# SUMMARY RECORD OF THE FIFTH MEETING

(Grand Ballroom, Lower Level I, Kowloon Shangri-la Hotel)
Wednesday, 23 September 2009, at 14:00

Chairperson: Dr P.Y. Lam (Hong Kong, (China))

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1. REGIONAL ACTION PLAN FOR THE TOBACCO FREE INITIATIVE IN THE WESTERN PACIFIC (2010–2014): Item 12 of the Agenda (Document WPR/RC60/7) (continued)

Dr O Heng Kin (Macao (China)) said that Macao's legislation on tobacco control had recently been updated and would enter into force as soon as it was approved by the Legislative Assembly. Under that legislation, a newly established tobacco control office would serve as the principal enforcement agency, employing 40 inspectors who were already engaged in intensive training. In May 2009, tobacco excise tax rates had also been tripled and further efforts would be made to advocate still higher taxes on tobacco products. Macao (China) would additionally seek to implement and enforce the MPOWER (the acronym for Monitor, Protect, Offer help, Warn, Enforce advertising bans and Raise taxes) package policies as its principal approach to curbing tobacco use.

Professor Judith MACKAY (Hong Kong (China)) said that prevalence, health and economic data on tobacco control were now more complete, tobacco company behaviour had been exposed, and tobacco use was known to be reduced by the introduction of such measures as tax increases, smoke-free areas and bans on tobacco promotion. As the effective action already taken by Asian countries had shown, tobacco control was not the prerogative of Western nations. Low- and middle-income countries had received significant funding for tobacco control. The WHO Western Pacific Region was unique in that all of its Member States had ratified the WHO Framework Convention on Tobacco Control (WHO FCTC), and in that regard she commended the leadership of Regional Director Emeritus, Dr Sang Tae Han. Legislation and policies to complement MPOWER were now being formulated accordingly. Hong Kong (China), for instance, had revamped its tobacco control law and introduced other legislative measures that were enforced by a dedicated office and also regularly strengthened. Tobacco tax had furthermore been doubled and a three-year pilot community-based smoking cessation programme was in place. As a result of such action, smoking prevalence had more than halved to 11.8%.

The Region nevertheless had the greatest number of smokers in the world and the draft Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2010–2014) was therefore both timely and necessary. Focusing on mobilization and capacity-building with a view to full implementation of the WHO FCTC, it contained specific measurable targets for WHO, governments and nongovernmental organizations. It would therefore serve as an important guide for Member States in combating the challenges posed by the tobacco epidemic.

Dr SKILLING (Federated States of Micronesia) said that her country had designated a national tobacco focal point and was already implementing components of the WHO FCTC. It endorsed the strategic actions set forth in the draft Regional Action Plan on the understanding that zero tobacco use prevalence was the ultimate goal. In the Federated States of Micronesia, however, careful planning and a sensitive approach were essential to achieving that goal in that the small-scale farming of tobacco as a cash crop was currently unregulated. Furthermore, tobacco excise tax was the sole source of scholarship funding for a desperately needed pool of postgraduates. Given those factors, the country would need time to reach that goal. It fully supported the draft Regional Action Plan, however, not least in view of its burden of tobacco use.

Dr VIVILI (Tonga) recalled the days of smoke-filled train carriages and sports sponsorship by tobacco companies as evidence of the encouraging progress achieved over the years in tobacco control, to which the WHO FCTC had been pivotal. The ratification of that Convention by all eligible parties in the Region was

commendable, but it was essential to remain ever adaptable and strengthen approaches in the face of ongoing efforts by multinational tobacco companies to adapt in order to cope with the changing environment. To that end, the proposed Regional Action Plan would be a vital tool that provided comprehensive coverage of the necessary spectrum of objectives.

Tonga was fully aware of the dire consequences that failure to address tobacco control and tobacco-related noncommunicable diseases would bring. Unfortunately, however, the process was often impeded by external factors that were beyond control. Tonga had nevertheless introduced robust tobacco control legislation and established other related mechanisms, including a health promotion foundation. Such endeavours to counter its pandemic of noncommunicable disease required every effort and it urged others to join its support of the draft Regional Action Plan.

