Expanded Programme on Immunization. The Western Pacific Region continues to make significant progress in achieving regional immunization objectives, including the twin goals of measles elimination and hepatitis B control. The Region has remained poliomyelitis-free, despite the continuing risk of a wild polio virus importation. The Republic of Korea declared in November 2006 that it had eliminated measles in 2006, while other countries such as Cambodia, China, the Philippines and Viet Nam are making significant progress towards measles elimination. Despite Government contribution, challenges remain in mobilizing sufficient resources for the fight against measles, especially in countries such as China and the Philippines that are not eligible for support from the Global Alliance for Vaccines and Immunization (GAVI). Vaccination programmes for hepatitis B also made significant progress over the past year, securing domestic funding in China, the Philippines and Viet Nam. There was continuing improvement in routine coverage for hepatitis B with three doses, as well as with timely birth doses, in the majority of the countries in the Region.

Accelerated introduction of new vaccines, where justified on the basis of disease burden and cost-effectiveness, remains an important goal of immunization programmes in the Region. Key Member States are being assisted to set up sentinel disease surveillance systems to quantify the disease burden in order to inform decisions on the introduction of new vaccines. Significant efforts also have been made to assist countries and areas in the Region with preparedness in the event of a human influenza pandemic.

Hepatitis B. Technical and operational strategies to achieve the goal of a chronic hepatitis B infection rate of less than 2% among children 5 years of age were recommended by the Technical Advisory Group (TAG) on Immunization and Vaccine-Preventable Diseases in the Western Pacific Region. These strategies guided work in the Region over the past year. In November 2006, the Philippines approved an administrative order calling for a birth dose within 24 hours of delivery and committing to full funding for procurement of hepatitis B vaccines through 2010. With this, all countries and areas in the Region are now providing hepatitis B vaccine to all infants on nationwide basis.1 Significant progress was achieved in ensuring financial security for hepatitis B vaccine when China and Viet Nam transitioned out of GAVI financing to full domestic funding for hepatitis B in 2007.

Since provision of the first dose of hepatitis B vaccine remains crucial in attaining the regional goal, the WHO Regional Office for the Western Pacific published Preventing Mother-to-Child Transmission of Hepatitis B: operational field guidelines for delivery of birth dose of hepatitis B vaccine. The hepatitis B expert working group, which had previously met in 1998 and 2002, gathered in Tokyo in March 2007. The meeting helped revise and finalize the second version of the hepatitis B regional plan of action in light of the new regional goal for 2012. In addition, certification guidelines were developed based on recommendations from this meeting. These guidelines will be used in the Region to certify the achievement of hepatitis B control goals by Member States. The certification guidelines and regional hepatitis B workplan were shared with Member States in a national EPI manager workshop in June 2007.

Measles. The Western Pacific Region achieved the largest percentage reduction (81%) in measles mortality between 1999 and 2005 among WHO regions. Almost all Member States are continuing to make

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1 Japan, with very low chronic HBV infection rates, provides hepatitis B vaccines only to children born to HBsAg-positive mothers on a nationwide basis.
progress towards the regional measles elimination goal for 2012 by using strategies that include appropriately targeted supplementary immunization activities, the introduction of a second dose of measles vaccine, the maintenance of high coverage with two doses of measles vaccine, and case-based measles surveillance. The Republic of Korea in November 2006 became the first Member State in Western Pacific Region to declare measles elimination, after satisfying nearly all the interim criteria.

Viet Nam is planning to introduce the second dose of measles vaccine in 2007, in addition to targeted supplementary immunization activities in high-risk areas. The country is likely to eliminate measles well ahead of its 2010 target.

China developed a national measles elimination plan and organized the first national technical advisory meeting for measles elimination in December 2006. The meeting reviewed the measles elimination status in four provinces and the progress made in other provinces. Special efforts are being made to mobilize additional resources from non-GAVI sources to support China’s measles elimination efforts. China received a pledge of support of US$ 1 million from the United Nations Foundation for supplemental activities in its western provinces. The Philippines received a pledge of US$ 1 million from The Church of Jesus Christ of Latter-day Saints to be funnelled through the Foundation for supplemental immunization. Cambodia developed a national measles plan with the goal of measles elimination by 2012, and conducted follow-up measles immunization campaigns during February and March 2007.

In January 2007, five of the GAVI-eligible countries (Cambodia, the Lao People’s Democratic Republic, Mongolia, Papua New Guinea and Viet Nam) received over US$ 8 million in support of supplementary measles immunization activities to be conducted in 2007–2008.

