WPR/RC51/SR/6

SUMMARY RECORD OF THE SIXTH MEETING

WHO Conference Hall, Manila
Thursday, 21 September 2000 at 9 a.m.

CHAIRPERSON: Dr Viliami TANGI (Tonga)

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1. MINISTERIAL ROUND TABLE: HEALTH AND POVERTY: Item 16 of the Agenda (Document WPR/RC51/10)

1.1 Summary by moderator

Dr PHUA, moderator of the ministerial round table, summarized the previous day's ministerial round table meeting (see Annex).

Professor TRUYEN (Viet Nam) made a statement relating to some of the issues that had been discussed at the previous day's ministerial round table and outlined the situation on poverty and health in his country.

2. TUBERCULOSIS PREVENTION AND CONTROL: Item 13 of the Agenda (Document WPR/RC51/7)

The REGIONAL DIRECTOR recalled that last year the Committee had declared that there was a "tuberculosis crisis" in the Western Pacific Region. He said that had been an extremely strong statement and one that the WHO Secretariat had taken very seriously.

In the resolution adopted by the Committee during its fiftieth session, it had also requested the Regional Director to make Stop TB a "special project" of the Regional Office. The Committee's concern had been mirrored at the global level last May when the Fifty-third World Health Assembly had adopted a resolution welcoming the establishment of the global Stop Tuberculosis Initiative.

In the last year WHO had laid the foundations for the Stop TB special project by implementing a wide range of activities.

- First, a regional strategic plan to Stop TB in the Western Pacific and a Pacific strategic plan to Stop TB had been prepared.

- Second, a tuberculosis Technical Advisory Group, or TAG, had been formed. The TAG had held its first meeting in February 2000.

- Third, a regional Interagency Coordinating Committee, or ICC, had been formed at the first TAG meeting. Members of the ICC included the Australian Agency for International Development (AusAID), the Department for International Development of the United Kingdom (DFID), the Government of Japan, the Japan International Cooperation Agency

(JICA), the United States Agency for International Development (USAID) and the World Bank.

- Fourth, ICCs were being formed or had been strengthened at the national level.

- Fifth, the Pacific Stop TB Initiative had been established at the first Stop TB meeting in the Pacific islands, held in Noumea in June 2000. The meeting had been jointly organized by WHO and the Secretariat for the Pacific Community and had endorsed the Pacific Strategic Plan to Stop TB.

- Sixth, at the Regional Office, a Stop TB Task Force had been formed.

- Seventh, WHO had been collaborating with Member States to develop five-year Stop TB national plans as a part of health system development.

The REGIONAL DIRECTOR said that, in the relatively short period of time since the last meeting, WHO had also been very active in gathering support from the international community for tuberculosis control. Earlier in the session, he had mentioned recent positive developments in attracting support from the World Bank, the Government of Japan through JICA and DFID from the UK for tuberculosis control in China. That was only one of several positive indications that international support for tuberculosis control in the Region was increasing.

When he had addressed the Committee in 1999, he had said that WHO must become more outcome-oriented. The targets that had been set by the Regional Committee and the TAG were ambitious ones and achieving them would not be easy. Nevertheless, he reminded the Committee of some very significant successes that had been achieved in recent years:

- The percentage of notified cases enrolled in DOTS programmes had increased from 46% in 1997 to 59% in 1998.

- The treatment success rate of the Region's DOTS programmes was 94%, well above the global and regional target of 85%.

Those success stories showed that the recent alarming increases in tuberculosis in the Region could be reversed. However, although WHO and its Member States should remain positive, they should be realistic about the magnitude of the task they had set themselves.

During 1998, only 44% of the estimated infectious cases had been detected and even fewer (32% of the estimated infectious cases) had received DOTS treatment. That was still a long way from the regional target of detecting 70% of the estimated infectious cases by 2005.

If DOTS implementation remained at current levels, the number of tuberculosis cases would not decrease during the next two decades. However, if 70% of estimated infectious cases were detected and 85% of them treated successfully by 2005, the number of cases and deaths from the disease in the Region would be halved by 2010 and no fewer than 500 lives a day would be saved.