Dr CABOTAJE (Philippines) affirmed her country's support for and commitment to the proposed Regional Action Plan and outlined its key tobacco control efforts at the national level, which included the introduction of a tobacco surveillance system, as well as capacity-building initiatives, smoke-free environments, a sectorwide approach to tobacco control and an annual award for smoke-free health units and hospitals. Lobbying for new anti-tobacco legislation was also ongoing and current tobacco control legislation was being enforced effectively. The Philippine Department of Health was furthermore strongly committed to formulating a medium-term investment plan for tobacco control, to providing technical assistance for tobacco control initiatives at the provincial level and to institutionalizing and ensuring sustainable actions on tobacco control.

Dr KIRITION (Kiribati) said that smoking was a major public health risk in his country, where progress in combating tobacco use was somewhat hampered by the reliance on outside experts for the updating and development of its health-related legislation. Kiribati nevertheless anticipated the enactment of new tobacco control legislation within the next several months. There was no one solution to achieving the common goal of tobacco control, however, and Kiribati had its own unique stumbling blocks in that tobacco use was highly integral to its culture—for instance, as a traditional gift to village elders and local gods. It was therefore imperative to gain grass-roots support for its tobacco control efforts, in particular from those elders, whose influence was such that they could cause the governing party to lose parliamentary seats if it adopted a less than cautious approach to the tobacco bill. The campaign now under way to win the backing of those elders was a labour- and resource-intensive exercise, given the geography of his country's islands. Kiribati would therefore welcome any further support in addition to the assistance already provided for that endeavour by the WHO Western Pacific Regional Office, to which he expressed gratitude. In conclusion, he expressed full support for the proposed Regional Action Plan.

Ms GOODSPEED (Australia) welcomed the draft Regional Action Plan but wished to note for the record that the ratification of all WHO FCTC protocols by all parties in the Region by 2014, identified as an overall indicator, might be premature; the first of those protocols on illicit trade in tobacco products, for example, was still under negotiation. She suggested that significant progress by all Member States in the Region in implementing the FCTC guidelines would be a more realistic indicator. Concerning regional programme target (e), Australia was somewhat uncomfortable with the direct link made between tobacco taxes and the spending of revenue derived from them, as its Treasury did not generally allow for the hypothecation of taxes. On the subject of country and area indicators, she asked whether the 100% tobacco-free regulations

mentioned was intended to mean smoking bans in 100% of public places.

As for regional programme targets (b) and (c), Australia considered that annual planning meetings with all partners and stakeholders and annual award programmes could be excessive, particularly where plans were well articulated and had been implemented over a long period. The same applied to country and area indicators (b) and (c). In the implementation of the Regional Action Plan, consideration should be given to the most appropriate period for such reviews and meetings. Some clarification, streamlining and alignment between the WHO FCTC, MPOWER and the Regional Action Plan would also be welcome. Given that annual reporting requirements under the WHO FCTC and MPOWER were resource-intensive and duplicative, a single annual reporting request covering both would be preferable. Lastly, in view of the existence and nature of those reporting requirements, she sought clarification concerning the 2012 review of the implementation of the Regional Action Plan and the level of work required by Member States.

Dr KUARTEI (Palau) said that implementation of the WHO FCTC ate into the limited resources of small island countries, sometimes straining political relationships and retarding the development of other programmes requiring political support. The enforcement of relevant laws posed another challenge. Palau supported the proposed Regional Action Plan but stressed the need for more emphasis on primary prevention in tobacco control, with a particular focus on children. Gender issues were integrated in traditional cultures and could also be utilized in the fight against tobacco. Another point to remember was that, in some countries, tobacco-chewing posed a greater health risk than smoking, leading as it did to spitting rather than to second-hand smoke. Furthermore, simplification of the language used in the WHO FCTC would improve understanding and perhaps even implementation. Lastly, the issue of commerce and health should be placed on the regional agenda, the irony being that financial and technical support for tobacco control was often provided by the very same countries that exported tobacco.

Dr Isimeli TUKANA (Fiji) expressed his country's whole-hearted support for the drive towards full implementation of the WHO FCTC. Fiji's own tobacco control initiatives included the amendment of its relevant legislation, the conduct of a youth tobacco survey, the promotion of tobacco-free settings and the enforcement of its tobacco law by a dedicated unit. It supported the draft Regional Action Plan and looked forward to continued collaboration with WHO in its implementation.

