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CHAIRPERSON: Honourable Pete Hodgson (New Zealand)

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For the list of representatives at the fifty-seventh session, see separately issued document WPR/RC57/DIV/1.

1. PREVENTION AND CONTROL OF HIV/AIDS, TOWARDS UNIVERSAL ACCESS:
Item 15 of the Agenda (Document WPR/RC57/10)(continued)

DR NAKASHIMA (Japan) welcomed the decision to raise the target in the Region to universal access to treatment. He praised the "3 by 5 Initiative" activities, and looked forward to an evaluation of that work, which helped inspire the goal of universal access.

Given that expanding access to antiretroviral therapy (ART) might lead to drug-resistant strains of the virus, there should be continual laboratory monitoring of drug susceptibility, viral load and CD4 cell count. Those infected with HIV who remained healthy in treatment needed support from the community. Coordination with tuberculosis control and other programmes was needed in order to reduce HIV-related TB and vertical transmission, and to raise people's awareness and reduce stigma.

Japan had been strongly committed to HIV/AIDS control in the Region for some time, through the Okinawa Infectious Disease Initiative adopted by G8 in 2000, the Health and Development Initiative adopted by the Japanese Government in 2005, support to the Global Fund to fight AIDS, Tuberculosis and Malaria, bilateral cooperation and other programmes. That work would continue.

Mr VILLAGOMEZ (United States of America) voiced his country's commitment to coming as close as possible to universal access to treatment by 2010. That would require urgent scaling up of treatment, care and support programmes, as stated in the Declaration of the 2006 United Nations General Assembly High-Level Session on HIV/AIDS, the 2005 World Summit outcome document, and the G8 Gleneagles Leaders' Statement. A message of hope had to be sent to people living with HIV/AIDS through words and actions. That would mean ambitious but achievable goals for each country. No health care data suggested that it would be possible to reach the target by 2010, hence the use of appropriate qualifiers to the term "universal access". Treatment, prevention and care would be channeled through the President's Emergency Plan for AIDS Relief, and through contributions to the Global Fund and UNAIDS. The United States of America supported the five strategic directions proposed by the WHO Secretariat, and advised that the five proposed actions for Member States in the Region should be supportive, measurable and in line with the "Political Declaration on HIV/AIDS" by the June 2006 United Nations General Assembly. The United Nations supported the establishment of an international HIV testing day, as a practical step

towards universal access to treatment. UNAIDS was currently studying the feasibility of such an event, and it was to be discussed at the General Assembly in September. The speaker asked for the support of other countries on that issue.

The United States of America supported all but one of the five actions proposed by the Secretariat. While recognizing the need for clean needles for clinical purposes, the United States of America did not support needle exchange programmes, and therefore proposed deletion of the word "needles".

Dr LAM (Hong Kong, China) said a surveillance system was central to prevention and control. Heterosexual contacts had accounted for over 50% of infections reported in Hong Kong (China), but in 2005 the category of infections among men who have sex with men (MSM) had overtaken that. Risk factors were unprotected sex, Internet dating, sex with noncommercial partners, and using soft drugs during sex. Risky behaviour, especially low rates of condom use, could lead to an exponential rise of the disease among MSM. Hong Kong (China) fully supported the actions proposed, devoting special attention to MSM, perhaps with biregional cooperation, as had been arranged on avian influenza.

Dr JACOBS (New Zealand) said that his country regarded HIV/AIDS as a domestic and regional development priority, for which cooperation with government, donors and multilateral organizations was essential. HIV was a high priority issue in the NZAID Multilateral Engagement Strategy; NZAID had recently doubled its support to United Nations agencies working directly on HIV/AIDS prevention, treatment and care. Several major projects were under way in the Pacific, with strong political, church and civil society leadership. Lessons learnt from the New Zealand response to the virus should encourage the regional response.

On HIV/AIDS and sexual and reproductive health, he noted that the vast majority of HIV infections had been sexually transmitted or associated with pregnancy, childbirth or breast-feeding. Poverty and gender discrimination were root causes. Critical links between health issues, especially in specific groups, had to be recognized to prevent stigmatizing those affected, to empower the vulnerable and to obtain resources needed for action.

More access to treatment and care involved not only antiretroviral drugs, but an effective, local programme of HIV education and prevention; a system of diagnosis of HIV infection, including confidentiality; free and

consistent provision of condoms; and a package of clinical care. There also had to be access to pharmacies that would provide reliable supplies of the drugs.

Dr LAM (Macao, China) noted that HIV treatment was free of charge in Macao (China). Of the 350 new infections reported in Macao (China) by June 2006, one third were in Macao citizens. Some 40% of new cases were among intravenous drug users, who were increasingly becoming infected with the virus. A Prevention and Control of AIDS Committee had therefore been established, chaired by the Secretary for Social and Cultural Affairs, and including directors of health, education and social affairs; the police; academic institutions; and several nongovernmental organizations. The committee had set up a pilot project for a methadone replacement programme, as well as education and behavioural study programmes for young people, with full participation of civil society. Education and training of health workers and AIDS prevention workers was being stepped up, and legislation was being reviewed. Macao (China) fully supported the document before the Committee.

Mr SAMO (Federated States of Micronesia) thanked WHO for scaling up its efforts to reach universal access, as enshrined in the "3 by 5 Initiative", and expressed support for the five actions, although he wanted it to be clear that ensuring provision of antiretroviral drugs to 3 million people meant that the drugs had to be available. In his country, ART still had not made headway. He agreed with the representative of Tonga that the issue was not how many people were treated, but how many were treated properly.

