SUMMARY RECORD OF THE SEVENTH MEETING

Indera Kayangan Ballroom, The Empire Hotel and Country Club
Friday, 14 September 2001 at 8 a.m.

CHAIRPERSON: Pehin Haji ABDUL AZIZ Umar (Brunei Darussalam)

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1. **PREVENTION AND CONTROL OF TUBERCULOSIS: Item 16 of the Agenda**  
(Document WPR/RC52/10) (continued)

Dr SAKOI (Japan) said that his delegation was pleased to note the high priority given by the Regional Office to the prevention and control of tuberculosis. The disease was a primary public health issue in Japan, and a state of emergency had been declared with respect to tuberculosis in 1999. Much assistance had been provided, and a nationwide survey of cases of tuberculosis had been conducted in 2000. Furthermore, Japan, as chair of the G8 summit meeting in 2000, had played an active role in calling the attention of the international community to strengthening measures against infectious diseases, including tuberculosis.

It was important for all those concerned that programmes for the control of tuberculosis be scientific and based on evidence and feasible plans. It was therefore appropriate that the strategic plans for the seven countries in the Region with a high burden of tuberculosis had been supported by the tuberculosis technical advisory group. As a country with an intermediate burden of tuberculosis, Japan would continue its efforts to tackle the problem nationally and in those countries with similar burdens, for instance by hosting the third meeting of the tuberculosis technical advisory group in 2002.

Recognizing the importance of accelerating expansion of the directly observed treatment, short-course (DOTS) strategy, he reminded the Committee that that involved political commitment in each country and securing the necessary resources, including pharmaceuticals, personnel and technical information. The Regional Office should continue to take an active role in expanding use of the DOTS strategy. He urged all countries and donors to strengthen tuberculosis control and prevention.

He asked for a report on progress in the implementation of the Stop TB Special Project, which he understood had been launched in 1999.

Dr CHAN (Hong Kong, China) said that Hong Kong (China) would continue to give full support to the Regional Strategic Plan to Stop TB in the Western Pacific and to participate in the WHO global project on antituberculosis drug surveillance.

Although Hong Kong (China) had a comprehensive programme for the prevention and control of tuberculosis, including vaccination with bacillus Calmette-Guerin (BCG) at birth, disease surveillance and notification, public education, active and passive case detection and free access to DOTS, the tuberculosis prevalence rate remained high. The notification rate had, however, dropped from a peak of 697 per 100 000 to 100-110 per 100 000. About 20%
of notified cases were treated by private practitioners. DOTS services had achieved an 85% treatment success rate for the 80% of notified cases they had treated, with a default rate of 4%, and a drug resistance rate of 2%.

It had been observed that 37% of all cases notified were in persons aged 65 or more, while that age group accounted for only 11% of the population. Furthermore, contrary to common belief, immigrants to Hong Kong (China) did not appear to have a higher rate of infection than the local population. She asked for advice from other Member States and the Regional Office on how the prevalence rate in Hong Kong (China) could be reduced further.

Dr TEMU (Papua New Guinea) reported that his country was one of the seven in the Region with the highest burden of tuberculosis, and the increasing prevalence of HIV/AIDS, and therefore of co-infection, meant that there was a desperate need for focused action at the country level. The Regional Office had provided support in the development of the country’s five-year strategic plan for the prevention and control of tuberculosis. The plan had been endorsed at the national level, and all provinces had agreed to adhere to it. The DOTS strategy had already been successfully expanded in two districts. His country was ready to implement the action plan and had calculated the shortfall in the necessary financial resources. He asked the Regional Director to specify the overall budget requirement for the Stop TB project in the Region and the final shortfall, and asked how WHO would address the issue at regional and country level.

Mr VAEVAE-PARE (Cook Islands) reported that the number of cases of tuberculosis in his country was relatively low, with three cases reported in 1999, one in 2000 and none in 2001. Nevertheless, the Ministry of Health continued to be vigilant in monitoring the disease. The DOTS strategy was adhered to strictly. His Government would consider and adopt the actions proposed in document WPR/RC52/10 and any other initiatives for minimizing or eliminating tuberculosis.

Dr KOI (Macao, China) said that tuberculosis was the most important infectious disease in Macao (China). Although the incidence rate was decreasing, it had remained at a level of around 100 per 100 000 persons for the past 10 years. The mortality rate was 7.9 per 100 000 persons in 1999. The tuberculosis prevention and control programme included free diagnosis and treatment, use of the DOTS strategy in over 95% of new cases in 2000, the provision of drugs at a health centre within a 20-minute walk or at home, and 99% coverage of infants with BCG immunization in 2000. Although a long-term programme was being
implemented at the central Tuberculosis Control Unit and health centres, the prevention and control of tuberculosis remained a challenge.

Ms KONG (China) expressed her delegation's appreciation of WHO's efforts in accelerating work in tuberculosis control in Member States, particularly the contribution of the Regional Office to her Government's policy, sectoral support, strategic advocacy, programming, fund-raising and technical support. China supported the analysis of the current situation and the plan of action proposed. China was a populous developing country which had the second highest tuberculosis prevalence rate in the world, and the task of controlling the epidemic was an arduous one. Expanding use of the DOTS strategy was the key to control of the disease. The Chinese Government was honouring its commitment made at the Ministerial Conference on Tuberculosis and Sustainable Development, held in Amsterdam, The Netherlands, in March 2000, and had earmarked funds from the regular budget to support tuberculosis prevention and control in the western provinces and less developed areas of the country. The tuberculosis control project was supported by the World Bank, the Department for International Development of the United Kingdom and the Government of Japan as well as WHO. WHO had played and would continue to play an important role in mobilizing national political and fiscal commitment and in promoting international cooperation.

Dr HAN (Republic of Korea) said that his country supported the regional strategy for the eradication of tuberculosis and use of the DOTS strategy to that end. As the sharing of accumulated knowledge on tuberculosis control was a key factor in eradication of the disease, he supported the establishment of the tuberculosis technical advisory group. He also hoped that the international community would be able to share knowledge on prevention and control of other communicable diseases.

Mr SOTHINATHAN (Malaysia) said that the rate of re-emergence of tuberculosis in Malaysia and in the rest of the world was alarming: it was the most frequently notified disease in his country. Launched in 1961, the national tuberculosis control programme had been integrated into the general health system in 1995. Although Malaysia was considered to have an intermediate burden of tuberculosis and a good health infrastructure, the incidence was still high and had not decreased in recent years. The rate had been 69.9 per 100 000 in 1984, 58 per 100 000 in 1995 and 67.8 per 100 000 in 2000. The incidence for infectious tuberculosis was 36.7 per 100 000, while the targeted indicator for infectious forms of the disease was 20 per 100 000. Treatment for tuberculosis was provided free of charge in government hospitals. Most cases occurred among local residents, and cases among immigrants contributed 10.6% of the total.
The dual epidemics of tuberculosis and HIV/AIDS formed a deadly partnership, each reinforcing the other. Close collaboration and cooperation between the programmes for the two infections were thus vital. Tuberculosis/HIV cases accounted for 4.9% of total tuberculosis cases in the country.