Dr RAHMAH (Brunei Darussalam) said that he particularly appreciated the guiding principles, indicators and practical actions set forth in the proposed Regional Action Plan; they could be adapted to the context of respective Member States, supporting and assisting their effective and timely implementation of the WHO FCTC. Tobacco control was high on her country's health agenda. Tobacco legislation was now in place to control, inter alia, the import, sale, promotion, packaging and use of tobacco products. Enforcement was problematic, however, and activities were therefore being reviewed with the assistance of law-enforcement agencies in order to strengthen it further. A national committee on tobacco control had also been established to enhance multi-agency cooperation in the field of tobacco control initiatives. Brunei Darussalam supported the draft Regional Action Plan and looked forward to continuation of the valuable forms of assistance provided to it by WHO.

Dr SODNOMPIL Tserendorj (Mongolia) said that the main principles of the WHO FCTC were reflected in his country's tobacco law. Various surveys had been conducted to determine the prevalence of current smokers and a technical working group had been established to improve the effectiveness of tobacco control.

Tobacco products were now imported only by license and a health promotion foundation, funded by tobacco excise tax, had been created. Governmental, nongovernmental and local administrative organizations were increasingly collaborating to implement tobacco control measures and activities that included community awareness-raising and advocacy for policy- and decision-makers to establish tobacco-free environments. Interference by the tobacco industry had grown as a result, however, which had adverse implications for the implementation of the WHO FCTC and tobacco-related legislation in the country.

Dr LI Xinhua (China) recalled that the Western Pacific had been the first WHO region in which all eligible parties had ratified the WHO FCTC. He welcomed the detailed draft Action Plan for 2010–2014, which had been discussed in consultations among eight ministries in his Government. His delegation supported the proposed Plan in general. As smokers in the Region accounted for over one third of all smokers in the world, his Government agreed with the overall goal of reducing the prevalence to the lowest rate possible and attaining the highest level of protection from second-hand smoke. Within the draft Regional Action Plan, China would further promote tobacco control, with the vision of "tobacco-free people, communities and environments". As the WHO FCTC was the legal basis for tobacco control, the requirements of the Action Plan should not exceed those laid down in the Convention. The draft Regional Action Plan was a plan for advocacy in the Region and, as such, offered guidance to tobacco control organizations in Member States; it should not be considered mandatory. His Government agreed that tobacco excise taxes should be increased gradually but considered that they should represent an average of 60% of the retail price and not apply to all tobacco products. He agreed with the representative of Australia that the revenue from tobacco taxes should be used as part of the national budget rather than being earmarked.

Ms MATTHEW (Marshall Islands) said that, despite the fact that all the Member States in the Western Pacific Region had ratified the WHO FCTC, people in the Region were still dying from tobacco-related diseases, such as diabetes. The Ministry of Health in her country had integrated tobacco control as part of the country's noncommunicable disease strategy and its comprehensive cancer programme. A recent challenge was the growing use of betel nut with tobacco, which had been taken up by young people, including medical staff. The Ministry hoped to gain access to so-called "sin taxes" to support primary health care and preventive measures. She looked forward to working with WHO and international partners on implementing the proposed Action Plan.

Dr BALACHANANDRAN Satiamurti (Malaysia) informed the Committee that, since becoming a State Party to the Framework Convention in 2005, Malaysia had accelerated its tobacco control efforts. It had introduced new legislative provisions, strengthened existing measures, including nationwide health promotion and anti-tobacco messages, and continued to raise tobacco taxation and prices. Malaysia had participated in many Framework Convention processes, including consultations on the development of the proposed Regional Action Plan based on the six-policy WHO MPOWER package, which it supported. The Malaysian Ministry of Health had developed a national package, "MPOWER Malaysia" ("PEKASA Malaysia"), based on the same six proven policies, which was in the final stages of endorsement. The comprehensive multisectoral plan would be implemented by six working committees headed by senior officials from relevant agencies, each responsible for one of the components. It was hoped that such broad participation would encourage commitment to the tobacco control agenda across all sectors.

Dr Teiji TAKEI (Japan) said that Japan had strengthened its tobacco control measures to comply with the WHO FCTC and in line with its national health promotion policy and health promotion legislation. The overall rate of smoking among adults was declining but the rate in males was still higher than that in other countries. The rate in females remained lower than in other countries but was relatively high in young women. Further control measures were therefore urgently needed. Japan would continue to support WHO global tobacco control efforts and hoped to further discussions on the Framework Convention at the fourth session of the International Negotiating Body on a Protocol on Illicit Trade in Tobacco Products and the fourth session of the Conference of the Parties to the Framework Convention in 2010. Japan supported the draft Regional Action Plan.

