

SUMMARY RECORD OF THE FOURTH MEETING

WHO Conference Hall, Manila  
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CHAIRPERSON: Dr Viliami TANGI (Tonga)

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1. PROPOSED PROGRAMME BUDGET: 2002–2003: Item 10 of the Agenda  
(Document WPR/RC51/4) (continued)

Mr LIU Peilong (China), remarked on the clear focus and structure of the first complete biennial programme budget from the new administration. It was a thorough reworking of form, content and methodology, showing clearly the 11 priority areas and 35 areas of work, with a conversion table explaining how the arrangements at WHO Headquarters related to the regional structure. The speaker also appreciated the explanation of cross-cutting areas of work. Showing regular and the extrabudgetary funds, the document portrayed "one WHO".

In terms of format, there was a breakdown of the global budget by area of work, but not by disease. Yet countries analysed the global situation in terms of disease burden. The budget did not allow them to see if their analysis was in line with priority diseases. He hoped that that could be remedied in future.

The global presentation of work was very logical, proceeding from issues and challenges, through goals and objectives, to expected results, indicators and resources. However, in the regional budget there were only issues and challenges, strategies, and resources; there were no expected outcomes or indicators. The regional director had said that, in the programme budget for 2002–2003, indicators for monitoring were to be developed. He hoped that expected results and indicators would be shown.

He also observed that, in the global budget, certain indicators were blank. He asked whether that was because there was no need for indicators or because no appropriate indicators had been found.

With regard to the level and distribution of the budget, although there was now a global budget with nominal zero growth, it was estimated that extrabudgetary funding for 2002–2003 would increase by 14%. However, the Western Pacific Region had experienced negative nominal growth and its extrabudgetary resources had not yet increased. Extrabudgetary resources for the Region seemed to have fallen by 27% in nominal terms since the 1996–1997 biennium. He asked the Secretariat for an explanation. He approved the allocation of 55.5% of the regional budget to country activities and 44.5% to regional and intercountry work. He also agreed with allocation by focuses and themes, and indicative figures for countries, although he sought clarification on how the country figures had been worked out.

The table on detailed allocation by area of work in part 1 of the programme budget (page 110) showed four areas of work for which the Western Pacific Region had received no budget at all. The areas were research and product development for communicable diseases, women's health, sustainable development, and budget and management reform. He sought an explanation of why no budgetary allocation had been made in those areas.

With regard to the budget formulation process, the speaker noted that under the previous system the country budget would have been discussed at that Regional Committee, whereas now country budgets should be formulated closer to the time of implementation. He appreciated the wisdom of that approach, but it raised a problem: the Regional Committee had discussed only the planned figures for countries, the next Executive Board session and World Health Assembly would approve the budget for 2002–2003 in May 2001, but would not discuss country budgets. He wished to know, therefore, the role of the Regional Committee in that matter.

Dr INIAKWALA (Solomon Islands) applauded the presentation of the regional budget in the context of the global budget of the World Health Organization, which was now clearly seen as a single organization. Political and economic changes were occurring in the Region, which meant that country priorities and needs might change also. He therefore welcomed the shorter lead time for budget formulation, which would reflect the real situation at country level more accurately.

He welcomed the increased allocation to Building healthy communities and populations, but he was concerned that the allocation to Healthy settings and environment had been reduced by almost 20%. He agreed with the Representative of Palau that the allocation should be increased, since it had been demonstrated in the Region that the healthy settings approach made for intersectoral collaboration. It also fostered community participation, addressed environmental and health-related issues, and mobilized resources.

Mr MOND (Papua New Guinea) welcomed the presentation of the 2002–2003 budget, since it was consistent with the framework of action. He also commended the linked presentation of global and regional budgets. He welcomed allocations by programme and country, but pointed out that, at country level, Papua New Guinea had its own 10-year health plan, with eight priority programme areas. He believed that the role of the World Health Organization at country level was simply to support the country programmes. The health system of Papua New Guinea was moving from project mode to sector mode, with pooled management and reporting systems to streamline the management of partner funds and to meet the objectives of the national health plan 2001–2010. To effectively monitor progress, a set of 19 national indicators was being established. He asked how WHO was going to support that process in the budget under discussion.

