Expanded Programme on Immunization

Expanded Programme on Immunization. EPI continued to see significant progress in the Western Pacific Region over the past year. There were important gains in maternal and neonatal tetanus elimination, with Viet Nam achieving elimination status in 2005. In addition, the Region continues to be free of poliomyelitis. The decision taken at the fifty-sixth session of the Regional Committee for the Western Pacific in September 2005 to endorse the twin regional goals of measles elimination and hepatitis B control by 2012 provided fresh impetus to those programmes. In addition, Mongolia, Papua New Guinea and Tonga have introduced or are planning to introduce the *Haemophilus influenzae* type B (Hib) vaccine in their national immunization programmes, bringing the total number of countries and areas in the Region using Hib vaccine to 18.

Poliomyelitis. The Region has maintained polio-free status despite the increased risk of the importation of wild polioviruses. Major surveillance indicators have met WHO requirements. The quality of acute flaccid paralysis surveillance and immunization activities has remained stable for the past five years in most countries and areas. In addition, the Region is now better prepared to rapidly detect and appropriately respond to an importation of wild poliovirus or a circulating vaccine-derived polioviruses. Efforts are continuing to complete and document the quality of Phase I laboratory containment of wild polioviruses in the Region.¹

The Regional Certification Commission in December 2005 concluded that 33 of 37 countries and areas in the Region have completed Phase I laboratory containment. Two more countries are expected to do so in 2006. Challenges remain in China, but there has been encouraging progress in Japan.

Measles Elimination. The Region’s measles elimination effort has been bolstered by the decision of the Regional Committee in September 2005 to set a target date of 2012 for the elimination of measles, one of the leading causes of vaccine-preventable morbidity and mortality in children.

In the Republic of Korea, the incidence of measles has been below the elimination level—less than one confirmed case per 1 million people—since 2002. This was achieved through a national supplementary immunization campaign that reached 99% of the target population and maintained high routine coverage of two doses of measles vaccine. It is expected that the Republic of Korea will declare measles elimination in 2006. Viet Nam is expected to eliminate measles ahead of its 2010 target. It concluded a successful national campaign and is planning to introduce a routine second dose of vaccine in its immunization schedule in 2006.

The Cambodia National Immunization Programme, in consultation with representatives of the United Nations Children’s Fund and WHO, developed a draft national plan for measles elimination,
including routine vaccinations, surveillance and supplementary immunizations. In November 2005, representatives of China’s Ministry of Health and the Chinese Center for Disease Control and Prevention, with technical assistance from WHO and several international experts, completed a draft national measles elimination plan.

Papua New Guinea completed national supplementary immunization activities in 2005. Both Malaysia and the Philippines held targeted mop-up immunization activities to provide additional opportunities to those who missed earlier immunizations. Progress has been made in efforts to further develop the regional measles laboratory network. In 2005, more than 20 000 serum samples from China and another 6000 samples from other countries were tested for measles and rubella IgM. At least seven countries have established timeliness and efficiency indicators for their surveillance systems.

**Hepatitis B.** In September 2005, the Regional Committee endorsed a regional goal for hepatitis B control—the reduction of the seroprevalence of HbsAg to less than 2% in 5-year-old children as an interim target towards the final regional goal of less than 1% seroprevalence.

Ten countries and areas in the Western Pacific Region already have achieved a less than 1% chronic infection goal. Two countries and areas with sustained high coverage for three doses of the vaccine, as well as for a timely birth dose, are nearing achievement of this goal. Significant improvements were observed in timely birth-dose coverage in hospital and health facility births. However, strategies must be developed for births at home, which account for 20%–30% of all births in China. Mongolia reviewed its practices for vaccine storage and the delivery of birth doses following higher than expected HbsAg seroprevalence in 2005. The Philippines is reviewing its immunization schedule to introduce birth doses and is attempting to procure a sufficient stock of vaccine.

**Tetanus Elimination.** Neonatal tetanus is a disease that kills tens of thousands of newborns each year. It is often called the “silent killer” because many newborns affected by it die at home in remote and poor communities where births and deaths often are unreported.

