REGIONAL COMMITTEE FOR THE WESTERN PACIFIC
SIXTY-SECOND SESSION
Manila, Philippines
10–13 October 2011

FINAL REPORT OF THE REGIONAL COMMITTEE

Manila
December 2011
The sixty-second session of the Regional Committee for the Western Pacific was held in Manila, Philippines, from 10 to 13 October 2011. Pehin Dato Adanan Yusof (Brunei Darussalam) and Dr Ren Minghui (China) were elected Chairperson and Vice-Chairperson, respectively. Ms Palanitina Tupuimatagi Toelupe (Samoa) and Dr Sok Touch (Cambodia) were elected Rapporteurs.

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I. INTRODUCTION

The sixty-second session of the Regional Committee for the Western Pacific was held at the WHO Regional Office for the Western Pacific, Manila, Philippines from 10 to 13 October 2011.

The session was attended by representatives of Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, Hong Kong (China), Japan, Kiribati, the Lao People’s Democratic Republic, Macao (China), Malaysia, the Marshall Islands, the Federated States of Micronesia, Mongolia, Nauru, New Zealand, Niue, Palau, Papua New Guinea, the Philippines, the Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu and Viet Nam, and by representatives of France and the United States of America as Member States responsible for areas in the Region; representatives from the Asian Development Bank, the Joint United Nations Programme on HIV/AIDS, and the Secretariat of the Pacific Community; representatives of 15 nongovernmental organizations; and observers from the Asian Medical Students’ Association, the Korea Foundation for International Healthcare–Dr Jong Wook-Lee Memorial Fund.

The resolutions adopted and decisions taken by the Regional Committee are set out below in Part II. Part III contains the report of the plenary meetings. The agenda and the list of participants are contained in Annexes 1 and 2.

During the opening of the session, a plaque was unveiled to mark the inauguration of the renovated Conference Hall at the Regional Office. There was also a short ceremony to open the WHO Art Gallery housed in the facility. The Ayala Foundation and the Ayala Museum were acknowledged for providing works of contemporary art in the Philippines for the opening temporary exhibition. A permanent exhibition on the theme of "Healing and Caring" would be developed in due course. Several Member States had already responded to the invitation to donate works of art.

II. RESOLUTIONS ADOPTED AND DECISION MADE BY THE REGIONAL COMMITTEE

WPR/RC62.R1 PROPOSED PROGRAMME BUDGET 2012–2013

The Regional Committee,

Acknowledging the proposed Programme Budget 2012–2013 for the Western Pacific Region, prepared according to the principles of results-based budgeting and with the inclusion of cross-cutting strategic objectives, regional expected results and measurable regional indicators;

Recognizing the continuing efforts to present a more focused Programme Budget aligned with the longer term strategic vision covering three bienniums as articulated in the Medium-term Strategic Plan (2008–2013) and national priorities as elaborated in the Country Strategic Frameworks,

1. ENDORSES the Programme Budget 2012–2013 for the Western Pacific Region;

2. REQUESTS the Regional Director to review and revise, as necessary, the budget allocations to countries and areas and the intercountry programmes by strategic objectives and regional expected

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results, based on the review of the Regional Committee and the detailed operational plans, which have been developed with respective countries and areas, prior to implementation;

3. NOTES the Programme Budget for the Western Pacific Region is to be financed by assessed contributions and voluntary contributions to the extent that the latter becomes available;

4. REQUESTS the Regional Director to make every effort to implement the Programme Budget 2012–2013 for the Western Pacific Region in close collaboration with Member States.

Fifth meeting, 12 October 2011

WPR/RC62.R2 EXPANDING AND INTENSIFYING NONCOMMUNICABLE DISEASE PREVENTION AND CONTROL

The Regional Committee,

Recognizing that noncommunicable diseases (NCDs) and their main risk factors are responsible for an estimated 30,000 deaths every day in the Western Pacific Region and constitute one of the critical challenges for development in the 21st century;

Further recognizing that NCDs are a threat to the economies of many Member States and likely to increase inequalities among countries and populations;

Acknowledging that the prevention and control of NCDs and their risk factors have a positive impact not only on health, but also on productivity and economic and social development;

Noting the progress made in the implementation of the Western Pacific Regional Action Plan for Noncommunicable Diseases, endorsed in 2008 at the fifty-ninth session of the Regional Committee for the Western Pacific;

Recalling the Seoul Declaration and Honiara Communiqué on NCD prevention and control (2011);

Reaffirming the September 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases;

Noting that the United Nations General Assembly Political Declaration recognized the leading role of the World Health Organization as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate;

Further noting that the United Nations General Assembly Political Declaration reaffirmed the World Health Organization's leadership and coordination role in promoting and monitoring global action against noncommunicable diseases in relation to the work of other relevant United Nations agencies, development banks, and other regional and international organizations in addressing noncommunicable diseases in a coordinated manner;

Reiterating the role of governments in ensuring political commitment and leadership, as well as human and financial resources for NCD prevention and control, including multisectoral national policies and plans;
Emphasizing the essential roles of development partners, civil society, professional organizations, academia, industry and the private sector in ensuring effective NCD prevention and control;

Recognizing that women's and children's health is inextricably linked with NCDs, and strategies to address NCDs need to be integrated with the global maternal, neonatal and child health agenda,

1. URGES Member States to fulfil urgently commitments made in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases;

2. REQUESTS the Regional Director:

   (1) to work with development partners to develop strategies for sufficient resources and to provide technical assistance and capacity-building in NCD prevention and control;

   (2) to develop mechanisms for sustained engagement with key partners and stakeholders for regional coordination, exchange and advocacy for NCD prevention and control;

   (3) to develop by 2013, in consultation with Member States and in collaboration with partners and stakeholders, a regional action plan for the period 2014–2018, that is integrated into the global monitoring framework and is consistent with voluntary global targets and indicators to be developed by WHO by the end of 2012;

   (4) to report periodically to the Regional Committee on the progress achieved in prevention and control of NCDs.

Fifth meeting, 12 October 2011

WPR/RC62.R3 ANTIMICROBIAL RESISTANCE

The Regional Committee,

Recalling resolutions WPR/RC53.R5 on Antimicrobial Resistance, WHA51.17 on Emerging and other communicable diseases, WPR/RC61.R4 on the Regional Strategy to Stop Tuberculosis in the Western Pacific (2011–2015), and WHA64.17 on Malaria, which recommended effective actions to combat antimicrobial resistance;

Recognizing that combating antimicrobial resistance remains an important global public health challenge that has not been fully addressed;

Further recognizing that the irrational use and inadequate management of antimicrobial medicines contribute to the development of resistance;

Acknowledging that multidrug-resistant microbes put patients at risk for serious and prolonged illness, which can lead to increased health care costs;

Mindful of the need to strengthen laboratory capacity, infection control and surveillance;

Affirming that the WHO Global Strategy for Containment of Antimicrobial Resistance provides a rational context for the development of regional and national action;
Noting that the WHO Director-General's Policy Package to Combat Antimicrobial Resistance can help governments pursue multisectoral strategies to combat drug resistance,

1. ENDORSES the Director-General's Policy Package to Combat Antimicrobial Resistance;

2. URGES Member States:
   (1) to take urgent steps to address the issues and challenges of antimicrobial resistance;
   (2) to use the Policy Package, as appropriate;
   (3) to develop and implement comprehensive and effective national and subnational plans for preventing and controlling antimicrobial resistance, as appropriate;

3. REQUESTS the Regional Director:
   (1) to take urgent steps to address the issues and challenges of antimicrobial resistance;
   (2) to provide technical cooperation to Member States upon request to prevent and control antimicrobial resistance and its consequences;
   (3) to monitor and assess the antimicrobial resistance situation across the Region and report regularly thereon.

Seventh meeting, 13 October 2011

WPR/RC62.R4 TRADITIONAL MEDICINE

The Regional Committee,

Acknowledging that traditional medicine is widely used in the Western Pacific Region;

Recognizing the wide diversity of traditional medicine in the Region, the different levels of development of traditional medicine, and the varying extent to which traditional medicine is included in national health systems;

Giving due consideration to the Beijing Declaration, adopted by the WHO Congress on Traditional Medicine, November 2008, and specific actions related to traditional medicine in the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (WHA61.21);

Acknowledging the progress that many Member States have achieved in legislation, regulation, national policy development, training, research and standardization of traditional medicine in the Region since the publication of the first Regional Strategy for Traditional Medicine in the Western Pacific, covering the period 2001 to 2010;

Respecting each Member State’s obligations to its own national capacities, priorities, relevant legislation and circumstances;

Taking note of relevant WHO guidelines related to safety monitoring of traditional medicines and other consumer protections;
Having considered the draft Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020),

1. ENDORSES the Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020);

2. URGES Member States:

   (1) to use, where appropriate, the Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020) as a framework for the development of national traditional medicine programmes, in accordance with national circumstances, including relevant legislation;

   (2) to strengthen the evidence base for traditional medicine and promote its safe and effective use;

   (3) to consider including traditional medicine in their national health systems, as appropriate;

   (4) to facilitate dialogue and cooperation among practitioners of traditional medicine and Western medicine;

   (5) to strengthen cooperation with Member States, particularly in the areas of information sharing, research, and regulatory standards for practice and products, consistent with national legislation and relevant international obligations;

3. REQUESTS the Regional Director:

   (1) to support Member States and collaborate with stakeholders in supporting implementation of the Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020);

   (2) to report to the Regional Committee regularly on the implementation of the Strategy.

Seventh meeting, 13 October 2011


The Regional Committee,

Recalling resolutions WHA53.15, which requested the Director-General to give greater emphasis to food safety; WPR/RC52.R2 on the Western Pacific Regional Strategy for Food Safety; WPR/RC55.R6 on the importance of multisectoral collaboration and sharing food safety information among Member States; and WHA63.3, which confirmed foodborne diseases as a serious threat and included a series of food safety initiatives;

Acknowledging that the increase in international trade in food and in international travel may impact food safety;
Recognizing the importance of new developments that, in part, address food safety issues, including the International Health Regulations (2005) and the Asia Pacific Strategy for Emerging Diseases (2010);

Recognizing the importance and value of a common framework for effective planning and coordination of various capacity-building activities at both national and regional levels;

Having reviewed the draft Western Pacific Regional Food Safety Strategy (2011–2015),

1. ENDORSES the Western Pacific Regional Food Safety Strategy (2011–2015);

2. URGES Member States:

   (1) to use the Western Pacific Regional Food Safety Strategy (2011–2015) as a framework for the strengthening of national food control systems to effectively protect public health, prevent fraud, avoid food adulteration, and facilitate safe and healthy food;

   (2) to strengthen or sustain, as appropriate, human and financial resources to facilitate the implementation of such systems;

   (3) to collaborate with other countries and areas to share information and experiences related to the development and implementation of national food control systems;

   (4) to participate in the International Food Safety Authorities Network (INFOSAN) and Codex Alimentarius Commission in an effort to improve regional and global health security;

3. REQUESTS the Regional Director:

   (1) to support Member States in capacity-building and in strengthening national food control systems based on the Western Pacific Regional Food Safety Strategy (2011–2015);

   (2) to advocate and disseminate the Western Pacific Regional Food Safety Strategy (2011–2015) to partner agencies to mobilize, coordinate and harmonize partner support in strengthening of national food control systems;

   (3) to enhance collaboration with partners to establish a food safety cooperation working group, as described in the Western Pacific Regional Food Safety Strategy (2011–2015);

   (4) to report to the Regional Committee periodically on the implementation of the Western Pacific Regional Food Safety Strategy (2011–2015).

Seventh meeting, 13 October 2011
The Regional Committee,

1. EXPRESSES its appreciation to the Government of Viet Nam for its offer to host the sixty-third session of the Regional Committee for the Western Pacific in 2012;

2. DECIDES that the sixty-third session will be held in Ha Noi, Viet Nam, provided the necessary agreements are concluded by 31 March 2012;

3. FURTHER DECIDES that the dates of the sixty-third session shall be from 24 to 28 September 2012;

4. CONFIRMS that the sixty-fourth session of the Regional Committee shall be held at the Regional Office in Manila.

Eighth meeting, 13 October 2011

The Regional Committee,

EXPRESSES its appreciation and thanks to:

1. the Chairperson, Vice-Chairperson and the Rapporteurs elected by the Committee;

2. the representatives of the intergovernmental and nongovernmental organizations for their oral and written statements.

Eighth meeting, 13 October 2011

The Regional Committee, noting that the period of tenure of the representative of the Government of Japan as a member of Category 2 of the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction expires on 31 December 2011, selects Viet Nam to nominate a representative to serve on the Policy and Coordination Committee, under Category 2, for a period of three years from 1 January 2012 to 31 December 2014.

(Eighth meeting, 13 October 2011)
III. MEETING REPORT

OPENING OF THE SESSION: Item 1 of the Provisional Agenda

1. The sixty-second session of the Regional Committee for the Western Pacific, held at the WHO Regional Office for the Western Pacific, Manila, the Philippines, from 10 to 13 October 2011, was declared open by the Chairperson of the sixty-first session.

ADDRESS BY THE RETIRING CHAIRPERSON: Item 2 of the Provisional Agenda

2. At the first plenary meeting, the retiring Chairperson addressed the Committee (Annex 4).

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

3. The Committee elected the following officers:

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<tr>
<th>Role</th>
<th>Name</th>
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<tbody>
<tr>
<td>Chairperson</td>
<td>Pehin Dato Adanan Yusof (Brunei Darussalam)</td>
</tr>
<tr>
<td>Vice-Chairperson</td>
<td>Dr Ren Minghui (China)</td>
</tr>
<tr>
<td>Rapporteur (Eng)</td>
<td>Ms Palanitina Tupuimatagi Toelupe (Samoa)</td>
</tr>
<tr>
<td>Rapporteur (Fr)</td>
<td>Dr Sok Touch (Cambodia)</td>
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ADDRESS BY THE INCOMING CHAIRPERSON: Item 4 of the Provisional Agenda

4. The chairperson of the sixty-second session of the Regional Committee addressed the Committee (Annex 5).

ADOPTION OF THE AGENDA: Item 5 of the Provisional Agenda (document WPR/RC62/1 Rev. 2)

5. Attention was drawn to the proposed inclusion of a supplementary agenda item on Emergencies and Disasters.

6. The Agenda was adopted, as amended (Annex 1).

ADDRESS BY THE DIRECTOR-GENERAL: Item 6 of the Agenda

7. The Director-General addressed the Committee. Her full presentation is contained in Annex 6 to this report.

8. In the ensuing discussion, the representative of Australia announced the introduction in January 2012 in her country of plain packaging of tobacco products. That legislative measure was being hotly opposed by the tobacco industry on several fronts. Representatives concurred with the
Director-General that the combined efforts of all relevant government ministries were required to counteract tobacco use.

9. The Regional Committee should consider setting specific targets with regard to noncommunicable diseases, through a regional action plan. WHO was congratulated on its actions to prevent and control major infectious and noncommunicable diseases and on the efficacy of the Framework Convention on Tobacco Control in stopping the spread of tobacco use.

10. One representative drew attention to the close relationship between noncommunicable diseases and ageing and offered to share his Government's experience in formulating health policies on that basis. As noncommunicable diseases were also linked to socioeconomic factors, measures to address the latter were necessary. Attention should be paid to the role of primary health care in combating noncommunicable diseases and the importance of involving other ministries and sectors. The countries of the Region should also cooperate in the fight against emerging infectious diseases.

11. The representative of New Zealand thanked the Director-General for her expression of solidarity with his Government's efforts to recover from the earthquake that had struck his country earlier in the year and expressed appreciation for the inclusion on the agenda of the present session of an item on emergencies and disasters.

12. In response to comments, the Director-General explained that WHO was mandated to set voluntary targets with a monitoring framework to track progress, as outlined in the *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases* (Annex 8). Targets were being formulated at meetings of the WHO Secretariat with experts and at the six regional committee meetings, for submission to the Executive Board and thereafter to the World Health Assembly. WHO had also been asked to convene a task force, including representatives from other United Nations agencies, to ensure intersectoral collaboration on noncommunicable diseases. Mechanisms were needed to bring together civil society, academia and the private sector in the fight against those diseases. Furthermore, governments must act to ensure primary prevention by enacting legislation to mitigate risk factors in a "whole-of-government" approach involving all relevant ministries. The Director-General welcomed a remark discussing the link between ageing and noncommunicable diseases, noting that World Health Day 2012 would be devoted to healthy ageing. She urged Member States to raise the issue of noncommunicable diseases at several important events to be held in the coming two years: the 15th World Conference on Tobacco or Health and the Conference of the Parties to the WHO Framework Convention on Tobacco Control to be hosted by Member States of the Region, and also conferences on the social determinants of health to be held in Brazil and on health promotion to be held in Finland.

**ADDRESS BY AND REPORT OF THE REGIONAL DIRECTOR: Item 7 of the Agenda (Document WPR/RC62/2)**

13. The Regional Director addressed the Committee. His full presentation is contained in Annex 7 to this report.

14. Representatives commended the progress over the previous year, noted the significant challenges remaining, and outlined the progress in various areas in their own countries. The support of WHO and other partners for country activities was acknowledged. Strong health systems and the multisectoral engagement were vital for sustainable national socioeconomic development and good leadership and governance from WHO were crucial. There were calls for greater attention to primary health care and the enhancement of maternal and child health services, in particular access to antenatal care and provision of skilled birth attendants, with a view to attaining the health-related Millennium
Development Goals, especially Goals 4 and 5. Close cooperation between Member States was needed to protect citizens through implementation of the International Health Regulations (2005) and to develop regional strategies for the delivery of services to marginalized populations. It was suggested that WHO should support the development of models for universal social and health insurance. The representative of Mongolia announced that his country had attained the health-related Millennium Development Goals.

15. The recently increased high-level attention at the regional and global level to the prevention and control of noncommunicable diseases was encouraging and the hope was expressed that noncommunicable diseases might be included in the Millennium Development Goals in due course, with global and regional prevention and control targets. Although prevention and control activities appeared to be resource-intensive, resources for deployment at the community level could often be found provided that there was an appropriate strategic framework for action. Noncommunicable diseases had been declared as having become an emergency in the Pacific region.

16. The Healthy Cities and Healthy Islands initiatives had proved effective in influencing the social determinants of health and reducing noncommunicable disease risk factors. The health sector should take a lead in engaging all stakeholders in strong multisectoral agendas to protect air quality, to reduce the harmful use of alcohol, and to develop interventions for surveillance and reduction of injuries and trauma.

17. The Regional Office was commended for its responses to recent disasters in the Region, and for its increased attention to emergency preparedness especially its inclusion on the agenda for the session. Implementation of the International Health Regulations (2005) was an important aspect of emergency response. The representative of New Zealand thanked the Regional Director for his supportive comments with respect to the disasters in New Zealand and Japan and for his visits to those countries following those events.

18. The current global economic uncertainties have a serious impact on resource mobilization, underscoring the need for priority-setting and reforms at all levels. The reform processes within WHO must ensure that the Organization remains effective, continues to play a leading role in global health and retains its capacity to respond to the needs of Member States.

19. The Regional Director commended Member States on the progress they had made over the previous year and assured them that the Regional Office would continue to serve their needs. He looked forward to more detailed discussions later in the session on many of the topics raised.

20. The Director-General explained that since the target date for the Millennium Development Goals was 2015, only four years away, it might be difficult to garner support for the inclusion of noncommunicable diseases in the current set of goals. The United Nations Secretary-General was currently preparing a report on progress towards the goals and thought was being given as to how best to proceed after 2015. Member States were urged to submit suggestions in that regard. The Rio+20 United Nations Conference on Sustainable Development to be held in Rio de Janeiro in June 2012, convened to mark the 20th anniversary of the 1992 United Nations Conference on Environment and Development, would provide another opportunity to ensure that health was on the development agenda. She urged ministers of health to collaborate with other ministers, including ministers of foreign affairs, to ensure a health perspective in all national policies.
PROGRAMME BUDGET 2010-2011: BUDGET PERFORMANCE (INTERIM REPORT):
Item 8 of the Agenda (document WPR/RC62/3)

21. The Director, Programme Management, presented the document describing interim implementation of assessed and voluntary contributions for the biennium 2010–2011 by source of funding, strategic objective and category of expenditure as of 31 May 2011 and also mid term reports on outputs and results. As of 30 September 2011, overall implementation had increased to US$ 227 million, representing 76.3% of the total resources for the period. The overall increase in implementation rates over the previous biennium reflected strengthened regional financial management and improved functioning of the Global Management System.

22. In the ensuing discussion, one representative said that the improved implementation rates reflected more reasonable budgeting and also the Region's support to countries for better planning. Implementation rates for specific strategic objectives were, however, difficult to determine from the document. A number of representatives noted the continued emphasis in the budget on communicable diseases such as AIDS, tuberculosis and malaria, with a gap in funding for maternal and child health. One representative asked whether the funds allocated to noncommunicable diseases and maternal and child health had made a difference in achieving the strategic objectives. Greater emphasis should be placed on meeting the goals necessary for achieving the health-related Millennium Development Goals. A query was made about possible mechanisms for re-prioritizing issues in the work programme.

23. Representatives described the improvements to health in their countries through WHO-supported health promotion, prevention and training. One representative said that concrete benefits in terms of reduced numbers of infections and hospitalizations had been derived from a “building healthy communities and populations” project funded by WHO. A major challenge was reaching populations in remote mountainous areas in order to achieve equity of access to health care throughout the country. WHO support had contributed to technology transfer and capacity-building of health care workers.

24. The Director, Programme Management, responding to comments, said that the increased performance at country level was due to greater reliance on results-based management and working more closely with countries and country offices to plan, monitor and follow up any problems identified. Some of the comments had shown that a difference could be made when more was done at country level, through primary health care, with the cooperation of various international partners.

25. WHO was in complete agreement with Member States that funding allocations were disproportionately focused on communicable diseases; whereas, the important areas of mother and child health and noncommunicable diseases received inadequate funding. Meeting Millennium Development Goals 4 and 5 and Strategic Objective 4 was of highest priority at WHO, but the necessary funds were not available owing to the earmarking of voluntary contributions. Meeting those Goals would require implementation, not only of Strategic Objective 4, but also of Strategic Objectives 9 on nutrition and 10 on health systems strengthening. Re-prioritizing was complex, involving negotiation with WHO headquarters and country offices. It was sometimes possible to reset priorities to meet an emerging public health issue, to respond to a country’s request or need, or by timely reallocation during implementation.

26. Replying to comments that the overall implementation rate disguised wide variation among countries, he said that a newly formed Programme Committee consisting of all the technical directors, the Director of Administration and Finance and the technical staff met each month to review implementation in each budget centre to identify problems and issues. The implementation rate might sometimes be slowed because time was taken to solve complex but important problems, such as
reaching remote populations. He agreed with representatives that Table 4 of the report should be expanded by including the implementation rate for each Strategic Objective. The delays in implementation of certain Strategic Objectives at the end of 2010, shown in Annex 2 of the report and noted by some representatives, had been due to lack of funding or technical competence. Those objectives had now been reached.

27. The Director of Administration and Finance responding to a comment that the category of expenditure that had increased the most was staff costs, explained that the increase was due to a weakening United States dollar and the incremental increases in salaries enshrined in the United Nations system. The number of staff in the Region was the same as at the end of 2009, although implementation had increased. The number of professional staff had been decreased, and greater use of national staff was envisaged.

28. The Regional Director said the imbalance between assessed contributions and voluntary funding was being addressed in the global WHO reform, by clearer prioritization. New internal indicators and targets had been extensively reviewed to make them more realistic, as would be seen in the proposed budget for 2012–2013. Although other regions and WHO headquarters had had to lay off some personnel, the Western Pacific Region had so far been able to maintain its staff. Responding to a question concerning the allocation for the newly established Pacific Technical Support division, he said that the 2012–2013 budget would provide secure funding for personnel both in that division and in the country liaison office in northern Micronesia.

PROPOSED PROGRAMME BUDGET 2012–2013: Item 9 of the Agenda
(Documents WPR/RC62/4 and WPR/RC62/4 Corr.1)

29. The Director, Programme Management, introduced the proposed programme budget for the Region for 2012–2013 (documents WPR/RC62/4 and WPR/RC62/4 Corr.1), the third and last biennial programme budget under the Medium-term Strategic Plan 2008–2013, which had been developed in close collaboration with WHO country offices and WHO headquarters. The Regional Expected Results and the regional Office-specific Expected Results showed some major shifts in emphasis to reflect the evolving global health situation and the closer alignment of WHO priorities with those of Member States. Other improvements included the development of regional Technical Strategic Frameworks and Country Strategic Frameworks, and clearer definition of expected results and indicators. The proposed programme budget was based on realistic rather than aspirational funding expectations; reliance on earmarked voluntary contributions supporting a limited number of specific programmes had contributed to the recent unstable financial situation, a lack of precision in priority-setting and operational difficulties. It was hoped that greater predictability and flexibility in financing could be achieved through dialogue with donors and increased accountability.