He strongly recommended a more comprehensive strategic plan of action with goals, objectives and strategies at regional and country levels. He would welcome an overall regional plan with clear goals and objectives, as well as outcome- and impact-oriented targets, rather than process input or output targets. He suggested that a five-year regional plan be considered.

Professor TRUYEN (Viet Nam) stressed the importance of traditional medicine, especially in primary health care and providing health care for low-income groups. Nevertheless, it received only a brief mention under Essential medicines in the global budget, and at regional level it was mentioned on pages 23 and 25 under health sector reform. He hoped that adequate funds would be allocated to traditional medicine in the detailed programme budget for 2002–2003.

In replying to general comments, the REGIONAL DIRECTOR provided an overview, with the aid of overhead projections, of the processes being used to develop the proposed programme budget for 2002–2003, comparing them to previous practice, and explaining the new roles of the various governing bodies.

In accordance with the new procedures, the initial phase, from December 1999 to September 2000, had comprised the preparation of part 1 (global) of the proposed programme budget for 2002–2003, which set out the overall budget directions, and part 2 (regional), contained in Annexes 1 and 2 to document WPR/RC51/4, respectively. No detailed country budgeting had been undertaken during that period and the Regional Committee was not expected to consider detailed country allocations at the current session. The Regional Committee would, however, have the opportunity to review parts 1 and 2. The indicative country planning figures shown in Annex 3 to document WPR/RC51/4 were provided for information and as a preliminary guide to country planning, which would commence following the current session. Thus, detailed country plans would be prepared closer to the time of implementation. Representatives would recall that, in the past, the initial phase had consisted of the allocation of a country planning figure at the outset, two years in advance of implementation, on the basis of which detailed country plans and regional and intercountry plans had been prepared. The regional programme budget, based on detailed plans from countries together with regional and intercountry plans, had been reviewed by the Regional Committee at the session held immediately after the initial phase.

In January 2001, the Executive Board would review the global proposed programme budget only, without individual country programme budgets, taking into account the views and concerns expressed by the six Regional Committees. Under past practice, it would have been expected to review a global programme budget consolidating all regional and country programme budgets.

In May 2001, the Health Assembly would be asked to adopt the global programme budget approved by the Executive Board. After adoption, final country planning figures would be given, which would form the basis for the preparation of detailed country budgets. That contrasted with past practice under which the Health Assembly would adopt the consolidated programme budget in its entirety at that point in the budget cycle.

In September 2001, the Regional Committee would have a further opportunity to review the regional programme budget, taking into account detailed country and intercountry plans. Under previous practice there would have been no further discussion at that stage, as the entire programme budget would already have been decided.

The procedure used in arriving at the indicative country planning figures was also new and had been instituted in an effort to improve transparency and objectivity and in accordance with the principles set out in resolution WPR/RC50.R1, adopted at the Regional Committee's fiftieth session. The resolution requested the Regional Director to ensure that 60% of the total allocation for country planning figure was determined in accordance with the model recommended in resolution WHA51.31, which was based on the UNDP Human Development Index, in turn derived from indicators such as life expectancy, literacy rate, per capita GDP, etc. The model was to be applied to all countries to derive an allocation factor, which would provide a basis for setting the model allocation.

The remaining 40% of the total allocation for country planning figures was to be determined taking into account four considerations: allocations to least developed countries should be at levels no lower than those for 2001–2002; minimum allocations of up to US\$ 50 000 should be introduced for developed countries which would receive zero allocation under strict application of the model; changes in allocations should be introduced gradually, over three bienniums; and specific health needs should be taken into account.

