthcare. The strategy aims to reduce the number of new cases by 95% and eliminate leprosy-related disabilities.

Global strategy to make world free of leprosy by 2022

The WHO said out of the 1,375,900 new leprosy cases in 2014, 94% were reported from 13 countries—Brazil, Indonesia, India, Myanmar, Nepal, the Philippines, Tajikistan, Tanzania, Vietnam, and the Democratic Republic of the Congo. According to the WHO, 5% of the world’s population is at risk of developing leprosy.

WHO launches plan to fight leprosy

New Delhi: The World Health Organization on Wednesday launched a global strategy aimed at eliminating leprosy in the world by 2030. The strategy aims to reduce the number of new cases by 90% and eliminate leprosy-related disabilities.

WHO launches Global Strategy to End Leprosy

The World Health Organization (WHO) Wednesday launched a new global strategy for a world free of leprosy, calling for strengthened commitments and accelerated efforts to stop disease transmission and end associated discrimination and stigma, to achieve a world free of leprosy.

The new strategy builds on the success of previous global leprosy strategies. It has been developed in consultation with national leprosy programmes, technical agencies and NGOs, as well as patients and communities affected by leprosy.
Rolling back the burden of communicable diseases is a task of ongoing attention. Communicable diseases such as HIV/AIDS, tuberculosis and viral hepatitis continue to be a major health concern in the South-East Asia Region, and must be tackled accordingly.

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

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

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

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

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

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

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

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

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

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

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

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

These achievements have also been facilitated by transformative international partnerships, not only between the North and South but also South-South partnerships. Thailand has not only benefitted from such partnerships, but has also served as a critical source of knowledge, learning and best practices in relation to AIDS.
Thailand has been home to some of the most important HIV clinical trials and implementation studies, including with respect to prevention of mother-to-child transmission. Thailand’s early pioneering of condom promotion for sex workers has inspired effective HIV prevention measures across the world, in both rich and not-so-rich countries. And as Thailand’s investments in health have placed it on track to achieve the 90-90-90 target before the 2020 deadline, it is showing the entire world what it takes to fully leverage antiretroviral therapy to reduce new HIV infections and AIDS-related deaths.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Did your baby get the hepatitis B vaccine at birth? They should have**

Opinion editorial article by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia
For those already suffering chronic hepatitis B and C, access to high-quality, safe and affordable treatment must be guaranteed at all levels of the health system.

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

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

New Delhi: Viral hepatitis has been ranked as one of the most serious public health problems in India by the World Health Organization (WHO), with an estimated 30 million people infected with chronic hepatitis B and C. According to the WHO, viral hepatitis is a widespread and often deadly infection that affects millions of people globally.

Viral hepatitis is a group of liver infections caused by several types of viruses. The most common types are hepatitis A, B, C, and D. These infections can range from mild to severe, and some can lead to cirrhosis (scarring of the liver) and liver cancer.

In South Asia, 100 million people are estimated to be living with hepatitis B and 10 million with hepatitis C. This is more than one-third of the world’s population, making South Asia one of the regions most affected by viral hepatitis.

The symptoms of viral hepatitis can be similar to those of other diseases, which makes it difficult to diagnose. According to the WHO, 95% of people infected with hepatitis B and C don’t notice the infection.

The New Delhi report highlights the need for increased awareness and effective treatment options. The WHO recommends vaccination as a key strategy to prevent hepatitis B, while hepatitis C can be treated with antiviral medications.

World Aids Day being celebrated, but ‘lack of awareness still exists’

This year, World AIDS Day is being observed on December 1, 2020, to raise awareness and support for those living with HIV and AIDS. The day serves as a reminder of the ongoing global AIDS epidemic and the urgent need for increased funding, research, and support for those affected.

The World Health Organization (WHO) has reported that there were an estimated 38 million people living with HIV at the end of 2019. India has the second-highest number of HIV cases in the world, with an estimated 2.9 million people living with HIV.

Despite advancements in treatment and prevention, there are still significant gaps in access to care and support for people living with HIV. The WHO emphasizes the importance of continued investment in HIV prevention, care, and treatment programs.

The report highlights the importance of continued efforts to increase awareness and reduce stigma associated with HIV and AIDS. It calls for increased funding and support for HIV prevention, care, and treatment programs, as well as for research into new prevention and treatment options.

The WHO urges governments and stakeholders to take action to reduce the impact of HIV and AIDS, and to work towards achieving the UN Sustainable Development Goals for health.