Dr TOURNEUX (France) thanked the Secretariat for adding the item to the agenda at France's request, although the brevity of the report did not reflect the scope of the sixtieth General Assembly of the United Nations in June 2006, with its list of vulnerable groups and its calls to end the trend of women overtaking men in the epidemic and to introduce science-based approaches to prevention. France saw the report as a reaffirmation of the prevention, treatment and care continuum expressed in the previous year's report. There was relative stabilization of the epidemic curves in the Region, which she hoped was due to the programmes that were in place, with free and anonymous testing, and individual counselling adapted to each person. She was convinced that such an approach would be much more effective than the, albeit necessary, public information campaigns. A regional solution was needed in order to provide the poorer countries of

the region with ARV. This would require Global Fund and World Bank involvement. The recent French initiative of UNITAID in collaboration with four countries, including the United Kingdom, was being launched by the French President at the General Assembly of the United Nations in New York. That initiative was designed to work in tandem with the Global Fund.

Ms PAUL (the Marshall Islands) said that the Marshall Islands endorsed the actions proposed to achieve universal access. New HIV cases had recently been reported in the Marshall Islands, and would have a significant impact on the small developing country. The Government's response had been to hasten the development of a national HIV strategic plan, with input from local and national leaders, various government departments and agencies, and nongovernmental organizations. The programme to scale up towards universal access by 2010 had relevance for the Marshall Islands, whose population was very mobile and tended to travel abroad for education or better job opportunities. Local capacity to meet demands on the public health system needed improvement; the lack of skilled and trained human resources, technical capacity, effective counselling services, laboratory testing and referral services, as well as the social stigma and discrimination attached to HIV/AIDS, were limitations that needed to be addressed. The Government's priorities were strengthening services for counselling, testing and referral, reviewing the course curriculum for health promotion and education, and improving surveillance and monitoring systems. Currently, second-generation surveillance of young people, pregnant women and commercial sex workers was under way. Based on the results, expected by year-end, the Government would formulate policies and programmes aimed at those vulnerable groups.

Ms GIDLOW (Samoa) said that the HIV/AIDS prevention and control programme, developed in the early 1980s, was still a priority in Samoa. Currently, a sectorwide approach was being implemented; a review of the national strategic plan had been planned. The Ministry of Health and the national health services coordinated the national programme, formulated policy, performed regulatory functions, and chaired the national AIDS committee and relevant technical committees. Civil society and nongovernmental organizations were involved in the operational aspects and advocacy. Technical and financial support would be needed to achieve universal access by 2010, in accordance with the proposed five strategic directions; WHO's support would be essential, particularly for developing and reviewing legislation.

Dr VILLAVERDE (the Philippines) said that the HIV/AIDS control programme remained a priority for the Philippines. As chair of the Council on HIV/AIDS, a multisectoral policy-making body, the Department of Health advocated greater allocation of financial resources towards HIV/AIDS programmes. The Government was fully committed to strengthening efforts for the prevention of HIV through expansion and intensification of voluntary counselling and testing, and to improving the treatment and care of people living with HIV/AIDS. Renewed attention would be given to the prevention and treatment of sexually transmitted infections, a factor in HIV transmission; surveillance for risk groups would be prioritized. The Philippines would collaborate with international and local partners to reduce social stigma and discrimination through education campaigns in work places and in health care settings. The Department of Health would continue to review, assess, implement, monitor and evaluate national strategies and interventions for HIV/AIDS and sexually transmitted infections, and would step up efforts towards the adoption of actions aimed at achieving universal access by 2010.

Mr VIVIAN (Niue) recalled a warning given by an expert from the Secretariat of the Pacific Community who was attending a recent workshop on AIDS in Niue: it was only a matter of time before Niue had its first case of HIV. In a country with a population of only 2000, that was a stark reminder of the special vulnerability of Pacific island countries and areas. In Niue, legislation had been initiated to provide for mandatory HIV-testing of all people, including tourists staying for at least two months. However, legal opinions indicated that such legislation would not be appropriate. He appealed to the Region's major players and stakeholders, particularly WHO, to pay particular attention to the special health concerns of small island countries.

Dr ABDUL WAHAB (Malaysia) said that Malaysia had demonstrated its commitment to HIV/AIDS prevention and control when it became a signatory to the United Nations Millennium Declaration, the United Nations General Assembly Special Session on AIDS in 2001, and the ASEAN Declaration on HIV/AIDS in 2001. The Government had advocated a multisectoral approach in policy-making and programme implementation. Major challenges to the control of HIV/AIDS in Malaysia had been identified through consultative meetings with key stakeholders. The national strategic plan on HIV/AIDS 2006-2010 focused on: (1) strengthening leadership and advocacy; (2) training and capacity enhancement; (3) reducing HIV vulnerability among injecting drug-users and their partners; (4) reducing HIV vulnerability

among marginalized and vulnerable populations; and (5) improving access to diagnostic services, treatment and care. The Government had initiated harm-reduction strategies for injecting drug users that included methadone maintenance therapy, a needle/syringe exchange programme, and promotion of condom use. Malaysia fully supported the actions and strategies proposed for achievement of universal access.

Dr Isiye NDOMBI (United Nations Children's Fund) urged Member States to adopt the five proposed strategies for universal access to treatment and to ensure that their programmes specifically targeted and reached children and young people, who were often omitted from or not fully covered by conventionally planned and implemented programmes. There was a broad range of experience available in that regard, and goals should include: reaching young people with youth-friendly health services that would enhance prompt diagnosis and treatment of sexually transmitted infections and facilitate greater access to voluntary testing; adopting communication approaches that appealed to and were led by young people; undertaking specific monitoring of the impact of HIV/AIDS on children, disaggregated for boys and girls, to sharpen responsive action to contain potential and continuing damage; ensuring that affected and infected children had access to social services and to welfare and judicial recourse to prevent exploitation and neglect; ensuring that as technical advances were made children were not neglected; focusing action to target at-risk and vulnerable populations at the community level by building competencies at that level to enable communities to design and implement their own effective responses; and supporting innovations to improve the quality of home care for people living with HIV/AIDS.