Dr NGUYEN QUOC TRIEU (Viet Nam) said that Viet Nam, as a country with one of the highest rates of tobacco smoking, supported the draft Regional Action Plan. The country had been taking steps to control tobacco use and was currently implementing the 2000-2010 national programme for tobacco control, which would be evaluated in 2010. It had become a signatory to the WHO FCTC in 2004 and the Prime Minister had approved the Framework Convention implementation plan in August 2009. Control activities had focused on increases in tobacco taxation and prohibition of tobacco advertising and promotions. A draft law on tobacco control would be submitted to the National Assembly for approval at the end of 2010. The three action strategies in the draft Regional Action Plan would guide Viet Nam in developing future tobacco control policies. WHO, other international organizations, and countries in the Region were requested to increase cooperation to control illicit trade in tobacco products and prevent the involvement of tobacco producers in the development of tobacco control policies.

Mr ABDOO (United States of America) said that his country was committed to reducing morbidity and mortality related to tobacco use and was in the process of implementing the 2009 Family Smoking Prevention and Tobacco Control Act, which gave the United States Food and Drug Administration broad authority to regulate tobacco and tobacco products. It also remained dedicated to working with partners in the Region and globally, as shown by its collaboration with 164 countries through the Global Tobacco Surveillance System, and looked forward to providing technical and financial support to Member States for capacity-building in the areas of monitoring and surveillance. He commended the leadership shown by the Regional Office in the fight against tobacco use and its efforts to keep the matter high on the public health agenda. The draft Regional Action Plan was appropriately built around the WHO FCTC and the MPOWER package and would guide priorities and actions over the coming five years.

Mrs GIDLOW (Samoa) supported the proposed Regional Action Plan and the proposed review of progress in its implementation by the Regional Committee in 2012. The plan would guide Member States, including Samoa, in developing national strategies in line with the global focus. Samoa had enacted tobacco control legislation in 2008 and had made progress in raising public awareness and undertaking communication and advocacy activities. However, further efforts were needed to improve: investment planning and resource management; human resource training; surveillance, monitoring and knowledge management; and treatment of tobacco dependents. Samoa's ratification of the Framework Convention entailed obligations that called for disciplined monitoring and reporting. Samoa acknowledged the support received from various external partners and welcomed WHO's assistance in the development of tobacco regulations, which would be completed before the end of the current biennium. The Samoan Parliament had established an advocacy group for healthy living, which would launch its plan of activities in October 2009 at the start of the next

parliamentary session.

Dr LEE Seon Kui (Republic of Korea) supported the draft Regional Action Plan, which would guide the implementation of the WHO FCTC. Technical support for Member States would be needed to achieve the targets and indicators specified in the plan, and progress should be carefully monitored. The Republic of Korea stood ready to share its experiences with anti-tobacco policies, including its national cessation programme and anti-smoking campaigns.

Mr SOALAOI (Solomon Islands) supported the proposed Regional Action Plan. The information in the document was alarming, indicating that, during the time of his intervention, two people in the Region would die from tobacco-related diseases, and listing the huge amounts of money that Member States were spending on those diseases. His country had initiated health promotion programmes and a tobacco control policy, and a draft tobacco control bill was awaiting Cabinet approval before presentation to the Parliament in the coming months. He had committed himself to passage of the bill and to its implementation, as the high prevalence of use among young people in his country was of great concern. The Government had increased the tax on tobacco and alcohol by 20%. Although his country received revenue from tobacco companies, it was aware that there were better ways to earn funds.

Dr HOMASI (Tuvalu) supported the draft Regional Action Plan. Recent studies in his country had shown that the prevalence of tobacco use among young people was 33%. A multisectoral tobacco coalition had been established in 2007 to lead tobacco control in the country and had been instrumental in ensuring passage of a tobacco control bill in 2008. The entire Government and all nongovernmental organizations in the country were involved in tobacco control. He acknowledged the assistance of WHO and other international partners.

