WORLD HEALTH ORGANIZATION

REGIONAL COMMITTEE FOR THE WESTERN PACIFIC
FIFTIETH SESSION
Macao, 13-17 September 1999

REPORT OF THE REGIONAL COMMITTEE
SUMMARY RECORDS OF THE PLENARY MEETINGS

Manila
November 1999
WORLD HEALTH ORGANIZATION

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The fiftieth session of the Regional Committee for the Western Pacific was held in Macao, from 13 to 17 September 1999. Dr José Alarcão TRONI (Macao) and Dr Sodov SONIN (Mongolia) were elected Chairperson and Vice-Chairperson, respectively. Dr Louisa WOONTON (Niue) and Dr Phoukhong CHOMMALA (Lao People’s Democratic Republic) were the Rapporteurs.

The Regional Committee met from 13 to 17 September. The Report of the Regional Committee is in Part I of this document, on pages 3–6, the summary records of the plenary meetings are in Part II, on pages 47–219.
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PART I

REPORT OF THE REGIONAL COMMITTEE
I. INTRODUCTION AND SUMMARY

The fiftieth session of the Regional Committee for the Western Pacific was held in Macao from 13 to 17 September 1999. The session was attended by representatives of Australia; Brunei Darussalam; Cambodia; China; Cook Islands; Fiji; Hong Kong, China; Japan; Kiribati; the Lao People’s Democratic Republic; Macao; Malaysia; the Federated States of Micronesia; Mongolia; Nauru; New Zealand; Niue; the Republic of Palau; Papua New Guinea; the Philippines; the Republic of Korea; Samoa; Singapore; Solomon Islands; Tonga; Tuvalu; Vanuatu; and Viet Nam, and by representatives of France, Portugal, the United Kingdom of Great Britain and Northern Ireland and the United States of America as Member States responsible for areas in the Region.

Representatives of the Pacific Community, 20 nongovernmental organizations and an observer from Canada also attended.

At the opening ceremony the Chairman of the Organizing Committee, Dr José Alarcão Troni, welcomed the Regional Committee and other guests. The Regional Director and the Chairman of the Regional Committee, Dr Margaret Chan (forty-ninth session) expressed their appreciation to the Government of Macao for hosting the fiftieth session of the Regional Committee. His Excellency, General Vasco Rocha Vieira, Governor of Macao, welcomed the members of the Committee and other guests. He explained that Macao, which would become a Special Administrative Region of the People’s Republic of China on 20 December 1999, would continue to be represented on the Regional Committee after that date as Macao, China.

At the first plenary meeting, the Committee elected the following officers:

Chairperson: Dr José Alarcão Troni (Macao)
Vice-Chairperson: Dr Sodov Sonin (Mongolia)
Rapporteurs
in English: Dr Louisa Woonton (Niue)
in French: Dr Phoukhong Chommala (Lao People’s Democratic Republic)
At the first meeting, the Committee also heard an address by the Regional Director in which he outlined the Organization’s guiding principles in the Region as contained in his document *WHO in the Western Pacific Region: a framework for action*. The Report of the Regional Director on the Work of WHO during the period 1 July 1998 to 30 June 1999 was then presented to the Committee, which discussed both the Regional Director’s address and his report at the first and second meetings. Representatives were supportive of the proposals outlined in the Regional Director’s address and his *Framework for action* and noted with appreciation the improvements that had been made to the report. The Committee therefore endorsed the *Framework for action*, requested Member States and the Regional Director to work together in implementing the budget for 2000–2001 in line with the themes and focuses proposed in the *Framework for action* and requested the Regional Director to continue to make improvements to his report (resolution WPR/RC50.R3).

Following the conclusion of the discussion of these two items at the second meeting, the Regional Committee turned to the programme budget. The discussion began with the interim report on the 1998–1999 programme budget. The Regional Director explained that, as at 31 August, 81% of the regular budget had been implemented. At the third and fourth meetings, the Committee reviewed the Regional Director’s proposal for country allocations in the proposed programme budget for 2002–2003 and beyond. The Committee supported the Regional Director’s proposal that 60% of the country planning figure should be determined in accordance with the model recommended by resolution WHA51.31, with allocation of the remaining 40% to be determined by the Regional Director, taking into account certain specified considerations. The Committee asked the Regional Director to forward its views to the Director-General (resolution WPR/RC50.R1).

The third meeting also discussed the annual reports on eradication of poliomyelitis and sexually transmitted infections, HIV infection and AIDS. Regarding the eradication of poliomyelitis, the Committee heard that, subject to the approval of the Regional Commission for the Certification of Poliomyelitis, the Region could be declared poliomyelitis-free in 2000. It urged Member States to provide documentation to the Regional Commission in order to bring that about (resolution WPR/RC50.R2). When the Committee came to examine the situation of sexually transmitted infections, HIV infection and AIDS, it noted the success of condom promotion and health education programmes and requested the Regional Director to further strengthen technical cooperation with Member States, including guidance on developing legislation (resolution WPR/RC50.R4).
The Committee’s discussion on AIDS, HIV infection and sexually-transmitted infections was concluded at the fourth meeting. That meeting also examined tuberculosis prevention and control. The Committee noted that there had been a steady increase in the number of tuberculosis cases in the Region over the last decade. It therefore declared a “tuberculosis crisis” in the Western Pacific Region and requested both Member States and the Regional Director to give high priority to tuberculosis control. In particular, it asked the Regional Director to make “Stop TB in the Western Pacific Region” a special project of WHO in the Region (resolution WPR/RC50.R5).

On the Wednesday afternoon of the session, the Regional Committee heard a technical briefing from the Government of Macao on “Health sector development in Macao: present and future”. This was followed by a ministerial round table on “Social safety nets in health sector development”.

The Committee’s discussion on tuberculosis prevention and control was continued at the fifth meeting. At that meeting the Committee also discussed hepatitis and related diseases, noting that hepatitis B carrier rates in some countries and areas of the Region were among the highest in the world.

The Committee discussed the Action Plan on Tobacco or Health at its fifth and sixth meetings. Implementation of the 1995–1999 Action Plan was reviewed and the Committee endorsed the 2000–2004 Regional Action Plan, with a number of amendments (resolution WPR/RC50.R6).

At the sixth meeting, the Committee also discussed health research in the Region and endorsed the recommendations of the Western Pacific Advisory Committee on Health Research (resolution WPR/RC50.R7). The report of the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation on criteria for candidates and selection methods and procedures for nomination of the Regional Director was also examined at this meeting. The Committee decided to accept the Sub-Committee’s proposed list of criteria for candidates for the post and its recommendation that the existing selection methods and procedures for nominating the Regional Director should be retained (resolution WPR/RC50.R8).
Before the Regional Committee’s discussion on technical briefings and ministerial round tables, the Moderator of the previous day’s roundtable presented a brief summary of the discussion. With regard to the wider question of the role of such round tables at future sessions, the Committee adopted a resolution on the method of work of the Regional Committee which decided: to make ministerial round tables a regular agenda item at future sessions; to discontinue technical briefings; to establish a working group on the method of the work of the Regional Committee; and to implement the recommendations of the working group at the fifty-first session, bearing in mind comments received from Members prior to the session (resolution WPR/RC50.R9). Following its review of the report on infant and young child nutrition and implementation of the International Code of Marketing of Breast-milk Substitutes, the Committee urged Member States to intensify efforts to improve infant and young child nutrition in the Region and asked the Regional Director to expand cooperation with Member States in this regard (resolution WPR/RC50.R10). The Regional Committee ended the sixth meeting by examining the strategic plan for the development of information systems in the Western Pacific Region.

At its seventh session, the Regional Committee heard an address from the Director-General, delivered on her behalf by the Regional Director. Regarding future sessions, it decided that the dates of the fifty-first session in Manila, the Philippines, should be from 18 to 22 September 2000 and accepted the invitation of the Government of Brunei Darussalam to act as host to the fifty-second session of the Regional Committee in 2001 (resolution WPR/RC50.R11). The regional implications of resolutions and decisions of the Fifty-second World Health Assembly and the WHO Executive Board at its 103rd and 104th sessions were then discussed. The Committee then selected China to serve on the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction (decision WPR/RC50(1)) and the Philippines to serve on the Management Advisory Committee on Essential Drugs and Other Medicines (decision WPR/RC50(2)). At the conclusion of the session the Committee thanked the Government of Macao for the excellent arrangements that had been made for the session (resolution WPR/RC50.R12).
II.  RESOLUTIONS AND DECISIONS ADOPTED BY THE REGIONAL COMMITTEE


The Regional Committee,

Recalling resolution WHA51.31 which recommended that regular budget allocations to regions should, for the most part, be guided by a model based upon an index;

Recognizing that the model recommended by resolution WHA51.31 to determine regional allocations appears to provide a reasonable basis for determining country planning figures within the Western Pacific Region;

Noting, however, the difficulties in applying the model in a mechanical manner;

Recognizing the need for a global approach to the way WHO determines budget allocations to countries, which takes into account regional differences in the health needs of individual countries;

1.  THANKS the Regional Director for his comprehensive report on the current method and process for determining country allocations and alternative ways of determining such allocations, including the possibility of using an index, which would allow the determination of individual country planning figures to be more objective;

2.  REQUESTS the Regional Director to use the following guiding principles when deciding the country allocations in the programme budget for 2002–2003 and beyond:

   60% of the country planning figure should be determined in accordance with the model recommended by resolution WHA51.31, with allocation of the remaining 40% to be determined by the Regional Director, in the course of preparing the proposed budget, taking into account the following considerations:

   (1) The difference between the allocation for 2000–2001 and the new allocation should be adjusted over three bienniums;

   (2) An adjustment should be made to ensure that least developed countries should not receive a lower allocation in 2002–2003 than they did in 2000–2001;

   (3) The possibility of a minimum allocation should be considered for countries and areas which would have received zero allocation if the model recommended by resolution WHA51.31 were applied;

   (4) The specific health needs of individual countries should be taken into account;
3. FURTHER REQUESTS the Regional Director to forward this resolution to the Director-General as representing Regional Committee for the Western Pacific’s preferred method of determining country allocations in future programme budgets.

WPR/RC50.R2 ERADICATION OF POLIOMYELITIS IN THE REGION

The Regional Committee,

Having considered the progress report of the Regional Director on the eradication of poliomyelitis in the Region;¹

Acknowledging the achievements made by Member States in sustaining high-quality surveillance for acute flaccid paralysis (AFP) and polioviruses;

Noting that the last reported case of poliomyelitis had onset of illness on 19 March 1997;

Noting further that, if all countries provide adequate documentary evidence consistent with the absence of wild poliovirus for three years under conditions of high quality surveillance, subject to the decision of the Regional Certification Commission, the Region can be declared poliomyelitis-free in 2000;

Noting further that the task of poliomyelitis eradication will not be complete until all potential sources of polioviruses, including laboratory sources, are properly contained;

1. URGES all Member States:

   (1) to ensure that the documentation for certification that is provided to the Regional Certification Commission will be of the highest possible quality;

   (2) to maintain the highest possible quality of AFP and virological surveillance;

   (3) to continue routine immunization coverage, together with supplementary immunization in high-risk areas, until global certification is achieved;

2. THANKS the international partners who have generously supported poliomyelitis eradication in the past year, particularly UNICEF, the governments of Australia, Japan, the Republic of Korea, the United States of America, Rotary International, and Rotary International Districts 2640 and 2650 of Japan, and other nongovernmental organizations;

3. REQUESTS the Regional Director to work closely with countries:

   (1) to ensure that substantial progress towards level 1 of laboratory containment of wild polioviruses and potentially infectious material is attained for regional certification;

¹ Document WPR/RC50/6.
(2) to ensure that external support is available to sustain surveillance and supplementary immunization until global certification is achieved and beyond, if necessary.

Fourth meeting, 15 September 1999
WPR/RC50/SR/4

WPR/RC50.R3 REFORM IN THE WESTERN PACIFIC REGION

The Regional Committee,

Having considered the document *WHO in the Western Pacific Region: a framework for action*¹ as a set of guiding principles for WHO’s work in the Western Pacific Region in the early years of the 21st century;

Acknowledging that the reforms described in the *Framework for action* will affect how the budget for the 2000–2001 biennium is implemented;

Having also considered the report of the Regional Director entitled *The Work of WHO in the Western Pacific Region: 1 July 1998 – 30 June 1999*;²

Noting with appreciation the improvements that have been made to the report of the Regional Director, in particular to its analytical and statistical content;

Recalling resolution WPR/RC47.R3 and recognizing that, in view of the improved analytical content of the report, there is no longer a need for an in-depth review of a selected issue;

1. **ENDORSES** the document *WHO in the Western Pacific Region: a framework for action*;

2. **APPROVES** of the changes that have been made to the report of the Regional Director;

3. **REQUESTS** Member States:

   (1) to work with WHO in implementing the Organization’s programme of technical cooperation in line with the approaches described in *WHO in the Western Pacific Region: a framework for action*;

   (2) in collaboration with WHO, to implement their country budgets for 2000–2001 taking into account the themes and focuses proposed in the *Framework for action*;

¹ Document WPR/RC50/2.
² Document WPR/RC50/3.
4. REQUESTS the Regional Director:

(1) to work closely with Member States to implement the approaches outlined in the *Framework for action*, with particular attention to least developed countries;

(2) in collaboration with Member States, to implement the programme budget for 2000–2001 in line with the themes and focuses proposed in the *Framework for action*;

(3) to continue to make improvements to the report of the Regional Director to ensure that it reflects the health situation in the Region as well as the themes and focuses proposed in the *Framework for action*, and that it includes a critical analysis and evaluation of WHO’s programmes with Member States;

(4) to discontinue the practice of including an in-depth review of a selected issue as Part 2 of the report.

Fifth meeting, 16 September 1999
WPR/RC50/SR/4

WPR/RC50.R4 SEXUALLY TRANSMITTED INFECTIONS, HIV INFECTION AND AIDS

The Regional Committee,

Having considered the annual report on sexually transmitted infections (STIs), HIV infection and AIDS;¹

Noting the expected increase in HIV infections and AIDS cases in the Region, and the potential impact on people and health systems;

Noting the initial successes of condom promotion and health education programmes targeting commercial sex workers and their clients in selected countries of the Region;

Acknowledging that antiretroviral therapies might have a role in treatment of AIDS patients, in post-exposure prophylaxis, and in reduction of mother-to-child transmission, but that their role will be limited by current costs, among other factors;

1. URGES Member States:

(1) to further strengthen STI and HIV prevention and control programmes, particularly condom promotion and health education programmes targeting commercial sex workers, their clients, and youth at risk, and harm reduction programmes targeting injecting drug users;

(2) to secure political commitment and to mobilize additional resources for these programmes within an integrated approach;

¹ Document WPR/RC50/7.
(3) to strengthen the epidemiological surveillance of STIs, HIV infection, AIDS and related bloodborne infections;

2. REQUESTS the Regional Director:

(1) to further strengthen technical collaboration with Member States, in particular those facing increasing numbers of infections, in the prevention and control of STIs and HIV/AIDS, including guidance on developing appropriate legislation, and to strengthen the technical capability within WHO;

(2) to continue to improve the regional surveillance system for STIs, HIV, AIDS and related bloodborne infections;

(3) to continue to strengthen WHO participation in UNAIDS theme group activities at country level, and coordination with UNAIDS at regional and national levels;

(4) to encourage and facilitate the exchange of social and behavioural research to enable prevention measures to be targeted more effectively;

(5) to continue to identify and mobilize resources for STI and HIV/AIDS activities in collaboration with other partners;

(6) to continue to report annually to the Regional Committee on the situation of STIs and HIV/AIDS in the Region and on collaboration with UNAIDS.

Fifth meeting, 16 September 1999
WPR/RC50/SR/5

WPR/RC50.R5 TUBERCULOSIS PREVENTION AND CONTROL

The Regional Committee,

Noting that tuberculosis kills more youths and adults than any other infectious disease in the world;

Noting further that tuberculosis is re-emerging as a major public health problem in the Region, as demonstrated by the steady increase in notified tuberculosis cases during the last decade and the fact that 29% of global tuberculosis cases are found in the Western Pacific Region;

Noting that political commitment has not yet been translated into increased resources for tuberculosis control;

Recognizing that tuberculosis has far-reaching socioeconomic impacts, especially in developing countries, because the disease mainly affects the poor and people of productive age;

Recognizing further that tuberculosis is also a serious public health problem in newly industrialized and developed countries;
Acknowledging that the directly-observed treatment, short course (DOTS) strategy is the most cost-effective way of controlling tuberculosis, saving the lives of patients and preventing the emergence of drug resistance;

Expressing concern that only 46% of notified tuberculosis cases in the Region were enrolled in DOTS programmes in 1998;

Expressing further concern at the negative impact of HIV on tuberculosis in some countries of the Region;

1. DECLARES a ‘Tuberculosis crisis’ in the Western Pacific Region;

2. URGES Member States:

   (1) to give high priority, and to allocate sufficient resources, to strengthening tuberculosis control;

   (2) to aim to increase the percentage of tuberculosis patients enrolled in DOTS programmes so that the regional targets of 60% of notified cases to be treated by DOTS by 2001 and 100% by 2005 are achieved;

   (3) to achieve and maintain a cure rate of at least 85% by ensuring high-quality DOTS implementation, as a minimum;

   (4) to implement surveillance for drug-resistant tuberculosis by 2001;

   (5) to establish regular surveillance and reporting of the impact of HIV on tuberculosis by 2001, if this is appropriate;

3. REQUESTS the Regional Director:

   (1) to give tuberculosis control high priority and to make “Stop TB in the Western Pacific Region” a special project of the Western Pacific Regional Office;

   (2) to take all possible steps to raise awareness of the tuberculosis problem based on evidence from epidemiological studies and cost-benefit and socioeconomic analysis and to take all necessary measures to influence leading political figures to translate political commitment into increased financial resources;

   (3) to strengthen technical collaboration with Member States in order to introduce and expand the DOTS strategy in the Region in the context of health sector reform and poverty alleviation;

   (4) to strengthen partnerships with other technical and funding agencies in the Western Pacific Region;

   (5) to report annually on progress in tuberculosis control to the Regional Committee.

Seventh Meeting, 17 September 1999
WPR/RC50/SR/7
The Regional Committee,

Recalling resolution WPR/RC48.R10;

Having reviewed the report of the Regional Director on the progress made in implementing the Action Plan on Tobacco or Health 1995–1999;¹

Acknowledging the progress that has been made in understanding the impact of tobacco use on public health;

Noting the growing burden of disease and death caused by tobacco in the Western Pacific Region and the urgency of controlling its use;

Recognizing that the burden of tobacco use is a matter of public health policy and not just a matter of personal choice;

Noting that multisectoral involvement is crucial to effective tobacco control;

Noting the need for a balance between international and national tobacco control initiatives;

1. ENDORSES the Regional Action Plan on Tobacco or Health 2000–2004 with amendments as specified in the summary record;

2. URGES Member States:

(1) to develop comprehensive National Plans of Action for Tobacco Control consistent with the Regional Action Plan on Tobacco or Health 2000–2004;

(2) to provide long-term support for the development and implementation of National Plans of Action for Tobacco Control;

(3) to promote and fully support the development and adoption of the international Framework Convention on Tobacco Control and to respond favourably to the invitation of the Director-General of WHO to participate in the global Working Group established to facilitate development and implementation of the international Framework Convention;

(4) to mobilize and coordinate the involvement of government departments in the above-stated activities; and

(5) to report to WHO at regular intervals on progress made in their national efforts to control tobacco use;

¹ Document WPR/RC50/11.
3. REQUESTS the Regional Director:

   (1) to support Member States in implementing the Regional Action Plan on Tobacco or Health 2000–2004;

   (2) to strongly support the Tobacco Free Initiative in the Western Pacific Region at a level that is sufficient to sustain the special emphasis initiated in 1999;

   (3) to advocate the development and adoption of the international Framework Convention on Tobacco Control;

   (4) to support national Focal Persons and Member States in building capacity for tobacco control;

   (5) to make good use of all opportunities to encourage the involvement of Member States in the Tobacco Free Initiative; and

   (6) to report to Member States at regular intervals on progress made in implementing the Regional Action Plan on Tobacco or Health 2000–2004.

Seventh Meeting, 17 September 1999
WPR/RC50/SR/7

WPR/RC50.R7 DEVELOPMENT OF HEALTH RESEARCH

The Regional Committee,

Having considered the report of the Regional Director on the development of health research;¹

Recalling resolution WPR/RC48.R7 on the development of health research;

1. ENDORSES the recommendations of the Western Pacific Advisory Committee on Health Research (WPACHR) at its seventeenth session;

2. URGES Member States:

   (1) to undertake research in priority areas identified in the Strategic plan for health research in the Western Pacific Region, 1997–2001, in accordance with their national health needs, and to disseminate results which can immediately be applied for policy-making;

   (2) to establish a national focal point to coordinate and manage health research activities, if this does not already exist;

3. REQUESTS the Regional Director, to do his utmost:

   (1) to implement the WPACHR recommendations;

¹ Document WPR/RC50/12.
(2) to continue to support individual and group research training activities;

(3) to support research proposals in priority areas;

(4) to disseminate the findings of the research projects; and

(5) to continue to support efforts to improve the communication between research agencies and the use of the Strategic plan in the Region.

Seventh Meeting, 17 September 1999
WPR/RC50/SR/7

WPR/RC50.R8 CRITERIA FOR CANDIDATES AND SELECTION METHODS AND PROCEDURES FOR NOMINATION OF THE REGIONAL DIRECTOR: REPORT OF THE SUB-COMMITTEE OF THE REGIONAL COMMITTEE ON PROGRAMMES AND TECHNICAL COOPERATION

The Regional Committee,

Recalling resolution WPR/RC49.R7;

Having considered the Report of the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation on Criteria for Candidates and Selection Methods and Procedures for Nomination of the Regional Director;¹

Noting the Sub-Committee’s conclusion that listing criteria for candidates for the post of Regional Director for the Western Pacific would help to clarify the personal commitment, qualifications and skills needed for the position;

Noting also the Sub-Committee’s view that a search committee would be time-consuming and expensive;

Recognizing that a statement by the Regional Committee would clarify the principles governing campaigning;

1. THANKS the Sub-Committee for its work;

2. RESOLVES that the candidate nominated by the Regional Committee for the post of Regional Director should have:

   (1) a strong technical and public health background and extensive experience in international health;

   (2) competency in organizational management;

¹ Document WPR/RC50/19.
(3) evidence of public health leadership;

(4) sensitivity to cultural, social and political differences;

(5) a strong commitment to the work of WHO;

(6) the good physical condition required of all staff members of the Organization; and

(7) sufficient skill in at least one of the working languages of the Regional Committee;

3. DECIDES to retain the current selection methods and procedures for nomination of the
Regional Director;

4. AFFIRMS that campaigns for elective office in the Western Pacific Region should be
open and fair, and based on the merits of the individual candidates.

Seventh Meeting, 17 September 1999
WPR/RC50/SR/7

WPR/RC50.R9

METHOD OF WORK OF THE REGIONAL COMMITTEE

The Regional Committee,

Noting the Regional Director’s objective, expressed in WHO in the Western Pacific
Region: a framework for action,¹ to make sessions of the Regional Committee more
outcome-oriented and less formal;

Recalling resolution WPR/RC48.R6, which requested the Regional Director to
continue to hold technical briefings in conjunction with the Regional Committee;

Noting that ministerial round tables can contribute to achieving the Regional Director’s
goal of making sessions of the Regional Committee more participatory;

Noting further that the lasting value of ministerial round tables would be enhanced if
they became a part of sessions of the Regional Committee;

Recognizing that the ministerial round table at the fiftieth session of the Regional
Committee provided many valuable insights for both Member States and WHO;

1. CONGRATULATES the Regional Director on the arrangements at the ministerial
round table;

2. DECIDES:

   (1) to make ministerial round tables a regular agenda item at sessions of the Regional
   Committee;

¹ Document WPR/RC50/2.
(2) to discontinue technical briefings with effect from the fifty-first session of the Regional Committee;

3. REQUESTS the Regional Director:

   (1) to make further reforms to the method of work of the Regional Committee to make the meetings less formal and more interactive and to establish a working group to make recommendations in this regard;

   (2) to circulate the findings of this working group to Members of the Regional Committee before its fifty-first session;

   (3) to arrange ministerial round tables on topics of contemporary relevance as a part of future sessions of the Regional Committee;

4. AUTHORIZES the Regional Director to implement the recommendations of the working group at the fifty-first session of the Regional Committee, bearing in mind comments received from Members prior to the session.

Seventh Meeting, 17 September 1999
WPR/RC50/SR/7


The Regional Committee,

Recalling resolutions WHA49.15 and WPR/RC48.R8;

Having reviewed the report of the Regional Director on infant and young child nutrition and implementation of the International Code of Marketing of Breast-milk Substitutes;¹

Acknowledging in particular the cooperation between WHO and other organizations in the field of nutrition, aimed at developing national plans of action for nutrition, including the promotion of breast-feeding;

Noting with satisfaction the increasing number of countries reporting on infant and young child nutrition, the continued expansion of the baby-friendly hospital initiative, and the introduction of breast-feeding counselling training in the curriculum of midwives;

Concerned that, notwithstanding the measures initiated by an increasing number of Member States to support the aim of the International Code, parts of the Code are frequently not complied with in some countries and areas;

¹ Document WPR/RC50/13.
Recognizing the growing need for support to working women who breast-feed, in view of the increased female participation in the workforce;

Recognizing further the lack of adequate information on child feeding practices in the first two years of life and the need for special consideration of HIV-infected mothers;

1. URGES Member States:

   (1) to intensify efforts directed towards the improvement of infant and young child nutrition, in particular support for the baby-friendly hospital initiative and the establishment and strict implementation of measures to give effect to the International Code of Marketing of Breast-milk Substitutes;

   (2) to increase and diversify support offered to working mothers in order to encourage breast-feeding, including collaboration between Ministries of Health and Ministries of Labour to improve maternity legislation for working mothers;

   (3) to expand training on breast-feeding counselling, making it an essential part of the curricula of midwives and other health workers, rather than only a part of in-service training;

   (4) to ensure that advice on good feeding practices in the first two years of life is made available to mothers, other child caretakers and policy-makers;

   (5) to report to WHO at regular intervals on progress made in their national efforts;

2. REQUESTS the Regional Director:

   (1) to expand cooperation with Member States in the above-mentioned activities;

   (2) to promote collaboration between Ministries of Health and Labour to improve maternity legislation for women in the workforce;

   (3) to explore additional ways of promoting breast-feeding;

   (4) to continue to expand the baby-friendly hospitals initiative, to include a greater focus on the needs of mothers; and

   (5) to disseminate updated WHO recommendations on feeding practices for infants of HIV-infected mothers.

Seventh Meeting, 17 September 1999
WPR/RC50/SR/7

WPR/RC50.R11       FIFTY-FIRST AND FIFTY-SECOND SESSIONS OF THE REGIONAL COMMITTEE

The Regional Committee,

1. DECIDES that the dates of the fifty-first session shall be from 18 to 22 September 2000;
2. CONFIRMS that the fifty-first session of the Regional Committee shall be held at the regional headquarters in Manila;

3. EXPRESSES its appreciation to the Government of Brunei Darussalam for its offer to act as host to the fifty-second session of the Regional Committee in 2001;

4. ACCEPTS the invitation of the Government of Brunei Darussalam provided a satisfactory agreement can be concluded between the Government and WHO by 31 March 2001.

WPR/RC50.R12 RESOLUTION OF APPRECIATION

The Regional Committee,

EXPRESSES its appreciation and thanks to:

1. the Government of Macao for:
   (1) hosting the fiftieth session of the Regional Committee in Macao;
   (2) the excellent arrangements and facilities provided;
   (3) the generous welcome and hospitality received;
   (4) the informative and well-presented technical briefing;

2. the Chairman, Vice-Chairman and the Rapporteurs elected by the Committee;

3. the Moderator of the ministerial round table;

4. the representatives of the nongovernmental organizations for their oral and written statements.
DECISIONS

WPR/RC50(1) SPECIAL PROGRAMME OF RESEARCH DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION: MEMBERSHIP OF THE POLICY AND COORDINATION COMMITTEE

The Regional Committee, noting that the period of tenure of the representative of the Government of Singapore on the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction expires on 31 December 1999, selects China to nominate a representative to serve on the Policy and Coordination Committee for a period of three years from 1 January 2000 to 31 December 2002.

(Seventh Meeting, 17 September 1999)

WPR/RC50(2) ESSENTIAL DRUGS AND OTHER MEDICINES: MEMBERSHIP OF THE MANAGEMENT ADVISORY COMMITTEE

The Regional Committee, noting that the period of tenure of Mongolia on the Management Advisory Committee on Essential Drugs and Other Medicines expires on 31 December 1999, selected the Philippines to nominate a representative to serve on the Management Advisory Committee for a period of three years from 1 January 2000 to 31 December 2002.

(Seventh Meeting, 17 September 1999)
AGENDA

1. Opening of the session

2. Address by the retiring Chairperson

3. Election of new officers: Chairperson, Vice-Chairperson and Rapporteurs

4. Address by the incoming Chairperson

5. Adoption of the agenda

   WPR/RC50/1 Rev.2 and WPR/RC50/1 (Annotated) Rev.1

6. Address by the Director-General

7. “Getting the Job Done Together”, Address by the Regional Director

   WPR/RC50/2

8. Report of the Regional Director

   WPR/RC50/3

9. Programme budget


   WPR/RC50/4


   WPR/RC50/5

10. Eradication of poliomyelitis in the Region: progress report

    WPR/RC50/6
Annex 1

11. Annual report on sexually transmitted infections, HIV infection and AIDS

WPR/RC50/7

12. Tuberculosis prevention and control

WPR/RC50/8

13. Hepatitis and related diseases

WPR/RC50/9

14. Technical briefings and ministerial round tables

WPR/RC50/10

15. Action Plan on Tobacco or Health

WPR/RC50/11

16. Development of health research

WPR/RC50/12

17. Infant and young child nutrition and implementation of the International Code of Marketing of Breast-milk Substitutes

WPR/RC50/13

18. Strategic plan for the development of information systems in the Western Pacific Region

WPR/RC50/14

19. Working relations with nongovernmental organizations

WPR/RC50/15
20. Regional implications of resolutions and decisions of the Fifty-second World Health Assembly and the WHO Executive Board at its 103rd and 104th sessions

   WPR/RC50/16

21. Membership from the Western Pacific Region in Global Committees

   21.1 Special Programme of Research, Development and Research Training in Human Reproduction: Membership of the Policy and Coordination Committee

   WPR/RC50/17

   21.2 Essential Drugs and Other Medicines: Membership of the Management Advisory Committee

   WPR/RC50/18

22. Sub-Committee of the Regional Committee on Programmes and Technical Cooperation: Report on criteria for candidates and selection methods and procedures for nomination of the Regional Director

   WPR/RC50/19

23. Time and place of the fifty-first and fifty-second sessions of the Regional Committee

24. Closure of the session
## LIST OF REPRESENTATIVES

### I. REPRESENTATIVES OF MEMBERS

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Position/Title</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUSTRALIA</strong></td>
<td>Professor Judith Whitworth</td>
<td>Director</td>
<td>Tel.: (612) 6249 2597</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fax: (612) 6249 2337</td>
</tr>
<tr>
<td></td>
<td>John Curtin School of Medical</td>
<td></td>
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<td>Research</td>
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<td>Canberra A.C.T.</td>
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<td>Tel.: (612) 6249 8848</td>
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<td>Fax: (612) 6289 7087</td>
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<tr>
<td></td>
<td>Professor Richard Smallwood</td>
<td>Chief Medical Officer (designate)</td>
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<td>Commonwealth Department of Health</td>
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<tr>
<td></td>
<td>Ms Joanna Davidson</td>
<td>Assistant Secretary</td>
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<td>Policy and International Branch</td>
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<td></td>
<td>Ms Lesley Paton</td>
<td>Director</td>
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<tr>
<td><strong>BRUNEI</strong></td>
<td>Pehin Abdul Aziz Umar</td>
<td>Acting Minister of Health</td>
<td>Tel.: (6732) 381 640</td>
</tr>
<tr>
<td><strong>DARUSSALAM</strong></td>
<td></td>
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<td>Fax: (6732) 381 440</td>
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(Chief Representative)
Annex 2

**BRUNEI DARUSSALAM**
(continued)

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Details</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Dr Haji Abdul Latif Ibrahim</td>
<td>Director of Medical and Health Services</td>
<td>Tel.: (6732) 382 031 Fax: (6732) 380 687</td>
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<tr>
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<tr>
<td>Dr Hajah Kalsom Abdul Latif</td>
<td>Acting Assistant Director of Medical and Health Services</td>
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<td>Hj Mahdi Hj Abd Rahman</td>
<td>Senior Administrative Officer</td>
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<td>Hjh Fatmah PJDSMSDU (Dr) Hj Md Jamil</td>
<td>Senior Public Relations Officer</td>
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<td>Hjh Norsiah Hj Johari</td>
<td>Special Duties Officer</td>
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**CAMBODIA**

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<th>Name</th>
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<tbody>
<tr>
<td>Dr Hong Sun Huot</td>
<td>Senior Minister and Minister of Health</td>
<td>Tel.: (855) 12 833 131 Fax: (855) 23 725 833</td>
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### CAMBODIA (continued)

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<th>Name</th>
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<tr>
<td>Dr Char Meng Chuor</td>
<td>Acting Director of Planning Ministry of Health Phnom Penh</td>
<td>(855) 15 850 879</td>
<td>(855) 23 880 407</td>
</tr>
<tr>
<td>Dr Youk Sambath</td>
<td>Deputy Director of Finance Ministry of Health Phnom Penh</td>
<td>(855) 23 880 406</td>
<td>(855) 23 880 407</td>
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### CHINA

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<th>Name</th>
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<tr>
<td>Dr Zhang Wenkang</td>
<td>Minister of Health Beijing</td>
<td>(8610) 6879 2030</td>
<td>(8610) 6879 2024</td>
</tr>
<tr>
<td>Mr Liu Peilong</td>
<td>Director-General Department of International Cooperation Ministry of Health Beijing</td>
<td>(8610) 6879 2281</td>
<td>(8610) 6879 2442</td>
</tr>
<tr>
<td>Dr Li Changming</td>
<td>Director General Department of Community Health and MCH Ministry of Health Beijing</td>
<td>(8610) 6879 2301</td>
<td>(8610) 6879 2321</td>
</tr>
<tr>
<td>Ms Wang Yuxun</td>
<td>Director Division of Planning and Price Department of Planning and Finance Ministry of Health Beijing</td>
<td>(8610) 6879 1252</td>
<td>(8610) 6879 1257</td>
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### Annexe 2

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<tr>
<th>CHINA (continued)</th>
<th>Dr Sun Xinhua</th>
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<td>Dr Qi Qingdong</td>
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<td>Dr Wang Liji</td>
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<td>Mr Ren Minghui</td>
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### COOK ISLANDS

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<tr>
<th>Mr Norman George</th>
<th>(Chief Representative)</th>
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<td>Deputy Prime Minister and Minister of Health</td>
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<tr>
<td>Rarotonga</td>
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<tr>
<td>Tel.: (682) 20266</td>
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<tr>
<td>Fax: (682) 24684</td>
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<tr>
<td>Dr Teariki Tamarua</td>
<td>(Alternate)</td>
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<tr>
<td>Secretary of Health</td>
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<td>Tel.: (682) 29664</td>
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<td>Fax: (682) 23109</td>
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</table>
| FIJI    | Dr Isimeli Cokanasiga | Minister for Health | Suva  
Tel.: (679) 306 177  
Fax: (679) 306 163 |
|         | Mr Luke Rokovada | Permanent Secretary for Health | Suva  
Tel.: (679) 306 177  
Fax: (679) 306 163 |
|         | Dr Asinate Boladuadua | Director | Primary and Preventive Health Services  
Suva  
Tel.: (679) 306 177  
Fax: (679) 306 163 |
| FRANCE  | M. Akusitino Manouhalalo | Membre du Gouvernement | Nouméa  
Nouvelle-Calédonie  
Tél.: (687) 24 37 00  
Fax: (687) 24 37 02 |
|         | Dr Patrick Tahiata Howell | Ministre de la Santé, de la Recherche et Porte Parole du Gouvernement | Polynésie française  
Tél.: (689) 46 00 99  
Fax: (689) 43 39 42 |
|         | Dr Dominique Marghem | Directeur adjoint à la Direction de la Santé | Polynésie française  
Tél.: (689) 46 00 02  
Fax: (689) 43 00 74 |
Annex 2

FRANCE (continued)  
Dr Jean-Paul Grangeon  
Médecin Inspecteur territorial de la Santé  
Nouméa, Nouvelle-Calédonie  
Tél.: (687) 24 37 00  
Fax: (687) 24 37 02

(M. Henri Roux  
Conseiller pour les Affaires sociales  
Ambassade de France à Singapour  
89 Neil Road  
Singapour 088849  
Tél.: (65) 326 06 58  
Fax: (65) 227 58 47

(M. Eric de Roodenbeke  
Chargé de Mission  
Ministère des Affaires Etrangères – Bureau Santé  
20 rue Monsieur 75700 Paris 07SP  
Tél.: (33-1) 53 69 3186  
Fax: (33-1) 53 69 3719

HONG KONG, CHINA  
Dr Margaret Chan  
Director of Health  
Department of Health  
The Government of the Hong Kong Special Administrative Region  
Hong Kong  
Tel.: (852) 2961 8888  
Fax: (852) 2836 0071

(Miss Angela Luk  
Principal Assistant Secretary for Health and Welfare (Medical)  
Health and Welfare Bureau  
The Government of the Hong Kong Special Administrative Region  
Hong Kong  
Tel.: (852) 2973 8103  
Fax: (852) 2840 0467
HONG KONG, CHINA  
(continued)  

Dr K.H. Mak  
Consultant (Community Medicine)  
Department of Health  
The Government of the Hong Kong Special Administrative Region  
Hong Kong  
Tel.: (852) 2961 8918  
Fax: (852) 2836 0071  

Dr Y.Y. Ho  
Community Physician (Hong Kong)  
Department of Health  
The Government of the Hong Kong Special Administrative Region  
Hong Kong  
Tel.: (852) 2961 8700  
Fax: (852) 2836 0293 / 2572 7582  

JAPAN  

Dr Hideo Shinozaki  
Director General  
Health Service Bureau  
Ministry of Health and Welfare  
Tokyo 100-8045  
Tel.: (813) 3503 1711  
Fax: (813) 3501 2532  

Mr Fumio Isobe  
Executive Director  
International Affairs Division  
Minister’s Secretariat  
Ministry of Health and Welfare  
Tokyo 100-8045  
Tel.: (813) 3503 1711  
Fax: (813) 3501 2532  

Mr Kazuo Hirayama  
Director  
Safety Division  
Pharmaceutical and Medical Safety Bureau  
Ministry of Health and Welfare  
Tokyo 100-8045  
Tel.: (813) 3503 1711  
Fax: (813) 3501 2532
Annex 2