Member States, in their planning, should take into account the demands of the HIV/AIDS burden on health systems, and HIV/AIDS activities should be a part of maternal health, integrated management of childhood illness, and human resources planning. Beyond the health sector, Member States should insist that every public and private sector had a costed HIV/AIDS response plan. UNICEF paid tribute to those countries that had reversed the trend of the epidemic and urged them to remain vigilant. Member States at all stages of the epidemic should learn lessons from their most successful peers.

At the invitation of the CHAIRPERSON, representatives of the Medical Women's International Association and the International Federation of Business and Professional Women made statements to the Committee.

The acting REGIONAL DIRECTOR thanked representatives for their comments, which would be taken into account by the Regional Office. WHO was committed to universal access; it was an ambitious goal, however, and would require action through strong partnerships at the country, regional and global levels. At the country level, activities were being undertaken in accordance with the "Three Ones" principle, and WHO country office staff were supporting the inter-agency coordination committees for projects financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Several speakers had called for strengthened cooperation at the regional level. The Western Pacific Regional Office was collaborating with the Regional Office for South-East Asia in many HIV/AIDS-related areas, in particular, harm reduction, care and treatment, and with other partners, such as the UNAIDS cosponsors. He had himself attended a number of meetings of the heads of the UNAIDS cosponsors. A number of representatives had expressed concern at the continuing high cost of antiretroviral drugs. While there had been several regional meetings on the subject, it was more likely that progress in that area would be made at the global level.

The REGIONAL ADVISER ON SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV/AIDS thanked representatives for their support and for their wide-ranging comments, which would guide the Regional Office in strengthening and adapting its activities. WHO was strongly committed to collaboration with Member States and with other organizations, in particular with UNAIDS and, at the regional level, with the Secretariat of the Pacific Community, to achieve universal access to treatment by 2010. A number of meetings and workshops had been arranged jointly by the Regional Office and various partners over the coming months, in conjunction with the Regional Office for South-East Asia, to contribute to the implementation, analysis and evaluation of activities to promote universal access. They included meetings in: Manila, the Philippines, in October 2006 on promotion of condom use, which remained the main tool for preventing HIV transmission; Mongolia in October 2006 on universal access in low-prevalence countries; Kuala Lumpur, Malaysia, in November 2006 on reproductive health and maternal health service activities in relation to sexually transmitted infections and prevention of mother-to-child transmission; and Manila, the Philippines, in December 2006 on the supply and management of antiretroviral drugs. The Regional Office was finalizing a strategic document on the implementation of universal access to treatment in all the Member States of the Region.

In the absence of further comments the CHAIRPERSON requested the Rapporteurs to prepare an appropriate draft resolution.

2. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolutions.

2.1 Noncommunicable disease prevention and control

(Document WPR/RC57/Conf. Paper No. 4)

Decision: The draft resolution was adopted (see resolution WPR/RC57.R4).

2.2 Regional Strategy to Reduce Alcohol-related Harm

(Document WPR/RC57/Conf. Paper No. 5)

Decision: The draft resolution was adopted (see resolution WPR/RC57.R5).

2.3 Prevention and control of tuberculosis, including the Strategic Plan to Stop TB in the Western Pacific 2006-2010

(Document WPR/RC57/Conf. Paper No. 6)

Decision: The draft resolution was adopted (see resolution WPR/RC57.R6).

3. PROGRAMME UPDATES: MEASLES ELIMINATION, HEPATITIS B CONTROL AND POLIOMYELITIS ERADICATION, TOBACCO CONTROL, MENTAL HEALTH, INCLUDING PATIENT AT THE CENTRE OF CARE INITIATIVE: Item 16 of the Agenda (Documents WPR/RC57/11 and WPR/RC57/11 Corr.1)

The acting REGIONAL DIRECTOR said that updates on four important programmes in the Western Pacific Region had been submitted to the Committee: measles elimination, hepatitis B control and poliomyelitis eradication; tobacco control; mental health, including the Patient at the Centre of Care Initiative; and environmental health.

The decision taken at the fifty-sixth session of the Committee to endorse the twin goals of measles elimination and hepatitis B control by 2012 had provided fresh impetus to programmes in those areas, and immunization services for measles elimination, hepatitis B control and poliomyelitis eradication continued to improve in the Region. However, although the risk of fresh outbreaks was still a serious threat owing to

low routine immunization rates and gaps in surveillance in some parts of the Region, 22 countries and areas had achieved more than 80% coverage for the first dose of measles vaccine for more than five years. Almost all Member States had plans to provide a second opportunity for measles vaccination, either through the introduction of a routine second dose or by conducting periodic supplementary activities.

Twenty-one countries in the Western Pacific Region had reported 80% coverage for more than five years for three doses of hepatitis B vaccine. China and Viet Nam, which accounted for 76% of all births in the Region, had made great progress in hepatitis B control activities, with substantial expansion of birth dose coverage to reduce mother-to-child transmission. For the considerable gains in immunization coverage already made in the Region to be sustained, a strong commitment would be required to address the lack of human resources, sustained funding and political will, the main stumbling blocks to further strengthening and monitoring immunization services.