In December 2005, a cluster sample survey conducted by the United Nations Children’s Fund, WHO and the Government of Viet Nam confirmed that maternal and neonatal tetanus had been eliminated as a public health problem in Viet Nam. A comprehensive review in November 2005 of the hepatitis B programme in China showed near-universal timely birth-dose coverage in hospital and health facility births. However, strategies must be developed for births at home, which account for 20%–30% of all births in China. Mongolia reviewed its practices for vaccine storage and the delivery of birth doses following higher than expected HbsAg seroprevalence in 2005. The Philippines is reviewing its immunization schedule to introduce birth doses and is attempting to procure a sufficient stock of vaccine.

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2 American Samoa, Australia, Fiji, French Polynesia, Japan, Macao (China), New Zealand, Samoa, Singapore and Wallis and Futuna.
3 Brunei Darussalam, Hong Kong (China), Malaysia, New Caledonia, the Republic of Korea and Tonga.
performing areas, it is considered as having been eliminated in better performing areas.

**Partnerships.** The Global Alliance for Vaccines and Immunization completed its first phase (2000–2005) in December 2005. Cambodia, China, Mongolia, the Lao People’s Democratic Republic, Papua New Guinea and Viet Nam received commitments of approximately US$ 78 million under Phase I to introduce new vaccines, improve injection safety and strengthen overall routine EPI services.

Also in 2005, WHO and its partners launched a new regional immunization partnership to mobilize and coordinate support for a range of immunization activities, including measles elimination, hepatitis B control, the maintenance of polio-free status and the strengthening of routine immunization in the Region.
Malaria. This vectorborne disease is a major cause of ill health in 10 endemic countries of the Region.\(^1\) WHO has been actively engaged in providing technical assistance in three areas: diagnosis, treatment and vector control.

The control of malaria in endemic areas is based on early effective treatment and preventive measures appropriate to local situations. Two diagnostic approaches are being used: rapid diagnostic tests and microscopy. To improve rapid diagnostic testing in the Region, WHO has developed a quality assurance system that addresses the problems of humidity and heat stability. It also has prepared easy-to-follow instructions for health workers at the village level. In addition, the Western Pacific Region, in collaboration with other WHO regions, is developing a system for the quality control of malaria microscopy.

Nearly all countries and areas have adopted artemisinin-based combination therapy to fight multidrug-resistant \textit{Plasmodium falciparum} malaria. WHO has worked with endemic countries to optimize the use of combination therapy and set up systems for the regular monitoring of drug efficacy.

An alarmingly high proportion of antimalarial drugs purchased in pharmacies and shops in the Region are counterfeit. More than 90\% of counterfeit artesunate, a potent derivative of artemisinin, are labelled falsely as manufactured by Guilin Pharma—the major producer of artesunate in Asia. Fake tablets are rampant in both the public and private sectors. Some 40\% of artesunate tablets sold in Cambodia are counterfeits with no active ingredients. Counterfeits pose the greatest risks to the poor and to remote populations where health systems are weak and malaria most intense. The distribution of counterfeits is part of a well-organized international criminal conspiracy. WHO is working with Interpol and other partners to shut down the source of these counterfeits. At the same time, WHO is working with national regulatory agencies to improve their drug control operations. WHO has produced a video designed to raise public awareness about the threat posed by counterfeits.

Dengue. This is the second-most important vectorborne disease in the Region. Following major epidemics in 1998, there was a decline in the number of cases. In recent years, however, there has been a steady upward

\(^1\) The endemic countries are Cambodia, China, the Lao People’s Democratic Republic, Malaysia, Papua New Guinea, the Philippines, the Republic of Korea, Solomon Islands, Vanuatu and Viet Nam.
Intestinal Helminths. Cambodia has become the first country in the world to regularly deworm all school-age children. The Lao People’s Democratic Republic and Viet Nam have come close to attaining that target—thanks in large part to donors that recognize the benefit deworming has on childhood growth and development. WHO has been working with the United Nations Children’s Fund, which is interested in deworming infants and pregnant women, in order to cover all high-risk groups. WHO has provided medicine and offered technical assistance to help initiate programmes in some of the smaller Pacific island countries and areas.