As advocated by WHO, political commitment to control tuberculosis should be strengthened. The national programme in Malaysia had formulated a five-year plan for 2001-2005, which was being implemented.

The DOTS strategy was still the most cost-effective means for combating the tuberculosis epidemic. However, in order to expand use of that strategy, adequate financing would be required to secure regular supplies of drugs and adequate human resources.

In order to determine the prevalence of tuberculosis in Malaysia accurately, a population survey would be conducted in 2002-2003, and a survey of drug resistance would be initiated in 2002. Multi-drug resistance did not appear to be a problem in Malaysia, as a survey in 1997 had shown that only 2% of cases were resistant. Nevertheless, Malaysia would try to prevent the emergence of drug resistance by improving the cure rate and expanding use of the DOTS strategy throughout the country. To that end, external technical, financial and other support would be required from WHO and other collaborating agencies.

Dr PHOMMASACK (Lao People's Democratic Republic) recalled the close relationship between poverty, malnutrition and tuberculosis and the emerging relationship between HIV/AIDS and tuberculosis. His country was promoting use of the DOTS strategy actively, but the identification and treatment of cases of tuberculosis was difficult in a country like his with sparsely distributed villages far from any health centres. The Ministry of Health was committed to reducing the prevalence of and mortality from tuberculosis by 50% by 2010. The target was to be achieved by expanding use of DOTS throughout the country by 2005, improving case detection rates and the accuracy of microscopic diagnosis, appropriate monitoring and supervision and improving logistics and drug distribution. Achieving those goals would require substantial financial resources, technical support and training of personnel at central, provincial and district levels, and he looked forward to support from WHO, other partners and bilateral donors.

Dr PRETRICK (Federated States of Micronesia) said that tuberculosis was a serious public health concern in his country, which had a case notification rate of over 60 per 100 000 persons, much higher than in most countries of the Region. Expansion of DOTS coverage had improved case management, but the expansion was in its early stages, and the cure rate
was still low. The objectives of the national programme to 2005 were to expand use of DOTS as the primary tuberculosis control strategy to 100% of the country, to ensure a treatment success rate of at least 90% of smear-positive pulmonary tuberculosis cases, to ensure that all new smear-positive cases were enrolled in the DOTS programme, and to detect 70% of estimated new smear-positive cases. The short-term objectives within the current year were to expand the DOTS enrolment rate to 80%, improve the cure rate of sputum-positive cases to 60%, increase laboratory confirmation to 50% and continue training of personnel within and outside the country. He hoped that WHO would continue to provide technical support and training for capacity-building and would identify the sources of funds for the procurement of drugs.

Dr DAYRIT (Philippines) said that there were an estimated 250 000 sputum-positive cases of tuberculosis in his country at present. The initiatives being undertaken to stop tuberculosis included implementation of the DOTS strategy. The Government had provided the necessary funds to buy drugs for about 120 000 patients. It was also strengthening laboratory capacity to diagnose tuberculosis in outlying areas and was working closely with a nongovernmental organization to ensure the guidelines for tuberculosis treatment were acceptable to all medical practitioners. Private practitioners were a weak link in the fight against tuberculosis, as many did not subscribe to the official treatment guidelines. The Government was also strengthening the country’s surveillance network for multidrug-resistant tuberculosis, and continuing to maintain high BCG immunization coverage for infants.

In view of the regional target of a 50% reduction in tuberculosis prevalence and mortality from tuberculosis by 2010, his delegation would be interested in knowing the amount of the total financial requirement for the strategy in the Region and how the Regional Office might support Member States in achieving these regional goals.

Dr CHEN (Singapore) informed the Committee that his Government had reviewed its BCG immunization programme in the light of the most recent WHO recommendations and had ceased its revaccination campaign. His country remained committed to the Regional Strategic Plan to Stop TB in the Western Pacific.

The REGIONAL DIRECTOR thanked the representative of Viet Nam for her proposal and assured her that he would discuss her suggestion to include multidrug resistance on the agenda of the next session with the Chairperson when they came to finalize the agenda. He noted that the problem raised by the representative of Hong Kong (China), with regard to the shift in the age groups most severely affected by tuberculosis, was common to all developed
countries with ageing populations, while in developing countries the worst affected group was people of productive age. A study was already being conducted with a view to formulating a specific strategy to deal with the problem. The tuberculosis technical advisory group could then discuss the issue at its 2002 meeting in Japan.

The representatives of Papua New Guinea, the Philippines, the Republic of Korea and others had asked about the shortfall in the budget for the Stop Tuberculosis programme in the Region. The total financial requirement for the seven countries with the highest tuberculosis burden was approximately US$ 600 million for the next five years, or US$ 120 million annually. However, 76% of that amount had already been committed by governments and 4% by international organizations. The shortfall was therefore 20% of the total requirement. The World Bank, the Government of Japan and the Department for International Development of the United Kingdom had reduced the shortfall by 70%, and efforts were being made to make up the remainder.

He referred the question from the representative of Japan regarding progress in implementation of the Stop TB Special Project to the regional adviser on that topic.

The REGIONAL ADVISER IN STOP TB AND LEPROSY ELIMINATION was pleased to report that the foundation of the Stop TB Project in the Region had been successfully laid over the previous two years through the formation of the tuberculosis technical advisory group, the development of the Regional Strategic Plan, and establishment of the regional and national interagency coordination committees. Five-year plans had been drawn up for the seven countries with the highest burdens of tuberculosis in the Region, including budgetary requirements and shortfalls. Progress had, on the whole, been good, and population coverage had increased from 58% in 1998 to 68% in 1999. In addition, over the previous two years, the enrolment rate for new cases had increased from 72% to 78%. However, the programmes would have to be accelerated to reach the targets set for 2005.

The CHAIRPERSON requested the Rapporteurs to prepare an appropriate draft resolution.
2. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolutions:

2.1 Regional strategy for mental health (Document WPR/RC52/Conf. Paper No. 5)

Dr OTTO (Palau) proposed that the words “and their families” should be inserted at the end of the preambular paragraph 7. He further proposed that in operative paragraph 2(3) the words “appropriate access to services” be replaced by “access to appropriate services” and that, in operative paragraph 3(3), “a needs assessment” be replaced by “an assessment of needs”.

Dr TEMU (Papua New Guinea), referring to preambular paragraph 3, suggested that the words “the increasing burden of mental and neurological disorders in the Western Pacific Region” would reflect the current situation better than “the poor state of mental health in the Western Pacific Region” and proposed that the paragraph should be amended accordingly. He further proposed that “pregnant or lactating women” or “women” should be added to preambular paragraph 5. Turning to the operative paragraphs he proposed that, in operative paragraph 2(2), “and nongovernmental organizations” should be inserted after “family welfare” and that a new operative paragraph 2(3) should be added to read “to ensure that national development programmes take into account the impact of social and economic factors on mental health and mental disorders”. Paragraph 2(3) would then become paragraph 2(4). He further proposed that, in operative paragraph 3(4), “and other international development partners” should be inserted after “Member States”, and that a new paragraph 3(5) should be added to read “to assess the feasibility of including non-health sector representation at Regional Committee meetings and other meetings as a means of raising awareness among non-health sector policy-makers and leaders”. Paragraph 3(5) would then become paragraph 3(6).