In the area of tobacco control, all 27 eligible Member States in the Western Pacific Region had become Parties to the WHO Framework Convention on Tobacco Control, making the Western Pacific the only WHO Region with all its eligible Member States Parties to the Convention. Countries in the Western Pacific Region had been major contributors to the success of the first session of the Conference of Parties, from China's leadership as Vice-Chair of the Conference Bureau and Chair of the Western Pacific Group, to Member States such as Australia, New Zealand and Palau, which took leading roles in chairing committees and work groups, as well as drafting documents. The Coordinator of the Special Focus on the Tobacco Free Initiative, would provide a more detailed briefing.

At the fifty-second session of the Regional Committee in 2001, a regional strategy on mental health had been presented. Since then, there had been considerable progress in the Region despite a number of obstacles to ensuring effective mental health services.

Progress had also been made in the Patient at the Centre of Care Initiative, which had been discussed by the Committee at its previous session. The Regional Adviser in Mental Health and Drug Dependence, would speak briefly on mental health, including the Patient at the Centre of Care Initiative.

In the area of environmental health, countries and areas in the Western Pacific Region were facing a variety of environmental health risks that were contributing to an estimated 2.9 million deaths annually. In 2005, the Regional Committee had urged Member States to enhance resources and capacity in environmental health risk assessment and management, strengthen multisectoral coordination, develop national and local action plans, increase health sector input to international environment agreements, and participate actively in regional initiatives on environmental health. The Committee had also requested the Regional Office for the Western Pacific to enhance collaboration with relevant United Nations agencies, regional partners and the Regional Office for South-East Asia to improve environmental health in Asia and the Pacific.

In response to those requests, several countries had convened multisectoral national forums on health and environment, and had initiated the development of national environmental health action plans. Some Member States had undertaken activities to strengthen national capacity in health risk assessment and management of water quality and sanitation, indoor and outdoor air quality, health-care waste, toxic chemicals and climate change. At the regional level, the Regional Office for the Western Pacific had worked in close collaboration with the Regional Office for South-East Asia and the United Nations Environment Programme to convene the Second High-Level Meeting on Environment and Health in ASEAN and East Asian Countries (Bangkok, Thailand, 12-13 December 2005). In the Pacific, WHO had formed partnerships with the South Pacific Applied Geoscience Commission, AusAID, NZAID and the New Zealand Ministry of Health to support the implementation of the Framework for Action on Drinking Water Quality and Health in Pacific Island Countries.

The first Ministerial Regional Forum on Environment and Health, involving ministers and high-level officials of ministries responsible for health and environment from ASEAN and East Asian countries, was planned to be held in early December 2006. All Member States were encouraged to continue increasing resources and capacity to make further progress in the development and implementation of national environmental health action plans, addressing priority issues in their countries.

Besides the two regional advisers already mentioned, the Regional Adviser for the Expanded Programme on Immunization and the Regional Adviser for Healthy Settings and Environment were also available to respond to questions.

The COORDINATOR OF THE SPECIAL FOCUS ON THE TOBACCO FREE INITIATIVE said that, during the past year, the Regional Office had focused on providing optimal support to Member States for implementing the WHO Framework Convention on Tobacco Control. With the direct support of the governments of Japan, New Zealand and the United States of America, the Secretariat had been able to provide technical assistance and funding to countries and areas to build capacity, draft and strengthen legislation, enlarge the evidence base for tobacco control, and help to establish health-promotion foundations. National programme officer posts were being created in several WHO country offices.

Since the adoption of resolution WPR/RC55.R7, which endorsed the regional action plan for the Tobacco Free Initiative, 2005-2009, good progress had been made in control of tobacco use, especially with regard to the Convention. He urged those countries and areas that had not already done so to review, as a matter of urgency, national legislation and programmes in order to determine what was needed to meet the requirements of the Convention, and to take steps to remove obstructions to progress. In particular, Parties had been supported in the four following actions: to prepare work plans for implementing the Convention and setting up sustainable mechanisms for managing and monitoring those plans; to undertake needs assessment for technical assistance and capacity-building for implementing the Convention; to make progress towards meeting the deadlines set by the Convention, especially those for Article 11 (Packaging and labelling of tobacco products) and Article 13 (Tobacco advertising, promotion and sponsorship), due respectively within a period of three and five years after entry into force of the Convention - that meant 2008 and 2010 for the 22 Member States in the Region that were Parties; and to satisfy the conditions of Article 21 (Reporting and exchange of information) - a copy of the pilot reporting questionnaire had been given to each delegation.

The Secretariat would continue to concentrate on supporting rapid and strong implementation of tobacco control measures, working with all Member States, including non-States Parties.

The REGIONAL ADVISER IN MENTAL HEALTH AND DRUG DEPENDENCE thanked Member States for their support, especially the governments of Japan and New Zealand for their continued, generous funding. Pursuant to resolution WPR/RC52.R5 on the Regional Strategy for Mental Health, the Regional Director was submitting a report to the Regional Committee.

The body of information on mental health issues and regional resources was expanding. The mental health situation had been comprehensively analysed in 16 countries in 2002-2003, and needs had been assessed recently in 20 Pacific island countries and areas. Those analyses had also covered the strategies being adopted to tackle mental health disorders. The resulting findings formed the basis for advocacy and the formulation or strengthening of mental health programmes at national level, in particular policies and legislation. Currently 12 countries were drafting, reviewing or consulting on their mental health policies and legislation. Strengthening human resources for mental health programmes had been identified as central to putting all aspects of the strategy into place, and workshops for ASEAN countries and Pacific island countries on developing those resources had been held in 2002 and 2003, respectively. Efforts to follow up the recommendations from those meetings had been continuous, including technical and financial support for the formulation or improvement of psychiatric curricula, workshops for primary-health-care workers, fellowships in mental health leadership, service planning and research.