A STEALTHY KILLER

Hepatitis C is a blood-borne virus caused by the Hepatitis C virus (HCV). It is one of the leading causes of chronic liver disease and cirrhosis. Hepatitis C can cause mild to severe liver damage, and in some cases, it can lead to liver cancer.

Hepatitis C is most often spread through contaminated needles or other instruments, such as tattooing or piercing equipment. It can also be spread through blood transfusions, organ transplants, and breastfeeding. In the United States, most cases of Hepatitis C are related to injecting drug use.

Hepatitis C can be treated with antiviral medications, and in many cases, it can be cured. The treatment is typically given over several months, and it can be expensive. It is important to get tested for Hepatitis C if you have ever injected drugs, shared needles, or had a blood transfusion.

WHO warns India over hepatitis incidence

With India alone being home to 30 million people living with chronic hepatitis B infection and another 30 million with chronic hepatitis C, the World Health Organization has warned of a “potentially catastrophic” situation in the region, particularly in the South-East Asia Region (SEAR).

WHO has highlighted the need for increased awareness and effective treatment options for hepatitis. The organization has recommended vaccination as a key strategy to prevent hepatitis B, while hepatitis C can be treated with antiviral medications.

WHO urges governments and stakeholders to take action to reduce the impact of hepatitis, and to work towards achieving the UN Sustainable Development Goals for health.
WHO: Thailand eliminates mother-to-baby HIV

Bangkok, June 8
Thailand has become the first Asian country to eliminate mother-to-child transmission of HIV, the World Health Organization said on Wednesday in a milestone in the fight against the disease.

The announcement is a boost for a generation of Thai health workers who have transformed the nation from one of Asia’s most HIV-vulnerable societies to a pioneer for how to effectively tackle the crisis. Describing the elimination as a “remarkable achievement”, the WHO said Thailand was “the first country with a large HIV epidemic to achieve an AIDS-free generation.”

Belarus and Armenia were also declared free of mother-to-baby HIV transmissions on Wednesday but both nations have a much lower prevalence of the virus.

Previously, Cuba was the only other country in the WHO’s criteria back in July 2015. The global health body said Thailand’s routine screening and universal free medication for pregnant women with HIV was crucial in dropping the virus being passed to new generations.

If left untreated, mothers with HIV have a 15-45 per cent chance of transmitting the virus to their children during pregnancy, childbirth or while breastfeeding.

Belarus, Armenia and Thailand were all declared free of mother-to-child transmission of HIV among children under five years of age. The US and Canada have previously eliminated mother-to-child transmission under the WHO’s criteria.

Adhere to injection safety guidelines: WHO to India

New Delhi: At the World Hepatitis Day on Tuesday, the World Health Organization urged India to strictly adhere to the WHO injection safety guidelines for hepatitis.

“The health sector needs to strengthen disease surveillance systems, thereby ensuring that all cases are taken into account. ‘Appropriate treatment of medicine is not the 100 per cent prevention of transmission of hepatitis B and C’,” Dr Poonam Khetrapal Singh, regional director for the WHO South-East Asia Region said on Tuesday.

The country, with 100,000 cases in 1990, has since seen a threefold increase. It is a major turnaround for Thailand. The country went from 100,000 HIV cases in 1990 to more than a million three years later, in part due to its mass treatment.

WHO urges South-East Asia to taper hepatitis cases

NEW DELHI: The World Health Organization on Wednesday urged the South-East Asian nations to increase access to hepatitis testing and treatment.

The WHO said it will release its first hepatitis testing guidelines in 2016 which “provide guidance on how testing and treatment should be done.”

An essential first step to reining in the spread of hepatitis B and C is to increase access to hepatitis testing, the WHO’s Regional Director for the South-East Asia Region, Dr Poonam Khetrapal Singh said.

“The new guidelines will also provide guidance on how hepatitis testing and treatment should be done,” Singh said.

WHO: Cheaper hepatitis treatment in India attracts foreign patients

Hyderabad: Cheaper hepatitis treatment in India is attracting foreign patients, according to the WHO.

The WHO said that hepatitis treatment in India is cheaper than in other countries, making it an attractive option for patients from other parts of the world. According to the WHO, hepatitis treatment in India costs less than $100, while in other countries like the US, treatment can cost up to $10,000.