A measles outbreak, following importation, was observed in Fiji from February to May 2006, with 132 reported cases. The outbreak demonstrated the importance of sustaining high coverage vaccinations through routine systems, as well as organizing periodic supplementary immunization activities to close population immunity gaps. Fiji responded to the outbreak by organizing a national measles immunization campaign, targeting children aged 6 months to 6 years. Coverage of 98% was achieved during the campaign. Additionally, Kiribati, Solomon Islands and Vanuatu implemented scheduled national measles campaigns in the second half of 2006 as part of their measles elimination strategies. Kiribati intends to introduce a second dose of measles vaccine in 2007–2008.

GAVI Partnerships. Phase II of GAVI, which started in January 2006, is wider in scope and time frame than the original phase. Started in 2006, it will run until 2015. In 2006–2007, six of the seven GAVI eligible countries applied for GAVI support: Mongolia and Viet Nam (immunization system strengthening); Cambodia and Viet Nam (introduction of measles, second dose); and Kiribati, Papua New Guinea and Solomon Islands (introduction of Hib vaccine).

In addition to mobilization of resources from global partnerships such as GAVI, substantial resources amounting to US$ 5.9 million were mobilized from the United Nations Foundation for measles elimination activities in the Region in 2007–2008. New sources, such as The Church
of Jesus Christ of Latter-day Saints, also are being tapped to mobilize resources for the Expanded Programme on Immunization in the Region.

**Poliomyelitis.** With wild poliovirus endemic in Afghanistan, India, Nigeria and Pakistan, Member States in the Western Pacific Region have remained vigilant about the continued importation risk and the need for ongoing high-quality immunization, surveillance and outbreak preparedness. Regionally, poliomyelitis surveillance quality, including high-quality laboratory performance, and routine immunization coverage have been maintained at levels similar to previous years. Still, the Region has remained poliomyelitis-free.

Work has begun to review national policies and legislation on the immunization of travellers from areas with circulating poliovirus, particularly in view of the International Health Regulations (2005), which came into force in June 2007. Any single case of polio due to wild poliovirus will be considered as an event that may constitute a public health emergency of international concern, requiring notification of WHO within 24 hours of assessment, in accordance with the IHR (2005).

Regional phase 1 wild-poliovirus laboratory containment is yet to be completed. However, significant progress has been made in the two remaining countries, China and Japan. Containment is intended to reduce any risk of virus reintroduction from laboratories into communities and also is being carried out in preparation to implement measures of phase 2 laboratory containment, which calls for either destruction of materials or higher biosafety storage requirements, according to the current *WHO Global Action Plan for Laboratory Containment of Wild Polioviruses, Second Edition*.

In the development of strategies for the eventual cessation of oral poliovirus vaccine once global polio eradication has been achieved, better understanding is required on the behaviour of vaccine-derived polioviruses (VDPV), particularly in individuals with immune deficiency who may develop prolonged virus excretion. To further understand the natural history and prevalence of VDPV in immuno-compromised individuals, particularly in middle-income countries, China is among several countries participating in a prospective study coordinated by WHO Headquarters.

**New and Underutilized Vaccines.** Introducing new and underutilized vaccines is one of the four strategic areas in the Global Immunization Vision and Strategies, jointly developed by WHO and the United Nations Children’s Fund. The Western Pacific Region made further progress in this area in Macao (China) and Papua New Guinea, which introduced Hib vaccine to their national immunization programmes in 2007, bringing the total number of countries and areas in the Region that have done so to 19. Viet Nam undertook a rapid assessment of Hib disease burden in September 2006 and is planning a pilot introduction of Hib vaccine in 2007. In addition, WHO has been collaborating with Member States, including Cambodia, the Lao People’s Democratic Republic and the Philippines, in 2006–2007 in developing sentinel surveillance for meningo-encephalitis. This will help evaluate disease burden due to Japanese encephalitis, Hib and pneumococcus so that vaccines can be introduced for these diseases in due time. Rotavirus sentinel surveillance continued in six priority countries in the Region in 2006–2007.
Malaria. Malaria morbidity and mortality continued to decrease in most endemic countries of the Western Pacific Region, with Pacific island countries and areas still having the highest morbidity rates. Eight out of 10 endemic countries in the Region are now recipients of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. For the sixth round of grants, all malaria proposals that were developed with WHO support were successful.

Included in the successful Global Fund proposals are: (1) a programme in Cambodia that engages the private sector to address the problems of migrants and forest workers through the introduction of insecticide-treated hammock nets and increased access to artemisinin-based combination therapy; (2) a comprehensive malaria control approach in the Cambodian provinces bordering Thailand to scale up the response to high antimalarial drug resistance; (3) a programme in China for the establishment of health centres and provision of treatment at and across the border of Myanmar; (4) a programme in the Lao People’s Democratic Republic to be executed by the drug regulatory authority to address the issue of monitoring and combating counterfeit antimalarials and other drugs; and (5) further support of malaria control in the Philippines with involvement of the private sector.