With regard to the Patient at the Centre of Care Initiative, a draft policy framework was being drawn up following an extensive and broad consultative process in both the Western Pacific and South-East Asia Regions, including a meeting of the reference group of experts (Manila, the Philippines, 4-5 July 2006) and, in the two subsequent months, stakeholder consultations in Thailand and Malaysia. Comments from all those meetings had been incorporated into the current draft of the framework. An advocacy plan would be drawn up to identify activities necessary if the initiative was to make a difference in the way health care was delivered to achieve the desired health outcomes and impact.

The CHAIRPERSON invited comments on measles elimination, hepatitis B control and poliomyelitis eradication.

Dr TSANG (Hong Kong, China) affirmed that Hong Kong (China) was committed to the goals of eliminating measles and controlling hepatitis B by 2012. The incidence of measles in Hong Kong (China) remained above the elimination target of 1 case per 1 million population, yet immunization coverage with two doses of MMR vaccine was high. A recent serological survey showed that more than 96% of the population older than 1 year of age carried antibodies to measles virus. The greatest challenge to meeting the target was implementing case-based surveillance of acute fever and rash.

Dr GRANGEON (France) said that his delegation endorsed the actions of the Regional Office with respect to the Expanded Programme on Immunization. In New Caledonia, the well-established immunization programme was based on a regulation that made immunization compulsory, particularly for school-aged children. The provision of information to parents had been strengthened to ensure the acceptability of the obligation, and refusals were exceptional. The fact that all immunizations were free of charge ensured universal coverage. The programme, which had received substantial financial assistance from public funds, had resulted in elimination of the diseases targeted in the programme. A survey of immunization coverage carried out several months previously among children aged seven years had shown 99.8% coverage with BCG vaccine at birth; 100% coverage at first immunization with diphtheria-tetanus-pertussis, poliomyelitis and *Haemophilus influenzae* type B vaccines and 98% coverage with the first booster dose; and 97.8% coverage with immunization against hepatitis B vaccine at birth. Those results were probably due to the policy of compulsory immunization in New Caledonia. The immunization policy in French Polynesia, where immunization was also compulsory and free, was equally effective. Thus, immunization coverage was virtually 100% among infants and children and 98%-99% for the rest of the population.

Dr PITAKAKA (Solomon Islands) said that his country still needed outside support to promote and implement its Expanded Programme on Immunization. A recent "pulse" immunization campaign had increased the immunization rate against measles from 72% to 96% within three months, which was an encouraging sign that Solomon Islands might meet its goal of eliminating measles. It also reflected the strong partnership between the Government and AusAID, NZAID, WHO, UNICEF and the Japan International Cooperation Agency. Immunization coverage with hepatitis B vaccine was 80% for both the first and second doses; coverage with a third dose was lower, reflecting the difficulty that health workers had in reaching local communities. Coverage with oral poliomyelitis vaccine was 80%, and no case of acute flaccid paralysis had been reported in the past 12 months.

Dr TRAN THANH DUONG (Viet Nam) said that his delegation fully concurred with the actions proposed for measles elimination, hepatitis B control and poliomyelitis eradication. Stringent surveillance of acute flaccid paralysis had been maintained. Although 469 cases had been detected in 2005, none had been due to wild-type virus. More than 90% of infants had received doses of oral poliomyelitis vaccine, and children under five years in 32 high-risk provinces had received two doses of oral vaccine in

November 2005 and early 2006. With regard to immunization against hepatitis B, more than 90% of infants had received three doses of vaccine in 2004-2005, and the rate of immunization at birth had increased from 59.5% in 2004 to 62% in 2005. The Global Alliance for Vaccines and Immunization had provided valuable support for the expansion of hepatitis B immunization over the past three years. Progress was also being made in reaching the goal of measles elimination by 2010. In 2005, immunization coverage of infants had been more than 90%. A pilot study of giving a second dose of measles vaccine to children starting school had been conducted in two provinces, before its introduction nationwide. Measles surveillance and serosurveillance at national reference laboratories had been strengthened. In 2005, there had been 410 cases of measles, which had achieved the 2005 target of fewer than 1200 cases.

Dr LAM (Macao, China) recalled a serious outbreak of measles in 1998, with several hundred cases. Vaccination had been introduced and since 2003 no case of measles had been reported. On the advice of WHO, the measles vaccination schedule had been changed and surveillance for individual cases had been strengthened. All such cases were investigated. Serological surveillance had detected no case acquired locally. In the current year, two imported cases had been detected, but in neither instance was there any further transmission.

A comprehensive vaccination programme against hepatitis B had been introduced in 1989, and in 2003 the carriage rate of hepatitis B virus surface antigen had been reduced to less than 1%.

Dr KONG (China) welcomed the progress reports. In order to attain the goal of eliminating measles by 2012, China had introduced its own strategy, which comprised compulsory routine vaccination and surveillance of suspect cases. Substantial progress had been made in China against hepatitis B, with hepatitis B vaccination incorporated into the children's immunization programme. With regard to poliomyelitis eradication, in order to prevent importation of wild-type virus, China had maintained sensitive surveillance of acute flaccid paralysis.

She assured the Committee that China would honour its commitments with a positive response to the Secretariat's appeal regarding those three diseases.