JAPAN (continued)  
Dr Hiroyoshi Endo  
Director  
Office of International Cooperation  
International Affairs Division  
Minister’s Secretariat  
Ministry of Health and Welfare  
Tokyo 100-8045  
Tel.: (813) 3503 1711  
Fax: (813) 3501 2532  
(Alternate)

Dr Norihiko Yoda  
Deputy Director  
International Affairs Division  
Minister’s Secretariat  
Ministry of Health and Welfare  
Tokyo 100-8045  
Tel.: (813) 3503 1711  
Fax: (813) 3501 2532  
(Alternate)

Mr Shigeki Tsuda  
Deputy Director  
International Affairs Division  
Minister’s Secretariat  
Ministry of Health and Welfare  
Tokyo 100-8045  
Tel.: (813) 3503 1711  
Fax: (813) 3501 2532  
(Alternate)

Mr Jun Kobayashi  
Chief  
International Affairs Division  
Minister’s Secretariat  
Ministry of Health and Welfare  
Tokyo 100-8045  
Tel.: (813) 3503 1711  
Fax: (813) 3501 2532  
(Alternate)

Dr Kenichi Tsujii  
Medical Officer  
Tuberculosis and Infectious Disease Control Division  
Health Service Bureau  
Ministry of Health and Welfare  
Tokyo 100-8045  
Tel.: (813) 3503 1711  
Fax: (813) 3501 2532  
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<td>KIRIBATI</td>
<td>Mr Baraniko Mooa</td>
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<td>LAO PEOPLE’S DEMOCRATIC REPUBLIC</td>
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<td>MACAO</td>
<td>Dr José Alarcão Troni</td>
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### Annex 2

**MACAO (continued)**  
Dr Rogerio Santos  
Deputy Director  
Department of Health Services  
Macao  
Tel.: (853) 3906511  
Fax: (853) 346818  
Dr Koi Kuok Ieng  
Deputy Director  
Department of Health Services  
Macao  
Tel.: (853) 569 011  
Fax: (853) 568 859

**MALAYSIA**  
Dato’ Chua Jui Meng  
Minister of Health  
Ministry of Health Malaysia  
Kuala Lumpur  
Tel.: (603) 298 5077  
Fax: (603) 292 8893  
Tan Sri Dato (Dr) Abu Bakar Dato’ Suleiman  
Director General of Health  
Ministry of Health Malaysia  
Kuala Lumpur  
Tel.: (603) 292 5196  
Fax: (603) 291 1436  
Dr Mohamad Taha Arif  
Director of Diseases Control  
Ministry of Health Malaysia  
Kuala Lumpur  
Tel.: (603) 254 8192  
Fax: (603) 254 3366 / 252 5667  
Ms Tan Lee Cheng  
Senior Confidential Secretary  
to the Minister of Health Malaysia  
Kuala Lumpur  
Tel.: (603) 298 5077  
Fax: (603) 292 8894

**REPUBLIC OF THE MARSHALL ISLANDS**  
* Unable to attend.
FEDERATED STATES OF MICRONESIA

Dr Eliuel K. Pretrick
Secretary of Health, Education and Social Affairs
Department of Health, Education and Social Affairs
Palikir, Pohnpei
Tel: (691) 320 2619
Fax: (691) 320 5263

MONGOLIA

Dr Sodov Sonin
Minister for Health and Social Welfare
Ulaanbaatar
Tel.: (976-1) 320 916
Fax: (976-1) 327 872

Dr Purevjav Altankhuyag
Director
Department of Information, Monitoring, Research and Evaluation
Ministry of Health and Social Welfare
Ulaanbaatar
Tel.: (976-1) 323 848
Fax: (976-1) 320 916

NAURU

Mr Ludwig D. Scotty
Special Envoy of the Minister of Health
Government Offices, Yaren
Republic of Nauru
Tel.: (674) 444 3702
Fax: (674) 444 3106

Dr Mark D. Kun
Secretary for Health and Medical Services
Government Offices, Yaren
Republic of Nauru
Tel.: (674) 444 3702
Fax: (674) 444 3106

NEW ZEALAND

Ms Ria Earp
Deputy Director-General Maori Health
Ministry of Health
Wellington
Tel.: (644) 496 2141
Fax: (644) 496 2050
Annex 2

NIUE

Mr Robert Matua Rex
Minister of Health
Alofi
Niue
Tel.: (683) 4200
Fax: (683) 4206
Dr Louisa Woonton
Director of Health
Alofi
Niue
Tel.: (683) 4100
Fax: (683) 4265

REPUBLIC OF PALAU

Mr Masao M. Ueda
Minister of Health
Ministry of Health
Koror
Tel.: (680) 488 2813
Fax: (680) 488 1211
Dr Caleb T. Otto
Director, Bureau of Public Health
Ministry of Health
Koror
Tel.: (680) 488 1757/2420
Fax: (680) 488 3115

PAPUA NEW GUINEA

Dr Puka I. Temu
Secretary of Health
Department of Health
Port Moresby
Tel.: (675) 301 3601 / 301 3602
Fax: (675) 325 1466
Dr Clement Malau
Director
National AIDS Council Secretariat
Boroko
Tel.: (675) 323 1619
Fax: (675) 325 9424
Mrs Bernadette Temu
c/o Department of Health
Port Moresby
Tel.: (675) 301 3601 / 301 3602
Fax: (675) 325 1466
### Annex 2

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<tr>
<td>Philippines</td>
<td>Dr Alberto G. Romualdez, Jr.</td>
<td>Secretary of Health</td>
<td>Department of Health</td>
<td>(632) 743 8301</td>
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<tr>
<td></td>
<td>Dr Conrado K. Galsim, Jr.</td>
<td>Director IV, Regional Health Office</td>
<td>Quezon City</td>
<td>(632) 913 4526</td>
<td>(632) 913 4654</td>
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<td>Ms Remedios V.S. Paulino</td>
<td>Director III</td>
<td>Foreign Assistance Coordination Service</td>
<td>(632) 743 8301</td>
<td>(632) 711 9582</td>
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<td>Portugal</td>
<td>Dra Maria Belém Roseira</td>
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<td>Dr Paula Pinto da Fonseca</td>
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<tr>
<td><strong>REPUBLIC OF KOREA</strong></td>
<td>Dr Joon Sang Lee</td>
<td>Director General</td>
<td>National Institute of Health Ministry of Health and Welfare Seoul Tel.: (822) 380 1401 Fax: (822) 388 4601</td>
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<tr>
<td></td>
<td>Mr Chan Hyung Park</td>
<td>Director International Cooperation Division Ministry of Health and Welfare Seoul Tel.: (822) 503 7524 Fax: (822) 504 6418</td>
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<tr>
<td></td>
<td>Mr Jin-Woong Moon</td>
<td>Deputy Director International Cooperation Division Ministry of Health and Welfare Seoul Tel.: (822) 503 7524 Fax: (822) 504 6418</td>
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<tr>
<td><strong>SAMOA</strong></td>
<td>Mr Misa Telefoni Retzlaff</td>
<td>Minister of Health</td>
<td>Apia Samoa Tel.: (685) 25210 Fax: (685) 25209</td>
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<td></td>
<td>Dr Eti Enosa</td>
<td>Director General of Health Department of Health Apia Samoa Tel.: (685) 23330 Fax: (685) 26553</td>
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<td>SINGAPORE</td>
<td>Dr Arthur Su Chung Chern</td>
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<td></td>
<td>Dr Loh Yik Hin</td>
<td>Assistant Director, Research</td>
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<td>SOLOMON ISLANDS</td>
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<td>Dr Lester Ross</td>
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<td>TOKELAU*</td>
<td>Dr Viliami T. Tangi</td>
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<td>TONGA</td>
<td>Mr Teagai Esekiia</td>
<td>Minister of Health, Women and Community Affairs</td>
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* Unable to attend.
Annex 2

TUVALU (continued)  Ms Mafa Levi Alaloto  
Acting Assistant Secretary  
Ministry of Health, Women and Community Affairs  
Funafuti  
Tel.: (688) 20832/404  
Fax: (688) 20405/481  
Dr Miliama Faleasiu  
Medical Officer  
Princess Margaret Hospital  
Funafuti  
Tel.: (688) 20751  
Fax: (688) 20481

UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND  Dr Wendy Thorne  
Senior Medical Officer  
Department of Health, International Branch  
Richmond House  
London  
Tel.: (0171) 210 5529  
Fax: (0171) 210 5804

UNITED STATES OF AMERICA  Mr Joseph Kevin P. Villagomez  
Secretary of Public Health  
Saipan  
Commonwealth of the Northern Mariana Islands  
Tel.: (670) 234 8950  
Fax: (670) 234 8930

Mr Neil Boyer  
Director  
Health and Transportation Programs  
Bureau of International Organization Affairs  
Department of State  
Washington D.C. 20520  
Tel.: (202) 647 1044  
Fax: (202) 647 8902
Annex 2

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<td>UNITED STATES OF AMERICA</td>
<td>Dr Thomas Novotny</td>
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<td>Tel.: (301) 443-1774</td>
<td>Fax: (301) 443 6288</td>
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<td>Ms Tina Chung</td>
<td>International Health Officer</td>
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<td>Fax: (684) 633 5379</td>
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<td>Mr Keasipai Song Shem</td>
<td>Minister of Health</td>
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<td>Fax: (678) 26113</td>
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<td>Mr Johnson Wabaiat</td>
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<td>VIET NAM</td>
<td>Dr Pham Manh Hung</td>
<td>Permanent Vice-Minister of Health</td>
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<tr>
<td></td>
<td>Tel.: (844) 846 0593</td>
<td>Fax: (844) 846 4051</td>
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Annex 2

VIET NAM (continued)  
Mr Trinh Bang Hop  
Director, Department of International Cooperation, Ministry of Health  
Hanoi  
Tel.: (844) 846 0493  
Fax: (844) 846 2195  
Dr Trinh Quan Huan  
Director, Department of Preventive Medicine, Ministry of Health  
Hanoi  
Tel.: (844) 846 2364  
Fax: (844) 846 0507  
Mrs Le Thi Thu Ha  
Deputy Director, Department of International Cooperation, Ministry of Health  
Hanoi  
Tel.: (844) 846 0593  
Fax: (844) 846 2195  
(Alternate)

II. OBSERVER

CANADA  
Dr Jean Larivière  
Senior Medical Adviser  
Health Canada  
International Affairs Directorate  
Ottawa

III. REPRESENTATIVES OF OTHER INTERGOVERNMENTAL ORGANIZATIONS

PACIFIC COMMUNITY  
Ms Michele Vanderlahn-Smith
IV. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS

FDI WORLD DENTAL FEDERATION
Dr Johnson Yip
Dr Joaquim Nicolau
Dr Choi Sai Hong
Dr Lei Wai Meng

INTERNATIONAL ASSOCIATION OF AGRICULTURAL MEDICINE AND RURAL HEALTH
Mr Shinichiro Yoshimoto

INTERNATIONAL COUNCIL OF NURSES
Ms Catherine Lo Siu Ha

INTERNATIONAL COUNCIL OF WOMEN
Ms Chor Swee Suet

INTERNATIONAL DIABETES FEDERATION
Mr Clive Cockram

INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS
Dr Dominic Li

INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS ASSOCIATIONS
Ms Alice Chin
Mr Robert Siu
Mrs Joy Ottway

INTERNATIONAL FEDERATION OF SPORTS MEDICINE
Dr Humberto Evora

INTERNATIONAL HOSPITAL FEDERATION
Dr Lawrence Lai

INTERNATIONAL PHARMACEUTICAL FEDERATION
Mr John A. Ware

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
Mrs Joyce Tai

INTERNATIONAL SPECIAL DIETARY FOODS INDUSTRIES
Mr Nophadol Siwabutr
Mr Mabini Antonio
Ms Beverly Halchack
Ms Jackie Keith
Mr Steve Tascher
### Annex 2

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<tr>
<td>INTERNATIONAL SOCIETY OF BLOOD TRANSFUSION</td>
<td>Dr Maria Natalia Prata Martins</td>
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<td>INTERNATIONAL UNION OF NUTRITIONAL SCIENCES</td>
<td>Professor Mohd Ismail Noor</td>
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<td>ITALIAN ASSOCIATION OF FRIENDS OF RAOUl FOLLEREAU</td>
<td>Sr Maria Pia Cantieri</td>
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<td>REHABILITATION INTERNATIONAL</td>
<td>Professor Joseph Kwok</td>
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<td>SOROPTIMIST INTERNATIONAL</td>
<td>Ms Susie Lum</td>
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<td>Dr Bruce Vaughan</td>
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<td>WORLD FEDERATION OF HYDROTHERAPY AND CLIMATOTHERAPY</td>
<td>Dr Nicolay A. Storozhenko Mr Vadim Loginov</td>
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<tr>
<td>WORLD FEDERATION OF OCCUPATIONAL THERAPISTS</td>
<td>Ms Anne Spencer</td>
</tr>
</tbody>
</table>
LIST OF NONGOVERNMENTAL ORGANIZATIONS WHOSE REPRESENTATIVES MADE STATEMENTS TO THE REGIONAL COMMITTEE AND SUBMITTED STATEMENTS FOR CIRCULATION TO MEMBERS

At the invitation of the CHAIRPERSON, statements were presented by the following nongovernmental organizations:

- International Council of Nurses
- International Union of Nutritional Sciences
- Soroptomist International
- World Federation of Chiropractic
- World Federation of Hydrotherapy and Climatotherapy
- World Federation of Occupational Therapists
## CONTENTS

**PART II - SUMMARY RECORDS OF THE PLENARY MEETINGS**

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SUMMARY RECORD OF THE FIRST MEETING

The Macau Landmark Convention and Exhibition Centre
and the Ballroom, Hyatt Regency Hotel, Macao
Monday, 13 September 1999 at 10.30 a.m. and 2 p.m.

CHAIRPERSON: Dr Margaret CHAN (Hong Kong, China)
later: Dr José Alarcão TRONI (Macao)

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Regional Director .............................................................. 79
1. OPENING CEREMONY

The opening ceremony was held at 10:30 a.m. at the Macau Landmark Convention and Exhibition Centre, Macao.

The Chairman of the Organizing Committee, Dr José Alarcão TRONI, presided over the welcoming ceremony, and welcomed the members of the Regional Committee and other guests (see Annex 1).

The REGIONAL DIRECTOR expressed his appreciation to the Government of Macao for hosting the fiftieth session of the Regional Committee. Since sovereignty over Macao would pass before the end of the year from Portugal to China, Portugal would therefore be leaving the Regional Committee. He thanked the Government of Portugal for its valuable contributions to the Committee since its inception. He also noted that, although he had attended many sessions of the Committee, this would be his first as Regional Director (see Annex 2).

The CHAIRMAN of the Regional Committee, Dr Margaret CHAN (forty-ninth session) likewise thanked the Government of Macao for its hospitality and for the arrangements made (see Annex 3).

His Excellency, General VASCO ROCHA VIEIRA, Governor of Macao, speaking in Portuguese, welcomed the members of the Committee and other guests. Macao, which would become a Special Administrative Region of the People’s Republic of China on 20 December 1999, would continue to be represented in the Regional Committee after that date as Macao, China (see Annex 4).

After the completion of the opening ceremony, the participants reconvened in the Ballroom, Hyatt Regency Hotel, Macao at 2.00 p.m.

2. OPENING OF THE SESSION: Item 1 of the Provisional Agenda

The retiring Chairperson, Dr MARGARET CHAN (Hong Kong, China) declared open the fiftieth session of the Regional Committee for the Western Pacific.
3. ADDRESS BY THE RETIRING CHAIRPERSON: Item 2 of the Provisional Agenda

The retiring Chairperson, Dr MARGARET CHAN (Hong Kong, China), made a statement to the Committee (see Annex 5).

4. ELECTION OF NEW OFFICERS: CHAIRPERSON, VICE-CHAIRPERSON AND RAPPORTEURS: Item 3 of the Provisional Agenda

4.1 Election of Chairperson

Dr Zhang Wenkang (China) nominated Dr José Alarcão TRONI (Macao) as Chairperson; the nomination was seconded by Dr Viliami T. TANGI (Tonga).

**Decision:** Dr TRONI (Macao) was elected unanimously.

Dr TRONI took the chair.

4.2 Election of Vice-Chairperson

Mr Misa Telefoni RETZLAFF (Samoa) nominated Dr Sodov SONIN (Mongolia) as Vice-Chairperson; the nomination was seconded by Professor Judith WHITWORTH (Australia).

**Decision:** Dr SONIN (Mongolia) was elected unanimously.

4.3 Election of Rapporteurs

Dr Alberto G. ROMUALDEZ, Jr. (Philippines) nominated Dr Louisa WOONTON (Niue) as Rapporteur for the English language; the nomination was seconded by Dr Isimeli COKANASIGA (Fiji).

Mr Akusitino MANUHALALO (France) nominated Dr Phoukhong CHOMMALA (Lao People’s Democratic Republic) as Rapporteur for the French language; the nomination was seconded by Mr Keasipai Song SHEM (Vanuatu).
Decision: Dr WOONTON (Niue) and Dr CHOMMALA (Lao People’s Democratic Republic) were elected unanimously.

5. ADOPTION OF THE AGENDA: Item 5 of the Provisional Agenda (Document WPR/RC50/1)

The CHAIRPERSON moved the adoption of the Agenda. He also drew attention to a new procedure for oral statements by representatives of intergovernmental and nongovernmental organizations. Organizations wishing to make an oral presentation would be invited to do so under the agenda item relating to their activity, rather than at the end of the session as in previous years.

Mr MANUHALALO (France) requested that all Regional Committee documentation should be made available in French prior to the session, to allow sufficient preparation time for French-speaking delegations.

Decision: In the absence of further comments, the Agenda was adopted.

6. “GETTING THE JOB DONE TOGETHER”, ADDRESS BY THE REGIONAL DIRECTOR: Item 7 of the Agenda (Document WPR/RC50/2); REPORT OF THE REGIONAL DIRECTOR: Item 8 of the Agenda (Document WPR/RC50/3)

The REGIONAL DIRECTOR addressed the meeting on his document *WHO in the Western Pacific Region: a framework for action* (see Annex 6).

Following his address, the Regional Director introduced his report for the period 1 July 1998 to 30 June 1999. He explained that preparation of the report had presented him with a dilemma. Should he prepare a report that reflected the new structure of the Organization, or should he simply prepare the same kind of report as in the past? After careful deliberation, he had decided to retain the overall structure of the report, but had made a number of key changes within that structure.

As in the past, the report was arranged in six chapters, corresponding to the appropriation sections in the proposed programme budget for 1998–1999, as approved by the Regional Committee in 1996. Within those chapters the sub-headings from previous reports had been retained. These corresponded to the major programmes in the budget.
He then outlined the major changes that had been made. First, the report’s analytical content had been improved. Second, the report’s reference value had been enhanced by the addition of a statistical annex and the inclusion of more graphs, tables and other illustrative matter. Third, he had tried to ensure that the report’s content reflected the Organization’s current activities more accurately. Fourth, the report had a new cover and layout.

He pointed out that the report was a transitional one covering the last seven months of Dr S.T. Han’s period as Regional Director and his own first five months in office. Therefore, it was appropriate that it should contain both old and new elements. However, if he was to give the Committee an accurate explanation of what WHO was doing in the Region, the structure of the annual report had to change. He requested the Committee’s approval to make further improvements to the report, based upon the themes and focuses described in document WPR/RC50/2, *WHO in the Western Pacific Region: a framework for action*. For example, if the report was to be a more rigorous and intellectually challenging document, he believed that Part 2, which had been designed to give a more analytical treatment to a selected topic, would no longer be necessary. He looked forward to hearing the Committee’s views on both the *Framework for action* and the report.

The CHAIRPERSON, commending the report, observed that it was a considerable improvement over previous reports in both form and content and welcomed the Regional Director’s intention to further improve it. He proposed that the report be considered in general, rather than section by section, as previously practised. Since there were no objections to the proposal, he called for comments on the document *WHO in the Western Pacific Region: a framework for action* and the Regional Director’s Report covering the period from 1 July 1998 to 30 June 1999.

Dr ROMUALDEZ (Philippines) expressed appreciation of the Regional Director’s two documents.

With respect to document WPR/RC50/2, *WHO in the Western Pacific Region: a framework for action*, he noted that the new, simplified programme structure which was composed of themes and focuses bore a marked similarity to the way in which countries viewed health problems and how they should be addressed. For example, the themes concerning communicable disease control, and environmental and behavioural health issues reflected the concerns of the Philippines. He hoped that the new approaches that were to be
adopted by the Regional Office would relate better to the new structure of clusters which had been adopted in WHO Headquarters. He supported Dr Omi’s call for a certain amount of flexibility in the implementation of the proposed programme budget for 2000–2001 in view of the restructuring at the Regional level.

Referring to the Regional Director’s report, he supported the suggestions for further improvements, noting that the present report already reflected the new orientation towards results-oriented approaches, premised on a thorough analysis of health problems.

Dr ZHANG (China) congratulated the Chairman on being elected to office and commended the Regional Director on his report. He said he was particularly pleased that the fiftieth session of the Regional Committee was being held in Macao, at a time when the country was soon to be returned to China.

He expressed appreciation of the efforts made by the Regional Director to institute a reform process by improving the organizational structure and health strategy of the Regional Office and also by focusing on WHO’s response to the changing health needs of Member States, in spite of financial restraints.

Noting the links between document WPR/RC50/2, WHO in the Western Pacific Region: a framework for action, and the concepts of New horizons in health, he hoped that the two documents would provide health directions for the years to come.

It was noteworthy that the Regional Director’s report contained improved analytical material that had added to its value as a source of reference on the health problems of the Region. These also made it more readable. The report highlighted priorities and was easy to comprehend. He commended the efforts of the Regional Director to direct initiatives towards a more results-oriented approach and supported the new leadership’s determination to initiate further reforms which would lead to greater conformity with the clusters at WHO Headquarters.

Referring to Chapter 2, Health Policy and Management, he welcomed the efforts of the Regional Director to shift the focus to intersectoral cooperation. The setting up of external advisory groups would not only provide valuable sources of expertise but would also encourage support from extrabudgetary resources. He commended the Regional Director’s efforts to promote transparency and a collective form of leadership through the establishment
of the Regional Director’s Cabinet. He stressed the importance of directing future initiatives towards bridging the widening economic discrepancies among countries and the resulting differences in health resources. He was pleased to note the decision to make social safety nets in health sector development the topic for the ministerial round table.

He hoped that Chapter 3, Health Services Development, would encourage health reform in every country of the Region. He noted that in the modern world it was impossible to solve health problems by relying solely on the health sector. The Regional Office should encourage Member States to chart new courses of action. In China, the cost-effectiveness approach was being used to respond to changing health needs and the reality of limited health resources. For example, efforts were being made to work on strengthening public health and preventive health care, establishing basic medical insurance, promoting community health services and improving compensation within government medical institutions. He was pleased to note Dr Omi’s interest in health reform in China and hoped that, with cooperation and support from WHO, it would be possible for Member States to learn from his country’s efforts in this area.

He thanked the Western Pacific Regional Office for close cooperation in the past and hoped that, under the able leadership of the new Regional Director, this relationship would be further strengthened and would contribute to improvements in health status in the Region and worldwide.

Professor WHITWORTH (Australia) congratulated the Regional Director on his two documents, in particular on the significant improvements to the layout and analytical quality of his report.

The report referred to some significant achievements in the Region. These included the efforts to eradicate poliomyelitis and to stem the resurgence of tuberculosis in the Region. She expressed support for increased tuberculosis control.

She hoped that future reports would continue to reflect changes in the way WHO worked in the Region. As suggested in the Introduction, they should be structured according to the 14 focuses and three cross-cutting focuses which made up the new regional organizational structure.
As the Regional Director rightly pointed out in his *Framework for action*, this was no time for complacency. However, his vision should ensure that the Regional Office was well equipped to deal with a range of future activities. Australia pledged its cooperation in implementing his proposals.

She said that since taking office the Regional Director had focused on the Organization itself and had instituted a number of structural and procedural changes aimed at making it more responsive and streamlined. She hoped that the next 12 months would be more outward-looking and would focus on strategies to implement the changes the Regional Director had announced. She was confident that the use of themes and “cross-cutting focuses” would enhance the ability of WHO to make a difference in the Region.

She strongly supported the proposed programme for health sector development within countries; WHO must be able to work in partnership with countries. If resources were to be directed properly, considerable consultative work must be undertaken to assess country needs, set priorities and develop appropriate strategies.

The time was right to implement changes to the structure, management and transparency of the Organization. The direction set by the Regional Director was the right one, but she agreed with the Regional Director that the Organization should focus more on outcomes, with resources linked to clearly defined objectives and priorities, and evaluation undertaken in terms of tangible results, not dollars spent.

She applauded the introduction of external advisory groups in priority areas to assist in evaluation; that had been a successful strategy for poliomyelitis eradication. An advisory group might also be established to assist with organizational reform generally and to provide independent advice on, for example, training needs and budget processes. Australia would be pleased to assist in that regard.

Finally, she encouraged the Regional Director to devise ways of making the Regional Committee less formal and more outcome-oriented. For example, other agencies concerned with international health could be asked to take part, and smaller working groups could be formed to discuss problems in greater depth.

As had rightly been pointed out by the Regional Director, there was an increasing need to achieve results in spite of decreasing resources. The Region still had far too many
people afflicted by overwhelming poverty, and a conscious effort by WHO was required to support the principle of directing available resources to those most in need.

At the global level, WHO was moving towards a budgeting framework based on relative health needs in countries. Australia called on Member States to embrace that principle; to accept decreased funding from WHO if called upon to do so; to seek to maximize the use of available funding, and in so doing, to demonstrate acceptance of the principle that the health of every nation affected that of every other.

Mr VILLAGOMEZ (United States of America) endorsed the Regional Director’s proposed Framework for action with its four major themes. He also welcomed the changes to the format of the Regional Director’s report; the statistical annexes to the report were particularly useful.

The two documents drew attention to the many health problems that still challenged the Region, including those of an ageing population, the emergence and re-emergence of infectious diseases, increases in chronic diseases, and the special health problems of vulnerable groups such as women and minorities.

The development of priorities and the tackling of new public health issues must also reflect the continuing environment of change and reform in the Region and in WHO as a whole.

Maximum use must be made of technical cooperation and the limited financial resources available. Collaborating centres should be encouraged to work with the Western Pacific Advisory Committee on Health Research, with growing partnership and links with other United Nations agencies, ASEAN, the Asian Development Bank, and the World Bank.

The Director-General’s leadership of the Organization was impressive. She had an important vision for the future work of WHO within a changing and increasingly complex global environment. The United States of America was confident that the Regional Director would make his own mark and would work hand-in-hand with Dr Brundtland to ensure the success of WHO’s initiatives in the Region.

He asked the Regional Director what had been done or was planned in relation to the structure of the Regional Office given the new nine clusters at WHO Headquarters.
The United States of America looked forward to the Region’s continued commitment to health for all.

Dr DALALOY (Lao People’s Democratic Republic) welcomed the directions indicated by the Regional Director in his Framework for action. These gave new impetus to the work to improve health while taking account of the real situation and needs in countries. Reinforced partnership was called for, together with a realistic and flexible approach.

The proposed policies coincided with the needs of the Lao People’s Democratic Republic and his country would cooperate with WHO in combating communicable diseases with immunization, vector control and specific measures against tuberculosis, leprosy, HIV/AIDS and sexually transmitted infections. Reproductive health, maternal and child health, school health and tobacco and substance abuse control would also receive high priority, as would the development of health systems and information technology.

Professor PHAM MANH HUNG (Viet Nam) endorsed the Regional Director’s proposed Framework for action, in particular the priority to be given to tuberculosis control.

He commended the improved analytical and illustrative content of the Regional Director’s report, which reflected the health situation of countries in the Region, their problems, and WHO’s collaborative efforts to tackle them. In particular he commended the section on reproductive and family health.

He expressed agreement with many points in Chapter 3: Health services development. Despite its low expenditure on health, the Government of Viet Nam had been trying to provide basic health services to its population in remote and disadvantaged areas, setting aside funds in 1999 to buy health insurance cards for 1.5 million people to help remove financial barriers to seeking care. Improving health financing was a major challenge for a country like Viet Nam, where compulsory health insurance currently covered only 10 million of the population. In 1998, the Government had adopted a Revised Health Insurance Decree to include low-income groups in the insurance scheme and school health insurance. It was expected that voluntary health insurance and health insurance for farmers would be introduced in the coming years. Also, there were pilot projects for the establishment of a health care fund for the poor in some areas. The Ministry of Health had submitted for approval a revision of hospital fees to allow full fee collection and to generate more revenue for the health sector and to reduce or eliminate fees for the poor. Despite many
fiscal constraints, the Government had decided to provide an additional amount of 420 000 million dong, equivalent to US$ 30 million to strengthen cancer hospitals and intensive care centres.

Viet Nam was experiencing a change in disease patterns. While infectious and communicable diseases remained the leading causes of morbidity, noncommunicable diseases, such as cardiovascular diseases and cancer, and traffic accidents were increasing.

During the last three years, with the establishment of Viet Nam’s Drug Administration within the Ministry of Health, drugs had been better controlled. Good progress had been made against counterfeit and sub-standard drugs.

To ensure better control of foodborne diseases and to support food quality, hygiene and safety, the Viet Nam Food Administration had been established in April 1999. The “Month of action for food quality, hygiene and safety” had been launched in the whole country in July with intensive information, education and communication campaigns and food inspection in order to raise public awareness and prevent food poisoning.

Viet Nam had been poliomyelitis-free since 1997. The number of malaria cases, including severe cases, had declined in 1997 and 1998. Antimalaria drugs were now widely available in primary health care outlets, and the technical and logistical capacity of the malaria control network had probably never been better. Deaths from tuberculosis were being prevented and control activities now covered 99% of the population, with 95% having access to short-course chemotherapy. However, in 1998, Viet Nam had suffered a dengue outbreak, the reported number of cases being 186 573, with 472 deaths, more than in any of the last ten years, as in other countries in the Region. The dengue vector control approach had been the subject of a pilot study in Viet Nam over the last three years, with very promising results.

WHO’s cooperation with Viet Nam had been very effective for many years in various areas, from health services development to disease control, human resources for health and health policy. He looked forward to collaborating further with WHO and other countries and partners in the Region to improve the people’s health in the coming years.

Mr WARAKOHIA (Solomon Islands) endorsed the Regional Director’s report and his *Framework for action.*
Solomon Islands, like other Member States in the Region, was undergoing structural reforms affecting the health sector. While economic factors seemed to be the driving force, the services provided by the sector should not be put at a disadvantage. It was pleasing to note that under the proposed reform and restructuring of the Regional Office, the focuses were clearly defined under four themes. This should be reflected in the next programme budget.

He noted with satisfaction the attention given in the Regional Director’s report to the relevant issues, with clear analysis and direction for future responses and for planning at country level. He saw the report not only as a review of the year’s progress but also as a meaningful document to assist Member States. The inclusion of sections on reproductive and family health, and statistical data was also useful. However, there was a need to improve data collection and analysis.

The next Regional Director’s report should reflect the new structure and programme organization; however, the approach should remain in the current form, indicating future responses.

He expressed appreciation of WHO’s part in the recent United Nations Humanitarian Mission to the Solomon Islands to assess the effects of civil unrest in Guadalcanal. WHO had committed US$ 274 700 to efforts to deal with the consequences.

Dr HONG SUN HUOT (Cambodia) endorsed the Regional Director’s proposals for meeting the four challenges in his position paper; his Ministry of Health pledged itself to help achieve the objectives outlined.

Dr COKANASIGA (Fiji) praised the Regional Director’s foresight in producing his Framework for action that would guide the Region during the coming years, and endorsed the proposals set out in the document. He also welcomed the clearer and more analytical approach taken in the Regional Director’s report. He looked forward to further changes in the next report, to reflect the new structure of the Regional Office. He agreed that Part 2 should be discontinued in future.

Dato’ CHUA Jui Meng (Malaysia) commended the enthusiasm of the Regional Director as reflected in his Framework for action. The proposal to establish external technical advisory groups was particularly interesting, provided that the experts were
appointed on the strength of their expertise and ability to produce positive outcomes. The criteria and process of selection should be transparent, and the work of the groups should promote evidence-based approaches.

He supported the concept of partnerships and suggested, in addition, that the work of the Region could be better integrated with that of the other regions. South-East Asia, in particular, had common borders with the Western Pacific and had to face similar challenges. He commended the efforts to enhance the participation of women in upper management in the Region, and suggested that progress in that direction should be incremental, possibly through the setting of targets.

His country greatly appreciated the support provided by WHO and other bodies during the recent outbreaks in his country of Japanese encephalitis and the newly discovered Nipah virus, associated with pig handling. That experience with an emerging microorganism pointed to the need for closer collaboration with other government agencies, such as the ministry of agriculture, and for bridging the gap between different agencies both within and among countries.

Mr MANUHALALO (France), referring to the four themes set out in document WPR/RC50/2, noted, with regard to building healthy populations, that intense urbanization was creating a new form of poverty stemming from the disruption of traditional social links. Emphasis should be laid on improving the access of marginalized groups to health care, together with the development of emergency care systems. The increase in mental health problems was linked not only to ageing, but also to urbanization and its attendant social breakdowns, and thus called for the development of a specific strategy.

With regard to health sector development, he supported all efforts made to improve management and organization that would back up the definition of intervention strategies within health policy. Health financing, as discussed at the ministerial round tables held during the 1999 World Health Assembly, should also be included as a specific focus. Strategies to be framed in that regard were linked to the type of solidarity that the Organization might wish to promote, and should be discussed by the Regional Committee. France would like other delegations to give their views on this proposal.

Improving communications should be a special priority since the resources of some countries with sparse populations were insufficient to develop comprehensive health systems.
In island states, use of new information and communication technology, in particular telemedicine, could help to improve referral systems. WHO should therefore promote the establishment of pooling mechanisms among Member States. In that regard, he stressed the importance of multilingualism within the Organization.

He supported the proposed restructuring of operations in the Region, particularly efforts to reach out in order to mobilize expertise, which would enable WHO to strengthen its technical credibility.

With regard to document WPR/RC50/3, he noted that the statistics given for New Caledonia, French Polynesia, and Wallis and Futuna were not always correct or up to date. He hoped that future reports would be able to correct this.

The establishment of external technical advisory groups was a priority, and more precise information was needed on their functioning and the selection of members.

Mr UEDA (Palau), commending the Regional Director’s Framework for action, urged the Regional Committee to consider taking rapid action to implement its proposals.

With regard to document WPR/RC50/3, he praised the acuity with which problems had been defined and actions identified for their solution, in addition to the clear presentation and useful visual aids.

Among WHO’s achievements in the past year, the virtual eradication of poliomyelitis in the Region deserved special praise. He welcomed the continuing effort to build up close collaboration with other organizations of the United Nations system and nongovernmental organizations working in health in the Region; the emphasis laid on combating tobacco consumption; and progress made in the use of information technology, which held great potential for the Region, in particular in the area of telemedicine. He strongly supported the proposal that the elimination of filariasis should be a priority for WHO’s collaboration with the Pacific island countries. The tools needed for control and elimination were available; however, the commitment to collaborate and to secure resources was still lacking, despite the continued support of the Government of Australia.

He noted with concern that the report had given little attention to dental health, even though it indicated that oral health status in the Region was very poor.
He drew attention to the Palau Action Statement, arising from the meeting of the Ministers of Health of the Pacific Island countries held in Koror, Palau in March 1999, which considered a number of practical recommendations, as indicated in the Regional Director’s report (WPR/RC50/3, page 50). He urged representatives from Pacific island countries to consider ways in which those recommendations could be implemented in their countries.

Dr SONIN (Mongolia) noted that reform of health systems was under way in many countries in order to improve the quality and accessibility of care, and that its impact needed to be assessed. In particular, people had the potential to better their own health; ministries of health had to promote that process through preventive health care and health education.

He endorsed the efforts of the Director-General to restructure the Organization and the new regional structure introduced in the Framework for action. The Regional Director should be authorized to implement activities by adjusting the programme budget approved for 2000–2001 according to the focuses set out in that document.

He welcomed the format and content of the Regional Director’s report and endorsed proposals for future changes, suggesting that the information currently provided in Part 2 could be incorporated in Part 1. Country-specific problems, such as brucellosis in Mongolia, should also be reflected.

Dr SHINOZAKI (Japan) expressed his satisfaction with the policy directions set by the Regional Director in response to the needs of the Region’s populations. He had established clear priorities in new areas and in ongoing activities, and provided a fresh look at important themes for the Region. He endorsed both documents WPR/RC50/2 and WPR/RC50/3 and promised to support the Regional Director in getting the job done together. He also supported the establishment of external technical advisory groups.

The meeting rose at 5.05 p.m.

On behalf of the Organizing Committee, I wish to welcome all of you to this opening ceremony of the fiftieth session of the World Health Organization Regional Committee for the Western Pacific.

I wish particularly to warmly welcome the Regional Director, Dr Omi, the Chairperson of the last session of the Regional Committee, Dr Margaret Chan, and all the distinguished representatives and participants.

This morning we are extremely honoured by the presence of his excellency, the Governor of Macao.

Since the very beginning, the Governor has given us the guidance and support that has enabled us to hold this ceremony today and, I am sure, we will have a successful meeting during this coming week.

The idea to invite the WHO Regional Committee to Macao was conceived a long time ago in 1993. 1993 was a significant year in the history of cooperation between Macao and the World Health Organization. Although Representatives from Macao had attended WHO’s regular meetings as part of the Portuguese delegation since 1953, it was in 1993 that, thanks to the sponsorship of both the Portuguese and Chinese Governments, Macao was officially accepted as a participant under its own name until 19 December 1999 and thereafter under the name of Macao, China.

Since, then, the cooperation between Macao and WHO has been further strengthened and Macao has become an active partner in regional activities.

In order to demonstrate our collaboration with and support to WHO, as well as to reciprocate the kind hospitality rendered to us in all the previous meetings hosted by various Member States, the Government of Macao decided to host the fiftieth session of the WHO Regional Committee. His Excellency, the Governor, extended his invitation during the forty-seventh session in Seoul, Republic of Korea, in 1996.
Annex 1

The invitation was accepted during the forty-eighth session in Sydney, Australia, in 1997, and confirmed at the Regional Committee meeting in Manila, Philippines, in 1998.

During the past year, we have made all the necessary arrangements for this meeting.

In the course of preparations, we have received constant support from the WHO Regional Office for the Western Pacific. I wish to thank the Regional Director and his staff for their assistance in our preparatory work.

I wish also to take this opportunity to express our appreciation to the Department of Health of Hong Kong for their kind assistance.

Last, but not least, I wish to thank the Macao Government Departments and all the Macao staff for their cooperation and hard work. Without their efforts during the preparatory work, this meeting would not have been possible.

In conclusion, I wish all of you a successful meeting and an enjoyable stay in Macao.

Thank you.