Antimalarial drug resistance is seriously hampering malaria control efforts in this Region. Data from the monitoring sentinel site system in the Greater Mekong Subregion have shown serious multidrug resistance, especially in the Cambodia-Thailand border areas, with suspected reduced sensitivity to artemisinin derivatives. This was addressed in an international meeting in January 2007, which determined the next steps to verify this and resulted in intensified cooperation between Cambodia and Thailand to comprehensively address the containment of multidrug-resistance.

The problem of malaria among ethnic minorities and underserved groups continues to be addressed by a joint project by WHO and the Asian Development Bank in the six Greater Mekong countries that are developing mixes of intervention strategies targeting those groups. All countries are using a community-based participatory approach. A recent midterm review demonstrated successful engagement of national programmes to address the unique problems of these neglected populations in high-transmission areas.

Significant progress also has been made in addressing the problem of counterfeit antimalarial drugs, especially artesunate, that until recently were widespread in some countries of the Greater Mekong Subregion. Collaboration with Interpol, the international police agency, has resulted in significant progress in tracing production and distribution of fake artesunate, and there is an indication that the flow of fake artesunate is slowing. A new concern is counterfeit insecticides and insecticide-impregnated nets that are beginning to appear in some places.

The Regional Office for the Western Pacific continues to coordinate activities to
improve the quality of malaria diagnosis through rapid diagnostic tests and microscopy. WHO malaria microscopy training manuals and bench aids are under final revision. Expert microscopists from eight countries were retrained in a biregional programme which included the introduction of a microscopy expert accreditation programme. Two regional institutions, supported by the Regional Office for the Western Pacific, have pioneered a rapid diagnostic quality testing programme utilized by Member States and manufacturers. This programme is being expanded globally in collaboration with the UNICEF-UNDP-World Bank-WHO Special Programme for Research and Training in Tropical Diseases and the Foundation for Innovative New Diagnostics to develop a product testing programme and research and monitoring network.

Accurate estimates of populations at risk and of the burden of malaria are important for planning and resource allocation. The Regional Office is developing a programme to produce new detailed risk maps for Asia, as well as burden estimates, in collaboration with the World Food Programme, the Global Fund, the WHO Regional Office for South-East Asia and the WHO Global Malaria Programme.

The private sector is the first point of access for those seeking treatment for fever in the majority of patients in several countries in the Region. A number of countries have now engaged the private sector in malaria control. Examples include the social marketing of antimalarial drugs and mosquito nets in Cambodia and the Lao People’s Democratic Republic, and the distribution of insecticide-treated nets through Rotary Against Malaria in Papua New Guinea and the Coalition Against Malaria in the Philippines which has the participation of several large private sector enterprises. During the regional programme managers meeting in October 2006 in Manila, participants asked the Regional Office to develop a framework for engaging the private sector. First steps include the establishment of a regional task force and a review of experiences from selected countries. Experiences and lessons learnt from the public-private mix for tuberculosis control initiative, which has been very successful in this Region, will be taken into account.

For 2007, a new initiative by the Australian Agency for International Development will provide funding for malaria control in the Pacific, a priority concern of the Regional Office. The Japanese Government also funded a meeting in January 2007 to launch the Asian Vivax Network, which aims to provide coordination, research and training for vivax control in eastern Asia and the Pacific.

Dengue. Dengue is the second most important vectorborne disease in the Region. In 2006, the number of cases remained high in highly endemic countries such as Cambodia, Malaysia, the Philippines and Viet Nam. Outbreaks have also been reported in some Pacific island countries. WHO has limited resources for dengue control and prevention, but continues to support surveillance, as well as a number of major
community-based vector control activities and outbreak response efforts, while seeking to establish a better funding base.

The Asian Development Bank is providing funds for the control of neglected diseases, including dengue, to the governments of Cambodia, the Lao People’s Democratic Republic and Viet Nam, within a comprehensive communicable disease control project. Cooperation between the Regional Office for the Western Pacific and the Asian Development Bank as part of this project enables the former to fund a dengue expert to coordinate activities in these countries. The WHO Western Pacific and South-East Asia Regions have begun the process of forming an Asia-Pacific Dengue Partnership to bring endemic countries and potential donors into partnership. There also has been a significant increase in funding from the United States Agency for International Development for dengue control both at regional and country levels in 2006.

**Helminths.** Population coverage by deworming programmes within the Region is steadily progressing towards the WHO global target of regularly deworming more than 75% of school-age children at risk. Cambodia continued to lead by deworming 2.8 million schoolchildren and has extended the intervention to preschool children. The Lao People’s Democratic Republic has reached the global target and Viet Nam is also approaching it. WHO is working with the Asian Development Bank and the United Nations Children’s Fund to expand deworming to include preschool children in the Mekong region. In the Pacific, WHO provided technical support and deworming tablets to programmes in Kiribati, Solomon Islands, Tuvalu and Vanuatu.