Dr YANG (Republic of Korea) said that, within the measles elimination plan in his country, measles immunization coverage was being maintained and

the case incidence rate was close to the elimination level. The country planned to declare elimination of measles in November 2006, in the presence of experts at home and abroad. A programme to reduce hepatitis B transmission was under way, and efforts were being made to attain the WHO strategic goal of reducing the seroprevalence of hepatitis B surface antigen in children under five to less than 2%. With regard to poliomyelitis, the Republic of Korea would maintain surveillance of acute flaccid paralysis until global eradication had been achieved and would maintain the current level of immunization coverage until WHO decided that it was no longer necessary.

Dr ABDUL WAHAB (Malaysia) said that the Ministry of Health in his country had decided to expand the programme for immunization against hepatitis B to schoolchildren who had been born before introduction of the vaccine in 1989. Those children, who were now over 16 years old, were in the age group at risk of infection due to lifestyle. Furthermore, the group was still easy to reach, as they were in educational establishments.

Dr NDOMBI (representative of the United Nations Children's Fund in Papua New Guinea) said that his organization supported the actions proposed by the Regional Office and urged Member States to support the related resolutions. He commented on immunization and environmental health.

UNICEF encouraged Member States to strengthen actions to meet the goals of measles elimination, hepatitis B control and maintenance of poliomyelitis-free status by 2012. In order to do so, monitoring and surveillance must be intensified and special efforts made to reach unserved populations. He urged WHO to increase support for quality control assurance in order to ensure that surveillance and monitoring met the minimum standards required.

With respect to environmental health, although the Region was broadly on track to achieve the Millennium Development Goal of reducing by one half the proportion of people without sustainable access to safe drinking water and sanitation, a number of countries would not meet that target. Furthermore, even if the target were reached, millions of children who had not been reached would continue to die as a result of diarrhoeal disease. A number of lessons had been learnt that might lead to faster, more effective implementation:

- Changes in hygiene behaviour were a key factor in improving health, and effective communication was needed to achieve that end.
- Sustainability depended on decentralization of authority, resources and expertise, with adequate central support.
- An enabling environment and adequate funding were prerequisites for meeting the goals.
- Partners should work within national frameworks and plans.
- Reaching the poor and addressing gender inequity were priorities and required specific strategies.
- Effective targeting of activities required solid, disaggregated information.
- Intersectoral approaches maximized the impact of programmes.
- Water quality was a key area for monitoring.
- Preparedness and coordination were necessary, especially in emergency situations.
- Water security required good management and equitable distribution.

Countries with poor water and sanitation coverage were encouraged to adopt a balanced strategy based on interventions to increase water safety and sanitation in all structures, including schools and health facilities; to promote behavioural change; and to create an enabling policy and institutional environment. Improved water and sanitation alone were not enough to affect health significantly; however, hygiene could not be promoted effectively in the absence of convenient, safe water and sanitation. Policies, institutions and decentralized capacity to support and sustain the management of hygiene, water and sanitation were essential to ensure long-term success. He therefore asked Member States to consider a comprehensive strategic approach to improving environmental health.

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

The REGIONAL ADVISER, EXPANDED PROGRAMME ON IMMUNIZATION, thanked the representatives for their comments and for sharing their experiences and future plans. Progress had been made in implementation of the major

strategies for achieving the twin regional goals by 2012 and the Region was now moving towards the implementation stage of increasing immunization coverage and improving disease surveillance systems, including technical support to strengthen laboratory capacities within countries.

He acknowledged the hard work of the Member States and the support of partner agencies. WHO would work harder to provide technical support and mobilize financial resources for Member States through partnerships.

The CHAIRPERSON invited comments on tobacco control.

Dr BLOOMFIELD (New Zealand) said his country remained strongly committed to reducing the burden of tobacco-related diseases nationally, regionally and globally. New Zealand continued to implement measures that went beyond the requirements of the Framework Convention on Tobacco Control (FCTC): legislation to ban smoking in all indoor workplaces, introduced in 2004, had been highly successful; 82% of New Zealanders supported that legislation, including 64% of smokers.

He was pleased to support ongoing FCTC activities, working with Ireland and Finland to develop guidelines to protect people from exposure to tobacco smoke, in accordance with article 8 of the FCTC, and hosting a WHO workshop on indigenous people and tobacco control later in 2006.

Dr KWONG (Hong Kong, China) congratulated WHO on the success of the FCTC, which Hong Kong (China) fully supported. Although smoking was still the single largest preventable cause of death in Hong Kong (China), a host of measures over the past decade, including legislation, high tobacco taxes, public awareness campaigns and smoking cessation programmes, had contributed to the lowering of smoking prevalence from over 80% in the early 1980s to 14% in 2005. That prevalence was relatively low among the countries of the Western Pacific Region.

Legislation played an important role in the overall strategy, in particular to protect the public from second-hand smoke. The Smoking Public Health Ordinance, first enacted in 1982, restricted the use, sale and promotion of tobacco products. It was further strengthened to ban smoking in workplaces and restaurants, with an amendment submitted to the legislature in 2005 to expand the restriction on smoking in certain public areas, including entertainment venues, schools, hospitals and outdoor areas such as children's playgrounds, beaches and parks. Other amendments included the introduction of health warnings on tobacco products and giving

the Department of Health tobacco control inspectors with powers to enforce compliance.

A multisectoral approach was being taken to health promotion, enlisting support from nongovernmental organizations and local advocates to provide information to the public on the hazards of tobacco and the importance of legislation. There had been significant community support for expanding the statutory no-smoking areas.

Dr LEPANI (Fiji) recalled that Fiji had been the third country in the world to ratify the FCTC, and was facing mounting and ongoing pressure to implement the Convention and formulate national legislation. The capacity of the Ministry of Health to enforce legislation needed to be reviewed, however, and WHO and international partner assistance was requested for that purpose.