On behalf of the World Health Organization, I would like to express our sincere thanks to the Governor of Macao for his support for this meeting and to Dr Troni for his gracious welcome. Unfortunately, our Director-General, Dr Gro Harlem Brundtland, cannot join us today, but she has asked me to extend to you her warm greetings and apologies for her delayed arrival. We are delighted that Macao is hosting this historic fiftieth session of the WHO Regional Committee for the Western Pacific. Those of us who have been in Macao for a few days have already had the pleasure of enjoying your famous hospitality. Your unique blend of cultures from the East and the West makes Macao an ideal venue for the last session of the Regional Committee to be held in this century.

This is a historic session of the Regional Committee for a number of reasons. It is the Committee’s fiftieth session. It is also the last in which Portugal will participate as a member of the Regional Committee, as in three months time sovereignty over Macao will pass from Portugal to China.

Portugal has been a member of the Regional Committee for the Western Pacific since the first session of the Committee in May 1951. Over almost half a century, Portugal has made many valuable contributions to the Committee’s work. On behalf of the Regional Committee, let me therefore take this opportunity to bid farewell to Portugal and to thank you for your support for the work of WHO in the Region.

On a personal note, although I have attended many sessions of the Regional Committee, this is the first one that I shall attend as Regional Director. I firmly believe that this meeting will help us to lay a foundation for public health in the Region for the next century.

Macao is one of the more urbanized and developed countries and areas in our Region. Its per capita GNP is almost exactly the same as Australia’s. In general, its health status indicators are excellent. Its infant mortality rate, for example, is 4.8 per 1000 live births, among the lowest in the Region. Its mortality rate for under fives is equally impressive.
These statistics are no doubt mainly due to Macao’s admirable health services, which are free to all citizens. With 17 doctors per 10,000 people, Macao has one of the better staffed health services in the Region. The Portuguese Administration has every reason to be proud of the health system it is leaving behind and I would like to take this opportunity to congratulate you for it. We will all be looking forward to hearing more about Macao’s health services during the technical briefing on Wednesday afternoon and the field visit on Friday.

While we are sorry to bid farewell to Portugal, we wish Macao every success in its new capacity as a special administrative region of China. Like Hong Kong, Macao will remain a member of the Committee. I am confident that you will continue to prosper and look forward to working with you as Macao, China in the years to come.

Thank you very much.

It is a great pleasure to be with you here in Macao for the fiftieth session of the Regional Committee. The sessions of the Regional Committee have always been good forums for us to discuss health issues we are facing in the Region, the problems we are encountering, and how we should address them. The sessions also provide us with the opportunity to exchange ideas and experiences so that we may have a better understanding of the issues at hand and come to a consensus on the actions that we, the Member States, should take to address such issues.

The fact that we who are involved in the management of health in our own countries are meeting here and not in the Regional Office in Manila means that we are also given the opportunity to look closely at one of the Members of the Regional Committee, in this case Macao.

Your Excellency, on behalf of the Regional Committee, of which I am the Retiring Chairperson, I want to extend to you our heartfelt thanks for inviting us to hold this fiftieth session of the Regional Committee in your beautiful city. We greatly appreciate the excellent arrangements your Government has made and the warm hospitality your people have shown us since we arrived.

We also look forward to learning more about the present and future directions in health sector development in Macao. This is of great interest to Member States, especially at this time when all countries in the Region have evolving health needs and increasing demands for better and more effective health systems. For example, the impact of lifestyle-related diseases is increasingly being felt in the Region, as well as other conditions related to rapid economic progress and industrialization. Rapid population growth and the needs of the rapidly ageing population have huge implications for the health sector. These trends will force us to rethink our health systems. As we all grapple with these issues, I am sure there are lessons we can learn from the experiences of Macao.
Annex 3

Distinguished Representatives, I will shortly be handing over my responsibilities to a new Chairperson. Let me just say that I greatly enjoyed doing the work that was entrusted to me and I would like to thank you for your support. As in the past, I trust that you will continue to make valuable contributions during our deliberations this week. We are on the threshold of a new millennium. Let us take this opportunity to chart a course that will lead us to our goal of better health for our people in the next century.

Your Excellency, allow me once again to thank you, and your people, for having us here.
OPENING REMARKS BY THE GOVERNOR OF MACAO, 
GENERAL VASCO ROCHA VIEIRA, AT THE OPENING CEREMONY 
OF THE FIFTIETH SESSION OF THE WHO REGIONAL COMMITTEE 
FOR THE WESTERN PACIFIC

It is both a pleasure and an honour for the Government of Macao, those working in the health sector and the territory’s population to host the fiftieth session of the World Health Organization Regional Committee for the Western Pacific.

I extend my warmest greetings to all the heads of the delegations and to the delegates and other participants who have come here to Macao to attend this meeting. We are deeply honoured by your presence.

I would like to address a special welcome to the Regional Director of the World Health Organization Regional Committee for the Western Pacific, Dr Shigeru Omi, and to express our public appreciation and acknowledgement of the work he has carried out over the years with such competence, dedication and sense of solidarity.

Macao is a small territory with a population of under half a million occupying an area of twenty-three square kilometres. It has been under Portuguese administration since 1557.

During your stay, you will discover a place rich in history and the fraternal coexistence of different cultures. For over four and a half centuries there has been a close link between the cultural values of Portugal and Europe and the heritage of China’s ancient civilization. Nowadays, in this part of the world, Macao takes pride in serving as a bridge between Portugal and China, Europe and Asia, East and West.

On 20 December this year, Macao will cease to be administered by Portugal and will instead become a Special Administrative Region of the People’s Republic of China.

Under the terms of the Sino-Portuguese Joint Declaration - the treaty laying the basis for Macao’s future that was signed by Portugal and the People’s Republic of China in 1987 - Macao will be a “second system” within greater China, preserving its political and legal systems, its tradition of western values, separate powers, independent courts, a market economy and respect for fundamental rights.
Beyond 20 December 1999, the deep-seated friendship enjoyed by Portugal and China will enter into a new phase in which Macao will remain a link, living on as a symbol of understanding and the ability for two completely different cultures and civilizations to enter into a relationship based on mutual respect and respect for each other’s differences.

In accordance with the Joint Declaration, Portugal has prepared all the conditions required for maintaining sustained development in Macao and ensuring the prosperity of its population. In terms of public finance, although Macao’s experience has not differed from that of its Asian neighbours hit by the recent financial crisis, the Portuguese Administration is leaving a balanced budget, having settled the cost of all the major construction projects and investment in basic infrastructures, the environment, health, education and social welfare. Macao is almost unique in the world in that it has neither foreign nor domestic public debt.

In addition to an excellent network of infrastructures and social facilities, the future Macao Special Administrative Region will also have a financial reserve in the form of the Land Fund established according to the terms of the Joint Declaration.

In the field of education, there is compulsory free educational provision up to the ninth year of education. Most schools, including university institutions and polytechnic colleges, provide free or subsidized education to over 100,000 pupils, in other words around 25% of the Territory’s population.

In terms of culture, there have been efforts to consolidate the roots of Macao’s identity by preserving both Portuguese and Chinese cultural heritage and building various museums and cultural facilities. The most recent addition has been the modern Macao Cultural Center. UNESCO has expressed its readiness to classify Macao’s Portuguese and Chinese architectural heritage as World Heritage.

Over the last 12 years, heavy investment has also been made in social facilities and the environment so as to promote Macao’s development as a city of culture offering quality tourism, particularly in the international congress tourism segment.

The Government of Macao has made health and education its top political and budget priority. As a result, the Territory’s health system and health indices have given Portugal and the local community just reason for pride.
In fact, following the World Health Organization’s “Health for All” directive, Macao’s health system is equipped with modern infrastructures and technology, at primary health care and hospital levels.

Ladies and Gentlemen,

Portugal is a founding member of the World Health Organization and has participated in its work over the last 50 years, both through Macao in the Regional Committee for the Western Pacific, and also directly in the World Health Assembly which it is chairing this year.

Please allow me to mention the gracious presence here of the Chairwoman of the WHO World Health Assembly, Portugal’s Minister for Health, Dr Maria de Belem Roseira.

After 19 December 1999 Macao will continue to be represented in the World Health Organization and the Regional Committee, under the name of “Macao, China”.

Through our Regional Committee, the World Health Organization has always, and especially since 1953 been a precious ally and strategic partner for Macao as it has worked to develop its health system. WHO cooperation in a wide variety of fields has done much to help our Territory, and I wish to express our public gratitude for this.

Ladies and Gentlemen,

Before concluding this speech I am moved to share with you the profound concern felt by Portugal, the European Union and the entire civilized world, in the face of the dramatic humanitarian situation suffered by the Timorese Nation in recent times.

This former Portuguese territory, our neighbour, is currently the victim of cold-blooded genocide planned by the military wing of the Indonesian regime, the country that has occupied East Timor illegally since 1975.

Portugal, as the de jure administrative power of East Timor, has striven relentlessly to force Indonesia to comply with the agreement signed by Portugal and the United Nations on 5 May this year, and the overwhelmingly positive vote in favour of freedom and independence expressed by the people of Timor in the ballot taken on 30 August last under the auspices of the United Nations.
Annex 4

I call on the States present here to exert pressure on Indonesia to comply with its international commitments, establishing conditions that can bring to a halt these massacres, and permit the organization and implementation of humanitarian aid for all displaced persons and refugees.

I call on States, churches and international organizations to work together so that we can provide immediate and substantial humanitarian aid to the Timorese nation, and to tell Indonesia that neither ethnic cleansing nor racial or religious genocide can be tolerated.

We must keep a keen watch and mobilize the international community so that peace and freedom can become a reality in Timor.

Ladies and Gentlemen,

I wish you a successful plenary session, and a pleasant stay in Macao.

It is with great pleasure that I hereby declare the fiftieth session of the World Health Organization Regional Committee for the Western Pacific open.

Thank you very much.

It has been a year like no other. I am sincerely grateful to the Regional Committee for having bestowed on me the honour of being Chairman of the forty-ninth session of the Committee that was held in Manila last year. It had been a very challenging job for me, but with your full support and cooperation, we had succeeded in carrying out our work. Once again, the regional solidarity for which this Region is known has carried us through a year full of challenges.

On behalf of the Committee, I would like to thank our host, the Government of Macao, for inviting us to hold this fiftieth session in this beautiful and vibrant city. The warm hospitality that we have been accorded even before we set foot in Macao, and the grand opening ceremony that we have just witnessed, are just a preview of what our gracious hosts have so carefully prepared to make this fiftieth session of the Regional Committee a truly memorable one.

Distinguished Representatives, there is every reason that it should be so. This is the last session of the Regional Committee of this century. Our deliberations during this Session will pave the way for our work into the next century and beyond.

For WHO, the past year had been an eventful one. Both at the global and regional levels, the Organization had a changing of the guard. As you know, the Director-General, Dr Gro Harlem Brundtland, assumed the global leadership of the Organization on 21 July 1998. In this Region, the new Regional Director, Dr Shigeru Omi, took over from his predecessor, Dr S.T. Han, on 1 February this year. These new appointments have ushered in many structural reforms and new initiatives to improve the Organization’s effectiveness.

In my address to the Committee last year, I said that as we enter a century of growing health needs and rising expectations, we need strong leadership at all levels. Leadership that will continue and sustain the gains that have been achieved; leadership that is visionary and that will make a difference.
I must confess that I was very pleased early on in Dr Omi’s tenure when I read the document that is now called *WHO in the Western Pacific Region: a framework for action*. I was particularly impressed by his honest assessment of the internal workings of the Organization and how these could be improved for the Organization to be more effective. The strategies to meet these challenges that are laid down in the *Framework for action* inspire hope and confidence that we will be moving into the new century better prepared to pursue our goal of health improvement in the Region.

I therefore very much look forward to the address of our Regional Director, Dr Omi, this afternoon. I am sure he will share with all of us his vision for this Region and how he wants the World Health Organization Western Pacific Region to conduct its work and continue to establish itself as the leading international Organization in health. I am sure you will all want to join me in wishing Dr Omi every success and that you will give him your full support during his tenure.

I believe that under his leadership, we, in this Region, will not only be better prepared and motivated to collectively face the challenges of the 21st century, but to make a valuable contribution to global health as well.

Before concluding, let me once again thank the Committee for giving me this honour and for supporting me in the conduct of my duties. As I said earlier, it has indeed been a great pleasure and privilege to have worked with you, especially during one of the most exciting times of the Organization. To the Secretariat, my sincere appreciation for your support and the great work you do with countries in our pursuit of a better quality of life for our peoples.

When I turn over the chair to my able successor, I also hand on to him or her the support that the Secretariat has extended to me and the excellent cooperation I have received from all of you.

Distinguished Representatives, thank you very much and I wish you all a very pleasant stay in Macao.
One year ago I was greatly privileged to be nominated by this Committee as Regional Director for the Western Pacific Region of WHO. I feel a deep sense of responsibility to you, to the people you represent and to the four previous Regional Directors for the Western Pacific, in particular to my immediate predecessor, Dr. S.T. Han. I will do my very best to live up to the high standards my predecessors have set.

Let me begin on a personal note. I spent the first few years of my professional career as a medical doctor working in isolated areas of Japan, including some small islands in the Pacific. Resources in these areas were scarce and during those formative years I became immersed in primary health care. I learned that, unlike their counterparts in metropolitan centres, health workers in outlying areas have to perform numerous functions, from setting broken limbs to working with community leaders to promote healthy behaviour. I realized that this was the kind of health care I wanted to work in. These experiences inspired me to want to work for the World Health Organization in later years.

During my ten years with WHO, working in the field of communicable disease prevention and control, including poliomyelitis eradication, I have developed a strong and enduring affection for this organization that has touched the lives of so many people. WHO brings together people from very different backgrounds and cultures and moulds them together to work for a common cause. It is the organization that the world looks to for guidance in all matters related to health.

In fact the potential of the World Health Organization is almost limitless. It can literally alter the course of the history of the health of our Region. I have always regarded myself as extremely fortunate to work for such an organization. To have been given the opportunity to lead WHO in the Western Pacific Region into the next century is the greatest challenge of my life.

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In my first speech to WHO staff in February this year, I asked my staff to consider a fundamental question. Why does the World Health Organization exist?
The answer is that we are here to serve the Member States by responding to their health needs. That has been the raison d’être of WHO since the Organization was founded in 1948 and that is why I called this address “Getting the job done together”. Working together, WHO and its Member States eradicated smallpox, a disease which had led to the collapse of empires. In the Region, we are on the verge of ensuring that no child in our Region need suffer the crippling disease of poliomyelitis. This achievement has been due to the tremendous efforts of Member States and the personal commitment of numerous individuals working in national immunization programmes, many of whom are in this room.

Yet, the challenges ahead are even greater than those we have already faced. In just over 100 days we will enter a new millennium. It is imperative that we revitalize the organization so that it is able to take on the health challenges of the 21st century.

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Casting my eye over the many regional challenges that face WHO at the beginning of the new century, it seems to me that they can be grouped under four headings.

First, we need to improve our understanding of the changing needs of Member States. If we are to get the job done together, the job has to be clearly defined. Our analysis must be thorough and it must guide our work towards real and measurable goals.

Second, in order improve our response to these needs we must reform ourselves. In many ways WHO has been too bureaucratic and formal. It has been too obsessed with paper work. It has sometimes been too focused on process at the expense of achieving tangible outcomes. We need to carry out a thorough reform of our attitudes and our organizational culture.

Third, we will get the job done far more effectively if we get it done together. The field of international public health is growing ever more complex and there are many new players. I welcome this development. The more intergovernmental, national and nongovernmental organizations working in public health in the Region, the greater the potential for good. However, we must recognize that there are also serious issues of coordination. Many of you will have your own stories of how different organizations in your countries have duplicated or even conflicted with each other.

The fourth and final challenge is to achieve more with fewer resources. As all of you know, the Fifty-first World Health Assembly held in Geneva last year significantly reduced
the financial allocation to the Western Pacific Region. Over the next six years, our funds from the regular budget will decrease by approximately 18%.

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I hope that the document *WHO in the Western Pacific Region: a framework for action* explains clearly and concisely how we intend to tackle these formidable challenges. I do not intend to go into the details of the document here, but please allow me to explain how it came into being and how it addresses the four challenges I have just identified.

Immediately after the Regional Committee nominated me as Regional Director in September last year, I started to prepare for my tenure as Regional Director. I knew that the seven months between my appointment on 1 February this year and the current session of the Committee would be crucial to defining my period as Regional Director. In the English expression, I wanted to “hit the ground running”. I wanted to produce a document that would lay a solid foundation for our work and I wanted that document to be the first stage of my collaboration with Member States. Even before I took office, therefore, I began an extensive consultative process. Looking around this table I can see many people with whom I discussed the document. All of you gave me invaluable advice and I would like to take this opportunity to thank all of you for the time and trouble you took. I hope that the document will be seen, not just as a set of principles for WHO, but as a starting point for our joint mission to improve the health of the peoples of the Western Pacific Region in the next century.

I also wanted to make sure that the document represented a more focused approach to the health problems of the Region. In the past, our work was spread across 50 programmes. While there are advantages to breaking down our activities in this way, on balance I felt that this contributed to a feeling of fragmentation, both internally and in the way WHO was perceived by the people it served. After consulting extensively with Member States I therefore decided to establish four main themes for our work: (1) combating communicable diseases; (2) building healthy communities and populations; (3) health sector development; and (4) reaching out. Let me briefly elaborate on some of the issues that I want the organization to tackle under these four themes.

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With regard to the first theme, combating communicable diseases, I am particularly worried about levels of tuberculosis in the Region. To me, it is simply unacceptable that we should be entering the new millennium with levels of tuberculosis in the Region that are actually *increasing*. Why is this when we have a tried and tested control strategy that cures nine out of ten patients? One reason may be that tuberculosis mainly strikes the poor, those who are traditionally without a voice. I hope that, working together, we can speak for those in our Region who either have tuberculosis or are
threatened by it. This is an area where enormous gains can be achieved quite quickly. In China, for example, after the introduction of directly-observed treatment, short course, or DOTS, in selected areas of the country the tuberculosis case fatality rate plummeted from 30% in 1991 to 7% in 1994. If DOTS is implemented regionwide it will be possible for us to achieve similar gains across the Region, saving tens of thousands of lives every year.

Moving on to the second theme, building healthy communities and populations, I believe that we must build on the excellent start that has been made in promoting healthy environments and healthy lifestyles. The regional document New horizons in health and Healthy Cities and Healthy Islands initiatives have already helped to change people’s attitudes towards their health. What we now have to do is to build on these successes. We have to make sure that the fine rhetoric we have produced so far is reflected in real health gains. That is why I am particularly pleased that many of our Healthy Islands projects in the Pacific, for example, now contain a noncommunicable diseases element. This is the direction I want us to move in.

Let me now talk about the third theme, health sector development. In preparing for the new century I want us to be honest in our assessment of what WHO has achieved and what it has neglected or done poorly. I think all of us in WHO would admit that health system development is an area where we have been weak. Yet strong and effective health systems must be the cornerstone of our work.

I firmly believe that if we manage to strengthen health systems in the Western Pacific Region we will be able to achieve far more in every area of our work. Almost everything we do in a country is affected, positively or negatively, by the status of the health system. Looking ahead to the challenges of the next century, it is clear that strong health services will be more important than ever. Let me just take one example, the growing number of older persons in the Region. In 30 years, the number of older persons in the Region will have doubled. Our health systems will need to provide the services they need, from preventive services such as early detection of chronic diseases, to curative care and rehabilitation, including psychological support. Not only that, they will also need to promote the healthy behaviour in childhood and middle age that is the basis for a fulfilling old age.

I intend to ensure that WHO asserts its leadership role in promoting better health systems in the Region in the next century. What constitutes a good health system, at both policy-making and community levels? What are the dangers of too rapid a move towards privatization in both the delivery of services and paying for health care? What sort of targets should Member States be aiming
for in terms of access? These are not simple questions, but I think Member States have a right to expect an organization like WHO to work with them to find the answers.

Let me talk about one aspect of the fourth theme, reaching out. I have already mentioned that WHO must improve its collaboration with its many partners. However, while it is important for WHO to reach out to other agencies, it is also essential that WHO in the Western Pacific Region should work closely with other parts of this Organization, particularly with WHO Headquarters. I was delighted when our new Director-General stressed in her acceptance speech to the World Health Assembly last year that WHO must be one organization. I completely agree, which is why I am making sure that we in the Region are giving full support to two of the Director-General’s cabinet projects, the Tobacco free Initiative and Roll Back Malaria.

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In order to achieve tangible results in these themes, we need to make some changes in the way we carry out our work. The first change concerns our culture and attitudes. Our overriding mission must be to achieve results. We need to make the organization more outcome-oriented, rather than process-driven. All other considerations must take second place to this goal.

In order to make our organization more geared towards outcomes I shall grant members of staff more authority. In turn I shall expect them shoulder more responsibility. I want them to realize that working for the World Health Organization gives them enormous potential to do good. I want them to think creatively and I want them to be focused on achieving quantifiable outcomes.

To maximize the potential of our staff I shall put in place a new structure. We need a structure that will increase the opportunity for collaboration and cross-fertilization of ideas. As you will have seen in the Framework for action, within the four themes, I have created 14 focuses and 3 cross-cutting focuses. I believe that this will allow much greater scope for team work. Under the new structure at the Regional Office, staff from, for example, nutrition will be able to work together with their colleagues in the Integrated Management of Childhood Illness to combat iodine deficiencies in children. This is just one example of how I shall ensure that our relatively meagre resources are concentrated together to achieve real and significant health gains. By encouraging staff from different disciplines to work together, we can achieve a critical mass of energy and resources that will allow the Organization to achieve far more than under the former 50 programmes.

Of course any restructuring, however justified, will have far-reaching implications, particularly on the budgeting process. You will recall that last year you approved the programme budget for 2000–2001, which was based on the 50 programmes I referred to a moment ago. I
therefore hope that you will appreciate the need for some flexibility in implementing the budget for 2000–2001 in line with the themes and focuses that are outlined in the Framework for action. We will of course need to ensure that we retain the transparency and openness that has characterized the work of WHO in the Western Pacific Region in the past.

Another reform that I believe we must make is to bring a sense of objectivity to the evaluation of our performance. Organizations such as ours are often criticized because our endless evaluations seldom seem to result in fundamental change. I must admit that there is some truth to this charge. I therefore intend to make greater use of people from outside the Organization in order to improve our work. I shall be appointing several external advisory groups to advise on future directions for key technical areas of our work and, where necessary, to tell us where we are going wrong. My model will be the Technical Advisory Group, or TAG, that has guided our work in poliomyelitis eradication for many years.

At the country level I believe there is great deal to be done and I look forward to working with all of you to ensure that WHO provides you with the best possible support. After all, as I said at the beginning of this address, WHO is here to serve the Member States by responding to their health needs. This will be a long process, but as a start we shall be delegating more authority to WHO Representatives and strengthening our operations at country level.

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Before closing, please allow me to touch on some of the changes that we have already initiated in the seven and half months since I assumed office. As I said a moment ago, my overriding priority is to make the organization more outcome-oriented. I want my staff to establish clear targets and then to direct all their energies at achieving them. Therefore, one of my first tasks was to request each of the focuses at the Regional Office to prepare very clear goals for the next two bienniums and to quantify these where possible. I asked every member of staff to know exactly where he or she wants to go and how to get there.

I have always felt that an organization can only be as good as its staff. I have therefore devoted considerable attention to ensuring that we are served by competent and highly motivated people, both at the Regional Office in Manila and at country level. I have already appointed my senior management team. Of the three new technical directors at the Regional Office, two are women. I have also appointed the first two female WHO Representatives in the Region.

Here at the Regional Committee, I have also made some changes, which I hope will meet with your approval. On Wednesday afternoon, we shall hold our first ever “ministerial round table” in
conjunction with the session. I have also scheduled an agenda item on “Technical briefings and ministerial round tables” which will give you an opportunity to give me your views on whether this should be a regular feature of our meetings.

The reforms I have just described are just a beginning. Many more initiatives are already underway. I have no doubt that they will lead to a much stronger, more focused and more nimble organization in the future.

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Ladies and gentlemen,

I face the new century full of hope. I believe that what we achieve in the next few years will set the tone for the health agenda for our Region for the 21st century. We have serious challenges ahead of us. But given the dedication and enthusiasm of the people in this room, and those they represent in their countries, I feel completely confident that we can overcome the challenges that lie ahead. I am looking forward very much to working with each and every one of you to improve the health of the people of the Western Pacific Region. The future is in our hands. Let’s get the job done together.
SUMMARY RECORD OF THE SECOND MEETING

Hyatt Regency Ballroom, Macao
Tuesday, 14 September 1999 at 9 a.m.

CHAIRPERSON: Dr José Alarcão TRONI (Macao)

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1. ADDRESS BY THE INCOMING CHAIRPERSON: Item 4 of the Agenda

The CHAIRPERSON addressed the Committee (see Annex 1).

2. ADDRESS BY THE CHAIRPERSON OF THE WORLD HEALTH ASSEMBLY

Dr Maria DE BELÉM ROSEIRA, Chairperson of the World Health Assembly and Minister of Health of Portugal, addressed the Committee (see Annex 2).

3. “GETTING THE JOB DONE TOGETHER”, ADDRESS BY THE REGIONAL DIRECTOR: Item 7 of the Agenda (Document WPR/RC50/2) (continued); REPORT OF THE REGIONAL DIRECTOR: Item 8 of the Agenda (Document WPR/RC50/3) (continued)

Dr LEE (Republic of Korea) commended the Regional Director’s Framework for action as a timely preparation for the new century. There was a need to focus on the outcome of work and on priority areas. WHO and the Member States had to work together to make healthy human environments and to protect and promote health for mankind.

Dr TEMU (Papua New Guinea) also welcomed the Regional Director’s Framework for action and followed other countries in promising to implement it. He asked for clarification on the timeframe for the action plan, which appeared to him to be five years. In addition to the two special projects selected by WHO Headquarters – tobacco and malaria – attention had to be paid to countries whose health status was below average, especially in key areas such as HIV/AIDS, tuberculosis, maternal and infant mortality, and there was inadequate health sector development due to political, social and economic circumstances. Criteria and targets should be set for partnerships with other organizations, such as the Pacific Community, in order to facilitate support to countries, particularly at programme level. He noted that current forms of bilateral and multilateral support on offer at country level required counterpart efforts that were not available in countries such as his. He asked the Regional Director to consider pursuing sector-wide expenditure, as opposed to project modes, as a means of improving collaboration and coordination with partner agencies. In “cross-cutting issues” the important area of drug supplies needed further attention, since it caused problems in smaller countries such as Papua New Guinea, not in drug policy and legislation, but in drug availability. He agreed with the Representative of Malaysia that equity among Member States as well as merit should be taken into account when staff were appointed. He expressed appreciation of the work that had been done by Dr S.T. Han, the former Regional Director.
On the presentation of future reports, he asked for benchmarks to be matched with resource inputs, so that the effectiveness of expenditure could be seen. He also called for targets at programme level - similar to the Human Development Index prepared by the United Nations Development Programme - so that the performance of countries could be measured since it would provide a very clear signal to governments that were not paying enough attention to health sector development. The current report did not enable the speaker to show his government the performance ranking of his country, something that was needed if health was to be advocated at all levels.

He expressed the gratitude of his country for the support of WHO and many Member States and organizations and for their assistance in coping with the effects of the tsunami that had affected his country.

Mr MOOA (Kiribati) recalled how the Regional Director had conducted extensive consultations before producing the Framework for action. It set out four main challenges for WHO in the Region, with partnerships and special projects to cater for the needs of Member States. He welcomed the work on building healthy communities and populations.

He praised the Report of the Regional Director, although he agreed with the representative of France that some of the figures needed to be updated. He particularly welcomed the continuing commitment of WHO to reproductive health issues, which was not a matter for the United Nations Population Fund (UNFPA) alone, and the intention to strengthen collaboration and partnership in that area.

Dr CLARO (Macao) observed that Macao’s situation illustrated the issues and challenges raised in the Framework for action: an integrated health system covering the whole territory provided free health care to all. The problem was how to upgrade and sustain the system while ensuring that it remained accessible, equitable and affordable – especially with a shrinking health budget. The population was ageing, the environment was deteriorating, and disease patterns were changing. The main causes of death were cardiovascular diseases and cancer, but tuberculosis and viral hepatitis remained public health problems. Development of human resources had to continue. Macao was prepared to work with WHO in the Region to build on previous achievements.
Dr CHAN (Hong Kong, China) commended the Regional Director for his user-friendly, concise and analytical report and his Framework for action. She pledged support for reform in the interests of reduced bureaucracy and greater sensitivity to the needs of Member States. She also supported the initiatives and strategies to revitalize the work of the Region; progress in such areas as strengthening of health systems, tuberculosis and tobacco control would be followed with interest.

On “reaching out”, she associated herself with other speakers in stressing the importance of greater cooperation with other agencies, and urged the extension of that concept to the private sector - a crucial issue in view of the scarcity of resources and the need for consolidation and sharing of expertise and experience. She said she would welcome the Regional Director’s comments on how countries should work with the private sector to ensure effective and ethical partnerships.

Mr TAMARUA (Cook Islands) also commended the Regional Director on the Framework for action. He noted that the themes and focuses provided clear guidelines to meet the needs of the Region, but they should be regularly revised. The Regional Director’s proposals concerning future reporting and planning were realistic and encouraging. The proposed strategies were practical and flexible and would allow more to be achieved in spite of financial limitations.

Dr ENOSA (Samoa) congratulated the Regional Director on his report which was clear and well focused. He also supported the Framework for action, urging in particular continued support for the tobacco free initiative, tuberculosis control and measures against malaria, as well as health sector management and “gender issues”. The outcome-oriented approach was also commendable. However, he stressed that nothing could be achieved without close cooperation between countries and partners in the Region.

Samoa appreciated WHO’s cooperation and looked forward to being the first country in the Pacific to eliminate filariasis.

Dr PEHIN ABDUL AZIZ (Brunei Darussalam) welcomed the Regional Director’s leadership in focusing on issues deserving high priority and the outcome-oriented approach, and endorsed the plans for “getting the job done together”.

He commended the improved format of the Regional Director’s Report with more analytical and illustrative material. Chapter 3 on “Health services development” raised particularly important issues. In Brunei Darussalam, a more rational and sustainable health care financing system was
needed to ensure the continued effectiveness of the health care system. He expressed gratitude for WHO’s cooperation in this area.

While agreeing that the situation in East Timor required attention, he reminded the Committee that there were areas within the Region that faced similar problems.

Brunei Darussalam looked forward to welcoming the Regional Committee for its session in 2001.

Mr SCOTTY (Nauru) expressed confidence in the Regional Director’s leadership and impartiality, welcoming the signs that there would be “less talk and more action” and proper attention to doing things well in a spirit of regional cooperation and with shared resources.

The smaller countries in the Region, like his own, required the assistance of larger and more fortunate Members in measures for public health and welfare.

He expressed regret that the regional budget was to be reduced when so much was being done to make WHO’s work more effective.

Dr PRETRICK (Federated States of Micronesia) also expressed support for the revised format of the Regional Director’s Report and for the Framework for action, urging measures to ensure tangible results. He considered the policies outlined in the framework were well designed and could be incorporated into national health plans.

The stress on cooperation and collaboration was also appropriate; many agencies were playing a vital part in improving health status in his country. He thanked them and urged continued support.

He noted with pleasure that tuberculosis control had been proposed as a special project.

Mr REX (Niue) wished the Regional Director well in his leadership role, commending his report and applauding the promise of continued concise readable reporting.

He endorsed the proposal to use external advisory groups.
Niue pledged its support for “getting the job done together” and expressed gratitude for WHO’s cooperation.

The REGIONAL DIRECTOR, thanking Representatives for their encouraging comments and pledges of support for his plans to strengthen the work of the Region, said he would reply on each issue by grouping the Representatives’ questions.

China and others had asked about the relation of his plans to New horizons in health, presented by his predecessor, Dr S.T. Han, in 1994 and endorsed by the Regional Committee. That publication had provided a policy framework with four very important themes: a proactive attitude to health concentrating on preventive measures; promotion of health throughout life; the role of individuals and the community in health; and the need for multisectoral approaches to cooperation for health.

His intention was to build on those elements, as reflected in his Framework for action, which was designed to operationalize the principles enunciated in New horizons in health.

In reply to questions raised by the United States of America, the Philippines, China and others on the linkage between the new structure at WHO Headquarters and that proposed for the Regional Office, he explained that the Director-General had regrouped the 50 former programmes into nine clusters, in turn divided into 34 departments. The smaller size of the Regional Office made it impractical to adopt the same structure in the Western Pacific Region. He had therefore selected 14 focuses and three cross-cutting focuses, taking account of present and future needs and challenges in the Region, as well as health problems common to its Member States. Those focuses were action-oriented and activities under each focus were being implemented by a team of several staff members with the relevant expertise in order to create synergy. With that more integrated and focused approach the Office could handle virtually all the areas covered by the departments at Headquarters.

He had discussed with the Director-General ways in which to ensure a clear linkage between the 34 departments at Headquarters and the 14 focuses and three cross-cutting focuses in the Regional Office. For example, in the Regional Office ageing came under the focus “Healthy settings”, whereas at Headquarters it came under the department of “Health promotion and lifestyles” in the cluster “Mental health and social change”. Similarly the area covered by the regional focus “Health sector reform” came under the department of “Health systems” in the cluster “Evidence and information for policy”. When reporting at global level on implementation of the programme budget it would be easy
to reformat the 14 focuses and three cross-cutting focuses to fit the 34-department structure, thus correlating work across the whole Organization.

With regard to ways in which collaboration between WHO Headquarters and the six regions could be strengthened, he agreed with the Director-General when she said that WHO should be one organization. The question was how to translate that concept into action. The Director-General and the Regional Directors met in Geneva after the World Health Assembly in May 1999 to discuss coordination between the three levels of the Organization. They had concluded that in addition to the Headquarters Cabinet, comprising the Director-General, the Executive Directors and senior policy advisers, a Global Cabinet should be established to deal with global policy issues, comprising the Director-General and the Regional Directors and, at the discretion of the Director-General, other senior staff, depending on the topic to be discussed. The Global Cabinet would discuss, among other matters, coordination between Headquarters and regional offices.

As part of the effort to ensure more frequent and open dialogue between the different levels of the Organization, up-to-date communications technology was being used, including video conferencing. In addition, several staff members had been reassigned between Headquarters and regional offices and among the regional offices, contributing to better understanding of activities in different parts of the world.

Although the regional programme budget described all activities to be undertaken, it did not define the relative roles of Headquarters and the regional offices. Neither did the global programme budget. When the programme budget proposals for the financial period 2002–2003 were to be prepared, he would propose that the relative roles of different levels of the Organization should be specified in order to avoid duplication and waste of resources.

Replying to the question raised by Malaysia and others on coordination with other regions, he agreed that interregional collaboration was crucial, particularly in control of communicable diseases. For example, the Western Pacific Region had been free of poliomyelitis for more than two years, and any risk of imported infection had to be avoided. To this end, interregional meetings had been held and cross-border immunization activities undertaken, especially between China and Myanmar. A meeting on malaria control between the countries of the Western Pacific and the South-East Asia regions was to be held shortly. It had been agreed that such collaboration would not be limited to communicable diseases; its scope would be expanded gradually to include noncommunicable
diseases, environmental health and other areas. Further, collaboration would be extended to regions other than South-East Asia.

With regard to the proposed external advisory groups, he concurred that selection should be transparent. He had based his proposal on his experience with eradication of poliomyelitis. Success could be attributed to many factors, but one of the key elements had been the input of the Technical Advisory Group on the Expanded Programme on Immunization and Poliomyelitis Eradication in the Western Pacific, which had been in operation for nearly ten years. The group had not only provided technical advice but had also contributed greatly by advocating and promoting awareness of the importance of immunization, mobilizing funds and solving problems. For that reason he sought to establish similar mechanisms in key areas such as tuberculosis control and health sector reform. In order to ensure transparency in the selection of members, he intended to follow certain principles: candidates should be multidisciplinary, competent and respected experts; membership should respect balanced geographical and socioeconomic distribution; membership would be for a fixed term and renewal would be possible but not automatic; and the approval of candidates would be sought from the Members States concerned to ensure the appropriateness of all members. Further, all information related to the activities of technical advisory groups would be made available to the Regional Committee.

Referring to the suggestion from the Representative of Papua New Guinea that document WPR/RC50/3 should also contain an analysis of the effectiveness of expenditure in the Region, he observed that the report was intended to serve various purposes. Aside from informing Members of the status of WHO’s activities in the Region, identifying problems in implementation and proposing solutions, he hoped that it would also be read by other policy-makers and public health professionals, who were not necessarily interested in the details of how the Regional Office used its financial resources. Nonetheless, the Regional Director was accountable to the Member States for budget implementation. Reporting was usually done through the interim report on budget performance and the biennial final report, which contained a full breakdown on the use of resources.

Referring to comments on the use of indicators for cross-country comparisons, he recalled that, when the Regional Committee had originally discussed *New horizons in health*, it had requested definition of relevant indicators. Those had been submitted to the Regional Committee, which in resolution WPR/RC48.R5 had requested the Regional Director “to further refine the minimum set of regional indicators … and to continue to work with countries to develop country-specific indicators”. Adopting a “bottom-up” approach, workshops had already been held in selected countries to
determine those indicators, which would be followed by definition of regional indicators, thus enabling Member States to make cross-country comparisons.

Hong Kong, China and others had mentioned cooperation with other sectors and bodies, including the Pacific Community and the Asian Development Bank. As he had said in the Framework for action, health issues were now so complex that one country or one organization alone could not solve all the difficulties encountered. Collaboration was therefore essential in order to make progress in such areas as control of communicable diseases or health sector reform, and to avoid different institutions giving countries conflicting advice. The international community should reach a consensus on the kind of advice it intended to provide.

With regard to collaboration with the private sector, he was willing to work with any entity provided that its interest lay in promoting health. He cautioned, however, against the risk that WHO might be influenced by, or misused to promote, commercial interests. Nonetheless, beneficial collaboration did already exist with the private sector, for example in the provision of drugs for the elimination of filariasis. WHO Headquarters was drafting guidelines for relations with the private sector which were be issued shortly and would be made available to Member States.

4. PROGRAMME BUDGET


The REGIONAL DIRECTOR, introducing the item, said that the interim report on the budget performance for the biennium 1998–1999 contained details of the financial implementation of the regular budget and disbursements from extrabudgetary sources from 1 January 1998 to 31 May 1999. The various changes in the budget were outlined in general terms in Annex 1 and in greater detail, including financial implementation as at 31 May 1999, in Annex 2. Annex 3 provided notes on the programmes in which there was substantial variation between the actual expenditures at 31 May 1999 and the operating budget. Annex 4 provided a summary of the obligations made from extrabudgetary funds.