Soil-transmitted helminth health education materials are included in the ‘Urbani School Health Kit’ (see Chapter 6, footnote 1), an initiative jointly developed with the Health Promotion unit of the Regional Office to provide health education materials throughout the Region. The school health promotion package containing communication materials on helminth control, oral health, personal hygiene, nutrition, tobacco and healthy environments is named in memory of Dr Carlo Urbani, the former WHO regional helminth control expert and the first person to recognize severe
acute respiratory syndrome (SARS) as a new disease. He died as a result of SARS. The Urbani School Health Kit is being piloted in the southern Philippines and is expected to be expanded throughout the Region.

Schistosomiasis control focused on Cambodia, where it is well controlled, and the Lao People’s Democratic Republic, where the national programme has been reactivated. Schistosomiasis also is a significant public health problem in the Philippines, and a major government priority in China where there is the potential for further spread due to the development of new dams. WHO is providing active support to programmes in these countries.

**Lymphatic Filariasis.** Countries and areas in the Western Pacific Region are making steady progress towards the global goal of the elimination of lymphatic filariasis by 2020. Among the Mekong-Plus countries, China is in the final process of verifying the interruption of transmission. The Republic of Korea is expected to be ready for verification of the interruption of transmission late in 2007. The Lao People’s Democratic Republic is implementing the final mapping surveys, while Cambodia, Malaysia, the Philippines and Viet Nam are continuing annual mass drug administration campaigns that have achieved high levels of coverage.

In Pacific island countries, the WHO Pacific Programme for the Elimination of Lymphatic Filariasis (PacELF) partnership continues to coordinate lymphatic filariasis elimination in partnership and close collaboration with the Japanese Government, GlaxoSmithKline and others. All endemic countries except Papua New Guinea have completed five rounds of mass drug administration and are at the critical stage of confirming that prevalence has dropped to below the 1% target level. The PacELF strategy and survey methodology are currently under review to address changing needs as elimination targets are approached.

![Patients afflicted with lymphatic filariasis.](image)
Tuberculosis. Despite considerable progress in recent years, tuberculosis (TB) continues to cause immense hardship in the Western Pacific Region. In 2005, the latest year for which data is available, of the estimated 1.9 million new TB cases in the Region, only 1.2 million cases were detected by countries and areas. Every year, nearly 300,000 people die from tuberculosis in the Region, including more than 3000 people co-infected with HIV. It is estimated that one quarter of the global burden of multidrug-resistant tuberculosis is in the Region, with 140,000 cases in China alone.

Evidence available in 2006 showed that TB control efforts in the Western Pacific Region had achieved important milestones that had been set for 2005, making it the first and only WHO region to meet those targets. Furthermore, the Strategic Plan to Stop TB in the Western Pacific 2006–2010, developed as a road map to achieve the eventual goal of reducing by half the number of cases and deaths in the decade ending in 2010, was endorsed by the WHO Regional Committee for the Western Pacific at its fifty-seventh session in September 2006.

Most countries face significant constraints to further progress in TB control necessary to achieve the 2010 goal. These constraints include, among other things: limited access to and quality of directly observed treatment, short-course (DOTS); multidrug-resistant TB (MDR-TB); TB-HIV co-infection; inadequate engagement of all care providers; and the lack of adequate human resources and other health systems weaknesses.

The work of WHO is guided by the Strategic Plan, which sets out activities expected to impact the TB burden and contribute to the achievement of the TB-related Millennium Development Goals. Thus, much of WHO’s work is directed towards the support of Member States in the implementation of their national plans.

National TB Programmes. In March 2007, WHO organized the meeting of national TB programme and TB laboratory managers, with the participation of seven countries in the Region with a high burden of TB, namely Cambodia, China, the Lao People’s Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam, and the host country, Malaysia. The meeting reviewed progress made towards the 2010 TB goal by individual countries and the Region as a whole, and identified areas that need to be strengthened.

Despite regionwide DOTS coverage, many TB patients often face significant barriers in accessing DOTS, which is the WHO-recommended strategy for TB prevention and treatment. These barriers impact vulnerable populations, including the poor, and those who seek care from the private sector and other non-national TB programme facilities. National TB programmes are increasing their efforts to address these challenges. The Philippines, as well as Cambodia and Viet Nam to a certain extent, are engaging the private sector to improve access and quality of care for TB. China is undertaking a major initiative to address the needs of its
huge migrant populations. Mongolia and Viet Nam are extending the reach of their TB control programmes to provide TB services to vulnerable populations, such as people in prisons or other institutions. Many countries and areas in the Region also have implemented community-based DOTS to improve the reach of services.

WHO, in collaboration with the Korean Institute of Tuberculosis, organized an advanced course that focused on public-private mix DOTS in December 2006. The course was attended by delegates from seven countries in the Region with a high burden of TB. In July 2006, WHO organized a workshop on advocacy, communications and social mobilization in the Philippines. Advocacy, communications and social mobilization are being promoted to raise awareness for better health-seeking behaviour and to mobilize affected people and their communities to play a critical role in achieving equitable access to TB services.