He thanked WHO for its support on tobacco control, including the awarding of the World No Tobacco Award to Nabila Village, Fiji, which had been a smoke-free village for over 10 years. He also acknowledged the contribution and support of the Secretariat of the Pacific Community for its work on tobacco control.

Dr VILLAVARDE (the Philippines) agreed with the major points of the programme update. The greatest challenge was to convince countries that the public health costs of tobacco use more than offset tobacco industry profits and government revenues from tobacco taxation. Governments should be guided by the FCTC provisions and the Tobacco Free Initiative Regional Action Plan (2005-2009).

His country was currently implementing a comprehensive tobacco regulation law. A new law had also been enacted to increase taxes on tobacco and alcohol: 5% of those taxes would be used for health promotion and social health insurance coverage for the poor. Those measures would ultimately help reduce the threat to public health caused by tobacco use.

Ms HEFFORD (Australia) reminded the Committee that, at the first session of the Conference of the Parties, Australia had agreed to chair a small working group to develop a framework for Member States to use in reporting on implementation of the Convention, and also had also undertaken additional work to develop guidelines on how that reporting document could be used. That had been completed, with a number of countries being

consulted in the process, and the guidelines had been forwarded to WHO Headquarters and to the Regional Office.

She wondered when the final version of the reporting document would be available, as those countries that had ratified the Framework Convention early would be required to submit their first reports in February 2007 and they would need sufficient time to fulfil the requirements.

Dr DING (China) congratulated the Secretariat on the excellently prepared document and expressed his support for the Tobacco-free Initiative.

In August 2005, China had become the 89th country to ratify the FCTC and government representatives from various ministries had participated in the first session of the Conference of Parties. Those ministries had established working mechanisms, and had held workshops and training sessions in all 31 provinces to set up a network to implement the FCTC. In September 2004, the Beijing Olympic Organizing Committee and six other cities had held workshops on a tobacco-free Olympics in 2008.

To promote smoke-free values, China considered the following should be included in the regional initiative:

- different country contexts and the promotion of country-level capacity;
- strategic cooperation and regionally integrated action and collaboration with other international organizations;
- further training on policy and technological guidance on emerging problems in implementing the FCTC, for example, how to manage products to help people quit smoking, and timely technical assistance from WHO; and
- award mechanisms to promote more agencies, NGOs and individuals to take part in work to encourage people to stop smoking and to promote sustainable tobacco control.

Dr YANG (Republic of Korea) stated that the FCTC provided important guidance on strengthening policies and programmes on tobacco control. His country had made substantial progress in implementing the FCTC provisions. Smoking prevalence in the Republic of Korea had dropped from 57.8% in 2004 to 47.5% in June 2006, which was a drastic decrease compared with the 1% drop in the 25 years prior to 2004. The Republic of Korea would continue to

expend every effort to meet the requirements of the FCTC and to lower smoking prevalence to 30% by 2010.

Ms GIDLOW (Samoa) said that her country had ratified the Convention only after consultation and much examination of the issue of the obligations and responsibilities associated with ratification of international treaties. Samoa's health sector had learnt from the experiences of focal points for other conventions that the country had ratified, recognizing the links in principles and mandates. More needed to be done to orient reporting obligations after entry into force. Countries needed to understand the essence of those obligations; it was not just for WHO reports but had to mean something to the countries themselves in terms of why they had ratified the Convention and the benefits they could expect.

She called for better links between international organizations driving different international conventions so as to facilitate complementarity at international and regional levels to guarantee positive spillover at the country level. She argued for properly facilitated country ownership, which should be enhanced as part of the work to implement the Framework Convention. The tobacco industry was targeting the health sector, using lessons learnt from its clashes with health advocates in developed countries. She called for help to counter the threat from that industry.

Dr AKE (Tonga) said that his country had been working hard on tobacco control. A tax on tobacco had been introduced in 2003 and, within two years, had resulted in an impressive 20-ton reduction in tobacco imports. At the same time, revenues had increased by US\$ 7 million. That achievement stood in marked contrast to previous years, during which health-education activities had had no effect. In 2005, the effects of taxation appeared to have slipped, and the tax was being reviewed.

The Tobacco Act had been passed into law in 2000. The Government had subsequently taken a tobacco company to court but had not been able to prove that the defendants' cigarettes were derived from *Nicotiana tobaccum*, as stated in the Act. The Government had lost the case and was working to amend the Act.

At the invitation of the Chairperson, a representative of the Asian Medical Students' Association addressed the Committee.

The REGIONAL COORDINATOR ON THE TOBACCO FREE INITIATIVE noted that the country activities which had been reported were best practices in tobacco

control. The pilot questionnaire and guidelines were to be distributed by WHO Headquarters within the next three weeks. The ratification by all eligible Member States in the Region showed the highest political commitment, and placed a special onus on the Regional Office to support the work of countries, which would require considerably more effort and resources. He hoped that the Regional Office would be able to respond to all requests for technical assistance and guidance, in the interests of rapid implementation of the treaty.

The CHAIRPERSON invited comments on mental health, including the Patient at the Centre of Care Initiative.

Ms IMAI (Japan) observed that, while mental health placed great physical and mental burdens on populations, it was not often discussed or dealt with. She therefore appreciated its inclusion on the agenda as an important topic. In Japan there was a policy to change ways of thinking about mental illness, moving from hospital to community-based care. Numerical targets had been set, and the system was being reformed and strengthened. Mental health was an important issue in the Region, and Japan was ready to share its experience with other countries.