30. In the ensuing discussion, representatives welcomed the use of a results-based approach in preparing the proposed programme budget, which should improve transparency and accountability, as well as the rate of implementation. Concern was expressed that the reductions in allocations to some areas could affect the ability of the Regional Office to respond to country needs; priorities should be clarified. The development of country strategic programmes should improve implementation at country level. The increased priority given to Strategic Objectives 3 and 10 was welcomed and there were calls for greater attention to Strategic Objective 7 and strengthening of primary health care services; for continued efforts to achieve targets under Strategic Objective 1; and for acceleration of activities related to attainment of Millennium Development Goals 4 and 5.

31. WHO should broaden the funding base and should explore ways of supporting Member States in seeking funding from donors that had made commitments at the 2009 United Nations Climate
Change Conference for activities to mitigate the health effects of climate change and from the 2010 United Nations General Assembly High-level Meeting to Review Progress towards the Millennium Development Goals, especially with respect to Goals 4 and 5.

32. The representative of the Republic of Korea announced that his Government would make an additional contribution of US$ 4.5 million over the next five years to WHO headquarters and the Regional Office for activities to combat noncommunicable diseases and the expansion of health promotion programmes.

33. The Director, Programme Management, in reply to a request for information on how the WHO reform agenda would be interpreted in the 2012–2013 proposed programme budget, in particular in relation to programmes at country level, how it would be reflected in future programme budgets and how, in the longer term, the final programme budget for the current Medium-term Strategic Plan would feed into the next Medium-term Strategic Plan and future programme budgets, said that the WHO reform process should improve links between the programme budget cycles to provide a longer term perspective in the future. Moreover, the strategic objectives were an arbitrary set of policy directions established by WHO that would evolve in line with changing health situations and would also be more closely linked in future. He agreed that WHO needed a broader funding base and that Member States required support in applying to donors. He stressed that, should further voluntary contributions become available, the Regional Office had the capacity to expand activities, for example in the area of maternal and child health; he reiterated that the proposed programme budget before the Committee reflected realistic funding expectations. In reply to comments on the impact of reductions in allocations on programme delivery, he said that efforts were under way to reduce administration and support costs in a number of ways, including the use of video conferencing and the rationalization of meeting schedules to reduce travel, and to work more closely with countries to ensure careful coordination in seeking better health outcomes.

34. The Director-General, recalling that WHO was required to comply with International Public Sector Accounting Standards, confirmed that programme budget planning and implementation were made more difficult by the lack of predictability in relation to the amount and timing of the receipt of voluntary contributions. Moreover, as a result of the current economic situation, some donors were reducing the amounts promised. So, while a high implementation rate was desirable, it was also important not to incur financial liabilities by proceeding with programme activities in the absence of secure funding. The WHO reform process should strengthen the capacity of WHO country offices to support ministries of health in facilitating contacts with partners and in developing sound national health policies that were more likely to attract donor support. While it was for countries to decide whether and how to interact with the private sector, it was vital to ensure declarations of interest and avoidance of influence on policy decisions. She welcomed the call for emphasis on strengthening primary health care, an area where she had sought renewed vigour since taking office.

35. The Regional Committee considered a draft resolution on the proposed Programme Budget 2012–2013.

36. The resolution was adopted (see resolution WPR/RC62.R1).

**ANTIMICROBIAL RESISTANCE: Item 10 of the Agenda (document WPR/RC62/5)**

37. The Regional Director, introducing the item, described the mounting threat of resistance to antimicrobial agents, which was resulting in rising rates of multidrug-resistant tuberculosis, outbreaks of malaria resistant to artemisinin combination therapy and hospital-acquired infections that were resistant to all but the most toxic, expensive antibiotics. Despite the WHO Global Strategy for
Containment of Antimicrobial Resistance, issued 10 years ago, reckless and inappropriate use of antimicrobial agents had continued. A six-point multisectoral policy package had been issued on World Health Day in April 2011 to combat the global threat, which called for stronger political commitment and government leadership.

38. Representatives welcomed the comprehensive new WHO initiative and the increased visibility of the problem since its presentation as the theme of World Health Day. Countries with a small medical workforce were subjected to pressure from transnational pharmaceutical companies to prescribe branded products when good-quality generic antibiotics could have been used, and antibiotics that were not on countries' essential drugs list were marketed to private practitioners. Furthermore, antibiotics were often prescribed for illnesses that were not caused by bacteria. Community infection protocols should be strengthened through WHO initiatives on laboratory strengthening and syndromic management, with monitoring and evaluation strategies; and national medication guidelines should be updated. Training should be made available in the rational use of medicines, and indicators should be defined to monitor use of antibiotics in the community. The emergence of resistant strains of organisms responsible for sexually transmitted infections should be monitored, especially in small island developing states. Agricultural practices should also be monitored to avoid infection, and the use of hormones and antibiotics in animal feeds should be more closely monitored to prevent antimicrobial resistance.

39. Continuous surveillance and cooperation between Member States were necessary to prevent cross-border passage of antimicrobial resistance, in view of increasing international travel and trade. Nevertheless, the problem was spreading globally, with economic and social consequences. The problem was beyond the control of any one country, and close collaboration with neighbouring countries would be necessary to contain the movement of counterfeit medicines, especially antimalarial agents.

40. The growing ineffectiveness of some common antibiotics indicated that new drugs would have to be developed. WHO should provide more information on scientific evidence for clinical management of diseases caused by microbes and on the causes of antimicrobial resistance.

41. The policy package could be improved by the inclusion of guidance on priority-setting for countries with few resources and by promoting the acquisition of better information on antimicrobial resistance associated with specific diseases. The proposal to establish intersectoral government committees mandated to establish partnerships with stakeholders was questioned, as some countries already had such mechanisms; furthermore, providing a secretariat to support such a committee would require financial and technical resources that many Member States lacked.

42. A statement was made on behalf of the Western Pacific Pharmaceutical Forum of the International Pharmaceutical Federation.

43. The Director, Division of Combating Communicable Diseases, emphasized the importance of strengthening national drug regulatory bodies in order to prevent antimicrobial resistance. A video on resistance to artemisinin, produced in various languages, had been effective in raising awareness. WHO had been collaborating with national regulatory authorities and with Interpol to combat the influx of counterfeit medicines and had been supporting Member States in enacting legislation to ensure that only the public sector could prescribe combination therapy and to combat the use of monotherapy for malaria. In the case of sexually transmitted infections also, the key actions were strengthening national regulatory authorities in order to enforce prescription delivery policies, set standards, design and implement drug resistance surveillance and help countries to develop specific action plans to combat antimicrobial resistance.
44. The Director, Division of Health Sector Development, said that antimicrobial resistance was a threat to all countries, and therefore collaboration was essential to share information and for mutual assistance. He was encouraged to note that most Member States had committees, strengthened surveillance and an action plan. He welcomed the setting of reduction targets in one country and urged other Member States to do likewise. WHO would pay special attention to supporting low-income countries to strengthen their laboratory capacity and surveillance activities. Greater emphasis should be placed on preventing hospital-acquired infections, and clear guidelines should be available on access to medicines and on their use. Education and awareness-raising were needed for both prescribers and communities. Rational use of drugs in animal husbandry was beyond the purview of ministries of health, but cooperation with that sector must be initiated. He agreed with representatives that research was vital to remain ahead of emerging problems in antimicrobial resistance.

45. The Committee considered a draft resolution on antimicrobial resistance. The Rapporteur for the English language read out an amendment that had been proposed by the representative of the United States of America. In operative paragraph 2(3), the words "and subnational" and "as appropriate" would be added, so that the paragraph would read "to develop and implement comprehensive and effective national and subnational plans for preventing and controlling antimicrobial resistance, as appropriate;". The representative of the United States of America explained that the amendments would make the resolution applicable to each country's circumstances and resources.

46. The resolution, as amended, was adopted (see resolution WPR/RC62.R3).

TRADITIONAL MEDICINE: Item 11 of the Agenda (Document WPR/RC62/6)

47. The Director, Programme Management, said that traditional medicine was a part of the culture of the Region and continued to be widely used, contributing to national health care. Since the endorsement by the Regional Committee of the first Regional Strategy for Traditional Medicine in the Western Pacific (2001–2010) in 2001, Member States had made progress on national policy development, legislation, regulation, training, research and the standardization of traditional medicines, and that further opportunities to promote traditional medicine had arisen. WHO had therefore conducted intensive surveys and consultations with experts and Member States in developing the draft Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020), which was set out in document WPR/RC62/6. The draft Strategy advocated further inclusion of traditional medicine in national health systems and promoted access to and the safe and effective use of traditional medicine. It also encouraged the protection and sustainable use of traditional medicine resources and supported greater cooperation in generating and sharing traditional medicine knowledge and skills, while acknowledging the diversity in the development and the role of traditional medicine in the Region. The Regional Committee was requested to review and endorse the draft Strategy.

48. Most representatives endorsed the draft regional strategy and its five strategic objectives, which provided a clear way forward. Progress at the country level included the incorporation of traditional medicine as a component in national health care systems, especially at the primary health care level. Some countries had seen a resurgence in the use of traditional medicine as part of health system reform, while others had seen an increase in coverage of traditional medicine by health insurance schemes. Efforts had also been made to ensure the safety and efficacy of traditional medicines and traditional practices through regulation, legislation and education programmes; to conserve and document information on medicinal plants; to develop sustainable cultivation of medicinal plants and commercial production of traditional medicines; and to protect intellectual property rights. With support from WHO, one Member State had undertaken a research project to ascertain knowledge, attitudes and practices among traditional healers and tuberculosis patients.
Attention was drawn to the potential effects of climate change on medicinal plant habitats. Implementation of the strategy would promote the implementation of World Health Assembly resolution WHA62.13 on traditional medicine, and improve coordination and policy development in that area across the Region. WHO was requested to monitor implementation and report regularly to Member States. The Organization was also requested to intensify its support for research and development, training, provision of guidance on quality control, and dissemination of knowledge about traditional medicine, including guidance on the conservation of medicinal plants.

49. The representative of the United States endorsed the draft strategy in principle and emphasized that it should be grounded in objective scientific data commensurate with the evidence-based standards that guide Western medicine. The draft strategy would therefore be improved by amending it to provide greater emphasis on rational, data-driven integration of health practices and care, drawing on best available options, regardless of their origins. Referring to Strategic Objective 1, she questioned the inclusion of Direction (2), since political advocacy should be undertaken by civil society rather than Member States, and requested the inclusion of the words "as appropriate" at the end of Strategic Action (3). Strategic Objective 2 implied that long-term prescription of traditional medicines provided sufficient evidence to understand therapeutic effectiveness and risk. The text would be strengthened by stressing the need for objective scientific evidence. She requested clarification of the sentence referring to "adoptive context". The term "sponsorship", included in the Direction for Strategic Objective 2, implied mutual responsibilities and contractual obligations and should be deleted. Further, the Direction appeared to lack a strategic action to cover collaboration reflecting the intersectoral nature of research, implementation of good practices and protection of intellectual property rights. Strategic Action (2) under Strategic Objective 3 should be amended by replacing the words "as necessary" with "as appropriate". Each of the directions and strategic actions listed under Strategic Objective 4 should be amended by adding the words "in accordance with national priorities, capacities, relevant legislation and circumstances". While the draft strategy gave sufficient general emphasis to regulation of practitioners, it lacked a reference to the problem of overstated and/or misleading claims, which was crucial to protect the public. Further, although it referred to the education of Western medicine practitioners about traditional medicine, there was no mention of the education of traditional medicine practitioners about research principles and practice, evidence-based practice and multidisciplinary collaboration.

50. One representative, advocating caution given the changing global medico-legal environment, emphasized the need for evidence-based practices, extensive objective trials and meta-analysis of available data. The placebo effect remained a reality. Moreover practitioners should respect the principle of "do no harm".

51. A statement was made on behalf of the International Federation of Medical Students' Associations.

52. The Director, Division of Health Sector Development, welcomed the support expressed for the draft strategy and commended the progress made by many countries and areas. He had taken note of the various requests for WHO action and support.

53. The Director, Programme Management, recalled that the draft strategy had been developed through an extensive consultation process, during which strong support had been expressed for the proposal before the Committee. He acknowledged that the comments made by the representative of the United States of America were relevant and that some of the proposed amendments may strengthen the draft strategy, but added that it may be difficult to reopen negotiations on the text during the current session.
54. The Chairperson said that, following information consultations and in light of the strong support for the draft strategy, the United States had agreed to withdraw its proposed amendments to the draft strategy.

55. The Regional Committee considered a draft resolution on traditional medicine.

56. The Rapporteur for the English language said that the United States of America proposed the insertion of three new preambular paragraphs after the current fourth preambular paragraph, which would read:

"Respecting each Member State’s obligations to its own national capacities, priorities, relevant legislation and circumstances;

"Taking note of relevant WHO guidelines related to safety monitoring of traditional medicines and other consumer protections;

"Noting the role of civil society in the promotion of traditional medicine within any community”.

57. The Committee approved the inclusion of the first and second additional preambular paragraphs. After a brief discussion on the role of civil society in relation to traditional medicine, the representative of the United States agreed to withdraw the third proposed additional preambular paragraph.

58. The Rapporteur for the English language said that the United States had further proposed that paragraph 2(5) should be amended by the addition of the words "consistent with national legislation and relevant international obligations" after the existing text. The Committee approved the amendment to paragraph 2(5).

59. The Regional Committee adopted the resolution, as amended (see resolution WPR/RC62.R4).

FOOD SAFETY: Item 12 of the Agenda (Document WPR/RC62/7)

60. The Regional Director said that foodborne disease continued to be a significant public health problem in both developed and developing countries. Furthermore, foodborne disease did not respect national borders. The draft Western Pacific Regional Food Safety Strategy (2011–2015) reflected the importance of food safety in global health security. It provided a common framework to strengthen national food control systems and to improve collaboration among Member States and partners.

61. Representatives endorsed the draft strategy, which would help countries to ensure safe food within the Region and globally. One country had established a national risk evaluation centre within the Ministry of Health, with a multisectoral board; it was hoped that it would be recognized as a WHO collaborating centre. Another had a comprehensive system in which all agencies with regulatory functions involving food products were linked to ensure synchronization of their activities and policies, with roles and responsibilities defined to ensure the safety of food along the entire food chain.

62. Risk- and science-based approaches to food safety control were described, which included enhancing capacity, handling emergencies and food inspection and providing training. Support was expressed for establishing a food safety working group to strengthen partnerships in the Region in order to maximize outcomes, minimize duplication and improve the efficiency of resource management in food safety activities. Information exchange and sharing should be established,
nationally, regionally and globally. Cooperative planning was to be conducted in Australia with relevant regional and international organizations. WHO was requested to draw up a comprehensive monitoring and evaluation protocol for food safety in the Region. The representative of Fiji invited regional candidates to participate in a new post-graduate training course on food safety, environmental health and disaster risk management offered by the Fiji National University College of Medicine.

63. Appropriate policies and regulations were necessary to ensure food safety, and existing regulatory frameworks might have to be revised in order to implement the proposed strategy. Member States that were heavily reliant on imported food, in particular, should remain vigilant with regard to food safety incidents both locally and elsewhere. One representative described the centre for food safety in her country, which undertook risk assessment, management and communication to ensure food safety and was in close contact with WHO through the International Food Safety Authorities Network (INFOSAN) and by submitting data to the Global Environment Monitoring and Assessment Programme. It had been designated as a WHO collaborating centre for risk analysis of chemicals in food, with responsibility for contributing to capacity-building for food contamination and risk assessment. Member States were encouraged to participate fully in the work of the Codex Alimentarius Commission, which issued food standards, guidelines and related texts, such as codes of practice, within the Joint FAO/WHO Food Standards Programme. Member States should adapt and implement the science-based guidelines and standards, as feasible.

64. Noting that the strategy covered the period 2011–2015, one representative pointed out that it had not yet been finalized and that each country would have to develop and approve a national strategy or action plan to implement it, which would take a year or more. He therefore suggested that the target for implementation be 2020. The plan should include standard measures for the inspection and control of imported and exported foods, so as to avoid duplication of effort. It should also make a stronger link between the regulatory and educational roles of food control authorities. Food safety education and training should be conducted for food businesses involved in incidents of foodborne disease and contamination. Another aspect that should be addressed in the strategy was improved labelling providing nutritional information.

65. One representative said that a first important step was to set up a network between health and food authorities at local, national and regional levels. Similarly, the interface between response plans for food safety incidents and other emergencies should be made clear; the detection of such incidents must be followed up with management of victims by the health sector. The level of alert at the international level should be clear. Collaboration between focal points for INFOSAN and for the International Health Regulations (2005) should be included in section 7 of the draft strategy, under strategic actions. It should be recalled that the International Health Regulations (2005) constituted the main alert network, covering all health institutions and laboratories, while INFOSAN was a system for exchanging information among countries.

66. The Director, Division of Health Security and Emergencies, welcomed the strong support for the draft strategy, which was the result of a wide consultative process. He had noted the calls for greater information-sharing among Member States. INFOSAN and the International Health Regulations (2005) would become more valuable the more they were used by Member States. Many representatives had stressed the importance of coordination with existing networks and initiatives. Prior consultations had been held with such partners and their activities had been incorporated into the draft strategy. With regard to the suggestion that the goal for implementation of the strategy be extended to 2020, he said that, as the food safety capacity of the different Member States varied, they were not expected to implement all the components at the same rate or in the same way. As food safety was a global health security issue, it required collective action; therefore, as 2015 approached, progress on implementing the strategy would be discussed again. Several representatives had
recommended establishing a link with other public health emergencies and also with other sectors, such as nutrition. Linkage with other mechanisms was the main theme of the strategy, and integration of food safety into the revised Asia Pacific Strategy for Emerging Diseases (2010) and the International Health Regulations (2005) was part of the draft strategy. He agreed with speakers who had urged continuous follow-up of implementation, perhaps through a food safety cooperation working group that would meet annually. A mechanism similar to that of the Asia Pacific Strategy for Emerging Diseases (2010) might be established, whereby all Member States, partners and WHO met once a year to record progress made and determine future action.

67. The Director, Food Safety, Zoonoses and Foodborne Diseases, WHO headquarters, recalled that the principles of food safety had been agreed upon in World Health Assembly resolution WHA63.3 and were reflected in the draft strategy. As a global strategy was considered unsuitable, the resolution requested each region to formulate a strategy; the Western Pacific Region was the first to do so, and other regions would certainly use it as inspiration for their own strategies. INFOSAN was a voluntary information-sharing mechanism for all national food authorities, which allowed the exchange of experiences. The function of the International Health Regulations (2005) was to alert countries to food safety emergencies, while INFOSAN included information such as import and export notifications; the two were complementary. Countries could decide to establish national focal points in any part of their territory. He agreed that Member States should contribute to Codex, and he described a trust fund that had been set up by Codex to support the participation of developing countries, with training in use of the standards and in obtaining data that contributed to the work of the Codex Alimentarius Commission. The draft strategy also recognized that food safety was a multisectoral activity, involving animal husbandry and agriculture, which should nevertheless remain under the leadership of the health sector. Links with epidemiological data were important, so that countries could inform health authorities rapidly.

68. The Committee considered a draft resolution on the Western Pacific Regional Food Safety Strategy (2011–2015). The Rapporteur for the English language read out two amendments that had been proposed by the representative of the United States of America. In operative paragraph 2(2), the words "ensure political commitment to mobilize" would be replaced by "strengthen or sustain, as appropriate", so that the paragraph would read "to strengthen or sustain, as appropriate, human and financial resources to facilitate the implementation of such systems". In operative paragraph 2(4), the words "and Codex Alimentarius Commission" would be added after "(INFOSAN)".

69. The resolution, as amended, was adopted (see resolution WPR/RC62.R5).

NONCOMMUNICABLE DISEASES: Item 13 of the Agenda (Document WPR/RC62/8)

70. The Regional Director, opened a panel discussion, referring to the progress made during 2011 in raising the profile of noncommunicable diseases, with the adoption of the Nadi Statement, the Seoul Declaration, the Honiara Communiqué on Noncommunicable Diseases and the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. The panel discussion would be moderated by Professor Don Matheson, Centre for Public Health Research, Massey University, Wellington, New Zealand.

71. Professor Matheson said that considerable experience in the prevention and control of noncommunicable diseases had been accumulated over the previous decade and that the panel discussion would focus on practical steps to implement programmes at the country level. The seven panellists would make presentations in their areas of expertise, after which there would be an opportunity for discussion.
Panellists’ presentations

72. Dr Han Tieru, Director, Division of Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, offering a regional perspective, said that there were high levels of activity to combat noncommunicable diseases but that progress was not universal. A WHO survey in 2010 to assess national capacity in the area had revealed inadequacies in various aspects of national plans in the 23 low- and middle-income countries in the Region. Reducing risk factors, a key element of prevention, required action on the social determinants of health, which in turn required population-based multisectoral interventions and a “whole-of-government” approach. Many countries had made good progress in controlling tobacco, reducing the harmful use of alcohol and promoting healthy diets and physical activity through a variety of measures that were known to be effective. The Healthy Cities and Healthy Islands initiatives, as well as the Pacific Food Summit and resulting framework for action on food security, had also proved successful in the Region. However, most low- and middle-income countries and areas had low primary health care coverage, and lacked the resources and training required to deal with noncommunicable diseases or the double burden of communicable and noncommunicable diseases. The service delivery model would need to change from the current focus on acute care of single episodes to management of chronic conditions. Health systems should be strengthened at all levels, with adequate funding and the development of appropriate guidelines. Essential services for noncommunicable disease prevention, treatment, care, rehabilitation and palliative care should be available at the primary health care level, with close links to district hospitals and more specialized services. Secondary and tertiary levels should provide cost-effective and evidence-based treatment options. There were a few good examples in the Region, for example hypertension management programmes in China and the Republic of Korea, health systems strengthening for the prevention and control of noncommunicable diseases in Mongolia, and progress towards universal coverage in the Philippines.

73. Funding levels for combating noncommunicable diseases were low. Moreover current expenditure was not always well spent, with more of the limited resources going to treat late stages of diseases and complications. Lack of universal coverage was precipitating catastrophic household expenditures. Primary health care and lifestyle interventions should be given high priority in financing policies for national health care. The WHO package of essential noncommunicable disease interventions provided a set of cost-effective interventions. At the global level only 2.3% of overall development assistance for health had gone to noncommunicable disease activities in 2007. Currently a number of development partners, including the Australian Agency for International Development and the New Zealand Agency for International Development were providing assistance for 22 Pacific island countries and areas through the 2-1-22 programme. Information was vital and Member States should establish or strengthen surveillance and monitoring. WHO STEPS surveys had been conducted by 22 countries and areas in the Region. However, those were often one-off surveys with no financial allocations and limited capacity for continued surveillance and reporting of key health indicators. There were several examples of successful partnerships in the Region for tackling noncommunicable diseases. However, consideration should be given to establishing a regional mechanism for engaging a wider range of partnerships for advocacy, information-sharing, resource mobilization and technical cooperation. Priority should be given to developing a WHO regional action plan for 2014–2018 with time-bound targets and indicators.

74. Dr Hasan bin Abdul Rahman, Director-General of Health, Malaysia, described his country’s policy and programme for the prevention and control of noncommunicable diseases, which was part of the Tenth Malaysia Plan (2011–2015). The strategic direction relevant to the prevention and control of noncommunicable diseases was to ensure access to high-quality health care and to promote a healthy lifestyle. Campaigns for a healthy lifestyle had been conducted annually since 1991, the emphasis shifting from the home to the workplace and schools, culminating in “wellness clinics” for screening. The strategies for the prevention and control of noncommunicable diseases were decided by representatives of 10 ministries, which met in a Cabinet committee chaired by the Deputy Prime
Minister, with the mandate to devise policies that ensured a living environment that encouraged healthy eating and physical activity.

75. One example of application of such policies was an agreement with the Ministry of Education for interventions in schools to prevent obesity, whereby the body mass index of children was measured twice a year and children were taught about the calorie content of foods and drinks and the calories burned during physical activities. The Ministry of Health was responsible for training teachers and for technical support, as well as for receiving referrals from schools. Furthermore, by-laws had been proposed for adoption by local authorities on the sale of unhealthy food and drink. A Malaysian Health Promotion Board had been established under the Ministry of Health in 2006, with representatives from other ministries, nongovernmental organizations and professional organizations to promote adoption of healthy lifestyles.

76. The main challenge was to ensure that the Ministry of Health retained strong leadership of the strategy. Other ministries could be encouraged to participate if they were shown that the interventions were of mutual interest. Economic and political considerations should remain paramount and be acknowledged as such. It was important to set clear, measurable targets with deadlines.