Sir Terepai MAOATE (Cook Islands) said that Cook Islands had long supported tobacco control efforts in the Region, enacting legislation to prevent smoking in public transport some time ago. He expressed support for the proposed Regional Action Plan. However, the fight to reduce tobacco consumption would be hard and great efforts would be needed to educate populations, counter claims that smoking was part of tradition and culture, and combat illicit trade in tobacco products. Targets should therefore be realistic. Cook Islands already levied import duties on tobacco and alcohol products, and banned direct advertising. However, product placement in films was encouraging young people to regard smoking and drinking as desirable, and should perhaps also be prohibited. The taxpayer currently funded health care for smokers; he sometimes felt that smokers should be requested to pay for their own health insurance. Lastly, countries with tobacco producers should be urged to influence those producers.

Mr SOAKAI (Nauru) acknowledged the support to Nauru provided by WHO, which had resulted in the enactment of tobacco control legislation in July 2009. However, local capacity to enforce the legislation and undertake other tobacco control activities was limited, and further support would therefore be needed. Nauru supported the proposed Regional Action Plan.

At the invitation of the CHAIRPERSON, statements were made to the Committee by representatives of the University of Hong Kong, the Framework Convention Alliance on Tobacco Control, and the International Federation of Medical Students Associations.

The REGIONAL ADVISER, TOBACCO FREE INITIATIVE, thanked speakers for their support of the draft Regional Action Plan, and for providing information on all the innovative measures being taken in countries despite the difficulties everyone faced. WHO hoped to continue working with Member States in the areas of policy and regulation, as well as in changing social norms and overcoming cultural barriers to achieving better tobacco control. The draft Action Plan essentially provided guidance, and could accommodate a wide range of concerns and interests, reflecting the different needs and different regulatory regimes in different countries, for example regarding taxation. It would not be mandatory, but there appeared to be a strong commitment to meeting the targets that it set out. A question had been raised about the meaning of 100% tobacco-free regulation: given that there were many "healthy settings", such as healthy cities or health-promoting schools, which were not implementing tobacco-free regulations, the draft Action Plan suggested bans on smoking, promotion, advertising and sponsorship.

The DIRECTOR, BUILDING HEALTHY COMMUNITIES AND POPULATIONS, said that WHO would strengthen efforts to achieve the targets set out in the draft Regional Action Plan through cross-sectoral action. Many countries and areas in the Western Pacific Region had achieved excellent results in tobacco control, and WHO would promote the sharing of their experience and technical expertise.

The DIRECTOR, TOBACCO FREE INITIATIVE/NONCOMMUNICABLE DISEASES AND MENTAL HEALTH, WHO HEADQUARTERS, welcomed the constructive comments on the draft Action Plan. When, a decade ago, WHO had launched the process leading to the Framework Convention on Tobacco Control, it had moved into uncharted waters. Never before had WHO Member States led a treaty negotiation. The WHO FCTC had taken its place among the 10 greatest achievements of WHO, alongside smallpox eradication. The Western Pacific Region was the leading region in tobacco control, with 100% ratification of the Framework Convention, and an action plan setting bold targets to implement the Convention over the coming five years. Harmonizing efforts to implement the Convention, in particular though the MPOWER technical assistance programme, was one of WHO's highest priorities. The aim was to scale up efforts, especially through demand reduction. A global meeting would be held in November 2009 to ensure maximum harmonization, complementarity and synergy, so as to reduce the burden on countries. He pointed out that taxation was a huge potential source of revenue for health development in low-income and middle-income countries.

The REGIONAL DIRECTOR thanked all representatives for their support for the draft Regional Action Plan. He appreciated the commitment to tobacco control of the Ministers of Health in the Western Pacific Region, a Region which had already achieved 100% ratification of the WHO FCTC. He praised the host, Hong Kong (China), which had been and continued to be a trailblazer in policy and action for effective and comprehensive tobacco control, not only in the Region but also in the world. He also recognized the outstanding contribution of Dr Judith Mackay, from Hong Kong (China), well known as a global advocate, who had been named one of the "most influential people in the world" by Time magazine in 2007 for her work in tobacco control, and who had recently been awarded the British Medical Journal Group's first award for lifetime achievement. Dr Mackay had been one of the early architects of the WHO FCTC and a key resource person for the formulation of the draft Regional Action Plan. He thanked Dr Mackay for her efforts in tobacco control and looked forward to her continuing and tireless leadership of tobacco control in the Western Pacific Region. Substantial progress had been made, but sustained and continuous commitment would be needed in order to meet shared objectives.