Dr ARIFFIN BIN OMAR (Malaysia) reported that mental health services had undergone major changes in his country, shifting from institutional to primary health and community care, with treatment in peripheral hospitals for acute and selected cases. The strategy was intended to reduce the number of beds in mental health institutions and increase the number in peripheral hospitals. There were now 763 health clinics providing follow-up for stable cases of mental illness. Rehabilitation services were imparting better living skills to patients and were reducing social stigma. Family support groups were being set up. The Healthy Lifestyle Campaign was promoting good mental health, and was providing the public with knowledge and skills in stress and anger management. A pilot programme called "Healthy Minds" had been set up in certain health clinics.

Dr JACOBS (New Zealand) spoke of the funding being provided by New Zealand for two mental health projects to be undertaken by the Pacific Region Mental Health Network: development of clinical guidelines for best practice in mental health and in mental health competencies, and human-rights-oriented mental health legislation. The "Patient at the Centre of Care" initiative was particularly welcomed.

Mr VILLAGOMEZ (United States of America) suggested that Member States and the Regional Office should focus on the people-centred or patient-centred part of the Initiative, rather than on the so-called rights-based component. That would help to reduce stigma through education. He held that the Region needed a more comprehensive approach to mental health care, including behavioural health. He would submit other suggested changes in writing.

Dr LO (Cambodia) spoke of the mental health programme that had begun in 1992, with assistance from NORAID (Norway), the International Organization on Migration and WHO, along with other agencies. Progress achieved included the training of twenty psychiatrists, who had completed a three-year residency, 40 psychiatric nurses with 18 months' training, and 254 nurses and 269 doctors with basic training in mental health.

Mental health service delivery now featured in the minimum package of activities at 35 of the 976 health centres in the country, and in the complementary package of activities at referral hospitals. Twenty-five outpatient departments and two mental health wards had been set up at referral hospitals. One psychosocial rehabilitation centre had been established.

A technical working group on mental health had been set up for Cambodia, providing strategic guidance and setting priorities. In spite of progress, there were problems, especially in remote facilities. Work had commenced on a Mental Health Strategic Plan for 2007-2010. The assistance of WHO was highly appreciated.

Dr VILLAVERDE (the Philippines) fully supported the policy framework on people-centred health along with the four domains for policy action: better informed and empowered individuals, families and communities; competent and responsive health practitioners; more effective health service organizations; more supportive health systems. It was time to put people and their needs at the centre of health care. The Philippines would appreciate joining the consultation process, especially in order to harmonize the initiative with ongoing reforms of the Philippine health service.

Dr KONG (China) said that the Chinese delegation had studied the update and felt it would improve dignity and help to re-integrate patients in the community. That reflected the "people first" principle of health care. China also noticed that the proposed policy framework spanned four

domains. Those policy domains were very important, but were not sufficient to achieve the stated goals. Great attention should be paid to factors beyond health systems, taking steps to provide multisectoral participation, and developing supportive environments. China would once again step up its commitment to mental health work in the pursuit of those goals.

Dr YANG (Republic of Korea) said that, in response to rising suicide rates, the Republic of Korea had formulated a five-year prevention plan in 2004; implementation of detailed provisions had begun in 2005. Young adults were an important target of programme activities, which included media campaigns, a youth mental health programme and fostering of peer leaders. It was hoped that the Regional Office's patient-centred care initiative would enhance ethical practices. However, health care systems varied widely across the Region and country consultations would therefore be essential for successful implementation. The Republic of Korea would like to follow the example of Malaysia and Thailand, which had already conducted such consultations.

The REGIONAL ADVISER ON MENTAL HEALTH AND DRUG DEPENDENCE, thanking representatives for their comments, said that it was most encouraging to hear of the progress made by Cambodia which, like many developing countries, had very limited resources. WHO clearly needed to work closely with Member States to move mental health up the agenda not only of health but also of general development. He welcomed the support expressed for the Patient at the Centre of Care Initiative, which reflected one of the three major goals of the regional mental health programme: to contribute to improvement of overall health through integration of the mental health care component in health care services.

The CHAIRPERSON invited comments on environmental health.

Ms IMAI (Japan) expressed appreciation for WHO's efforts to enhance collaboration with other international, regional and national organizations in its activities at national and regional levels in response to the decisions taken at the fifty-sixth session of the Regional Committee in 2005. In collaboration with WHO, Japan, through the Japan International Cooperation Agency and the Japan International Corporation of Welfare Services, had held seminars on water supply management with a view to providing support for improvements in management of water quality and supply in countries in South-East Asia. It had also supported the activities on water supply, including workshops, organized by the Operation

and Maintenance Network and coordinated by the Japan National Institute of Public Health. Japan would continue that support and hoped that WHO would continue to take the lead in the area of environmental health.

Dr YANG (Republic of Korea) said that his country would participate actively in the various regional initiatives on environmental health, including the Regional Forum on Environment and Health. Member States and WHO should strengthen their collaboration in respect of transboundary environmental health hazards such as air pollution, yellow dust and acid rain.

The REGIONAL ADVISER ON HEALTHY SETTINGS AND THE ENVIRONMENT said that, as mentioned by previous speakers, cooperation with other partners was of great importance in the area of environmental health. WHO would continue to strengthen collaboration at the international and regional levels and would encourage ministries of health to work with other sectors, including ministries concerned with the environment. He acknowledged the valuable contributions made by a number of Member States, including Australia, Japan, New Zealand, the Republic of Korea and the United States of America, without which the progress made in environmental health would not have been possible.

The meeting rose at 16:50.