Dr SAKOI (Japan) said that the regional strategy included demand reduction and harm reduction in relation to use of harmful substances. However, there was some ambiguity in the term “harm reduction” as it might include prescription of drugs and provision of injection tools for existing drug users, activities for which consensus had not been reached among Member States. Japan, for example, considered that it was more effective to prevent people from beginning to use such substances in the first place, and to offer care and rehabilitation to existing users. He, therefore, proposed that, in operative paragraph 2(1), the words “adjusting certain aspects of it where appropriate” should be added.
Mr SOTHINATHAN (Malaysia) suggested that the term "psychosocial problems" was more appropriate than "psychosocial disorders" and that the first preambular paragraph should be amended accordingly. Agreeing with the representative of Papua New Guinea that the phrase "poor state of mental health in the Western Pacific Region" did not accurately reflect the current situation, proposed that those words be replaced by "prevalence of mental illness in the Western Pacific Region". He suggested that, in preambular paragraph 5, it would be preferable to insert "women" rather than "pregnant and lactating women". Referring to the wording for a new paragraph 2(3) proposed by the representative of Papua New Guinea, he suggested that it would be preferable to delete "mental disorders" as it would be sufficient to refer to mental health.

Ms AHN (Republic of Korea) agreed to the proposal made by the representative of Malaysia in relation to the preambular paragraph 5, but proposed that "children" also be added.

Dr NOVOTNY (United States of America) said that he welcomed the proposed amendments in general but could not support the new paragraph 3(5) proposed by the representative of Papua New Guinea, since it had important policy implications. He suggested that the Legal Counsel should be consulted in that regard.

The REGIONAL DIRECTOR welcomed the proposed amendments but suggested that, in the preambular paragraph 3, it might be preferable to replace "poor state of mental health" by "increasing challenges to mental health". He pointed out that he did not think it appropriate for him to carry out a feasibility study on non-health sector representation as proposed in new paragraph 3(5). Moreover, the need to raise awareness among non-health sector leaders and policy-makers did not apply only to mental health. He, therefore, suggested that the proposed new paragraph 3(5) should not be included in the draft resolution and requested representatives to allow him to determine the best approach to partnerships with the non-health sector.

Referring to the original paragraph 3(5), he said that requests for regular reporting on many different technical fields gave rise to difficulties in establishing agendas with a reasonable workload for meetings of the Regional Committee. There were three options for reporting back on a particular subject: by designating a specific agenda item; by submitting a report to the Regional Committee for information, with no discussion; or by incorporating a progress report on the area concerned in his report on the work of WHO in the Western
Pacific Region. He requested representatives to allow him to judge which of those options was the most appropriate.

It was so agreed.

**Decision:** The draft resolution, as amended, was adopted (see resolution WPR/RC52.R5).

2.2 **Prevention and control of tobacco use** (Document WPR/RC52/Conf. Paper No. 6)

Dr NOVOTNY (United States of America) expressed support for the draft resolution in principle but suggested that, while legislation was an important approach to tobacco control, operative paragraph 1(2) should be deleted or amended by replacing “FCTC goals” with “the Regional Action Plan for Tobacco or Health”, since the FCTC negotiating process was at an early stage and FCTC goals had not yet been established.

Dr TEMU (Papua New Guinea) said that he would prefer paragraph 1(2) to remain as it stood. If the FCTC was to be ratified by countries, their legislation must be consistent with FCTC goals.

Dr NOVOTNY (United States of America) further suggested that the paragraph might be amended to read “to support the FCTC process through the eventual adoption of appropriate legislation”.

Dr TEMU (Papua New Guinea) proposed that, in preambular paragraph 3, “efforts of the tobacco industry against prevention and control efforts, and” should be inserted after “continued”. He further proposed that, in preambular paragraph 5, “importance that the tobacco-industry gives to the promotion of tobacco products through association with and sponsorship” should be replaced by “negative impact of tobacco-industry-sponsored promotion”. Finally, he proposed that, in paragraph 1(1), “to support high-level political leaders to take the lead in” should be replaced by “to secure high-level political support for”.

The REGIONAL DIRECTOR suggested that, in operative paragraph 1(1), the wording should be “to secure high-level political support for the development” deleting the words “to take the lead”.

Professor SMALLWOOD (Australia) pointed out that it was inappropriate to urge Member States to secure high-level political support as the health department was surely part of the political process.
Dr TEMU (Papua New Guinea) replied that, in some countries, ministries of health were considered of lesser importance than the prime minister’s office and senior ministries such as those of finance and planning, and that it was, therefore, indeed important to secure high-level political support.

Dr TANGI (Tonga) agreed with the representative of Australia and pointed out that it was the responsibility of health ministers to ensure political support in cabinet. Referring to the proposed amendment to preambular paragraph 7, he suggested the insertion of “on health” after “negative impact”.

Dr TEMU (Papua New Guinea) pointed out that the negative impacts of tobacco use were not confined to those on health; there were also adverse economic and social effects.

Dr TANGI (Tonga) maintained that the major impact was on health.

Dr OTTO (Palau), referring to paragraph 1(1), said that in his intervention during the discussion of the regional strategy at an earlier meeting he had mentioned a workshop on tobacco prevention and control and the FCTC for senior government personnel from all ministries. Such a workshop was a useful means of supporting ministries of health in raising awareness of those issues in other sectors.

Professor SMALLWOOD (Australia) suggested that it might be preferable to amend operative paragraph 1(1) by replacing “to support high-level political leaders to take the lead in” by “to support at the highest political level”.

Mr SOTHINATHAN (Malaysia) proposed that it might be more appropriate to replace that phrase by “to seek the commitment of all other ministries to”.

Professor SMALLWOOD (Australia) further suggested the phrase “to secure commitment at the highest political level”.

Mr SOTHINATHAN (Malaysia) stressed that health ministries should be given due recognition as being on par with all other ministries. It was important to refer to the commitment of other ministries to a national intersectoral tobacco prevention and control strategy, and not appear to be seeking support for the health ministry.

Dr TANGI (Tonga) endorsed that view. It was not for the Regional Committee to decide on sensitive national political matters.
Dr PHOMMASACK (Lao People's Democratic Republic) said he wished to see the inclusion of "support" and "commitment".

Mr LEO (Vanuatu) said that it was important to find a solution that was appropriate to the political situation in all countries and proposed that the phrase should read "to secure high-level support and commitment".

In light of the discussion, the CHAIRPERSON suggested that paragraph 1(1) should be amended by replacing "to support high-level political leaders to take the lead" with "to secure the support and commitment of all government ministries".

Dr DAYRIT (Philippines) proposed that it would be more logical to place paragraph 1(6) before paragraph 1(2) and to renumber the following subparagraphs accordingly.

It was so agreed.

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC52.R6).