The CHAIRPERSON asked the Rapporteurs to draft an appropriate resolution for consideration later in the session.

## 2. REGIONAL ACTION PLAN FOR MALARIA CONTROL AND ELIMINATION IN THE WESTERN PACIFIC (2010–2015): Item 13 of the Agenda (Document WPR/RC60/8)

The REGIONAL DIRECTOR presented the draft Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015), telling the Regional Committee that malaria continued to be a significant public health burden in the Western Pacific Region, despite significant reductions in recent years in morbidity and mortality. Ten countries in the Region were still endemic. In addition, new threats had emerged, such as resistance to the most effective antimalarial drugs, the emergence of insecticide-resistant mosquitoes, and a flood of ineffective counterfeit medicines.

However, over the previous decade many countries in the Western Pacific Region had been highly successful in reducing the burden of malaria. Strong political commitment, increased technical expertise and the integration of malaria control into community-based health systems had been key elements of that success.

Building on experience, the draft Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010-2015) called for consolidating and building on recent achievements in malaria control in the Region and for a move towards malaria elimination—rather than control—where possible. It was a critical step towards securing sustained political commitment, ensuring adequate allocation of resources and improving coordination among Member States and other stakeholders.

The Action Plan had been developed by the Regional Office in close collaboration with Member States and in consultation with the Regional Office for South-East Asia, and was intended as a road map for the two Regions, a framework for updating national plans, and a tool for monitoring national programmes, as well as for resource mobilization.

The Regional Director called on the Regional Committee to consider and support the draft Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015) as a guide for action in the following five years and to use the Action Plan as the basis for strengthening WHO's efforts in countries.

Mr Len TARIVONDA (Vanuatu) supported the draft Regional Action Plan for malaria, noting that malaria continued to be a significant public health problem in his country. Over the past 20 years, and particularly over the past five years, malaria morbidity and mortality had been reduced significantly, thanks to the long-term support of WHO, the Secretariat of the Pacific Community, the Government of Australia, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2008, the annual malaria parasite incidence rate had been 14 cases per 1000 population, and there had been no deaths. Vanuatu had reached the point of changing the programme goal from routine control to intensified control and elimination. A formal announcement had been made to that effect in 2008, and the shift to elimination would be progressive, starting in selected geographical areas.

With the renewed interest and commitment to malaria elimination at the global level (through the Malaria Elimination Network) and the regional level (through the Asia Pacific Malaria Elimination Network), and with the availability of new tools, Vanuatu was already committed at the highest political and decision-

making levels to ensure that the dream of eliminating malaria from the country became a reality. There was, however, a need for proper coordination and harmonization. Because of the high levels of funding, and the subsequent implementation process expected, the Ministry of Health could easily lose its leadership role, being overwhelmed by efforts to satisfy donor requirements. He called for the different donor reporting and management requirements to be streamlined and simplified at national level, to ease the workload of national staff so that their efforts could focus on achieving the expected outcomes. Also, more technical assistance was desperately needed in-country to assist with financial and programme management, and with reporting requirements, because of the severe capacity constraints the country faced. In order to win the fight against malaria and achieve the goal of elimination, clear and aligned plans and strategies at the national, regional and global levels, were essential.

Dr SHIMIZU (Japan) welcomed the draft Regional Action Plan for Malaria Control and Elimination in the Western Pacific, stressing that integrating anti-malaria measures into countries' health systems would be preferable to vertical programmes. Within integrated programmes, linking malaria activities to maternal and child health care would seem to be the most effective approach. It was also important to take account of the specific context of each country. The fight against malaria was based on the use of insecticide-treated bednets and early treatment, but those measures were no panacea. It was important to select the most effective and appropriate measures for each country, on the basis of scientific evidence. He furthermore stressed the need to anchor activities in the community by raising awareness. The draft Action Plan rightly envisaged the maintenance of bednets, but people would also need to be taught how to use them correctly. Japan would continue to support the fight against malaria, through contributions to WHO and the Global Fund, bilateral cooperation, and research.