77. Dr Timothy Armstrong, Chronic Diseases and Health Promotion, WHO headquarters, stressed the importance of surveillance in the prevention and control of noncommunicable diseases in order to identify trends and to provide background information for policies and programmes. The challenges in surveillance were the same throughout the world: data collection was not standardized and therefore data could not be integrated into national health information systems; data on trends in mortality were often poor; and there was a lack of data on morbidity. WHO had prepared a framework for surveillance, which comprised determining risk factors, recording morbidity and mortality and ensuring a health system response. Investment in adequate surveillance systems was essential. In a survey of the capacity of countries in the Region to address noncommunicable diseases, it was found that 63% had useable registers of vital statistics, 57% had surveyed risk factors within the past five years, and 34% had a national population-based cancer registry.

78. As noted by the Director-General, the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases had mandated WHO to develop a comprehensive global monitoring framework, with indicators and voluntary targets. Member States would be consulted during development of the proposed targets, which would be discussed by the WHO Governing Bodies. The criteria on which they were based would encourage the establishment of reliable, sustainable surveillance systems.

79. Dr Yong-ik Kim, Department of Health Policy and Management, College of Medicine, Seoul National University, Republic of Korea, described the role of health systems strengthening in the prevention and control of noncommunicable diseases. Greater numbers of skilled community health workers and primary health care doctors were required for prevention and control activities to complement those involved in communicable disease activities. In his country, a "health promotion fund" had been established, based on a tax on tobacco products, to finance and monitor noncommunicable disease activities. For surveillance, national health and nutrition surveys were conducted every three years, with interviews and examinations of 30 000 people. Community health surveys had been initiated in 2008, in which 1000 people in each of the 250 districts of the country were interviewed. Both types of survey were conducted with the assistance of personnel from medical and nursing schools. Community health infrastructure was reinforced by training field managers and retraining nurses, and free risk-factor modification programmes were conducted in health centres. A national health screening programme ensured basic screening of the entire population every two years, two or three health check-ups for preschool children, specific screening for noncommunicable diseases for people aged 40 and 66 years and screening for five major cancers every two years. Private
doctors were given financial incentives to participate in the screening programme. More intersectoral collaboration was needed, with greater involvement of the ministries of labour and education, and health "sub-centres" would be established in communities to further reduce the prevalence of known risk factors.

80. Dr Liang Xiaofeng, Deputy Director-General, Centre for Disease Control, China, described health system strengthening for the prevention and management of noncommunicable diseases in his country. The priorities of the country's health care reform programme were development of a basic health insurance system, provision of essential medicines and primary health care and ensuring equality of access to essential public health services, all of which would enhance the prevention and control of noncommunicable diseases. Coverage with basic health insurance had increased from 15% to 95% between 2000 and 2010, with raised subsidies and reimbursements, decreased prices of essential medicines and better coverage with basic public health services. Hypertension and diabetes were managed mainly in community health centres, with technical support and training at local general hospitals, while the Center for Disease Control and Prevention planned, monitored and evaluated the programmes. The number of community health workers was still inadequate, and administrative and management personnel were often used as health assistants. Community service teams had been established, consisting of a clinician, a public health worker and a nurse, who delivered services to patients with noncommunicable diseases at home, the frequency of follow-up depending on disease severity.

81. Experience with the programme had shown that government support, multisectoral collaboration, coordination of different organizations and institutions and community involvement were the most important factors. Staffing of community health centres was the key challenge for noncommunicable disease prevention and management.

82. Professor Fran Baum, Director, Southgate Institute, School of Medicine, Flinders University, Adelaide, Australia, focusing on multisectoral actions for risk reduction, said that risk factors at the societal level had the most powerful impact on noncommunicable diseases and that ensuring attention to health in all policies was the governance and implementation mechanism needed to make action on the determinants a reality. Success required a cross-cutting, holistic and integrative approach that was led from the top politically and had popular support.

83. Social determinants such as poverty, racism, social isolation, unemployment, insecurity and social isolation could lead to a lack of control over work and home life, in turn producing long-term chronic stress and then chronic disease, anxiety and depression. Some people coped by using substances harmful to health (alcohol, tobacco, illegal drugs). Social and economic barriers to seeking mental health care only compounded the situation.

84. The 2008 report of the Commission on the Social Determinants of Health had made it clear that action to address systematic unfairness in all sectors (education, employment, housing, health, environment, etc.) was needed to reduce inequalities associated with noncommunicable diseases—changing conditions of everyday life and putting health at the centre of government decision-making.

85. The approach of "health in all policies" built on many previous multisectoral approaches, going back to the 1978 Alma Ata Declaration. Its implementation in South Australia illustrated the elements for success. There had been a history of action on the social determinants of health, so that there was already a skilled workforce with good understanding of the area. A strategic plan was in place, with chief executives accountable for achieving targets. An external expert had been employed as a "thinker in residence" and a specific unit within South Australia Health had been established to promote the approach. The plan had received high-level political support, sponsorship and leadership, and appropriate mechanisms for financing, implementation and regulation had been established.
Evidence indicated that there were significant limits to industry self-regulation and Member States should use regulation to enforce health-promoting behaviours from the private sector. The unit and partner agencies had been carefully monitored and analysed to provide feedback, since early signs of progress were vital to ensure that sectors remained committed to the approach and others were drawn in. The initial approach had led to other actions in the areas of transport, housing, urban planning, advertising, diet and physical activity. Action on the social determinants of noncommunicable diseases in South Australia had produced a healthier population and economic benefits and was compatible with environmental policies for a sustainable future.

86. Ms Johanna Ralston, Chief Executive Officer, World Heart Federation, Geneva, Switzerland, presenting information on advocacy and partnerships, said that health partnerships were of two types: partnerships across diseases and partnerships across sectors. They should be based on ethical frameworks and should build on existing mechanisms, including WHO strategies. The World Heart Federation, the International Diabetes Federation, the Union for International Cancer Control and subsequently the International Union against Tuberculosis and Lung Disease had come together to form a partnership across diseases—the NCD Alliance. In its work with WHO and others to advocate for the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Alliance had learnt that sacrifices had to be made on individual short-term gains in order to define common messages and goals and identify priorities. The High-level Meeting had succeeded in attracting strong participation and media attention. As a follow-up, the NCD Alliance was continuing to collaborate with other partners to advocate for the inclusion of noncommunicable diseases in the Millennium Development Goals and for the development of suitable targets and indicators. Consideration was also being given to the development of a framework for the future engagement of civil society, the public and private sectors and the United Nations system.

87. Partnerships across sectors that involved a wide range of stakeholders were also essential in tackling noncommunicable diseases and Member States should identify WHO “best buys” among the possible interventions. For example, the New Zealand initiative HeartSAFE (sodium advisory and food evaluation) was an industry-led partnership to reduce salt levels in foods, facilitated by the National Heart Foundation under contract to the Ministry of Health. Progress in reducing salt levels towards national targets since 2007 through voluntary commitments had been substantial. However, legislative approaches might be required to achieve additional improvements. Other examples included worldwide efforts to promote smoke-free workplaces, activities to eliminate sales of soft drinks in schools, an initiative to improve cardiovascular health in children in megacities in low- and middle-income countries, and a project to integrate cervical cancer screening and breast cancer awareness into HIV/AIDS programmes.

88. Professor Kenji Hayashi, President, National Institute of Public Health, Japan, described the Health Japan 21 programme formulated by the Ministry of Health, Labour and Welfare in 2000, which was aimed at enhancing quality of life and increasing life expectancy. The programme had around 70 targets in nine areas to be attained by 2011. It received high-level political support, and government leaders had joined the campaign by agreeing to undergo waist measurement and checks on diet and physical activity. A health guidance service had been introduced in 2008 to reinforce the programme. The National Institute of Health had provided administrative and technical support for the programme, developed teaching materials, run training courses, including an international training programme organized jointly with the Regional Office, and conducted monitoring and surveillance. Analysis of data indicated that men and women involved in the health guidance service had reduced their body weights and waist circumferences. Overweight prevalence surveys indicated that prevalence in women, particularly those over the age of 40, had decreased more than in other groups. A community-level communication tool was under development with a view to encouraging more people to undergo health examinations and benefit from the health guidance service.
89. The Japan-WHO International Visitors Programme conducted by the Institute had included the opportunity to practise desirable lifestyles in addition to class learning. Activities had included health checks, daily physical exercise and guidance on dietary choices. At a meeting in Tokyo in 2009, programme participants over the past five years had recommended that policy development, population-based interventions and monitoring and evaluation should be given priority in advancing implementation of the Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases.

Panel discussion

90. Speakers welcomed adoption of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which had drawn international attention to the problem. That declaration emphasized the economic impact of those diseases on countries and their health systems, primary prevention, access to essential medicines, the effectiveness of measures such as taxation and legislation and the involvement of health ministers in multisectoral policies.

91. The representatives of several small island countries raised the problem of their reliance on imported food items and produce, many of which were unhealthy, as they contained preservatives and high levels of salt and sugar. That made it difficult to design policies to address noncommunicable diseases. One representative welcomed the suggestion to post a "sodium and salt advisory" in shops selling canned food. Ms Baum said that the report of the WHO Commission on the Social Determinants of Health contained recommendations for designing trade policies with a health perspective that might be applicable for countries with little power over their imports. Ms Ralston said that the food and beverage industry would soon be obliged to change their norms in order to maintain their credibility and "edibility". A collective effort was needed in terms of research to determine standards and on appropriate legislation for each country situation. One representative drew the Committee's attention to several studies on the cost-effectiveness of various interventions for the control and prevention of noncommunicable diseases. He urged countries to choose the "best buys" among the available interventions.

92. Ms Baum said that a requirement in government offices in South Australia for a "healthy weight" had increased the involvement and accountability of a number of ministries. The targets were revised every few years, with community involvement. One representative commented that in his country and many others, most politicians were overweight, smoked, chewed betel nut, drank alcohol and did no physical exercise. How could they be convinced to take action against noncommunicable diseases? Dr Hayashi said that one way of increasing their commitment to health was to point out that food security represented about 30% of the total national budget.

93. As the situations of different countries varied, the range of noncommunicable diseases considered should be broadened. Furthermore, it was important to set priorities, in view of the limited resources available. The analysis of risk factors in each country should be as detailed as possible to provide clear evidence for preventive activities. Governments and ministers wanted simpler approaches to tackling the diseases, and WHO should provide the relevant advice.

94. In answer to a comment about the relative power of ministries of health to coordinate multisectoral groups, Dr Hasan emphasized that the system used in his country depended on the high-level support it received: from a Cabinet committee chaired by the Deputy Prime Minister. That involvement had been achieved because of recognition of the high burden of noncommunicable diseases in the country.
95. The involvement of the private sector in the prevention and control of noncommunicable diseases was essential, and representatives asked for advice on avoiding conflicts of interest. Ms Ralston stressed that the private sector should have no role in policy formulation; its only role should be in implementation of policies. The roles and responsibilities of the State and the private sector should be clearly defined. Furthermore, public health officials should provide the initial evidence for any policy, rather than politicians, and the mandate of the government should be based on consultation, including public opinion. Dr Hasan added that in his country new policies were first discussed by an expert group, then extended to the scrutiny of relevant stakeholders, academics and the public, and only then presented to the Government to implement.

96. Dr Hayashi said that waist circumference reduction and weight-loss programmes in his country were sustained by follow up under the national health insurance scheme. Employees were followed up in company clinics; whereas the rate of follow up for other people was only about 30% to 40%. Private doctors were motivated to screen the latter group in private hospitals through a scheme whereby the Government reduced its subsidy to a hospital by 10% for longer hospital stays.

97. Ms Baum said that addressing noncommunicable diseases now would give a better life to future generations, as healthier people were better parents, and less money would be wasted on treatment. The best investments were in safe pregnancy and early childhood development. Schools should be involved, by teaching not only healthy behaviour but also critical evaluation of advertising. Dr Kim added that health programmes should be lifelong, but school health and occupational health were neglected areas. Health visitors saw housewives and disabled people who were unable to leave their homes; whereas, the working population was screened only rarely.

98. In response to a request for advice on best practices for obtaining reliable information on behavioural risk factors, Mr Armstrong said that WHO had validated tools for surveillance of four of the main risk factors, including tobacco use, and that training in surveillance methods was available through the Regional Office; workshops had been conducted recently in Cambodia and Malaysia, including on sampling methods. In answer to a query about the effectiveness of a public policy for opportunistic population-based screening, Dr Matheson cited the WHO criteria for screening, in which the technique used depended on the population to be screened. It was important to ensure that screening resulted in follow-up.

99. One representative pointed out that health systems strengthening was essential, including universal coverage with health insurance. Interventions should include educational programmes on healthy behaviour and medical services to provide treatment. Such measures should be implemented with those for infectious diseases, in a sustained cross-sectoral effort. Human resources from sectors other than health should be involved in the control and prevention of noncommunicable diseases. In a multisectoral approach, personnel in urban planning, for example, could take the need for physical activity into consideration. Long-term care was given not only in health facilities but also in the community and by charity organizations; it was important to work together with such bodies to identify roles and responsibilities to ensure participation.

100. In answer to a query about the sources of financing for the prevention and control of noncommunicable diseases, Dr Kim said that the health promotion fund in the system in the Republic of Korea was financed only from the tax on tobacco products because tobacco had previously been a government monopoly, and it had been relatively easy to obtain that commitment. The Government had less influence over alcohol companies.

101. Dr Matheson, summarizing the discussion, said that the new ideas that had been presented had been enriched by the questions and comments of representatives. The challenge now was to apply those new ideas in their own countries. The first, important step was to establish their precise situation
with regard to noncommunicable diseases. The political window for raising the profile of those diseases was slightly ajar as a result of the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which was a precious moment and should be seized. As the countries of the Region had different needs with regard to noncommunicable diseases and were at different stages of development, their actions should be incremental, based on “best buys” in interventions.

**Plenary discussion**

102. The Regional Director said that the necessary knowledge about noncommunicable diseases was available, and they had become a global political issue. The challenge was to work together and with others, for instance to increase taxes on tobacco and alcohol. A strong resolution was needed. Then, representatives could discuss practical ways of implementing that resolution in the Region.

103. One representative proposed that the Regional Office should take advantage of the political declaration issued by the High-level Meeting to increase the budgetary allocation for noncommunicable disease prevention and control, establish a unified monitoring and assessment system with time-bound targets and indicators, assess progress in all countries, and support them in implementing the global strategy and action plan. The Regional Office should also urge Member States to conduct high-level governmental dialogue and to integrate the prevention and control of noncommunicable diseases into their health and development agendas. Another representative asked the Regional Office to clarify the practical application of the United Nations political declaration in making national implementation strategies meaningful and effective.

104. Representatives considered that a further resolution on noncommunicable diseases would be useful, but urged that it be complementary to and not overlap with other recent resolutions, statements and documents, such as the Honiara Communiqué. The resolution should request the Regional Office to contribute not only to regional targets but also to global targets for the prevention and control of noncommunicable diseases. It should also require reporting to future sessions of the Regional Committee on progress made. The representative of New Zealand reported that his country had set the goal of becoming smoke-free by 2025 and urged other countries to consider setting such targets.

105. National noncommunicable diseases programmes were difficult to establish, especially in countries with limited resources and capacity. Emergency management tools, such as incident or unified command systems, could be used to manage the crisis in Pacific island countries, as those tools integrated activities into a vertical system. That approach was being used in Palau, which had declared a state of emergency with regard to noncommunicable diseases. Moving implementation of strategies for the prevention and control of noncommunicable diseases from the health sector to a multisectoral entity with an emergency orientation was good model for mobilizing communities. Concurrent management of diseases and health, such as in the “integrated environmental approach to wellness” used in Palau, required further research. It was important to integrate the environment into the classical biomedical and psychosocial model used by health systems. Alcohol and tobacco abuse not only contributed to the high incidence of noncommunicable diseases but also caused social and family problems. “Wellness” initiatives targeting younger generations were priorities.

106. The targets in the proposed regional action plan for 2014–2018 must incorporate some flexibility, in view of differences in resources among Member States of the Region. Targets and indicators to monitor progress in the prevention and control of noncommunicable diseases should also be included. Disease management should be incorporated into existing systems, with strengthening of primary health care.

107. A statement was made on behalf of the World Confederation for Physical Therapy.
108. The Director, Division of Building Healthy Communities and Populations, said that the Regional Office would consult fully with Member States in developing a surveillance and monitoring framework for noncommunicable diseases and would support them in defining country-specific time-bound targets and indicators. The political declaration of the High-level Meeting could serve as a guide for national and regional plans of action. The Regional Office would continue to work with countries to strengthen their health systems and to ensure that they shared best practices in that regard. A multisectoral approach to the identification of risk factors for all diseases was a cost-effective way of addressing the double burden of diseases faced by many countries in the Region. He agreed with previous speakers that the prevention and control of noncommunicable diseases should be integrated into existing health systems, with identification of needs and gaps. Suitable regional mechanisms would be sought to engage all interested groups. WHO was considering convening a meeting involving representatives of technical associations, foundations, universities, industry and the private sector in order to identify their roles and responsibilities and to agree on collaborative activities for addressing noncommunicable diseases.

109. The Regional Director congratulated the panel members on their thought-provoking presentations on practical approaches to the prevention and control of noncommunicable diseases. The United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases had given WHO a new coordinating function, bringing together other United Nations agencies and other sectors, including the private sector. The Regional Office would support countries in their efforts to prevent and control noncommunicable diseases, beginning with detailed analyses of the risk factors for those diseases in individual countries, using the STEPwise approach and other methods. On that basis, each country should then set targets, with deadlines. Although a regional action plan with indicators was to be drawn up by the end of 2012, the Region could not wait until then and should outline its own indicators, reflecting the social, political and economic contexts of the widely diverse Member States of the Region. The newly established Division of Pacific Technical Support in Fiji would help the Pacific island countries and areas to devise indicators that reflected their unique problems, which were very different from those of, for instance, China. Collaborative work had already been done in several countries, involving health, trade and agriculture ministries. Some countries of the Region were leading in implementation of the WHO Framework Convention on Tobacco Control and other initiatives for the prevention and control of noncommunicable diseases, and they should share their information with others, both in the Region and globally. The Western Pacific Region’s pioneering work in promoting Healthy Cities and Healthy Islands initiatives was very important in the prevention and control of noncommunicable diseases and was also a good mechanism for involving other sectors and civil society.

110. The Committee considered a conference paper containing a draft resolution on expanding and intensifying noncommunicable disease prevention and control. The Rapporteur for the English language read out several amendments that had been proposed by the representatives of Australia, New Zealand and the United States of America. The end of preambular paragraph 9 would read "including multisectoral national policies and plans", and a new preambular paragraph 11 would be added, reading "Recognizing that women's and children's health is inextricably linked with noncommunicable diseases, and strategies to address noncommunicable diseases should be integrated into global maternal, neonatal and child health agenda.". In operative paragraph 2(1), "advocate" would be changed to "develop strategies". In operative paragraph 2(3), the words ", with a set of time-bound targets and indicators that will contribute to global monitoring" would be replaced by "that is integrated into the global monitoring framework and is consistent with voluntary global targets and indicators, to be developed by WHO by the end of 2012". The representative of Australia explained that the term "voluntary targets" was used in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

111. The resolution, as amended, was adopted (see resolution WPR/RC62.R2).
112. The representative of the Legal Counsel, WHO headquarters, recalled that the Regional Committee had considered the process of nomination of the Regional Director on several occasions over previous years, as indicated in document WPR/RC62/9. At its sixty-first session, the Committee had approved a proposal relating to a process for short-listing and interviewing candidates, amended its Rules of Procedure accordingly, and expressed an interest in developing a regional code of conduct. A draft code was annexed to the document. There were no precedents for such a code within the United Nations system, but codes elsewhere in the international arena had been taken into account in developing the draft. While it was not legally binding and compliance would not be monitored by an external group, the draft code represented a political statement by Member States and implementation was expected as a matter of good faith. The Committee was invited to review the draft code and consider how it wished to proceed.

113. Most representatives agreed that the draft code contained many elements that would allow for a more transparent process. Some expressed support for the draft—such a code could provide a model for other regions—but there was general agreement that the matter required further consideration, in consultation with Member States. There is still time for such consultation before the next nomination process in 2013. A number of suggestions for improvements were made: the recommendations in the 2009 Joint Inspection Unit report on the selection and conditions of executive heads in United Nations organizations should be taken into account; should a code be adopted, it should be pilot tested and subsequently refined; the recommendation that names and curricula vitae should be made available electronically should be implemented in all three official languages; and full disclosure of grants or aid funding between nominating countries and other Member States over the previous two years might inform the selection of candidates. However, the lack of a precedent suggested the difficulty of codifying such a process. It might therefore be preferable to limit agreement to what had been approved at the sixty-first session of the Regional Committee or to amend the Rules of Procedure further, rather than adopt a formal code.

114. One representative found the draft unacceptable for a number of reasons. For example the proposal in Part B, section II, paragraph 5 that, wherever possible, meetings between candidates should be arranged on the occasion of conferences or other events rather than through bilateral visits was simply not realistic, especially given the culture and customs of the Western Pacific Region, which included the exchange of "souvenirs"; candidates would always prefer to speak directly with the person in the country who would decide on which candidate to support. Another representative, referring to the dual promotional activities by Member States proposing candidates and by the individual candidates themselves, said that implementation of the code might be difficult, as sovereign prerogatives dictated foreign policy, which directly influenced the nature of campaigning. Attention was drawn to a possible contradiction regarding the proposals for campaigning mentioned in Part A, section II, paragraph 2 and Part B, section II, paragraphs 5 and 6; decisions by Member States would continue to depend on political and bilateral relationships.

115. There was little support for the development of a trust fund to assist candidates from less developed countries as it would be complex to administer, take scarce resources from priority health activities and would still not guarantee a level playing field for all candidates.

116. The representative of the Legal Counsel, WHO headquarters, said that a document on best practices regarding codes of conduct was being prepared for consideration by the Headquarters Working Group on the Election of the Director-General of the World Health Organization in November 2011. The recommendations in the 2009 Joint Inspection Unit report were being taken into account. There was clearly a need to balance sovereign prerogatives with the need for a merit-
based system. He had noted the concern expressed regarding the establishment of a trust fund and agreed that it was unquestionably a complex proposition.

117. The Director, Programme Management, added that, as mentioned during the discussion of WHO reform earlier in the session, proposals for improvements in governance included the development of uniform procedures for nomination of the Regional Director across the six regions and that it might therefore be premature to adopt a region-specific code. However, the Committee's comments on the draft code, clearly reflecting a desire for transparency, fairness and conduct in good faith, would provide a valuable contribution to the forthcoming deliberations at the Executive Board special session in November 2011.

118. The Chairperson suggested that, in the absence of consensus, the Committee might wish to affirm that the basic principles set out in Part A, section I of the draft code should guide the nomination process, and that those principles, together with the report of its discussions, should be submitted for consideration at the Executive Board special session.

119. The question was raised as to whether it was necessary to wait until a decision had been taken at global level, which might take some years, before proceeding at the regional level. The Committee had been mandated to consider a code of conduct and it would be a pity to waste the considerable efforts that had gone into development of the draft code. While the proposal to establish a trust fund did not appear to be acceptable, many representatives supported much of the remaining content of the draft code. It might therefore be preferable to continue consultations and to prepare a revised draft code for consideration at the Committee's next session. Electronic consultation with Member States on the basis of a revised text might be the best way forward.

120. The Regional Committee requested the Secretariat to revise the draft code taking into account the Committee's comments; to make the revised text available to Member States electronically for further consideration and submission of amendments; to prepare a revised draft code for consideration at the Committee's next session, to be circulated well in advance of the session; and to forward the revised text and the Committee's comments to WHO headquarters for consideration during discussion of governance in the context of WHO reform by the Executive Board at its special session in November 2011 and its subsequent regular session in January 2012, and by the Headquarters Working Group on the Election of the Director-General of the World Health Organization in November 2011.

PROGRESS REPORTS ON TECHNICAL PROGRAMMES: Item 15 of the Agenda (Document WPR/RC62/10)

121. The Director, Programme Management, said that the eight progress reports would be discussed in two parts, the first covering work on malaria, dengue, the Expanded Programme on Immunization and mental health; and the second covering essential medicines, the Asia Pacific Observatory on Health Systems and Policies, human resources for health and the biennial meeting of the Ministers of Health for the Pacific island countries. He congratulated Member States on the significant progress made in malaria control, although the disease was still prevalent in some countries. Resistance to artemisinin combined therapy was a growing threat in the Region. Dengue continued to be a serious public health problem, and WHO was providing technical support for practical implementation of the guidelines that had been issued in 2009. Member States had shown their commitment to fighting dengue in the priority they had given to "Dengue Day" in June 2011. With regard to the Expanded Programme on Immunization, he noted the importation and apparent spread of wild poliovirus in August 2011 in the western part of China, with 17 reported cases of poliomyelitis. He congratulated the Chinese Government on its rapid
reaction to the outbreak. Progress had been made in terms of eliminating measles and controlling rubella and hepatitis B, and a mechanism was being developed for verification of measles elimination.