He explained that the interim report was intended to keep the Regional Committee informed of developments since the original budget proposals were endorsed in 1996. He then explained some of the details of financial implementation outlined in Annex 2 of the document, where columns 1–5
represented changes that had taken place between endorsement of the budget by the Regional Committee in September 1996, through approval of the budget by the World Health Assembly in May 1997 to the revised working allocation in December 1997.

Some of the changes made before the World Health Assembly in May 1997 had not involved a change to the budget total but had strengthened global priorities. For example, US$ 699 800 had been taken from administration and, of that amount, US$ 300 000 had been transferred to strengthen National Health Systems and Policies (programme 3.1.2) and US$ 399 800 to strengthen the control of other communicable diseases (programme 5.2). Furthermore, the duty station of a shared country-based post had been transferred from Viet Nam to Cambodia in order to increase the allocation to least developed countries.

Changes that had altered the overall total of the budget, shown in Annex I, and changes in programming made during implementation had resulted in the operating budget shown in column 9 of US$ 75 554 900.

The obligations incurred as of 31 May 1999 for the regular budget amounted to US$ 52 230 200, which represented 69% of the operating budget; however, by the end of August, regular budget implementation had risen to 81% owing to obligation of a further US$ 8 900 000. He was confident that 100% of the regular budget would be implemented by the end of the biennium since the new structure of the Regional Office was operative and new directors, new WHO representatives and new technical members of staff had been appointed.

In respect of extrabudgetary funds, US$ 26 100 000 had been disbursed by the end of May and a further US$ 2 900 000 by the end of August.

To facilitate comparison of the different expenditures in each programme with the total of all funds disbursed, regular budget and extrabudgetary expenditures had been combined in column 13. The percentage of total implementation was shown in column 14. The distribution of expenditure could be assessed more meaningfully only at the end of the biennium when implementation had been completed.

As the accounting procedures at WHO required that the salaries and allowances for filled long-term posts be fully obligated at the start of the biennium, programmes with long-term posts would show a relatively high rate of implementation. Although the period to 31 May 1999 represented 17 out of 24 months or approximately 71% of the biennium, salaries were in many cases obligated for the full 24 months. In contrast, other provisions were obligated progressively during the
biennium, depending on which quarter of the year they had been planned for, and commitments for some of those components had not therefore been made by the end of May 1999.

He reminded representatives that the final report on the budget performance would be presented to the Regional Committee at its fifty-first session, at which time the final implementation results could be discussed.

Mr BOYER (United States of America) commiserated with the Regional Director on the difficulty of implementing a budget during a period in which extensive changes had been made in the classification of programmes and in the priorities set by the Executive Board and in which other factors had led to increases and decreases in the overall budget. The report showed clearly the movement of funds from one part of the budget to another. He recognized the necessity to allow the Secretariat flexibility in administering the budget, which was prepared long before it was implemented, since health conditions might change during that time and indeed in the present case the Regional Director had changed.

He was pleased to learn that the dialogue between the Regional Office and WHO Headquarters was considered fruitful, as he was aware that the reorganization of the Organization into nine clusters had resulted in an impression among some programme directors and staff members in Headquarters that they were receiving inadequate support. It was important that such dialogue existed between the Director-General and the Regional Directors to ensure one cohesive Organization and not seven separate organizations. He noted in that context that the interim report on the budget provided information on all 50 programmes of WHO, whereas details of specific programmes were lost in the format newly adopted at Headquarters. He was concerned that the proposal of the Regional Director to restructure the budget according to the 14 focuses and three cross-cutting focuses would mean that less detailed information would be provided. However, it was important that the structures of the budgets of the regional offices and Headquarters be comparable. He noted with approval that the Regional Office had succeeded in adjusting its expenditures to meet the requested 3% savings and that it had used those funds to increase resources in programme areas of high priority. His delegation considered that WHO should in general concentrate its resources on programmes in areas in which it had a real opportunity to make progress and not try to address all health problems. He commented that the term ‘implementation’ was used in the report to refer only to the amount of money spent, whereas it should include the actual performance of the programme: whether the work had made a significant difference, whether health indicators had changed as a result and whether changes in the approach were needed. Such evaluations might be included in the annual report on the activities of the Regional Office, as suggested by the Regional Director.
Dr SHINOZAKI (Japan) commented that the implementation rate of 69% as at 31 May 1999 was low, but he was confident that the remaining budget would be implemented now that the Secretariat had been strengthened by new personnel.

Mr ROKOVADA (Fiji) was gratified to see that implementation of the 1998–1999 budget was progressing well despite the difficulties imposed by budgetary cuts and rigid financial discipline. The challenge was to do more with the available resources. He suggested that further cost-effectiveness could be achieved in two areas: short-term consultancies and human resource development. Prudence should be exercised in hiring short-term consultants, and greater use could be made of local personnel at lesser cost. In human resource development, cost-effective training should be devised. The Fiji School of Medicine offered post-graduate training in clinical, public health and health services management disciplines, and had upgraded some undergraduate programmes in allied health and paramedical services to graduate level. Those courses were not only relevant to the needs of Fiji and other Pacific island countries but were also considerably cheaper than similar courses in developed countries. They had been supported by WHO and the governments of Australia, Japan and New Zealand. He urged the Regional Director to continue to seek extrabudgetary funding for important programmes.

Mr ESEKIA (Tuvalu) thanked the Regional Office, the WHO Representative in Fiji and the governments of countries such as Japan, Australia and New Zealand for their support in the implementation and development of health programmes in his country, which suffered from limited resources and geographical isolation. He hoped that such support would continue to be given to least developed countries such as his own.

Ms DAVIDSON (Australia) acknowledged that financial planning and monitoring for the Region were facing a period of transition, with new programme structures and new priorities identified by a new Director-General and a new Regional Director. She welcomed the restructuring of the format of the regional budget to reflect the programmes at WHO Headquarters, which would provide a clearer picture of how the programmes, activities and expenditure of the Region interacted with global programmes and priorities. She welcomed the proposal of the Regional Director to ensure that future budget documents showed the relative roles of Headquarters and the regional offices in the implementation of programmes. She reiterated the comment of the Representative of the United States of America with regard to the absence from the report of information on the effectiveness of programmes. She hoped that future budgets and reports would describe not only the amounts spent but also the objectives for which funds were allocated and the results that had been delivered. Since September 1998 when the programme budget for the next biennium had been agreed, the World
Health Assembly had taken decisions that would affect the budget of the Region; she asked how those decisions were to be implemented.

Mr MANUOHALALO (France) remarked that as the proposed budget took into consideration resolutions of the World Health Assembly and decisions of the Executive Board, it showed a clear reduction in the allocations for health systems reform, institutional support and training for human resources. Although he did not wish to question the decisions that had resulted in those changes, it was important to maintain sufficient funds for such activities. Sustainable development depended on the systematic construction of a health system that met the needs of the population. The major diseases could be overcome only by efficient health systems. Funds for coordinated action had also been reduced, even though that was a major role of WHO, particularly in countries to which many partner agencies were active.

Mr WARAKOHIA (Solomon Islands) said that his country had benefited from the prioritization process in the form of additional funds for its malaria control programme. Those funds had been used to purchase insecticides and equipment such as bed nets and microscopes, for training technicians and spraying houses, especially on the islands of Malaita and Guadalcanal. He noted the programme budget for 2000–2001 should focus more on priority themes and focus areas, and extrabudgetary funds should be mobilized for cross-cutting issues.

Mr LIU (China) noted that the changes that had occurred in the structure and priorities of WHO were reflected in the revised budget. Reductions had been made in administrative and personnel costs and in the allocation for technical cooperation, and transfers had been made within the budget. Priority programmes and national health policies had been strengthened at country level, partly from the 3% savings that had been achieved, and increased allocations had been made to least developed countries. Although only 81% of the budget had been implemented as of 31 August 1999, he was confident that the entire budget would be implemented by the end of the year. He noted that in May 1999 the rate of implementation of the different programmes varied widely, from 20% to 96%. He asked whether that disparity had since been reduced. He supported the request of the Representative of the United States of America for information on the effectiveness of programme implementation. He noted that the rate of implementation reflected only the difference between the actual expenditure and the budget allocation. A low rate of implementation might therefore indicate that a programme had been conducted at less cost than originally planned, with greater efficiency and cost savings. He suggested that the Secretariat develop simple indicators to evaluate not only financial implementation but also the overall implementation of programmes.
Ms EARP (New Zealand) emphasized the importance of maintaining a focus on outcomes and achieving results. She congratulated the Regional Director on his efforts to attain a gender balance among WHO personnel in the Region. The budget had been implemented under difficult circumstances of continuous changes and cuts. She had been pleased to learn that future budgets would be restructured according to the themes outlined in the document *WHO in the Western Pacific Region: a framework for action* but she shared the concern of the Representative of the United States of America that important detail might be lost. Consideration should be given to making the budgets of successive years comparable. The challenge in the current period of transition would be to meet the priorities of the Region while remaining within the budget.

Dr TEMU (Papua New Guinea) noted with concern the delay in appointing key people to certain programme areas. He asked for information on which programme areas were being covered by extrabudgetary funds and joined the Representative of Fiji in requesting the Regional Director to intensify his efforts to seek more such funding.

The REGIONAL DIRECTOR responded to the issues raised by Australia, China and the United States, of programme classification and implementation in terms of US dollars rather than accountability on the basis of effectiveness.

The interim report on the 1998–1999 programme budget had been based, as in the past, on 50 programmes, although the information would in future be presented in terms of 14 focuses and three cross-cutting focuses, which were not necessarily identical to the 34 Headquarters departments. In the next report to the Regional Committee, and indeed to governing bodies at WHO Headquarters, budgetary information would be presented in accordance with the 34 headings used at Headquarters. However, it would also be presented in terms of the 14 focuses and three cross-cutting focuses, since this was the presentation relevant to the Region. None of this changed the activities themselves. Each of the focuses already reflected expected outcomes. Each of the 34 departments at Headquarters also identified its expected outcome, and it was at that level that linkage would be made. The focuses would be the basis for action in the Region. Nevertheless, the Regional Director was willing to present the following year’s report in terms of both the 34 departments, as required by Headquarters, and the 14 focuses and three cross-cutting focuses plus three cross-cutting focuses, as had been agreed by the Regional Committee.

The second important issue raised by China and the United States was that of reporting only how much had been spent and how much remained and how much had been carried over. The Regional Director assured the Regional Committee that future reports would be more analytical.
Fiji, Tuvalu and other countries had asked how extrabudgetary resources were to be gathered for countries in greatest need. Australia had asked how the Region was to manage the reduced budget. There was no hiding from the fact that the budget was to be cut by 18% over six years. The many ways of dealing with the problem included prioritization and extrabudgetary funding. The central issue was that WHO and Member States had to come up with very good results and to provide information on how they spent the money, with frequent feedback to donor agencies so that more funds could be obtained. One staff member had now been made responsible for such coordination. In relation to the 2000–2001 budget, approved by the Regional Committee, despite reductions more resources had been transferred to priorities. On the positive side, the World Health Assembly had agreed to allocate US$ 15 million from casual income to priority areas at country level. Furthermore, the Assembly had asked the Secretariat to come up with a 2%–3% efficiency saving, and that would be allocated to countries and programme areas where the need was greatest.

The Representative of China had asked why the level of implementation in some programmes was low. There were two different causes. One was simply that, during the transitional period, many posts had been vacant; now the full team was in place, so that implementation would be accelerated. The other was that resources had been switched in the course of transition from lower to higher priority areas such as malaria and tuberculosis. Thus the total working budget for the higher priorities had increased. The obligation rate stated in the report followed allocation of the new funds. The real implementation rate would increase by the end of the year, to 100%.

On the matter of extrabudgetary resources, the Regional Director drew attention to relevant information in document WPR/RC50/4, on page 9, column 12 of annex 2, and in annex 4.

The meeting rose at 12.15 p.m.
ADDRESS BY THE INCOMING CHAIRPERSON, DR JOSÉ ALARCÃO TRONI

It is a great honour for me and for Macao to have the privilege of chairing the fiftieth session of the Regional Committee for the Western Pacific. This session is particularly significant both for the Member States and the Organization as our discussions will set the stage for health development in the next century. I sincerely thank the Committee for its trust and confidence. I shall do my best to assist the work of the Committee and lead it to a successful conclusion.

Distinguished Representatives, WHO is under new leadership at both global and regional levels.

Yesterday, our Regional Director explained his vision for the Region. In the document, *WHO in the Western Pacific Region: a framework for action*, Dr Omi has shown us how we can, as a Region, work together to build on what has been achieved already and to lay the foundation for health for the next century. I must congratulate Dr Omi for his thoughtful consideration of the regional health issues that we had been struggling with for many years and for identifying reforms that need to be made to further enhance the work of WHO.

In just over three months we shall be stepping into a new century. In the second half of the 20th century, we have had many successes in improving the health of the people of the Western Pacific Region. However, we also know that health problems are evolving. New threats have arrived before we have conquered the old ones. We now realize that we have to broaden our approach to health. It is becoming increasingly clear that all the solutions do not lie within the health sector itself, but that we must involve other sectors in our work. Meanwhile resources are dwindling, challenging us to look critically at our priorities.

Let me turn to the business ahead of us. On Wednesday afternoon we have an important innovation. This session of the Committee will be the first to feature both a technical briefing and a ministerial round table. The technical briefing will feature a presentation on the health sector here in Macao which I hope the distinguished representatives will find informative. This briefing will be followed by a ministerial round table on “Social safety nets in health sector development”. This is an extremely important subject, in view of both the recent Asian economic crisis and the reform measures that almost all of us are engaged in, and I am sure that all the participants will have much to contribute.
Yesterday, the Regional Director presented his report on the work of the Organization from 1 July 1998 to 30 June 1999. Let me comment on the report’s new look. I am sure you will agree with me that the report’s technical and analytical content is excellent, and its reference value is very important to us.

This afternoon we are scheduled to discuss the eradication of poliomyelitis. This is an achievement we can be very proud of. Thanks to the determined efforts of Member States, partner agencies and WHO, we shall soon rid the Region of this crippling disease.

On the other hand, the effective control of tuberculosis remains a daunting challenge, not only to developing countries of the Region but to all countries. Despite previous global initiatives for its control, only limited progress has been made. The strategy to control the disease is available. It has been proved to be cost-effective. I believe that this is an area where WHO can and, I am sure will make a significant contribution.

The Region continues to control the spread of HIV/AIDS through improved surveillance, effective sexually transmitted infections (STI) education and counselling, and strengthening of STI programmes in Member States. While it remains a serious public health problem, HIV/AIDS has not spread rapidly in the Region. However, we need to remain vigilant and continue to strengthen our STI and HIV/AIDS control activities to contain the epidemic.

Another area we must turn our attention to is the increasing use of tobacco in the Region. High tobacco-related morbidity and mortality are among the most significant health problems we face. Tobacco-related illness also results in substantial health care costs and economic losses. We have to address this problem urgently. I therefore request the Committee to study this problem carefully and commit itself to reducing tobacco use in our Region.

Distinguished Representatives, we have a full agenda ahead of us. I hope that we can concentrate on achieving a consensus on how we, as a Region, can move ahead.

I am sure you will take back home the issues we have discussed and act on the commitments we make at this meeting. As I said earlier, this fiftieth session of the Regional Committee is particularly significant as it will prepare us to meet the challenges of the 21st century.

Dear Representatives. I would like to call your attention to a very important and relevant issue to Portugal, the European Union, the United Nations and all the civilized world.
It is extremely urgent that all the member countries of the United Nations and specially those of Asia and the Pacific Region help the people of East Timor.

The humanitarian situation of East Timor is extremely critical and we are all obligated to help them in order to fulfil the agreements reached under the auspices of the United Nations.

It is a matter concerning us all, governments and nongovernmental organizations, to help this nation that is undergoing a process of deliberate programmed elimination.

I would also like to take this opportunity at the fiftieth session of the Regional Committee for the Western Pacific to express my deep gratitude to the Governments of Portugal, China and the Special Administrative Region of Hong Kong for their support to the health administration of Macao.

Before the end of the Portuguese administration, after a presence in Macao of more than four hundred and fifty years, it is my intention to pay a courtesy call to the health authorities in Beijing and Hong Kong, and to WHO Regional Office in Manila, Philippines, to express our appreciation for all the collaboration received during my mandate.

Again, I thank the Committee for this honour. As this year’s host, I invite you on behalf of the Governor of Macao, to testify your support for the friendly transition of Macao from Portuguese administration to Special Administrative Region of the People’s Republic of China under the principal of “one country, two systems” and to find the time to enjoy your stay with us.
ADDRESS BY THE CHAIRPERSON OF THE WORLD HEALTH ASSEMBLY
AND MINISTER OF HEALTH OF PORTUGAL,
DR MARIA DE BELEM ROSEIRA

It is both a pleasure and a privilege for me to take part in this, the fiftieth plenary session of the World Health Organization Regional Committee for the Western Pacific, as Portugal’s Minister of Health. I was also honoured this year to have been appointed Chairperson of the Fifty-second World Health Assembly, a post which has given me additional responsibility for protecting and pursuing the institutional goals of WHO.

The agenda for this meeting basically focuses on examining health-related data for the Region. It also covers the issue of reforming health care in this part of the world in a fashion that will not be detrimental to accessibility but rather provide more extensive forms of social support that can sustain or maximize the scope of health services.

The topic of the ministerial round table provides ample evidence of just how important and essential health is to development, thus highlighting the overriding need for us to pursue efficiency, efficacy and quality in health systems.

In fact, despite the tremendous inroads already made, current threats such as regional conflicts, poverty and the sustainability of a healthy environment demand extra efforts from us all.

These messages were conveyed by the WHO Director-General, Dr Brundtland, in this year’s World Health Report entitled Making a Difference.

There has been great progress in this part of the world over the last 50 years. However, I am sure that the uncertainties of the future should move us all to find solutions that can prevent those results already achieved from being undermined, despite constant scientific progress and our ever-increasing understanding of the causes and effects of certain pathologies.

The World Health Organization’s whole mission is based on respect for people. Human dignity is the foremost value to be preserved. If we look at results, it is clear that the protection of human beings based on universal solidarity has been shown to be the most effective model.
The more vulnerable groups – the poor, children, women and the elderly – must be our priority concern. However, it is precisely these groups that are most readily affected by disease and violence.

Disease, suffering and the incapacity generated by violence amount to dreadful brutality and, since they are avoidable, they are unacceptable. WHO cannot remain indifferent in the face of brutality and it has worked in many parts of the world to coordinate humanitarian action.

As I address this Assembly in this part of the world where we have witnessed the brutal massacre of the population of East Timor, perpetrated in the wake of an accepted referendum process and results, I can but appeal to your consciences and ask you to raise your voices to demand the effective and speedy implementation of an international force that can ensure security in the Territory. The first step lies with humanitarian aid.

The chilling situation in East Timor – where hundred of deaths have occurred, thousands of people have disappeared or been deported, and tens of thousands have had to flee into conditions lacking even basic sanitation and security – cries out to the international community to establish conditions under which an independent state of East Timor can be created, respecting the results of the ballot that Indonesia itself proclaimed as legitimate.

I am making this appeal to you, for only then shall we be able to say that we are supporting the highest value underpinning the WHO Constitution: human dignity and respect for this dignity in life and in death. Wherever this is lacking, we are committed to contributing through our work, our dedication and our goals.

I am counting on you to respect the goals presiding over this noble Organization.

The history of my own country has been intimately connected to the history of the Orient for almost five centuries, providing just reason for my presence here in Macao during the last year of Portuguese administration in the Territory.

I hope that the progress achieved in terms of health indices can continue along the same tracks making this meeting an effective forum for exchanging ideas and experiences. Should this be the case, then ultimately this Committee meeting will have contributed towards a healthier new millennium in this part of the world.
I wish Dr Omi the greatest success in the first session of the Regional Committee of his term of office. I can assure you that our country will always be open to any cooperation you may wish.

To all my colleagues and participants, I hope you have an excellent meeting in pursuit of the goal of “health for all in the next millennium”.
SUMMARY RECORD OF THE THIRD MEETING

Hyatt Regency Ballroom, Macao
Tuesday, 14 September 1999 at 2 p.m.

CHAIRPERSON: Dr José Alarcão TRONI (Macao)

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1. PROGRAMME BUDGET: Item 9 of the Agenda (continued)


The REGIONAL DIRECTOR, introducing the subitem at the invitation of the CHAIRPERSON, said that the second paper on the programme budget made proposals concerning the method and process by which WHO would determine individual country allocations in the programme budget for the 2002–2003 biennium, as requested in resolution WPR/RC49.R5.

The Committee’s request was in line with resolution WHA51.31, which had been adopted by the Fifty-first World Health Assembly in May 1998. The resolution had recommended that future programme budgets approved by the Health Assembly should, for the most part, be guided by a model that drew upon UNDP’s Human Development Index, adjusted by immunization coverage and population statistics. The consequence for the Western Pacific Region was an 18% reduction in allocation over three bienniums, beginning in 2000–2001. What the Committee had to consider were the criteria that should be used to determine allocations to individual countries within the Western Pacific Region, given that reduction.

There were several advantages to using the model recommended by resolution WHA51.31 to determine country planning figures within the Region. The model attempted to provide an objective means of dividing the allocation and had been approved by WHO’s global governing body. However, it did have some shortcomings. First, there would be inevitable delays in gathering the indicators, some of which might never become available. Second, the use of health indicators would reduce allocations to countries with more favourable statistics. For example, some developing countries had better immunization coverage than some developed countries. Third, for some countries within the Region, specific factors needed to be taken into account, which were not necessarily quantifiable. Fourth, Human Development Index factors were not available for every country. Finally, the allocation for some countries would be reduced to zero because their GNP per capita was greater than US$ 9636.
To minimize those shortcomings in the model, a number of scenarios had been developed by the Secretariat. Consideration had been given to using a model based on disability-adjusted life years (DALYs). The dilemma had been how to maximize the objectivity of the global model, while minimizing its shortcomings. It had been concluded that the best solution would be to use the model for a proportion of the total allocation for country planning figures. The remainder could then be used to rectify any anomalies, based upon judgement of the health needs of individual countries. That approach was in the spirit of the Health Assembly resolution, which stated that allocations “should for the most part be guided by” the model.

He therefore proposed that, as a guiding principle for future budget allocations, 60% of the total allocation for country planning figures should be determined in accordance with the model recommended by resolution WHA51.31. The remaining 40% would be distributed in accordance with the following criteria: (1) the difference between the allocation for 2000–2001 and the new allocation should be adjusted over three bienniums to avoid radical changes; (2) an adjustment should be made to ensure that least developed countries (LDCs) should not receive a lower allocation in 2002–2003 than they did in 2000–2001; (3) the possibility of a minimum allocation should be considered for countries and areas that would receive zero allocation if the model recommended by resolution WHA51.31 was applied; and (4) the specific health needs of individual countries should be taken into account.

The Regional Committee’s discussion on the item would relate to WHO’s global policy on country allocations. In line with her expressed wish for there to be “One WHO”, the Director-General had indicated that she wished to explore the possibility of developing a global approach to the method of determining country allocations. He supported that move and suggested that the Committee’s views on the matter should be forwarded to the Director-General as representing the views of the Regional Committee for the Western Pacific on country allocations.

Dr ROMUALDEZ (Philippines), commending the clarity of the interim report presented under agenda item 9.1 and expressing satisfaction at the expectation that implementation of the regular budget for 1998–1999 was expected to be 100% by the end of the biennium, said that in the face of impending reductions improved financial management became even more vital. The appropriate use of scarce resources was extremely important if the new and reduced set of priorities outlined in the Framework for action was to be applied. The Regional Office would play a vital role in mediating and reconciling priorities for
countries and the various levels of WHO, and he therefore welcomed the Regional Director’s plans for coordinating mechanisms in that regard. Referring to Annex 2 to document WPR/RC50/5, he noted with concern that the regional allocation agreed upon by the Health Assembly had disproportionately weakened some regions in comparison with Headquarters in budgetary terms.

The urgent need to redistribute resources to meet the many unserved requirements of Africa and Central Europe, for example, were understandable, but the major part of the resulting burden of reallocation seemed to fall on regions, compared with a reduction of only slightly over 1% for Headquarters. That would appear to run counter to the principle of decentralization of health management, an extension of the hallowed primary health care policy of bringing responsibility and capacity for health closer to the people. He hoped that those considerations would be taken into account in discussions of respective roles at the highest levels of management in WHO.

The Philippines strongly supported the Regional Director’s proposals outlined in document WPR/RC50/5.

Mr Chan Hyung PARK (Republic of Korea) expressed appreciation for the Regional Director’s report on the item, which drew attention to a number of difficulties with the model recommended in resolution WHA51.31 for determining country allocations. The suggested adjustment of the allocation over three bienniums appeared reasonable. In particular, falling health indices and economic standards in Asian countries affected by the economic crisis must be reflected in the allocations for 2002–2003 if negative effects on their long-term efforts for recovery were to be avoided. The Republic of Korea no longer fell into the supposed category of countries with a per capita GNP greater than US$ 9636, which would have resulted in a zero budget allocation if the model were applied strictly. Per capita GNP in 1998 was nearer US$ 6800.

Furthermore, a sudden reduction in the Republic of Korea’s allocation would mean the closure of the country liaison office in 2002–2003 and a decrease in the country planning figures, causing serious damage in the health field.
He therefore supported the Regional Director’s proposals, particularly that of gradual implementation using the model, and proposed that the country liaison office in the Republic of Korea should not be closed for the time being.

Dr SHINOZAKI (Japan) supported the Regional Director’s proposal to apply the formula to 60% of the total allocation for country planning figures in accordance with the model recommended in resolution WHA51.31 and to apply the criteria set out in document WPR/RC50/5 in determining the remaining 40%, which would result in a good balance between objectivity and flexibility.

Referring to criteria (4), concerning specific needs of individual countries, he requested that for Japan the current fellowship programme should continue to receive a budget allocation.

Mr LIU Peilong (China) agreed that a flexible approach was required to the application of the model proposed in resolution WHA51.31 and supported the Regional Director’s proposal to use the proportions of 60%-40% to achieve such flexibility, which appeared both realistic and reasonable. He also supported the suggestion that the conclusions of the current discussion should be reported to the Director-General.

He noted that the current process for determining country allocations took place largely within WHO, involving the Regional Office, WHO Representatives and Country Liaison Officers, with little direct participation by countries themselves. He called for a more open process involving the governments of the Region. Finally, resolution WHA51.31 called for the Director-General to monitor and evaluate the application of the model. He hoped that a similar evaluation of the application of the Regional Director’s proposed guiding principles for improvement of the process would be undertaken.

He asked whether the Regional Director could indicate the proportions of budgetary allocations at the country, intercountry and regional levels for 2002-2003 compared with those for 2000–2001.

Dr YOUK SAMBATH (Cambodia), expressing appreciation for the Regional Director’s efforts to institute reform and improve the structure and strategy of the Region in response to the changing health needs of Member States in spite of financial constraints, supported the proposals outlined in document WPR/RC50/5.
Where Cambodia was concerned, she requested WHO to take into account the need for public investment in six areas: development of health information systems; human resources development; disaster preparedness; control of tuberculosis, dengue hemorrhagic fever and hepatitis B; development of blood transfusion services; and health services along the borders with the Lao People’s Democratic Republic, Thailand and Viet Nam.

Ms EARP (New Zealand) endorsed the application of the formula to 60% of the total allocation for country planning figures, taking into account the criteria set out in the document under review, in order to determine individual country allocations. She agreed that the possibility of a minimum allocation should apply only to countries in need and not to those which were Members of the OECD. Countries which had special needs as a result of changing circumstances, such as those outlined by the Republic of Korea, should be considered on a case-by-case basis.

The process should be seen as a transitional measure that would help the Region to adapt to changes in budget allocation. The proposed criteria should subsequently be reviewed against actual allocations, in order to ensure that resources were being focused on countries in need and on the health priorities identified.

Mr ROKOVADA (Fiji) agreed that the allocation model recommended in resolution WHA51.31 had shortcomings, which precluded its exclusive use. He therefore supported the Regional Director’s proposals and emphasized the importance of taking into account the specific health needs of individual countries in distributing the discretionary portion of the allocations.

Ms DAVIDSON (Australia) strongly supported the formula proposed for implementing resolution WHA51.31, which provided a clear and transparent system for determining regular budget allocations to regions. She was concerned, however, at the proposal to apply the formula to only 60% of the total allocation for country planning figures, the remaining 40% to be allocated at the discretion of the Regional Director. If those discretionary funds need to be substantial to permit adjustment to country allocations, they should also be subject to a transparent and objective distribution process.

She did not support the proposal to consider a minimum allocation for countries that would not receive resources under the model outlined in resolution WHA51.31. If, as a result of applying a fair and objective model, a country did not receive funds, that outcome was
reasonable on the basis of relative needs. There was no need for minimum allocations; indeed in line with that principle her country had foregone its entire country allocation.

Noting that the global formula established by resolution WHA51.31 would be reviewed by the Executive Board at its 105th session in January 2000, she suggested that a final decision on the model to be used in the Western Pacific Region should be postponed until the outcome had been considered.

Dato’ CHUA Jui Meng (Malaysia) endorsed the proposed guiding principles for future country allocations. He agreed with the previous speakers that the discretionary allocation, which would involve considerable sums should also be subject to a transparent and objective process. The specific needs of individual countries had to be taken into account, and should be discussed extensively between the Regional Director and the countries concerned, in view of their varying priorities. The allocations would contribute greatly to the effective implementation of priority activities in countries. WHO also had to have the necessary resources to respond to disasters in the Region, including outbreaks of disease.

Mr MOOA (Kiribati), noting that application of resolution WHA51.31 had resulted in a significant reduction in the overall budget allocations for the Region in 2000–2001, and that there was no easy method to determine country allocations, endorsed the proposals for 2002–2003 set out in document WPR/RC50/5.

Mr MANUOHALALO (France) stressed the importance of transparency in the use of funds, and of maintaining levels of support to LDCs. He supported the proposal of China for closer consultation between the Regional Office and Member States in order to determine priorities for country budget allocations.

Dr ALTANKHUYAG (Mongolia) pointed out that full application of the model recommended in resolution WHA51.31 could have a significant impact in a country like his own with a sparse population scattered over a large area. He therefore endorsed the Regional Director’s proposals, stressing the need to take account of the specific health situation in countries.
Mr UEDA (Palau), endorsed the proposed method for determining country allocations. The method proposed was the least painful way of deploying reduced resources to meet increasing needs.

Mr WARAKOHIA (Solomon Islands) likewise endorsed the proposed method for country budget allocation, noting that various factors had to be considered in addition to the UNDP Human Development Index.

Dr DALALOY (Lao People’s Democratic Republic) also supported the application of the formula proposed, taking into account the considerations set out in the document under review.

Mr TRING BANG HOP (Viet Nam) similarly endorsed the Regional Director’s proposal.

Mr BOYER (United States of America) pointed out that other resources were available, which should be taken into account. For example, the Health Assembly in May 1999 had decided that US$ 15 million of casual income would be distributed among the regions for countries in greatest need, a decision from which the Western Pacific would benefit. With regard to extrabudgetary resources, Annex 4 of document WPR/RC50/4 listed the donors that had cooperated with the Western Pacific Region. However, the funds indicated did not include resources that countries received directly from multilateral donors to support their health programmes.

While he too supported the Regional Director’s proposals for country allocations, he agreed with Australia and Malaysia that the final decision should be held open until the Director-General had examined the issue on a global basis.

Ms ALALOTO (Tuvalu) also expressed her support for the proposed method for determining country allocations.

Referring to the release of funds through local cost advance requests, she noted that although budgets were drawn up in United States dollars, the funds were released in local currency. She was concerned that exchange rate losses might further reduce an already limited budget, and requested the release of funds in United States dollars.
Dr TAMARUA (Cook Islands), referring to the comment of the Philippines concerning the 52% of the budget allocated to Headquarters as indicated in Annex 2 of the document under review, considered that more resources should be shifted to the regions, which were closer to the countries. He fully supported the proposals contained in the document, and agreed with previous speakers that procedures should be transparent and geared to serving the countries most in need.

The REGIONAL DIRECTOR said that he appreciated the support expressed for his proposals. He pointed out that the figures had not been chosen arbitrarily. Different combinations had been examined but it had been concluded that a 60%–40% split provided an optimal balance between the requirements for objectivity and for meeting the real needs of countries. The 60% portion was to be applied according to a mathematical formula: there would be no margin for adjustment. The issue was how to deal with the remaining 40%. He had set out four criteria in document WPR/RC50/5 for determining the allocation of that portion.

He agreed with the representatives of China and Australia that transparency in applying the criteria would be crucial. Although the first three were quite open and transparent, the consideration of criterion (4) concerning the specific health needs of countries might be more difficult to quantify. Most of the discretionary 40% would be absorbed by criteria (1) to (3), but that would still leave some US$ 1 million for adjustments according to criterion (4). He assured the Committee that these funds would be disbursed in a way that was as transparent and accountable as possible.

In reply to questions from the Republic of Korea and Japan, he confirmed that the special needs of countries would be taken into consideration and that his proposals would be implemented gradually, so that no country would suffer from a drastic change.

In reply to the request of China for an indication of the proportions of budgetary allocations at the three levels of the Organization, he said that, for the forthcoming biennium, 83% of the total regional budget would be allocated to country and intercountry activities. Only 17% would be allocated to the Regional Office. With regard to the 2002–2003 biennium, the country allocation would be decided in October by the Director-General and the Regional Directors. Although he could not give a firm commitment at the moment, levels similar to those of the 2000–2001 budget should be maintained during 2002–2003.
The ACTING DIRECTOR, ADMINISTRATION AND FINANCE, replying to the question raised by the representative of Tuvalu on possible payments in United States dollars, said that advances given towards local costs were measured in terms of local currency. The components against which advances were made were also regularly reviewed, so that any losses that might occur should be minimal.

The CHAIRPERSON requested the Rapporteurs to prepare an appropriate draft resolution.

2. ERADICATION OF POLIOMYELITIS IN THE REGION: PROGRESS REPORT: Item 10 of the Agenda (Document WPR/RC50/6)

The REGIONAL DIRECTOR said that the fact that there had been no new cases of poliomyelitis in the Western Pacific Region for over two years was a real credit to all Member States, especially those which had until recently suffered from the burden of poliomyelitis. The annual number of cases had been reduced from 6000 in 1990 to zero in 1998.

He thanked UNICEF; the governments of Australia, Japan, the Republic of Korea and the United States of America; the Agency for Cooperation on International Health; Rotary International; and Rotary International Districts 2640 and 2650 for their support. He also thanked the governments of Canada, Finland, France, Italy, Malaysia and Sweden, which had supported the initiative in the past.

The quality of surveillance had been maintained at the highest level throughout the Region. Over 12 000 cases of acute flaccid paralysis (AFP) had been reported and investigated since the onset of the last case in March 1997, and stool samples from 85% of those cases had been tested in reliable laboratories. Although cases of AFP had been sought even in the more inaccessible, sparsely populated areas of the Region, not a single wild poliovirus had been found. He was therefore confident that the transmission of wild poliovirus had finally been interrupted.

By 2000, no new case of poliomyelitis would have been diagnosed in the Region for three consecutive years. Subject to the approval of the Regional Commission for the Certification of the Eradication of Poliomyelitis after it had reviewed documentation from every country, the Region could be declared poliomyelitis-free. That would not be the end of the story, however, as surveillance for AFP would have to be maintained until global
certification, in particular in the border areas with neighbouring Regions of WHO. Supplementary immunization on a reduced scale would still be needed for populations that were considered to be at high risk from potential re-introduction, including people living in border areas and some mobile populations.

Member States must remain aware of the need to contain laboratory stocks of wild poliovirus, which would be the only source of the virus following eradication.

He concluded by drawing attention to the long-term benefits of poliomyelitis eradication. In many countries, the investment in human resources that had been part of the poliomyelitis eradication initiative had resulted in improved immunization programme coverage and strengthened communicable disease surveillance systems. Those countries were now better equipped in technical and management terms to accelerate the control of communicable diseases. Although poliomyelitis was a disease of the 20th century, the legacy of its eradication would live on.

Ms EARP (New Zealand) applauded the efforts and level of priority that had been given to the eradication of poliomyelitis by Member States. It would be important to continue to support immunization programmes and to maintain surveillance at the highest level. She requested the Regional Director to provide clear advice to countries on the containment of laboratory stocks of wild poliovirus. Her country was tracing the location of all laboratory stocks in order to establish an inventory and to ensure that all isolates were effectively and safely contained.

Dr KUN (Nauru) asked the Regional Director whether there was any guarantee that wild poliovirus could be contained safely and whether poliomyelitis might be reintroduced if the virus escaped.

Dr TEMU (Papua New Guinea) expressed his thanks to the Governments of Australia and Japan, UNICEF, WHO and the United Nations Population Fund for helping his country to achieve the goals of its national and subnational poliomyelitis eradication programmes. A subnational immunization day was to be held imminently on the island of Bougainville. His country was committed to the goal of poliomyelitis eradication.

Dr ARIF (Malaysia) said his country continued to support WHO’s global poliomyelitis eradication initiative and was ensuring that the quality of surveillance for AFP and poliovirus was sustained at the level required for certification. Immunization coverage
with three oral doses of poliomyelitis vaccine exceeded 90% and would be further improved in order to protect against the effects of any wild poliovirus imported from endemic regions. Exhaustive retrospective records searches for cases of AFP were being made in certain areas to gauge the sensitivity of the AFP surveillance system. He urged Member States to collaborate with WHO in establishing an inventory of laboratories in which wild poliovirus was being held, and to ensure that laboratories that handled and stored the virus applied the appropriate safety measures.

Dr KOI (Macao) reported that although no case of poliomyelitis had been found in Macao since 1975, the Expanded Programme on Immunization had been continued, with five oral doses of vaccine given free of charge to all residents under the age of 18. Coverage with three oral doses of poliomyelitis vaccine in infants under 12 months of age had been 92% in 1998. A certification committee had been established in 1996, and a comprehensive programme had been developed to meet WHO requirements. Active surveillance for AFP had been carried out since 1997, and intensive investigations requiring two adequate samples for virological analysis had been conducted. No poliovirus had been found in any stool samples analysed in the previous three years. A workshop on eradication of poliomyelitis had been organized in March 1999. He was confident that Macao would fulfil the requirements for certification of eradication in the year 2000.

Mr MOOA (Kiribati) commented that the collaboration between Member States, UNICEF and WHO in poliomyelitis eradication was an excellent example of partnership in health. His country worked closely with UNICEF and a reference laboratory in Australia to ensure monitoring and surveillance of cases of AFP, which with immunization were prerequisites for poliomyelitis eradication. Safe laboratory storage, containment and perhaps destruction of wild poliovirus were important issues that required clarification. The Regional Director had been dedicated to poliomyelitis eradication for many years and, with collaboration, external funding and technical support, the Region should be in a good position to be declared poliomyelitis-free by 2000.