3. SEXUALLY TRANSMITTED INFECTIONS, HIV INFECTION AND AIDS: Item 16 of the Agenda (Document WPR/RC52/11)

The REGIONAL DIRECTOR told the Committee that, by the end of 2000, WHO estimated that there were over 1 million people in the Western Pacific Region who were infected with HIV. HIV transmission was still increasing among many population groups with high-risk behaviour. Deaths from AIDS were continuing to rise – on average, 150 young adults in the Region died from AIDS daily. Rates of sexually transmitted infections, or STI, were rising sharply in the general population in many countries.

He explained that this was because many individuals at high risk of HIV infection had not adopted simple but essential protective measures such as using condoms or clean injecting equipment.

Nevertheless, despite the seriousness of the situation, the REGIONAL DIRECTOR said that an analysis of the HIV/AIDS situation in Asia and the Pacific region by the Western Pacific and South-East Asian regions of WHO provided evidence that it was possible to reduce HIV transmission substantially.

He said that, during the past year, all over the Region there had been a stronger commitment by governments to tackle sexually-transmitted infections and HIV/AIDS. It was
particularly important that interventions were increasingly directed towards those most at risk of infection. Reaching such groups was not an easy task, but the evidence indicated that this was the only way to confront the epidemic.

Working within the UNAIDS framework, the Regional Office continued to concentrate its efforts on public health interventions, such as surveillance, preventive efforts and reinforcement of AIDS care. WHO supported national consensus workshops, monitored the regional situation closely and shared information through its website and regular newsletters. The Regional Office had also recently combined its surveillance efforts with those of the South-East Asia Region, because the spread of HIV was closely linked to population movements.

WHO's main strategy for tackling HIV/AIDS remained primary prevention; particularly "100% condom use" in entertainment establishments. Substantial progress had been made in both advocacy and technical support. WHO was also continuing to support Member States to improve STI case management.

Support for the development of policies and guidelines for care for the growing number of AIDS patients in the Region had increased. Health care professionals throughout the Region were being updated on developments in antiretroviral therapy through regular newsletters.

Globally, there had been some very important developments in the battle against AIDS, both at the Fifty-fourth World Health Assembly in Geneva, and subsequently at the United Nations General Assembly in New York, meeting in a special session. The General Assembly had reaffirmed the urgency of the battle against AIDS and adopted a far-reaching Declaration of Commitment. In April 2000, UN Secretary-General Kofi Annan called for the establishment of a global fund on AIDS and health. All these events indicated the seriousness with which the international community regarded the problem of AIDS.

He concluded by observing that the international community was mobilizing against the pandemic as never before and the Western Pacific Region was an important part of that process. He urged Member States to implement nationwide interventions targeting individuals at high risk of infection.

Dr TUKUITONGA (New Zealand) affirmed that prevention should be the mainstay of the international response to AIDS. Several lines of action were common to successful national prevention programmes, including framing of policy and delivery of programmes in
partnership with vulnerable groups, and political leadership. Many societies, however, continued to have difficulty facing the challenge of HIV, in talking openly about sexual matters, and in supporting initiatives for vulnerable groups.

In line with its emphasis on HIV/AIDS in the Western Pacific, his Government had financed the participation of several ministers and of representatives of nongovernmental organizations at the special session of the United Nations General Assembly on AIDS.

New Zealand was formulating a strategy on sexual and reproductive health that would be geared towards improving access to sexual health services, improving health education for the individual, and teaching skills for healthy lifestyles and techniques for safer sexual practices. This meant gathering information on how vulnerable groups perceived sex and sexuality and on progress being made.

Dr HONG Sun Huot (Cambodia) reported that HIV/AIDS had been given highest priority in Cambodia, as both a health and a development issue, after the first sentinel surveillance round, in 1995, had indicated high prevalence levels. The necessary institutional mechanisms had been set up and the HIV/AIDS programme had been integrated into the Government's Socioeconomic Development Plan and the Poverty Reduction Strategy Framework. National HIV/AIDS prevention strategies had been drawn up and were being implemented. The placing of prevention and care within a broader perspective, together with empowerment of civil society and increased budget allocations, had proved to be an effective and sustainable response to the epidemic.

The strategies had recently been reviewed and reformulated on the basis of that experience, and after analysis of epidemiological and behavioural data. The current strategy for prevention and control of sexually transmitted infections and HIV/AIDS focused on reduction of transmission among high-risk groups through targeted care of such infections and increased condom use; increased public awareness and provision of counselling and testing services and equipping the health system to cope with increase demand.

Further, the “100% condom use” project, which had raised condom use to over 90% was currently being expanded. That project had demonstrated that the highest commitment of local authorities and their cooperation with outreach workers, owners of entertainment establishments, and sex workers were essential to promote and monitor condom use.

Although HIV prevalence was decreasing, the need for AIDS care at the current stage of the epidemic placed a heavy demand on the health services. He requested WHO to
examine further the questions of increased access to, and proper use of, antiretroviral drugs, and of home-based care.

Dr TEMU (Papua New Guinea) reported that the prevalence of both HIV and sexually transmitted infections were rising in Papua New Guinea. His Government particularly appreciated the generous support provided for the national HIV/AIDS programme by Australia, the European Union, the Asian Development Bank and several organizations of the United Nations system.

The National AIDS Council had adopted the “100% condom use” strategy and a media campaign was underway. A nongovernmental organization – the National HIV/AIDS Care Foundation – had been established by his country’s First Lady to provide additional support for care and prevention efforts.

He hoped that those combined efforts would lead to a levelling out of the epidemic in the medium term, although efforts were hampered by a weak health system and the effects of the epidemiological transition. National HIV/AIDS programmes were geared to prevention, but his Government was concerned about the rise in the number of individuals and families living with AIDS, as treatment could only be provided for opportunistic illnesses. They were also continuing to see a high prevalence of sexually transmitted infections and an increasing number of children born with HIV.

He expressed his disappointment at the inactivity of UNAIDS in his country, at a time when the Government and its partners were making considerable efforts to tackle the epidemic. He hoped that access to resources from the Global AIDS and Health Fund would be less cumbersome than under the current method of handling international funding.

Dr PHOMMASACK (Lao People’s Democratic Republic) observed that the low prevalence of HIV infection in his country had stemmed from its relative isolation, limited movement of the population, and certain cultural values. However, the virus had now started to appear in the population and its transmission was facilitated by the high prevalence of sexually transmitted infections.

It was still possible to contain the epidemic in his country but it would soon be too late. At the moment, there was still time to invest in education, information, communication and prevention, and he requested that Lao People’s Democratic Republic should be included among the priority countries for HIV/AIDS activities. Support was needed for establishment of a comprehensive and intersectoral reproductive health programme.
Dr SAKOI (Japan), while fully supporting the focus on preventive measures, stressed that it was important to monitor the effectiveness of that policy by strengthening the surveillance system.

Better access to HIV/AIDS drugs called for well-trained medical experts and good quality laboratories in order to ensure effective and safe use of drugs. The development of human resources and the strengthening of medical infrastructure should, therefore, be given high priority. Further, new measures that were taken should be merged with existing ones; the Regional Office should play a more active role in that regard.

His Government had supported HIV/AIDS activities in the Region, including prevention of mother-to-child transmission, through bilateral assistance and programmes for development of human resources, in close cooperation with UNAIDS.