122. He recalled that Monday 10 October had been "Mental Health Day". An estimated 100 million people in the Region suffered from mental disorders of varying severity, and regional mechanisms to strengthen care systems were needed, with better data, integration of mental health into development plans and national health systems and additional investment in human resources.

123. Introducing the second set of progress reports, he said that the Regional Framework on Action on Access to Essential Medicines in the Western Pacific (2011–2016), annexed to the document, took into account the expert evaluation that the 2005–2010 Regional Strategy for Improving Access to Essential Medicines was still valid, and incorporated recent challenges including the financing for medicines. The update on the Asia Pacific Observatory on Health Systems and Policies, which had been launched by the Regional Offices for South-East Asia and the Western Pacific in June 2011 in pursuance of resolution WPR/RC59.R4, provided an overview of the consultative process that had led up to the launch, and the purpose and management of the Observatory. The Human Resources for Health Action Framework for the Western Pacific Region, which was annexed to the progress report on the Regional Strategy on Human Resources for Health (2006–2015), proposed solutions for tackling the critical human resource gaps identified through a comprehensive regional assessment. The final progress report provided information on the Ninth Meeting of Ministers of Health for the Pacific Island Countries, held in Honiara, Solomon Islands in June 2011. The Committee was invited to note the progress reports.

Regional action plan for malaria control and elimination in the Western Pacific (2010-2015)

124. Successes were reported in the control of malaria but resistance had occurred along borders with other countries and in remote areas. Regional cooperation was needed to ensure elimination in neighbouring countries, with control strategies conducted simultaneously on both sides of the border and sharing of experience. Furthermore, research was needed to shorten treatment courses, in order to prevent resurgence of Plasmodium vivax. Research should also be conducted to develop new, effective chemicals for malaria vector control to replace resistant ones and to develop vaccines against malaria. Training courses to build capacity for vector control would also allow sharing of information and experiences with regard to resistance to treatment and insecticides.

125. The representative of China asked that the WHO list of antimalarial drugs be updated and requested that the prequalification procedure for acceptance of artemisinin combination therapy produced in China be accelerated, so that those drugs could become available in order to overcome resistance to artemisinin. WHO should provide more technical support for the development of sensitive, convenient rapid diagnostic tests and for establishment of a laboratory quality control network and verification procedures and methods. WHO should also encourage further cooperation among Member States in developing laboratory diagnostic tools and genetic tracing. Both the Western Pacific and the South-East Asia Regional Offices should continue their support to countries for malaria and dengue control in border areas to reduce cross-border transmission. In the final stage of malaria elimination, when there were fewer cases, it was often considered that no further funding was required. That was a misconception, and WHO should continue to support Member States in combating malaria.

Dengue fever and dengue haemorrhagic fever prevention and control

126. Climate change, rapid urbanization, increased travel and the custom of keeping water in open containers in which mosquitoes could breed increased the risk for dengue outbreaks. It was important to share information on dengue regularly through the designated focal point for the International
Health Regulations (2005). The new case definition for dengue published in WHO’s 2009 guidelines for dengue diagnosis, treatment and control should be incorporated uniformly into report forms used throughout the Region. Research should be conducted to develop new insecticides for dengue vector control to replace resistant ones, and regional cooperation in scientific research on the viruses, vector control, vaccine development and case treatment and exchange of surveillance data should be encouraged. In the absence of a vaccine against dengue, integrated vector management was an acceptable approach. WHO should help Member States to prepare guidelines for the use of genetically modified mosquitoes in the prevention of control of dengue and dengue haemorrhagic fever. The Regional Offices for the Western Pacific and South-East Asia should cooperate in preventing cross-border transmission of dengue.

**Mental health**

127. A holistic approach was needed to prevent and control mental health problems, in order to build resilience and to integrate care into the community, with a monitoring and evaluation system. More human resources were needed to improve care and service delivery, including the training of family caregivers. Even mental health units in hospitals should take into consideration the responsibilities and need for understanding and support of family members. An area that had received inadequate attention was how mental health problems affected people with chronic noncommunicable diseases, especially those with disabilities that required long-term care, and also people with communicable diseases.

128. In view of the high suicide rates in some countries of the Region, studies were being carried out to design interventions and to evaluate their efficacy. A more active, comprehensive policy was needed to counteract the increasing rates of depression and suicide. The small island developing countries of the Pacific, in particular, required culturally sensitive, locally applicable technical support and generic medicines. Changes in legislation, decentralization of care, and training with regard to mental health were long overdue. Current medical training for mental health management was not holistic, and new strategies should be taught at local universities covering the full range of mental health issues. The Asian Federation of Psychiatrists was prepared to assist in training and service delivery, if WHO was willing to engage with that group.

**Expanded Programme on Immunization**

129. Even in countries in which the Expanded Programme on Immunization had achieved success in controlling various diseases, vaccination weeks should continue to be organized, and advocacy to highlight the importance of vaccination should be continued in order to raise awareness, encourage community participation and mobilize funding. Several countries in the Region were under-using vaccines. WHO should therefore provide technical support to low-income countries in making evidence-based decisions on which vaccines to use, when to introduce them and how to deliver them equitably for universal coverage. The evidence on which such decisions were based would include the country’s disease burden, cold-chain capacity and quality, cost-effectiveness and known adverse events. WHO should work more closely with countries, in partnership with GAVI, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and UNICEF, to implement the health system funding platform, in order to integrate donor support for health system strengthening in a more harmonized, aligned manner into national plans and priorities, remove inequities, and improve the sustainability of the immunization programme.

130. One representative commented that, although the report noted that 25 countries and areas in the Region might already have eliminated measles, they represented only a small percentage of the population of the Region; measles was still widespread in other countries, which accounted for over 90% of the population. Careful monitoring and evaluation and supplementary vaccination were
required to prevent importation of cases. Investment in programmes to control poliovirus in neighbouring regions was worthwhile in order to prevent importation of cases. It was important that the success of special immunization activities, catch-up programmes and new vaccines did not lead to complacency, as countries should continue to improve routine vaccination and coverage. Surveillance activities should be clearly linked to public health action.

131. The representative of France said that cases of chikungunya had occurred in New Caledonia at the beginning of the year. The disease had not previously been seen in the Pacific islands, and he feared a catastrophic epidemic. The Government had rapidly used all means to limit spread of the disease beyond the seven foci in Noumea, with more than 20 biologically confirmed cases, and no new cases had been seen since June. He asked for more concrete support in the choice of biocides against vectors, taking into account both resistance to such products and their toxicity.

132. A statement was made on behalf of Alzheimer's Disease International.

**Action Framework on Essential Medicines**

133. The Regional Framework on Action on Access to Essential Medicines was endorsed in principle and should enhance regional cooperation and strengthen capacity-building. Two representatives indicated that they would submit proposed amendments to the Regional Framework to the Secretariat. Speakers also reported on national progress in improving access to essential medicines and thanked WHO for the technical assistance provided

**Asia Pacific Observatory on Health Systems and Policies**

134. The Committee welcomed the launch of the Asia Pacific Observatory on Health Systems and Policies and looked forward to participating in the anticipated exchange of information. However, health information system strengthening would be required if countries were to provide reliable data and should be given priority in the 2012–2013 biennium. One representative expressed concern regarding the Observatory's future, given the current WHO reform process, and requested clarification of its legal relationship with WHO and WHO's role in its management. He questioned the practice of linking Steering Committee membership with financial contributions, since such financing was not sustainable, and asked whether there was any allocation to the Observatory from the regular budget for 2012–2013. The Steering Committee, which set directions for the strategic objectives, should include health decision-makers and research experts from Member States across the Region in order to take into account the differing situations in countries and areas, to link research to decision-making, and to ensure attention to priority areas of health reform and development. It was proposed that indicators should be developed to monitor the Observatory's performance. Countries should be supported in developing country profiles using the Health Systems in Transition template.


135. In discussing the Human Resources for Health Action Framework for the Western Pacific, representatives confirmed that shortages of human resources for health remained a significant obstacle to health development, especially in rural areas, and that implementation would be important for the attainment of the health-related Millennium Development Goals. Member States were making efforts, inter alia, to raise awareness of the Global Code of Practice on the international recruitment of health personnel, and to improve education and training.
Pacific Health Ministers Meeting

136. The representative of Solomon Islands expressed appreciation to the participants in the Ninth Meeting of Ministers of Health for the Pacific Island Countries hosted by his country in June 2011 and drew attention to the Honiara Communiqué, which was annexed to the Honiara Outcome document. The 10th Meeting would be hosted by Samoa. Together with other representatives, he thanked WHO and the Secretariat of the Pacific Community for their support.

137. The representative of the Secretariat of the Pacific Community expressed appreciation for WHO's strategic leadership and policy-setting action in the Pacific region. The Secretariat of the Pacific Community greatly valued the strong and equitable partnership between the two organizations and the establishment of the WHO Division of Pacific Technical Support. During 2011, the Secretariat had been able to facilitate improved access by WHO to political leadership through meetings of the Pacific Plan Action Committee and the Pacific Island Forum, which should ensure that health was placed high on the development agenda. The Secretariat of the Pacific Community would continue its collaboration with WHO and encouraged the Organization to explore opportunities for joint programming to influence the social determinants of health. Development partners should ensure that good quality technical support to countries was maintained.

138. The Chairperson drew the Committee's attention to "World Sight Day", which was held to raise awareness about avoidable blindness and visual impairment. WHO estimated that there were 90 million people with visual impairment and 10 million who were blind in the Region, including those with diabetes-related loss of vision. Blindness affected mainly people in low-income countries and eight out of 10 cases were avoidable. As a founding member of the global campaign "Vision 2020", WHO coordinated international efforts to reduce visual impairment, especially through strengthening of health systems.

139. The Secretariat responded to the comments on the eight progress reports.

140. The Director, Division of Combating Communicable Diseases, noted the significant progress that had been made by countries in combating malaria. That was due in large part to the unprecedented increase in funding that has become available. The principal challenge was the emergence of areas of resistance to artemisinin, mainly along the Cambodia-Thailand border; the situation was exacerbated by the introduction of counterfeit and poor-quality drugs. The artemisinin resistance containment project has been successful, although reports have been received of further potential areas of artemisinin resistance along the Myanmar-China border and Viet Nam, which are being investigated. Another challenge in some countries is reaching remote populations, which has always been a priority of the Regional Office. With respect to dengue, he noted that it was no longer considered a neglected disease, as an increasing number of Member States were raising awareness about the issue, developing national plans, commemorating Dengue Day with the backing of ASEAN and allocating financial resources. The representative of China identified artemisinin-based combination therapies as the first-line treatment against malaria, stressing the need to accelerate the process to produce primaquine in the country. WHO was asked to provide more technical support to establish a drug quality assurance network and more cooperation regarding diagnostic tools including gene tracing.

141. The Director, Division of Health Security and Emergencies, congratulated Member States on the progress they had made in controlling dengue, with strong government support. The first "Dengue Day" had been very successful, but it was important to maintain the momentum, as dengue would not disappear. WHO was committed to sustaining the efforts made by integrating dengue control activities into integrated vector management and into the revised Asia Pacific Strategy for Emerging
Diseases (2010). WHO would follow with interest France's response to the outbreak of chikungunya in New Caledonia.

142. The Director, Division of Building Healthy Communities and Populations, said there was an urgent need to strengthen mental health programmes. The problem had been recognized as a high priority at both the United Nations High-level Meeting on Prevention and Control Noncommunicable Diseases and at the Meeting of Ministers of Health for the Pacific Island Countries. WHO had been instrumental in supporting countries with capacity-building for the development of policies, laws and programmes. Analyses would be carried out on the trends in mental health in the Region and their consequences, especially with respect to dementia and suicide. Pilot and demonstration projects were being conducted in order to find evidence-based solutions, and WHO looked forward to receiving the results. Several representatives had raised the problem of a shortage of manpower for mental health interventions. Such activities should be integrated more fully into primary health care, with strengthened training and country visits by senior mental health professionals. He noted that the Fiji School of Medicine had initiated mental health training in order to increase the human resources in the Region. The new division of programme support in that country would improve communication with the Pacific island countries and strengthen links among activities and priorities.

143. The Director, Division of Health Sector Development, welcomed the support expressed for the proposed Regional Framework of Action on Access to Essential Medicines in the Western Pacific and looked forward to receiving written proposals for amendments. Access to essential medicines continued to vary considerably in the Member States of the Region. In some countries access, for example, to medicines related to maternal and child health and noncommunicable diseases was only possible via the private sector. It was hoped that the Framework would go beyond policy development and promote increased availability and access to safe and good-quality drugs. WHO would revise the Framework in accordance with the Committee's comments and written submissions, and circulate the revised text. The Asia Pacific Observatory on Health Systems and Policies would provide support to all participating countries, and health system analyses would be undertaken in each of them in due course. The Observatory would operate in accordance with WHO regulations and policies, and the agenda for its work would be set in consultation with countries and other stakeholders, as indicated in the institution's statement of intent and its terms of reference. The WHO Regions for South-East Asia and the Western Pacific were permanent members of the partnership so that full accountability rested with the Organization. The Steering Committee was endeavouring to ensure financial sustainability of the institution and was also seeking input from research networks across the two regions. Those matters would be discussed at the February 2012 meeting of the Steering Committee. The Secretariat would revise the Regional Strategy on Human Resources for Health in light of representatives' comments and written submissions. The Regional Office would continue to pay particular attention to the implementation of the Strategy in the Pacific region.

144. The Director, Programme Management, responding to the concern raised in relation to the Observatory Steering Committee, observed that the operations of the institution were in the early stages since its recent launch, and assured the Regional Committee that the Steering Committee would consult with Member States. Funding was reflected in the proposed programme budget for 2012–2013 as voluntary contributions through specific pledges from donor partners.

145. The Regional Director said that the eight progress reports that had been presented represented the essence of the Region's work. He noted that there was broad support for the Observatory, with strong expectations. Although it would not solve all problems, it was an innovative approach to improving health care policy, management and assessment, from the perspective of the World Bank and the Asian Development Bank, with different mechanisms and management. The WHO European Region had undertaken a similar experience, with interaction of governments and academia; the
assessment had been positive. The fact that the Observatory would serve both the Western Pacific and the South-East Asia Regions had made its establishment more complex.

146. Mental health was a serious problem in the Region, with some of the highest suicide rates in the world. Isolated Pacific island developing countries, in particular, required professional support, and one of his priorities was to find funds and human resources to provide such support. Collaboration among countries through training courses, meetings and workshops was one means of assistance. He recalled that the theme of the next World Health Day would be “healthy ageing”, which included both mental health and other noncommunicable diseases. The Region and countries should develop action plans to improve healthy ageing.

147. Within the Expanded Programme on Immunization, it would be difficult for some countries to achieve the goals for measles and hepatitis B by 2012, although each Member State was doing its best to do so, with its own system. He commended China on the way in which it had dealt with the importation of wild poliovirus over its border.

(Document WPR/RC62/11)

World Health Assembly resolution WHA64.2, WHO Reform

148. The Director, Programme Management, recalled that in pursuance of World Health Assembly resolution WHA64.2, the Executive Board, through decision EB129(8), had requested the regional committees to engage in strategic discussions on the WHO reform process, with its three main components—core business, financial and managerial reform, and governance—and to provide input to the Board’s special session in November 2011. The Committee was invited to review and endorse the proposals on those components, which were set out in document WPR/RC62/11. Additional information was provided in three concept papers annexed to the document, which covered WHO governance, an independent evaluation of WHO, and the convening of a World Health Forum in 2012.

149. In the ensuing discussion, it was noted that reform was never easy, especially at a time of financial and global health crises, and that Member States could not demand an efficient, cost-effective, targeted WHO while continuing to expect the Organization’s instant support in a variety of circumstances. Member States must reform their expectations of what WHO can deliver. The five core areas of business are consistent with the current six core functions and appear to cover most of WHO’s existing work. The challenges were to exercise discipline, to identify priorities within the core business areas, and to improve governance and transparency. WHO should refocus on its main roles, which comprised standard-setting, formulation of recommendations, health monitoring and the provision of technical support. Given the limited time and resources, independent evaluation should be selective, focusing for example on primary health care.

150. The preparation of the programme budget was one of WHO’s greatest challenges given the nature of the Organization’s income: a small regular budget financed by assessed contributions of Member States that were all experiencing financial constraints, plus the less predictable and often earmarked voluntary contributions. The proposals for increasing financial flexibility would therefore require careful consideration. Strategic objectives would need to be reconciled with the available means. Transparency should be improved by providing greater detail in relation to actual expenditure. A dedicated agency or office to handle financing might avoid problems of internal competition. In examining innovative financing mechanisms, WHO should consider accepting donations from nongovernmental organizations and corporations. The budget implications of WHO reform should be
reviewed, in particular allocations for new structures, and consideration should be given to financing the reforms from a set proportion of countries' assessed contributions. Support was expressed for use of the rotation and mobility system in a revised human resource management structure.

151. WHO was the only health organization in the United Nations family and should strengthen its leadership in setting the direction of multi-stakeholder programmes and clarifying the roles of the parties involved. The proposed World Health Forum would reflect the diversity of the current health scene and provide a platform for expressions of opinion, informing decision-making by the WHO governing bodies. However, its proposed structure and functions required further definition, with clear criteria for participation. A mechanism for the collection of information on the work of participating organizations should be established to promote coherence, rational programming and deployment of resources, and monitoring and evaluation. The Committee agreed that governance at the Headquarters, regional and country levels of WHO should be streamlined, with a better-defined system of accountability, and that the work of the governing bodies should be better aligned. Headquarters should focus on technical standards, guidance and guidelines; the regional and country offices should focus on support to Member States. Member States should define the real priorities. WHO should review the ways in which it provided information to Member States to ensure that communications responded better to country needs. It might be preferable to make better use of the governing bodies, where the views of Member States and multiple stakeholders were already expressed, rather than creating new bodies such as the proposed open-ended working group of the Executive Board and the World Health Forum. To protect WHO independence, the terms of reference for consultative mechanisms that involved the profit-making private sector should follow principles defined by public authorities based on the concept of health as a global public good.

152. The Committee looked forward to further consideration of WHO reform at the Executive Board special session in November 2011. The hope was expressed that the reform agenda could be defined in precise terms rather than vague language to address sensitive issues.

153. The Director-General said that reform, initiated to ensure that WHO remained relevant and could continue to address both its existing agenda and emerging problems, must be an open and honest process. The 194 Member States were shareholders of WHO and oversight for management and resource monitoring were their responsibility—Member States must decide what kind of Organization they wanted. At the time of its establishment, 64 years ago, WHO had been the only multilateral health organization in the world. Now, there were many global players, including civil society, academia, research institutions and the private sector. Governments alone could not improve health. As mentioned earlier, health is a global public good, involving many issues that are outside the public health sector.

154. In some respects, the five core areas of business are eternal, defining the Organization's reason to exist. She agreed, however, that WHO should refocus its work on its normative function, technical support, monitoring and evaluation with clear delineation of roles at the different levels of the Organization. She also restated the fundamental principle that any involvement of the private sector would continue to require declarations of interest and would have no influence on WHO's normative function. For the special session of the Executive Board, a consolidated report would be prepared combining the three concept papers. The report would provide further details of the core business areas as well as reflect the proposals and choices discussed at the six regional committee meetings.

155. In relation to financing, she reminded the Committee that only the 20% of the programme budget derived from assessed contributions was flexible; the remainder, while gratefully received, was unpredictable and usually closely earmarked so that it could not be used for other work—few donors gave flexible funds. Moreover, donors were unwilling to pay the 13% programme support
costs, so that WHO had to subsidize the activities from assessed contributions—becoming in effect a subcontractor. The result was funding gaps in many areas. During the Sixty-fourth World Health Assembly in May 2011, 28 resolutions had been adopted after extensive negotiation, yet the majority could not be implemented because of lack of financing. Because of the diversity of Member States, objections were made to proposals to cut any programme, and countries sometimes expressed conflicting directions in their regional committee sessions and at Headquarters. Member States must define priorities and then negotiate which of them could be financed. Innovative financing mechanisms must be sought. It would not be realistic to increase assessed contributions in the short term. However, countries could contribute further by providing bilateral support, experts or commodities. She agreed to provide greater detail on budget expenditure in future.

156. A World Health Forum had been proposed to give a voice to stakeholders other than Member States; it would not compromise the decision-making power of Member States but would provide information on what other entities could contribute. It had been proposed that better use of existing mechanisms would be preferable to a forum. Other options would be presented at the special session of the Executive Board. Consultations with civil society and the business sector had been successful in the case of pandemic influenza preparedness, and that model for capturing the views of stakeholders had not incurred further costs. WHO needed its partners. The aim of the reform was not to expand WHO membership but to consolidate existing partnerships. Discrepancies between the decisions taken by partners and those agreed in WHO created policy difficulties, yet Member States were represented on the boards of those partner. Further, decisions on health priorities were taken by ministries of health, whereas funding was decided on by ministries of foreign affairs or development, which might have different priorities. It was up to Member States to align their priorities.

157. WHO was the only democratic health organization in the world, in which each country had one vote, ensuring representation and legitimacy. Each regional director decided in consultation with Member States which global priorities applied to the region. Success depended on strengthening the country offices and, as agreed by all the regional committees, informing and empowering country offices was the first priority of the reform. It had been suggested that WHO should abolish its regional offices, but in her view that would not be appropriate. They played a vital role and ensured coherent interaction and communication between Member States and the many different related regional, subregional and national entities becoming involved in health activities. WHO sometimes went beyond its mandate, but so did other organizations, and Member States must exercise due diligence. It was also important to improve the alignment among WHO governing bodies. It was the role of the Executive Board to maintain oversight of the Organization’s work, but it was becoming more like a mini-World Health Assembly. Member States must oversee the work of the Board but not interfere in that work. In particular they must ensure that the Board’s special session was effective. There would be no progress if every item was discussed by all 194 Member States.

158. In summary, none of the regional committees had asked her not to proceed with WHO reform; there was a clear recognition that the Organization must adapt to changing circumstances. The reform would be a continuous process, some actions being taken rapidly while strategic decisions would require more discussion. It was also agreed that independent evaluation of WHO was an important instrument for assessing the Organization’s performance. Views differed on the scope and conduct of such a review. Managerial reform should be discussed on the basis of results-based planning, management, monitoring, evaluation and accountability. With regard to financing, work at the three levels should be synergistic but also attributable to the organizational level at which it was done.

159. The Director, Programme Management, said that the Committee's comments would be reported to WHO headquarters. The special session of the Executive Board would consider the consolidated paper mentioned by the Director-General, bringing together the three components of the
proposed WHO reform and a report on the conclusions of the six regional committees. The Board's decisions on WHO reform would be transmitted to its next regular session, in January 2012, and then to the World Health Assembly.

**World Health Assembly resolution WHA64.10, Strengthening national health emergency and disaster management capacities and resilience of health systems**

160. The resolution was considered in conjunction with Item 17 of the Agenda, Emergencies and disasters (see below).

**World Health Assembly resolution WHA64.5, Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits;**

**World Health Assembly resolution WHA64.8, Strengthening national policy dialogue to build more robust health policies strategies and plans;**

**World Health Assembly resolution WHA64.12, WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals**

161. The Committee took note of the three resolutions.

**EMERGENCIES AND DISASTERS: Item 17 of the Agenda (Document WPR/RC62/13)**

162. The Regional Director introduced document WPR/RC62/13 on emergencies and disasters, and invited the Regional Committee to take note of World Health Assembly resolution WHA64.10 on strengthening national health emergency and disaster management capacities and resilience of health systems, which was set out in document WPR/RC62/11. The countries and areas of the Region were prone to different types of emergencies and disasters, sometimes resulting in massive loss of life and damage to health infrastructure and systems. The new Division of Health Security and Emergencies in the Regional Office provided an integrated operational platform for emergency response. At a meeting of major humanitarian response agencies convened by WHO after the recent disasters in New Zealand and Japan, agreement had been reached on a common operational framework to guide future responses. New Zealand and Japan had shown great strength, determination and community spirit in their efforts to overcome the disasters and there was much to be learnt from their experiences and those of other Member States in similar situations.