Lymphatic Filariasis. Countries and areas in the Western Pacific Region are making steady progress towards the global goal of the elimination of lymphatic filariasis by 2020. China this year will become the first country to be verified as filariasis free after an intensive programme spanning 50 years. The Republic of Korea is expected to complete the verification process by the end of 2006, which would make it the second country in the Region to be declared filariasis free. In the Pacific, all but one country will have completed five rounds of mass drug administration by the end of 2006, putting the area on target to achieve elimination by 2013. This will mark a major achievement for the Pacific island countries and areas that have shared resources and expertise in the fight against lymphatic filariasis. Other endemic countries are at various stages of their elimination programmes.
Tuberculosis. TB continues to cause immense suffering in the Western Pacific Region. In 2004, the most recent year for which statistics are available, nearly 2 million new cases of tuberculosis were reported and more than 300,000 people died from the disease. The HIV/AIDS epidemic and multidrug-resistant tuberculosis are increasing threats to tuberculosis control. WHO is collaborating with Member States to make a strategic shift from the expansion of directly observed treatment, short-course (DOTS) to improving the quality of DOTS services and addressing emerging threats.

Through the Stop TB special project, established following the declaration of a tuberculosis crisis in the Western Pacific Region in 2000, substantial progress has been made in achieving the targets set for 2005—providing access to DOTS to 100% of the Region’s population, detecting 70% of estimated TB cases and successfully treating 85% of detected cases. From 2000 to 2004, case detection increased from 45% to 67% and DOTS coverage from 67% to 94%. The treatment success rate has exceeded the target of 85% for several years.

Early reports suggest that the Region has met the targets for 2005. However, the 2005 targets are only an intermediate step towards achieving the 10-year regional goal of reducing cases and deaths by one half, targets in line with the Millennium Development Goals.

Considering the large-scale expansion of DOTS in recent years, it is vital to ensure that the quality of service is not compromised. All countries with a high burden of tuberculosis are implementing quality assurance programmes for tuberculosis laboratories.1 WHO is collaborating with international reference laboratories in Australia, Hong Kong (China), Japan and the Republic of Korea to strengthen laboratory services throughout the Region.

WHO has established and continued to implement the Pacific TB Laboratories Initiative (PATLAB) in the Pacific island countries and areas in collaboration with the Secretariat of the Pacific Community and the United States Centers for Disease Control and Prevention. The initiative aims both to improve the quality of sputum microscopy through external quality assessments and to expand surveillance for drug resistance. In January 2006, a consultation of laboratory experts agreed on essential steps in developing a regional policy on sputum culture for diagnosis and drug-sensitivity testing services. WHO has assisted and participated in several programme reviews and evaluations in the past year. In collaboration with the Global Drug Facility, a workshop on drug management was organized in September 2005.

The guiding principle of tuberculosis control is the identification of infectious cases and their successful treatment to prevent further transmission of the disease. For this to occur, DOTS services must be accessible to all tuberculosis patients. The Philippines has taken the lead in involving private health care providers in tuberculosis services through an approach called public-private mix DOTS, resulting in a 10% increase in case detection in some areas. China,

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1 Cambodia, China, the Lao People’s Democratic Republic, Mongolia, Papua New Guinea, the Philippines, Viet Nam.
following the success of its initiative to improve collaboration between general hospitals and tuberculosis dispensaries, is now planning to improve access for its poor and migrant populations. Cambodia is further decentralizing services through community-based DOTS.

The Lao People’s Democratic Republic is decentralizing DOTS services to the health centre level in an effort to improve access to tuberculosis services. Mongolia is implementing a special programme to address the high burden of tuberculosis among prisoners and the homeless. WHO has helped secure funds and is providing technical assistance to these countries to push this initiative forward.

Multidrug-resistant TB. MDR-TB is an ongoing challenge in the Region and a major problem in countries such as China, Mongolia and the Philippines. Approximately one quarter of the world’s MDR-TB cases are in China. In some provinces of China, the rate of MDR-TB in previously untreated cases ranges from 4.5% to 10%. Routine data from Ulaanbaatar in Mongolia show high rates of MDR-TB in previously treated cases—43% in 2005. Preliminary data from the Philippines indicate a significant level of MDR-TB. WHO, in collaboration with other partners, is assisting countries to conduct drug-resistance surveillance and implement DOTS-Plus programmes for the management of MDR-TB patients. With funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, China and the Philippines are scaling up DOTS-Plus projects and Mongolia has initiated a pilot project. However, activities to address MDR-TB need to expand faster to meet needs in the Region.