**Multidrug-resistant TB.** In 2006, reports emerged globally of extensively drug-resistant TB, which also has been documented in our Region in the Republic of Korea and the Philippines. There is an urgent need to prevent extensively drug-resistant TB by first establishing adequate surveillance mechanisms, followed by the strengthening of laboratories to diagnose MDR-TB cases, and finally by setting up treatment centres to manage these cases. All of this must occur in the context of a strong DOTS programme. Reflecting the urgency to tackle MDR-TB in the Region, the theme for World TB Day 2007 was Drug-resistant TB: Treat it, Prevent it! An advocacy kit with this theme was produced and distributed to national TB programmes and partners in the Region.

A major activity of WHO over the past year focused on support for countries to establish the necessary infrastructure for programmatic management of MDR-TB. Strengthening the laboratory network and capacity is a crucial step before embarking on MDR-TB management. In collaboration with the WHO Regional Office for South-East Asia, the Regional Office for the Western Pacific organized a TB laboratory course in Beijing in October 2006 aimed at improving the managerial and technical skills of senior TB laboratory managers from the Asia Pacific region. WHO supported participants from China, Mongolia and the Philippines to attend an MDR-TB training course in Latvia, and organized the first regional training course on MDR-TB management, which was part of the advanced TB course. Several visits also were made by WHO consultants to China, Mongolia and the Philippines in support of the preparation and implementation of MDR-TB management.

The Philippines was the site of the first DOTS-Plus pilot project on MDR-TB management and has made significant progress in expanding the management of MDR-TB under the national TB programme. Mongolia has also implemented the programmatic management of MDR-TB. In China, where MDR-TB has reached alarming rates in some areas, an encouraging start has been made by implementing programmatic management of MDR-TB in a few provinces that eventually could be brought to scale. Viet Nam is planning its response to MDR-
TB within its national TB programme. Cambodia is implementing programmatic management of MDR-TB in the context of a research study.

**TB-HIV co-infection.** TB-HIV co-infection is a major challenge in Cambodia and Papua New Guinea, both of which have generalized HIV epidemics. In Viet Nam, the HIV epidemic is likely contributing to the fact that there has not been a decline in the incidence of TB, despite good performance of the National TB Programme over the past several years. TB-HIV co-infection also is of increasing concern in some areas of China, and in settings where TB and HIV share common risk factors, such as in Malaysia. While good progress has been made in implementing TB-HIV collaborative activities in Cambodia and in some areas in Viet Nam with high HIV prevalence, other countries need to strengthen TB-HIV collaborative activities through formally established mechanisms and plans.

WHO and the Secretariat of the Pacific Community jointly organized a Pacific TB-HIV meeting in August 2006. Attended by representatives from all Pacific island countries and areas, as well as partners in the Pacific, the meeting established the need to strengthen policies on HIV, TB and TB-HIV co-infection. Participants agreed to review existing national policies relevant to TB-HIV and, as appropriate, incorporate TB-HIV policies in existing general policies or develop national policies and operational guidelines for TB-HIV that are in line with regional and global frameworks.

**Surveillance.** Concerns about the accuracy of published estimates of the TB burden in the Pacific have been raised by experts and national TB programme managers. In July 2006, the Regional Office organized a workshop on estimating TB burden in 20 Pacific island countries and areas, the first meeting of its kind. Improved estimates derived from this work are now being used by WHO in TB control reports.

In an effort to demonstrate the impact of DOTS implementation, the need for guidelines on prevalence surveys has become important. The Regional Office took the lead in developing international guidelines for the standardization of methods and procedures on TB prevalence surveys. The committee tasked with writing the guidelines, consisting of global TB experts, discussed the first draft during a workshop held in February 2007.

Over the past year, WHO co-organized or participated in external reviews of national TB programmes in Cambodia, China and Viet Nam.

**The Global Fund to Fight AIDS, Tuberculosis and Malaria.** The Global Fund remains the largest single funding source for TB in the Region. With strong support from WHO for the preparation of proposals, all countries and areas with a high burden of TB, including several in the Pacific, now have Global Fund grants, typically running for five years. A total of 15 TB grants have been approved by the Global Fund during six rounds between 2002 and 2006. These grants total US$ 290 million committed.
over the lifetime of the grants. Although very significant, the Global Fund covers less than 15% of the entire resources needed for TB control in the Region. More than half the resources required are provided by domestic funding from governments. Member States need to continue to prioritize TB control and further increase their investment in TB control.

Increasingly, WHO is supporting the implementation of activities funded by the Global Fund through its participation in technical working groups at the country level that are created to provide technical advice to the Country Coordinating Mechanisms. Additional technical support is provided through WHO consultants.