Dr TUFA (United States of America) said that no case of AFP had been recorded in American Samoa since the beginning of active surveillance. The international campaign to eradicate poliomyelitis by 2000 was entering its final phase. Although the Region would almost certainly be certified as poliomyelitis-free, high-quality surveillance and supplementary immunization with oral vaccine in high-risk areas must be maintained; even after certification, the Region must remain vigilant until global eradication had been achieved.
A strategy for post-eradication immunization should be devised that addressed the questions of whether immunization should be continued, who should be immunized, with what vaccine and for how long. The role of research in long-term eradication should be considered. Unless global eradication were achieved, poliomyelitis would re-emerge as a major problem, as had tuberculosis and malaria. The global financial savings that would be seen following the eradication of poliomyelitis had been estimated to amount to US$ 1 500 million per year, some of which could be used for other health needs and global challenges. Eradication of the scourge of poliomyelitis was close. Countries should work together to make it a reality that all of them could share.

Dr THORNE (United Kingdom of Great Britain and Northern Ireland) paid tribute to the Regional Director and his staff and to Member States for their achievements in the eradication of poliomyelitis. The process had brought great benefit to communicable disease surveillance as a whole. She joined other representatives in stressing the importance of maintaining that surveillance.

Dr ROSS (Solomon Islands) said that no case of poliomyelitis had been recorded in his country in the past 10 years, but surveillance for cases of AFP was incomplete owing to an inadequate reporting system. The immunization programme continued to be intensified by training and mobilizing communities to update the vaccination records of their children. Although annual immunization coverage was better than 85%, funding for vaccine was waning because of the economic recession. He asked the Regional Director for support in procuring vaccine. The safe handling and storage of existing stocks of wild poliovirus must be ensured, and plans should be made for the ultimate destruction of those stocks when global eradication had been certified.

Dr LEE (Republic of Korea) said that although no case of poliomyelitis due to wild poliovirus had been reported in his country since 1983, the nationwide AFP surveillance system, involving more than 70 hospitals, was being strengthened with support from WHO. Only 11 cases of AFP had been found since September 1998. A national workshop was to be held later in 1999 and participation at the annual convention of the Korean Paediatric Association was planned. WHO should play a core role in the containment of stocks of wild poliovirus and in setting up a strategic plan for their ultimate destruction.

Dr SHINOZAKI (Japan) said that the fact that no case of poliomyelitis due to wild poliovirus had been found in the Region since March 1997 was attributable to the work of the
Regional Director and his predecessor. His Government regarded the eradication of poliomyelitis as a priority in international health cooperation and, in that respect, had provided oral vaccine and assistance in strengthening surveillance and laboratory diagnosis to Member States of the Regions of the Western Pacific and South-East Asia. The National Institute of Infectious Diseases had served as a regional reference laboratory and was one of six specialized reference laboratories. Surveillance systems were gaining in importance during the last phase of the poliomyelitis eradication initiative, and the high level of surveillance for AFP and the supporting network of laboratories for diagnosis must be maintained or improved further. Another task would be the appropriate management of stocks of wild poliovirus, including an inventory and plans for safe handling and containment. Although no case of poliomyelitis had been seen in the Region for some time, a number of cases had been reported in neighbouring regions, indicating the need for strengthened surveillance and supplementary immunization. His country would continue to support the WHO goal of global poliomyelitis eradication.

Dr BOLADUADUA (Fiji) welcoming the substantial progress made towards eradicating poliomyelitis in the Region, said that the Pacific island countries were doing their utmost to maintain immunization coverage and sustain surveillance activities in respect of AFP. She acknowledged the support received from UNICEF, the Governments of Australia, Japan, Malaysia, Republic of Korea, United States of America and other international partners such as Rotary International and Rotary International Districts 2640 and 2650 of Japan. It was important to sustain efforts so that regional certification of eradication could be achieved.

Fiji was in the process of compiling an inventory of laboratories and undertaking annual accreditation reviews in order to ensure effective containment of wild poliovirus stocks.

Mr MANOUHALALO (France) emphasized the need to continue surveillance activities and immunization campaigns in high-risk areas. New Caledonia had had no case of poliomyelitis since 1979. Under the surveillance system recommended by WHO, his Government had notified two cases of AFP in 1998.

Dr SUN Xinhua (China) congratulated all concerned on the outstanding achievements of the last year which would make poliomyelitis eradication achievable by 2000. If eradication was to be assured, it was important to ensure compliance with resolution WHA52.22 which had urged Member States to establish adequate laboratory containment of
wild poliovirus. His Government had started containment measures in provincial laboratories and would draw up an inventory of laboratories holding wild poliovirus stocks and develop a mechanism for their destruction. Other Member States should be encouraged to do likewise. In addition, although wild poliovirus had disappeared in the Region, the presence of the virus in neighbouring countries had to be considered. It was necessary to strengthen vigilance and establish closer contact with countries in neighbouring Regions. Finally, it was important to develop a regional plan for continued high immunization coverage and maintenance of surveillance after the eventual certification of eradication.

Dr CHAR MENG CHOUR (Cambodia) thanked WHO and other partner countries for providing financial and technical support to Cambodia in implementing its immunization campaign, as a result of which, reported poliomyelitis cases had fallen to zero cases in 1998. Supplementary immunization would be conducted in November and December 1999, targeting 30% of the national population in high-risk areas.

He informed the Committee that, at a recent meeting, Cambodia and Thailand had agreed to develop a strategic framework for responding to cross-border health problems, including surveillance of poliomyelitis. He appealed to WHO and other partners for support in that regard.

Dr MAK (Hong Kong, China) wished to be associated with the commendations of other delegations; the achievement of regional certification of eradication would be the result of concerted efforts of Member States and international agencies.

Dr PRETRICK (Federated States of Micronesia) said that his country had remained free of poliomyelitis. He expressed his country’s commitment to participating in high-quality surveillance and maintaining high immunization coverage.

Dr DALALOY (Lao People’s Democratic Republic) expressed his delegation’s appreciation of the efforts made by all concerned to achieve the goal of eradication. In his country, the last case attributable to wild poliovirus had been reported in July 1996. Surveillance of cases of AFP had been established in 1995 and had gradually improved. The majority of surveillance indicators were now in compliance with WHO requirements. At a meeting of the national certification committee for reexamining high-risk AFP cases, there had been no cases of poliomyelitis reported. Successful national immunization days had been organized from 1994 to 1998 and subnational immunization days had also been arranged in
January and February 1999 for areas where there was a risk of importation of wild poliovirus and where surveillance was weak. Coverage of children below five years had reached 88%. However, routine immunization coverage had been only 68% in 1998. Reporting of AFP cases with stool samples was still too low. In addition, the country’s terrain presented transportation difficulties.

Further subimmunization days would be held in January and February 2000 in areas where there was a high risk of importation.

Dr TRINH QUAN HUAN (Viet Nam) commended the report and expressed his country’s commitment to the goal of poliomyelitis eradication by 2000. Over the last five years, Viet Nam had maintained immunization coverage of more than 90% of children under one year of age. From 1993 to 1997, it had implemented national immunization days, covering more than 99% of children under five years with two doses of oral polio vaccine. High-risk-response immunization had been implemented in 1997 and 1998 and would continue in 1999, covering more than 60 districts in southern and central Viet Nam. Supplementary immunization had also been conducted in 1998 and more than 99% of children under five years received two doses of oral polio vaccine.

Despite budget constraints, Viet Nam had maintained its level of investment in immunization and poliomyelitis eradication programmes and would continue efforts to strengthen local vaccine production, aiming for self-sufficiency in polio vaccine supply. His country would continue with high-risk-response immunization, supplementary immunization, and high-quality AFP and virological surveillance. The National Committee for Certification of Polio Eradication had been established in December 1997 and had met regularly. The Committee had certified the destruction of laboratory stocks of wild poliovirus and in August 1999 had concluded that Viet Nam was eligible to be recognized free of poliomyelitis by 2000.

The REGIONAL DIRECTOR thanked all concerned for their positive comments and suggestions. He agreed that there was no room for complacency: efforts to achieve global eradication were now more important than ever. In order to attain that goal it would be essential to maintain routine immunization coverage, formulate measures to ensure high-quality surveillance; prepare plans for supplementary immunization activities in countries at high risk, and remain vigilant for possible importation of wild poliovirus from neighbouring regions. He drew attention to efforts being made by the Regional Commission.
for the Certification of Poliomyelitis in the Western Pacific to reinforce high-quality surveillance to ensure that wild poliovirus was no longer circulating.

The DIRECTOR, COMMUNICABLE DISEASE PREVENTION AND CONTROL said that, at a meeting held in August 1999, the Regional Certification Commission had noted the importance of the containment of laboratory stocks of wild poliovirus. Materials were currently held in a large number of government departments, universities and research institutions. Coordination between those institutions would be essential to ensure adequate containment. WHO had drawn up a Regional Plan of Action for Containment which was being distributed to all Member States. For regional certification, all Member States should have substantially completed both an inventory of facilities where wild poliovirus or wild poliovirus infectious materials could be held, and a clear national plan based on WHO guidelines for completing the containment process.

The CHAIRPERSON requested the Rapporteurs to prepare a suitable draft resolution.

3. ANNUAL REPORT ON SEXUALLY TRANSMITTED INFECTIONS, HIV INFECTION AND AIDS: Item 11 of the Agenda (Document WPR/RC50/7)

The REGIONAL DIRECTOR said that the number of HIV infections and AIDS cases being reported in the Region continued to increase every year. A cumulative total of 94,167 HIV infections and 17,596 cases of AIDS had been reported by the end of 1998. However, there was significant underreporting and underdiagnosis. WHO estimated that, by 1998, 700,000 individuals were HIV-infected, and the cumulative total of AIDS cases in the Region was over 70,000. Transmission of HIV infection was increasing through sexual contact in most countries, although a few experienced epidemics among injecting drug users.

By 2000, the total number of people in the Region infected with HIV was expected to reach 1 million, at which time the annual number of new cases of AIDS was expected to be double that for 1998.

In some countries, the number of HIV infections appeared to be stabilizing or even declining. However, considering the high incidence and prevalence of sexually transmitted infections (STIs) in the Region, there was potential for increased HIV transmission in many countries. It was therefore essential that HIV prevention measures were continued, strengthened and directed at those most at risk of infection – commercial sex workers and
their clients.

WHO had an active STI and HIV/AIDS programme in the Region to meet that challenge. Epidemiological surveillance for STIs and HIV/AIDS was being reinforced in collaboration with national epidemiologists. Considerable efforts were being directed at commercial sex workers and their clients: 100% condom use was being promoted and support was being given to specific programmes, such as model clinics or outreach programmes. Support for the prevention and control of STIs through strengthening of health services included training for STI programme management, promoting STI syndromic case management and developing counselling skills for health workers. WHO was continuing to work with Member States to improve the safety of blood transfusions and blood products. Finally, WHO was increasingly involved in supporting AIDS care activities.

Over the past three years, in countries which could afford them, the use of antiretrovirals had significantly reduced morbidity and mortality due to HIV. However, the cost remained high, at about US$ 1000 per month per person, and treatment required close clinical and biological monitoring. Moreover, it was often difficult for patients to adhere to treatment regimens, because of the numerous side-effects and treatment constraints. Emerging resistance to the treatment was also a serious concern.

Progress had been made in the reduction of transmission of HIV from mother to child, mainly because of the introduction of short-course regimens, which were both cheaper and easier to administer. However, to be effective, such treatments still required extensive HIV testing and counselling as well as the procurement of breast-milk substitutes for the infants of HIV-positive mothers.

He concluded by giving an assurance that WHO would continue to focus its efforts on public health interventions, in close collaboration with Member States, UNAIDS and all other partners involved.

Dr KOI (Macao) said that there had been five cases of HIV infection in Macao from 1 January to 15 July 1999, all of them female, and two cases of AIDS, which had proved fatal. The cumulative total from 1986 to 15 July 1999 was 198 cases of HIV infection, 136 in females, 61 in males, and one unknown; 27 of the persons concerned were permanent residents of Macao, and 153 were temporary. A total of 17 people had developed AIDS, nine of whom had already died. A stable AIDS programme was in operation and intensified health
education and HIV surveillance were continuing. The compulsory testing of foreign workers in entertainment facilities, started in 1992, had been maintained. Health education and information exchange had been stepped up, and public awareness of HIV and AIDS control had been raised considerably.

Dr ENDO (Japan) drew attention to the fact that, although the number of cases of HIV infection and AIDS in the Region remained moderate, the spread of HIV infection among intravenous drug users and people living in areas of high population mobility, such as the Mekong region, was alarming. More should be done to promote measures to prevent HIV/AIDS, including control of STIs, since experience had shown that they worked. That was why the Japanese Government had been cooperating with countries in the Region where HIV prevalence was high, organizing seminars and workshops in close collaboration with WHO and UNAIDS. Japan had also made financial contributions to HIV/AIDS and STI control through UNAIDS.

The time had come to pay more attention to the presence of AIDS orphans in the region, although that was an issue for the social development sector as well as the health sector. To that end, the Regional Office should strengthen partnerships with various agencies in the Region, including nongovernmental organizations and the private sector.

Dr KUN (Nauru) said that the geographical isolation of Nauru accounted for the fact that HIV infection was absent from his country. The Healthy Island Programme Centre, which had been established in 1997, ran a prevention programme in collaboration with WHO and the South Pacific Commission to increase public awareness of STIs, HIV and AIDS. The authorities were, however, concerned about the possibility of transmission from neighbouring islands. In order to prevent that, the Government was considering passing a law whereby workers on arrival and people working for longer than three months would have to prove that they were free of HIV infection.

He asked for clarification concerning financial assistance for country programmes, in particular through UNAIDS.

Dr MALAU (Papua New Guinea) said that HIV/AIDS was an expanding problem in his country and the Government was committed to a comprehensive multisectoral response to the epidemic. A National AIDS Council had been set up in December 1997, with a secretariat and participants from the public and private sectors. In its first four and a half months,
national and regional workshops had been conducted to ensure a multisectoral response at all political levels, and to identify and deal with risk settings. He acknowledged the support of Australia and of all the UNAIDS cosponsoring agencies, including WHO. However, coordination and collaboration was proving difficult, and he asked for clear guidelines on the role of UNAIDS and the various partners involved in UNAIDS.

Dr LEE (Republic of Korea) said that in addition to a law on HIV/AIDS that had been passed in the Republic of Korea in 1987, there were promotional activities and free health examinations for the public and AZT treatment for people living with HIV. In August 1999, a special project had been launched to improve STI and HIV surveillance in the country. In addition, gonococcal drug resistance was being watched. A database on drug resistance, started in 1998, was now available on the Internet. An international seminar was to be organized in Seoul in March 2000 by the Korean Government. His Government had now turned to the problem of the underreporting of cases of STIs. He agreed with WHO that high incidence and prevalence of STIs had to be watched carefully as it might indicate the potential for increase levels of HIV infection. He proposed that WHO conduct a study of
health care systems in Member States, in order to provide evidence on underreporting. Depending on the gravity of the problem, a standard protocol should be developed by WHO to guide each Member State on the production of data on drug resistance.

The meeting rose at 4.55 p.m.
SUMMARY RECORD OF THE FOURTH MEETING

Hyatt Regency Ballroom, Macao
Wednesday, 15 September 1999 at 9 a.m.

CHAIRPERSON: Dr José Alarcão TRONI (Macao)

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1. ANNUAL REPORT ON SEXUALLY TRANSMITTED INFECTIONS, HIV INFECTION AND AIDS: Item 11 of the Agenda (Document WPR/RC50/7) (continued)

Dr SUN (China) noted that with the rapid spread of HIV/AIDS, collaboration between WHO and UNAIDS was very important. In order to prevent and control the disease, the link between AIDS and the use of injected drugs should be addressed. In the Region, 40% of HIV infections were associated with the use of injected drugs. Although antiretroviral treatment had proved very effective, the high cost prevented its large-scale use. The problem of how to make it affordable posed a great challenge. In addition, further research was needed on emerging resistance to the treatment. He stressed that approaches to sexually transmitted infections (STIs) and HIV/AIDS should be interlinked to make the prevention and control of both diseases more effective.

Dr NOVOTNY (United States of America) remarked that, although the number of HIV infections might be stabilizing in some countries, he agreed with the Representative of China that the potential for an explosive HIV/AIDS epidemic was still present. It was important to address such issues as strengthening of primary and secondary prevention, which could be key in controlling the spread of the disease, particularly in countries without the resources for antiretroviral therapy. Behavioural and clinical surveillance should also be strengthened to better understand and monitor changes in patterns of HIV infections. Countries with increasing incidence should learn from the experience of others in the Region and strive to find a successful mix of methods appropriate to their own conditions. While development of therapies and research into a vaccine continued, the basic elements of prevention, such as education, voluntary testing and counselling, prevention of perinatal transmission, and political commitment should be emphasized. He encouraged the development of a regional strategic plan for prevention.

Dr HONG SUN HUOT (Cambodia) described the HIV/AIDS situation in his country, where it was a priority health problem. The prevalence of HIV-positive cases among blood donors had increased from 0.1% in 1991 when it was first detected, to 3.6% in 1997. In 1998, the prevalence of HIV-positive cases had been 3.75% among adults from 15 to 45 years, 2.6% among women of child-bearing age, and from 30% to 60% among commercial sex workers. In the same year, figures had shown that there were approximately 16,000 AIDS patients in the country. There was also concern about the increasing incidence of tuberculosis associated with AIDS. In 1993, a comprehensive national plan for the prevention and control of AIDS and sexually transmitted infections had been developed and the National Policy on HIV/AIDS had been approved in 1995. The current focus was on the introduction of the "100% condom use" programme among commercial sex workers and their
In spite of serious financial constraints, his country had continued to respond to the problem of HIV/AIDS and sexually transmitted infections, using a multisectoral approach. Long-term impacts of the epidemic, such as the problem of children orphaned as a result of their infected parents’ deaths, were being addressed. An attempt was also being made to respond to social and economic conditions which increased the risk of infection for certain communities. Cross-border issues were being addressed through collaboration with Thailand.

Mr PEHIN ABDUL AZIZ (Brunei Darussalam) reported that the prevalence of HIV/AIDS had stabilized in his country. The vast majority of reported cases involved foreign nationals, the chief mode of transmission being heterosexual. Key control and prevention measures were epidemiological surveillance, protection of the national blood supply, health education and awareness raising, religious approaches, and clinical management of and support to infected persons. Antiretroviral treatment was provided free of charge.

Although STI prevention and care was important for reducing HIV transmission, his country faced certain problems related to case management, including underreporting and lack of trained health workers. Steps were therefore being taken to improve case notification and to recruit trained doctors.

Dr HUAN (Viet Nam) informed the Committee that the number of reported HIV cases had continued to rise each year in his country, over half being attributable to intravenous drug use. The number of AIDS cases and deaths had doubled since 1998, and transmission rates were increasing among commercial sex workers, pregnant women and military recruits. The number of STI cases was also rising rapidly and there was known to be considerable underreporting.

Control and prevention measures were targeting high-risk groups, and included promotion of peer education, use of condoms and disposable syringes, and self-help groups. The community approach was being developed through clubs, counselling and small-group education in order to improve access to information. Public information was being stepped up through use of the media. With international support, antiretroviral therapy should shortly be available for pregnant women.

Mr MARGHEM (France) observed that promotion of appropriate use not only of blood products, but also of substitute products, was essential to blood safety. Further, self-transfusion, which reduced the risk of contamination, was little used, even though it required only modest resources. WHO could be more active in that respect. Greater emphasis on blood safety would help
control all diseases transmitted through blood use, and seemed preferable to a disease-specific approach.

Stronger emphasis should be placed on case management, including the provision of psychosocial support to infected persons and their families. Associations and community groups made a considerable contribution to the social acceptance of people living with AIDS, and their work should be promoted. Cases should be managed first within existing health care structures. In view of the risk of recurring opportunistic diseases, networks should be set up to coordinate care and assure follow-up in the home, together with psychosocial support and supply of generic essential drugs to health services.

With regard to access to antiretroviral therapies, France had been instrumental in establishing the International Therapeutic Solidarity Fund in order to reduce inequality in access to treatment. Aware of the difficulty of assuring access to such treatment in developing countries, France was providing support for the control of vertical transmission and the follow-up of such cases.

He recommended that WHO should give more attention to case management of infected persons in the Region within the context of the International Fund for Therapeutic Solidarity Fund, in which all countries were welcome to participate.

Dato’ CHUA (Malaysia) was gratified to see that the number of HIV cases appeared to be stabilizing in several countries in the Region. Intravenous drug users accounted for the majority of cases in his country, and transmission among them continued to increase because of needle sharing and unprotected sex. Those in rehabilitation centres were not being discharged until they had been fully counselled.

Cases were actively detected through screening of all blood donors, compulsory testing of drug users, and introduction of HIV testing in STI clinics. Extensive antenatal screening had recently been introduced in order to prevent vertical transmission and to provide data on the prevalence of HIV. Roughly 250 000 pregnant women had been tested on a voluntary basis. Results indicated that vertical transmission was very low, and that the AZT treatment provided free of charge to infected mothers had proved extremely effective in protecting their babies.

With regard to case reporting, he questioned the accuracy of the figures provided by some countries. Accuracy of the data depended on the extent of surveillance and active case detection. Although the estimates given in Table 1 of document WPR/RC50/7 were helpful in this regard, he
asked to what extent those figures were accurate, acceptable, and fairly reflected AIDS incidence in each country of the Region.

Discrimination against people living with HIV/AIDS and even opposition to the establishment of HIV clinics in certain areas were major problems in all countries of the Region and an obstacle to HIV control. Public education had not yet succeeded in overcoming the prejudice that infected persons had to face. Further study on stigmatization would help countries find ways to combat it.

Mr WARAKOHIA (Solomon Islands) reported that although there were no HIV cases in his country, rising STI incidence, especially among young people, was a cause of concern. With the support of the Macfarlane Burnet Centre for Medical Research, country assessment of HIV/AIDS was currently under way as a first step in preparing a comprehensive HIV/AIDS prevention and control strategy.

Professor WHITWORTH (Australia) said that her country was keenly interested in the collective response to HIV/AIDS in the Region, and a considerable and growing portion of its overseas aid was donated to STI and HIV/AIDS prevention and control. Regional workshops had pointed to the need for more social and behavioural research to help target prevention measures at people most at risk. Australia had included such research in its national control strategies and would welcome the opportunity both to share its experience and to learn from similar projects in the Region.

Noting the benefit that could be derived from genuine cooperation with other bodies active in HIV prevention and control, she called for closer collaboration between the Regional Office, UNAIDS and other partners working at country and regional levels. In order to encourage such collaboration, she requested that details of specific activities involving collaboration between the Regional Office and UNAIDS, including identification of factors contributing to successful outcomes, should be included in the following year’s report.

Dr CHERN (Singapore) reported that the number of reported HIV infections in his country was rising, although from a very low base, heterosexual contact being the chief mode of transmission. He agreed with previous speakers that cases could well be seriously underreported and shared the concern of Malaysia about the accuracy of the figures.

Continued vigilance was required to combat transmission of HIV through intravenous drug use and heterosexual contact in particular. The latter accounted for the rise in vertical transmission, and he urged Member States to strengthen HIV screening for pregnant women. Singapore was
offering HIV screening at a subsidized rate in all government clinics to encourage pregnant women to be tested. It had also set up anonymous test sites which could contribute to reducing transmission in countries where people feared discrimination. However, disclosure of certain information might be necessary in order to improve public health control of transmission. Singapore had therefore amended its legislation to make provisions for disclosure to a spouse or partner of information relating to an infected person if there was a risk to public health or safety. It had also made it an offence to furnish false information to a blood bank in relation to the donation of blood or blood products.

The coverage of the national medical saving scheme had been extended to include all antiretroviral drugs registered in Singapore. However, the key to HIV control in his country was prevention through health education.

Dr PRETRICK (Federated States of Micronesia) said that there were few cases of HIV infection in his country, although the true extent of prevalence was not known. However, several factors might contribute to a rise in prevalence: a large young, sexually active, and mobile population; an increasing tourist trade; and high STI prevalence.

The national HIV prevention and control plan, carried out in collaboration with UNAIDS and integrated in the existing primary health care delivery services, was geared to programme management, framing of HIV policy, public information, improved testing capacity, and condom distribution. Surveillance was an ongoing activity and over 5000 people had been tested in 1998, although up-to-date testing techniques were not yet available.

Community-awareness activities were underway, including workshops, seminars and health education messages through the media. Technical support to strengthen HIV prevention and control would be welcome in such areas as quality assistance, surveillance test kits, condom procurement, policy development and staff training.

Dr KIENENE (Kiribati) reported that his country had one of the highest HIV infection rates in the Region, although the STI rate was relatively low. The focus of prevention and control had shifted from vertical programmes run by the Ministry of Health to a social approach involving the community and nongovernmental organizations.

Kiribati appreciated the support provided by WHO and other agencies such as the Pacific Community and the Australian Agency for International Development.

WHO should take a leading role in such areas as law and ethics related to HIV/AIDS,
development of human resources for counselling, and policy issues. Those areas were essential elements in small countries with small populations, where confidentiality had to be maintained.

Referring to clarification of the role and priorities of UNAIDS, he observed that the experience of Kiribati had indicated a loss of momentum in programme implementation since UNAIDS had assumed responsibility for supervising and coordinating AIDS control efforts.

Ms EARP (New Zealand) noted that although rates of HIV/AIDS infection had stabilized in certain countries, they were rising in others, and she urged WHO to maintain its support in those cases. The infection rates in her country were declining as a result of intense prevention and control efforts after AIDS had been declared a notifiable disease. A range of approaches which targeted specific communities or groups had proved effective in cases where appropriate messages could be communicated.

Appropriate prevention strategies were essential, including such components as active surveillance methods, safe blood supply, integration of HIV/AIDS prevention in STI programmes, encouragement of support groups of infected people, programmes targeted at sex workers and intravenous drug users, and promotion of behavioural change.

WHO should continue to seek ways of improving access to antiretroviral treatment in order to prevent vertical transmission. She endorsed the comments of previous speakers regarding the need for improved liaison between the Regional Office and UNAIDS in order to improve the support UNAIDS provided in the Region.

Dr TANGI (Tonga) expressed concern at the estimate that by 2000 there would be 1 million people infected with HIV in the Region and agreed that a proactive approach to prevention and treatment was required. However, measures for young people, such as early provision of condoms, would need careful consideration. Regular use of condoms, as advocated for protection against HIV infection, must be generating large profits for the manufacturers. He suggested that ways should be sought of channelling some of those profits back into the Region’s prevention programmes.

Dr TAMARUA (Cook Islands) commented that the report showed that sexually transmitted and HIV infections were still serious health problems in the Region. Although no cases of HIV infection had been reported in Cook Islands, the population was mobile and infected persons were known to travel in the country. A situational analysis of the national HIV/AIDS programme had been undertaken with the assistance of the Macfarlane Burnet Centre for Medical Research, Australia. It was encouraging to see from the report that public health measures and control strategies did indeed
work. However, the cost of antiretroviral agents was a significant drawback for most countries of the
Region. Primary prevention based on behavioural change in respect of sexual relationships was still
the most cost-effective measure. Surveillance, prevention and control of STIs must be maintained,
and collaboration between Member States was essential.

Mr ROKOVADA (Fiji) said that collaboration to improve surveillance for STIs, HIV and
AIDS, to improve programme management, to improve the use of STI syndromic case management,
to further develop interventions focusing on commercial sex workers and their clients and to support
the development of care for patients with AIDS and STIs was essential in view of the high rates of
curable STIs in the Region. He welcomed the availability of short-term antiretroviral therapy to
reduce mother-to-child transmission of HIV which should prove affordable. WHO should continue
its monitoring activities and support for the public health components of STI prevention and control.
He joined previous speakers in requesting information about the activities of the United Nations
Theme Group on HIV/AIDS in the Pacific region. The Regional Director’s interim report on budget
performance for the 1998-1999 programme budget (document WPR/RC50/4) indicated that
US$ 748,271 had been provided by UNAIDS for the biennium. He asked whether countries with
limited transmission were entitled to a share of that allocation.

Mr SHEM (Vanuatu) said that, although no cases of HIV infection or AIDS had been
reported in his country, it maintained an awareness and surveillance programme targeting
communities, groups at high risk and advocacy groups. Progress had been made in developing a
national HIV/AIDS policy, collaboration with nongovernmental organizations, strengthening STI case
management by health workers and developing ongoing public awareness programmes. Although the
report before the Committee described programmes for integrating STI services with education for
female sex workers, he considered that attention should also be paid to men and young people.
Another target group in countries such as Vanuatu was fishermen who could be an important source
of transmission. He thanked WHO, the Australian Government and the Macfarlane Burnet Centre for
their continuing support.

Mr RETZLAFF (Samoa) reported that his research on legal strategies for combating
HIV/AIDS had shown that the best generic legislation in the world was that of the Philippines, which
provided a holistic means of protecting the victims and preventing the spread of infection and disease.
The existing legal approaches were to do nothing, as in most countries; to use coercion, as in Cuba; or
to use a generic approach, as in the Philippines. Most countries used a piecemeal approach, amending
existing legislation gradually. A document entitled AIDS and the law: does protection exist for AIDS
victims?, which outlined his findings was available to interested representatives.
HIV infection was a war in which the enemy was the virus. It was important to overcome prejudice in which the victim was looked upon as the enemy. The Honourable Justice Kirby of Australia had described a paradox in the fight against AIDS: as the most effective weapon was to change behaviour, it was essential not to alienate the victims but to take their interests into consideration. Experience in Samoa had shown that people with AIDS who were prepared to waive their rights to confidentiality and to speak about their experiences were highly effective advocates of behavioural change. He considered that there was a direct correlation between the prevalence of HIV/AIDS and the rights of women. Countries that respected the rights of women were able to control the epidemic more effectively than those where such rights were ignored. Positive changes were needed in customs, attitudes and lifestyles, backed by strong, effective leadership at the highest level. Huge resources were required to treat the opportunistic infections of people infected with HIV, which could quickly use up all the health resources of a country. Further burdens were the “brain drain to the grave”, - the deaths of young people who had been educated at great expense - and the resources necessary for looking after the orphans of victims of AIDS.

Mr UEDA (Palau) reported that two cases of AIDS had been detected in his country, both of which had been imported and both of which had been fatal. After the second AIDS-related death, the family of the deceased had been counselled on the nature and process of the disease. In addition, radio broadcasts explaining that HIV/AIDS was sexually transmitted, much like other STIs, had allayed public fears. He agreed that HIV/AIDS should be tackled through an integrated STI approach, and that the stigmatization attached to HIV/AIDS must be addressed. He acknowledged the assistance given to his country by the United States of America and the Secretariat of the Pacific Community among others.

The REGIONAL DIRECTOR, replying to the points that had been raised, proposed that his next report on STIs, HIV infection and AIDS should include annexes describing collaboration between the Region and UNAIDS; the experiences of countries in the Region with regard to control of STIs, HIV infection and AIDS; and the legislative approach used in the Philippines, which might be used as a framework for further development in other countries.

A number of representatives had raised questions about the relationship between WHO and UNAIDS with regard to both funding and activities. Relations had initially been difficult, owing largely to lack of coordination; they had since improved, and the relative roles of the two organizations had been clarified. Thus, WHO focused on public health issues such as the STI syndromic approach, epidemiological information, training, educating commercial sex workers and their clients through provision of condoms, and interventions for intravenous drug users. The other
cosponsoring agencies, such as UNICEF and UNDP, also dealt with the areas in which they had the greatest strengths. Before the establishment of UNAIDS, WHO funds for HIV/AIDS programmes had been allocated directly to countries. Now, they were channelled through the United Nations Theme Groups on HIV/AIDS established in more than ten countries in the Region. Countries received other allocations directly from the Regional Office and from bilateral funding agencies. The funds received from UNAIDS would be used as efficiently as possible in consultation with the countries.

The REGIONAL ADVISER ON AIDS AND SEXUALLY TRANSMITTED INFECTIONS added that UNAIDS had provided US$ 2 million for HIV/AIDS activities in the Region for the biennium, through the Theme Groups. The Regional Office had mobilized additional funds, giving a total of US$ 7 million, two-thirds of which was allocated to country activities and one-third to intercountry activities. Of that amount, US$ 1.5 million had been provided by UNAIDS. Funding for HIV/AIDS in the Region had therefore returned to the level achieved prior to the establishment of UNAIDS. Further funding from bilateral agencies and other United Nations agencies had also increased substantially in the past few years.

In response to the representative of Malaysia, he said that the estimates and projections of the prevalences of HIV infection and AIDS were based on the results of workshops of experts organized in selected countries. Those data were revised continuously on the basis of country surveillance results. The estimates provided figures that were accurate enough to guide public health interventions by indicating the magnitude of the problem and trends. The accuracy of the estimates depended on the accuracy of the epidemiological data collected in the countries.

At the invitation of the CHAIRPERSON, the representative of Soroptimist International made a statement to the Committee.

2. CONSIDERATION OF DRAFT RESOLUTIONS

2.1 Reform in the Western Pacific Region (Document WPR/RC50/Conf. Paper No. 1)

Dr WOONTON (Niue), Rapporteur for the English language, proposed that operative paragraph 4(4) be amended by changing the end of the phrase to read “a selected issue in part 2 of the report”.

Dr ROMUALDEZ (Philippines) added that the word “in” in that part of the phrase should be
changed to “as”.

Mr VILLAGOMEZ (United States of America) suggested that operative paragraph 4(3) be strengthened by changing the phrase after the comma to “and that it includes a critical analysis and evaluation of WHO programmes with Member States in the Western Pacific Region.”

The CHAIRPERSON requested the Rapporteurs to prepare a revised version of the draft resolution reflecting the amendments proposed for consideration at a later meeting.

2.2 Proposed programme budget 2002–2003: country allocations
(Document WPR/RC50/Conf. Paper No. 2)

In response to a query from Mr LIU Peilong (China) regarding operative paragraph 3, the REGIONAL DIRECTOR said that there was no statement in the policy organs of the Organization regarding responsibility for deciding on country allocations. Recent practice had been that the governing bodies decided on the regional allocation, and the Regional Director decided on the country allocations. In attempting to ensure that the Organization was one entity, the Director-General would take the opinions of the Regional Committees into account in making a decision for WHO as a whole. That approach was reflected in the fourth preambular paragraph and operative paragraph 3. In 1998, the Regional Committee had mandated the Regional Director to draw up criteria for deciding on country allocations, which had been discussed by the Committee at its current session. He undertook to convey the opinions of the Committee to the Director-General at the meeting with the six Regional Directors that would be held in tandem with a retreat of Executive Board members in October 1999.

Dr ROMUALDEZ (Philippines) shared the concern of the representative of China and therefore proposed that the fourth preambular paragraph 4 be amended to reflect that concern by the addition of the words “which takes into account regional differences in the health needs of different countries” at the end of the paragraph.

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC50.R1).

2.3 Eradication of poliomyelitis in the Region: progress report
(Document WPR/RC50/Conf. Paper No. 3)

Mr LIU Peilong (China) questioned the last clause in operative paragraph 3(2), which suggested that external support for surveillance and supplementary immunization might cease once
global certification had been achieved.

The REGIONAL DIRECTOR said that it was difficult to gain a clear idea of the extent to which external support would be necessary or available after eradication but, if smallpox eradication was anything to go by, surveillance would be continued, but supplementary immunization may no longer be necessary. As long as stocks of virus were kept in laboratories outbreaks were still possible. He proposed that, in order to meet the concerns expressed, the words “and beyond, if necessary” should be added to the end of the resolution.

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC50.R2).

3. TUBERCULOSIS PREVENTION AND CONTROL: Item 12 of the Agenda

The REGIONAL DIRECTOR, introducing the item at the invitation of the CHAIRPERSON, recalled that earlier in the session he had said that it was unacceptable that the Region should be entering the new millennium with rising levels of tuberculosis. When he had consulted with the Member States of the Region after his nomination, virtually all, developed and developing, had voiced their concern about the disease.

He pointed out that directly-observed treatment, short course (DOTS) was already an effective weapon with which to fight tuberculosis. With the political will, the number of cases in the Region could be halved within ten years, as indicated in Figure 6 of his report.

WHO had declared tuberculosis to be a global emergency in 1993 and in 1998 the Organization had launched the global Stop TB initiative. The problem was particularly severe in the Western Pacific Region, which was home to approximately 29% of global tuberculosis cases, more than any other region apart from the South-East Asia Region. It was estimated that there were almost 2 million new cases of tuberculosis in the Region every year, only 43% of which were notified. WHO also estimated that about 355 000 people in the Region had died from tuberculosis in 1998. Not only was that a personal tragedy for the victims and their families, it also had profound implications for national economies, because the disease was particularly prevalent in the 15 to 54 age group, the most productive segment of the population.

The problem was growing; the regional notification rate for infectious cases had increased from 18 per 100 000 in 1994 to 23 in 1998, a 28% increase. One reason for this was the increasing
gap between rich and poor in some countries. The burden of the disease was much heavier in poor populations than in more affluent ones. If an infected breadwinner of a family was not properly diagnosed and treated, he or she could lose, on average, a full year of work. If the breadwinner died, an entire family could be pushed over the brink into poverty.

He pointed out that the WHO-recommended DOTS strategy cured nine out of ten tuberculosis patients. It was also one of the least expensive health interventions in low- and middle-income countries. The price of the drugs to treat one patient for six months ranged from US$ 20 to US$ 30. If DOTS was implemented regionwide, tens of thousands of people every year would be spared from unnecessary suffering and death.

DOTS implementation in the Region had started in the early 1990s. Coverage had steadily increased and, by the end of 1998, 46% of notified patients in the Region had been receiving the treatment. However, almost 60% of the estimated cases remained undetected, so that only 20% of the total estimated cases in the Region were currently benefiting from DOTS.

Tuberculosis was often seen as an unchangeable fact of life, so insufficient attention had been paid to its control in the majority of the countries where the disease was most prevalent. Moreover, resources for tuberculosis control had been reduced at both institutional and community levels. As a consequence, many health systems were not adequately equipped to deliver appropriate tuberculosis care. The development of a good DOTS programme could both benefit from and contribute to improvements to health systems.

To make real progress against tuberculosis in the Region a special effort was needed. He therefore proposed that tuberculosis should become a special project of WHO in the Region, with an increased allocation of resources. A Stop TB external advisory group would be created in order to involve international experts in the Stop TB project, and a special effort would be made to ensure that DOTS was established regionwide by 2005. He urged all Member States to give the highest priority to tuberculosis control, using the DOTS strategy within the framework of health sector development. He was confident that, working together, Member States and WHO would succeed in halving the number of tuberculosis cases in the Region in ten years.

Dr GALSIM (Philippines), commending the report, said that it was clear that the war against tuberculosis was far from over. That was the case in his country, which was one of 22 accounting for 80% of the global burden, and he welcomed and strongly supported the Regional Director’s proposal for a special project. The Philippines was committed to 100% DOTS coverage by 2001, and
tuberculosis control was a priority in its health sector reform agenda, the budgetary provision having been doubled for 2000. The national health insurance programme covered DOTS for outpatients; a “TB Alert” had been launched to encourage those with symptoms to report for treatment; and 25 organizations had signed a memorandum of understanding in support of DOTS. Continued national and international collaboration was crucial for the provision of improved laboratory services to ensure case-finding and reliable drug supplies. WHO’s cooperation was needed in advocacy and training and to provide leadership.