Overcoming the challenges in all areas of TB control will require a further strengthening of efforts over the next five years. Currently, TB prevalence and mortality is declining by 4% annually. But that rate of decline must double to an annual average of 8% if the Region is to achieve its target for 2010—a reduction of the number of TB cases and deaths by one half as compared to the 2000 level. Mathematical modelling projections indicate the need to increase the case detection rate to more than 80%. In consultation with Member States, WHO developed the Strategic Plan for Tuberculosis Control in the Western Pacific Region, 2006–2010 to address future challenges. Consistent with the regional plan, seven countries in the Region with a high burden of tuberculosis have developed five-year national TB control plans.

TB-HIV. The TB-HIV coinfection has the potential to undermine gains made in tuberculosis control because of the high mortality rate of HIV-positive tuberculosis patients. The estimated prevalence of HIV in new adult tuberculosis patients is 13% in Cambodia, 3% in Viet Nam and 2.5% in Malaysia. The TB-HIV coinfection is reported to be on the rise in Papua New Guinea. The 2005 national estimates for China indicate a continuing rise in people with HIV/AIDS, pointing to a potential increase in the TB-HIV coinfection. WHO is assisting countries and areas to carry out TB-HIV collaborative activities based on TB and HIV: A framework to address TB/HIV coinfection in the Western Pacific Region. Cambodia has expanded TB-HIV collaborative activities, while Viet Nam is implementing such activities in several areas with high HIV prevalence. China has formulated a national framework for collaboration. All countries and areas, particularly those with a high and intermediate burden of tuberculosis, are being encouraged to monitor TB-HIV through HIV surveillance among tuberculosis patients. Responding to the need for skilled personnel, WHO organized an intercountry training-of-trainers workshop on TB-HIV in
February 2006 for countries of the Western Pacific and South-East Asia Regions.

**Human Resource Capacity.** WHO supported the attendance of participants from 14 countries in international tuberculosis training courses and conferences over the past year. WHO also assists countries in preparing proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria and in implementing, monitoring and evaluating approved projects. In 2005, tuberculosis proposals from Cambodia, China and the Philippines amounting to more than US$ 100 million over five years were approved by the Global Fund.

WHO has played an important role in raising awareness of tuberculosis and in the successful implementation of tuberculosis control activities in the Region. It also has been instrumental in strengthening partnerships and mobilizing resources for tuberculosis control.

Despite the achievements, current rates of progress in tuberculosis control are insufficient to halve tuberculosis mortality and prevalence by 2010. In the coming years, WHO’s assistance will be critical to countries and areas hoping to effectively implement their national plans as part of the effort to meet the regional goal.

**Leprosy.** Most countries and areas in the Western Pacific Region had eliminated leprosy as a public health problem by the end of 2000. With the exception of a few endemic pockets, a prevalence rate of less than 1 case per 10,000 people has been sustained.

In 2004, the most recent year for which statistics are available, 6195 new cases were reported in the Region. China and the Philippines registered more than 1000 cases each, while 22 countries and areas had less than 10 cases. Five countries and areas reported zero prevalence and detected no new cases.

Between 1996 and 2004, a total of 86 special projects were implemented covering about 42 million people in the Region and detecting 5241 cases. In 2005, WHO provided technical support to set up cost-effective post-elimination surveillance systems throughout Cambodia, in nearly one half of the provinces in Viet Nam, and in six areas in the Lao People’s Democratic Republic.

Technical support has been provided to Cambodia, China, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines and Viet Nam, which still have leprosy endemic pockets at provincial and district levels. Continuous technical support also has been extended to the Marshall Islands and the Federated States of Micronesia.

Continuous collaboration has been maintained with the partners involved in leprosy elimination activities in the Region. Coordination meetings with governments and nongovernmental organizations for leprosy elimination have been held in a number of Member States.

A biregional post-elimination strategy for leprosy, which was developed with the WHO South-East Asia Region, has been
distributed to Member States. The Strategy to Sustain Leprosy Services in Asia and the Pacific set out broad post-elimination activities. The Strategy was translated into Chinese, Japanese, Khmer and Vietnamese. Workshops were conducted for provincial coordinators in Cambodia and Viet Nam and are scheduled in other countries.