Ms SURENCHIMEG (Mongolia) reported that the prevalence of HIV/AIDS was starting to rise in Mongolia. The Government had launched a public awareness campaign and had initiated a survey to define the prevalence of sexually transmitted infections.

Cases that had been detected indicated that HIV/AIDS had entered into an expansion phase, which required the Government to revise existing prevention and early detection strategies. The "100% condom use" strategy needed to be applied urgently among high-risk groups, and external support was needed to improve surveillance and laboratory capacity.

Mr CAPELLE (Marshall Islands) reported that the rising prevalence of sexually transmitted infections, particularly among young people, increased the possibility of introducing HIV/AIDS in the Marshall Islands. A number of measures had been taken to ensure that all sectors of the population were covered by prevention and control efforts, and related programmes had been integrated into primary health care.

The Ministry of Health was worried about the potential cost of treating HIV/AIDS patients and had implemented an aggressive health education and promotion campaign aimed at 15-39 year-olds. However, the task of devising effective, informative and culturally acceptable methods of communicating the risks of sexually transmitted infections and HIV/AIDS remained a challenge.

Mr LEO (Vanuatu) said that the spread of sexually transmitted infections was also a cause of concern in his country. A recent prevalence study had shown that 40% of women under the age of 25 had already been infected more than once, and drastic prevention and
control measures were being taken. He stressed the commitment of nongovernmental organizations, which were active in raising awareness and promoting condom use and safer sexual practices.

Even although no case of HIV/AIDS had yet been detected, there was no room for complacency. He suggested that WHO should consider exchange programmes to countries where the infection was present so that health workers would be ready to handle any eventual case.

Mrs ROBINSON (Australia) stressed the need for close collaboration between the Regional Office, UNAIDS and other partners involved in prevention and control of sexually transmitted infections and HIV/AIDS at country and regional levels. The Regional Office should build up its relations with those partners to ensure that activities maintained a high profile, and that global responses maintained a strong focus on the Western Pacific Region.

She advised the Committee that her Government would be hosting a regional ministerial meeting on HIV/AIDS in the Asia/Pacific (Melbourne, Australia, 9-10 October 2001). Ministers from different sectors would be able to discuss effective responses to HIV/AIDS and to demonstrate their commitment to countering the growing epidemic both nationally and regionally.

Mr PENG KEI (Macao, China) said that, although Macao (China) had low HIV prevalence, the Health Department had considered prevention and control of HIV/AIDS an important issue that required continuous attention. A commission on HIV/AIDS prevention and control had been established to coordinate activities. Several approaches had been undertaken, including screening of selected target groups and anonymous surveillance, and HIV testing of transfused blood. All HIV/AIDS cases must be declared confidentially. The Macao Government supplied free medical treatment services, including counselling services, to HIV/AIDS patients.

From 1986 to 2001 there had been only a limited number of positive cases among most population groups screened. The exception had been temporary residents working in the entertainment industry, who comprised 70% of the total 236 HIV infections detected.

The situation was evolving rapidly, with increasing cross-border movements and behavioural changes in some population groups. However, Macao (China) was committed to continuing improve its HIV/AIDS prevention and control programme, including enhancing
the behaviour surveillance programme and conducting health education activities for the IDU population.

Dr KONG (China) stated that China endorsed WHO’s analysis of the current regional situation and the plan of action. The Chinese Government attached great importance to prevention and control of AIDS and had earmarked funds from the regular budget. Further efforts would be made to ensure safe blood and blood products, information dissemination, improvement of health services and the medical insurance scheme.

China agreed with Australia’s proposal that WHO should continue follow-up action even after the UN Special Session on HIV/AIDS through strengthening cooperation with UNAIDS and other international organizations. WHO should assume a leadership role in high-level mobilization initiatives to promote high-level political commitment and financial input. WHO should also continue to promote dialogue and coordination between national governments and pharmaceutical companies to reduce the cost of antiretrovirals. Lower cost would enable more HIV carriers and AIDS patients to have access to medication.

Document WPR/RC52/11 suggested the establishment of health service facilities for sex workers. She fully understood this and strongly supported providing health services to high-risk populations. However, bearing in mind that the phrase “sex workers” had sensitive connotations in some cultures, she suggested a change in the wording to read: “Establish and improve STI health services, according to specific national conditions, to provide health services to high-risk populations”.

Mme COENT (France) said that the French delegation fully approved the analysis and the recommendations prepared for Member States of the Regional Committee regarding HIV/AIDS. France welcomed the support that WHO continued to give to countries and appreciated the results apparent in some countries, such as Cambodia.

In Section 3 of the document — Actions Proposed, item 1 — France did not like the phrase “individuals at risk”, which implied some kind of stigmatization, and recommended the term “vulnerable persons”. In item 4, concerning the improvement of care, she felt that care should be carried out in parallel with prevention, which should be linked to increased access to treatment for all. Still on paragraph 4, on page 5 of the English text, France regretted that the principle embodied in resolution WHA54.10, operative paragraph 1(5) and in the Declaration of Commitment on HIV/AIDS had not been included in item 4, concerning care.
Regarding the national strategic plans referred to in item 4, the French delegation felt that people living with AIDS should be given an opportunity to participate in the development and implementation of such plans.

Finally, it would be useful to mention, in actions proposed, the promotion of exchange of information and the sharing of experiences from various countries and areas.

The French delegation wished to underline that to facilitate increased access to treatment, it was necessary to combine three supplementary objectives: the reduction in the cost of drugs, the development of financial solidarity mechanisms, such as the global fund on AIDS and health, and the strengthening of health systems capacity in developing countries in accordance with national development plans. In order to achieve the third objective, she reported that an initiative to promote hospital partnerships in the field of therapeutic care of patients suffering from HIV/AIDS had been suggested by many European countries, including France. That initiative could be the basis for a concrete action plan designed to disseminate and share expertise and knowledge.

Dr RICARDO (Philippines) reported that the number of HIV/AIDS cases in the Philippines had remained small, with approximately 1500 HIV infections registered over the last 15 years. The estimated prevalence was around 10 000 infections.

Her delegation fully supported the Declaration of Commitment on HIV/AIDS that was attached to document WPR/RC52/11. However, she echoed the concern that had been expressed by China on the difficulty of HIV-infected individuals accessing antiretroviral drugs because of their prohibitive cost. The Philippine Government had very limited resources and looked forward to hearing the results of WHO's efforts at the international level to lower the cost of the drugs.

Dr HAN (Republic of Korea) said his country supported resolution WHA54.10 and the Declaration of Commitment. Every country should actively support and participate in the development of WHO policies on AIDS control. He asked WHO and other international organizations to assume a leadership role in AIDS prevention. Effective measures should be taken to prevent the spread of the disease. Voluntary medical testing and counselling should be encouraged to reduce the number of unreported cases. In addition, health education activities should be conducted among commercial sex workers to prevent further transmission of STI.
Dr ARIF (Malaysia) noted that some countries had been able to manufacture antiretroviral drugs and were thus benefiting from lower costs. That, however, was not a practical solution for a small country like Malaysia, which was still pursuing discussions on reduction of drug prices. Although multinational drug companies had offered price reductions ranging from 5% to 65%, that had not helped much to alleviate the burden of treatment. WHO and other United Nations agencies should play an active role in negotiating with drug companies to reduce drug prices.