To derive the indicative country planning figures, therefore, a theoretical model allocation had been calculated for each country and the difference between the new figure and the allocation for 2000–2001 had been divided by three to arrive at the change in allocation for the first biennial programme budget prepared under the new procedures, i.e. that for 2002–2003. The additional changes would be introduced over the bienniums 2004–2005 and 2006–2007. The calculations made in applying the model and in taking the first three considerations into account had used almost all the regional allocation for 2002–2003, so that there was little leeway to take account of specific health needs. Nevertheless he had tried to ensure transparency and objectivity in using the remaining funds, which had been allocated according to greatest need after assessing all countries in respect of five

health areas: infant mortality, tobacco control, tuberculosis, cardiovascular disease and skilled health worker status.

He next turned to specific questions raised by representatives.

In reply to the representative of Philippines, he said that since the Regional Committee had requested that any changes in allocation brought about by the new procedures be introduced gradually, the same procedures would be used for the preparation of the programme budgets for the next three bienniums, unless the Regional Committee decided otherwise in the light of experience. The impact of the new procedures, which he would endeavour to apply flexibly and with due consideration of specific health needs, would of course be monitored and evaluated in close collaboration with Member States.

In answer to the representative of Japan, he said that the term "total other resources" was synonymous with "extrabudgetary resources".

In reply to the representative of Palau, he explained that the overall allocation to the Region had continued to decline (by 5.8% in 2000–2001 and a further 3.5% in 2002–2003) in accordance with resolution WHA51.31. Second, the healthy settings initiative had been incorporated in the theme Building healthy communities and populations. All those working in the five focuses covered by that theme would work as a team and would contribute to the healthy settings initiative. Under the new arrangements, the budget allocation in fact showed a slight increase for the theme as a whole. Moreover, the team approach should enhance the effectiveness of the programme. In the past, Emergency and humanitarian action had been funded entirely from other sources, primarily from one country. While there was every indication that those contributions would continue, a regular budget allocation was also being made for 2002–2003 in order to strengthen activities.

In answer to the question raised by the representative of the United Kingdom concerning the decline in extrabudgetary resources for the theme Reaching out, he said that the figure for the previous biennium had included a one-off contribution of some US\$ 3 million given by one partner for a specific programme. Excluding that figure, the extrabudgetary resources predicted for 2002–2003 were likely to show an increase over the previous biennium.

Links between the 35 areas of work established at Headquarters and the 17 focuses that guided the work of the Regional Office had been identified and he felt it would be difficult to supply information by every specific disease as well, as requested by the representative of China. For example, while expenditure on tuberculosis was relatively easy to establish, precise expenditure on a

disease such as dengue was much more difficult to determine, since it was included under the focuses Malaria, other vectorborne and parasitic diseases.

Development of the indicators shown in part 1 of the proposed programme budget had not been completed prior to publication of the budget document, which was why some of the indicator boxes were blank. Once those had been decided, region-specific indicators and outcomes would also be developed.

It was true that, as indicated by the representative of China, certain areas of work at Headquarters, such as women's health and research, were not reflected in the regional programme budget. That was partly due to the different structure of the two budgets and did not necessarily mean that no work on the area of work concerned was being undertaken by the Regional Office. In addition, it was considered that some activities were best undertaken at the regional level while for others, for example, communicable disease research, it was felt that the focus should be at Headquarter level.

In reply to the representative of Papua New Guinea, he said that following the Regional Committee, Regional Office staff would be happy to provide support to Member States in their preparation of country programmes, on the basis of the indicative country planning figures.

He had taken note of the comments made by the representative of Viet Nam concerning traditional medicine.

The DIRECTOR, BUDGET AND MANAGEMENT REFORM, WHO Headquarters, in response to comments from several representatives, said that considerable efforts had been made by the Department of Resource Mobilization, working with the 35 programme areas and the Regional Offices, to project expected extrabudgetary resources for 2002–2003. Coupled with the increasing importance of health on the development agenda, there was every reason to expect that that work would mean that the predicted 14% increase in extrabudgetary resources could be achieved. He recalled that there had been an increase of 19% for 1999–2000 compared to 1998–1999.