163. The representative of New Zealand expressed appreciation for the support and sympathy received following the earthquake in February 2011, which had devastated the city of Christchurch. The immediate response to the emergency—search and rescue, and treatment of injuries had been followed by activities to restore basic infrastructure and services, and to provide public information. Those actions had been coordinated across Government, community and international teams thanks to whole-of-government emergency plans and systems that were already in place, which included a common incident command system with well-defined roles and functions, and shared terminology. Previous national and regional exercises to test the plans had enabled them to be updated and improved, so that teams worked well together immediately. The disaster had shown that regular and open communications with the general public during emergencies, including frankness about uncertainties, and effective existing relationships across sectors at all levels, built over time during routine work, were of fundamental importance for effective responses. Long-term recovery, including dealing with displacement of people from homes to which they could not return, and rebuilding commercial and community activities, was the greatest challenge. However, it also provided opportunities, for example for innovative rebuilding that improved the determinants of health and well-being and created more sustainable cities. As part of the efforts to strengthen regional emergency planning and response, Member States and WHO should build common emergency
systems based on agreed principles, which would allow the sharing of resources as necessary during emergencies.

164. The representative of Japan described the events of March 2011 in which a massive earthquake off the coast had been followed by numerous aftershocks of considerable magnitude, a rapid, devastating tsunami, and the resulting nuclear accident, leaving more than 15 000 dead and 4000 missing, and causing extensive damage to infrastructure. A health counselling service had been established immediately after the radiation leak from the Fukushima Daiichi nuclear power plant. Residents evacuated from the evacuation and sheltering zones had been examined for contamination. Those registering 13 000 cpm or more had been asked to remove contaminated clothing and had been wiped with wet paper towelling, tested again, seen by a physician and sent home, with follow-up as necessary. Those registering less than 13 000 counts per minute had been seen by a physician, given health counselling by a public health nurse and discharged. Residents from outside those zones had been given health counselling by public health nurses, without surveillance for contamination. A survey one week after the earthquake had shown that more than 400 health facilities across Japan had treated potentially irradiated patients. A health management survey of all residents of the Fukushima Prefecture (some 2 million inhabitants) would be implemented, with a detailed survey of those living within 20 km of the nuclear plant and ultrasound thyroid examinations of all residents aged up to 18 years.

165. Whole body counter surveys of 122 residents with potential internal exposure had shown exposures to total caesium-134 and caesium-137 of less than 1 millisievert. The Government had set provisional values for radioactive materials in food, with stricter restrictions for infant foods, and regular inspections were being conducted on tap water, especially in areas surrounding the nuclear power plant and neighbouring regions. Good emergency preparedness was vital. The responsibilities of the management of nuclear power plant following an accident included assessment of the situation and estimation of the effects; implementation of emergency response plans; and provision of information to local and central government. Local government authorities should implement and manage emergency responses, seek expert advice, determine the necessary measures to secure the safety of residents, provide information to the public and report to central Government. In turn central Government should report to relevant international organizations, including WHO. Japan would continue to provide information.

166. Representatives reiterated their condolences to New Zealand and Japan and wished them well in their reconstruction efforts. They also expressed appreciation for WHO’s regional and global efforts to strengthen emergency preparedness planning and capacity, and for the support provided by the Organization and countries for individual Member States. WHO country offices could provide useful assistance during emergencies.

167. The cluster approach through the new Division of Health Security and Emergencies should build on existing international, regional and national strategies and mechanisms, including the International Health Regulations (2005). Timely sharing of information and rapid, well-targeted technical assistance during and after emergencies were essential elements of successful responses and should include support for mental health programmes. Consideration should be given to what was necessary for emergency preparedness and how capacity could best be deployed within and across countries. Expert health advice should be available during all aspects of deployment. The potential effects of climate change on the frequency and nature of emergencies, and planning for continuity of government, community and commercial operations should also be taken into account. Subsequent sharing of experiences and best practices would strengthen preparedness.

168. National emergencies experienced by other Member States were described, together with the obstacles encountered. Progress in improving emergency preparedness was outlined. Member States
should take steps to implement World Health Assembly resolution WHA64.10 and United Nations General Assembly resolution 60/195 and to ensure the provision of adequate resources for such action. The Regional Office would need to continue its support for small island countries and areas in that regard. Emergencies required strong local responses, supplemented by provincial and national support as necessary. Increased training of primary health care staff in emergency and disaster response would increase overall preparedness and hasten recovery and reconstruction after disasters. The importance of the Regional Food Safety Strategy (2011–2015) was discussed under item 12 in the context of emergencies. There was a request for more information on radionuclide contamination in Japan, including its potential effects on marine life.

169. A statement was made on behalf of the International Federation of Medical Students Associations.

170. The Director, Division of Health Security and Emergencies, thanked representatives, for sharing their experiences of various types of emergency response, which would be taken into account in developing future regional activities. The events in Japan and New Zealand had shown that even developed countries with advanced emergency response capacities could be overwhelmed by large disasters and it was essential to learn lessons from such experiences. The value of investment in emergency preparedness was clear, resulting in lives saved, clearer coordination of responses, mitigation of the impact on health and socioeconomic development, and strengthening of capacity for health system and service recovery. The Regional Office would continue to share information on experiences and operational research, to seek ways of improving multisectoral coordination and to consider preparations for long-term recovery initiatives, which provided an opportunity to strengthen health systems and improve disease surveillance and response capacities in affected areas.

171. The Director-General reminded the Committee that emergency preparedness would be considered by the Executive Board at its January 2012 session. Emergencies, while remaining unpredictable, were occurring more frequently and with greater magnitude. The decentralized structure of WHO enabled the Organization to respond quickly to crises, and work was being restructured to promote cross-regional collaboration and improve WHO country office capacity. She agreed that countries should also plan their multisectoral approaches and implement the International Health Regulations (2005) to strengthen their responses. WHO was strengthening the common response platform through its participation in the United Nations Inter-Agency Steering Committee for Humanitarian Affairs, and would use its comparative advantage as the leader in health, with experience in health crises. However, coordination remained a challenge. Command and control mechanisms and needs assessments for every individual crisis were vital to ensure operations and supplies. Countries and development partners should question why emergency preparedness was not covered by the United Nations Central Emergency Response Fund.

172. The Regional Committee took note of World Health Assembly resolution WHA64.10.

SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION: MEMBERSHIP OF THE POLICY AND COORDINATION COMMITTEE: Item 18 of the Agenda (document WPR/RC62/12)

173. The Director, Programme Management, said that the three Member States from the Region on the Policy and Coordination Committee of the WHO Special Programme of Research, Development and Research Training in Human Reproduction were currently Japan, the Philippines and Malaysia. The term of office of Japan would expire on 31 December 2011, and the Regional Committee was requested to elect a Member State to succeed Japan.
174. The Regional Committee selected Viet Nam to replace Japan (see decision WPR/RC62(1)).

TIME AND PLACE OF THE SIXTY-THIRD AND SIXTY-FOURTH SESSIONS OF THE REGIONAL COMMITTEE: Item 19 of the Agenda

175. The Regional Director said that the Regional Office had received an invitation to hold the sixty-third session of the Regional Committee in Ha Noi, Viet Nam.

176. The representative of Viet Nam said that the health status of the people of her country had improved dramatically in recent years, with socioeconomic development, Government investment in health and strong support from the international community, especially WHO. If the rate of reduction in mortality of infants and children under 5 years were maintained, the country would achieve the fourth Millennium Development Goal by 2015. Her country had been chosen as the venue for many international health-related meetings, conferences, workshops and training courses. Viet Nam would be honoured to host the sixty-third session of the WHO Regional Committee for the Western Pacific, which would be a milestone in its 35 years of relations with WHO. Ha Noi had celebrated its 1000th anniversary in 2010, and she hoped representatives would use the occasion to experience the charm, history and culture of the city. The national diet was a key factor in preventing noncommunicable diseases.

177. The Regional Director proposed 24–28 September 2012 as the dates for the sixty-third session of the Regional Committee. The sixty-fourth session would be held at the Regional Office in Manila.

178. The representative of the Philippines proposed that the sixty-fourth session be hosted by the Philippine Government.

179. The Committee agreed that its sixty-third session would be held in Ha Noi, Viet Nam on 24–28 September 2012 (see resolution WPR/RC62.R6).

CLOSURE OF THE SESSION: Item 20 of the Agenda

180. The Chairperson announced that the draft report of the sixty-second session would be sent to all representatives, with a deadline for the submission of proposed changes. After that deadline, the report would be considered approved.

181. After the usual exchange of courtesies, in which the representative of Solomon Islands, speaking on behalf of all Member States, the Regional Director and the Chairperson took part, the sixty-second session of the Regional Committee was declared closed.
AGENDA

Opening of the session and adoption of the agenda
1. Opening of the session
2. Address by the retiring Chairperson
3. Election of new officers: Chairperson, Vice-Chairperson and Rapporteurs
4. Address by the incoming Chairperson
5. Adoption of the agenda

Keynote address
6. Address by the Director-General

Review of the work of WHO
7. Address by and Report of the Regional Director
   WPR/RC62/2
   WPR/RC62/3

Policies, programmes and directions for the future
   WPR/RC62/4
10. Antimicrobial resistance
    WPR/RC62/5
11. Traditional medicine
    WPR/RC62/6
12. Food safety
    WPR/RC62/7
13. Noncommunicable diseases
    WPR/RC62/8
14. Nomination of the Regional Director: Code of conduct
    WPR/RC62/9
Annex 1

Policies, programmes and directions for the future (continued)

15. Progress reports on technical programmes
   15.1 Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015)
   15.2 Dengue fever and dengue haemorrhagic fever prevention and control
   15.3 Mental health
   15.4 Action Framework on Essential Medicines
   15.5 Asia Pacific Observatory on Health Systems and Policies
   15.7 Expanded Programme on Immunization
   15.8 Pacific Health Ministers Meeting

WPR/RC62/10

16. Coordination of the work of the World Health Assembly, the Executive Board and the Regional Committee

WPR/RC62/11

17. Emergencies and disasters

WPR/RC62/13

Membership of Global Committee

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

WPR/RC62/12

Other matters

19. Time and place of the sixty-third and sixty-fourth sessions of the Regional Committee

20. Closure of the session
**LIST OF REPRESENTATIVES**

**I. REPRESENTATIVES OF MEMBER STATES**

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<tr>
<th>Country</th>
<th>Representative</th>
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<tr>
<td><strong>AUSTRALIA</strong></td>
<td>Ms Jane Halton, Secretary Department of Health and Ageing, Canberra, <em>Chief Representative</em></td>
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<td>Ms Sally Jane Goodspeed, Assistant Secretary Population Health Strategy, Department of Health and Ageing, Canberra, <em>Alternate</em></td>
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<td>Mr Neil John Ellis, Director International Health Policy Section, Department of Health and Ageing, Canberra, <em>Alternate</em></td>
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<td>Mrs Janice Evelyn Bennett, Principal Adviser Department of Health and Ageing, Canberra, <em>Alternate</em></td>
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<td>Ms Amber Cernovs, Program Officer, Global Health Programs Health and HIV Thematic Group, Australian Agency for International Development, Canberra, <em>Alternate</em></td>
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<td><strong>BRUNEI DARUSSALAM</strong></td>
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<td>Mr Dato Abd Salam Momin, Permanent Secretary, Ministry of Health Bandar Seri Begawan, <em>Alternate</em></td>
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<td>Pengiran Dr Khalifah Ismail, Acting Director General of Health Services Ministry of Health, Bandar Seri Begawan, <em>Alternate</em></td>
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<td>Ms Zahrah DP Hashim, Acting Director of Policy and Planning Ministry of Health, Bandar Seri Begawan, <em>Alternate</em></td>
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<td>Dr Mohammad Fandy Osman, Health Facilitating Officer Department of Clinical Laboratory Services, Ministry of Health, Bandar Seri Begawan, <em>Alternate</em></td>
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<td>Mr Shahrul Anaz Ismail, Second Secretary, Embassy of Brunei Darussalam, <em>Alternate</em></td>
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<td><strong>CAMBODIA</strong></td>
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<td></td>
<td>Dr Sok Touch, Director, Communicable Disease Control Department Ministry of Health, Phnom Penh, <em>Alternate</em></td>
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Annex 2

CAMBODIA

(continued)

Mr Tan Chandaravuth, Second Secretary and Consul
Cambodian Embassy (Philippines), Alternate

CHINA

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Dr Wang Xiaopin, Director General, Department of International
Cooperation, State Administration of Traditional Chinese Medicine,
Beijing, Alternate

Dr Qi Guixin, Deputy Director General, Bureau of Food Safety
Coordination and Health Supervision, Ministry of Health, Beijing,
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Mr Fan Xuehui, Deputy Director General, Department of Food Safety
Supervision, State Food and Drug Administration, Beijing, Alternate

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<br>(continued)

- **Dr Ho Shuk Yee**, Catherine, Senior Medical and Health Officer  
  Department of Health, Government of the Hong Kong Special Administrative Region, *Alternate*

- **Dr Sharma Geeta**, Senior Medical and Health Officer  
  Department of Health, Government of the Hong Kong Special Administrative Region, *Alternate*

### CHINA (MACAO)

- **Dr Cheang Seng Ip**, Deputy Director of Health Bureau  
  Health Bureau of the Macao Special Administration Government, *Chief Representative*

- **Dr Chan Tan Mui**, Head of Unit for Noncommunicable Disease Prevention and Health Promotion, Health Bureau of the Macao Special Administration Government, *Alternate*

- **Dr Lei Wai Seng**, Assistant Medical Director,  
  Health Bureau of the Macao Special Administration Government, *Alternate*

### COOK ISLANDS

- **Mr Nandi Glassie**, Minister of Health, Ministry of Health  
  Rarotonga, *Chief Representative*

- **Mr Tupou Faireka**, Secretary of Health, Ministry of Health  
  Rarotonga, *Alternate*

### FIJI

- **Dr Neil Sharma**, Minister for Health, Ministry of Health,  
  *Chief Representative*

- **Mr Ifereimi Corerega**, Head of National Centre for Health Promotion, Ministry of Health, Women and Social Welfare, Suva, *Alternate*

### FRANCE

- **Ms Sylvie Robineau**, Membre du gouvernement de Nouvelle-Calédonie chargé de la santé, Nouméa, *Chief Representative*

- **Ms Brigitte Arthur**, Chef du bureau des affaires internationales, Ministère du travail, de l'emploi et de la santé, Paris, *Alternate*

- **Mr Jean-Alain Course**, Directeur des affaires sanitaires et sociales de Nouvelle-Calédonie, Direction des affaires sanitaires et sociales, Nouméa, *Alternate*

- **Dr Jean-Paul Grangeon**, Chef du service des actions sanitaires de Nouvelle-Calédonie, Direction des affaires sanitaires et sociales Nouméa, *Alternate*

- **Ms Cécile Orosco**, Chargée de mission auprès de Madame Sylvie Robineau, Nouméa, *Alternate*

### JAPAN

- **Dr Masato Mugitani**, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare, Tokyo, *Chief Representative*
Annex 2

JAPAN
(continued)
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Dr Shiho Takaoka, Deputy Director, International Affairs Division, Ministry of Health, Labour and Welfare, Tokyo, Alternate

Dr Ikuma Nozaki, Deputy Director, International Affairs Division, Ministry of Health, Labour and Welfare, Tokyo, Alternate

Dr Haruka Sakamoto, Section Chief, Office of International Cooperation, International Affairs Division, Ministry of Health, Labour and Welfare, Tokyo, Alternate

Dr Shoko Ogawa, Second Secretary, Economic Section, Embassy of Japan, Pasay City, Alternate

KIRIBATI
Mr Elliot Ali, Secretary for Health and Medical Services, Ministry of Health and Medical Services, Tarawa, Chief Representative

Dr Teatao Tira, Director Public Health Services, Ministry of Health and Medical Services, Tarawa, Alternate

LAO PEOPLE’S DEMOCRATIC REPUBLIC
Associate Professor Bounkong Syhavong, Vice Minister of Health, Ministry of Health, Vientiane, Chief Representative

Dr Bounfeng Phoummalaysith, Deputy Director-General of Cabinet, Ministry of Health, Vientiane, Alternate

Dr Soulivanh Pholsena, Secretary to Minister of Health, Ministry of Health, Vientiane, Alternate

MALAYSIA
Dato' Sri Liow Tiong Lai, Minister of Health, Ministry of Health Malaysia, Putrajaya, Chief Representative

Dato’ Dr Hasan Bin Abdul Rahman, Director General of Health, Ministry of Health Malaysia, Putrajaya, Alternate

Dato' Seri Dr Ibrahim Saad, Malaysian Ambassador to the Republic of the Philippines, Embasssdy of Malaysia, Alternate

Ms Noraini Dato’ Mohd Othman, Senior Director, Food Safety Quality Division, Ministry of Health Malaysia, Putrajaya, Alternate

Dr Chong Chee Kheong, Director of Disease Control, Ministry of Health Malaysia, Putrajaya, Alternate

Dr Goh Cheng Soon, Senior Principal Assistant Director, Traditional and Complimentary Medicine Division, Ministry of Health Malaysia, Kuala Lumpur, Alternate
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<th>Country</th>
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<td>Mr Lim Chau Leng, Press Secretary to the Minister of Health Malaysia,</td>
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<td>Ministry of Health Malaysia, Putrajaya, <em>Alternate</em></td>
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<td></td>
<td>Ms Gaithri Chandran, Senior Assistant Secretary, Policy and</td>
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<td></td>
<td>International Relations Division, Ministry of Health Malaysia, Putrajaya,</td>
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<td>**REPUBLIC OF THE</td>
<td>Ms Amenta Matthew, Minister of Health, Majuro, <em>Chief Representative</em></td>
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<td>MARSHALL ISLANDS</td>
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<td>Mr Russell Edwards, Assistant Secretary, Majuro, <em>Alternate</em></td>
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<td><strong>FEDERATED STATES</strong></td>
<td>Dr Vita Skilling, Secretary of Health and Social Affairs, Department</td>
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<td>OF MICRONESIA</td>
<td>of Health and Social Affairs, Pohnpei, <em>Chief Representative</em></td>
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<td>Dr Louisa Helgenberger, Immunization Program Manager, Department</td>
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<td></td>
<td>of Health and Social Affairs, Pohnpei, <em>Alternate</em></td>
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<td>Ms Agnes Willyander, Drug Medical Supplies Coordinator, Pohnpei,</td>
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<td><strong>MONGOLIA</strong></td>
<td>Dr Lambaa Sambuu, Minister and a Member of the Parliament, Ministry</td>
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<td>of Health, Ulaanbaatar, <em>Chief Representative</em></td>
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<td>Dr Sodnomdarjaa Tuul, Director of Ulaanbaatar City Health Department,</td>
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<td>Dr Lkhagvasuren Nasantsengel, Deputy Director of National Center for</td>
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<td>Mental Health, National Mental Health Center, Bayanzurkh District,</td>
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<td>Dr Enkhbat Shagdarsuren, Director, State Implementing Agency of Health,</td>
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<td>Ministry of Health, Ulaanbaatar, <em>Alternate</em></td>
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<td>Ms Nanjaa Tsogzolmaa, Deputy Director, Strategic Policy Planning</td>
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<td>Department, Ministry of Health, Ulaanbaatar, <em>Alternate</em></td>
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<td>Dr Chuluunbaatar Batsaikhan, Director of National Center of Pathology,</td>
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<td>Dr Ganbold Zolbayar, Officer, Division of International Cooperation</td>
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<td>Ministry of Health, Ulaanbaatar, <em>Alternate</em></td>
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Annex 2

MONGOLIA (continued)  
Ms Saldan Odontuya, Policy Advisor to the Minister of Health, Ministry of Health, Ulaanbaatar, Alternate

NAURU  
Mr Taniela Sunia Soakai, Secretary for Health and Medical Services, Ministry of Health and Medical Services, Central Pacific, Chief Representative

NEW ZEALAND  
Dr Darren Hunt, Deputy Director of Public Health Ministry of Health, Wellington, Chief Representative

Ms Salli Davidson, Principal Development Manager-Health, New Zealand Aid Programme, Ministry of Foreign Affairs and Trade, Wellington, Alternate

NIUE  
Mrs Joan Tahafa Viliamu, Minister of Health, Alofi, Chief Representative

REPUBLIC OF PALAU  
Dr Stevenson J. Kuartei, Minister of Health, Ministry of Health, Government of Republic of Palau, Koror, Chief Representative

Mr Temengil Temengil, Coordinator, International Health, Ministry of Health, Government of Republic of Palau, Koror, Alternate

Ms Joanne Maireng Sengebau, Director of Public Health, Ministry of Health, Government of Republic of Palau, Alternate

Ms Johana Ngiruchelbad, Chief, Division of Primary and Preventive Health, Ministry of Health, Government of Republic of Palau, Koror, Alternate

PAPUA NEW GUINEA  
Mr Jamie Maxtone-Graham, Minister for Health Ministry of Health, Waigani, Chief Representative

Mr Pasco Kase, Acting Secretary, National Department of Health, Waigani, Alternate

Dr Paison Dakulala, Deputy Secretary, National Health Service Standards, National Department of Health, Waigani, Alternate

Mr Kupun Marang, Second Secretary to the Minister, Ministry of Health, Waigani, Alternate

PHILIPPINES  
Dr Enrique T. Ona, Secretary of Health, Department of Health Manila, Chief Representative

Dr Gerardo V. Bayugo, Undersecretary of Health, Department of Health, Manila, Alternate

Dr Lilibeth C. David, Director IV, National Center for Disease Prevention and Control, Department of Health, Manila, Alternate

Dr Teodoro J. Herbosa, Undersecretary of Health, Department of Health, Manila, Alternate
REPUBLIC OF KOREA

Mr Choi Won Young, Vice Minister for Health and Welfare, Ministry of Health and Welfare, Seoul, Chief Representative

Dr Jun Byung Yool, Deputy Minister of Health, Korea Centers for Disease Control and Prevention, Seoul, Alternate

Dr Lee Dukhyoung, Director of Disease Prevention Control, Korea Centers for Disease Control and Prevention, Seoul, Alternate

Dr Shin Kkotshigye, Director, Division of International Cooperation Ministry of Health and Welfare, Seoul, Alternate

Dr Song Byung-Il, Deputy Director, Ministry of Health and Welfare, Seoul, Alternate

Dr Chu Chaeshin, Assistant Director, Korea Centers for Disease Control and Prevention, Seoul, Alternate

Dr Jung Sung Hoon, Deputy Director, Ministry of Health and Welfare, Seoul, Alternate

Dr Jo Sung Duk, Assistant Director, Division of International Cooperation, Ministry of Health and Welfare, Seoul, Alternate

Dr Park Hye Kyung, Director, Division of Infectious Disease Control, Korea Centers for Disease Control and Prevention, Seoul, Alternate

Dr Park Mira, Deputy Director, Ministry of Health and Welfare, Seoul, Alternate

Ms Kim Hana, Interpreter, Ministry of Health and Welfare, Seoul, Alternate

SAMOA

Tuitama Dr Leao Talalelei Tuiatama, Minister of Health, Ministry of Health, Apia, Chief Representative

Ms Palanitina Tupuimatagi Toelupe, Chief Executive Officer/Director General of Health, Ministry of Health, Apia, Alternate

Dr Robert Edward Thomsen, Assistant Chief Executive Officer, Medical and Allied Division, Ministry of Health, Apia, Alternate

SINGAPORE

Dr Lyn James, Director in the Public Health Office, Ministry of Health, Singapore, Chief Representative

Ms Yeo Wen Qing, Assistant Director, Corporate Communications Division, Ministry of Health, Singapore, Alternate

Mr David Ho, Senior Health Policy Analyst, Industry Development and International Cooperation Division, Ministry of Health, Singapore, Alternate
Annex 2

SOLOMON ISLANDS
Mr Charles Sigoto, Minister of Health and Medical Services
Ministry of Health and Medical Services, Honiara, Chief Representative

Dr Cedric Alependava, Under Secretary Health Improvement, Ministry of Health and Medical Services, Honiara, Alternate

Dr Tenneth Dalipanda, Director Public Health, Ministry of Health and Medical Services, Honiara, Alternate

TOKELAUA*

TONGA
Dr Siale ’Akaoula, Director of Health, Ministry of Health, Nuku'alofa, Chief Representative

Dr Malakai Heneli ’Ake, Chief Medical Officer, Ministry of Health Nuku'alofa, Alternate

TUVALU
Dr Taom Tanukale, Minister of Health, Ministry of Health, Funafuti, Chief Representative

Mr Uale Taleni, Permanent Secretary, Ministry of Health, Funafuti, Alternate

UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND*

UNITED STATES OF AMERICA
Mr James Gillan, Director, Department of Public Health and Social Service, Guam, Chief Representative

Ms Erika Elvander, Branch Chief, Asia and the Pacific, Office of Global Affairs, Department of Health and Human Services, Washington, D.C., Alternate

Ms Elizabeth Ponausuia, Director of Health, Department of Health American Samoa, Alternate

Ms Judnefera Rasayon, International Relations Officer, Office of Human Security, International Organizations Affairs, Department of State, Washington, D.C., Alternate

Ms Anne Yu, Senior International Health Analyst, Office of Global Affairs, Department of Health and Human Services, Washington D.C., Alternate

*did not attend.