Dr NOVOTNY (United States of America) reminded the Committee that at the United Nations General Assembly Special Session on HIV/AIDS, nations had agreed work together to halt and begin to reverse the spread of HIV/AIDS. A key goal was to reduce HIV prevalence among young men and women by 25% by 2005. Other key goals contained in the Declaration of Commitment included: implementing national strategies to confront stigma, silence and denial; eliminating discrimination; partnering with civil society to reach both those living with HIV/AIDS and the most vulnerable groups; providing national budget resources and international cooperation; addressing risk, prevention, care, treatment and support; and strengthening health, education and legal capacity on HIV/AIDS.

Those reflected only a portion of the commitments that nations had agreed to. It had been shown, however, that political leadership at the national level was the single most important factor in responding to the epidemic.

The United States of America commended WHO's support for evidence-based approaches to HIV and STI prevention, blood safety, AIDS care, epidemiological data collection, and coordination with partners.

His government also supported prevention interventions for individuals with behaviours that placed them and/or others at risk for HIV or other sexually transmitted infections. There was a need to target both HIV-negative and HIV-positive persons to prevent transmission.

He noted that countries in the Region, such as Cambodia, had achieved successes in reducing the prevalence of HIV/AIDS and stressed that every country – regardless of its rates of infection and number of persons infected – could learn from the successes of others.

He also affirmed his country's strong support for the global fund on AIDS and health, which was a multipartner effort, including governments, the public and private sectors, and
international organizations. He encouraged all governments in the Region to help to get the fund up and running by 1 January 2002.

Dr PRETRICK (Federated States of Micronesia) commended the Regional Office on the excellent report on HIV/AIDS status in the Region.

He described the spread of HIV infection in his country since detection of the first two HIV-positive cases in 1989-1990. The first AIDS case in someone who had never travelled out of the country had been found in January 2001. In July 2001, a team from the Centers for Disease Control, United States of America, had tested 378 patients and had found four HIV-positive persons. Current prevention and control activities included HIV/AIDS testing for high-risk groups at prenatal clinics, STI clinics, family planning clinics and special clinics; education activities to increase public awareness; establishment of community planning groups; outreach activities; HIV testing and counselling; and public education on the use of condoms.

Mrs HA (Viet Nam) reported that the HIV/AIDS epidemic was continuing to spread each year in her country. By early July 2001, a cumulative total of 38,359 HIV infections had been reported from all 61 provinces of the country; 70% attributed to injecting drug use. There had been 5,784 cases of AIDS, with 3,123 deaths. Numbers had doubled since 1999. Intervention in the country concentrated on high-risk groups such as injecting drug users, commercial sex workers and young people. Activities included peer education, promotion of condom use and disposable syringes, and self-help groups. A community approach had been developed to provide access to information on prevention and control. The mass media had been involved in information, education and communication work, and the distribution network for condoms had been improved.

Following a successful pilot project on sexually transmitted infection management and 100% condom use, which WHO had supported in Viet Nam over the previous three years, a large-scale, four-year project on promotion of 100% condom use was being finalized, supported by the Department for International Development of the United Kingdom with WHO as the executive agency. She thanked the Government of the United Kingdom and WHO for their support with that project.

She also hoped that WHO and other United Nations agencies would negotiate with drug companies to secure affordable prices for treatment drugs.
Dr KIENENE (Kiribati) spoke of the rapidly increasing numbers of STI/HIV/AIDS cases in his country, one of the most rapid increases among Pacific island countries and areas. By the end of August 2001 there had been 38 HIV cases (including AIDS cases) in Kiribati, 65% of which were seafarers and their spouses.

In line with the national STI, HIV/AIDS strategic plan 2000, developed with the support of WHO and the MacFarlane Burnett Centre of Australia, prevention would continue to be the central activity. The following actions were planned or ongoing: a parliamentary seminar for ministers and members of parliament during the November 2001 session; the drafting of laws in collaboration with a WHO consultant; improved condom distribution in bars and nightclubs; an adolescent health programme, with the support of the United Nations Population Fund and with the South Pacific Community as the executive agency; strengthened safe blood supply, involving laboratory testing; and regular counselling and health education to those graduating from high school and maritime schools.

Dr HOMASI (Tuvalu) said that his country had completed a five-year plan on HIV/AIDS, which was now being implemented. Although there had been only two HIV cases reported in the country, HIV/AIDS was a threat to the 10 000 population of his small nation. Seafarers were most at risk, as were the many young people studying abroad. He referred to the successful work in the Caribbean, which placed care and support for infected people at the top of the HIV/AIDS agenda. In Tuvalu, also, care and support for people living with HIV/AIDS, their families and the island community was the first priority in the national plan, which also prioritized the reduction of vulnerability, promotion of safe sexual behaviour, prevention and control of STI, safe blood supply, and a multisectoral response to HIV/AIDS.

As yet, there was no provision for drugs or treatment guidelines for the use of antiretroviral preparations; the budget was restricted to the priority areas, with no allocation for treatment. His delegation suggested that WHO should look to the successful work on that issue in Brazil, and help Member States in the Western Pacific Region to strengthen treatment. He supported the Declaration of Commitment on HIV/AIDS adopted by the Special Session of the General Assembly of the United Nations.

The REGIONAL DIRECTOR concluded from the foregoing discussion that, now that there were many cases of AIDS in the Region, the provision of care, including antiretroviral treatment, was now a critical question in many countries. The cost of drugs remained high, although progress had been made. He welcomed the United Nations decision to establish a
global fund on AIDS and health, although it had to be acknowledged that availability of drugs alone did not solve the problem. Good infrastructure was needed to ensure drugs were administered properly. He agreed with the representative of France that cost- mechanisms and strengthening of health systems were essential. Drugs should be made available so that care could be provided, but health systems also had to be strengthened.

The REGIONAL DIRECTOR took note of the concerns of the representative of Papua New Guinea with regard to UNAIDS in that country; he further noted the concern of China on the term 'sex workers', and the suggestion from France that the term 'vulnerable persons' be used instead of 'at risk groups'.

The REGIONAL ADVISER ON SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV/AIDS noted that the global fund on AIDS and health had been established very recently, with a transitional working group on which WHO was represented. WHO would have a major role to play in development of the operation of the fund. He was monitoring the fund and would inform Member States regularly on its progress, and provide support in submitting proposals to the fund when appropriate.

The CHAIRPERSON invited the representative of the International Council of Nurses to address the meeting.