Dr YU (China) appreciated the efforts of the Regional Office for the Western Pacific and its partners in promoting the control and elimination of malaria in Member States, including in China. The Chinese Ministry of Health had set out a strategy for the elimination of malaria by 2015 and, since 2007, had provided funds amounting to nearly RMB 50 million (US$ 7.3 million) for blood tests for patients with fever, staff training, and the provision of free drugs and pesticides. He hoped that WHO would update the essential drugs list to reflect the effectiveness of artemisinin-based combination therapy and support China in achieving prequalification of such drugs produced in China. He supported the draft Action Plan and hoped that the Regional Office for the Western Pacific would continue to provide technical assistance to all Member States.

Dr RAHMAH (Brunei Darussalam) welcomed the inclusion of malaria in the Regional Committee's agenda for the current year, and appreciated the tireless efforts of the Regional Director to support endemic countries, including in mobilizing external funding. A result had been an encouraging reduction in morbidity and mortality. Although Brunei Darussalam had been malaria-free since 1987, there were still concerns, in particular relating to drug and insecticide resistance, as well as to the circulation of ineffective counterfeit medicines which might hamper or even reverse progress achieved thus far. There was indeed a need for better integration and linkages of efforts to fight malaria within broader efforts to strengthen health systems. With globalization, extensive movement of people, and climate change, concerns had to be taken seriously. The draft Action Plan was timely and would provide a relevant framework for auditing and reviewing national initiatives for malaria vigilance.

Dr Azmi ABDUL RAHIM (Malaysia) supported the draft Regional Action Plan for Malaria Control and Elimination in the Western Pacific. Malaysia was finalizing a strategic plan for malaria elimination, in line with the Regional Plan, and would ensure that adequate human and financial resources would be made available. With regard to drug-resistant malaria, planned measures included the promotion of artemisinin combination therapy, and the strengthening of drug enforcement to ensure the appropriate use of antimalarials in both the public and private sectors. All communities, including marginalized and migrant populations, would get appropriate vector control, parasite-based early diagnosis, and safe and effective antimalarial combination treatment. The surveillance system would be further strengthened by monitoring malaria trends, the drug efficacy of antimalarials, and insecticide resistance, along with impact assessment and the control of malaria outbreaks. Intersectoral cooperation and collaboration would also be strengthened. WHO's support to countries of the Region was much appreciated, especially its efforts to facilitate intercountry cooperation to control malaria among migrants and along border areas.

Dr Minerva MOLON (Philippines) said that morbidity due to malaria had been declining continuously in her country, with a 35% decrease between 2007 and 2008; 22 of the 58 malaria-endemic provinces had been declared malaria-free. The country was thus about to attain the WHO target for reduced mortality from malaria by 2010. The decline in morbidity and mortality from the disease could be attributed to the health system reforms undertaken by the Philippines and, in particular, the "disease-free zone" initiative, which comprised comprehensive strategies in which elimination measures were implemented province-by-province, with the full participation of local government and development partners. The strategies included entomological and clinical assessment of endemic provinces, a package of vector-control measures, stockpiling of malaria control commodities, strengthening surveillance and instituting a quality assurance system for microscopists.

Mr CHANG (Republic of Korea) said that his country was implementing a medium- to long-term plan to reduce the incidence of malaria in endemic areas near the Demilitarized Zone to less than 1 per 100 000 population by 2015, and the incidence had been reduced by 53% between 2007 and 2008. He thanked WHO and Member States for their support in that initiative and pledged to continue efforts to eliminate malaria in both his country and others.

Dr Lester ROSS (Solomon Islands) said that malaria was the leading cause of morbidity and mortality in his country. He thanked WHO and other partners for their support, also recognizing the contributions of nongovernmental, community-based and faith-based organizations. He proposed that the latter be included in the Regional Action Plan. A pilot project for malaria elimination had begun in Temotu Province, with the aim of eliminating malaria by 2013. The second province selected was Isabel, where the Government, the church and communities were working together to address community needs. Solomon Islands would continue to work with WHO and its development partners to eliminate the disease from the country.

Mr ABDOO (United States of America) commended the Regional Action Plan and the objectives, activities and indicators that had been identified. Member States should identify the priorities in their national programmes on the basis of evidence and ensure that their surveillance and monitoring systems provided high-quality data. He voiced strong support for increasing coordination among initiatives to combat malaria and other diseases, such as HIV/AIDS, and measures to improve maternal and child health. He also expressed support for interventions of known efficacy for the prevention of malaria, case detection and treatment. His Government was planning to support the Mekong regional initiative to contain the spread of multi-drug-

resistant malaria. Progressive elimination of malaria would lead to the long-term goal of eradication.