*did not attend.
VANUATU

Mr Willie Reuben Abel Titongoa, Minister of Health
Ministry of Health, Port Vila, *Chief Representative*

Mr Mark Peter Bekonan, Director General of Health, Ministry of Health,
Port Vila, *Alternate*

VIET NAM

Professor Dr Nguyen Thi Kim Tien, Minister of Health, Ministry of Health, Ha Noi, *Chief Representative*

Mrs Dao Thi Khan Hoa, Deputy Chief of Cabinet Office, Ministry of Health, Ha Noi, *Alternate*

Dr Tran Thi Giang Huong, Director-General, International Cooperation Department, Ministry of Health, Ha Noi, *Alternate*

Associate Professor Dr Pham Le Tuan, Director-General, Planning and Finance Department, Ministry of Health, Ha Noi, *Alternate*

Dr Luong Ngoc Khue, Director-General, Department of Health Examination and Treatment, Ministry of Health, Ha Noi, *Alternate*

Mr Truong Quoc Cuong, Director-General, Department of Drug Administration, Ministry of Health, Ha Noi, *Alternate*

Dr Vu Sinh Nam, Deputy-Director, Department of Preventive Medicine Ministry of Health, Ha Noi, *Alternate*

Dr Nguyen Hung Long, Deputy-Director, Department of Food Hygiene and Safety, Ministry of Health, Ha Noi, *Alternate*

Mr Tran Viet Hung, Vice-Director, Department of Organization and Personnel, Ministry of Health, Ha Noi, *Alternate*

Dr Luu Thi Hong, Vice-Director, Department of Mother and Child Health, Ministry of Health, Ha Noi, *Alternate*

Dr Le Quang Cuong, Director-General, Institute of Health Strategy and Policy, Ministry of Health, Ha Noi, *Alternate*

Dr Nguyen Tran Hien, Director-General, National Institute of Hygiene and Epidemiology, Ha Noi, *Alternate*

Ms Nguyen Boi Huong, Vice-Director, National Hospital of Traditional Medicine, Ministry of Health, Ha Noi, *Alternate*

Mrs Doan Phuong Thao, Officer-in-Charge of cooperation with WHO, International Cooperation Department, Ministry of Health, Ha Noi, *Alternate*
II. REPRESENTATIVES OF UNITED NATIONS OFFICES, SPECIALIZED AGENCIES AND RELATED ORGANIZATIONS

ASIAN DEVELOPMENT BANK (ADB)  
Ms Patricia Moser, Lead Health Specialist  
Poverty Reduction, Gender and Social Development Division, Asian Development Bank, Manila  
Dr Gerard Servais, Health Specialist  
Human and Social Development Division  
Southeast Asia Department, Asian Development Bank, Manila  

SECRETARIAT OF THE PACIFIC COMMUNITY (SPC)  
Mr William Parr, Director for Public Health Division  
Secretariat of the Pacific Community, New Caledonia  

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS)  
Ms Teresita Marie P. Bagasao, Country Coordinator  
UNAIDS Country Office, Makati City  
Mr Zimmbodilion Y. Mosende, Monitoring and Evaluation Adviser, Makati City  
Ms Merceditas B. Apilado, Social Mobilization Adviser, Makati City  

III. OBSERVERS  

Asian Medical Student's Association (AMSA)  
Mr Miguel Manuel Dorotan  
Ms Da Jung Park  
Mr Rizki Febrianto  

Korea Foundation for International Healthcare  
Dr Jong Wook-Lee Memorial F  
Ms Ryu, Kyung-nam  
Ms Koo, Bo-yeon  
Mr Kwon, Oh-min  
Ms Kim, Yoo-jin  
Mr Kim, Jae-sung  
Ms Kim, Hyun-ah  
Ms Im, Suna  
Ms Cho, Won-kung  
Ms Choi, Hyun-jin  

Department of Health, Philippines  
Dr Romulo Busuego  
Dr Juan Antonio Perez III  
Dr Kenneth G. Ronquillo  
Dr Asuncion Anden  
Dr Ma.Virginia A. Ala  
Ms Maylene M. Beltran  
Mr Laureano Cruz  
Dr Jojo Vito G. Roque  
Dr Benjamin Reyes  
Dr Juvencio Ordona
Department of Health, Philippines (continued)

Department of Health, Philippines

Dr Suzette H. Lazo
Dr Aleli Anne Grace Sudiacal
Dr Allan Evangelista
Ms Jeanne Bernas
Ms Maria Cristy Yuson
Mr Edwin Anoso
Ms Heidi Umadac
Ms Gloria De Jesus
Dr David J. Lozada, Jr.
Dr Paulyn Rosell-Ubial
Dr Nemesio T. Gako
Ms Maria Bernarditha T. Flores

Ministry of Health, Viet Nam

Ministry of Health, Viet Nam

Mr Nguyen Manh Cuong
Ms Pham Thi Ngan
Mr Lai Binh
Ms Pham Thi Minh Nga

IV. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS

Alzheimer's Disease International

Mr Ramon Lorenzo Luis Guinto
Ms Maria Lioni Kusuma Tatang

International Federation of Medical Students' Association (IFMSA)

Mr Kai-Yuan Cheng

International Agency for the Prevention of Blindness (IAPB)

Ms Maria Lioni Kusuma Tatang

International Alliance of Patient's Organization (IAPO)

Mr Richard Le Mesurier
Professor Do Nhu Hon
Dr Noel Chua
Dr John Szetsu
Dr Leshan Tan
Ms Sheona McGraw
Ms Komal Ram

International Ergonomics Association (IEA)

Mr Jeremiah Mwangi
Mrs Jo Groves
Mr Kin Ping Tsang

International Federation of Gynecology and Obstetrics (FIGO)

Professor Sylvia de las Alas-Carnero

International Federation of Pharmaceutical Manufacturers and Associations (IFPMA)

Mr Nobuki Sato
Ms Janice Armstrong
Ms Desiree Cembrano

International Pharmaceutical Federation (FIP)

Mr Reynaldo Umali
Annex 2

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<tr>
<th>Organization</th>
<th>Representative</th>
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<tr>
<td>International Society for Telemedicine and Health (ISfTeH)</td>
<td>Dr Alvin B. Marcelo</td>
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<td>International Society of Radiographers and Radiological Technologists (ISSRT)</td>
<td>Dr Maria Law</td>
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<tr>
<td>International Special Dietary Foods Industries (ISDI)</td>
<td>Mr Alejandro Vergel De Dios Castro</td>
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<td>Medical Women’s International Association (MWIA)</td>
<td>Dr Rosa Nancho</td>
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<td>Dr Corazon Yabes-Almirante</td>
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<td>World Confederation for Physical Therapy (WCPT)</td>
<td>Professor Gayline F. Manalang Jr.</td>
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<td>World Federation of Occupational Therapists (WFOT)</td>
<td>Professor Cynthia V. Isaac</td>
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<td>Mr Rolland Lyle Duque</td>
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<td>World Vision International</td>
<td>Dr Sri Chander</td>
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LIST OF ORGANIZATIONS WHOSE REPRESENTATIVES MADE STATEMENTS TO THE REGIONAL COMMITTEE

Alzheimer's Disease International
International Federation of Medical Students' Association (IFMSA)
International Federation of Pharmaceutical Manufacturers and Associations (IFPMA)
Secretariat of the Pacific Community (SPC)
World Confederation for Physical Therapy (WCPT)
Annex 3
 ADDRESS BY THE RETIRING CHAIRPERSON, MR LIOW TIONG LAI, MINISTER OF HEALTH, MALAYSIA, AT THE SIXTY-SECOND SESSION OF THE WHO REGIONAL COMMITTEE FOR THE WESTERN PACIFIC

It is so good to see you all again. Welcome to the sixty-second session of this Regional Committee. At around this time last year, I was given the singular honour of chairing the sixty-first session of the Regional Committee for the Western Pacific. It has been a professionally rewarding experience for me, knowing that meetings of the Regional Committee are forums where we reflect on health matters in the Region and agree on our future direction. It is with this expectation that I am sure we all look forward to this week’s session.

Before I begin, I would like to express this Committee’s sympathy to the governments and peoples of Japan and New Zealand in connection with the massive earthquakes that occurred early this year and, in the case of Japan, the resulting tsunami and nuclear accident. We are saddened by the loss of human lives, the displacement of people and the destruction of infrastructures. We laud the great courage of their people and the actions taken by the governments in responding to and handling the emergencies and their aftermath. We wish Japan and New Zealand well as they continue with recovery, reconstruction and rehabilitation.

Allow me to start my address with the obvious. I am sure, many of us who have been coming to Manila in previous years were very pleasantly surprised this morning when the gates opened and we were ushered into the headquarters of the WHO Regional Office for the Western Pacific. Just to put it in perspective, as many of you know, when the Government of Malaysia learned late in 2009 of the devastation brought by the typhoon to our neighbour, the Philippines, which unfortunately did not spare even the WHO Regional Office, we offered to host last year’s Regional Committee to allow WHO to recover, rehabilitate, refurbish and bring back to their functional state whatever structures had been damaged. Little did I know that from the floodwaters would rise this beautifully rehabilitated Conference Hall, sitting amidst a refreshing tropical garden, truly an oasis in the heart of bustling Manila. And what is more, I understand that the structures that were installed to prevent the same situation from happening again have withstood the recent onslaught of typhoons that have battered the country these past couple of months. So what we have are not only aesthetically restored facilities but, equally important, a safe haven for staff and visitors alike as they go about their work. To Dr Shin and the staff of the Regional Office, my congratulations for a good job done. And thank you for providing us with these facilities that will no doubt contribute to making our work over the next four days more pleasant and productive. I am personally very impressed with the rehabilitated Regional Office.

I would like to take a quick look at the year that was. It was a year of challenges and consolidation. Highlighted in my address last year were challenges that the health sector has to address…and urgently. I said that globalization made countries and peoples closer, that all of us have “become global villagers”. Globalization poses a threat to global security especially from emerging and re-emerging diseases, climate change and environmental degradation – challenges that are too complex for one country to solve on its own. The increasing degradation of our physical environment reminds us that cooperation is no longer a choice, but a necessity and that we need to talk less but communicate and coordinate better within and across countries. We reap the gains from rapid growth and development but we also have to balance this with ensuring that people enjoy the benefit of that progress. We look around and see the prevailing/widening inequity, the gap between those who benefit from modern technology and those who do not. And we saw how financial crisis compromises the capacity of countries and agencies such as WHO to carry out their mandate effectively.
And how did we, the Committee, fare last year? Those who were in Malaysia last year know that we finished our meeting in a record four days but we achieved what we had set out to do, thanks to everyone’s cooperation. Our frank and informed discussions resulted in important agreements. We agreed on the development of strong and robust health systems anchored on the values of primary health care, leading to universal coverage of quality health services as defined by respective countries. In my address to the Committee last year, I highlighted the critical role that health systems play in achieving the universal goal of health for all; and the fact that health programmes stand or collapse on the level of efficiency and effectiveness of health systems to deliver goods and services where and when they are needed. This could not be any less relevant now considering the shocks, the pounding and the beating that health systems everywhere experience – be it from the onslaught of natural and manmade emergencies, the emergence of some new or unfamiliar diseases, the insidious and worsening threat from a once neglected or inadequately addressed health problem, or the global financial crunch that strips countries of required resources to enable health systems to function optimally.

We adopted the Asia Pacific Strategy for Emerging Diseases (APSED) 2010 as a strategic framework: to guide national and local capacity-building programmes for emerging diseases and public health events; and to participate actively in regional preparedness, alert and response systems and networks. Our experience has shown how critical a common strategic framework is in enhancing our collective approach to addressing threats to global security. Of over 350 acute public health events detected last year, almost 60% were related to infectious diseases. Emerging diseases will continue to occur – what these are, and where and when these will happen, we cannot tell. Hence, the importance of our being equipped and prepared in order to mitigate their potential impact. While APSED (2010) continues its focus on emerging diseases, it has also widened its scope to include other public health threats, such as food safety events, disasters and emergencies.

We endorsed the strategy to stop tuberculosis in the Region. Yes, the disease has been with us for quite a while. But as we all know, there have been, time and again, developments that pose a challenge to effective and sustained tuberculosis control programmes. The emergence of drug-resistant tuberculosis, the increase in tuberculosis-HIV co-infection and some weaknesses in our health systems needed to be addressed in order to sustain whatever gains countries have achieved and ensure further success. The strategy, which introduces new evidence-based interventions and technologies, should, it is hoped, provide guidance so that all countries can, through comprehensive plans, reach and care for all tuberculosis patients at an early stage of their disease.

We also acknowledged and recognized the need for continued vigilance and the usual regional cooperation to maintain the Region’s poliomyelitis-free status. Reports of wild poliovirus importation into Xinjiang Uygur Autonomous Region in western China two months ago only underscore the critical importance of effective surveillance, investigation and decisive response. We also renewed our commitment to achieve measles elimination and hepatitis B control goals by 2012; and, of course, to face and address the worsening challenges of protecting our people’s health from the effects of climate change.

Our Region is rich with good experiences in addressing the many challenges to health of our people. Acknowledging that the broad determinants of health require multisectoral approaches, we confirmed that healthy settings have been effective in establishing partnerships between health and other development sectors, thus addressing public health priorities and integrating health promotion and health protection. We agreed to explore the full potential of and further scale up healthy settings activities for a holistic and comprehensive approach to promoting and protecting health.
The Region has remained strong, prepared and committed, and has stood up to many challenges – be that as individual Member States, or as a Region as a whole. We have worked and supported each other in times of difficulties and we have celebrated our successes together. I believe we have been able to reflect and agree on our direction for the future.

Before I turn over my responsibilities as Chairperson of this Committee, I would like to focus on two important health issues, noncommunicable diseases, and emergencies and disasters. I am sure you will all agree that over a decade ago we had, on a number of occasions, serious discussions and debates on the looming epidemic of noncommunicable diseases, the social and economic impact, the link to growth and development, and how countries or governments should address this complex problem. Over the years, our understanding of the magnitude and implications of noncommunicable diseases has grown, our knowledge of what needed to be done has increased, the technology and tools have become available, frameworks of action have been drawn up, and commitments to address the noncommunicable disease challenge have been made at various levels. The Political Declaration that resulted from the High-level Meeting of the United Nations General Assembly, which took place in New York last month, may yet be the tipping point for our decades-old struggle against noncommunicable diseases, and I must take the opportunity of congratulating Dr Margaret Chan on her role in putting this on the agenda of the General Assembly. Around 17 countries from this Region participated in this High-level Meeting. We were reminded of the global burden and threat of noncommunicable diseases, of the primary role of governments in responding to the challenge they pose, the common risk factors that need to be addressed, and the critical importance of strong and functioning health systems. The Meeting recognized that the cornerstone of the global response to noncommunicable diseases is prevention, and that leadership and multisectoral approaches for health at the government level are required. The commitment of heads of state and governments, namely to reduce risk factors and create health-promoting environments, to strengthen national policies and health systems, to strengthen international cooperation and collaborative partnerships, to promote research and development and the use of information and communications technology, and to look seriously into monitoring trends and progress made in the implementation of relevant plans and strategies, is expected to provide the needed push for the global response to noncommunicable diseases.

Tomorrow this Committee will again discuss noncommunicable diseases. The last time it was on our agenda was in 2008, when we endorsed the Regional Action Plan for Noncommunicable Diseases. I believe that since that time, Member States will have initiated action or further enhanced their national noncommunicable disease plans. In Malaysia, we have completed our National Strategic Plan for Noncommunicable Diseases. Guided by global and regional mandates, and consistent with the Tenth Malaysia Plan 2011–2015, which emphasizes the shift towards wellness and disease prevention, the National Strategic Plan presents a way to operationalize existing knowledge and current scientific evidence in reducing the burden of noncommunicable diseases within the Malaysian context. To push the policy and regulatory intervention agenda forward, the Cabinet Committee for a Health-Promoting Environment, comprising ten ministries, has been established and is chaired by the Honourable Deputy Prime Minister. The Plan identifies seven strategies and describes the role of key government ministries as well as key activities that will be undertaken. I hope that in our discussion tomorrow, we will learn more from each other as to how we may be able to translate into action all those commitments that were made in the past so that we may truly begin to move forward in addressing the noncommunicable disease challenge. And we should definitely discuss further how we might set and meet noncommunicable disease targets.

On 28 July 2011, Malaysia again proved its achievement in improving health outcomes of its people. I am proud to inform you that Malaysia has achieved the Western Pacific goal of reducing chronic hepatitis B infection rates to less than 1% among five-year-old children. This remarkable public health achievement is clearly a reflection of the implementation of a highly successful strategy to
control hepatitis B as part of the national immunization programme. This verification status granted through WHO is a recognition of our commitment to the resolutions of the Regional Committee for the Western Pacific and the World Health Assembly. Malaysia will continue to play its role in improving national, regional and global health security.

Finally, I close my address with some words regarding emergencies and disasters. I wish to acknowledge the Regional Director’s concern and unwavering support in strengthening capacities of Member States for health sector preparedness and response. Our Region has been known to be prone to events that threaten health security. Reports have it that our Region experiences the greatest number of natural disasters and emergencies. In almost every month since 2010, we have had some emergency occurring somewhere in the Region – from floods and cyclones in the Pacific, to typhoons, floods and volcanic activities in Vanuatu and the Philippines, to earthquakes of varying intensities that shook Vanuatu and Solomon Islands in the Pacific, and in China, Japan and New Zealand. The year 2010 was reported to be one of the worst years on record for natural disasters and, as I indicated early in my address, two tragic events occurred during the first quarter of 2011 – events that sent ripples within and beyond the Region. There is no telling where and when disaster will strike. And so there is nothing like being constantly prepared to respond to acute emergencies with reliable mechanisms to coordinate efforts and deliver emergency response, and to be able to step up risk reduction efforts to mitigate the impact of these events. The lessons that we have learnt from our experiences should be valuable inputs to improving further the capacities of the health sector to respond more effectively whenever disaster strikes again.

As I step down and hand over my responsibilities to the incoming Chairperson, I do so with the confidence that this Committee will continue to take the lead and guide our actions in the coming months and years. I am optimistic that our resolve to serve, to promote and to protect the health of peoples in our Region will bring us closer to our shared goal of improving health and quality of life in the Region. To my fellow office-bearers, thank you for your support. To all of you distinguished representatives, thank you for a most unforgettable experience of chairing our sixty-first session. And to the WHO Secretariat, my heartfelt thanks for being around to make my work easier and most enjoyable. I wish you all a memorable time in Manila and I look forward to continuing to work with you in the future.
ADDRESS BY THE INCOMING CHAIRPERSON, PEHIN DATO ADANAN YUSOF, MINISTER OF HEALTH, BRUNEI DARUSSALAM, AT THE SIXTY-SECOND SESSION OF THE WHO REGIONAL COMMITTEE FOR THE WESTERN PACIFIC

Exactly 10 years and one month ago today, my country, Brunei Darussalam played host for the first time to the Regional Committee, for its the fifty-second session. I refer to this for three reasons. First, we are all too aware of what happened on that tragic day of 11 September 2001. And it seemed a coincidence that, in his address to the Regional Committee at the opening ceremony on 10 September 2001, His Majesty the Sultan referred to “historians commenting on the 20th century as the most violent and destructive period in the history of mankind… but pointing to one shining light of achievement, and that is, the magnificent advance of medicine and health care”. I believe that those observations still ring true today. Second, that fifty-second session produced important policy documents, which have guided the work of the Region during the past decade. I refer to the regional strategies on food safety and on traditional medicine. During this session, we have for the Committee’s deliberation the follow-up strategies for these two important programme areas. Third, this is the second time that Brunei Darussalam has been honoured to chair this august body. For someone who may be regarded as “the new kid on the block”, having been in the job as Minister of Health for only 15 months, being entrusted to steer the deliberations of this Committee is a great personal privilege and a challenge. I thank you most sincerely for this singular honour of chairing the sixty-second session of the Regional Committee. I am humbled by your trust and confidence, and I assure you that I shall be doing my utmost to meet your expectations. With your support and full cooperation and that of my fellow office bearers and the Secretariat, I am sure we shall be able to achieve what we have set out to do and probably with some time to spare to enjoy the beauty of Manila and the Philippines.

And now to the business at hand. As you know, our agenda is full. Our task is to deliberate and make decisions on important issues such as the Programme Budget for the next biennium, the two strategy documents to which I referred to earlier, on food safety and traditional medicine, antimicrobial resistance, emergencies and disasters and, of course, noncommunicable diseases. Many of us participated in the United Nations General Assembly High-level Meeting, and I am sure our discussions on this subject will thus be more informed and deeply incisive. We shall also review progress of work in a number of programme areas, and I hope that at this session the Committee will be able to reach closure on our debates on the nomination of the Regional Director.

Allow me to just elaborate on some of the items on our agenda. Yesterday we heard from our Director-General. I appreciate her openness and courage to address up front a problem that for some time has affected work on promoting and improving health, not only in the Member States but in WHO as an organization. And I admire her resolve to initiate reforms within the Organization – directed to WHO’s core business, financial and managerial reforms and governance – to weather the storm, so to speak, of the financial crisis. Many of us would like to think that the global financial crisis was a thing of the past, that the threat of exclusion and inequity, the divide between the haves and the have-nots will no longer matter. But unfortunately, this is not the case. The Director-General has taken measures to lead the Organization through this crisis, to continue to buffer the crunch from both sides: stagnating if not decreasing inflow and increasing need for outflow. Health needs everywhere, including in our Region, are greater, while the traditional resource base is less secure.

I am sure you will agree with me that our discussions yesterday on the proposed WHO reform were productive and that we provided this Committee’s views on the issues, challenges and the overall reform process as input to the special session of the Executive Board in early November. And may I add that it has been very useful for me personally to have more insight into the issues, as I am also a member of the Executive Board. Earlier, I mentioned the reality of a stagnating or even decreasing inflow of resources and a less secure traditional resource base. This point is brought closer to home as we discuss the 2012-2013 programme budget later this morning. You will note that while the
percentage share of our Region from the global WHO budget remains almost the same, the actual amount may be much smaller with a reduced global budget. A challenge for all of us is to ensure that the Organization can do more with less, meaning more value for money, to reach out more aggressively to both traditional and non-traditional partners for the needed resources and to further utilize innovative collaborative approaches that are better able to support this work.

On a more positive note, the address and report of our Regional Director yesterday demonstrates what is achievable with a strong and focused leadership and with effective and efficient use of limited resources biased towards enhanced country presence. While 2010 was a year of great challenge, we also heard that there has been progress in addressing priority areas, including the health-related MDGs, noncommunicable diseases, health security, strengthening of health systems and renewed emphasis on some neglected diseases. It was also reported that new, more effective partnerships have been critical in the Region’s achievements. Reforms that were instituted in the Region over a year ago in the areas of financial, administrative and human resource management have begun to reap rewards in terms of a streamlined, more dynamic and efficient regional organization. While Dr Shin acknowledged that the job is far from being finished, we are confident that, with the people and the systems that have been put in place, WHO will continue to make progress in improving the health and quality of life of peoples in our Region.

Apart from the above achievements, I would also like to congratulate Dr Shin for the magnificent job he did with the physical infrastructure of the Regional Office: the pleasant and relaxing surroundings and a well-equipped conference hall, not to mention the excellent display of art that is truly a feast for our minds and soul. Like Dr Shin, I also believe that a beautiful and pleasant environment is good for our mental and physical health and contributes to bringing out the best in people. While I may not have had the chance to visit the Regional Office in the past, what I have heard so far and what I have seen truly deserve our congratulations, especially to Dr Shin.

I thank the Regional Director for his deep concern and for including emergencies and disasters on our agenda. The Honourable Minister Liow spoke about this in his address to the Committee yesterday. In addition, I would like to express my sympathy to the Government and people of the Philippines for the lives that were lost, the suffering and damage to property brought about by the recent typhoons that hit the country. Brunei Darussalam is fortunate in that it is not usually visited by natural disasters like typhoons, earthquakes and flooding; nonetheless, these and other health emergencies, like pandemic influenza (H1N1), SARS and other emerging infectious diseases, have heavily affected the Region and continue to threaten many of our Member States. Thus, it is worthwhile reviewing our preparedness and response mechanisms and further improving them, where necessary, in light of the lessons that have been learnt from recent events.