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

In 2005, the most recent year for which statistics are available, 7201 new cases were reported in the Region. China and the Philippines registered more than 1000 cases each, while 22 countries and areas had less than 10 cases each. Cook Islands, Mongolia, Niue, Tonga and Tuvalu reported zero prevalence and detected no new cases.

Technical support has been provided in workshops for provincial coordinators in China and the Philippines who are implementing the Strategy to Sustain Leprosy Services in Asia and the Pacific. Another workshop was held in Fiji in April 2007 for 14 national programme managers from Pacific island countries and areas in collaboration with partners involved in leprosy activities. Monitoring of the implementation of the Strategy took place in Cambodia in July 2006 and in Viet Nam in March 2007, where workshops at the provincial and district level were also conducted. Community-based group discussions on leprosy and self-care for the prevention of disability were undertaken in collaboration with the national programme and other partners in three provinces in Cambodia.

Technical support has been extended to the Marshall Islands and the Federated States of Micronesia—the only two countries that had not reached the elimination target.

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

To address the remaining challenges of leprosy and to improve the quality and accessibility of leprosy services, the Consensus Development Conference on the Prevention of Disability took place in Cebu, Philippines, in September 2006. The conference was cosponsored by WHO, the
American Leprosy Missions, the International Federation of Anti-Leprosy Associations and other partners. Participants from about 30 countries included national programme managers, WHO staff from the Regional Office and Headquarters, and a wide range of therapists and practitioners. The contribution of people affected by leprosy enhanced the resulting consensus.

Yohei Sasakawa, WHO goodwill ambassador for the elimination of leprosy, launched *Global Appeal 2007* in January in Manila, an effort intended to halt discrimination against people affected by leprosy. The Philippine Declaration to end stigma and discrimination against people affected by leprosy was presented to Mr Sasakawa by the Secretary of Health of the Philippines in support of the Global Appeal. The ceremony was co-hosted by the Department of Health of the Philippines, the Nippon Foundation, the Sasakawa Memorial Health Foundation, WHO, and other national and international partners. The event was also attended by more than 50 people affected by leprosy from various countries and received broad media coverage.

Collaboration has been maintained with all partners involved in leprosy elimination activities in the Region. Coordination meetings with governments and nongovernmental organizations for leprosy elimination have been held in several Member States.

Leprosy elimination efforts must be sustained over the long term. This entails integrating leprosy services into general health services across the Region. WHO will need to continue to provide technical support in 2007 for the preparation and implementation of action plans for the *Strategy to Sustain Leprosy Services in Asia and the Pacific* in the Lao People’s Democratic Republic, Malaysia and Papua New Guinea. The Strategy will need to be implemented across the Region by 2010, and awareness campaigns must be sustained, particularly in the Pacific island countries and areas. Targeted interventions for mobile populations are needed in a number of countries and areas in the Region.
HIV/AIDS and STI. It is estimated that 1.3 million people were living with HIV/AIDS in the Western Pacific Region in 2006. Two countries have generalized epidemics: Cambodia, where the estimated rate of HIV prevalence in adults has decreased from 2.5% in 2000 to 1.6% in 2005; and Papua New Guinea, where the rate has risen from 1.7% in 2004 to 1.8% in 2005. Concentrated epidemics are growing in China, Malaysia and Viet Nam, where HIV transmission occurs primarily among populations with high-risk behaviours, such as injecting drug users and sex workers.

Recent data on sexually transmitted infections (STI) show high prevalence rates even in low-risk groups, for example in Fiji where 29% of pregnant women tested positive for Chlamydia infection in a 2005 survey. Sexually transmitted infections are on the rise in China. Syphilis, which reportedly disappeared from the Chinese mainland for two decades ending in 1980, is now re-emerging. Increases of nearly fivefold between 1993 and 2005 among adults and 72% in newborns have been reported. These findings also indicate a significant potential for further transmission of HIV infection.

Evidence suggests that for most heavily affected countries in the Region, the MDG target of halting or reversing the spread of HIV/AIDS is difficult, but achievable. Large-scale prevention programmes have helped to avert new infections and slowed the epidemic in Cambodia. However, mounting infection rates can be found throughout the Region, including in Papua New Guinea and Viet Nam.

Strategic information. During 2006–2007, WHO supported Member States in strengthening their activities on strategic information for HIV/AIDS which include: development of national monitoring and evaluation frameworks in Cambodia, China and Viet Nam; second-generation HIV surveillance in Papua New Guinea, Mongolia and the Pacific island countries and areas; HIV estimation in China, Papua New Guinea and the Philippines; HIV drug-resistance surveillance and monitoring, including early warning measures in Cambodia, China, the Philippines and Viet Nam; and monitoring progress of the health sector response towards universal access in Cambodia, China, Papua New Guinea and Viet Nam.