The WHO also noted that hepatitis treatment in India is more accessible, with many patients being able to receive treatment within a week of diagnosis. According to the WHO, hepatitis treatment in India is more accessible, with many patients being able to receive treatment within a week of diagnosis. According to the WHO, hepatitis treatment in India is more accessible, with many patients being able to receive treatment within a week of diagnosis. According to the WHO, hepatitis treatment in India is more accessible, with many patients being able to receive treatment within a week of diagnosis.

Hepatitis C treatment in India is also more affordable. According to the WHO, a 12-week course of hepatitis C treatment in India costs around $1,000, while in other countries like the US, the cost can be as high as $50,000.

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

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Combating antimicrobial resistance means taking on one of the greatest threats to the health and wellbeing of people across the South-East Asia Region. The inappropriate use of antibiotics is leading to bacterial infections that cannot be treated and which are already killing approximately 700,000 people worldwide every year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Excellencies, ladies and gentlemen,

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

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

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

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

I wish the meeting all success.

Thank You.
**Stop antimicrobial resistance now**

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

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

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

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

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

There are simple and effective measures that governments must take. They must ensure legitimate antibiotics are only obtained via a doctor’s prescription, not over-the-counter, and must strengthen and enforce legislation to prevent the manufacture, sale and distribution of substandard antibiotics. This will disrupt our tendency to reach for, say, amoxicillin at the first sign of a cough or skin sore, and will ensure that the antibiotics consumed are of the highest quality.

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

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

**“Resistance to first-line antibiotics means treating once-basic illnesses is more difficult, costly and time-consuming. In resource-poor settings, this matters.”**

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

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

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

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

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

The Centre is set to kickstart an awareness campaign ‘Medicines with the Red Line’ to sensitize people on the rational use of antibiotics.

“India is committed to combating antimicrobial resistance (AMR). However, a collective action is required by all stakeholders within a country and across nations to control AMR,” the Health Ministry said.

India, which has the biggest number of TB patients in the world with over 2.5 million new cases and 8.8 lakh deaths every year, has already prepared a standard treatment protocol to restrict procurement and sale of antibiotics. However, the government has so far failed to enforce the MBARV guidelines because of an absence of monitoring mechanism.

In India, an additional two million lives can be lost by 2050 due to drug resistance. Antibiotics are the most sold drugs segment in India, with sales over Rs 1,000 crore.

“Antibiotics are prescribed without a true indication. There is a lot of misuse and inappropriate use of antibiotics,” said health experts.

The UN agency has cautioned the government and public health experts that “if enough was not done now, common bacterial infections such as skin sores or diarrhoea would become impossible to treat.”

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18.04.2016

Asia Pacific countries vow to jointly tackle antimicrobial resistance

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

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

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

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

“It is a looming health and economic crisis that requires 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,” she told ministers during the meeting.

Khetrapal Singh further said antibiotic resistance was one of the biggest threats to human health today.

“Having effective antimicrobials is also critical to the social and economic development of nations. We have a limited window of opportunity to take action and avoid a post-antibiotic era,” she said.

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


“Pertemuan ini dimaksudkan sebagai wadah untuk memperkuat kerjasama antar negara dalam hal penanganan masalah resitensi antimikroba,” kata Menteri Kesehatan Sussan Ley.

Pada pertemuan ini, menteri kesehatan dari 12 negara Asia Pasifik, termasuk Indonesia, Korea Selatan, Australia, Jepang, Singapura, dan Malaysia, dibahas mengenai masalah resitensi antimikroba. Selain itu, mereka juga membahas bagaimana mempersiapkan diri untuk menghadapi tantangan yang mungkin di masa mendatang.

Menteri Kesehatan Sussan Ley, yang menghadiri pertemuan ini, menyebutkan bahwa resitensi antimikroba adalah masalah yang semakin kompleks dan mendesak. Menurutnya, resitensi antimikroba harus dihadapi dengan sikap yang proaktif dan berkoordinasi untuk memastikan bahwa masyarakat mendapat akses ke pengobatan yang efektif.

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Curb non-rational use of antibiotics: Centre

AGE CORRESPONDENT
NEW DELHI, FEB 23

Terminating antimicrobial resistance as the number one public health challenge before the world today, the government on Thursday issued a notification for non-rational use of antibiotics.

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

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

WHO (00 on Tuesday) launched its strong measures by the governments to stop the availability of antibiotics over the counters. Governments must take strong measures to stop over-the-counter availability of antibiotics, while strengthening and enforcing legislation to prevent the manufacture, sale and distribution of substandard antibiotics.