Referring to the request by the representative of China for budgeting by disease, he explained that, in part 1 of the budget, the aim was to summarize the information for each area of work on two pages only. For each of the 11 priorities, there was a further page of information, which showed the extent of contributions from other areas of work, together with an estimated budget allocation for those activities.

He confirmed that development of indicators for part 1 of the proposed programme budget was still underway. It had proved an extremely difficult process to establish appropriate and useful indicators that would provide for proper accountability, monitoring and evaluation. However, it was envisaged that the exercise would be completed by the time the document was reviewed by the Executive Board in January 2001.

Mr LIU Peilong (China) replied that a disease-based budget need not reflect allocations for every disease but only for the major ones. He suggested that an additional table be inserted in part 1 of the proposed programme budget giving that information. He reiterated his previous query about the actual amount of the extrabudgetary resources of the Region. He noted that the projected level in the global budget would increase by 14%, while that for the Western Pacific Region would decrease in comparison with the total available for 1998–1999, and even more so with respect to that for 1996–1997.

The REGIONAL DIRECTOR said that the requested table would be provided in the next presentation of the proposed budget for 2002–2003. He explained that extrabudgetary resources at the global level consisted of funds mobilized at the regional level and also by the clusters at Headquarters. The estimate for the Region was a conservative one, based only on expected contributions from partner agencies. He reiterated that not only were old partnerships being strengthened but new ones were being formed.

The CHAIRPERSON requested the Rapporteurs to prepare an appropriate draft resolution.

2. ERADICATION OF POLIOMYELITIS IN THE REGION: Item 11 of the Agenda  
(Documents WPR/RC51/5 and WPR/RC51/INF.DOC./4)

The REGIONAL DIRECTOR introduced the report, announcing that no new cases of poliomyelitis due to indigenous wild poliovirus had been found in the Western Pacific Region for over three years. That was a real credit to all Member States, who had acted together to reduce the total number of cases from more than 6000 in 1990 to 0 over the past three years. However, there had been one case of poliomyelitis in the Region, in China in October 1999, which had been due to imported wild poliovirus from a neighbouring region. The continued absence of indigenous wild poliovirus should be a source of satisfaction to WHO and its Member States, but the evidence that wild poliovirus could be imported was a timely warning not to relax vigilance until global eradication had been achieved. The case of poliomyelitis in China showed that wild poliovirus could travel from an endemic area into a poliomyelitis-free area and demonstrated that no country was safe from importation while wild poliovirus was circulating anywhere in the world. However, the episode had strengthened rather than weakened the certification process. The speed with which the case had been



detected by the Ministry of Health of China, even in the remote area in which it occurred, and the magnitude of the response had increased confidence in the quality of surveillance in China.

Concern was sometimes expressed that circulation of wild poliovirus might be missed. Although such concern was natural, surveillance had been maintained at a high level throughout the Region. As noted in the report, between the onset of the last case due to indigenous wild poliovirus in March 1997 and March 2000, nearly 18 000 cases of acute flaccid paralysis had been reported and investigated. At mid-July 2000, that figure stood at over 20 000 cases, which was greater than the requirement for certification. Stool samples had been tested in accredited laboratories in more than 80% of those cases. Additional surveillance activities had been carried out, including house-to-house searches for cases of acute flaccid paralysis in high-risk areas of the Region. The quality of surveillance was carefully monitored by the Technical Advisory Group on the Expanded Programme on Immunization and Vaccine Preventable Diseases in the Western Pacific Region, and also by the Regional Commission for the Certification of the Eradication of Poliomyelitis. Yet, apart from the single case in China, no case of poliomyelitis due to wild poliovirus had been detected for over three years. The REGIONAL DIRECTOR was therefore confident in saying that the transmission of wild poliovirus had been interrupted.