Dr Joon Sang LEE (Republic of Korea) commended WHO’s efforts to extend DOTS in the Region with the support of the World Bank and nongovernmental organizations. He asked the Regional Director why tuberculosis control was to be a special project and how that had been decided.

Dr TEMU (Papua New Guinea) also commended the efforts of the Regional Office and Member States, but expressed concern at the slow progress in introducing DOTS in his country, which suffered under the constraints listed in section 5 of the report. The health system was weak and lacked qualified staff, the drug supply was unreliable, the terrain difficult and financial resources short. Convinced of the effectiveness of DOTS, his country sought support for tuberculosis control together with measures against HIV/AIDS. With a multisectoral approach, Papua New Guinea hoped to develop a sustainable delivery system and achieve full DOTS coverage by 2005.

He inquired about the cost-effectiveness of DOTS and its current costs and benefits compared with the short-course chemotherapy of the 1980s.

He also requested additional information on “best practices” for the Region in integrated HIV/AIDS and tuberculosis control, and suggested that research on sustainable cost-effective implementation in the affected countries be provided for in the budgets for the next three bienniums, together with measures to mobilize external funds. He further recommended that HIV/AIDS and tuberculosis be declared as regional emergencies and that a commitment be made to give them priority in those budget periods.

Mr LIU Peilong (China) said that the report contained an excellent analysis of the epidemiological situation and some striking figures, in particular referring to the preponderance of cases in the Western Pacific Region (29%) and of deaths in China, where with improved reporting China’s regional share of mortality in the Region was revealed to be about 70%.

DOTS coverage in the Region, had increased from 30% in 1996 to 46% in 1998, largely due to increased coverage in China, China fully supported the regional efforts for control and the Regional
Director’s proposal that tuberculosis should be a special project. In China, control was becoming a national priority, and DOTS had been implemented in several provinces since 1993 with the support of the World Bank. The outstanding results showing that it was the right strategy, necessitating and contributing to improvements in the health care delivery system.

The greatest difficulties were financial. China appeared in the first group of countries in Annex 3 to the report, those with a high burden of tuberculosis and low implementation of DOTS, and the “financial constraints” were rightly mentioned. Large-scale financing would have to be guaranteed if the programme was to succeed and if the targets given in Table 1 were to be considered realistically attainable.

In 2000 the Chinese Ministry of Health was launching the Fourth Tuberculosis Epidemiological Survey and convening a high-level workshop on control in an attempt to win political support for sustainable efforts. However, owing to the magnitude of the problem, national efforts were insufficient, and he appealed to WHO to support China to persuade decision-makers of the magnitude and urgency of the problem, to mobilize the international community to provide financial aid to China, and to enhance technical cooperation for laboratory services and training of staff.

Referring again to Table 1, he observed that some of the targets were too high to be realizable for China by 2005.

Dr SHINOZAKI (Japan) said that the number of tuberculosis cases in his country had fallen steadily every year for some 40 years until 1997, when there had been a surprising increase with reports of nosocomial and group infections and drug resistance, necessitating revision of the strategy. The Minister of Health had declared an emergency in July 1999, and many national NGOs had joined in measures to combat the disease.

The low implementation of DOTS in some countries of the Region might be due to the lack of availability of drugs free of charge, which together with the need for patient registers, should be made the subject of measures to ensure political commitment.

Japan had contributed to training programmes and technical support through the Tuberculosis Research Institute in Tokyo.

The country was classified in Group 5 with Australia and New Zealand in Annex 3 to the report but he felt that, with a prevalence rate of over 30 cases per 100 000 population, it should rather
be among countries with a “middle burden”. The importance of collaboration with countries with a high or similar burden was recognized, and he proposed that a mechanism be set up for exchange of experience in tackling drug resistance and group infection, in promotion of DOTS and in provision of anti-tuberculosis drugs.

Japan thus pledged both technical and financial support to the Regional Office and countries of the Region. He stressed the importance it attached to wide DOTS coverage, human resources development and improvement of laboratory services. Understanding conditions in “middle-burden” countries was vital.

Japan fully supported the Regional Director’s proposal for tuberculosis to be a special project.

Dr MARGHEM (France) expressed full support for WHO’s efforts to control tuberculosis. The resurgence of the disease called for the mobilization of all countries of the Region.

While recognizing the progress achieved with DOTS, he inquired whether only those countries applying all five components of the strategy were considered to be implementing it.

In addition to DOTS, he felt that supplementary measures were necessary. In particular, weaknesses in the organization of health services, poor observance of treatment regimens and follow-up, irregular drug supply and the failure to integrate all such activities in primary health care would limit the effectiveness of DOTS and endanger tuberculosis control. He also stressed the importance of research on foci of infection however costly, if transmission was to be interrupted, not forgetting the social causes of the disease and the need to improve hygiene and reduce poverty. To that end, multisectoral action and economic development were the key to prevention of tuberculosis, the reappearance of which bore witness to new poverty in some “developed” countries where tuberculosis was not merely a result of co-infection with HIV. In countries where this co-infection occurs, WHO should promote an integrated tuberculosis/AIDS strategy similar to that being implemented in other regions.

The meeting rose at 12:30 p.m.
SUMMARY RECORD OF THE FIFTH MEETING

Hyatt Regency Ballroom, Macao
Thursday, 16 September 1999 at 9 a.m.

CHAIRPERSON: Dr Sodov SONIN (Mongolia)

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1. **TUBERCULOSIS PREVENTION AND CONTROL: Item 12 of the Agenda**

   (Document WPR/RC50/8 Rev.1) (continued)

   Dr HO (Hong Kong, China) commended the Regional Director and his staff for the comprehensive review of tuberculosis prevention and control in the Region. The high priority given to the subject had alerted Member States to the importance of cooperation to combat the global resurgence of an old enemy of mankind.

   Tuberculosis had been one of the most important public health problems in Hong Kong, China, for decades, and high priority had long been given to its control and prevention. A network of chest clinics was strategically located throughout the territory. Directly-observed treatment, short course (DOTS) had been introduced in the 1970s. Treatment was accessible to the whole population and was provided free of charge. Drug treatment compliance had been good and the default rate was low (5%). As a result, multidrug resistance was relatively low (2%). Over the previous 40 years there had been a marked and steady decline in incidence. However, with the global resurgence of tuberculosis, Hong Kong had witnessed a small rebound in disease incidence in recent years, and would join other Member States in the battle against this important threat to public health; it would not be easy, because Hong Kong also faced overcrowding and had an ageing population.

   He welcomed the proposal to designate tuberculosis as a special project in the Region.

   Dr DALALOY (Lao People's Democratic Republic) said that in spite of encouraging progress tuberculosis remained a serious problem in his country. In 1998 the number of cases had risen. Since 1995, DOTS had been extended to 13 provinces with 82 districts, covering more than 3 500 000 (more than 71% of the population). New cases treated in 1997 had been evaluated in 1999, revealing a success rate of 73%, but mortality and interruption of treatment remained high. Follow-up teams had been set up in difficult foci, and education and surveillance had been intensified.

   The target for 2000–2001 was to extend coverage to the whole country, necessitating reinforcement of the programme and development of the health system.

   He expressed support for the proposal for a special project to receive priority in the Region, and requested increased technical cooperation and mobilization of resources.

   Dr LIU Guo-bin (Macao) supported the proposal for a special project, which was most timely. Macao had followed the global trend of tuberculosis resurgence, with 320 cases in 1988, increasing to
465 new reported cases in 1998 - 65% of the 715 cases of all notifiable infectious diseases. The mortality rate was 4.7 per 100,000 (20 deaths in 1998), attributable mainly to interrupted treatment and drug resistance.

The majority of the cases (70%) had occurred in the age group 15–64 years, 25% in the group of 65 and above; the morbidity pattern had obvious socioeconomic significance.

BCG vaccination for all newborn infants had been included in the Macao vaccination programme for a long time and, by 1998, a satisfactory coverage of 98% of all children under one year of age had been achieved.

Tuberculosis control needed to be further strengthened, particularly DOTS. Greater efforts needed to be made to standardize therapy and promote adherence to treatment. Case detection by passive case-finding should be improved. Contact investigation and screening in high-risk groups should be carried out. Health education, involvement of the community and the private sector were also important aspects of prevention and control. Finally, the immunization programme needed to be continued and strengthened.

Mr VILLAGOMEZ (United States of America), applauding the proposal for a special project, called for the development and implementation of a uniform WHO screening protocol. The Northern Mariana Islands required immigrants to have tuberculosis clearance, but documents were frequently forged, presenting a serious threat to such small island communities. Dialogue within the Region and with the South-East Asia Region would be useful in that regard.
The United States Government was committed to research on new methods of detection and treatment for tuberculosis, concentrating on vaccine development. The disease was as much a social as a medical problem. The need to prevent its spread and the occurrence of multidrug resistance were serious public health concerns. He urged the pursuit of WHO’s strategy, DOTS, with the use of high-quality drugs and sound laboratory diagnosis, meticulous case-reporting, monitoring and analysis, which had ensured 95% cure rates in some countries. He urged Members in the Region to continue to cooperate in the Stop TB initiative.

Dr ALTANKHUYAG (Mongolia) said that his country’s programme had been successfully implemented according to WHO principles since 1994 and DOTS was effectively applied throughout the country. However, tuberculosis was increasing, particularly in prisons. The supply of drugs and reagents under a project funded by DANIDA and other donors was ending in 1999, at the time when control needed to be strengthened, thus resulting in a problem of financing for the Government. He endorsed the proposal to give priority to the disease.

Dr TRINH BANG HOP (Viet Nam) said that the comprehensive report provided full information on the magnitude of the problem and control activities in the Region. He fully supported the proposal for a special project in the Region.

In Annex 3 of the report, Viet Nam was classified among those countries with a high burden of tuberculosis and high implementation of DOTS (Group 2). Tuberculosis remained a major health problem, with more than 50,000 new smear-positive cases and about 20,000 deaths per year. Therefore control was a high priority and the Government’s commitment was strong. Activities had been carried out since 1985 and now covered 99% of the population; DOTS had been implemented since 1993, with 95% access. Thanks to the extensive control network integrated into the existing health system and the implementation of DOTS, deaths from tuberculosis were being prevented. Case-finding continued to increase (from 55,800 cases in 1995 to 87,500 in 1998), short-course therapy being provided to 97% of cases in 1998 (from 49% in 1995). Even though the number of cases had increased, the programme had maintained its cure rates from short-course therapy at 86%–89% for all new smear-positive cases treated between 1995 and 1998.

The constraints affecting the programme were: difficulty of implementing control in remote and mountainous areas; factors related to private practitioners; the increasing number of HIV-related cases; and drug resistance.

Viet Nam closely collaborated with WHO and other partners including the World Bank, the
Netherlands Government and the Netherlands-Viet Nam Medical Committee, the Japan International Cooperation Agency, the United States Centers for Disease Control and Prevention and the Australian Tuberculosis and Chest Association, and looked forward to expanding partnerships to further reduce the tuberculosis burden.

Professor WHITWORTH (Australia) said that tuberculosis control was clearly a health priority in the Region and thus a well-chosen special project. WHO should apply its technical expertise and establish its authority, so as to forge the partnerships necessary to control the spread of the disease. The growth in the number of cases was attributed to poor control strategies and weakened immune systems. Countries with poor control strategies had witnessed a rapid rise in the number of cases of multidrug resistance. The importance of patients following treatment regimens to completion could not be emphasized too strongly. Any strategy such as DOTS that assisted in ensuring completed treatment should be supported.

In Australia, the incidence of tuberculosis was low and had remained stable at between 5 and 6 per 100,000 population per year for many years, so that formal adoption of the DOTS strategy was considered inappropriate. The current success was due to the ability to minimize transmission through the rapid detection and to ensure completed treatment. However, Australia recognized the disease as a major and growing public health problem in developing countries and had provided financial and technical support for the implementation of DOTS in the Region. She urged Member States to adopt the DOTS approach; her country would continue to give support where possible.

Dr THORNE (United Kingdom of Great Britain and Northern Ireland), commending the report, welcomed the priority given to tuberculosis prevention and control in the Region and its designation as a special project.

As in the case of sexually transmitted infections, drug resistance was a major concern. She therefore welcomed the Region’s involvement in measures to tackle it.

Dr TAHA ARIF (Malaysia), noting the report, expressed deep concern at the information that approximately 29% of global tuberculosis cases were in the Western Pacific Region, of which almost 70% were in the most productive segment of the population (15–54 years). In Malaysia, 27.6% of new tuberculosis cases detected in 1998 were in that age group.

The dual epidemics of tuberculosis and HIV/AIDS formed a deadly partnership, each disease reinforcing the other. Close collaboration and cooperation between programmes was therefore vital. A systematic survey of HIV infection in tuberculosis patients was recommended in countries with a
high prevalence of HIV to measure the trend in the association of the two infections. In Malaysia, all tuberculosis patients were screened for HIV, and 545 cases had been detected among them (11.7%).

Tuberculosis control using DOTS was one of the most cost-effective health interventions and contributed substantially to socioeconomic development by reducing the burden of disease and death in the productive age group. Malaysia had adapted the DOTS strategy to its particular situation.

The emergence of drug resistance was another serious trend. A collaborative study was being carried out in Malaysia with support from WHO and the Republic of Korea. Preliminary results showed that multidrug-resistant tuberculosis was still not a major cause for concern. However, Malaysia welcomed continued assistance in drug resistance surveillance in the form of technical support from WHO and other collaborating agencies. He endorsed the proposal to make tuberculosis control a priority in the Region.

Dr CHERN (Singapore) approved the high priority to be given to the intensified control of tuberculosis and the proposal to establish a special project in the Region.

The incidence of the disease in Singapore, having fallen from 307 per 100 000 in 1960 to 56 per 100 000 in 1987, had since been fluctuating between 49 and 57, with no further reduction. The Singapore Tuberculosis Elimination Programme had been initiated in 1997 to intensify control through health education and other preventive measures, active case detection and follow-up and treatment. Of the cases treated in 1998, 70% had been on DOTS, which had been adopted in all government primary care clinics.

Singapore was committed to cooperation with WHO and other countries in efforts to control tuberculosis.

Dr OTTO (Republic of Palau) said that his country had come close to eliminating tuberculosis in the 1980s but had experienced a resurgence of the disease in the 1990s. A first case of drug resistance had been reported in 1999. He agreed with the representatives of the United Kingdom and Malaysia on the importance of the problem.

He acknowledged the support provided by WHO for drug procurement and by the United States of America for laboratory services, programme planning and capacity-building.

He endorsed the proposal for a special project, which responded to the appeal contained in the Palau Action Statement, arising from the 1999 meeting of Ministers of Health for the Pacific island
countries. DOTS would prove a powerful tool in future control efforts.

Mr ROKOVADA (Fiji) commended the report and endorsed the proposal for a special project to give tuberculosis priority in the Region.

DOTS had proved cost-effective, and had been introduced in Fiji, where a cure rate of 83% had been achieved. The guidelines for DOTS in the South Pacific published by WHO in May 1999 were much appreciated.

He expressed concern at the slow progress made against tuberculosis in the Region six years after declaration of the global emergency. He requested the Regional Director to strengthen technical support and mobilize resources for control, to which Fiji pledged to give priority.

Dr TAMARUA (Cook Islands), commending the report for its clear description of the situation, said that DOTS was a key strategy for control.

The disease was not a significant problem in his country, but he was fully aware of the possibility of re-emergence. A retraining programme for health care workers and other measures for strengthening case management had been undertaken. DOTS, he believed, was not only effective for control and treatment, it also ensured compliance and discouraged drug resistance.

Cook Islands endorsed the report and proposals, and the Stop TB Initiative.

Mr WARAKOHIA (Solomon Islands) reported that his country had intensified its tuberculosis control programme and adopted DOTS. Rates for completion of treatment and cure had risen by 100% and 90% respectively in the previous two years.

He expressed gratitude for the support provided by WHO and Japan and endorsed the proposal for a special project.

The REGIONAL DIRECTOR thanked the representatives for their positive comments and their endorsement of the proposal to make tuberculosis a special project in the Region. In reply to the question from the Republic of Korea as to why and how the special project had been conceived, he said that it had been noted that tuberculosis was affecting both developed and developing countries and, as reported, nearly 30% of cases occurred in the Western Pacific Region; 700 people died of the disease each day in China, and 67 in the Philippines. If the subject had been, for example, road accidents, it would have been headline material. Since the problem persisted, a special project was called for.
There was also the fact that tuberculosis particularly affected the 16–64 year age group, with serious repercussions on countries’ economies. Disability-adjusted life years (DALYs) for tuberculosis were among the highest for any communicable disease. Low-income groups were especially vulnerable, so social reform was an important aspect of prevention and control. WHO had demonstrated the success of DOTS, and it was essential to continue efforts in the context of reform in the health sector. To China’s remark that the targets shown in Table 1 of the documents were too high to be met by the dates indicated, he replied by reminding representatives that the DOTS strategy had two components: first, as Palau had noted, it was essential to pursue effective case-finding; second, DOTS had to be applied. The target of a 70% detection rate was based on the suggestion that the real number of cases could be extrapolated from reported numbers; with that knowledge it would be feasible to treat a high proportion of cases effectively so as to reduce incidence of the disease - once cases were detected there was a moral responsibility to treat 100%.

Although the targets appeared ambitious, it was imperative that that should be attempted. He maintained that by 2005 the current detection rate of 43% could be raised to 70%. Similarly, 100% access to DOTS might appear an ambitious target, but he felt it was not unrealistic.

The MEDICAL OFFICER (TUBERCULOSIS) explained, with the help of slides, that WHO had studied the burden of different diseases and health conditions in the Region using the measurement of disability-adjusted life years (DALYs). Results showed that infectious diseases accounted for one third of the total disease burden in the Region, and that tuberculosis accounted for 83% of the DALYs lost on account of infectious diseases.

In response to the question from the Representative of Papua New Guinea on the cost-effectiveness and cost-benefit of tuberculosis control, he explained that, according to World Bank data, tuberculosis care was one of the most favourable public health interventions in terms of cost to save one year of health life: US$ 5 secured one year of healthy life of a tuberculosis patient. A WHO cost-benefit study carried out in the Philippines indicated that every dollar invested in tuberculosis control would lead to a societal return of some US$ 60 in five years. In other words, the benefit resulting from improvement of tuberculosis control through DOTS could be expected to be much greater than the required investment.

In response to his question on the fate of the short-course chemotherapy formerly used, he explained that, although it had shortened the duration of treatment to six months, around half the tuberculosis patients had taken medication only irregularly or had discontinued it. WHO had therefore adopted DOTS, whereby patients were given a short-course chemotherapy regimen under
direct observation. DOTS was producing a cure rate of 90%.

In response to the question from the representative of France on whether countries in the Region which were classified as implementing DOTS were implementing all five components, he said that most of them were doing so; in the few newly industrialized countries that were not, the recording and reporting systems were missing.

The CHAIRPERSON requested the Rapporteurs to prepare an appropriate draft resolution.

2. HEPATITIS AND RELATED DISEASES: Item 13 of the Agenda
(Document WPR/RC50/9)

Introducing the item, the Regional Director said that viral hepatitis remained a significant public health problem in many countries and areas of the Western Pacific Region. In particular, hepatitis B and hepatitis C caused considerable morbidity and mortality. Chronic liver disease and hepatocellular carcinoma caused by hepatitis B and C were among the most important public health problems in the Region.

Hepatitis B carrier rates in some countries and areas of the Region, especially Pacific island countries, were among the highest in the world. Twenty-five countries and areas had reported carrier rates of more than 8% of the general population. Up to 10% of these chronic carriers could be expected to die of the effects of the infection. Immunization of infants was the main strategy to prevent these infections and to reduce the prevalence of chronic infection. In the Region, over 150 million people were chronic carriers of hepatitis B.

In addition, it was estimated that up to 50 million people in the Region might be infected with hepatitis C. Morbidity and mortality patterns of chronic carriers of hepatitis C were similar to those of carriers of hepatitis B. There was no vaccine for hepatitis C.

Hepatitis A, although endemic in most countries, did not constitute a major public health problem in the Region. Hepatitis E, however, was more widespread than previously recognized and was emerging as a major cause of viral hepatitis in some Member States.

In December 1998 a meeting of the Western Pacific Region Working Group on Viral Hepatitis had reviewed the current situation of viral hepatitis and had identified priorities for action. The Working Group had noted that significant progress had been made in controlling hepatitis B through immunization and in reducing post-transmission hepatitis. However, it had also noted that
major efforts were still needed to ensure the sustainability of hepatitis B immunization activities, to improve blood safety and to reduce the risk of viral transmission through medical and other unsafe practices. It had also been noted that viral hepatitis needed to be closely monitored in order to improve planning for long-term control.

The Regional Director strongly encouraged those countries which had not already included hepatitis B in their national immunization programmes to do so as soon as possible. With regard to blood safety, he warned that, although some progress had been made, the situation was not optimal in many of the countries and areas of the Region.

Outlining WHO’s future support for hepatitis control in the Region, he said that WHO would continue to concentrate on achieving and maintaining high hepatitis B immunization coverage in all countries and areas of the Region. This would include facilitating the introduction of adequate supplies of hepatitis B vaccine in Cambodia and the Lao People’s Democratic Republic.

In order to improve blood safety, WHO would continue to support the development of appropriate screening and quality assurance in laboratories. In addition, WHO would encourage the collection of blood exclusively from voluntary and non-remunerated donors and would promote both the effective use of blood plasma derivatives and the reduction of unnecessary transfusions.

Lastly, WHO would continue to closely monitor hepatitis A and E, as well as other newly emerging hepatitis diseases.

Dr CHERN (Singapore) pointed out an error in Table 1 of the document under review. Hepatitis B chronic carrier prevalence in Singapore was 5.0%, and not 12.0% as indicated.

Dr LEE (Republic of Korea) agreed that the best strategy to tackle hepatitis and related diseases was through the vaccination of children. He was pleased to inform the Committee that the Republic of Korea was hosting and supporting the International Vaccine Institute, an international organization dedicated to vaccine-related research and development and to capacity building in the field of vaccine technology in developing countries. He called on all Member States in the Region to support its activities.

Mr LEUNG (Hong Kong, China) observed that hepatitis represented a distinct public health challenge because of the variety of causative agents transmitted through different modes. His country had introduced hepatitis B vaccination for high-risk groups some years ago, since extended to neonates, and was looking forward to a reduction in hepatitis B carrier prevalence in the population.
In addition, as a result of the rigorous screening of donors, no case of post-transfusion hepatitis had been recorded in Hong Kong for the past five years.

Mr HIRAYAMA (Japan) agreed with previous speakers that strengthened immunization and surveillance and improved blood safety were the key elements of hepatitis control. He was pleased to note efforts in the Region to halt commercial blood donations.

Dr TUFA (United States of America) reported that the immunization of neonates had been introduced in American Samoa some years ago, and efforts were being made to determine the hepatitis B status of all pregnant women who registered for antenatal care. The Centers for Disease Control and Prevention, Atlanta, United States of America, had been actively involved in the hepatitis B programme and had provided funds for vaccine and personnel as well as undertaking evaluation studies.

He was gratified to see the increasing number of Member States that had included hepatitis B vaccine in their routine infant immunization schedule, resulting in a dramatic reduction in the transmission of chronic hepatitis B infection among vaccinated children. In addition, epidemiological surveys helped to monitor better the effectiveness of immunization activities and should be encouraged. They also helped to define the extent of hepatitis C infection, and current risk factors for its transmission. Similarly, surveillance for new cases of symptomatic hepatitis could be used to monitor the burden of the disease and the impact of prevention programmes. Hepatitis control in the Region also required enhanced capacity of health personnel, improved laboratory diagnosis, and effective health education.

Dr TANGI (Tonga) noted that Table 1 of the document indicated a hepatitis B prevalence rate among adults in Tonga of 20%; the prevalence among children under eight years of age in 1983 had been 4%. Immunization of newborn infants had begun in the late 1980s, and coverage of that group was now greater than 95%. In 2000, a survey was to be carried out among schoolchildren to determine the prevalence of carriers. As there was as yet no means of treating persons carrying the virus, a certain number of cases of cirrhosis and hepatoma were to be expected.

Dr BOLADUADUA (Fiji) acknowledged the support provided by WHO, UNICEF and the governments of Australia and New Zealand. This support had allowed her country to meet its hepatitis B vaccine requirements for the years 1996–2000 and to achieve immunization coverage of 98%. Hepatitis C was an emerging problem, however, and the available information indicated that hepatitis E infection was more widespread than had been recognized previously. She urged all
Member States to maintain their efforts to meet the target of reducing the hepatitis B carrier rate among children by 80% by the year 2000 and requested that attempts be made to secure reliable funding for vaccine acquisition by the Pacific island countries.

Dr TAMARUA (Cook Islands) said that his country had initiated a programme of hepatitis B immunization for all children under the age of 15 more than ten years previously, although the focus had subsequently been on neonates. The carrier rate was now 12% but should decline as the immunized children became adults. It was well recognized that carriers could develop hepatoma. In view of the emergence of hepatitis C infection, he requested support for screening of blood and blood products.

Dr TEMU (Papua New Guinea), noting that his country had the second highest prevalence rates of hepatitis B and C in the Region, said that hepatitis B immunization had been introduced in 1991. Coverage, however, was still low owing to major financial and logistic problems. Studies indicated a very high rate of vertical transmission during pregnancy or delivery. It was believed that this could explain why the onset of hepatocellular carcinoma secondary to chronic liver damage had been seen recently among young adults. He requested information on possible intervention strategies, as it would appear that immunization was not the optimal approach. If no studies on the question were being conducted, he asked that such an investigation be carried out in Papua New Guinea. Like the Representative of Fiji, he asked for support for screening of blood and blood products for hepatitis C. Papua New Guinea also had a need for hepatitis B vaccine.

Ms EARP (New Zealand) said that hepatitis B was one of the nine diseases covered by the national childhood immunization programme in New Zealand. Although the report under consideration indicated that coverage in New Zealand was 100%, estimates for 1998 placed the rate at 87%. Of specific concern were Maori and Pacific island communities, which had lower coverage than other population groups. Antenatal care included testing of all pregnant women for hepatitis B, so that babies born to mothers who were carriers could be immunized soon after birth. A screening programme soon to be introduced would target communities at greatest risk. Those identified as hepatitis B carriers would be encouraged to have annual check-ups and be told how to decrease their risk of disease. Hepatitis B could be prevented by immunizing infants, and that remained the best strategy for its control.

The two main strategies for the control of hepatitis C were ensuring the safety of blood supplies and providing clean needles and syringes to intravenous drug users. Other activities concerned the prison population and guidelines for safe body piercing.
Dr OTTO (Palau) reported that the last epidemic of hepatitis A in Palau had occurred in 1985. The steps being taken to prevent further epidemics included improvement of environmental health and ensuring food safety. The programme for the prevention of hepatitis B was similar to that of American Samoa, and he thanked the United States of America for its support. The hepatitis B carrier rate among adults in his country was probably greater than the 12% indicated in the document, and hepatoma was one of the most prevalent causes of death from cancer. Palau was working with the Red Cross to ensure a safe blood supply but otherwise had no activities directed to the control of hepatitis C. He reiterated the requests of the Cook Islands and Fiji for assistance in that respect.

Dr ALTANKHUYAG (Mongolia) said that although morbidity due to hepatitis had halved over the preceding 30 years, the disease was still the most prevalent of all infectious diseases in Mongolia. The incidence of liver cancer among patients with chronic hepatitis was increasing. All children born since 1991 had been immunized, and a national programme against hepatitis had been initiated in 1998. Centralized disinfection of medical instruments and materials had been introduced in all hospitals, domestic production of disposable syringes was adequate to cover national needs, and modern techniques and treatment for hepatitis had been introduced. He considered that national programmes against hepatitis should include a review of guidelines and regulations for preventing the disease; the provision to hospitals of diagnostic kits and reagents for identifying markers of hepatitis B, C, D, E and G; and cooperation with WHO to strengthen laboratory diagnosis of hepatitis. He suggested that a pilot project be mounted to include provision of hepatitis B vaccine in the national immunization programme of Mongolia.

Dr LIU Guo-bin (Macao) noted that viral hepatitis was a major public health problem in Macao. In 1998, 151 cases had been notified, 5% of which were hepatitis A, 25% hepatitis B and 68% hepatitis C. There had been two outbreaks of hepatitis A within the past ten years, both due to the consumption of raw or undercooked seafood from polluted water. The main preventive strategies were health education of the general population, ensuring the safety of blood and blood products and immunization. The immunization programme had begun in 1984 with administration of hepatitis B vaccine to the newborn infants of carrier mothers. In 1989, immunization had become compulsory for all neonates and for people in high-risk groups, such as intravenous drug users, haemodialysis patients and health workers. Since 1994, all children under 13 years of age had been vaccinated. Hepatitis C infection was steadily increasing in Macao, especially among intravenous drug users, and had almost doubled since 1997. It was planned to strengthen surveillance and to formulate a prevention and control strategy to stem the increasing prevalence.

Mr LIU Peilong (China) said that great efforts had been made in his country over the past 20
years to contain viral hepatitis, including the development of vaccines against hepatitis A and B. Owing to financial constraints, however, immunization against hepatitis B was yet to be introduced into the expanded programme on immunization, and those who wished to receive the vaccine were obliged to pay for it. He noted inaccuracies and omissions in the data for China in Table 1 of document WPR/RC50/9 and proposed to provide those figures to the Secretariat.

Mr MANUOHALALO (France) also pointed out an error in Table 1 of the document regarding immunization coverage in New Caledonia. Immunization had been compulsory for babies born to mothers who were carriers of hepatitis B since 1985 and for all newborn infants since 1989.

Mr KIENENE (Kiribati) conceded that his country had one of the highest prevalences of hepatitis B carriage in the Region. It was hoped that the rate would be reduced by increasing coverage with hepatitis B immunization, providing vaccine to all newborn infants within 24 hours of birth. That, however, was not always practicable in view of the isolation of many of the islands. Nevertheless, coverage had increased from 6% in 1992 to 97% in 1997. He acknowledged the support of WHO and UNICEF and hoped that it would continue and be extended to help in screening for hepatitis C.

Dr LATIF (Brunei Darussalam) indicated that the figure for the prevalence of hepatitis B infection in his country shown, as in Table 1 of the document, had been based on screening of patients attending the gastroenterology department of a referral hospital. Although a serological survey of the general population had not been performed, hepatitis B screening had shown a prevalence rate of 3% among women in antenatal clinics and 1.5% among blood donors. Screening of blood donors for hepatitis C at that time had shown a prevalence of 0.64%. Free immunization against hepatitis B had been introduced for the newborn infants of infected mothers in 1984 and had since been incorporated into the expanded programme of immunization, with a high level of coverage being maintained. All donated blood was screened for both hepatitis B and C.

Dr KUN (Nauru), said that, although the number of deaths from hepatitis B in Nauru was small, these deaths represented a serious loss to a national population of only 10 000. He was confident that his country’s energetic programme of immunization among children, continued surveillance and the support of WHO in providing vaccine would eradicate the problem.

Mrs LE THI THU HA (Viet Nam) indicated that the prevalence rates of hepatitis B and C viral infection in her country were among the highest in the Region. Vaccine against hepatitis B was produced locally but on a small scale, and vaccine had to be imported to implement the current
immunization programme in major cities. A project to expand local vaccine production with assistance from the Republic of Korea was awaiting approval from the donor Government. Her Government had approached the governments of Australia and New Zealand for assistance in acquiring vaccine so that coverage with hepatitis B immunization could be extended to all newborn infants in Viet Nam. Efforts were being made to promote voluntary blood donation.

The REGIONAL DIRECTOR thanked representatives for their comments and apologized for the inaccuracies in some of the country information given in the report. He would endeavour to ensure that accurate data were provided in the next Regional Director’s report.

Replying to the representative of Papua New Guinea, he said that, although the proportion of hepatocellular carcinoma due to hepatitis B varied from country to country, it was higher in the Pacific island countries than in countries with high immunization coverage, like Australia and Japan. The two main modes of transmission of hepatitis B were from carrier mothers to their children and through infected blood and the use of contaminated needles. It was WHO policy to integrate hepatitis B immunization in the Expanded Programme on Immunization, since evidence had shown that it was an effective means of protection. Since there was no vaccine against hepatitis C, the main strategies for the prevention of hepatocellular carcinoma caused by hepatitis C were the screening of blood transfusions and ensuring safety of injections and medical procedures.

The TECHNICAL OFFICER, EXPANDED PROGRAMME ON IMMUNIZATION recognized the difficulty of screening pregnant women in countries with a high prevalence of hepatitis, especially since many of those countries had limited resources. Efforts had therefore been focused on universal immunization coverage and the prevention of transmission from carrier mothers to their children by immunization of infants against hepatitis B as close to birth as possible. Early immunization had been shown to be highly effective.

3. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolutions:
3.1  **Reform in the Western Pacific Region** (Document WPR/RC50/Conf. Paper No. 1 Rev. 1)

Dr TEMU (Papua New Guinea) proposed the addition of the words “with particular attention to least developed countries” to the end of operative paragraph 4(1).

The REGIONAL DIRECTOR said that, while WHO must take into account the needs of all Member States, the proposed amendment was consistent with the decision to give special attention to the least developed countries in respect of country allocations under the 2000–2001 programme budget.

**Decision:** The draft resolution, as amended, was adopted (see resolution WPR/RC50.R3).

3.2  **Sexually transmitted infections, HIV infection and AIDS**
(Document WPR/RC50/Conf. Paper No. 4)

Professor WHITWORTH (Australia) suggested the addition of a new operative paragraph 2(4) to read: “to encourage and facilitate the exchange of social and behavioural research to enable prevention measures to be targeted more effectively”. The remaining subparagraphs would be renumbered accordingly.

Dr TEMU (Papua New Guinea) proposed: the insertion of the words “and health education” after “condom promotion” in the third preambular paragraph and operative paragraph 1(1); the insertion of “secure political commitment and” after “to” in operative paragraph 1(2); the insertion of “including guidance in development of appropriate legislation for control of HIV/AIDS” after the words “HIV/AIDS” in operative paragraph 2(1); and the addition of “in collaboration with other partners” at the end of operative paragraph 2(4).

Dr OTTO (Palau) suggested the addition of the words “within an integrated approach” at the end of operative paragraph 1(2).

In reply to Dr KIENENE (Kiribati), the REGIONAL DIRECTOR said that, in relation to the “bloodborne infections” mentioned in operative paragraph 2(2), hepatitis was also included.

**Decision:** The draft resolution, as amended, was adopted (see resolution WPR/RC50.R4).
4. ACTION PLAN ON TOBACCO OR HEALTH: Item 15 of Agenda  
(Document WPR/RC50/11)

In his introduction to the item, the REGIONAL DIRECTOR pointed out that the 1999 *World Health Report* clearly showed the magnitude of the tobacco problem:

- half of all long-term smokers eventually died from smoking, losing 15–25 years of life;
- within 20 years tobacco use would be the leading cause of death, rising from the current level of one in ten of all deaths to one in six by the year 2025.
- in the Western Pacific Region there were more than 400 million smokers, and they accounted for almost half of all cigarettes consumed in the world; and
- the Western Pacific Region had experienced the largest increase in per capita tobacco consumption of any Region in the world.

Despite the significant progress that had been made to control tobacco use, he said that significantly more resources needed to be devoted to this problem than in the past. Tobacco use within the Western Pacific had reached a crisis.

He explained that the Regional Action Plan on Tobacco or Health 2000–2004 was being presented to the Regional Committee for its approval. This Action Plan had initially been developed at the Fourth Meeting of the Working Group on Tobacco in November 1998.

In cooperation with the initiative launched by the Director-General of WHO, and the wishes expressed by all Member States at the World Health Assembly, the Western Pacific Region gave strong support to the international Framework Convention for Tobacco Control. The first meeting on the Convention would take place from 25 to 29 October 1999 in Geneva, and the Regional Director urged all Member States to respond positively to the Director General’s invitation to attend the meeting.
In conclusion, the Regional Director said that the review of the Action Plan for Tobacco or Health 1995–1999 showed that significant progress had been made during the last five years. However, efforts needed to be redoubled if a significant reduction in tobacco use in the Region was to be achieved. He hoped that the Committee would support the Regional Action Plan on Tobacco or Health 2000–2004 as a framework which they could use to formulate their own tobacco or health initiatives for the first five years of the 21st century.

Dr NOVOTNY (United States of America) congratulated the Regional Director on the Action Plan and said that the tobacco epidemic called for a concerted and a stronger response. The United States was most concerned about the increasing prevalence of smoking among adolescents and women in the Region. Campaigns were needed to encourage people not to start and to quit smoking. The youth risk survey planned by the Centers for Disease Control and the World Health Organization should elucidate the dynamics of tobacco use among youth worldwide. New alliances were needed especially with drug regulators, and with the worlds of sports, entertainment and finance. The speaker reiterated points made in the World Bank and WHO document entitled *Curbing the Epidemic*, on raising of taxes on tobacco in order to reduce consumption without reducing revenue, on support for cessation of smoking, on elimination of advertising and of smoking in public places, as well as elimination of smuggling, so as to increase revenue and cut supplies. Farmers should be helped to turn to alternative crops.

Research needs in countries of the Region that could be met only through international collaboration should be identified. The US National Institute of Health now budgeted for international tobacco research, and the Centers for Disease Control would provide additional technical assistance to the Region through personnel assignments. WHO had to ensure that global tobacco surveillance and information systems were better utilized and more readily available. He welcomed the planned GLOBAL network to provide information on a country-by-country basis. Exposure of information on tobacco was an excellent tool, especially the previously secret tobacco industry documents that were now available in the United States and the United Kingdom.

He encouraged Member States to take an active part in the Framework Convention on Tobacco Control, and invited all to attend the eleventh world conference on tobacco and health, which was to be held in Chicago, United States of America, in 2000.

Dr THORNE (United Kingdom) returned to the Regional Director’s point that within 20 years tobacco would be the leading cause of death worldwide, and would be responsible for 10 million deaths each year. An effective tobacco strategy was an opportunity to make enormous gains in public
health status, and she welcomed the Action Plan.

Dr TANGI (Tonga) fully supported the Organization on the Action Plan on Tobacco or Health. The World Health Assembly in May 1999 had brought home to him the scale of the problem, on which there was no national policy in his country. Having realized that it was a political issue, he had provided all his colleagues in cabinet with a copy of the WHO document. They had agreed to increase tobacco tax by 50%, and a national policy on tobacco was expected in the following weeks.