Leprosy elimination now must be sustained over the long term. This entails integrating leprosy services into general health services and providing technical support for the preparation of action plans for implementation of the Strategy in China, the Lao People’s Democratic Republic and Papua New Guinea during 2006. In addition, implementation of the Strategy must be phased in throughout the Region by 2010 and awareness campaigns must be sustained, particularly in the Pacific island countries and areas. Targeting interventions to mobile populations also is needed in a number of countries and areas.
Sexually Transmitted Infections, including HIV/AIDS

STI and HIV/AIDS. An estimated 1.5 million people in the Western Pacific Region were living with HIV/AIDS in 2005. AIDS claimed the lives of approximately 78,000 people in the Region during the year. In the two countries with generalized epidemics, HIV prevalence continues to decrease in Cambodia while it is on the rise in Papua New Guinea. The epidemic is growing in China, Malaysia and Viet Nam, where HIV infection is concentrated in populations with high-risk behaviours, such as injecting drug users and sex workers. Major risk factors are the sharing of syringes and needles among drug users and the failure of some sex workers and their clients to use condoms. Recent data on sexually transmitted infections show high prevalence rates in both low- and high-risk groups. These findings indicate a significant potential for the growth of the HIV epidemic. HIV prevention needs to include strategies for controlling the spread of sexually transmitted infections. A number of countries and areas continue to have inadequate surveillance systems. The stigma associated with HIV/AIDS and discrimination against those with the disease—sometimes in the health sector itself—remain as significant barriers limiting the expansion of HIV prevention and care programmes.

Cost-effective interventions—changing high-risk behaviour in groups with a high prevalence of HIV infection, promoting the use of clean needles and condoms, and expanding voluntary screening and referrals to care—could prevent most HIV infections. Until these proven interventions are carried out more widely, opportunities to reduce the spread of the HIV infection will be missed.


Throughout the Region, the 100% condom use programme that targets sex workers and their clients continues to expand in countries with HIV infections linked to sex work. WHO supported training in the 100% condom use programme in China, the Lao People’s Democratic Republic, the Philippines and Viet Nam. This strategy recently has been expanded in China to cover men who have sex with men. WHO has been supporting efforts to advocate social tolerance towards this group and also has provided technical support for targeted HIV prevention and care programmes in Beijing, Shanghai and Shenzhen. But there are still many barriers to an effective response among men who have sex with men in China, including the stigma often associated with their lifestyle and insufficient resources.

In the field of injecting drug use, the Biregional Harm Reduction Strategy 2005–2009 provides a framework for the development of expanded, evidence-based HIV prevention and care programmes in Beijing, Shanghai and Shenzhen. But there are still many barriers to an effective response among men who have sex with men in China, including the stigma often associated with their lifestyle and insufficient resources.
venues for substitution treatment, including methadone programmes. Needle and syringe exchanges will be available at some 1400 venues. Malaysia is pilot testing both methadone maintenance programmes and needle and syringe access projects in a number of different sites. The projects are expected to provide valuable information for the refinement and expansion of the programme.

“3 by 5” Initiative. This programme, intended to provide 3 million people in developing countries with antiretroviral therapy by the end of 2005, has contributed substantially to improving care and treatment in the four countries initially targeted in the Region—Cambodia, China, Papua New Guinea and Viet Nam. But many challenges remain. Better and more sustainable partnerships, as well as political and financial commitments from national bodies and their partners, should be strengthened. These efforts should include the growing involvement of people living with HIV/AIDS and local communities in all HIV/AIDS activities. As an example, in Papua New Guinea, national training involves doctors, nurses and people living with HIV/AIDS. This training uses a public health approach based on the principles of standardization, decentralization and integration. It covers the range of HIV/AIDS-related prevention, care and treatment issues—clinical staging, treatment of acute conditions and opportunistic infections, and antiretroviral treatment and palliative care. This approach supports a network model, with support for services provided at health centres and district hospitals by clinical mentors.

WHO also is providing technical support for procurement and logistical supply issues. The scarce supply of quality generic drugs due to insufficient global production is a risk that developing countries may soon face.

Universal Access. Following a commitment by the Group of Eight (G8) members, the goal of universal access to HIV/AIDS prevention, treatment and care by 2010 was subsequently endorsed by all Member States of the United Nations at the High-Level Plenary Meeting of the 60th session of the General Assembly. WHO has identified priority interventions that have the potential to significantly impact the pandemic. These priority interventions include: enabling people to know their HIV status through HIV testing and counselling; accelerating the scale-up of HIV/AIDS treatment and care; maximizing the health sector’s contribution to HIV prevention; taking urgent measures to strengthen and expand health systems; and investing in strategic information to guide a more effective response. In partnership with the Joint United Nations Programme on AIDS, a consultation on universal access was organized in December 2005 at the WHO Regional Office in Manila.