4. COORDINATION OF THE WORK OF THE WORLD HEALTH ASSEMBLY, THE EXECUTIVE BOARD AND THE REGIONAL COMMITTEE: Item 18 of the Agenda (Documents WPR/RC52/12 and WPR/RC52/INF.DOC/1)

The DIRECTOR, PROGRAMME MANAGEMENT, drew the attention of the Committee to resolution WHA54.2, on infant and young child nutrition. In the Western Pacific Region, two country level reviews of the global strategy had been held in 2000, in collaboration with UNICEF. They had taken place in China and the Philippines. WHO would be holding a regional consultation on the global strategy in Kuala Lumpur in October 2001, in collaboration with UNICEF. The meeting would look at how the strategy could be implemented most effectively in the Region.

The strategy would be submitted to the Executive Board and the World Health Assembly in 2002 for adoption.

With regard to resolution WHA54.12 on strengthening nursing and midwifery, the DIRECTOR, PROGRAMME MANAGEMENT explained that that was an issue of central
importance to every Member State in the Region. Many Member States had reported the
difficulties they were having in recruiting and retaining trained nursing staff. He believed that
nursing and midwifery shortages in the Region, combined with inequitable distribution of the
workforce, posed a considerable challenge to everyone. In many Member States, the delivery
of safe standards of nursing care was already being affected, and that problem had to be
addressed as part of the health sector reform that was taking place in many countries.

With regard to resolution WHA54.16, on the International Decade of the World's
Indigenous People, he reminded representatives that, last year, it had been proposed that the
Regional Office should work closely with its colleagues in WHO Headquarters to develop a
framework for a global plan of action. That collaboration had begun, and the actions needed
to address the health needs of indigenous people in the Region were being considered as the
framework was being set up.

The DIRECTOR, PROGRAMME MANAGEMENT concluded by mentioning a
resolution adopted by the Executive Board at its 107th session, on Health Systems
Performance Assessment. Since the previous session of the Regional Committee, there had
been a number of important consultations with Member States, at both global and regional
levels. In July 2001, a consultation for the Western Pacific had been held in Manila with
representatives from Member States and technical experts. It had been a very useful meeting,
summarized in the document before the Committee. Finally, he drew the attention of the
Committee to information document WPR/RC52/INF.DOC./I, the provisional agenda for the
109th session of the Executive Board of WHO, to take place in January 2002.

Dr NOVOTNY (United States of America) commended the results of the WHO
regional consultation on health systems measurement; the Region clearly shared with others
concerns about the appropriateness of various measures promoted in the 2000 World health
report: the validity of various data sources; the utility of summary measures for health policy,
planning, and outcome improvement; and the wisdom of reporting rankings, which might not
be helpful to individual countries as they addressed system deficiencies. He joined with other
speakers in asking WHO to listen to the results of regional consultations and to continue to
review the entire process. He looked forward to the Director-General's response to the input
from Member States.

Mr KINGDON (Australia) also spoke of the health systems assessment report, and
welcomed the Director-General's commitment to establish a technical consultation process to
revise the methodology, to consult members on WHO's data analysis and its findings, and to
establish an advisory group to assist her in monitoring the assessment of health system performance. He had welcomed the opportunity to take part in the regional consultation in Manila in July. As document WPR/RC52/12 indicated, the consultation had produced a consensus on the importance of performance measurement and WHO's lead role in developing measurement tools. Nevertheless, the consultation had found that the existing measures were too complicated for in-country use. Much remained to be done before the next assessment in 2002. He had therefore been surprised to learn that WHO had decided to publish comparative life expectancy information and the national health accounts for Member States in the 2001 World health report. In accordance with the Director-General's commitment, however, Australia had been given the opportunity to comment. It had discovered that the 1.4 year fall in life expectancy in Australia over the year since the previous report had resulted, not from changes to the burden of disease, but from the use of a new measure, health-adjusted life expectancy (HALE). The speaker accepted that WHO preferred the HALE to the disability-adjusted life year (DALE) measure, since it was more comprehensive, but he urged caution in applying and publishing such measures before their utility and validity had been clearly established.

Dr JEON (Republic of Korea) said that health systems performance assessment should make it possible to compare national health care systems, and should provide an opportunity to increase effectiveness, but that it was very difficult to clarify and measure the relationship between input and outcomes. He, therefore, suggested that the methods of measurement and analysis used in calculating health-adjusted life expectancy be simplified. The measure of equity of contribution was also too complex. A method should be developed to find out who benefited from public expenditure and government support, as well as a method for assessing private health care. In view of the methodological difficulties involved, it would be preferable to exclude the rankings of health care systems from the WHO report.

The DIRECTOR, PROGRAMME MANAGEMENT, took note of those comments, and said that the Regional Director would raise them with the Director-General, possibly at the forthcoming global cabinet.

At the invitation of the CHAIRPERSON, the CHAIRMAN OF THE EXECUTIVE BOARD made a short statement to the Committee. She expressed her thanks to the host country, and to the Regional Director. She had listened attentively to what had been said at the meeting, and would echo those discussions at global level.
The CHAIRPERSON invited the representative of the Medical Women's International Association and the representative of the International Federation of Pharmaceutical Manufacturers' Associations (IFPMA) to address the meeting.

5. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolution:

5.1 Prevention and control of tuberculosis (Document WPR/RC52/Conf. Paper No. 7)

Mr LIU (China) recalled that, during the discussion on tuberculosis, he had emphasized the important advocacy role of WHO. He therefore suggested that a new operative paragraph 2(1) be inserted, to read “to continue to work with other international organizations to advocate at the highest political level for increased political and financial commitment to tuberculosis control and to enhance international cooperation”.

The numbers of the following paragraphs should be changed accordingly.

Dr OTTO (Palau), referring to operative paragraph 2(5), asked what tools were needed to measure mortality. He suggested that perhaps morbidity, the burden of disease, was being referred to.

The REGIONAL DIRECTOR, in reply to the representative of Palau, recalled that the technical advisory group and the Regional Committee had endorsed the targets of reducing the rates of mortality and prevalence by half by 2010. Tools for measuring morbidity were already available, but mortality rates were difficult to measure.

Referring to the suggestion of China, he said he would make sure that the views of the Chinese delegation were reflected in the resolution.

Decision: The draft resolution, as amended, was adopted.

6. JACQUES PARISOT FOUNDATION FELLOWSHIP AWARD: Item 20 of the Agenda (Documents WPR/RC52/15 and WPR/RC52/INF.DOC./2)

The DIRECTOR, PROGRAMME MANAGEMENT, introducing the item, told the Committee that the Jacques Parisot Foundation had been established in 1969 by Madame J. Parisot to perpetuate the memory of Dr Jacques Parisot, former President of the World Health Assembly. Since 1975, a fellowship for research in social medicine or public health had been awarded every two years. The Foundation was administered by the Director-General of the
World Health Organization, who implemented the decisions of the Foundation Committee, which consisted of at least five members appointed by the Executive Board.

Each region took it in turn to propose candidates, and the Regional Office for the Western Pacific had been invited to propose three candidates for the award, to be made in January 2002 by the Executive Board. A fellowship to the value of US$ 5000 would be awarded to a candidate who submitted a worthy research project and was considered capable of bringing it into fruition. The research should be completed within 12 months.