Mrs LE THI THU HA (Viet Nam) pledged the full support of her country for implementation of the Regional Action Plan on Tobacco or Health for 2000–2004. The Vietnam Steering Committee on Tobacco Control had prepared an Action Plan on Tobacco or Health for 1995–1999 in order to reduce tobacco consumption, especially among youth, students and soldiers. The tobacco tax rate had been set at 32%–70%, and bans had been imposed on tobacco advertising in the media, smoking in schools and health institutions, and on international and domestic flights of Vietnam Airlines. Health warnings, though not required by law, appeared in Vietnamese and English on cigarette packets. Articles on the hazards of smoking appeared regularly in the media, in addition to materials for World No Tobacco Day and Vietnam No Tobacco Week, which had been marked since 1998. Data on the relation between smoking and cancer, respiratory and cardiovascular diseases were gathered in several hospitals. Prevalence of smoking in Viet Nam had fallen from 61% in 1993 to 50% in 1998. In January 1999 the Prime Minister had formed a working group to draft a national policy for tobacco control, with representatives of 11 ministries. The policy, which had now been submitted to the Prime Minister for approval, was to cover demand reduction, health education, control of advertising, and compulsory health warnings on cigarette packets. It would also control the production, trading, importation and smuggling of tobacco. Much remained to be done, and the speaker counted on further support from WHO.

Dr LI Changming (China) was pleased to note that, following implementation of the Regional Action Plan on Tobacco or Health 1995–1999, the Region was putting forward a Regional Action Plan for 2000–2004. Implementation of such a plan would help control tobacco in the Region and would also contribute to support for the international Framework Convention on Tobacco Control. China fully endorsed the Regional Action Plan 2000–2004 and would produce a national action plan for the same period. The speaker made a number of suggestions for the final version of the Regional Action Plan: it should make allowances for the great political, economic and social disparities between countries in the Region; international organizations should be involved in the process; the Tobacco Free Initiative should involve many sectors, and leading players in those sectors should be invited to future meetings on tobacco control.
Rates of tobacco consumption in China were extremely high. In spite of great progress on tobacco control, public awareness of the dangers remained perilously low, and no immediate reduction in smoking could be expected. The Action Plan called for health warnings and increased taxation of tobacco products, which were difficult matters since they touched on many sectors. Tobacco production and consumption were connected to the national economy, and developed countries were trying to promote tobacco consumption in China. This meant that tobacco control had to be stepped up. The speaker hoped that WHO, other international organizations and other countries would provide technical and financial support and training, in furtherance of the Regional Action Plan on Tobacco or Health 2000–2004.

Dr WARAKOHIA (Solomon Islands) requested that his Government should be assisted at every stage of implementation of the Action Plan on Tobacco or Health 2000–2004, because cooperation from the international community was required, as well as political will. Countries should not be left to face the tobacco industries on their own.

Now that evidence-based policies were required, more data were needed to secure the commitment of government and leaders. Plans should therefore be made to strengthen data analysis and assess country situations. Strategies to convince legislators and policy-makers should be included in the plan of action.

The Solomon Islands had banned smoking in government offices, public amenities and aircraft. Since over half the population was under 21 years of age, smoking among young people, and especially women, was a particular concern.

Ms PATON (Australia) welcomed the Action Plan and spoke of Australian achievements in tobacco control. Advertising had been restricted, a national strategy on passive smoking had been drafted, taxation had been changed from a weight-based to a per-stick system, and a very successful National Tobacco Campaign had been run. However, much remained to be done. In June 1999 health and law enforcement ministers from all Australian governments had endorsed a National Tobacco Strategy as a framework for tobacco control over the next five years.

Australia had taken part in the National Focal Persons on Tobacco or Health meeting held in Manila in August 1999. While useful, the meeting had not allowed for detailed discussion of the draft Regional Plan. The Regional Office was urged to make more use of the National Focal Persons forum in future, in view of the key role of governments in implementing such plans. In terms of content of the Regional Action Plan, she advocated greater flexibility over expected results, and suggested that
“should” rather than “will” be used in outlining the expected results, which might not all be appropriate for some countries. The speaker further suggested that the categories of “most effective” and “effective” strategies, on page ten of the plan, be merged into a heading “range of effective strategies”, unless there was evidence for their separation. Since the plan ought to be evidence-based, the speaker wished to see the strategies on generic packaging and low-tar policy deleted, in view of evidence from Canada on an association between adenocarcinoma and smokers of “light” cigarettes. She suggested further that Objective three be worded more positively, as “To support people to quit tobacco use”.

Australia supported the proposal by the meeting of National Focal Persons on Tobacco or Health that the slogan “United for a Tobacco-Free World” be used rather than “United for a Nicotine-Free World”. Australia found the symbol of an orchid on an ashtray inappropriate, as it continued the association with tobacco smoking.

The speaker suggested that, to set an example, Regional Committee social events, as well as meetings, should be smoke-free.

Dr Chern (Singapore) said that his country had closely followed the Regional Action Plans for 1990–1994 and 1995–1999. A month-long smoking control campaign was timed to coincide with the annual World No Tobacco Day; the media had been involved, and smoking cessation hotlines had been set up. Smoking cessation clinics were to be found in government clinics, Cancer Society clinics and the private health sector. Teachers were given training to help their pupils stop smoking.

In 1993, legislation had been introduced to ban tobacco advertising, and all cigarette packets had to carry health warnings that occupied 20% of the front or back of the packet. Tar and nicotine levels had been reduced to 15mg and 1.3mg respectively, and the sale of tobacco products to people aged under 18 was prohibited, as was the public consumption of such products by under-18s. In 1995, smoking was banned in all air-conditioned workplaces, shopping centres, public queues and pedestrian underpasses. In 1997 the ban was extended to all educational establishments, air-conditioned shops and private clubs, hotels and petrol stations. As of 1998, tobacco retailers were required to have a licence which required them to check the age of the buyer, and under-18s were banned from selling tobacco products. Smoking was banned in all military facilities, as was smoking in uniform in public places. All international flights were smoke-free.

The Ministry of Health was aware of the importance of data, and had conducted surveys of the prevalence of smoking every other year since the start of its National Smoking Control
Programme in 1986. Prevalence had fallen from 20% in 1984 to 15% in 1998. The speaker concluded by emphasizing the importance of supporting the Framework Convention for Tobacco Control in the Action Plan, since it would help to deal with transnational tobacco control issues such as smuggling and advertising on the Internet. He suggested that the third objective “To support those wishing to quit smoking” be stated more strongly as “To motivate smokers to stop smoking” or “To increase the number of people who want to stop smoking”.

Ms LUK (Hong Kong, China) spoke of the phased introduction since 1982 of comprehensive legislation on smoking and measures to deter smoking, such as an advertising ban, a requirement that cigarette packets and adverts carry a health warning, and designation of no-smoking areas. Prevalence of smoking among those aged 15 and over had fallen from 23.3% in 1982 to 15% in 1998. The number of cigarettes consumed had fallen by half over the previous ten years. She agreed with the Representative of Tonga that top-level support was needed in order to push through reforms. All government offices in Hong Kong were now smoke-free. The requirements for health warnings would be stepped up, and the number of no-smoking areas would be increased. Education to prevent smoking would be increased among the general public and in schools.

Mr MANOUHALALO (France) said that his country recognized the problems caused by tobacco consumption in the Pacific and the world, and that France strongly supported the Action Plan.

Mr ISOBE (Japan) said that among its activities to develop policies for tobacco control Japan was finalizing a campaign called “Healthy Japan in the Twenty-first Century”, and had set up a sub-committee on tobacco which was establishing targets for reduced tobacco use.

Japan also recognized the need for many other measures to implement the Regional Action Plan on Tobacco or Health 2000–2004, which it supported.

Mr Chan-Hyung PARK (Republic of Korea) expressed strong support for the Regional Action Plan on Tobacco or Health and the international Framework Convention on Tobacco Control.

His country, where 68.2% of men over 15 years of age were reported to smoke, needed strong measures under the Tobacco free Initiative.

The National Health Promotion Act (1995) aimed to limit outdoor tobacco advertising and make warnings on cigarette packets obligatory. In 1997 a National Health Promotion Fund had been established to support programmes against smoking.
The Government had set a goal to reduce the promotion of men smoking to 55% by 2003, and was promoting anti-smoking campaigns and tobacco-free premises. There was a focus on adolescents, using such measures as health camps.

A national committee on the international Framework Convention had been organized, and the Republic of Korea hoped to have its experts take part in the WHO working group. It was also willing to provide staff and resources to help finalize the anti-smoking agreement and protocol.

He encouraged WHO to continue its related activities in information and media services, and offered support in collecting and disseminating information on policies and programmes in Member States.

Ms PAULINO (Philippines) commended the proposed Action Plan, which would facilitate implementation of the Tobacco Free Initiative in the Region and at country level. She said that the campaign in the Philippines had been arduous: tobacco products, and especially cigarettes, were readily accessible, and advertising targeted at children, adolescents and women had increased the prevalence of smoking in those groups dramatically. The Framework Convention for Tobacco Control and the Regional Plan of Action would serve Member States as tools for strengthening national legislation. Anti-tobacco legislators in the Philippine Senate were steering debate away from deadlocked issues, such as the rights of smokers and non-smokers, and towards consideration of the Government's role in protecting people from a harmful and addictive substance, nicotine. National and local legislators should inform the public about the possibilities presented by the Framework Convention for reinforcing national tobacco control policy, and people who influenced public opinion should be made to understand that school-based programmes and campaigns for a healthy lifestyle were insufficient to control tobacco use.

Ms EARP (New Zealand) found that the draft Action Plan would serve as a good basis for her country to identify areas in which further efforts could be made. She welcomed the enhanced focus on smoking cessation, since most effort had hitherto been concentrated on trying to reduce the prevalence of smoking among young people. She regretted that her Government had had little opportunity to comment on the proposed Plan before it was submitted to the Committee and asked that such opportunity be provided in the future. She suggested that Objective 3 of the draft Regional Action Plan be amended to reflect the need to actively encourage people to take the decision to stop smoking as well as to provide support for those who had already taken that decision. Regulation of nicotine as a drug and imposition of a “tied” tax on tobacco should be presented as options rather than as “additional desirable areas”. She supported the request of the representative of Australia that the
Plan be presented as an aspirational document, the words “will” and “would” being replaced by “should”, as the Plan would place great demands on the resources of Member States. Additional support from the Regional Office would be required if the Plan was to be implemented successfully.

Dr LIU Guo-bin (Macao) described the tobacco control policy of Macao as being based mainly on legislation and health education. The first law, passed in 1983, had not been effectively implemented. In the law that had come into effect in December 1998, all kinds of cigarette advertising were banned and enforcement agencies were allowed to impose stronger penalties and had been given greater power. Education on the health hazards of smoking and on healthy lifestyles was provided jointly by governmental and nongovernmental organizations and was directed primarily at children and adolescents. Efforts were continuing to make Macao a smoke-free city.

The meeting rose at 12.30 p.m.
SUMMARY RECORD OF THE SIXTH MEETING

Hyatt Regency Ballroom, Macao
Thursday, 16 September 1999 at 2 p.m.

CHAIRPERSON:  Dr Sodov SONIN (Mongolia)
later:  Dr José Alarcão TRONI (Macao)

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1. **ACTION PLAN ON TOBACCO OR HEALTH**: Item 15 of Agenda  
(Document WPR/RC50/11) (continued)

Dr ARIF (Malaysia) expressed his deep concern about the rising trend in smoking among young people in his country. As tobacco products were legal, a total ban on their use or sale would be difficult. Tobacco control regulations had been enacted some years ago and were regularly enforced. Restrictions on smoking in public places had recently been introduced, and regulations were to be made more stringent and comprehensive. Efforts would be made to collaborate with neighbouring countries to control cigarette smuggling.

Malaysia strongly supported the Regional Action Plan on Tobacco or Health and the international Framework Convention on Tobacco Control.

Mr SCOTTY (Nauru) noted that tobacco-related diseases were not only a significant cause of morbidity in Nauru, but also a considerable drain on resources as the more serious cases had to be sent abroad for treatment. Legislation was being introduced to raise the import tax on tobacco products, to discourage tobacco advertising, and to ban smoking in public places. Public education campaigns were also being carried out. The lines of action for tobacco control set out by WHO were being pursued, and a local action plan had been drawn up.

He was saddened to report that the drastic increase in the price of tobacco products had not produced the desired effect. A total ban on the import of tobacco products was not feasible. However, the Ministry of Health was pursuing its efforts and fully endorsed the Regional Action Plan on Tobacco or Health.

Dr OTTO (Palau) reported that, among recent control activities in Palau, legislation had been enacted to ban smoking and chewing tobacco in public buildings, and to prohibit the sale of tobacco to minors. Taxes on tobacco products had been raised and, more recently, a law had been passed authorizing the Government to sue tobacco companies for harm done to its citizens. In addition, the Micronesian games had refused to accept tobacco sponsorship, despite severe financial difficulties. None the less, more measures were needed, especially to protect children.

He welcomed the Regional Action Plan on Tobacco or Health, which helped countries to focus on appropriate control activities. He agreed that efforts needed to be
extended beyond smoking, and recommended that activities should cover all forms of tobacco consumption. Palau fully supported WHO and other bodies in the fight against tobacco, and wished to participate actively in development of the Framework Convention on Tobacco Control.

Mr ROKOVADA (Fiji) welcomed the progress made in achieving smoke-free airlines, which had been recommended in the first Regional Action Plan almost a decade ago. In his view, the Plan proposed did not adequately cover the consumption of tobacco by women and young people, even though initiatives for research, education and awareness-raising in such groups existed in the Region. He fully supported implementation of the proposed Action Plan, which would guide countries in allocating resources and carrying out activities.

His country had recently introduced tobacco control legislation which banned advertising, restricted the sale of tobacco products to minors, limited smoking in public places, and required new health warnings on tobacco products. A ban on sponsorship would come into effect shortly.

Dr LATIF (Brunei Darussalam) said that his country had taken a number of tobacco control measures, including compulsory health warnings on tobacco products, higher tobacco taxes, health education, smoke-free government buildings and flights on the national airline, and a ban on advertising on State-controlled television and radio. He fully supported both the Regional Action Plan and the proposed Framework Convention on Tobacco Control.

Dr PRETRICK (Federated States of Micronesia), expressing his full support for the Regional Action Plan, said that his country was focusing on the introduction of a comprehensive tobacco control and prevention programme. Technical guidance would be needed to improve capacity in programme planning and implementation.

Tobacco use was prevalent among all age groups and there was a clear need to raise the awareness of decision-makers. Efforts were being made to bring together business, nongovernmental organizations and government agencies to frame policies that would create an environment that discouraged tobacco use.

Dr MALAU (Papua New Guinea) reported that it had been difficult for his country to implement and enforce its tobacco control act, as tobacco companies had used loopholes to continue advertising. Control activities included public health and awareness campaigns and
the use of health-promoting schools, healthy villages and healthy offices. Although coverage of such programmes was slowly increasing, they had not produced the desired effects. The tobacco control act would therefore be re-examined with a view to imposing a total ban on all forms of tobacco advertising, controlling pricing and increasing taxes.

He endorsed the Regional Action Plan and agreed with paragraph 4 of document WPR/RC50/11 that active collaboration was needed with public health associations in order to help strengthen the position of vulnerable countries when confronting transnational tobacco enterprises.

Dr SHEM (Vanuatu) deplored the rising numbers of smokers in his country and the increasing tonnage of tobacco imports. All forms of media were needed in awareness campaigns in view of literacy difficulties in isolated communities. The Ministry of Health had been able, however, to discourage sporting associations from seeking sponsorship.

Vanuatu fully supported the Regional Action Plan and wished to be included among the Pacific island countries in which an economic analysis of the cost of tobacco use was conducted. He suggested that if public health officials were to work for change, they should set an example by not smoking themselves.

The REGIONAL DIRECTOR commented that as the tobacco companies were focusing their promotion campaigns on the Region, the problem of tobacco control had become too large for any one country to handle by itself. The Framework Convention was designed to assist countries in that respect. A working group made up of representatives of Member States would meet at WHO Headquarters in October 1999 to draw up the first draft of the Convention and Protocol and would report to the World Health Assembly in May 2000. He urged Member States to take up the Director-General’s invitation to attend the meeting.

The REGIONAL ADVISER IN ENVIRONMENTAL HEALTH, summarizing the proposed changes to the Action Plan on Tobacco or Health, suggested that objective 3 on page 4 be altered to read “To motivate and support people to quit tobacco use.” It had been pointed out that although all Member States appeared to support the need for strong national action, not all of them would be able to achieve the expected results outlined on pages 6 and 7 of the Plan. On both those pages, therefore, the words ‘will’ and ‘would’ would be changed to ‘should’. In the table on page 10 of the Plan, the two headings would be deleted and replaced by one overall heading reading ‘Range of effective strategies.’ In the same table, the
seventh bullet point would be changed to read ‘Strong, prominent pack warnings and full product disclosure and testing at manufacturers’ expense;’. 

As the Framework Convention would be based on national plans of action, it was essential that those be formulated before the Convention was developed. WHO would be pleased to work in parallel with countries to develop sound plans. It would also be important for countries to interact in developing tobacco control strategies and in issues of trade and economic development associated with tobacco control.

In the absence of further comments, the CHAIRPERSON asked the Rapporteurs to prepare a draft resolution.

2. DEVELOPMENT OF HEALTH RESEARCH: Item 16 of the Agenda
(Document WPR/RC50/12)

The DIRECTOR, PROGRAMME MANAGEMENT, introducing the item, said that the document provided information on the main activities of the Regional research policy and strategy coordination programme, which had two closely related purposes: to support research that was relevant and applicable and to strengthen national research capacities.

WHO aimed to promote national research coordination so as to aim research at solving priority problems. Although there were considerable differences between countries in the way that they had developed mechanisms for national research coordination, there had been increasing interest in that activity. The Strategic plan for health research in the Western Pacific Region 1997–2001 continued to provide guidance on the setting of research agendas by linking research objectives closely to the health objectives outlined in New horizons in health. As explained in the document, efforts were under way to improve dissemination of the Strategic plan.

WHO continued to provide grants for research and research training in order to promote research in areas of priority for the Region.

The 220 collaborating centres in the Region remained fundamental to WHO’s support for health research. This was in accordance with the World Health Assembly resolution WHA50.2, which had requested the Director-General to strengthen cooperation between WHO and its collaborating centres in priority areas. Their role was being examined at the
global level and would be discussed by the Executive Board at its 105th session in January 2000.

The document also included recommendations made by the Western Pacific Advisory Committee on Health Research at its seventeenth session in June 1998. He explained that it was customary for the Regional Committee to consider the recommendations of the Advisory Committee and, if it saw fit, to endorse them.

Mr LIU Peilong (China) looked forward to receiving the report of the Executive Board on the role of WHO collaborating centres. Of the 220 collaborating centres in the Region, 69 were in China. The directors of those centres met every two years; a representative of the Regional Office had attended the latest meeting and had provided guidance on future work. Most of the centres were active and made important contributions to both China and WHO. At the latest meeting, the directors had recommended that centres should be given more guidance and support by WHO, and that two-way communication should be strengthened. He suggested that the reports of the centres should be consolidated by WHO and feedback given to the centres. He also suggested that the research policy and agenda of WHO should be sent to each collaborating centre.

He agreed that the Strategic plan for health research in the Western Pacific Region for 1997-2001 should be translated into various languages. China had established a medical ethics committee and encouraged other Member States to formulate ethical guidelines.

Ms CHUNG (United States of America) was concerned that there was no evidence that Member States were using the Strategic plan to reorient or enhance research agendas in their countries. She suggested that collaborating centres should be encouraged to work together in support of the Strategic plan and that, in view of the decreased budget of the Region, Member States should take advantage of the resources of collaborating centres and other institutions, such as the Asia-Pacific International Molecular Biology Network. The Internet provided another possibility for sharing research results and obtaining up-to-date information. It was important to enhance the capacity to conduct more basic research in the Region.

Ms ALALOTO (Tuvalu) asked that more short-term consultants be sent to her country to assist health professionals and administrators in identifying priorities, conducting research and perhaps setting up a medical ethics committee, as suggested by the
Representative of China. The Ministry of Health in her country had a severe shortage of qualified health personnel, and short-term consultants helped to bridge the gap. She requested that copies of the Strategic plan be made available to health professionals in Tuvalu.

Dr ABU BAKAR (Malaysia) thanked the Regional Director for making the Strategic plan widely available in a number of languages, as it would be useful for countries developing or reviewing national priorities in health research. As the funds available for research were limited, it was important that they be concentrated in areas identified as priorities. Collaborating centres were a key resource in implementation of the Strategic plan and should therefore be given clearer directions on their role.

Professor WHITWORTH (Australia) reiterated that, within the Strategic plan, Member States should set their research priorities and strategic research plans according to their own health priorities and circumstances. The Strategic plan emphasized the importance of defining ‘researchable’ priorities in health and strengthening strategies and methods. Australia considered that links between national research bodies and the Western Pacific Advisory Committee on Health Research were beneficial for both and for the Region. In order to develop such links, however, it would be useful to have reports on progress in research activities.

Mr MANOUHALALO (France) said that the development of basic, and particularly of applied, research was important both for improving the quality of national laboratories and for finding solutions to major public health problems in the Region. It was also important to develop research in the field of social anthropology to better understand what determines care-seeking since health services in many countries are underutilized. WHO should concentrate its efforts on research on public health. Significant research was being carried out in the Region but more attention should be given to how that research was being applied. It was also essential to programme research work in the Region in order to optimize the available resources. French territories in the Pacific would like to integrate their research institutes into the network of WHO collaborating centres.

Dr LIU Guo-bin (Macao) said that no health research or basic research was being carried out in Macao, owing to limited resources. His country would welcome support in strengthening research capabilities. Referring to Annex 3 of the document on Development of health research (WPR/RC50/12), paragraph 3.1.5, he said that an ethical committee on life science research had recently been set up. Referring to paragraph 3.2.6, he said that the
Healthy Cities project in Macao was reaching a critical stage and he hoped that support would continue to enable it to come to fruition.

Ms EARP (New Zealand) urged WHO to encourage all countries to establish ethical review committees and to encourage research centres to communicate with each other to ensure closer links between developed and developing countries in order to assist in implementation of the Strategic plan. Support should be given to the smaller Pacific island nations to find funding for their research, not only from WHO but also from other sources.

The DIRECTOR, PROGRAMME MANAGEMENT recalled that a global review of the work of the WHO collaborating centres was to be undertaken on the basis of the deliberations of an internal working group composed of representatives from WHO Headquarters and the regional offices. Their recommendations, to be submitted to the Executive Board in January 2000, would reflect the need for more stringent criteria in selecting collaborating centres. Centres that did not meet those criteria would be phased out. The procedures for designation would be simplified, and management of the collaboration would be strengthened. Application of the recommendation should reduce the number of collaborating centres in the Region, which would allow better communication between the remaining centres and both the Regional Office and country offices.

The REGIONAL ADVISER IN RESEARCH PROMOTION AND DEVELOPMENT AND HEALTH LABORATORY TECHNOLOGY informed the Committee that the results of research projects funded by the Regional Office during the past five years and a summary of the annual reports of the collaborating centres in the Region were available both in hard copies and on the Western Pacific Regional Office website. He assured the representatives that additional copies of the Strategic plan would be made available. It had already been distributed to all governments in the Region, to collaborating centres and to many individuals. Translations into Chinese, Japanese and Korean would be available towards the end of the 1999. Links with the Australian National Health and Medical Research Council were very close, and representatives of the Council were invited to research meetings at the Regional Office.

In the absence of further comments, the CHAIRPERSON asked the Rapporteurs to prepare a draft resolution.
3. SUB-COMMITTEE OF THE REGIONAL COMMITTEE ON PROGRAMMES AND TECHNICAL COOPERATION: REPORT ON CRITERIA FOR CANDIDATES AND SELECTION METHODS AND PROCEDURES FOR NOMINATION OF THE REGIONAL DIRECTOR: Item 22 of the Agenda (Document WPR/RC50/19)

Dr OTTO (Palau), Chairman of the Sub-Committee, said that the fact that the Regional Committee had twice requested the Sub-Committee to re-examine the criteria and selection procedures for nomination of the Regional Director was indicative of the importance of that task. He drew attention to the Sub-Committee’s conclusions as contained in document WPR/RC50/19, in particular those on criteria for candidates, use of search committees and rules on campaigning.

Dr ROMUALDEZ (Philippines), commending the report, said that his delegation supported the conclusions and recommendations of the Sub-Committee.

Mr UEDA (Palau) praised the work of the Sub-Committee and fully supported the recommendations. His Government agreed that the current selection procedures for the Regional Director had been effective in the past and had allowed each Member State equal opportunity to field the best candidate of their choice. The use of a search committee would be too time-consuming and costly. He felt that the present limitation to two terms of the position of Regional Director would avoid the division that had been experienced in the Region during the last election.

Mr MOON (Republic of Korea), mindful of the divisiveness that arose from the last election of the Regional Director, supported the conclusions of the Sub-Committee. He believed that the current selection procedure would be appropriate as long as Member States avoided pursuing national interests during the election period.
Mr RETZLAFF (Samoa) joined the other representatives in supporting the recommendations of the Sub-Committee. He pointed out that the Western Pacific Region was made up of a diversity of countries, from very populous Asian nations to the small island states of the South Pacific. It was important that whoever was elected Regional Director should feel that a clear mandate had been given to him by all Member States, both big and small, and would endeavor to ensure that the particular needs of each country would be addressed.

Dr LIU Guo-bin (Macao) expressed his appreciation of the work of the Sub-Committee and said that Macao was in full agreement with the conclusions reached in its report.

Mr BOYER (United States of America) expressed disappointment with the conclusion that no change in the present procedure was necessary. At the forty-ninth session of the Regional Committee, he had spoken in favour of using a search committee; he still believed that that was a better procedure. He had thought that now would have been an opportune time to institute a search committee since it was the first year of a new Regional Director and would, therefore, not reflect on the incumbent’s performance. However, the Sub-Committee had considered the process carefully, and he would accept the recommendations in its report.

Mr ROKOVADA (Fiji) expressed appreciation of the Sub-Committee’s work. His delegation agreed with the Sub-Committee that a system of geographical rotation for the position of Regional Director would restrict the field of potential candidates and accepted the conclusions of the report.

On behalf of the other members, Dr OTTO (Palau), Chairman of the Sub-Committee, thanked the representatives for their support of the Sub-Committee’s recommendations.

In answer to a query from Mr BOYER (United States of America), the REGIONAL DIRECTOR said that under the Rules of Procedure of the Regional Committee, the Committee could decide whether to take note that a consensus had been reached or whether a resolution should be adopted.

Dr TAMARUA (Cook Islands) thought that a resolution should be adopted as a result of the recommendations of the Sub-Committee.
The CHAIRPERSON asked the Rapporteurs to draft an appropriate resolution.

4. TECHNICAL BRIEFING AND MINISTERIAL ROUND TABLES: Item 14 of the Agenda (Document WPR/RC50/10)

Dr CHAN (Hong Kong, China), summarized the previous day’s ministerial round table meeting (see Annex).

The REGIONAL DIRECTOR said that the ministerial round table on "Social safety nets in health sector development", held after the technical briefing on Wednesday, 15 September 1999, had been the first of its kind. Thanking the Moderator, Dr Margaret Chan, for her excellent management of the discussion and for her succinct summing up of the main points that were covered, he expressed appreciation to all who had contributed to the high-quality discussions. The technical briefing from the Government of Macao had provided a valuable insight into Macao’s excellent health system in operation.

In the Framework for action he had expressed the wish that sessions of the Regional Committee should be more outcome-oriented and less formal. He believed that the ministerial round table provided an opportunity for ministers, heads of delegations and other senior level officials to discuss important policy issues in an informal and participatory manner.

Ministerial round tables had been introduced at the Fifty-second World Health Assembly in May 1999. Summaries of the conclusions had been included in the records of the Health Assembly. In planning the regional round table, some changes had been made to the format used at the Health Assembly. In particular, less restrictive criteria for participation had been used and a moderator had been nominated from among the Members of the Committee.

Document WPR/RC50/10 provided background information on technical briefings and ministerial round tables. There was a long tradition of technical briefings or discussions being held in conjunction with sessions of the Regional Committee. However, they had not been part of the Committee and had often been relegated to the last day. Interest and attendance had therefore often been low.
Ministerial round tables could be viewed as another step in the process of making the sessions of the Regional Committee more relevant and informative and ensuring that they had an impact on the health of the Region. He firmly believed that if ministerial round tables were to continue they should be part of the Regional Committee.

He therefore proposed, first, that ministerial round tables should be held at future sessions of the Committee; secondly, that ministerial round tables should replace the technical briefings; and thirdly, that ministerial round tables should become part of the agenda of the Regional Committee. He would welcome any further suggestions from the Committee as to how future sessions might be improved further.

Dr TANGI (Tonga) welcomed the initiation of the ministerial round tables; he agreed that they should be continued within the context of Regional Committee sessions, which he felt were too formal, with considerable repetition, for example, in comments on the Regional Director’s report – an item that had taken up a considerable proportion of the limited time available. He wondered whether such comments could be collected and analysed before the session so as to provide a brief summary, allowing more time for discussion of more substantive items.

Dr ROMUALDEZ (Philippines) also expressed appreciation of the round table which could throw new light on policy issues; perhaps more time could be allocated for such discussions.

He supported the Regional Director’s proposals and agreed with the preceding speaker that time was of the essence; it might be possible to review the Regional Committee’s agenda in future with a view to reducing the number of items and delegating certain issues for consideration by a sub-committee.

Dr TEMU (Papua New Guinea) said that after the excellent summing-up by Dr Chan his fears had evaporated; he agreed that the round tables should be made a regular feature of Regional Committee sessions.
He suggested the establishment of a sub-committee to make recommendations to the Regional Director on possible changes to the Regional Committee format. Their comments might be submitted for preliminary review by correspondence. The Regional Director could then advise Members on the arrangements for the Regional Committee to be initiated in the year 2000.

Mr RETZLAFF (Samoa) said that, once it was agreed that ministers’ attendance at Regional Committee sessions was useful, the question became one of taking full advantage of their presence. At WHO Headquarters, round tables had attracted the participation of high-level ministerial staff of the United States of America and the United Kingdom. He agreed that it was important to select an appropriate moderator from among the members of the Committee. The use of experts from the media to steer meetings was in his opinion counter-productive.

On the question of use of time during the session, he thought it might be useful to add country position statements to reports; they could be submitted to the Regional Office in writing two months before a Regional Committee session.

Mrs LE THI THU HA (Viet Nam) also expressed appreciation of the round table held in conjunction with the Regional Committee, which had provided an excellent opportunity for exchanges of experience and information on issues of shared concern. She congratulated the moderator, Dr Chan, and supported the Regional Director’s three suggestions.

Professor WHITWORTH (Australia) welcomed efforts to provide opportunities for members of the Committee to share information, and expressed interest in his suggestions for more productive sessions, which she hoped could be made more outcome-oriented. For example, it would be useful to know more about activities and changes in WHO; technical briefings like those at the World Health Assembly might serve that purpose.

In addition to the ministerial round table, she proposed that consideration be given to smaller discussion groups and open sessions for questions not directly related to the agenda.

A small working group could be formed to make proposals on how to make meetings less formal and more interactive as from 2000.

The REGIONAL DIRECTOR expressed his gratitude for the supportive comments. Many representatives had agreed that much time was spent on items of lesser weight. On the
question of timing, any group of the kind suggested by the Representative of Papua New Guinea that would study matters prior to a forthcoming session would be procedurally obliged to report back to the Regional Committee, which would mean delaying approval of possible vital action for up to a year and the action itself for a further year. Without wishing to act unconstitutionally, he sought, as he understood Members wished him to do, a way of obtaining the preliminary approval of the Committee of the recommendations of such a group. That could be done by using modern rapid means of communication to obtain consensus. Action could then be implemented at the fifty-first session. The Committee would, of course, be free to comment on any innovations at the fifty-first session, and, if necessary, to propose changes.

Membership of any group of the kind envisaged would also necessitate extremely careful selection according to expertise and availability.

Dr ROMUALDEZ (Philippines) observed that the Regional Director’s constructive suggestions deserved full support.

The CHAIRPERSON requested the Rapporteurs to prepare an appropriate draft resolution.

5. INFANT AND YOUNG CHILD NUTRITION AND IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES:
Item 17 of the Agenda (document WPR/RC50/13)

The DIRECTOR, PROGRAMME MANAGEMENT, introducing the item on behalf of the Regional Director at the invitation of the CHAIRPERSON, said that the document was based on reports received from Member States in compliance with the Regional Committee resolution WPR/RC48.R8. It was noted that 34 countries and areas, or 93% of those in the Region, had reported.

He drew the Committee’s attention to the continued expansion of the baby-friendly hospital initiative in the Region. The number of baby-friendly hospitals had risen to over 7500 in 10 countries. Although the impact of the initiative was not yet reflected in the rates of exclusive breast-feeding in many countries, encouraging results had been reported by Member States. In addition, it was encouraging to note that countries were starting to include breast-feeding counselling in pre-service training, notably in Viet Nam.
WHO would continue to cooperate with other United Nations agencies, such as UNICEF, with governments, and with nongovernmental organizations in activities that supported and promoted breast-feeding and the improvement of the health of infants and young children. Not only should the role of health workers to support breast-feeding mothers in hospitals and community health services be stressed, but also the role of employers in providing paid maternity leave and other forms of support to breast-feeding mothers after they returned to work.

The Committee should also note that 24 countries now had national policies on breast-feeding and promoted the implementation of the International Code of Marketing of Breast-milk Substitutes. Meanwhile, in some countries parts of the Code were not complied with. For example, four countries reported that breast-milk substitutes or other inducements were being offered to health workers, which was contrary to Article 7 of the Code.

Breast-feeding required continuous collaborative support from government, the private sector and society, and the importance of the continuation of exclusive breast-feeding and appropriate complementary feeding must be stressed. National measures within the scope of the International Code should be strictly implemented. WHO would continue to support Member States in their efforts to improve infant and young child nutrition in the Region.

Mr LIU Peilong (China) commended the comprehensive report. Referring to Table 1 in the report, he noted that there was no entry for China in respect of the implementation of Article 11 of the Code. In fact, China had commenced activities in June 1995 and had issued the method of implementation and monitoring. Good results had been achieved in spite of many constraints. For example, although numerous baby-friendly hospitals had been established, it was difficult to ensure sustainable development of those facilities in the face of marketing of breast-milk substitutes. A WHO meeting on baby-friendly hospitals was planned for November 1999. Rural community hospitals were also being established, especially in poor and remote mountainous areas where breast-feeding and supplementary feeding required strengthening. He urged WHO and other international organizations to support China’s efforts in the area under discussion.

Dr TEMU (Papua New Guinea) said that his country strongly supported breast-feeding and had introduced relevant legislation in 1977, four years before the introduction of the Code. Research was under way to determine whether application of the legislation was effective and a recent report on breast-feeding in working mothers was being analysed. In
view of the current emphasis on integrated approaches, he suggested that the concept of baby-friendly hospitals should be expanded to include mothers. Referring to recent reports in the *Lancet*, he noted the absence in the report of any specific mention of breast-feeding and HIV infection and the risks involved, and requested guidance in that regard.

Mr VILLAGOMEZ (United States of America) observed that according to the 1999 World Health Report diarrhoeal diseases ranked fourth in the global burden of disease, and foodborne diarrhoea was a major cause of infant and child mortality in developing countries. According to UNICEF, 2.2 million children died from diarrhoeal dehydration that was often aggravated by malnutrition. Those figures reinforced the need to promote breast-feeding to improve the health of infants and young children. In a most varied region, cultural factors were central to promotion of breast-feeding among women. WHO collaboration with other agencies and organizations and with governments would help national measures to succeed. The United States Breastfeeding Committee had recently been set up; its members were the main national provider organizations, whose mission was to protect, promote and support breast-feeding. By July 1999, the United States had 20 designated “baby-friendly” hospitals and 73 facilities that had received a certificate of intent. The movement was gradually making headway in spite of limited funding. It was organized through a non-profit organization called Baby-Friendly USA.

Dr ROMUALDEZ (Philippines) noted with satisfaction that there had been at least a decade of relatively good compliance with the International Code of Marketing of Breast-milk Substitutes. Corresponding national legislation had been passed in the Philippines. The WHO/UNICEF Baby-Friendly Hospital Initiative had been implemented successfully – indeed in the Philippines it was a “mother and baby-friendly” initiative – and the recommendations of the Innocenti Declaration had been implemented almost in full. Nevertheless, breast-feeding rates for the one week to six month age group had not improved significantly, and might even be declining. New promotion methods were needed. Professional and other nongovernmental organizations had been enlisted in the campaign. It had even been suggested that the infant milk companies themselves be prevailed upon to promote breast-feeding instead of merely refraining from marketing their products. It was imperative, in any event, that WHO and Member States explore new ways of improving infant feeding practices in the Region.

Dr ARIF (Malaysia) said that his Ministry of Health, as the leading breast-feeding promoter in the country, had introduced the Baby-Friendly Hospital Initiative in all public
hospitals and maternity wards. Progress was slower in private hospitals. The Government had aligned the 1979 Code of Ethics for Infant Formula Products with the International Code of Marketing of Breast-milk Substitutes. Article 7.3(d)(iii) of the National Code required notification to WHO of non-compliance by industry. The speaker urged that WHO take action and circulate information so as to prevent further non-compliance.

Miss UNG Pui Kun (Macao) said that a study of 346 mothers had found that 47% breast-fed for two months and only a quarter persisted for longer. This was because the mothers knew little about breast-feeding. Less than half had consulted health workers about breast-feeding during antenatal visits. Only half were told about breast-feeding in obstetric departments. Furthermore, only 15% of those who sought assistance with breast-feeding received it from medical staff. Half the mothers had breast-feeding problems, half the newborn babies were not kept with their mothers, and almost all hospitals and health centres were providing free milk powder.

The situation had to be improved, by taking the “Ten Steps for Successful Breast-feeding” and using the “International Code of Marketing of Breast-milk Substitutes”. Baby-friendly hospitals had to be further promoted, and working mothers had to be taught how to express and store their milk so that helpers could feed their babies.

The REGIONAL DIRECTOR welcomed the suggestion from the Representative of Papua New Guinea on mother and baby-friendly hospitals and said that the Healthy Settings Initiative would include healthy hospitals. Turning to the technically difficult subject of how and whether to promote breast-feeding among HIV-positive mothers, he alluded to the economic and social factors that had to be taken into account. The first thing, however, when a mother was found to be HIV-positive, was to tell her of her status and give her psychological support. Whether or not to breast-feed would depend on whether the mother could afford to buy substitutes; and then, in countries where disease was widespread, the use of breast-milk substitutes in itself could increase morbidity and mortality.

The CHAIRPERSON requested the Rapporteurs to prepare an appropriate draft resolution.
6. STRATEGIC PLAN FOR THE DEVELOPMENT OF INFORMATION SYSTEMS IN THE WESTERN PACIFIC REGION: Agenda item 18 (Document WPR/50/14)

The DIRECTOR, PROGRAMME MANAGEMENT, introducing the item, recalled that following the discussion on health indicators for New Horizons in health at the 1998 session, the Regional Committee had asked WHO to develop a strategic plan for the development of information systems in the Western Pacific Region. The strategic plan contained in the document was intended to help countries to formulate national action plans for health information systems. How countries responded to its recommendations would depend on the current status of their information systems. Some countries might need to change their systems substantially while others might need to upgrade only some components. However, the plan should help all countries to prioritize the tasks needed to enable their health information systems to make a real contribution to the decision-making process in health management.