“These measures must be accompanied by campaigns to make behavioural and cultural changes in prescribers and patients so that antibiotics are no longer considered the first treatment option,” WHO chief Margaret Chan said.

Globally, around 70,000 people die every year due to once-treatable health conditions. In South-East Asia region, “the lack of public awareness, public health gaps and public health governance, coupled with dense population and sub-optimal sanitation, contribute to a breeding ground for bacterial infections, Dr Poornam Khetrapal Singh said.

12 Asia Pacific countries join hands to deal with antibiotic resistance

The Himalayan

https://thenationaltimes.in/timesnepal/asia-pacific-countries-join-hands-to-deal-with-antibiotic-resistance/

17.04.2015

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

Countries in the Asia Pacific region today pledged to collaborate to combat the increasing threat of antimicrobial resistance which threatens to erode the gains made globally in the fight against antibiotic ineffective.

Countries in the Asia Pacific region today pledged to collaborate to combat the increasing threat of antimicrobial resistance which threatens to erode the gains made globally in the fight against antibiotic ineffective. Health ministers from 12 countries of the region agreed to improve the way information on antimicrobial resistance is collected and shared to guide effective policies and actions, to harmonize and strengthen the regulation, surveillance and use of antibiotics, to use robust and timely data to support research and development of new antibiotics, diagnostic tests, and vaccines.

FOLLOW RIGHT PRESCRIPTION PRACTICES

Rhythmika Kaul

NEW DELHI: “Do not use medicines that carry a red strip without consulting a doctor,” Health minister J.P. Nadda, who launched ‘Medicine with the Red Line’ campaign to tackle the growing problem of antimicrobial resistance at the three-day International Conference on Combating Antimicrobial Resistance (AMR) on Tuesday.

The health minister highlighted the need to follow correct prescription practices. “Prescriptions should be regular, prescription audits and maintaining a digital repository of patients’ medical history at hospitals to combat misuse of antibiotics,” he said.

Noting that antimicrobial resistance has emerged as the number one public health challenge worldwide, Nadda said it would be useless to avoid the need for antibiotics completely.

“This is best done through improved water and sanitation, in the absence of which proliferation of diarrhoeal diseases results in inappropriate antimicrobial use. Through the Swachh Bharat programme, the government has taken active steps to improve hygiene and sanitation and reduce the environmental spread of pathogens,” he said.

Vaccination is an equally important to prevent disease and increase AMR. “Through the Mission Indradhanush, India has set itself an ambitious goal of increasing routine immunisation coverage from 90% to 95%,” Nadda said.

Secretary health Harsh Vardhan drew attention to the importance of surveillance and monitoring in dealing with the problem.

“The ministry has undertaken an exercise for mapping health facilities in the private and public sectors across the country that shall be complete in the next three years. This shall provide a useful database to analyse the various determinants and impacts of non-rational use of antibiotics,” he said.

Dr Sanjukta Bhattacharya, DO, ICAR, said that community based surveillance will play a major role in finding solutions to anti-TB drug resistance and other viral diseases. "AMR is a priority at ICAR; and there is need to study how resistance spreads and what the food chain is for AMR," she said.

To provide a regional perspective on AMR, Dr Poornam Khetrapal Singh, regional director for South-East Asia, Regional Office for South-East Asia, speaking at the inauguration, said: “We as a region, through the AMR monitoring programme, aim to monitor AMR trends, and provide a baseline to understand the problem and how to address it.”

WHO IN THE MEDIA ON ANTIMICROBIAL RESISTANCE

With coverage in
DNA
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Business Standard
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The NewsToday
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Menkes se-Asia Pasifik Bahas Ancaman Resisten Antimikroba


17.04.2016

Para menteri kesehatan Se-Asia Pasifik pose bersama usia memahami resistensi antimikroba global di Tokyo, Sabtu 16 April 2016. (Humas Kemkes)


Pada pertemuan ini para delegasi berbagi pengalaman mengenai situasi dan program pengendalian AMR di negara masing-masing. Para AHM dari WHO, Badan Pangan Dunia (FACO), Organisasi Kesehatan Hewan Dunia (OIE) serta akademisi dan praktisi yang hadir pada pertemuan tersebut, meminggatkan ancaman kesehatan global yang serius apalaba AMR tidak segara ditangani secara terpadu dan multisektorial.

Asia Pacific countries Saw to tackle antimicrobial resistance together


Health ministers from 12 countries of the region agreed to improve the way infections resistance is collected and shared to guide effective policies and actions.