And speaking of disasters (I hope you will excuse the analogy), noncommunicable diseases are like a slowly but surely raging tsunami that will rudely awaken us tomorrow if we don’t deal with its root causes now, today. In our Region, as elsewhere, there is truly growing political commitment at the highest level to preventing and controlling the impending tsunami of noncommunicable diseases. Governments have, on a number of occasions, collectively committed themselves to the prevention and control of these diseases, and plans of action have been endorsed at global and regional levels. I am particularly keen for us to make further headway in addressing this complex health challenge. In Brunei Darussalam, noncommunicable diseases are among the top five causes of death, accounting for almost 80%. Although the results of the second national health and nutritional status survey will begin to be available only by the middle of next year, the results of the first survey show a rising prevalence of noncommunicable diseases in Brunei. There is a worrying rise in the prevalence of risk factors in
the population. The Government has moved swiftly to put in place policies and legislation to address these risk factors. In addition, in 2008, a 'health promotion centre' was established to drive the Government’s efforts to raise awareness and knowledge on health matters generally and on lifestyle-related diseases in particular. To empower people to live healthily, the health promotion centre serves as a resource centre to provide public access to information and to help them acquire skills and tools to manage their own health.

The High-level Meeting on the Prevention and Control of Noncommunicable Diseases convened by the United Nations General Assembly three weeks ago has given us much food for thought and pointers for policy and action in stronger terms than ever before. Our meeting is a timely opportunity to set us in the right direction. Yes, we do have broad and comprehensive guidance for addressing noncommunicable diseases. I hope, this time, we may be able to move towards better implementation of interventions that have been proven to be effective and efficient, with some time-bound targets and better monitoring for us to be able to track progress from time to time.

When I looked at our agenda, I thought that the Committee would be likely to have rich, interesting and educational discussions when it took up traditional medicine and food safety. The debates on the two strategies at the fifty-second session of the Regional Committee 10 years ago already reflected a high level of interest among Member States. With recent developments and advances in knowledge and technology, I am sure we will have much to share and discuss. I say this because traditional medicine, as we all know, has been around for centuries, either used by populations to meet their health needs or as a complement to western and modern medicine. The level of government commitment and support varies across the Region, and there is a wide diversity in practices and products as well as differences in the development and roles of traditional medicine. But one thing is sure. We are all for the use of safe and effective practices and products that contribute to making health care accessible and affordable to the peoples of our Region.

The other policy document that is placed before us is on food safety. No one would argue about the importance of ensuring the safety and quality of food and food products for all the people in this Region. Our own experience shows us that issues related to food safety have serious public health and economic impacts that are not confined to one country but, with increasing international trade and travel, can result in food safety emergencies across borders. I therefore look forward to the Committee’s deliberations on these two important agenda items.

Ours is a dynamic and interconnected world. We who work in the field of health know only too well our increasing interdependence on each other. We therefore need to look beyond our borders, beyond traditional approaches of doing things. The complexity of health issues demands that we reach out to different sectors, interact with and understand the situation of our neighbours and, most of all, work collectively in addressing the challenges that prevent our people from enjoying their right to health and well-being. This is what makes me proud to be a member of this Committee, of this Region. As diverse as our countries may be, we have been moving as one to ensure that our people, our Region has the right to health and well-being. We may not have reached our goal yet, but we are well on our way. Sessions of this Committee have time and again reached consensus on difficult issues, because we all have the good of the Region as the guiding principle for our actions. Let us continue to work together for the health and well-being of all the peoples of the Western Pacific Region.
ADDRESS BY THE DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION, DR MARGARET CHAN, AT THE SIXTY-SECOND SESSION OF THE WHO REGIONAL COMMITTEE FOR THE WESTERN PACIFIC

First, I wish to echo the words of the outgoing Chairperson in expressing my condolences to and solidarity with Japan and New Zealand, as they work to recover from the devastating natural disasters that affected them earlier this year.

This century began with the Millennium Development Goals and the elevated role they gave to health in the drive to reduce poverty and human misery. Great progress has been made in broad-based efforts that also gave us many innovations, from new funding agencies and financial instruments to public-private partnerships to develop new products for diseases of the poor. Nearly 7 million people in low- and middle-income countries are seeing their lives revived and prolonged by antiretroviral therapy. The tuberculosis epidemic, once declared a health emergency, has been turned around. Malaria cases and mortality have dropped in some African countries by more than 50%. The most recent UNICEF/WHO estimates demonstrate tremendous progress in reducing child mortality in the Asia-Pacific region. This group of countries has achieved a nearly 70% decline in mortality of children under 5 in just 20 years, dropping from 2.2 million in 1990 to just under 700,000 in 2010. This is dramatic. This amounts to 4000 young lives being saved each and every day. That is also 4000 mothers and fathers being spared the immense grief of losing a child.

Yet this progress has been made against some ever-growing odds. In reality, the first decade of the twenty-first century evolved in turmoil. A world of radically increased interdependence found itself beset by one global crisis after another. The global economic downturn has deepened. Food prices continue to soar, and food security has become a far more critical issue, which is difficult to address. Last year, the World Bank estimated that 64 million people in low- and middle-income countries had been forced into extreme poverty as a result of the fuel, food and financial crises. Emerging infectious diseases are now a much larger health and economic menace in a world tied together by the speed of international travel and 'live-wired' by chat rooms, blogs and Twitter.

As the scare raised by the alleged association between measles, mumps and rubella vaccine and autism taught us, countering unfounded public fears and ignorance with first-rate science has become much harder than it was just a decade ago. The climate is warming. Natural disasters are becoming more frequent and destructive, as mentioned by the outgoing Chairperson. And civil strife and conflict, sometimes brief, sometimes sustained, mar nearly every region in the world. Chronic noncommunicable diseases have spread everywhere, fuelled as they are by universal trends like rapid unplanned urbanization and the globalization of unhealthy lifestyles. Diseases like heart disease, diabetes and cancer know no north-south, tropical-temperate or rich-poor divide. These are the diseases that break the bank. Just last month, an expert study concluded that the costs of treating cancer are now unsustainable in even the richest nations. In some developing countries, the costs of treating diabetes alone devour 15% of the entire national budget for health.

The year 2011 has experienced this turmoil in concentrated form. The face of the Middle East is changing. Populations have risen up to demand democratic reforms and respect for human rights, and this includes the right to health. These transformational events have been, at times, highly inspiring, at other times deeply disquieting. The triple tragedies that struck Japan in March quickly became the most expensive natural disaster on record. In the wake of last year’s devastating earthquake, Haiti remains crippled by the worst cholera outbreak in modern history. Drought, crop failure, livestock deaths and human starvation ravage the Horn of Africa in the worst food security crisis experienced in decades. For multiple reasons, humanitarian agencies have been able to deliver only a fraction of the
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aid that is needed. Levels of malnutrition are at a record high. The crisis is expected to continue for some months. Tens of thousands have already died.

In September, WHO received confirmation that the most dangerous strain of poliovirus has spread from Pakistan to China. China eradicated polio in 1994 and has since been free of this disease, save for a single imported case in 1999. Again, this tells us that endemic transmission of the poliovirus anywhere in the world threatens the world everywhere. I want to congratulate China on its impressive response to this setback. Health officials, led by the Minister of Health himself, are following an ambitious outbreak response plan that is fully aligned with guidelines issued by the World Health Assembly in 2006. This gives all other countries the confidence that a sudden setback can be swiftly countered with a massive aggressive response, and this response is continuing.

This year also saw the United Nations General Assembly address a health problem, for only the second time in its history, during its special session on noncommunicable diseases. I commend the leadership during that meeting of Member States from the Western Pacific Region and in particular the contributions of the Pacific island nations. The United Nations event on noncommunicable diseases unquestionably raised the profile of these diseases, focused attention on their costs to economies as well as to health and gave appropriate priority to population-wide interventions. The high-level event also made it clear that the responsibility for preventing and controlling noncommunicable diseases cannot fall on the health sector alone. Another noncommunicable disease is mental health. Today is ‘mental health day’, for which WHO headquarters is launching a new mental health atlas.

The determinants of these diseases are too broad. A whole-of-government approach is needed, in which health is included in all relevant policies. The forces driving the globalization of unhealthy lifestyles are too powerful. The response to these trends must come with equal power, with top-level power that can command the right protective policies across all sectors. The growing prevalence of obesity in many populations is not an indicator of a failure of individual willpower. It indicates a failure of the social environment, as shaped by high-level policies. More and more, we see that many of today’s biggest health challenges have global dimensions with broad root causes that demand whole-of-government approaches. This is true for noncommunicable diseases, for antimicrobial resistance and for food safety, items that you will be discussing during this session.

The high-level meeting on noncommunicable diseases had another bright side, with another smart acknowledgement. Consensus is now solid that a robust primary health care system is the only way that countries will be able to cope with the growing burden of chronic diseases. As challenges like these mount, the question on the tip of the tongue of anyone concerned about the future prospects of public health is this: Can the striking momentum for better health that marked the start of this century be maintained in the current climate of deepening financial austerity? For HIV/AIDS, this question is not on the tip of the tongue. It is loudly spoken. Growing evidence tells us that antiretroviral therapy is more than just a treatment. It is also our most powerful preventive tool, capable of reducing the risk of transmission when infection is detected early enough and patients promptly receive the right treatment. But treating more people earlier and therefore for a longer time has huge financial implications. Who will pay?

When money is tight, donors start comparing how much health can be bought for a given sum, with childhood vaccines usually coming out as the winning investment by far. This is a dangerous calculation, as it fails to take into account the magnitude of human suffering, especially when the suffering is chronic.
Dr Shin has often stated the top priority for this region very clearly and succinctly. That is, strengthening health systems based on primary health care. And that means striving for universal health care coverage, finding fair ways to finance health services, improving access to medical products and health information and developing the health workforce. This is the mind-set behind some shifts in thinking about the role of traditional medicine in this Region, as set out in the draft regional strategy for traditional medicine. In comparison with the previous strategy, the draft gives greater emphasis to the values of primary health care and to the contribution that traditional medicine can make to universal coverage. This makes perfect sense, especially in a region where traditional medicine has a centuries-old home. Most appropriately, the strategy emphasizes the importance of adequate regulatory frameworks for ensuring the quality, safety and efficacy of traditional medicines and practices.

The alarming problem of antimicrobial resistance is on your agenda. As the document notes, countries in this Region have a number of so-called “perverse incentives” that encourage and sustain the misuse and overuse of antibiotics. These include the policy of using money from the sale of medicines to finance health services. The unethical promotion of antibiotics adds to the problem. As a result, many countries have an abundance of expensive, non-essential medicines but a shortage of essential medicines. For far too long, we have taken precious, fragile medicines for granted, assuming that the ones lost to drug resistance will simply be replaced by newer and better ones. This is not at all what is happening, with the pipeline for new antimicrobials all but dried up. The threat of returning to a pre-antibiotic era is genuine and probably most vividly illustrated by the rise of multidrug-resistant and extensively drug-resistant tuberculosis. For malaria, stepped-up surveillance has detected treatment failures with the currently used artemisinin-combination therapy along the Thai-Cambodian border. This failure is due to resistance to artemisinin, our best and last class of effective antimalarials. Such trends usher in a financial catastrophe as well as a health catastrophe. Second-line drugs are sometimes more toxic and nearly always more expensive than first-line drugs, often hundreds of times more costly. This is the last thing we need at a time of deepening financial austerity worldwide. We need the opposite. We need health programmes that show a thirst for efficiency and an intolerance of waste. Condoning behaviour, whether by prescribers, consumers or veterinarians, that contributes to the loss of front-line treatments is an extreme expression of waste. In supporting primary health care, health officials must explode the myth that inexpensive care, including inexpensive medicines, is second-rate care for the poor. More spending on health does not automatically bring better health outcomes. Buying the most expensive drugs and medical devices does not automatically buy better health.

A draft food safety strategy is on your agenda. The strategy emphasizes the development of national food control systems and makes frequent reference to the capacities needed for compliance with the International Health Regulations (2005) and for participation in the International Food Safety Authorities Network (INFOSAN). INFOSAN was initiated by WHO in 2007 and operates as the investigative arm of efforts to protect the safety of the food supply. The Network conducts trace-back studies with particular attention to contaminated items that may have entered international trade and commerce. Outbreaks of foodborne disease have become an especially large menace in a world bound together by huge volumes of international trade and travel. They are large in their potentially wide geographical spread, often involving multiple countries. They are large in the costs of recalls, measured in tonnes. And they are large in the complexity of investigations, especially when a meal may contain food items and ingredients from all around the world, making investigations extremely difficult. Today, problems can arise from any link or kink in a convoluted food chain. Adding to the complexity are the increasing use of formerly exotic cuisines, where ingredients like, say, a sprinkling of bean sprouts as a garnish, are almost subliminal and unlikely to be recalled in a food history. This problem was experienced most recently in Germany’s especially large and lethal Escherichia coli outbreak that began in May. The strategy’s particular emphasis on risk-based regulatory frameworks
and strengthened capacity for inspections is a wise move. Such a move protects consumers and protects economies.

A progress report on dengue is on your agenda. The prevention and control of dengue is a high priority in this Region, and rightly so, and also in other regions, such as the Eastern Mediterranean Region, where there have been large outbreaks. We need to address this priority more aggressively through collaboration with other sectors, including environmental sanitation. The recent ASEAN initiative to mark "dengue day" on 15 June is a commendable way to improve awareness and encourage responsible preventive behaviour at community and individual levels. I wish to thank the Government of Singapore for organizing last year’s dengue workshop, which continues to benefit this Region and two others.

You will devote some time to noncommunicable diseases. I have a final comment, which is a simple reminder of the importance of educating the public and engaging civil society organizations. These are resources that can help quench that thirst for efficiency I mentioned earlier, especially as you work to combat the rise of noncommunicable diseases. Worldwide, the prevalence of obesity and overweight in young children is rising several times faster than in the adult population. Children the world over love the same cartoon characters that tell them what to eat and drink. Watch out!

Big Tobacco’s efforts to subvert the WHO Framework Convention on Tobacco Control have reached new heights. Tactics that were previously covert are now out in the open and extremely aggressive. The high-profile commercial and investment arbitrations targeting Uruguay and Australia are deliberately designed to instil fear in other countries wishing to introduce similarly tough tobacco control measures. Numerous other countries are being subjected to the same kind of aggressive scare tactics. It is hard for any country to bear the financial burden of this kind of litigation, but most especially so for small countries. I urge all the Member States of WHO to stand firm together, in solidarity with these countries and with Australia in this Region. Do not bow to pressure. Big Tobacco can afford to hire the best lawyers and public relations firms that money can buy. Big Money can speak louder than any moral, ethical or public health argument, and can trample even the most damning scientific evidence. We have seen this happen before. It is horrific to think that an industry known for its dirty tricks and dirty laundry could be allowed to trump what is clearly in the public’s best interest. We must stand firm. In the face of such pressures and tactics, my reminder is this: a health-wise population fights back street-wise.

Keep the importance of health information in mind, as often stressed by Dr Shin, and exploit the capacity of primary health care to make your populations health-wise. They will mobilize your politicians to fight back. We must never allow the tobacco industry to take the upper hand.

Thank you.
ADDRESS BY THE WORLD HEALTH ORGANIZATION REGIONAL DIRECTOR FOR
THE WESTERN PACIFIC, DR SHIN YOUNG-SOO, AT THE
SIXTY-SECOND SESSION OF THE WHO REGIONAL COMMITTEE
FOR THE WESTERN PACIFIC

Welcome to the sixty-second session of the Regional Committee for the Western Pacific – the first session of our governing body to be held in our newly renovated Conference Hall. We had planned to meet in Manila last year but the typhoon that swept through the Philippines in September 2009 caused extensive damage to this Conference Hall and to other facilities at the Regional Office. Knowing that repairs would take time, the Government of Malaysia graciously offered to host last year’s session in Putrajaya. On behalf of WHO and all of our Member States, I wish to once again thank Malaysia for hosting a successful meeting.

Those of you who have not visited the Regional Office for some time will immediately notice changes to our building. We removed the parking area just inside our gate so that visitors are now greeted by a more open and inviting tropical setting. The renovated Conference Hall has retained its iconic look but with a modern twist. Artful internal design has created an elegant but functional interior. Better use of the space allows for more breakout meetings and functions. And there are also many renovations that you cannot see, such as better drainage and improved fresh air intake. These buildings belong to you, our Member States. I hope that you will agree with me that we now have a Regional Office to be proud of and one that will serve us well for generations.

Many of you will have seen the art exhibition around the Conference Hall. The exhibit has been generously loaned to us by the Ayala Museum to celebrate the first use of the Conference Hall by the Regional Committee. As you heard earlier this morning, we are hoping that Member States will donate artwork for a permanent exhibition on the theme of "Healing and caring" that will reflect the diversity of the Western Pacific Region.

Since we last met, the global public health community has faced a year of change and challenge. The global financial crisis has impacted on many of us, limiting resources and constraining the ability of WHO to develop new initiatives to assist Member States. Despite the challenging environment much has been achieved this year. Our annual report – The Work of WHO in the Western Pacific Region – provides details of these achievements. I trust that you have had an opportunity to read the report and will raise any questions you might have with me or any of our Directors.

Rather than go over the details in the annual report, I would like to focus much of my speech today on the challenges that remain as we work together to reach our shared goal of good health for all people of the Western Pacific Region.

Last year I made some personal commitments to you. I promised to continue to push forward in four priority areas: achieving the health-related Millennium Development Goals, addressing noncommunicable diseases, improving health security, and strengthening health systems. I also promised to pull some neglected diseases back into the spotlight. And finally, I promised to reach out and work in greater partnership with others.

As a Region, we can be pleased with the progress made towards Millennium Development Goal 4, Reducing child mortality. I am also pleased to report that the Western Pacific Region is on track to meet Goal 6, Combating HIV/AIDS, malaria and tuberculosis. Such has been the progress with malaria that nine out of the ten malaria-affected countries in our Region have now formulated national elimination plans. But these gains could soon be reversed if we do not tackle antimicrobial resistance.
Multidrug resistance to malaria and tuberculosis treatments is rising in our Region. None of us wants to return to the era before antibiotic treatment. That is why antimicrobial resistance is on our agenda for discussion this week. I look forward to hearing your thoughts on how we might urgently tackle this critical issue.

Progress towards Millennium Development Goal 5, Improving maternal health, is still lagging behind. The reasons for this are complex. Certainly weak health systems and lack of well-trained community health workers are major factors. But the more I travel, the more I realize that much of our failure is related to the low position that women occupy in many of our societies. Gender-based violence in our Region is shockingly high. Too many women lack access to safe contraceptives and hence have little control over their own fate. Promoting gender equality and empowering women – the focus of Millennium Development Goal 3 – are keys to reducing the tragic toll of maternal, infant and child deaths. That is why last year I highlighted the need to mainstream gender perspectives in all our technical work. I am therefore pleased to announce that a new report – Women and health in the Western Pacific Region: remaining challenges and new opportunities – has just been published. The report shows us where we are now and, most importantly, what still needs to be done.

Tomorrow, we will be devoting more than half a day to noncommunicable diseases. The United Nations General Assembly High-level Meeting on Noncommunicable Disease Prevention and Control – held just three weeks ago in New York – was a remarkable success. World leaders made a commitment to taking a multisectoral approach to addressing these diseases. They also reaffirmed WHO’s role as leader in the global battle against them. Work on noncommunicable diseases undertaken by our Member States – including the Nadi Statement, the Seoul Declaration and the Honiara Communiqué – helped ensure that the collective voice of the Western Pacific Region was reflected in the summit’s political declaration. We now need to turn political recognition into concrete action, particularly in low-resource settings where the impact of the rising tide of noncommunicable diseases will be felt the hardest.

The strenuous work by many of our Member States, in particular in implementing the WHO Framework Convention on Tobacco Control even in the face of pressure by the tobacco industry, provides examples of what can be achieved through strong political commitment. I was delighted earlier this year when Dr Chan recognized the courage and leadership of Dr York Chow, Secretary for Food and Health, Hong Kong, China, and the Honourable Nicola Roxon, Minister of Health and Ageing, Australia. Both leaders have worked tirelessly to reduce tobacco consumption and have demonstrated what can be achieved when there is strong political commitment to addressing noncommunicable disease risk factors.

As we are all aware, our Region sadly encounters more than its fair share of natural disasters. Worldwide attention was drawn to the tragic earthquake in Christchurch, New Zealand, and the devastating triple emergency – earthquake, tsunami and nuclear disaster – in Japan. I visited the site of these disasters and thank both governments for hosting me during such difficult times. Despite the tragic loss of lives and billions and billions of dollars in damage, the strength, determination and community spirit of the people of Japan and the people of New Zealand was evident everywhere I travelled.

The triple disaster in Japan tested all aspects of WHO’s emergency response. It also demonstrated the importance of preparedness and the need for an integrated approach to disaster management. We owe it to the victims of these – and the many other disasters in our Region – to put the lessons learnt into practice and to continue to build a health-secure Region. That is why we have added a special item on disasters and emergencies to our agenda on Wednesday.
As we all know, our Region was declared poliomyelitis-free more than a decade ago. Thus, the news of the importation of a wild poliovirus in China required urgent action. China has responded quickly to the outbreak, dispatching many experts to the field and undertaking mass vaccination campaigns. WHO staff from Headquarters, the Regional Office and our Country Office are working closely with Chinese experts to address the remaining challenges. The outbreak in China is a powerful reminder to all of us that, until the world is free from poliomyelitis, all countries remain vulnerable to importations. We must maintain high vaccination coverage rates throughout our Region and continue to support endemic countries in neighbouring regions to eradicate poliomyelitis as soon as possible.

Now, I wish to report on the successes that have been achieved in some neglected diseases. Work to eliminate yaws, leprosy and lymphatic filariasis – awful diseases that should have been banished from the Pacific a long time ago – is progressing rapidly. A new Action Framework for Leprosy Control and Rehabilitation in the Pacific Island Countries is now in place. An action framework, based on the findings of an in-depth survey, will soon be available to support yaws elimination in Vanuatu. And country-specific plans to eliminate lymphatic filariasis completely from the Pacific are now being implemented.

My final commitment last year concerned reaching out and working in greater partnership with others. After many years of working on somewhat parallel tracks, a series of very constructive discussions this year resulted in the signing of a special memorandum of understanding between myself and my counterpart in UNAIDS in Bangkok, Thailand. This agreement is more than just a piece of paper. It represents a new level of engagement at regional level between the two agencies and a clear path through which we can now work to support our Member States. Collaborative agreements that again focus on how we can work side by side at country level were also reached with the Global Fund to fight AIDS, Tuberculosis and Malaria and the International Federation of Red Cross and Red Crescent Societies.

I am also particularly proud of two additional achievements this year – our strengthened focus and partnerships in the Pacific and our stronger relationships with the United Nations Secretariat. The new Division of Pacific Technical Support, based in Fiji, has allowed us to reach out more effectively to our Member States in the Pacific and work more closely with key partners, in particular the Secretariat of the Pacific Community. The Ninth Meeting of Ministers of Health for the Pacific Island Countries, generously hosted by the Government of Solomon Islands in June, provided an invaluable opportunity to understand better the needs of the Pacific. Representatives from 21 Pacific island countries and areas took part in this meeting, as well as 11 representatives from United Nations offices and other organizations. Priorities raised are now forming the basis for our work over the next two years in the Pacific.

As I mentioned earlier, I am also proud of our strengthened engagement with the United Nations Secretariat. In September, I joined the United Nations Secretary-General Ban Ki-moon on his official visit to Australia, Kiribati, New Zealand and Solomon Islands. The visit provided insights into the many challenges faced across the Pacific and a chance to explore how, as a United Nations family, we can better serve the people of the region.

Health systems remain fragmented in many parts of the Western Pacific Region. We need to work together to strengthen systems in a more coherent manner. We have seen some remarkable progress when the focus for health system strengthening has been placed on developing good primary health care and on achieving universal access – the twin foundations of an effective health system. Investment in developing primary health care has resulted in significant progress in the Lao People's Democratic Republic. WHO and other partners have worked with the Government to focus efforts on
strengthening health care at grassroots level, and documented improvements in maternal and child health have already been achieved. The Philippines is moving forward with efforts to achieve universal health care for all Filipinos. The Aquino Health Agenda provides strong political support for expansion of current health insurance systems to create a national health insurance programme that could ultimately provide protection of all citizens. I commend these efforts and the leadership that President Aquino is taking in this critical area.

Our Director-General has highlighted WHO’s need to keep pace with evolving global health needs. She updated us on the consultative process to seek guidance from our Member States on reforming WHO for a healthy future. Consultations with Member States and internal discussions will soon result in a comprehensive global reform plan for WHO. Reform will encompass our technical work, the way we manage that work and the way in which our Organization is governed. I fully support all the steps that Dr Chan is taking to ensure that our Organization is "fit for purpose" and I applaud Dr Chan for her tireless efforts.