Dr Jeffrey CUTTER (Singapore) welcomed the comprehensive draft Action Plan proposed by the Secretariat. He noted, however, that 182 activities were listed under the seven strategic objectives in Appendix 1 of Annex 1, which might lead to a loss of focus on the main activities in national control plans. He suggested that two or three particularly important activities be highlighted under each strategic objective.

The REGIONAL ADVISER IN MALARIA AND OTHER VECTOBORNE AND PARASITIC DISEASES noted that most speakers had endorsed the Plan. He took note of Vanuatu's comment on coordination. Japan had spoken of issues concerning local conditions, and a key component was community-based actions, where progress had been made with few exceptions. He noted also suggestions on specificities: the regional plan had been extensively discussed by Member States and stakeholders, but country-specific features were welcome.

China was congratulated for shifting from monotherapy to artemisinin-based combination therapy. Brunei Darussalam, which was not a malaria-endemic country, was concerned with maintaining surveillance since there were endemic countries around it. That was important, not only for the 10 endemic countries, but also for the others. In Malaysia, the national and regional plans were in accord, and elimination was feasible there. For the Philippines, health system reform had been the key to progress, and WHO was coordinating such efforts with the Department of Health to guarantee sustainable action. The Republic of Korea was working on Plasmodium vivax; scientists were trying to gain a better understanding of its epidemiology and case management of relapses. In Solomon Islands, the strategy was to target certain areas, and WHO would be working with the Government and other stakeholders. Vanuatu also was heading for malaria elimination, on a targeted basis.

He thanked the representative of the United States of America for mentioning the work on indicators. The Kunming Indicators had reduced the list to a manageable number. Singapore's point was well taken: the large number of activities was something to be reconsidered, although extensive discussions had taken place, and the numbers resulted from the consensus of programme managers. Many activities needed to be carried out. Perfect programmes were needed if elimination was to be achieved. The key elements had to be maintained with financial resources and political will, and endorsement of the document would help with that.

The DIRECTOR, HIV/AIDS, TB AND NEGLECTED TROPICAL DISEASES/ GLOBAL MALARIA PROGRAMME, WHO HEADQUARTERS, commended the Region, which had been a source of innovation in malaria control, on the thoughtful draft Plan which should help achieve, not only World Health Assembly and Roll Back Malaria targets, but also the related Millennium Development Goals by 2015. The funding increases for malaria, coupled with new control tools, offered an opportunity for highly endemic areas to move gradually towards elimination. Gains in malaria control, however, were often fragile and strengthened surveillance systems were needed. Sharp drops in transmission brought the temptation to relax, but drug and insecticide resistance, as well as poor quality medicines, diagnostics or health services, could compromise what had been achieved. Artemisinin resistance in the Region remained a real threat to the world.

Japan's point that bednets had to be used as well as distributed was important, as was China's point that drug lists had to be kept up-to-date, with prequalification of artemisinin-based combination therapies. As Malaysia had noted, even when financing and supplies were adequate, there were not always the human

resources to channel the goods at all levels. Intersectoral collaboration had to be used more, in education, agriculture and defence. Border collaboration on surveillance would be especially important as prevalence fell. Surveillance, when prevalence dropped, was not only for monitoring, but was also a control tool. As Solomon Islands had noted, nongovernmental and faith-based organizations were very important in the process, as long as they were in line with the Plan.

The REGIONAL DIRECTOR drew attention to two issues: the first was that malaria elimination, as initiated by many global donors and partners, could strengthen primary health care. In Solomon Islands and Vanuatu the previous June, he had visited a programme that had been launched with the support of AusAID and other partners. He had realized that that was not just another political programme, but a matter of government ownership and leadership to revitalize district and peripheral primary health care. The work had been done by health workers, the community, churches and nongovernmental organizations. A similar approach could work for maternal and child health, vaccination, HIV prevention and other tasks. He had asked that the South Pacific Country Office in Fiji take special care of a primary health care initiative.

His second point was that antimalarial drug resistance, especially in the Mekong border area, was a global concern that would require hard work. Commitment to preventing its spread was needed, and all resistant cases should be treated with artemisinin-based combination therapy, since monotherapy no longer worked.

The CHAIRPERSON asked the Rapporteurs to draft an appropriate resolution for consideration later in the session.

The meeting rose at 16:45.