WHO and its Members States must strive to maintain a good balance between prevention and care programmes, and ensure that all vulnerable groups benefit from prevention and care services.

HIV infection can be passed from mother to her children

During pregnancy

During childbirth

Or while breastfeeding

Consult a qualified health worker for testing and counseling.

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2 G8 members are Canada, France, Germany, Italy, Japan, the Russian Federation, the United Kingdom of Great Britain and Northern Ireland, and the United States of America.
Avian Influenza. Outbreaks of highly pathogenic avian influenza A(H5N1) in poultry that began in Asia in mid-2003 have now been reported in other regions, including Europe, Africa and the Middle East. Despite progress in responding to avian influenza, outbreaks continue to occur. China reported its first human cases of avian influenza in November 2005. Between December 2003 and June 2006, 117 laboratory-confirmed human cases of A(H5N1), with a case fatality rate of approximately 50%, have been reported by Cambodia, China and Viet Nam. Human cases also have been reported from Azerbaijan, Egypt, Indonesia, Iraq, Turkey and Thailand.

WHO has been working very closely with the affected countries and areas, donor agencies, and other partners to provide technical and financial assistance in responding to outbreaks, including field epidemiology investigations, intensified surveillance, laboratory diagnostic confirmation, the implementation of aggressive control measures and information dissemination. With the world facing a continuously growing pandemic threat, an important meeting focusing on an early response to a potential influenza pandemic was jointly convened by WHO and the Government of Japan in Tokyo in January 2006. The meeting produced recommendations on preparations for rapid response and containment by Member States, WHO, and international and regional partners.

The possibility that other influenza virus subtypes may cause a pandemic cannot be ruled out, but A(H5N1) is presently the virus of greatest concern. WHO has made great efforts to accelerate influenza pandemic preparedness in the Region. For example, the Western Pacific Regional Office, in collaboration with Asia-Pacific Economic Cooperation (APEC), conducted pandemic preparedness assessments in 2005 to identify gaps in pandemic planning in Asian countries. Several national pandemic preparedness plans, including those from Cambodia, China, the Lao People’s Democratic Republic, Mongolia, Viet Nam and some Pacific island countries and areas, were reviewed. Additionally, interim infection control guidelines on avian influenza for health care facilities and an exercise development guide for validating influenza pandemic
preparedness plans are now available on the WHO Communicable Disease Surveillance and Response website.

Global efforts currently are focused on common actions to contain the spread of avian influenza. But it is clear that there also is a need to increase future defences against similar infectious disease outbreaks as well as other new threats and challenges in a planned and coordinated manner. The Asia Pacific Strategy for Emerging Diseases, a biregional strategy endorsed by the WHO Regional Committee for the Western Pacific at its fifty-sixth session in September 2005, is currently being used as a framework to strengthen the capacity of Member States in the Western Pacific and South-East Asia Regions with regard to emerging infectious diseases. The Strategy provides a means to meet the core capacity requirements for surveillance and response under the revised International Health Regulations (2005). A regional action plan to implement the Strategy is being developed. The First Meeting of the Technical Advisory Group on Emerging Infectious Diseases is planned for July 2006. WHO also has been working closely with other stakeholders and partners, including the Food and Agriculture Organization of the United Nations and the World Organization for Animal Health, to prevent and control zoonoses and to strengthen national and regional surveillance and laboratory capacity for communicable diseases.

The International Health Regulations (2005), adopted by the World Health Assembly in May 2005, provide a legal framework for protecting regional and global health security. WHO held its first workshop on the regulations and pandemic influenza preparedness in the Pacific in November 2005 in Fiji, with the participation of 19 Pacific island countries and areas. A guide for national policy-makers and partners is being developed to raise awareness of the new requirements and new opportunities under the International Health Regulations (2005). WHO technical assistance, including country visits to Fiji and Kiribati, is being provided to Member States to facilitate the effective implementation of the new regulations. In line with the core capacity requirements for surveillance and response contained in the regulations, early warning and response assessments were conducted in Cook Islands and Mongolia between June and August 2005.

WHO has been establishing, developing and maintaining partnerships with various donor agencies. The long-term strategy and midterm goals regarding communicable disease surveillance and response currently are being supported at both the regional and country levels by partners such as the Australian Agency for International Development, the United States Centers for Disease Control and Prevention, the Government of Japan, the Asian Development Bank, and other regional and international agencies.