The Regional Commission for Certification of the Eradication of Poliomyelitis had held its fifth meeting in Manila in August 2000 to review the documentation on the status of poliomyelitis eradication provided by national certification committees and by the subregional commission for the Pacific island countries and areas. They had concluded that the quality of the documentation provided was high, reflecting efforts made by every country in the Region. The Commission would meet again in October 2000 to review additional information that had been requested and to decide whether the Region could be declared poliomyelitis-free.

Regional certification would not be the end of the story of poliomyelitis eradication, however, as the Region would have to maintain surveillance for acute flaccid paralysis until global certification had been achieved. WHO and its Member States must guard against the reintroduction of wild poliovirus as long as it circulated anywhere in the world and particularly in border areas between neighbouring regions. In addition, high levels of routine immunization and supplementary immunization for populations considered to be at high risk, including people who lived in border areas and certain mobile populations, would still be needed.

The REGIONAL DIRECTOR emphasized the critical issue of containment of laboratory stocks of wild poliovirus, which would be the only source of the virus after eradication. As part of the certification process, all countries had a plan of action for containment and had initiated the process.

He urged all Member States to ensure that the required steps were completed on time, both for regional certification and, ultimately, for global certification.

Ten years had passed since the Member States had set off on the journey towards poliomyelitis eradication in the Western Pacific Region. They had achieved much together, establishing surveillance for acute flaccid paralysis and a laboratory network and conducting effective supplementary immunization during national immunization days. When they had begun the journey, they had had the technical knowledge but not enough funds to make much progress. Fortunately, within a couple of years, many international partners had joined and had helped to make poliomyelitis eradication possible. The REGIONAL DIRECTOR said that he felt privileged to have been involved in the truly international partnership that had provided both technical and financial support for the initiative. He expressed his thanks to all WHO's partners in the effort, in particular UNICEF; the governments of Australia, Japan, and the United States of America through the Centers for Disease Control and Prevention, Atlanta; the Japanese Agency for Cooperation on International Health; Rotary International; and Rotary International Districts 2650 and 2640 for their continuous support. He also thanked the governments of Canada, Finland, France, Italy, the Republic of Korea, Malaysia and Sweden, and other governmental and nongovernmental organizations, which had supported the initiative in the past.

Nevertheless, most of the resources required for poliomyelitis eradication in the Region had been provided by the countries themselves. Their efforts were a great achievement for the Region and an encouragement to other countries of the world. They had shown the effectiveness of political commitment, clear strategies and an international partnership. He paid tribute to the many thousands of dedicated and often unrecognized health workers in poliomyelitis eradication, some of whom had given their lives while carrying out activities related to immunization. He hoped that the Committee would give him licence to explore ways in which WHO could acknowledge the contributions of individual health workers.

Finally, he drew attention to the long-term benefits of poliomyelitis eradication. The investment in human and other resources that had been part of the initiative had improved national immunization programmes in many countries and had strengthened their surveillance systems for other communicable diseases, both technically and in terms of management capability. The benefits derived from the eradication of poliomyelitis would continue when it was only a memory.

Dr SAKAI (Japan) said that eradication of poliomyelitis was a priority in the international cooperation policy of his country. In that context, it had seconded experts, provided oral vaccine, and supported surveillance and laboratory testing in the Region. Japan also planned to send experts in

poliomyelitis to the South East Asia Region. Preparations were being made for the next meeting of the Regional Commission for Certification of the Eradication of Poliomyelitis at which it would decide whether the Region could be certified free of poliomyelitis. That meeting would be held in Kyoto, Japan, in October 2000. Information about his country's programme for the containment of wild poliovirus in Japanese laboratories was being made available on the Internet.

Dr MATHEWS (Australia) noted that poliomyelitis differed from smallpox in that there was a high rate of subclinical infection with poliovirus. He asked the Regional Director how confident he could be that transmission of wild poliovirus had actually been interrupted.