Countries in the Asia Pacific region have pledged to collaborate to combat the spread of antimicrobial resistance which transcends borders and endangers global health by antibiotic ineffective.

Health ministers from 12 countries of the region agreed to improve the way antimicrobial resistance is collected and shared to guide effective policies and actions, harmonize how they regulate the production, sale and use of antibiotics and medicines; and to take innovative approaches to stimulate research and development of new drugs, vaccines and other medicines. The meeting was co-hosted by the Ministry of Health.

"Antimicrobial resistance is a threat to global security and economic stability. It is a global economic crisis that requires both global and local solutions. Since drug resistant diseases have higher levels of economic and social organisation and have a stake in the problems taken by less developed countries. In the fight against antimicrobial resistance, we are the weakest link," Dr. Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, said in a meeting.

The ministerial meeting followed a two-day brainstorming session among experts representing public health, agriculture and animal health, was organised by the Global Antimicrobial Resistance Alliance (GABA), in collaboration with the Food and Agriculture Organization of the United Nations (FAO) and WHO.

"Antibiotic resistance is one of the biggest threats to human health today. Antimicrobials are also critical to the social and economic development of nations. The selection of opportunity to take action and avoid a post-antibiotic era, WHO is using the Asia Pacific region to take critical steps to preserve the effectiveness of these life-saving medicines. We must strengthen health systems’ responses and cooperation with the agriculture sector to contain this threat, and improve understanding of the problem among the public." The Tokyo meeting...
एन्टीबॉयडीतिक प्रतिरोध से लड़ने के लिए जल्द से जल्द कारावास करना ज़रूरी: डक्टर एचयूएचो

हमें संचालन

इस संदर्भ में, एन्टीबॉयडीतिक दायरा की गतिविधियों के क्रम में लॉन्गर नजर से जल्द झुकाव करना चाहिए। इस दिसंबर में अपनी स्वीकृति का निर्माण किया गया था। यह एक विशेष शासन से आज, जिसमें एन्टीबॉयडीतिक के लिए कार्यक्षमता का आयोजन किया गया था।

एन्टीबॉयडीतिक दायरा की गतिविधियों के साथ इंग्लैंड से, जैसे अनुमान जनता के कोर्स से संबंधित था, वह सूचना देने के लिए थी। इन सार्वजनिक समारोहों के द्वारा एन्टीबॉयडीतिक के मामले में इस्तेमाल के लिए आयोजन किया गया।

अन्यतर, एन्टीबॉयडीतिक के मामले में इस्तेमाल के लिए आयोजन किया गया।

सरकार को एन्टीबॉयडीतिक के दायरे की गतिविधियों के साथ इंग्लैंड के मामले में सहयोग करना चाहिए।

WHO की विभागों ने ज्ञान प्राप्त किया और इन सार्वजनिक समारोहों के द्वारा इन्फॉर्मेशन प्रसारण के लिए कार्यक्षमता का आयोजन किया।

NET INDIA

12 Asia Pacific countries vow to jointly tackle antimicrobial resistance

Concerted action must be taken to battle drug-resistant bacteria from the Asia Pacific region today pledged to collaborate to combat the increasing threat of antimicrobial resistance which endangers global health by restricting 65-saving antibiotics inactivation. Health ministers from the 12 countries agreed to strengthen and harmonize registries for the production, use and sale of antibiotics and other antimicrobial medicines to and take an innovative approach to stimulate research and development of new antibiotics, diagnostic tests, vaccines and other technologies, a commune issued in the Tokyo Meeting of Health Ministers on Antimicrobial Resistance, a statement here said. The ministers voiced the need for urgent action to raise awareness across all sectors of the need for responsible use of antibiotics and pledged to take a multi-sectoral approach "with effective governance mechanisms, to mobilize all relevant sectors effectively," to harness health and economic crises that require both global and local solutions. Since drug-resistant genes can travel, countries with higher levels of resistance and would appreciate have a stake in the success of measures taken by the developing world, namely "are only strong as the non-biogrophic and cultural changes, coupled with the collaboration of the Asia Pacific region or better" by the spread of multi-drug resistant strains of bacterial pathogens, and that "promising new treatments that prevent and control infections with use of numbers" and strengthening these systems is key to the success of measures taken by the developing world, namely "are only strong as the non-biogrophic and cultural changes, coupled with the collaboration of the Asia Pacific region or better."