Prevention. WHO continues to provide technical support targeting populations with high-risk behaviour in the Western Pacific Region. In 2006, an assessment was conducted in Guam on the feasibility of implementing the 100% condom use programme among establishment-based sex workers. Experience-sharing meetings also were conducted in the Lao People’s Democratic Republic and Mongolia with the aim of expanding the strategy to additional
provinces. During the last quarter of 2006, training workshops on implementation of the 100% condom use programme were conducted in selected sites in China and the Philippines. Three years after the introduction of the 100% condom use programme in Li County, Hunan Province, China, self-reported condom use increased almost fourfold, while the number of reported STI cases dropped by almost two thirds. A biregional meeting, jointly sponsored by WHO and the United Nations Population Fund, to consider the expansion of the 100% condom use programme was held in Manila in October 2006, with participants from 16 countries.

Technical support for STI prevention and control continues to be provided to Pacific island countries and areas. WHO provided both financial and technical support to a July 2006 conference in Malaysia of the International Union Against Sexually Transmitted Infections.

In China, WHO has supported the development of key tools and events related to HIV transmission among men who have sex with men, including intervention guidelines on HIV prevention, a draft advocacy strategy paper, and advocacy workshops in both Guangzhou and Shenzhen.

**Harm reduction.** Technical assistance was provided for the development of tools and guidelines. A new guide for antiretroviral treatment and care for injecting drug users promotes comprehensive treatment and care and links to harm reduction services. A new training manual focuses on the needs of injecting drug users to prevent the transmission of HIV in closed settings.

WHO supported activities to scale up harm reduction services at regional and national levels. To strengthen intergovernmental collaboration, a regional harm reduction training network was launched through a workshop with representatives from health and law enforcement sectors of eight countries.

The Philippines started a process of developing a national harm reduction strategy and is considering harmonization of laws and regulations. In Malaysia, pilot programmes on needle and syringe exchange and methadone substitution therapy were evaluated with representatives from the health and law enforcement sectors. Both interventions are currently scaled up nationwide.

A new HIV/AIDS law in Viet Nam provides for a range of harm reduction services, including methadone substitution therapy. WHO is providing technical support for the development of guidelines and comprehensive service delivery models.

**Intellectual Property Rights.** In June 2006, an intercountry workshop on Intellectual Property Rights and Access to HIV commodities was conducted in Fiji. This workshop was co-organized by the Third World Network, WHO, the United Nations Development Programme, and the Commonwealth Secretariat. Nine Pacific island countries were represented in the workshop. Technical support was provided to China, the Philippines and Viet Nam in procurement and supply management, including support to the Association of Southeast Asian Nations (ASEAN) consultations on barriers and options for increasing access to HIV/AIDS diagnostics, drugs and consumables. In December 2006, a
biregional workshop co-organized with Management Sciences for Health, a nongovernmental organization, was conducted in Manila to foster competencies in HIV/AIDS commodities forecasting, stock management, monitoring and reporting.

Care and treatment. The number of people living with AIDS receiving antiretroviral treatment is increasing in all countries in the Region. By the end of 2006, China was providing antiretroviral treatment to more than 30,000 patients, which represents 27% of those in need. In Viet Nam, 8,217 patients, including 428 children, were receiving antiretroviral treatment, reaching close to 20% of those in need. In Papua New Guinea, 1,098 patients or 11% of those in need, were receiving antiretroviral treatment. To facilitate the expansion of their care and treatment programmes, WHO provided technical support to China, the Lao People’s Democratic Republic and Papua New Guinea. This support included training in the Integrated Management of Adolescent and Adult Illness.

Universal access. In October 2006, the First Asia-Pacific Regional Conference on Universal Access to HIV Prevention, Treatment, Care and Support in Low-Prevalence Countries was held in Ulaanbaatar, Mongolia. The Ulaanbaatar 2006 Call for Action recommended several key action areas for government, civil society, international donors and multilateral institutions. For efficient and cost-effective prevention efforts in countries where HIV/AIDS is still relatively rare, targeted HIV prevention should focus on people most at risk of acquiring HIV, including sex workers and their clients, injecting drug users, men who have sex with men, and young migrants, in order to prevent the spread of HIV.

Remaining challenges include making treatment more widely available, while simultaneously increasing access to and coverage of HIV/AIDS services. Genuine political interest and commitment are essential foundations for success, demanding advocacy at all levels to drive policy, mobilize sufficient resources and take effective actions.

The international community has made a commitment to provide universal access to HIV/AIDS prevention, treatment, care and support by 2010. WHO’s work towards universal access for the next five years will be structured around five strategic directions for the health sector: HIV/AIDS testing and counselling; maximizing health sector contribution to HIV prevention; treatment and care; strengthening and expanding health systems; and strategic information. By reinforcing the programmes in place, the Regional Office for the Western Pacific will continue to work with partners and Member States to contribute to the achievement of this major public health goal.
Pandemic Influenza Threat.