Since several years were required for the development and implementation of an information system, it was not cost-effective to make frequent changes to the system. Countries were therefore recommended to conduct careful needs assessment and analysis of resource availability before making major changes.

The document addressed the specific issues identified in the resolution adopted by the Regional Committee at its forty-ninth session: methods of data collection, data harmonization, dissemination of information, data analysis and utilization, and human resources assessment. It was intended to help countries to prepare action plans for developing their own health information systems, whether these systems were at a relatively early stage or needed improvement only in particular components. It could not be stressed too strongly that well-coordinated and rational planning was the basis of any successful information system.

Ms DAVIDSON (Australia) regarded the plan as a useful first step, but considered that it would need more detail if it were to be used as a generic plan, especially for countries with limited information systems. There should be a checklist of features of a good system, indications of common definitions, methods of training and useful types of reporting. Intercountry information systems in the Western Pacific should also be considered, including the question of compatibility.
Ms ALATOLO (Tuvalu) sought assistance from the Regional Office in upgrading its health information system. Effective health research could not be conducted in Tuvalu without a proper information system. UNFPA had offered some assistance but only for that part of the system related to reproductive health.

Dr CHERN (Singapore) emphasized that the health ministry of each country should coordinate the development of compatible national information systems, since the simultaneous development of several systems could lead to duplication or to confusion. He proposed that strategy 1.2 of the proposed strategic plan, “Review of national policies and systems of data collection management”, cover also the implications of confidentiality and other legal-medical matters. He thanked the Government of Australia for support in developing the Casemix system, which was to start up in October 1999. It was a clinical classification system that would add to the national health information system and provide information related to health financing.

Mr VILLAGOMEZ (United States of America) endorsed the view that the development of better health information systems could help reduce inequality of care and improve health status. WHO was crucial to that process and the strategic plan provided a useful basis. He assumed that the Regional Office had already begun to assess current capacity at country level in terms of accessibility and completeness of information, national priorities, and human resources. The Regional Office could be particularly helpful in ensuring the compatibility of methods and comparability of information throughout the Region. In addition to that, Member States had to recognize the value of information in the decision-making process.

Dr QI Qingdong (China) said that health information was an important aid to health work and expressed support for the strategic plan. He hoped that the Regional Office would collaborate with Member States in adopting methods to advance implementation. He urged the Organization to help Member States formulate a unified indicator system in the interests of comparability of data, and set up medical information systems and information exchange using modern methods. Adequate human resources were essential; most developing countries needed to train health information technicians. Countries with experience in information technology could be requested to provide training for those where the systems were not well developed.

Mr MANOUHALALO (France) stressed the importance of the plan, especially for
epidemiological surveillance and an intervention system that would allow rapid response to epidemics. Better circulation of information would help cope with diseases and natural disasters. The plan should also be of use in the planning of primary health care activities, and for the evaluation of work done. The data should be harmonized, with common, relevant indicators to simplify the collaboration of countries with agencies, donors and various national authorities. WHO should prepare a guide containing case definitions and common terminology. The health and social data on New Caledonia available on the Internet demonstrated the utility of an information system at country level.

Dr ABU BAKAR (Malaysia) expressed support for the Strategic plan and the six strategic goals. Successful implementation could facilitate integration of health services.

The setting of standards, including those for transfer of and access to data and for security of information, would have to be done internationally.

He noted the absence of references to telemedicine or telehealth, and hoped those aspects could be studied.

Dr ALTANKHUYAG (Mongolia) expressed appreciation of the plan, which would assist countries in formulating long-term plans for information system development and in streamlining developmental activities for health information.

He also thanked WHO for the support provided in the past years in improving the various components of its health information system, in health indicator development, use of health information, training in ICD-10 and networking. All of these activities had greatly facilitated the production of health reports which provided useful information to strengthen the health planning and evaluation process in health sector development.

Dr ROSS (Solomon Islands) noted the goals and strategies put in place but stressed that any information system must reflect country-specific needs and policies.

Dr WOONTON (Niue) supported and commended the formulation of the Strategic plan for the development of information systems in the Western Pacific Region. She noted on strategic goal 4 that the system should improve the use of information for decision making and suggested that telehealth be included as part of the same goal.

The DIRECTOR, PROGRAMME MANAGEMENT thanked representatives for their
useful comments. Some difficulty had been encountered in the preparation of the plan in view of the great diversity of information systems in the Region. The very constructive suggestions made would be incorporated. The applications of the information technology of the type known as “telehealth” or “telemedicine” were being studied, and it might be possible to include such findings in a later version.

The REGIONAL ADVISER IN HEALTH INFORMATION confirmed that applications such as “telemedicine” and “telehealth” were being studied. Attention was also being paid to training on the tenth revision of the International statistical classification of diseases and health-related problems (ICD-10) as part of the harmonization of reporting and to facilitate international comparison of data; courses had been held for key trainers from 16 countries and national staff from 6 countries.

7. WORKING RELATIONS WITH NONGOVERNMENTAL ORGANIZATIONS:

Agenda item 19 (Document WPR/RC50/15)

The DIRECTOR, PROGRAMME MANAGEMENT said that the report had been prepared in compliance with resolution WPR/RC45.R9, which requested the Regional Director to review working relations with nongovernmental organizations (NGOs) and report to the Regional Committee in 1999.

Since the adoption of the resolution in 1994, working relations had been steadily developed both with NGOs in official relations with WHO and those having informal relations. Through such collaboration, many innovative partnerships between WHO and NGOs had been developed at both formal and informal levels. A number of NGOs had been working closely and successfully for a long time with WHO technical programmes, a good example being Rotary International’s which had worked closely with WHO in eradicating poliomyelitis from the Region.

Despite the excellent progress made in the last five years to develop closer partnerships, there was much more that both sides could do to ensure even closer collaboration. A number of constraints and challenges were identified in the report and several recommendations were proposed for representatives’ consideration.

In the document WHO in the Western Pacific Region: A framework for action the Regional Director had stressed the need for WHO to strengthen partnerships. Those with
nongovernmental organizations were an essential part of WHO’s mission to “reach out” to others working for health in the Region. He had already started to put in place mechanisms to strengthen relations with NGOs by making external relations a focus within the “reaching out” theme and appointing an external relations officer. That was a start in ensuring that during his term of office, the Regional Director and his staff would be working hard to develop closer and more effective partnerships with NGOs at all levels.

At the invitation of the CHAIRPERSON, statements were presented by the following nongovernmental organizations:

World Federation of Hydrotherapy and Climathotherapy

World Federation of Occupational Therapists.

The meeting rose at 5.30 p.m.
The ministerial round table focused on the definition of social safety nets, in both social protection and social assistance forms, and highlighted the reasons for the current importance of these mechanisms. Participation in the round table included 31 Member States, and the experiences of 17 countries and areas were shared by the Ministers or their representatives. These experiences reflected understanding of the issues, the diversity of situations and solutions. While the exchange of information on experience was useful, this was not an area in which the transfer of models could be simple or even appropriate.

The following major experiences and issues came out of the discussion:

The responsibility of government to establish social safety nets was widely recognized. The importance of political will to develop policy and to implement the necessary legislative process was stressed. The relevance of social safety nets in the broader context of social development was noted.

Several countries reported on their progress to date in establishing, expanding and reforming social health insurance mechanisms. These included the Philippines, and then China and Viet Nam, which now need to deal with changes from previous social protection arrangements in response to the shift to a market economy. A common problem was coverage of the informal sector, particularly in rural areas. Community health care financing initiatives were suggested as one possibility to establish social protection at the local level. However, the need for broader pooling among the large rural populations was stressed as a major challenge.

Within their current efforts to expand coverage, several countries are deliberately targeting economically disadvantaged populations. Viet Nam and the Philippines reported on government allocations to cover the poor through the existing health insurance mechanisms.

In the search for the optimal development of social protection to enable the shift from full government financing to cost-sharing, the protection of equity was stressed. An important point was that along with rights to health care, the obligations of the individual in contributing to the system should be considered.
At the other end of the spectrum, the dependency of the population on government services was noted in countries where health services are provided free of charge. While the need to provide care free of charge to the most needy population sector was seen as a continued responsibility of government, several countries, such as Samoa and Fiji, noted efforts to expand the private sector, through both private providers and insurers. It was, however, noted that only a small percentage of the population could currently be covered by private systems in these countries, and indeed Papua New Guinea noted that only 2% of the population could be covered through private for-profit insurance.

A number of countries reported on the effects of the recent economic crisis in Asia. The importance of protecting public health budgets from cuts which would affect the provision of essential services was noted, as was the need to maintain and develop the safety nets which would provide protection for those disadvantaged by the economic crisis.

Within the health system reform efforts, it was stressed that public health services, of the nature generally considered as public rather than personal services, should be strengthened. The positive example of emphasis on prevention and health education in Macao was noted. It was suggested that earmarked taxation could be used, as well as allocations from social health insurance. It was pointed out that a higher expenditure and utilization of personal health care does not necessarily lead to improved health for the population as a whole.

The current problems of controlling health care costs were widely recognized and seen as an integral part of health sector development. The cost issues are compounded by increasing health care needs related to the ageing of the population and the difficulty in controlling the use and expenditure on specific health care components, such as drugs and high cost diagnostic services. To deal with cost issues, several countries are promoting better primary health care at the community level and increased use of low cost alternatives, including traditional medicine. Regulation of the private sector was also noted as a measure to control health care expenditure.

In conclusion, the discussion showed the concern of the Member States with the need for effective social safety nets in health sector development and the role of these mechanisms in general health and social development. The exchange of opinions and experiences elicited a positive and constructive approach to solving the problems. The issues raised reflect areas in which Member States may need support to develop their own social safety nets. There is clearly a need for continued dialogue and sharing of experiences, respecting the particular circumstances in each country.
SUMMARY RECORD OF THE SEVENTH MEETING

Hyatt Regency Ballroom, Macao
Friday, 17 September 1999 at 9 a.m.

CHAIRPERSON: Dr José Alarcão TRONI (Macao)

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1. ADDRESS BY THE DIRECTOR-GENERAL: Item 6 of the Agenda

The CHAIRPERSON invited the Regional Director to address the meeting on behalf of the Director-General (see Annex).

2. TIME AND PLACE OF THE FIFTY-FIRST AND FIFTY-SECOND SESSIONS OF THE REGIONAL COMMITTEE: Item 23 of the Agenda

The REGIONAL DIRECTOR recalled that, at its forty-ninth session, the Committee had decided to hold its fifty-first session at the Regional Office in Manila. He proposed that the fifty-first session be held from 18 to 22 September 2000.

The CHAIRPERSON noted that the Committee agreed the dates of its fifty-first session as 18 to 22 September 2000 and requested the Rapporteurs to include those dates in the resolution.

Dr LATIF (Brunei Darussalam) confirmed the invitation of his Government to hold the fifty-second session of the Regional Committee in 2001 in Brunei Darussalam.

The CHAIRPERSON asked the Rapporteurs to prepare an appropriate draft resolution.

Mr ISOBE (Japan) announced that his Government wished to invite the Regional Committee to hold its fifty-third session in 2002 in Japan.

3. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolutions:

3.1 Tuberculosis prevention and control (Document WPR/RC50/Conf. Paper No.5)

Mr LIU Peilong (China) noted that the report contained in document WPR/RC50/8 indicated that governments should take responsibility for the treatment of tuberculosis by providing the necessary funds. WHO should play an advocacy role in making high-ranking government officials, including finance ministers, aware of the importance of tuberculosis and persuading them to back up their political commitment with increased resources.
He therefore suggested that a new third preambular paragraph be added, to read -
“Noting that political commitment has not yet been translated into increased resources for
tuberculosis control;”. He suggested further that operative paragraph 3(2) be extended by the
following addition: “and to take all necessary measures to influence leading political figures
to translate political commitment into increased financial resources;”.

Professor WHITWORTH (Australia) suggested that the phrase “as a minimum” be
added at the end of paragraph 2(3).

Dr THORNE (United Kingdom of Great Britain and Northern Ireland) asked that the
words “if this is appropriate” be removed from operative paragraph 2.

Dr KIENENE (Kiribati) proposed that the second preambular paragraph be extended
by addition of the phrase “and the fact that 29% of global tuberculosis cases are found in the
Western Pacific Region”.

Decision: The draft resolution, as amended, was adopted (see resolution
WPR/RC50.R5).

3.2 Regional Action Plan on Tobacco or Health 2000–2004:
(Document WPR/RC50/Conf. Paper No.6)

Mr LIU Peilong (China) said that the resolution did not reflect the importance of the
involvement of multiple sectors in tobacco control, which his delegation had stressed. He
suggested that the following insertion be made after the fifth preambular paragraph: “Noting
that multisectoral involvement is crucial to effective tobacco control;”. He further proposed
that a new subparagraph be added after operative paragraph 2(3), to read: “to mobilize and
coordinate the involvement of government departments in the above-stated activities;”, and
that a new subparagraph be added after operative paragraph 3(4), which would read: “to make
good use of all opportunities to encourage the involvement of Member States in the Tobacco
Free Initiative;”.

Professor WHITWORTH (Australia) asked that the words “with amendments as
specified in the summary record” be added to operative paragraph 1.
**Decision:** The draft resolution, as amended, was adopted (see resolution WPR/RC50.R6).

### 3.3 Development of health research (Document WPR/RC50/Conf. Paper No.7)

Professor WHITWORTH (Australia), noting that if research were not disseminated there was no use in doing it, asked that the words “where appropriate” be deleted from operative paragraph 3(4).

Dr KIENENE (Kiribati) noted that the phrase “subject to availability of resources”, which appeared in operative paragraph 3, had not been included in requests to the Regional Director in other resolutions. As it had a negative connotation, he asked that it be deleted.

Dr NOVOTNY (United States of America) said that the phrase was necessary as the list of requests to the Regional Director included a number of projects that would be expensive to implement and the necessary resources might not be available.

The REGIONAL DIRECTOR, replying to a suggestion from Dr MALAU (Papua New Guinea) to replace the words in question by “to secure and mobilize resources”, said that he made every effort to do just that for all programmes and not just health research. He therefore suggested that operational paragraph 3 be amended to read: “REQUESTS the Regional Director to do his utmost:”.

Ms EARP (New Zealand) asked that operational paragraph 3(5) be amended to read “to continue to support efforts to improve the communication between research agencies and the use of the Strategic Plan in the Region.”

**Decision:** The draft resolution, as amended, was adopted (see resolution WPR/RC50.R7).

### 3.4 Criteria for candidates and selection methods and procedures for nomination of the Regional Director: Report of the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation (Document WPR/RC50/Conf. Paper No. 8)

Dr TEMU (Papua New Guinea) asked for an explanation of the criterion of “good physical condition” required by operative paragraph 2 (6).
Dr OTTO (Palau), Chairman of the Sub-Committee on Programmes and Technical Cooperation, explained that the provision in question had been based on the criteria for selection of the Director-General, which had been adopted in most regions for Regional Directors. The purpose was to guarantee, as for all staff of the Organization, that the candidate fulfilled certain conditions of good health. It was in no way to be taken as the expression of any kind of discrimination against persons with physical disabilities.

Dr TEMU (Papua New Guinea) expressed satisfaction with the explanation.

**Decision: The draft resolution was adopted (see resolution WPR/RC50.R8).**

3.5 **Method of work of the Regional Committee**

(Document WPR/RC50/Conf. Paper No. 9)

Professor WHITWORTH (Australia) proposed the addition at the start of operative paragraph 3(1), of the words: “to make the meetings less formal and more interactive, and ...”.

**Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC50.R9).**

3.6 **Infant and young child nutrition and implementation of the International Code of Marketing of Breast-milk Substitutes** (Document WPR/RC50/Conf. Paper No.10)

Dr NOVOTNY (United States of America) said he had understood that the question of transmission of HIV/AIDS through breast-feeding had been raised and that some recognition of that should be included in the resolution.

The REGIONAL DIRECTOR said that he recalled the issue had been raised by the Representative of Papua New Guinea as a policy issue, and that had been reported in the summary record of the relevant discussion.

Dr NOVOTNY (United States of America) proposed that “and the need for special consideration of HIV-infected mothers” be added to the end of preambular paragraph 7.
He also proposed that an operative paragraph should be added at the end of the resolution, requesting the Regional Director:

“to disseminate updated WHO recommendations on feeding practices for infants of HIV-infected mothers.”

Dr ROMUALDEZ (Philippines) proposed that preambular paragraph 5 should be amended by deletion of the words “some countries have reported that”, and substitution of “still often not” for “frequently not”.

Professor WHITWORTH (Australia) proposed the addition of a subparagraph in operative paragraph 2, requesting the Regional Director:

(4) to continue to expand the “Baby-friendly hospitals” initiative to include a greater focus on the needs of mothers;

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC50/.R10).

3.7 Fifty-first and fifty-second sessions of the Regional Committee
(Document WPR/RC50/Conf. Paper No. 11).

Decision: The draft resolution was adopted (see resolution WPR/RC50.R11).

4. REGIONAL IMPLICATIONS OF RESOLUTIONS AND DECISIONS OF THE FIFTY-SECOND WORLD HEALTH ASSEMBLY AND THE WHO EXECUTIVE BOARD AT ITS 103RD AND 104TH SESSIONS: Item 20 of the Agenda
(Document WPR/RC50/16)

The DIRECTOR, PROGRAMME MANAGEMENT presented document WPR/RC50/16 which referred to resolutions adopted by the World Health Assembly and the Executive Board which were of significance to the Western Pacific Region. Seven resolutions adopted by the Fifty-second World Health Assembly were included in the document, which provided some information on activities in the Region that were of relevance to the terms of the resolutions. The resolutions themselves were attached to the document. He drew the attention of the Committee to the operative paragraphs which related to activities that
Member States could undertake in the Region to implement the resolutions.

The CHAIRPERSON then read out the titles of the resolutions one by one, inviting comments from the representatives.

There were no comments.

5. MEMBERSHIP FROM THE WESTERN PACIFIC REGION IN GLOBAL COMMITTEES: Item 21 of the Agenda

5.1 Special Programme of Research, Development and Research Training in Human Reproduction: Membership of the Policy and Coordination Committee: Item 21.1 of the Agenda (Document WPR/RC50/17)

The DIRECTOR, PROGRAMME MANAGEMENT said that the Policy and Coordination Committee (PCC) was the governing body of the Special Programme on Research, Development and Research Training in Human Reproduction. It was composed of four categories of members from the various Member States with a total of 32 members. One of the categories, category (2), had 14 members, three allocated to the Western Pacific Region. Those members were to be elected by the Regional Committee for three-year terms, giving due consideration to a country’s financial or technical support for the Special Programme, and its interest in that field, as reflected by national policies and programmes.

At present, the three category (2) members from the Western Pacific Region were Malaysia, the Republic of Korea and Singapore. The period of tenure of the member from Singapore was due to expire on 31 December 1999.

In order to maintain the full representation of the Western Pacific Region on the Policy Coordination Committee, the Regional Committee should elect one Member State to nominate a member whose three-year term would start on 1 January 2000. The Regional Committee might wish to elect China.

The next meeting of the Policy and Coordination Committee would be held from 22 to 23 June 2000.

The CHAIRPERSON said that, since there were no further comments, China would serve on the Committee.
5.2 Essential Drugs and Other Medicines: Membership of the Management Advisory Committee: Item 21.2 of the Agenda (Document WPR/RC50/18)

The DIRECTOR, PROGRAMME MANAGEMENT explained that the Management Advisory Committee had been set up in 1989 to replace the Meeting of Interested Parties. The Committee advised the Director-General of WHO on matters related to policy, strategy, finance, management, monitoring and evaluation of the WHO programme on Essential Drugs and Other Medicines. The Management Advisory Committee met once a year or more often upon the proposal of either its Chairperson or the Director-General. Two Member States undertaking drug policy and programme development from each of WHO’s six regions were selected by the respective Regional Committees for three-year terms. Mongolia and Viet Nam were currently the Member States from the Western Pacific Region whose representatives served on the Management Advisory Committee. Mongolia’s term of office was due to end on 31 December 1999. The Regional Committee therefore had to select one Member State to replace Mongolia as a representative of the Western Pacific Region on the Management Advisory Committee. The selected Member State would serve for three years from 1 January 2000 to 31 December 2002. The Committee might wish to consider Philippines as the representative.

The CHAIRPERSON said that, as there were no further comments, the Philippines would serve on the Committee.

It was so decided (see decision WPR/RC50(2)).

6. TOBACCO OR HEALTH MEDAL PRESENTATION

The CHAIRPERSON gave the floor to the Regional Director, who presented the 1999 Tobacco or Health Medal and Citation to Professor Anthony Hedley, Head of the Community Medicine Department at the University of Hong Kong, for his untiring work on tobacco control in the Region and beyond.

7. RESOLUTION OF APPRECIATION

Dr ROMUALDEZ (Philippines) presented a draft resolution of appreciation.
Professor WHITWORTH (Australia) and Dr THORNE (United Kingdom of Great Britain and Northern Ireland) endorsed the proposed resolution.

Decision: The draft resolution was adopted (see resolution WPR/RC50.R12)

8. CLOSURE OF THE SESSION: Item 24 of the Agenda

The CHAIRPERSON thanked the Committee for its trust and confidence. Macao would participate in the subsequent session as a special administrative region of the People’s Republic of China. Portugal had administered Macao for five centuries and was proud of its achievements, especially in the health sector. As a Portuguese and as a citizen of the European Union and of the civilized world, he congratulated the Security Council of the United Nations on its resolution 12/64 of 15 September 1999, authorizing a peace force under the leadership of Australia to impose respect for human rights and the results of the referendum in East Timor. Portugal would always support East Timor, and he appealed to the countries of the Region to do likewise.

The CHAIRPERSON said that the draft report of the session would be sent to each representative with a covering letter stating the date by which any comments on the draft should reach the Regional Office. After that date, the report would be considered final.

The REGIONAL DIRECTOR presented a gavel set to the Chairperson in appreciation of his chairmanship.

The CHAIRPERSON declared the fiftieth session of the Regional Committee closed.

The meeting rose at 12.15 p.m.
Mr Chairman, Dr José Alarcão Troni, Ministers, Dr Omi, Excellencies, Ladies and gentlemen,

It gives me great pleasure to be with you here in beautiful Macao at this historic time. We are all grateful to the Government of Macao for hosting this Regional Committee meeting of WHO.

Year 2000 is now only a few months away and the world is taking stock. We who devote our work to health can celebrate many remarkable achievements. But there is also a legacy. More than a billion people who are poor - hundreds of millions of whom live in this Region - will enter the next century without having shared in the gains of the health revolution of the 20th century.

That we have to change. With a combination of vision, commitment, effective organization, and working together, we can achieve notable accomplishments in the years ahead. The knowledge which produced the revolution of past decades can still bring the excluded billion into our midst.

Mr Chairman,

Today I wish to take the opportunity to share with you how I see the role of the World Health Organization in this major transition. You know our mandate and I can assure you of our commitment: We are after a better deal for world health. A better deal with the prime purpose of delivering a better, healthier future to all, but especially to the poor.

Such a better deal will matter immensely in this Region, which is home to a quarter of the world’s population.

As Director-General of WHO, I have seen it as one of my prime tasks to improve the effectiveness of our Organization’s work. Working together more effectively, as one WHO, is key. We - WHO - cannot do everything, but what we decide to do, we must do well. It goes for all of us: In times of many conflicting challenges we must all learn to focus on the health issues that matter most - and we must reach out and convince our partners to do likewise. Reaching out to civil society, NGOs, our UN partners and to the private sector - as we do it in this Region - increases the impact we can make.
Let me share with you today our assessment of our work with the Western Pacific Region, based on four global strategic directions.

**First**, we have to reduce the burden of excess mortality and disability, especially that suffered by poor and marginalized populations.

On many fronts, the Western Pacific Region can stand as an example for hope and optimism. Through systematic and effective intervention, the Region has achieved some impressive improvements in health over the past few years. These improvements show that what often seem like endless fights against diseases that constantly defeat us can be winnable battles, if we only take a systematic, result oriented approach to them.

Malaria continues to be a major health problem. In this Region, about 110 million people are at risk from malaria in 10 countries, with unacceptably high incidence rates in several countries and a growing problem of increasing drug resistance. About one million clinical cases are reported in Eastern Asia and Oceania. We face an increasing malaria burden.

China, Viet Nam and other countries in this Region have shown us that it is possible to reverse this trend. We know it is possible to cut malaria-related mortality by half by the year 2010 if existing interventions are used according to available evidence. This is the goal of our Roll Back Malaria effort - a goal that can be achieved as health services become more focused on helping communities tackle priority diseases.

The long-term success of Roll Back Malaria will require better interventions, new preventive measures and treatments. New alliances for more effective research and product development, such as the Multilateral Initiative on Malaria, and the Medicines for Malaria Venture, are essential to this success.

The world can learn a lot from the way China has been able to contain the epidemic. China also has an impressive track record for the development of anti-malarials. We hope that China would help the world with the production and distribution of anti-malarial compounds. I discussed this with Chinese leaders when I visited them last November. Then there is Viet Nam, where the systematic use of insect repellent bednets and the wide distribution of malaria drugs have led to a drastic reduction in deaths from malaria over the past few years.

Countries in the Western Pacific Region are showing the way in identifying actions to Roll Back Malaria. They are breaking new ground. China, Viet Nam, Cambodia and Laos are working with Thailand and Myanmar from the South-East Asia Region to harmonize
responses to malaria across borders and ensure that all adopt consistent strategies and action.

Malaria is not the only area of progress. The greatest feat of this Region is the elimination of polio. Since 1997 there have been no new cases of polio in the Western Pacific Region, despite intense surveillance. Unless something unforeseen happens over the next few months, this Region can be declared polio-free next year. Truly a great victory!

Although we have good reasons to celebrate, we must remember that this is a fragile victory as long as polio is frequent among the Region’s neighbours. The South-East Asia Region is fighting a final battle to eradicate polio in their Region. Last week I visited Dhaka and saw the extraordinary effort being made to reach the target of a polio-free world by the end of 2000. Supporting their effort is in this Region’s interest, and I urge all Member States that have resources to contribute to this final push to do so. In a global village where any country can be reached in less than twenty-four hours, no country is safe from polio unless all countries are safe.

Mr Chairman,

Contrasting these positive developments, formidable long-term sustained efforts are needed in the global response to HIV/AIDS. WHO’s commitment is unshakeable. We are addressing it on every front, from issues of blood safety and mother-to-child transmission, to the use of anti-retroviral treatments and the care of people living with HIV, and of course, the dual epidemics of HIV and tuberculosis. We will push for new drugs and eventually the vaccine against HIV. And we will push for every deal that can make these innovations available for all.

This will not be easy. By 2000, the number of HIV infected individuals in the Western Pacific Region is expected to exceed 1 million and the annual number of new AIDS cases, 18000 in 1998, will double. Compared with other parts of the world, the Region appears to be experiencing only a moderate epidemic, but that must not make us complacent. Realistically, it will continue to increase despite our best efforts and it will cause a heavy toll to the health system.

Drug use injection is the main mode of HIV transmission in the Region. It is alarming that this is the case especially in the most populous countries, including China and Viet Nam.

Nearly 90% of the HIV cases due to sexual transmission are through heterosexual contacts. Therefore, HIV cases are no longer confined to homosexual or bisexual groups. The hardest hit countries are usually the ones with weak health system infrastructures, in this as in
other regions.

Countries like Uganda and Thailand have shown us that openness, intense public awareness campaigns and innovative approaches towards research and treatment can stem this epidemic, also in nations without the huge economic resources of industrialized countries. Let us all learn the lessons from these countries, and be inspired by them.

Even without HIV as its deadly ally, tuberculosis is a major global threat to health, and demands an urgent and massive response. I have made the project against TB a priority and I will strongly urge you to endorse the Regional Director’s proposal to make tuberculosis a priority programme in this Region.

Last month, I moved all of WHO’s TB control efforts under the single umbrella of the Stop TB Initiative. It will redouble its efforts to bring new partners into the coalition working to control TB, and aims to double the worldwide expenditure on TB control within three years.

We must all commit ourselves to achieving 100% coverage with the DOTS (Directly Observed Treatment Short Course) TB control strategy by the year 2005. Countries in this Region hold some of the highest numbers of TB patients in the world, and many lag behind in DOTS coverage. Success in the Western Pacific Region will go a long way to achieving success worldwide. I can assure you of WHO’s strong support in these efforts.

Mr Chairman,

In the Western Pacific Region, six common preventable and treatable childhood conditions account for up to 70% of death of children under 5 years of age. Maternal and perinatal problems also take a serious toll on women and infants.

Yet, also here we can note significant successes. 32 countries and areas out of 36 have achieved infant mortality rates of less than 50 per 1000 live births. 21 countries in the Region enjoy more than 90% adult literacy rate. Immunization coverage for BCG, DPT, OPV and measles is more than 95%. We can make a long list of success stories.

Five countries in the Region, including China, have already adopted the Integrated Management of Childhood Illness, a highly effective strategy to attack the traditional childhood killers by breaking down the limitations of single-disease treatment, and to educate health workers and parents to see their child’s health and nutrition as a whole.
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We will intensify our work on reducing maternal mortality. To push the agenda on reproductive health forward, WHO has developed a strategy to make pregnancy safer. The Making Pregnancy Safer Initiative will encourage governments and our international partners to ensure that safe motherhood is placed high on the political agenda. It is a matter of social responsibility and economic good sense.

Immunization remains one of the most cost-effective public health interventions there is. Over the last year, the issue of vaccines and immunization has been reviewed by WHO with the major partners - UNICEF, the World Bank, bilateral donors, and the private sector.

We have agreed to establish a Global Alliance for Vaccines and Immunization to push for a renewed effort to develop new vaccines and to help increase immunization rates all over the world. WHO will be chairing this Alliance in its first two years.

Let me end by also stressing the critical rising tide of noncommunicable diseases - exposing all countries in this Region to new challenges. At WHO we are building capacity to better advise and support countries, especially as health sectors have to go through profound change.

One of the most critical areas that needs our attention is mental health. The Global Burden of Disease tells us that mental health conditions are emerging as one of tomorrow’s major public health concerns, in rich and poor countries alike. We have to rise to properly face this challenge. I am looking forward to the opportunity to visit China in November to participate in the Nations for Mental Health Conference in Beijing. This will be an important occasion to strengthen the work that is being done to de-stigmatize mental illness and further develop humane treatment for these diseases.

Mr Chairman,

Let me briefly move to the second strategic direction. Focusing on the things that matter does not just mean diseases. There is also the need to counter potential threats to health that result from economic crises, unhealthy environments and risky behaviour.

We need to strengthen the focus on how sectors outside the health sector have a major impact on health. In the environmental field, air pollution is an ever-growing problem in cities in this Region. For the tens of millions who crowd into the slums of these mega-cities, the effects of pollution, crowding and lack of proper sanitation are the largest threats to their health. Neither health interventions nor economic growth will on their own solve these problems. It will take active government intervention - concerted policies towards sustainable
development and vigorous enforcement - before we will see any meaningful improvements in the overall health situation for the urban poor.

Talking about air pollution - there is another threat that is already with us in a big way - an emerging epidemic about to hit the developing world. I am referring to tobacco.

Western Pacific countries are under threat from a tobacco epidemic. The tobacco industry is conducting a major offensive. It is now focusing its attention and advertising power on the developing world and on Asia - and especially on Asian women and children.

Young generations are lighting a fuse. The explosion will kill one out of two smokers and load new, expensive and totally avoidable burdens on the health sector.

Let’s be frank. Adolescents are being lured into tobacco addiction. In most countries, as many as nine out of ten addicted smokers say they started before the age of 18. We are no longer talking about free choice. We are talking about a violation of children’s rights.

The experience from Europe shows that strict tobacco advertising legislation and time-limited information campaigns are necessary but not enough. We need to keep a constant global vigil against tobacco. In this Region, governments need to be more consistent in their health warnings. One such warning reads: “As there is a risk that it might damage your health, try not to smoke too much. And be sure to observe smokers’ etiquette.” This is something of an understatement!

But we are progressing. When I took office, one person in WHO Headquarters devoted part of his time to tobacco. During these 13 months, a broad and talented team is pulling the efforts of WHO and its partners together. In May, the World Health Assembly endorsed our work to create a WHO Framework Convention on Tobacco Control. We will welcome representatives from the Western Pacific at the meeting in Geneva of the working group on the Convention which will take place in a few weeks.

Still, some continue to say that after all tobacco may be good for the economy because of employment opportunities and tax incomes to the government. They are making a big mistake. Health is WHO’s business, so we let the World Bank answer the question on economics; in their latest report - *Curbing the Epidemic* - their message is clear: Tobacco is not only bad for health - it is also bad for the economy. Let me show you another example. According to a recent report, “Healthy Japan 21” of the Ministry of Health and Welfare of the Government of Japan, the Finance Ministry expects to receive 7.5 billion US dollar tax income from tobacco sales in the current fiscal year. The report noted that the cost of health
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care from smoking related illness, death, and accidents amounted to 33 billion US dollars. There were 95000 deaths, that is 12% of the total, in 1995.

Mr Chairman,

The third strategic focus concerns health systems. WHO will give renewed priority to helping countries develop health systems that can better respond to present and future challenges.

Building on the impressive achievements of the last half century, health systems must assure protection for all within - of course - limits set by available resources. This is the key message of the New Universalism that WHO spelled out in this year’s World Health Report. It means in short that we must develop a process of priority setting which is evidence based, ethically grounded and socially acceptable. Our best hope lies in a health system that makes the improvement of health status and the recognition of health inequalities its defining goal. A health system that responds to the legitimate needs of the population. A system that protects people from financial loss due to health care costs and that distributes such economic burdens fairly.

The challenges that face you who sit here today range widely: some of you have welfare states that are under pressure for reform; others are facing continuous pressure to shrink government expenditure and open up more sectors to the private sector in the face of slower economic growth and insufficient fiscal revenues. All of you have to take into consideration a substantial number of the relatively poor, who must not be left without basic health coverage.

There will be tough choices: not just in deciding which services should be covered but in determining how health care should be financed. Health care has to be paid for - but solidarity through some form of pre-payment system places less of a burden on the poor than systems which rely on out-of-pocket payment. A growing body of evidence suggests that pre-payment is an efficient as well as an equitable financial policy.

Country after country is now looking to WHO for guidance on health sector reform. They want to engage us in how to handle the rapid growth of private medical care and to harness the energies of the private sector for public goals. We will respond to that call, and we are considerably expanding our capacity to do that.

We need to be able to understand why one country’s health system performs better than another. A better understanding - of success, failure and best practice - needs to underpin
the new agenda for health systems reform. To indicate the importance of this subject, the whole of the forthcoming World Health Report 2000 is being dedicated to it.

Mr Chairman,

The **fourth** direction concerns the development agenda itself. I have pledged to do what I can to place health at the core of that agenda - where it belongs. Health is key to human development and progress.

Research illustrates clearly how illness is not only a result of poverty - but can also cause it. What we are increasingly seeing is that improved health conditions can turn this vicious circle around. Healthier, better fed people are more productive and can focus their resources on improving their livelihood. It is no coincidence that marked improvements in health status and life expectancy preceded the 20-year period of strong economic growth in East and South-East Asia. One of Asia’s own leading economists, Nobel Laureate Amartya Sen, has eminently shown how closely linked health is to progress and development.

The Asian economic crisis was a wake-up call. It showed how tenuous was the toehold that tens of millions of poor had gained into the middle class. Lacking a security net, they were plunged back into poverty almost overnight. Unless health systems are made to provide basic services to all, this economic and social setback will translate to a setback in health levels as well.

The challenge for those of us who are gathered here today is to turn this knowledge into concrete policies and to execute them. Our responsibility is to see that enough resources are spent on health - and spent in an equitable fashion - so that the poor are given their chance to join the rest of us in enjoying the health achievements of the 20th century.

Mr Chairman,

You have to face many players in development - and we all are facing many players in international health. As the lead agency in health with a broad mandate, WHO needs to refine its role and see how we can best be of use to our Member States. Let me share with you some of the issues. They will indeed be brought to your attention as we start planning for the 2002–2003 budget.

In each area - be it HIV/AIDS, or making pregnancy safer - we need to ask ourselves where WHO’s comparative advantage really lies. Which functions are we best equipped to
Annex

perform? Which are better left to other organizations? Or where can we call on our collaborating centres?

WHO is a technical agency, not a major donor. We also need to think of ourselves as a catalyst - forging alliances and building consensus in many different contexts - at national and international level. This catalytic role lies at the heart of all our core functions, and will be a dominant theme as we prepare our coming budget.

Focusing means having clearer priorities so that we can have a greater impact where the needs are greatest. There is the famous example of how in one country 4.9 million US dollars from WHO’s regular budget was allocated to cover the cost of 428 priority activities in 44 different national health programmes. That is not the best way to make a difference and should now be a history lesson.

In too many countries our resources are divided between too many disparate activities, and there is little coordination between our activities. We are in the process of changing that, and I hope you will support this process.

Mr Chairman,

I would like to conclude with some comments on the World Health Assembly budget resolution, and the work that is now underway in response to it. The Assembly decided not to compensate us for cost increases. And in addition we were asked to shift resources from so-called low priority areas to high priority areas.

It has been a tough task. But I believe we have found a realistic way forward, one which avoids cutting our key activities.

You know where I stand: WHO’s most important tasks lie in countries, and our budgets and joint efforts will reflect this. The efficiency shifts we have to make in the 2000–2001 budget will not lead to a reduction in spending at the country level. But throughout WHO, we can become more efficient.

In reviewing the options for efficiencies, I have looked first at measures that are applicable across the whole of WHO. We are concentrating on cutting our travel bill, for example, and taking a critical look at what we publish and what we procure.

Globally, I have decided on a figure for efficiency measures of around 50 to 60 million US dollars at this stage, in line with what the World Health Assembly called for. I
would ask for your cooperation as Ministers when it comes to focusing the funding that this will free up for priority health areas within your country.

Mr Chairman, Excellencies, Ladies and Gentlemen,

This is a region of diversity. There is a Member State of 1.2 billion population, and there is a Member State of 1500 population. The second biggest economy in the world is here. Here are also eight countries with per capita GNP less than 1000 US dollars.

Big or small, rich or poor, together you have achieved remarkable success. Let us not forget that achieving the health needs and rights of a population requires a basic respect for human rights and popular democracy. These two basic institutions are crucial in improving health and reducing poverty. Only when there is commitment among the leaders to respect the will and the basic rights of its people, can real development take place.

This Region holds the key to answering the question of eradicating poverty and creating a world where all its citizens enjoy the basic human rights of health and nourishment. The progress so far makes me optimistic. I am confident that you will succeed, and WHO stands ready to support you.

Thank you.