Dato' Seri Dr SULEIMAN Mohamed (Malaysia) said that his country was taking all measures to sustain the quality of surveillance of acute flaccid paralysis and poliovirus. He noted that the Region had a good chance of meeting the requirements for certification of poliomyelitis-free status, in which his country had played a part. Nevertheless, poliovirus could still be imported, despite a plan of action for such incidents, in view of frequent movement in and out of countries. He therefore urged the Director-General to assist other regions to eradicate poliomyelitis as soon as possible. At an ASEAN health conference, Brunei Darussalam, Malaysia and Singapore, with Indonesia and Thailand, had agreed on closer cooperation to help neighbouring countries to achieve poliomyelitis-free status.

Dr CHEN (China) recognized that the case of poliomyelitis due to imported wild poliovirus that had occurred in China in October 1999 had drawn much attention. With the assistance of friendly governments and international organizations, no indigenous case of poliomyelitis had been detected in his country since October 1994, but importation of the virus remained a threat. The Ministry of Health had organized four rounds of mopping-up immunization in various areas of the country and on a larger scale had increased surveillance for acute flaccid paralysis. Those timely measures appeared to have prevented further transmission. However, the geographical position of China, as well as the extent of population movements, meant that wild poliovirus could be imported at any time. To respond to that threat, activities were being continued at border points. He suggested that the Regional Office should:

- guarantee high-quality surveillance activities after the Region had been declared poliomyelitis-free and formulate guidance for such activities;
- strengthen coordination with other regional offices to eradicate poliomyelitis in countries where it was endemic; and

- mobilize funds to provide special support for countries where wild poliovirus importation was a potential problem.

Dr VILLAGOMEZ (United States of America) commended WHO's leadership in the Region, which was essential for achieving eradication of poliomyelitis. However, the highest quality surveillance had to be maintained until the disease had been eradicated globally, in order to avoid any importation of wild poliovirus from endemic countries.

In view of the cost involved in responding to a recent case in China, and the global shortage of both vaccine and funding, he recommended that the Regional Office should draw up a regional contingency plan for responding to eventual imported cases, including an assessment of vaccine needs, so that a vaccine stockpile for rapid mobilization could be created. The Office should also determine the budget needed, which should be included in the global budget in preparation at WHO Headquarters under the five-year strategic plan.

Savings would be considerable once global eradication had been achieved, and those resources could be channelled to other priority health needs, including the maintenance of the public health infrastructure required to prevent re-emergence of diseases.

Mr CAPELLE (Republic of the Marshall Islands) recalled that his country had been struck by a serious epidemic of poliomyelitis in 1966, which had strengthened its resolve in executing an aggressive immunization campaign and maintaining a robust surveillance system. As a result, the Republic of the Marshall Islands had no suspected, reported or confirmed cases. He looked forward to certification of the Region as free of poliomyelitis.

Dr LAM (Macao, China) reported that the last case of poliomyelitis in Macao had occurred in 1975. Immunization was provided free of charge to those under 18 years, and coverage of infants had reached 92%. A detailed plan was in place to respond to imported cases.

The search for infectious or potentially infectious poliomyelitis material in laboratories had been completed, and Macao would shortly be declared free of the disease. Both good-quality surveillance and a high level of immunization coverage would be maintained until the achievement of global eradication.

Dr NAO BOUTTA (Lao People's Democratic Republic) announced that the Lao People's Democratic Republic was ready to be certified free of poliomyelitis, since the last case had occurred in 1996. None the less, child immunization had to be maintained in order to prevent a resurgence of the disease.

The eradication campaign and the resources used had served to strengthen the entire national expanded programme on immunization. Thanks to support from WHO, as well as other organizations and partners, new vaccines would now be added to the programme, which would also extend its geographical coverage.

However, to be cost-effective, the mobile immunization teams should also undertake outreach work, especially in isolated areas, helping to educate and inform people on a variety of health issues and providing food supplements and certain drugs. His Government would appreciate all offers of technical and financial support in order to build up comprehensive health teams that could provide integrated care in all provinces.