As you are aware, in this Region we launched a programme to revitalize and develop our Organization two years ago. Some of the initiatives we have put in place have already improved the way we work. And some of these initiatives, I am proud to say, are now being used as models in other WHO regions. We have done a lot to make our Organization leaner and more effective. But I firmly believe that we still need to do more. We need to show that we can add value particularly where it matters most – at country level. With support from the Australian Government, we have now launched a further programme of development within the Region focused specifically on enhancing our performance at country level. This complements the areas of global reform that Dr Chan is proposing and will provide examples that could be adopted elsewhere in the Organization. But what do we mean by "adding value" and enhancing our performance at country level? We mean supporting our Member States and partners to understand better the health problems faced in their countries, in particular by those people living in the margins of society. We mean being able to provide advice on interventions in a way that can easily be transformed into robust national policies and plans. And we mean being able to help facilitate the processes – global, regional and within countries – needed to improve health.

A regional office cannot do this alone. We are part of a much larger organization. We need your input on the global reform that Dr Chan has courageously embarked upon. And we need your support to develop a better global and regional WHO. The Organization is at a tipping point. Together we have the opportunity to move it forward. I look forward to hearing your thoughts this afternoon as we discuss reforming WHO for a healthy future.
Sixty-sixth session
Agenda item 117
Follow-up to the outcome of the Millennium Summit

Draft resolution submitted by the President of the General Assembly

Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

The General Assembly,

Adopts the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases annexed to the present resolution.

Annex

Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations from 19 to 20 September 2011, to address the prevention and control of non-communicable diseases worldwide, with a particular focus on developmental and other challenges and social and economic impacts, particularly for developing countries,

1. Acknowledge that the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century, which undermines social and economic development throughout the world, and threatens the achievement of internationally agreed development goals;

2. Recognize that non-communicable diseases are a threat to the economies of many Member States, and may lead to increasing inequalities between countries and populations;

3. Recognize the primary role and responsibility of Governments in responding to the challenge of non-communicable diseases and the essential need for the efforts
and engagement of all sectors of society to generate effective responses for the prevention and control of non-communicable diseases;

4. Recognize also the important role of the international community and international cooperation in assisting Member States, particularly developing countries, in complementing national efforts to generate an effective response to non-communicable diseases;

5. Reaffirm the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

6. Recognize the urgent need for greater measures at global, regional and national levels to prevent and control non-communicable diseases in order to contribute to the full realization of the right of everyone to the highest attainable standard of physical and mental health;

7. Recall the relevant mandates of the United Nations General Assembly, in particular resolutions 64/265 and 65/238;

8. Note with appreciation the World Health Organization (WHO) Framework Convention on Tobacco Control, reaffirm all relevant resolutions and decisions adopted by the World Health Assembly on the prevention and control of non-communicable diseases, and underline the importance for Member States to continue addressing common risk factors for non-communicable diseases through the implementation of the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases as well as the Global Strategy on Diet, Physical Activity and Health, and the Global Strategy to Reduce the Harmful Use of Alcohol;

9. Recall the Ministerial Declaration adopted at the 2009 high-level segment of the United Nations Economic and Social Council, which called for urgent action to implement the WHO Global Strategy for the Prevention and Control of Non-communicable Diseases and its related action plan;


11. Take note also with appreciation of the outcomes of the regional multisectoral consultations, including the adoption of Ministerial Declarations, which were held by the World Health Organization in collaboration with Member States, with the support and active participation of regional commissions and other relevant United
Nations agencies and entities, and served to provide inputs to the preparations for the high-level meeting in accordance with resolution 65/238;

12. Welcome the convening of the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control, which was organized by the Russian Federation and WHO and held on 28 and 29 April 2011, in Moscow, and the adoption of the Moscow Declaration, and recall resolution 64/11 of the World Health Assembly;

13. Recognize the leading role of the World Health Organization as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate, and reaffirm its leadership and coordination role in promoting and monitoring global action against non-communicable diseases in relation to the work of other relevant United Nations agencies, development banks, and other regional and international organizations in addressing non-communicable diseases in a coordinated manner;

A challenge of epidemic proportions and its socio-economic and developmental impacts

14. Note with profound concern that, according to WHO, in 2008, an estimated 36 million of the 57 million global deaths were due to non-communicable diseases, principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, including about 9 million before the age of 60, and that nearly 80 per cent of those deaths occurred in developing countries;

15. Note also with profound concern that non-communicable diseases are among the leading causes of preventable morbidity and of related disability;

16. Recognize further that communicable diseases, maternal and perinatal conditions and nutritional deficiencies are currently the most common causes of death in Africa, and note with concern the growing double burden of disease, including in Africa, caused by the rapidly rising incidence of non-communicable diseases, which are projected to become the most common causes of death by 2030;

17. Note further that there is a range of other non-communicable diseases and conditions, for which the risk factors and the need for preventive measures, screening, treatment and care are linked with the four most prominent non-communicable diseases;

18. Recognize that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global non-communicable disease burden, for which there is a need to provide equitable access to effective programmes and health-care interventions;

19. Recognize that renal, oral and eye diseases pose a major health burden for many countries and that these diseases share common risk factors and can benefit from common responses to non-communicable diseases;

20. Recognize that the most prominent non-communicable diseases are linked to common risk factors, namely tobacco use, harmful use of alcohol, an unhealthy diet, and lack of physical activity;

21. Recognize that the conditions in which people live and their lifestyles influence their health and quality of life, and that poverty, uneven distribution of
wealth, lack of education, rapid urbanization and population ageing, and the economic social, gender, political, behavioural and environmental determinants of health are among the contributing factors to the rising incidence and prevalence of non-communicable diseases;

22. Note with grave concern the vicious cycle whereby non-communicable diseases and their risk factors worsen poverty, while poverty contributes to rising rates of non-communicable diseases, posing a threat to public health and economic and social development;

23. Note with concern that the rapidly growing magnitude of non-communicable diseases affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in developing countries bear a disproportionate burden and that non-communicable diseases can affect women and men differently;

24. Note with concern the rising levels of obesity in different regions, particularly among children and youth, and note that obesity, an unhealthy diet and physical inactivity have strong linkages with the four main non-communicable diseases, and are associated with higher health costs and reduced productivity;

25. Express deep concern that women bear a disproportionate share of the burden of care-giving and that, in some populations, women tend to be less physically active than men, are more likely to be obese and are taking up smoking at alarming rates;

26. Note also with concern that maternal and child health is inextricably linked with non-communicable diseases and their risk factors, specifically as prenatal malnutrition and low birth weight create a predisposition to obesity, high blood pressure, heart disease and diabetes later in life, and that pregnancy conditions, such as maternal obesity and gestational diabetes, are associated with similar risks in both the mother and her offspring;

27. Note with concern the possible linkages between non-communicable diseases and some communicable diseases, such as HIV/AIDS, and call to integrate, as appropriate, responses for HIV/AIDS and non-communicable diseases and, in this regard, for attention to be given to people living with HIV/AIDS, especially in countries with a high prevalence of HIV/AIDS and in accordance with national priorities;

28. Recognize that smoke exposure from the use of inefficient cooking stoves for indoor cooking or heating contributes to and may exacerbate lung and respiratory conditions, with a disproportionate effect on women and children in poor populations whose households may be dependant on such fuels;

29. Acknowledge also the existence of significant inequalities in the burden of non-communicable diseases and in access to non-communicable disease prevention and control, both between countries, and within countries and communities;

30. Recognize the critical importance of strengthening health systems, including health-care infrastructure, human resources for health, health and social protection systems, particularly in developing countries in order to respond effectively and equitably to the health-care needs of people with non-communicable diseases;
31. Note with grave concern that non-communicable diseases and their risk factors lead to increased burdens on individuals, families and communities, including impoverishment from long-term treatment and care costs, and to a loss of productivity that threatens household income and leads to productivity loss for individuals and their families and to the economies of Member States, making non-communicable diseases a contributing factor to poverty and hunger, which may have a direct impact on the achievement of the internationally agreed development goals, including the Millennium Development Goals;

32. Express deep concern at the ongoing negative impacts of the financial and economic crisis, volatile energy and food prices and ongoing concerns over food security, as well as the increasing challenges posed by climate change and the loss of biodiversity, and their effect on the control and prevention of non-communicable diseases, and emphasize, in this regard, the need for prompt and robust, coordinated and multisectoral efforts to address those impacts, while building on efforts already under way;

Responding to the challenge: a whole-of-government and a whole-of-society effort

33. Recognize that the rising prevalence, morbidity and mortality of non-communicable diseases worldwide can be largely prevented and controlled through collective and multisectoral action by all Member States and other relevant stakeholders at local, national, regional, and global levels, and by raising the priority accorded to non-communicable diseases in development cooperation by enhancing such cooperation in this regard;

34. Recognize that prevention must be the cornerstone of the global response to non-communicable diseases;

35. Recognize also the critical importance of reducing the level of exposure of individuals and populations to the common modifiable risk factors for non-communicable diseases, namely, tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol, and their determinants, while at the same time strengthening the capacity of individuals and populations to make healthier choices and follow lifestyle patterns that foster good health;

36. Recognize that effective non-communicable disease prevention and control require leadership and multisectoral approaches for health at the government level, including, as appropriate, health in all policies and whole-of-government approaches across such sectors as health, education, energy, agriculture, sports, transport, communication, urban planning, environment, labour, employment, industry and trade, finance and social and economic development;

37. Acknowledge the contribution and important role played by all relevant stakeholders, including individuals, families, and communities, intergovernmental organizations and religious institutions, civil society, academis, media, voluntary associations, and, where and as appropriate, the private sector and industry, in support of national efforts for non-communicable disease prevention and control, and recognize the need to further support the strengthening of coordination among these stakeholders in order to improve effectiveness of these efforts;

38. Recognize the fundamental conflict of interest between the tobacco industry and public health;
39. Recognize that the incidence and impacts of non-communicable diseases can be largely prevented or reduced with an approach that incorporates evidence-based, affordable, cost-effective, population-wide and multisectoral interventions;

40. Acknowledge that resources devoted to combating the challenges posed by non-communicable diseases at the national, regional and international levels are not commensurate with the magnitude of the problem;

41. Recognize the importance of strengthening local, provincial, national and regional capacities to address and effectively combat non-communicable diseases, particularly in developing countries, and that this may entail increased and sustained human, financial and technical resources;

42. Acknowledge the need to put forward a multisectoral approach for health at all government levels, to address non-communicable disease risk factors and underlying determinants of health comprehensively and decisively;

Non-communicable diseases can be prevented and their impacts significantly reduced, with millions of lives saved and untold suffering avoided. We therefore commit to:

**Reduce risk factors and create health-promoting environments**

43. Advance the implementation of multisectoral, cost-effective, population-wide interventions in order to reduce the impact of the common non-communicable disease risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, through the implementation of relevant international agreements and strategies, and education, legislative, regulatory and fiscal measures, without prejudice to the right of sovereign Nations to determine and establish their taxation policies, other policies, where appropriate, by involving all relevant sectors, civil society and communities as appropriate and by taking the following actions:

(a) Encourage the development of multisectoral public policies that create equitable health-promoting environments that empower individuals, families and communities to make healthy choices and lead healthy lives;

(b) Develop, strengthen and implement, as appropriate, multisectoral public policies and action plans to promote health education and health literacy, including through evidence-based education and information strategies and programmes in and out of schools, and through public awareness campaigns, as important factors in furthering the prevention and control of non-communicable diseases, recognizing that a strong focus on health literacy is at an early stage in many countries;

(c) Accelerate implementation by States parties of the WHO Framework Convention on Tobacco Control, recognizing the full range of measures, including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the Framework Convention on Tobacco Control, recognizing that substantially reducing tobacco consumption is an important contribution to reducing non-communicable diseases and can have considerable health benefits for individuals and countries, and that price and tax measures are an effective and important means of reducing tobacco consumption;

(d) Advance the implementation of the WHO Global Strategy on Diet, Physical Activity and Health, including, where appropriate, through the introduction
of policies and actions aimed at promoting healthy diets and increasing physical activity in the entire population, including in all aspects of daily living, such as giving priority to regular and intense physical education classes in schools, urban planning and re-engineering for active transport, the provision of incentives for work-site healthy-lifestyle programmes, and increased availability of safe environments in public parks and recreational spaces to encourage physical activity.

(e) Promote the implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol, while recognizing the need to develop appropriate domestic action plans, in consultation with relevant stakeholders, for developing specific policies and programmes, including taking into account the full range of options as identified in the global strategy, as well as raise awareness of the problems caused by the harmful use of alcohol, particularly among young people, and call upon WHO to intensify efforts to assist Member States in this regard.

(f) Promote the implementation of the WHO Set of recommendations on the marketing of foods and non-alcoholic beverages to children, including foods that are high in saturated fats, trans-fatty acids, free sugars, or salt, recognizing that research shows that food advertising to children is extensive, that a significant amount of the marketing is for foods with a high content of fat, sugar or salt and that television advertising influences children's food preferences, purchase requests and consumption patterns, while taking into account the existing legislation and national policies, as appropriate;

(g) Promote the development and initiate the implementation, as appropriate, of cost-effective interventions to reduce salt, sugar and saturated fats, and eliminate industrially produced trans-fats in foods, including through discouraging the production and marketing of foods that contribute to unhealthy diet, while taking into account existing legislation and policies;

(h) Encourage policies that support the production and manufacture of, and facilitate access to, foods that contribute to healthy diet, and provide greater opportunities for utilization of healthy local agricultural products and foods, thus contributing to efforts to cope with the challenges and take advantage of the opportunities posed by globalization and to achieve food security;

(i) Promote, protect and support breastfeeding, including exclusive breastfeeding for about six months from birth, as appropriate, as breastfeeding reduces susceptibility to infections and the risk of undernutrition, promotes infant and young children's growth and development and helps to reduce the risk of developing conditions such as obesity and non-communicable diseases later in life, and, in this regard, strengthen the implementation of the international code of marketing of breast milk substitutes and subsequent relevant World Health Assembly resolutions;

(j) Promote increased access to cost-effective vaccinations to prevent infections associated with cancers, as part of national immunization schedules;

(k) Promote increased access to cost-effective cancer-screening programmes as determined by national situations;

(l) Scale up, where appropriate, a package of proven effective interventions, such as health promotion and primary prevention approaches, and galvanize actions
for the prevention and control of non-communicable diseases through a meaningful multisectoral response, addressing risk factors and determinants of health;

44. With a view to strengthening its contribution to non-communicable disease prevention and control, call upon the private sector, where appropriate, to:

(a) Take measures to implement the WHO set of recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children, while taking into account existing national legislation and policies;

(b) Consider producing and promoting more food products consistent with a healthy diet, including by reformulating products to provide healthier options that are affordable and accessible and that follow relevant nutrition facts and labelling standards, including information on sugars, salt and fats and, where appropriate, trans-fat content;

(c) Promote and create an enabling environment for healthy behaviours among workers, including by establishing tobacco-free workplaces and safe and healthy working environments through occupational safety and health measures, including, where appropriate, through good corporate practices, workplace wellness programmes and health insurance plans;

(d) Work towards reducing the use of salt in the food industry in order to lower sodium consumption;

(e) Contribute to efforts to improve access and affordability for medicines and technologies in the prevention and control of non-communicable diseases;

**Strengthen national policies and health systems**

45. Promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of non-communicable diseases, taking into account, as appropriate, the 2008-2013 WHO Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases, and the objectives contained therein and take steps to implement such policies and plans;

(a) Strengthen and integrate, as appropriate, non-communicable disease policies and programmes into health-planning processes and the national development agenda of each Member State;

(b) Pursue, as appropriate, comprehensive strengthening of health systems that support primary health care, deliver effective, sustainable and coordinated responses and evidence-based, cost-effective, equitable and integrated essential services for addressing non-communicable disease risk factors and for the prevention, treatment and care of non-communicable diseases, acknowledging the importance of promoting patient empowerment, rehabilitation and palliative care for persons with non-communicable diseases, and a life course approach, given the often chronic nature of non-communicable diseases;

(c) According to national priorities, and taking into account domestic circumstances, increase and prioritize budgetary allocations for addressing non-communicable disease risk factors and for surveillance, prevention, early detection, and treatment of non-communicable diseases, and the related care and support including palliative care;
(d) Explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms;

(e) Pursue and promote gender-based approaches for the prevention and control of non-communicable diseases founded on data disaggregated by sex and age in an effort to address the critical differences in the risks of morbidity and mortality from non-communicable diseases for women and men;

(f) Promote multisectoral and multi-stakeholder engagement in order to reverse, stop and decrease the rising trends of obesity in child, youth and adult populations respectively;

(g) Recognize where health disparities exist between indigenous peoples and non-indigenous populations in the incidence of non-communicable diseases, and their common risk factors, that these disparities are often linked to historical, economic and social factors, encourage the involvement of indigenous peoples and communities in the development, implementation, and evaluation of non-communicable disease prevention and control policies, plans and programmes, where appropriate, while promoting the development and strengthening of capacities at various levels and recognizing the cultural heritage and traditional knowledge of indigenous peoples and respecting, preserving and promoting, as appropriate, their traditional medicine, including conservation of their vital medicinal plants, animals and minerals;

(h) Recognize further the potential and contribution of traditional and local knowledge and in this regard, respect and preserve, in accordance with national capacities, priorities, relevant legislation and circumstances, the knowledge and safe and effective use of traditional medicine, treatments and practices, appropriately based on the circumstances in each country;

(i) Pursue all necessary efforts to strengthen nationally driven, sustainable, cost-effective and comprehensive responses in all sectors for the prevention of non-communicable diseases, with the full and active participation of people living with these diseases, civil society and the private sector, where appropriate,

(j) Promote the production, training and retention of health workers with a view to facilitating adequate deployment of a skilled health workforce within countries and regions, in accordance with the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel;

(k) Strengthen, as appropriate, information systems for health planning and management, including through the collection, disaggregation, analysis, interpretation, and dissemination of data and the development of population-based national registries and surveys, where appropriate, to facilitate appropriate and timely interventions for the entire population;

(l) According to national priorities, give greater priority to surveillance, early detection, screening, diagnosis and treatment of non-communicable diseases and prevention and control, and to improving the accessibility to the safe, affordable, effective and quality medicines and technologies to diagnose and to treat them; provide sustainable access to medicines and technologies, including through the development and use of evidence-based guidelines for the treatment of non-communicable diseases, and efficient procurement and distribution of
medicines in countries; and strengthen viable financing options and promote the use of affordable medicines, including generics, as well as improved access to preventive, curative, palliative and rehabilitative services, particularly at the community level;

(m) According to country-led prioritization, ensure the scaling-up of effective, evidence-based and cost-effective interventions that demonstrate the potential to treat individuals with non-communicable diseases, protect those at high risk of developing them and reduce risk across populations;

(n) Recognize the importance of universal coverage in national health systems, especially through primary health-care and social protection mechanisms, to provide access to health services for all, in particular, for the poorest segments of the population;

(o) Promote the inclusion of non-communicable disease prevention and control within sexual and reproductive health and maternal and child-health programmes, especially at the primary health-care level, as well as other programmes, as appropriate, and also integrate interventions in these areas into non-communicable disease prevention programmes;

(p) Promote access to comprehensive and cost-effective prevention, treatment and care for the integrated management of non-communicable diseases, including, inter alia, increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, including through the full use of trade-related aspects of intellectual property rights (TRIPS) flexibilities;

(q) Improve diagnostic services, including by increasing the capacity of and access to laboratory and imaging services with adequate and skilled manpower to deliver such services, and collaborate with the private sector to improve affordability, accessibility and maintenance of diagnostic equipment and technologies;

(r) Encourage alliances and networks that bring together national, regional and global actors, including academic and research institutes, for the development of new medicines, vaccines, diagnostics and technologies, learning from experiences in the field of HIV/AIDS, among others, according to national priorities and strategies;

(s) Strengthen health-care infrastructure, including for procurement, storage and distribution of medicine, in particular transportation and storage networks to facilitate efficient service delivery;

**International cooperation, including collaborative partnerships**

46. Strengthen international cooperation in support of national, regional, and global plans for the prevention and control of non-communicable diseases, inter alia, through the exchange of best practices in the areas of health promotion, legislation, regulation and health systems strengthening, training of health personnel, development of appropriate health-care infrastructure, diagnostics, and promoting the development, dissemination of appropriate, affordable and sustainable transfer of technology on mutually agreed terms and the production of affordable, safe, effective and quality medicines and vaccines, while recognizing the leading role of WHO as the primary specialized agency for health in that regard;
47. Acknowledge the contribution of aid targeted at the health sector, while recognizing that much more needs to be done. We call for the fulfilment of all official development assistance-related commitments, including the commitments by many developed countries to achieve the target of 0.7 per cent of gross national income for official development assistance by 2015, as well as the commitments contained in the Istanbul Programme of Action for the Least Developed Countries for the Decade 2011-2020, and strongly urge those developed countries that have not yet done so to make additional concrete efforts to fulfill their commitments;

48. Stress the importance of North-South, South-South and triangular cooperation, in the prevention and control of non-communicable diseases to promote at national, regional, and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation;

49. Promote all possible means to identify and mobilize adequate, predictable and sustained financial resources and the necessary human and technical resources, and to consider support for voluntary, cost-effective, innovative approaches for a long-term financing of non-communicable disease prevention and control, taking into account the Millennium Development Goals;

50. Acknowledge the contribution of international cooperation and assistance in the prevention and control of non-communicable diseases and, in this regard, encourage the continued inclusion of non-communicable diseases in development cooperation agendas and initiatives;

51. Call upon WHO, as the lead United Nations specialized agency for health, and all other relevant United Nations system agencies, funds and programmes, the international financial institutions, development banks, and other key international organizations to work together in a coordinated manner to support national efforts to prevent and control non-communicable diseases and mitigate their impacts;

52. Urge relevant international organizations to continue to provide technical assistance and capacity-building to developing countries, especially to the least developed countries, in the areas of non-communicable disease prevention and control and promotion of access to medicines for all, including through the full use of trade-related aspects of intellectual property rights flexibilities and provisions;

53. Enhance the quality of aid by strengthening national ownership, alignment, harmonization, predictability, mutual accountability and transparency, and results-orientation;

54. Engage non-health actors and key stakeholders, where appropriate, including the private sector and civil society, in collaborative partnerships to promote health and to reduce non-communicable disease risk factors, including through building community capacity in promoting healthy diets and lifestyles;

55. Foster partnerships between Government and civil society, building on the contribution of health-related NGOs and patients’ organizations, to support, as appropriate, the provision of services for the prevention and control, treatment, care, including palliative care, of non-communicable diseases;

56. Promote the capacity-building of non-communicable disease-related NGOs at the national and regional levels, in order to realize their full potential as partners in the prevention and control of non-communicable diseases;
Research and development

57. Promote actively national and international investments and strengthen national capacity for quality research and development, for all aspects related to the prevention and control of non-communicable diseases in a sustainable and cost-effective manner, while noting the importance of continuing to incentivize innovation;

58. Promote the use of information and communications technology to improve programme implementation, health outcomes, health promotion, and reporting and surveillance systems and to disseminate, as appropriate, information on affordable, cost-effective, sustainable and quality interventions, best practices and lessons learned in the field of non-communicable diseases;

59. Support and facilitate non-communicable disease-related research and its translation to enhance the knowledge base for ongoing national, regional and global action;

Monitoring and evaluation

60. Strengthen, as appropriate, country-level surveillance and monitoring systems, including surveys that are integrated into existing national health information systems and include monitoring exposure to risk factors, outcomes, social and economic determinants of health, and health system responses, recognizing that such systems are critical in appropriately addressing non-communicable diseases;

61. Call upon WHO, with the full participation of Member States, informed by their national situations, through its existing structures, and in collaboration with United Nations agencies, funds and programmes, and other relevant regional and international organizations, as appropriate, building on continuing efforts to develop before the end of 2012, a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, including through multisectoral approaches, to monitor trends and to assess progress made in the implementation of national strategies and plans on non-communicable diseases;

62. Call upon WHO, in collaboration with Member States through the governing bodies of WHO, and in collaboration with United Nations agencies, funds and programmes, and other relevant regional and international organizations, as appropriate, building on the work already under way, to prepare recommendations for a set of voluntary global targets for the prevention and control of non-communicable diseases, before the end of 2012;

63. Consider the development of national targets and indicators based on national situations, building on guidance provided by WHO, to focus on efforts to address the impacts of non-communicable diseases, and to assess the progress made in the prevention and control of non-communicable diseases and their risk factors and determinants;

Follow-up

64. Request the Secretary-General, in close collaboration with the Director-General of WHO, and in consultations with Member States, United Nations funds and programmes and other relevant international organizations, to submit by the end
of 2012 to the General Assembly, at its sixty-seventh session, for consideration by Member States, options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases through effective partnership;

65. Request the Secretary-General, in collaboration with Member States, WHO, and relevant funds, programmes and specialized agencies of the United Nations system to present to the General Assembly at the sixty-eighth session a report on the progress achieved in realizing the commitments made in this Political Declaration, including on the progress of multisectoral action, and the impact on the achievement of the internationally agreed development goals, including the Millennium Development Goals, in preparation for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of non-communicable diseases.