The REGIONAL DIRECTOR therefore urged the governments of all Member States to develop or refine five-year national plans of action with targets of 70% case detection and 85% treatment success by 2005. To ensure that those goals were achieved, he also urged countries to form national Interagency Coordinating Committees or to strengthen existing Committees.

Given the urgency of the tuberculosis crisis that faced the Region, he believed that an endorsement of the "Regional strategic plan to Stop TB in the Western Pacific" would send a powerful message about how serious the Committee was about tackling the problem of tuberculosis in the Region. He therefore invited the Committee to endorse the document that was attached as Annex 2 of the paper.

Mr ROODENBEKE (France) expressed his country's strong support for tuberculosis control and its concern about the re-emergence of the disease. He particularly noted tuberculosis's relationship to HIV/AIDS and poverty. France had equipped itself to face the challenge of the disease, and would continue to give it priority in the various programmes of support given to other countries. It would also continue to cooperate with WHO in supporting the national programmes in Cambodia, the Lao People's Democratic Republic and Viet Nam.

Dr SAKAI (Japan) commended WHO for giving tuberculosis prevention and control high priority in the light of the danger it posed to the entire Region. Japan had responded to the seriousness of the problem by declaring a tuberculosis emergency in 1998. Nationwide surveillance had since been conducted and preventive measures focused on high-risk groups had been strengthened.

He felt that ensuring a regular supply of tuberculosis drugs was a critical element of tuberculosis control, particularly in developing countries with a high incidence of the disease. WHO's guidance on how that could be achieved would be useful. Japan would continue to support WHO's efforts based on the regional strategic plan for tuberculosis control.

Dr CHAN (Macao, China) stated that 1996 saw the re-emergence of tuberculosis in Macao. In 1998, the disease had ranked 20th among the most common causes of death, prompting the Government to make it a priority. The Tuberculosis Prevention and Control Programme had been reinforced in accordance with WHO's recommended strategies. Implementation of the DOTS strategy had been strengthened by providing diagnostic and treatment services free of charge to the entire population. In 1999, DOTS had been implemented for 98% of all new cases. Screening of contacts and other high-risk groups had also been reinforced. BCG immunization of infants was also being undertaken and maximum coverage had been achieved in 1999. While those efforts had been rewarded with a marked decrease in tuberculosis incidence, the Government would remain vigilant in its stand against the disease.

Dr Haji AFFENDY Dato Haji Abidin (Brunei Darussalam) reported that the declining trend in tuberculosis incidence in his country since 1970 had been reversed in the last three years. In response, His Majesty's Government had formed a National Tuberculosis Control Committee with representatives from relevant services within the Ministry of Health. The Committee's functions were to develop policies, and plan and implement programmes. One of the Committee's initial tasks was the review and subsequent re-orientation of the National Tuberculosis Programme, in collaboration with WHO. The Committee's strong advocacy for DOTS had resulted in its wide use among hospitals and chest clinics where tuberculosis cases were managed. The expansion of DOTS to all community-based health centres was now underway.

Mr CAPELLE (Marshall Islands) stated that, based on available data for the last five years, tuberculosis remained a public health concern in the Marshall Islands. A National Tuberculosis Programme, incorporating recommendations of the Centers for Disease Control, Atlanta, United States of America, and WHO, was being implemented. With the significant reduction in new registered cases in 1999, greater emphasis was now being given to ensuring patient compliance through the DOTS strategy. However, the difficulty of providing treatment to those in the outer islands remained a challenge. In addition, the inadequacy of existing facilities necessitated obtaining laboratory confirmations from outside the country. The main concern of the Ministry of Health was ensuring a regular supply of tuberculosis drugs, which was currently hampered by logistical problems in receipt and distribution. If the problem of inadequate and inconsistent delivery of drugs was not resolved immediately, there was a potential danger of drug resistance developing among tuberculosis patients.