The risk that avian influenza A(H5N1) could mutate into a virus that could cause a human influenza pandemic remained high over the past year. Despite efforts to control outbreaks, the virus has become entrenched in domestic birds in many parts of Asia. Meanwhile, migratory birds continue to carry the virus.

WHO’s work during the past year focused on supporting Member States in responding to avian influenza and improving human influenza pandemic preparedness. A regional workshop on pandemic management, which included an emergency exercise, was held in December 2006 in Manila. In May 2007, the first biregional meeting of national influenza centres was convened in Australia to discuss and identify the roles of national influenza centres during different pandemic phases.

Pandemic influenza rapid response and containment has been a chief priority in the Western Pacific Region over the past year. WHO’s rapid response and containment strategy aims to stop—or at least slow down—the spread of pandemic influenza at the source of its emergence to minimize the enormous impact it could have on health, economic activity and social development. A WHO pandemic influenza draft protocol for rapid response and containment has been developed. Advocacy materials that target senior government officials and emphasize the extraordinary containment measures that would be needed at the very early stage of a pandemic have been developed to help countries obtain political commitment for rapid containment operations that might be necessary at the country level.

The second international workshop on pandemic influenza rapid containment was held in March 2007 in Cambodia. It emphasized the need for country-level preparations for rapid response and containment, including the development of country operational plans. In April 2007, an emergency management exercise was organized to test the ability of WHO and ASEAN to respond in the event of a pandemic and to mobilize supplies of antiviral drugs and personal protective equipment provided by the Government of Japan and stockpiled in Singapore. The exercise highlighted the importance of essential information for decision-making in launching rapid containment protocols and guidelines at international and national levels. It also identified some gaps in the rapid deployment of the regional stockpile,
Asia Pacific Strategy for Emerging Diseases. Recent and severe outbreaks of emerging infectious diseases have clearly highlighted the need for long-term capacity-building. The International Health Regulations (2005), which entered into force in June 2007, set out country core capacity requirements for surveillance and response.

Following the endorsement of the Asia Pacific Strategy for Emerging Diseases (APSED) in September 2005 by the WHO Regional Committees for the Western Pacific and South-East Asia, a five-year WHO workplan for APSED implementation was developed and reviewed by the first meeting of the Asia Pacific Technical Advisory Group (TAG) for Emerging Infectious Diseases, held in July 2006 in Manila. The workplan is intended to help ensure that all countries and areas in the Region will have at least the minimum capacity for epidemic alert and response by 2010. The workplan includes priority activities that should be urgently implemented in responding to avian influenza and preparing for pandemic influenza and containment and in further improving pandemic preparedness.

In September 2006, the fifty-seventh session of the Regional Committee for the Western Pacific reviewed the recommendations of the first TAG meeting and urged Member States to develop country-level workplans to implement the Strategy and to achieve the minimum capacity goals. The country plans should meet the surveillance and response capacity-development obligations required under the International Health Regulations (2005). Since then, WHO has been working towards developing the APSED baseline data collection checklists and to assist Cambodia, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam in conducting baseline capacity assessments, using the checklists. As a result of such assessments, some countries, including the Lao People’s Democratic Republic, have now developed their draft strategic plans for core capacity strengthening.

WHO has also been working with the Secretariat of the Pacific Community to develop the core capacity-building approach through the effective implementation of APSED in Pacific island countries and areas. The strategic approach was reviewed at the Meeting of Ministers of Health for the Pacific Island Countries in March 2007 in Vanuatu. The second biregional meeting of the Asia Pacific Technical Advisory Group for Emerging Infectious Diseases will be held in July 2007 in India. The meeting will review the progress made in APSED implementation and provide technical advice on the next steps to move the agenda forward, especially the further development and implementation of national plans.

International Health Regulations (2005). Following the adoption in May 2006 of World Health Assembly resolution WHA59.2 on voluntary compliance with the IHR (2005), almost all Member States in the Western Pacific Region have officially designated their national IHR focal points. The WHO IHR contact point for the Western Pacific has been designated, and an IHR communications and duty officer system was
set up in December 2006 for communications with national IHR focal points.

Since 2006, several national-level multisectoral advocacy meetings and workshops on IHR (2005) have been conducted in Cambodia, China, Fiji, Kiribati, the Lao People’s Democratic Republic, the Marshall Islands, the Philippines, Tonga and Viet Nam, with support from WHO. The IHR (2005) guide for national policy-makers and partners was distributed to national health officials and other stakeholders beginning in July 2006. A workshop on public health law for Pacific island countries was held in February 2007 in New Zealand to support countries in developing an up-to-date legal framework, including the IHR (2005). WHO continues to work closely with all Member States and other partners to fulfil the obligations under these revised regulations and to contribute to international public health security.