Professor TRUYEN (Viet Nam) reported that no case of poliomyelitis had been notified in his country since 1997 and that good quality surveillance was being maintained. Full immunization coverage of infants exceeded 90%. Supplementary immunization campaigns had been carried out in central provinces and would shortly be conducted in border areas.

Stocks of wild poliovirus stored at enterovirus laboratories had been destroyed and Viet Nam was eligible to be certified as free of the disease. However, the country would maintain high vaccination coverage and a good-quality surveillance system until global eradication had been achieved, in order to ensure early detection of and swift response to any imported case.

Dr BENJAMIN (Federated States of Micronesia) reported that his country was maintaining a high rate of vaccination coverage and an active surveillance and reporting system. A case of acute flaccid paralysis occurred roughly every two years in his country; the last was not poliomyelitis. Thanks to the efforts of WHO and other organizations, he looked forward to global eradication in the near future.

Dr MATHESON (New Zealand) reported that the last imported case of poliomyelitis in New Zealand had occurred in 1976. His country was finalizing the documentation that would allow WHO to determine whether it could be certified free of the disease.

He expressed concern that achievement of eradication in the Region should not result in any relaxation of surveillance measures. He asked what countries would have to do to maintain poliomyelitis-free status and how long would those measures have to remain in place?

Mr MOND (Papua New Guinea) commended WHO for efforts in eradicating poliomyelitis from the Region and acknowledged the support received from international organizations and partner

agencies. He observed that the results demonstrated what cooperation could achieve. The example of poliomyelitis eradication should be extended to other disease control programmes.

Continued vigilance was needed as the final stage of eradication approached, and Member States should be fully committed to the lines of action set out in the report under consideration. He looked forward to eradication of the disease in the Region in the near future, to which many health workers and volunteers had contributed. His country would continue to maintain an intensive surveillance programme after certification.

Dr SENG SUTWANTHA (Cambodia) reported that her country's intensive poliomyelitis programme had been launched in 1994; the national immunization days it had organized in 1995 and 1996 had reached 1.8 million children under five years of age (a coverage of over 90%). Since the last cases that had been confirmed in laboratories, eight rounds of supplementary oral poliovirus immunization had been conducted, with over 11 million doses being distributed to children. However, the country would continue in its efforts to stay free of poliomyelitis, by integrating surveillance with measles and neonatal tetanus surveillance, in order to maintain motivation of health staff after certification at regional level. Oral poliovirus coverage would be kept up by means of routine immunization activities, with any supplementary immunization activities when needed, especially in areas at risk from importation of wild poliovirus. National disease surveillance should be built on the success of the poliomyelitis surveillance system. She thanked the governments of Japan and Australia, and also UNICEF, Rotary International and WHO for continuous support of poliomyelitis eradication in Cambodia.

Dr Hajah Rahmah Haji Md SAID (Brunei Darussalam) said that, although the last documented case of poliomyelitis in her country had been in 1978, there remained the danger of importation through population movement between regions, and by foreign workers from endemic countries. A high level of acute flaccid paralysis surveillance was maintained, and poliomyelitis immunization coverage was very high. The National Certification Committee, formed in 1996, had ensured that a high standard of surveillance was maintained nationally, that timely action was taken, and that documentation was completed when required. She thanked WHO for its technical support and assistance.

Dr KIM (Republic of Korea) said that, although there had been no cases due to wild poliovirus in his country since 1983, the acute flaccid paralysis surveillance system was being strengthened, since the country bordered a country from another region – the Democratic People's Republic of Korea - and was willing to participate actively in the programme to eradicate poliomyelitis.

Dr CHEW (Singapore) pledged that in the post-eradication period in the Western Pacific Region his country would continue to work with WHO to achieve global poliomyelitis eradication.

The CHAIRPERSON, speaking in his capacity as the Representative of Tonga, asked how many laboratories in the Region held poliovirus stocks.