Professor NYMADAWA (Mongolia) pointed out that Mongolia was one of the seven countries in the Region with the highest incidence of the disease and that it welcomed WHO's support for tuberculosis control. Since 1994, a National Tuberculosis Programme had been implemented, which aimed to improve microbiological diagnosis and treatment of cases. The notification rate had increased from 7.6 per 10 000 population in 1994 to 13.3 per 10 000 in 1999, while the proportion of smear-positive cases and cure rates had also increased over the same period. Technical and financial support from WHO and the Governments of Denmark and Japan were highly appreciated. The programme was now being reviewed and updated to take account of the recommendations contained in the Regional Strategic Plan.

Dr SOK TOUCH (Cambodia) reported on some of the remarkable results achieved by Cambodia's National Tuberculosis Programme since 1994. Cambodia was among the few countries in the Region which had implemented the DOTS strategy on a countrywide basis over a period of five years. Case detection had continued to improve, while a cure rate of more than 85% had been maintained. Despite those achievements, the programme still faced a number of challenges, such as patient compliance, an increasing number of cases, a high prevalence of HIV infection, and the threat of multidrug resistance. The continuing technical and financial support of partners such as WHO, the Japanese International Cooperation Agency (JICA), Médecins sans Frontières, the Research Institute of Tuberculosis in Japan, the Voluntary Services Overseas (VSO) in the United Kingdom, the World Food Programme (WFP), and World Vision International was greatly appreciated.

Mr MOND (Papua New Guinea), expressing appreciation for the special attention and technical support his country received from WHO, joined the delegate of Japan in asking how the regular supply and timely availability of antituberculosis drugs would be assured.

The impact of the rising number of HIV infections and AIDS cases on the already high prevalence of tuberculosis was a cause of concern. The DOTS programme was to be extended to cover the whole country; however, a holistic approach was needed so that the implementation of DOTS would also contribute to strengthening the weak health system. Delivery of health services in rural areas was an expensive undertaking, and the cost-effectiveness of DOTS was therefore an important factor. He doubted, however, that the regional target of reducing tuberculosis prevalence and mortality by 50% by 2010 could be achieved in his country because of the combined effect of the HIV/AIDS epidemic and the weak health system.

Mr RODRIGUEZ (United States of America), noting that one-third of all tuberculosis cases occurred in the Region, expressed concern about underreporting of the disease, and asked what steps were being taken to remedy that.

DOTS provided an effective and affordable strategy to combat tuberculosis until new drugs and vaccines became available. Successful implementation, however, required laboratory-based diagnostic tests, high-quality drugs and careful monitoring, as well as political commitment. While endorsing the lines of action proposed in the document under review, he asked what support would be provided to Member States for implementation of the strategy.

He pointed out that cooperation between the Regional Office and Member States was essential in order to ensure sound management of multidrug-resistant tuberculosis. Further, the impact of the HIV/AIDS epidemic on the spread of tuberculosis had to be assessed in order to devise strategies for tackling the disease among people living with HIV/AIDS.

Dato' Seri Dr SULEIMAN Mohamed (Malaysia) noted that the number of tuberculosis cases was rising in his country, although the contributing factors had not yet been identified. He would appreciate learning from the experience of other countries. A community-based prevalence study was to be conducted shortly.

It was important to monitor the effectiveness of the DOTS strategy and his country had developed a number of quality assurance indicators.

Dr NAO BUTTA (Lao People's Democratic Republic) reported that tuberculosis continued to be serious problem in his country. Case detection was poor and the number of new cases was underreported.

The DOTS strategy covered about 60% of the population; lack of financial and technical support, and poor monitoring and supervision of activities, hindered improvement. Substantial financial support was required and staff skills needed to be improved. The strategy had to be adapted to conditions in his country, as most of the population lived in remote areas, far from a health centre. Innovative approaches were therefore needed. He welcomed technical advice from WHO or others in that regard. Village health workers had to be trained to implement the strategy, which had to be sustained over time. A continuous supply of drugs also had to be assured, and health staff at all levels had to be involved in active case finding.

Dr OTTO (Palau), commending the strengthening of WHO's activities to prevent and control tuberculosis, reported that the Stop TB project was progressing well in his country, thanks to the continuous supply of drugs and to financing from partners.