The Regional Director had written to Member States in April 2001 inviting them to submit the names of candidates for the award. He had selected “Combating communicable diseases and sustainable health service development, focused on identifying barriers of service utilization for diseases of poverty” as the topic for research. The Regional Office had received 18 proposals from six countries in the Region. Of those, seven had been short-listed by a technical review group in the Regional Office and sent to members of the Western Pacific Advisory Committee on Health Research for further review.

A summary of the Advisory Committee’s assessment and the criteria used for selection were provided in WPR/RC52/INF.DOC./2, which also contained the Advisory Committee’s suggested ranking of the seven proposals. He invited the Committee to select three proposals from that list of seven, which would be submitted to the selection panel. He respectfully suggested that the Committee might like to follow the assessment of the advisory committee, which had ranked the top three research proposals as those by Dr Yu Dongbao; Professor Hui Zhuang; and Professor Xu Longqi.

Professor SMALLWOOD (Australia) noted that the research proposals for the award of the Jacques Parisot Foundation received by the Regional Office had been reviewed and ranked by members of the Regional Advisory Committee for Health Research. His delegation proposed that the Regional Committee submit the short-list of the first three candidatures based on the ranking of the Regional Advisory Committee to the selection panel of the Jacques Parisot Foundation for further review.

Dr DAYRIT (Philippines) seconded the proposal of the representative of Australia.

It was so decided (see decision WPR/RC52(1)).
7. MEMBERSHIP OF VARIOUS COMMITTEES: Item 21 of the Agenda

7.1 Sub-Committee of the Regional Committee on Programmes and Technical Cooperation: Item 21.1 of the Agenda

The REGIONAL DIRECTOR said that the current members of the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation were Brunei Darussalam, Malaysia, New Zealand, Niue, the Republic of Korea, Tonga, Vanuatu and Viet Nam.

The members of the Sub-Committee whose periods of tenure were due to expire in 2001 were Brunei Darussalam, New Zealand, Niue and Tonga.

Resolution WPR/RC49.R8 recommended that the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation should support the Regional Committee only when called upon to perform a specific task. He therefore respectfully suggested that the Regional Committee should postpone appointing new members of the Sub-Committee until the Sub-Committee was required to perform a specific task.

It was so decided (see decision WPR/RC52(2)).

7.2 Special Programme of Research, Development and Research Training in Human Reproduction: Membership of the Policy and Coordination Committee: Item 21.2 of the Agenda (Document WPR/RC52/16)

The DIRECTOR, PROGRAMME MANAGEMENT explained to the Committee that the Policy and Coordination Committee (PCC) was the governing body of the Special Programme of Research, Development and Research Training in Human Reproduction.

It was composed of four categories of members and had a total of 32 members. One of the categories, Category 2, had 14 members, three of which were allocated to the Western Pacific Region. Those members were elected by the Regional Committee for three-year terms.

In electing members, due consideration was given to a Member State's financial or technical support to the Special Programme and its interest in the field of human reproduction, as reflected by its national policies and programmes.
At present, the three members of Category 2 from the Western Pacific Region were Cambodia, Malaysia and Papua New Guinea. The term of Malaysia was due to expire on 31 December 2001.

In order to maintain the full representation of the Western Pacific Region on the Policy and Coordination Committee, the Regional Committee was requested to elect one Member State to nominate a member whose three-year term would start on 1 January 2002. The Regional Committee might wish to elect Viet Nam.

The next meeting of the Policy and Coordination Committee would be held from 20 to 21 June 2002.

It was so decided (see decision WPR/RC52(3)).

Mr SOTHINATHAN (Malaysia) thanked the Committee for having given his country the opportunity to serve on the Policy and Coordination Committee, which had been a rewarding and enriching experience.

7.3 Special Programme for Research and Training in Tropical Diseases: Membership of the Joint Coordinating Board: Item 21.3 of the Agenda (Document WPR/RC52/17)

The DIRECTOR, PROGRAMME MANAGEMENT said that paragraph 2.2.2 of the Memorandum of Understanding on the Administrative and Technical Structures of the Special Programme for Research and Training in Tropical Diseases provided for the selection by the WHO regional committees of two Member States from among those directly affected by the diseases dealt with by the Special Programme, or from among those providing technical or scientific support to the Special Programme.

The two Member States of the Western Pacific Region who were members of the Joint Coordinating Board in this category were the Lao People's Democratic Republic and Papua New Guinea. Since the three-year period of tenure of the representative designated by Papua New Guinea ended on 31 December 2001, the Committee would wish to appoint a Member State to send a representative to represent the Region from 1 January 2002. It might wish to consider Cambodia as a replacement for Papua New Guinea.

The exact dates and place of the 2001 meeting of the Joint Coordinating Board would be conveyed to Member States in due course.

It was so decided (see decision WPR/RC52(4)).

The REGIONAL DIRECTOR recalled that, at its fifty-first session, the Committee had decided to accept the kind invitation of the Government of Japan to act as host for the fifty-third session of the Committee in 2002. It only remained for him to propose the dates of the session. WHO tried to coordinate the dates of all six regional committees, first, to enable the Director-General to attend at least part of them all; and second, to allow enough time for the discussions of all the regional committees to be reflected in the documentation for the Executive Board meeting in January. Therefore, he proposed 16 to 20 September 2002 as the dates of the fifty-third session.

Mr TASAKA (Japan) said that it would be a great pleasure to host the fifty-third session of the Regional Committee in Kyoto, the former capital of Japan. He doubted that his Government could provide a welcome as warm as that of the Government of Brunei Darussalam, but it would do its best.

The CHAIRPERSON expressed the Committee's appreciation for the kind invitation of the Government of Japan.

The REGIONAL DIRECTOR informed the Committee that the venue of the fifty-fourth session would be the Regional Office in Manila.

Decision: The draft resolution was adopted (see resolution WPR/RC52.R8).

9. CLOSURE OF THE SESSION: Item 23 of the Agenda

Dr HONG (Cambodia), on behalf of the Regional Committee, expressed the appreciation and thanks of the Regional Committee first, to the His Majesty the Sultan of Brunei Darussalam and his Government for hosting the session, for the excellent facilities provided and for its generous hospitality, and second to the Chairperson, Vice-Chairperson and Rapporteurs, to the panellists of the special session of mental health, to the moderator of the ministerial round table, and to the representatives of governmental and nongovernmental organizations for their contributions.

Dr TANGI (Tonga) seconded the sentiments expressed by the previous speaker.

The CHAIRPERSON said that the remaining draft summary record would be sent out to each representative who had been present, with a covering letter indicating the date by
which any comments on the draft should reach the Regional Office. After that date, it would be considered that the summary records had been accepted.

The CHAIRPERSON said that it had been a great honour for Brunei Darussalam to host the session and a challenging task for him to chair it. The session had been both busy and productive. A number of important issues had been tackled that had an impact on the health of the people in the Region. Discussions had been serious, open and frank. Despite some divergence of views, the regional tradition of consensus-building and cooperation had proved itself again. He had been touched by the dedication and commitment of all representatives to finding workable solutions to the health challenges faced by the countries of the Region. He thanked all the participants and the secretariat for their work.

The CHAIRPERSON declared the fifty-second session of the Regional Committee closed.

The meeting rose at 12:05 p.m.