The REGIONAL DIRECTOR said that the overall message from speakers was that complacency would be inappropriate. In response to the question from Australia as to why or whether the Regional Director was confident that transmission had been interrupted, he reminded the Committee of certain unique features of the virus in question. Unless it was passed from one person to another following excretion, the lifespan of poliovirus was one to three months. Only one in every 100–200 infected people developed symptoms of the disease. The path of transmission could be traced retrospectively.

The Regional Commission, the independent body that scrutinized all information provided by Member States, had produced the criteria for certification; one criterion was that the acute flaccid paralysis rate should be more than one case per 100 000 population under 15 years of age, even if there was no poliovirus present. That was the global background level of cases of acute flaccid paralysis due to causes other than poliovirus. Where such a level was not found, reporting was deficient.

As of the end August 2000, more than 21 000 cases of acute flaccid paralysis had been reported, which was 40% above the required level. Out of those 21 000 AFP cases, over 85% had had two stool specimens collected within two weeks of onset (the period during which the biologically active poliovirus could be found). Also, in addition to routine immunization, a total of 26 national and 20 subnational immunization days had been conducted. If the virus was still circulating in the Region then within one to three years someone would develop the disease.

Surveillance was now very efficient, which was why the case in China due to imported poliovirus had been picked up very quickly. The Regional Director was, therefore, quite confident, but the final decision was to be made in October by the Regional Commission, an independent body.

He endorsed the comments from the representative of China, who had warned against complacency and appealed to partners not to turn away. The Representative of the United States of America had spoken of the need for contingency plans, and those plans would be described by the Secretariat.

New Zealand had asked what steps had to be taken after certification, if it were achieved in Kyoto in October 2000. The Regional Certification Commission and the National Certification Committees would continue to evaluate the quality of surveillance, suggesting improvements when necessary. The TAG meetings would continue, surveillance would be maintained until certification, and limited subnational immunization days would be conducted, especially in border areas and for mobile populations. WHO would continue to mobilize support until certification had been completed.

The REGIONAL DIRECTOR said he would refer the CHAIRPERSON's question as to how many laboratories still kept poliovirus samples to his colleagues.

The TECHNICAL OFFICER, THE EXPANDED PROGRAMME ON IMMUNIZATION said that Phase 1 of virological containment, making an inventory of laboratories, was being implemented. It was, therefore, not yet known exactly how many laboratories held the virus or potentially infective materials. At its fourth meeting in August 1999, the Regional Commission for Certification of Poliomyelitis Eradication had recommended that substantial progress towards completion of Phase 1 of laboratory containment be obtained before certification. At its fifth meeting in August 2000, the Commission had recommended that all countries and areas should provide a plan of action for laboratory containment, including a progress report and a timetable for completion of Phase 1. So far, all countries had developed a national plan of action and identified a body responsible for laboratory containment, and six countries had completed or almost completed their national inventories. All other countries had started to list the laboratories and institutes to be searched by the team. Substantial progress had, therefore, been made in the previous 12 months. All other countries and areas were following up the recommendations of the Regional Certification Commission, and were expected to fulfil its requirements before its sixth meeting, on 27–28 October 2000. More progress was needed if certification was to be achieved.

The DIRECTOR, COMBATING COMMUNICABLE DISEASES replied to the question from the United States of America about contingency plans on importation of wild poliovirus. A plan of action on importation had been developed regionally, and every country had prepared such a plan. China's plan of action had been implemented rapidly late in 1999 and early 2000. The Ministry of Health of China had very quickly mobilized resources for very extensive surveillance and immunization activities in response to the episode of imported wild poliovirus. At the same time, WHO had coordinated technical and financial support for those activities in China.

With regard to maintaining a supply of vaccine for such eventualities, it had been found preferable in practical terms to use the readily available stocks of vaccine in the country concerned,



and to bring in further stocks as needed. All countries had routine supplies that could be used very quickly, after which more could be brought in within a few weeks.

The CHAIRPERSON asked the rapporteurs to draft a resolution on the subject.

The meeting rose at 4.50 pm.