He fully supported the regional strategic plan to Stop TB in the Western Pacific (Annex 2 of the document under review), which provided clear and concise guidelines for tuberculosis control.

Dr CHEW (Singapore), similarly endorsing the strategic plan, reported that, although the incidence of tuberculosis had fallen dramatically in his country, it remained higher than in some of the other countries in the Region. Singapore had strengthened its control programme by enhancing epidemiological surveillance and clinical management based on the DOTS strategy. Early results appeared promising.

In view of the high prevalence rates of the disease in some countries of the Region, he asked for clarification of WHO's policy with regard to BCG vaccination and revaccination. In particular, what was the potential long-term impact on incidence of the cessation of BCG revaccination in countries that had incorporated revaccination in their child immunization schedule?

Dr CHEN (China), expressing his full support for the regional strategic control plan, pointed out that China had one of the highest burdens of tuberculosis. His Government had therefore always given great attention to prevention and control. The DOTS strategy covered almost half the population and had produced remarkable results, despite a lack of financial resources. China was making every effort to respect the commitments it had made at the Ministerial Conference on TB and Sustainable Development (Amsterdam, March 2000), namely the formulation of mid- and long-term control programmes, mobilization of financial support, and an emphasis on case diagnosis and treatment.

Referring to the first target under paragraph 2.1 of document WPR/RC51/10, he observed that it would be difficult to estimate the smear-positive pulmonary cases, and he hoped that WHO would provide effective methods for evaluation. Referring to the first requirement under paragraph 3.1, he trusted that, especially in the case of those countries with a heavy tuberculosis burden, WHO would continue to support Member States by mobilizing high-ranking leaders to make both political and financial commitments to improving the health system. WHO should continue to mobilize international support for tuberculosis control in developing countries. He suggested that WHO should intensify its efforts to promote exchange of experiences among Member States with a high tuberculosis burden, together with training and technical guidance, in addition to assuring the link between global tuberculosis control strategies and national programmes. WHO should also maintain its efforts to assure training of human resources and provision of laboratory equipment.

Dr KIM (Republic of Korea), expressing his full support for the regional Stop TB strategy, announced that Korea had launched a new tuberculosis surveillance system, replacing the five-yearly nationwide survey. It had set up a surveillance database, known as "TBnet". It comprised a system of case reporting using the Internet, with automatic analysis of data, which was intended to shorten the time for reporting, analysis and response. Initial results were very promising.

Dr BENJAMIN (Federated States of Micronesia) reported that the number of cases of tuberculosis in his country continued to increase, and the disease remained the cause of much preventable morbidity and mortality. Pulmonary tuberculosis was the most frequently diagnosed type in his country. Shortages of skilled staff, medication and funds had resulted in inadequate treatment of most cases. Few persons completed a full course of treatment, and close contacts were often not evaluated. Few cases were confirmed in the laboratory. Despite those limitations, efforts were being made to improve the programme against tuberculosis.

His Government considered that the DOTS strategy could work well in the Federated States of Micronesia, since it ensured that the appropriate drugs were given directly to the patient. Care should be taken, however, that patients actually swallowed their medication, as older patients in particular might not wish to do so in front of others, for cultural reasons. The Government also considered that DOTS would decrease the incidence of multidrug resistance. All of the Federated States had requested funding to enable them to implement the DOTS strategy as the key to reducing the incidence of tuberculosis.

Dr. ALCANTARA (Philippines) said that tuberculosis was still a major public health problem in her country and was one of the 10 leading causes of morbidity and mortality. Despite use of the DOTS strategy, improved case definition, advocacy, networking and capacity building for service providers, there remained three unresolved issues: multidrug resistance, tuberculosis among children and discontinuation of treatment. Those aspects were being addressed within an ongoing reform of the health sector, which included improving the quality and financing of tuberculosis programmes. Furthermore, tuberculosis management would become part of an outpatient package covered by health insurance. The DOTS strategy would be implemented in Government institutions and local units and would be expanded to the private sector. Nongovernmental organizations would be asked to become involved in management of the strategy. A national survey was planned in 2003 to monitor the success of the programme.

Dr CHAN (Hong Kong, China) said that tuberculosis was still the most important infectious disease in Hong Kong in terms of morbidity and mortality. A comprehensive control programme had been in place since 1952, which had been modified regularly to take account of changing circumstances. The programme involved administration of BCG vaccine at birth, surveillance, case finding, tracing of contacts, DOTS, tracing of drop-outs and health education.

DOTS had been introduced in Hong Kong in the 1970s in specific tuberculosis and chest clinics. The rate of notification of cases of tuberculosis had fallen from 697 per 100 000 population in 1952 to 110 per 100 000 in 1999; however, the rate had levelled out at between 100 and 110 per 100 000 since 1990. The death rate had fallen between 1952 and 1999 from 168 to 4.6 per 100 000. Of all cases confirmed from smears, 80% came to the clinics for treatment, where the cure rate was about 90%, the drop-out rate about 5% and the proportion of multidrug-resistant cases was 2%. A recent review of use of the DOTS strategy had shown it to be cost-effective.

The challenges for Hong Kong were now to integrate the DOTS strategy into primary health care services, rather than confining it to special tuberculosis and chest clinics, and to determine the barriers to a further reduction in the incidence of the disease. One approach would be to collect data from the private sector, in which the remaining 20% of cases were treated.

Mr MOOA (Kiribati) commented that the plan of action outlined in Annex 2 of the report was appropriate in view of the fact that 30% of all new cases of tuberculosis in the world were diagnosed in the Western Pacific Region. While the DOTS strategy was being implemented in his country, its geographical extent resulted in poor communications and a lack of laboratory staff on the outer islands. Considerable problems had therefore been encountered in fulfilling the five key components of DOTS, especially case detection by sputum smear microscopy.

Dr INIAKWALA (Solomon Islands) said that tuberculosis still represented a threat to public health in his country. Of particular concern was the fact that more than 70% of cases occurred in the economically active age group, 15–45 years. Use of DOTS had increased the rates of both cure and compliance to greater than 95%. In partnership with WHO and the Tuberculosis Association of Japan, Solomon Islands was now focusing its efforts on strengthening laboratory support in rural areas. A consistent supply of drugs for treatment and of reagents for diagnosis was crucial. Use of blister packs for self-administration of the drugs had been found effective, especially with respect to compliance and for avoiding drug resistance. He welcomed the launching of the Stop TB Project and endorsed the regional plan of action.

Dr MATHESON (New Zealand) said that, although the incidence of tuberculosis in his country was low, it had increased recently to more than 12 cases per 100 000 population. Much of that increase had been among Maoris and other Pacific island peoples living in New Zealand, and it had been recognized that the underlying causes of the increase were overcrowded living conditions and poverty. Although his country was implementing a modified version of DOTS, he considered that strategies for the control of tuberculosis should also address fundamental socioeconomic issues in order to be successful.

The REGIONAL DIRECTOR, replying to the query from the representative of Japan about how the supply of antituberculosis drugs to countries with high incidence of the disease was to be ensured, said that the Regional Office maintained close contact with Member States and channelled information on their needs to the Interagency Coordination Committee and, in addition, passed on the information to WHO Headquarters. That mechanism would be strengthened further. The Member States fell into two categories: those that were more or less self-sufficient in antituberculosis drugs (the majority) and those that needed external support. The latter could be subdivided into those that would have no shortage during the current year and those (two countries) that would be unable to meet the needs of their populations. Efforts at the country level and support from the international community would mean that sufficient drugs would be available for the entire Region for the period 2001–2002. The situation from 2003 onwards was less clear, but frequent contact with the Interagency Coordination Committee would be maintained to ensure that the availability of drugs was not an issue. The role of WHO was clearly to coordinate the activities of the various partners.

The representative of Papua New Guinea had asked whether the target of halving the prevalence and mortality rates of tuberculosis by 2010 was too ambitious. Discussions with members of the Technical Advisory Group and with the representatives of countries in which rapid progress had been made had shown that it would be difficult, but was possible.

Although the question from the representative of the United States of America about the steps WHO planned to take to avoid underreporting of cases of tuberculosis would be answered by his colleagues, he said that that was an inherent problem in the control of any communicable disease. However, one of the components of the DOTS strategy was to reduce underreporting.

The representative of China had asked how the number of cases of pulmonary tuberculosis confirmed from smears could be estimated. The control of any communicable disease involved not only treatment but also surveillance, in order to ensure that all cases had been detected. The prevalence of tuberculosis could be estimated in surveys, and such surveys were being carried out in countries where prevalence rates were high. The Regional Office was ready to help any country that wished to carry out such a study.

He fully agreed with the representative of Hong Kong, China, that the private sector should be included in the DOTS strategy within the process of health sector reform. Ministries of finance and education could also usefully be drawn into the effort.

The REGIONAL ADVISER IN STOP TB AND LEPROSY ELIMINATION, addressing the query as to whether the incidence of tuberculosis could be halved by 2010, showed a graph of the results of a survey conducted in the Republic of Korea between 1965 and 1995, indicating that the number of cases confirmed by smear testing had been halved within less than 10 years. In response to the comment of the representative of the United States of America about underreporting, he noted that only about 42% of the estimated new cases in the Region that were confirmed by smear testing were reported. In order to increase that percentage to 70% by the year 2005, three approaches were envisaged: expansion of the information and laboratory components of the DOTS strategy; involvement of the private sector and of nongovernmental organizations to improve referral between the private and public sectors; and the introduction of quarterly instead of annual reporting, at least for countries with a high burden of tuberculosis.

He reported that surveillance for multidrug resistance was being carried out in six countries and two areas, in collaboration with reference laboratories in Australia, Japan and the Republic of Korea. In China, surveillance had been extended to four provinces. Multidrug resistance was difficult to overcome with first-line drugs once it had developed, and a "DOTS-plus" operational research initiative had been launched in selected countries to investigate the cost-effectiveness of introducing second-line drugs, in order to develop policy recommendations for Member States.

The DIRECTOR, COMBATING COMMUNICABLE DISEASES, replying to the question from the Representative of Singapore on revaccination with BCG, said that WHO supported BCG vaccination at birth, which was very effective in preventing severe forms of tuberculosis in young children. However, in 1995 WHO had issued a policy statement, based on evidence from many studies all over the world, that had recommended against BCG revaccination. A recent study in Hong Kong had provided further evidence against the use of BCG revaccination in immunization programmes.

3. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolution:

3.1 Sexually transmitted infections, HIV infection and AIDS

(Document WPR/RC51/Conf. Paper No.3)

Mr MOND (Papua New Guinea) proposed: the insertion of the word 'negative' after 'potential' in preambular paragraph 2; the addition of the wording 'Noting the lessons that can be learned from those and other successful programmes in the Region' as a new preambular paragraph 4; the insertion

of the word 'transmission' after 'HIV' in operative paragraph 1(1); the deletion of the words 'increase in' and insertion of the word 'increasing' in operative paragraph 1(4); the deletion of the words 'and to reduce the stigmatization of patients with AIDS' in operative paragraph 1(4); the addition of a new operative paragraph 1(5) with the wording 'to strengthen the implementation of programmes aimed at reducing the stigmatization of patients with AIDS', the remaining subparagraphs to be renumbered accordingly; the addition of a new operative paragraph 1(10) with the wording 'to strengthen multisectoral collaboration and increase resource mobilization'; and the insertion of the words 'strengthen multisectoral collaboration and' before 'increase' in operative paragraph 2(3).

Ms BLACKWOOD (United States of America) proposed replacing the word 'recognizing' with the words 'noting with deep concern' in preambular paragraph 2; the addition of a new preambular paragraph 3 with the wording 'recognizing that the prevention of new HIV infections is central to curtailing the epidemic in the Region'; the deletion of the words 'with satisfaction' from the original preambular paragraph 3 (now preambular paragraph 4); the insertion of the word 'including' before the words 'targeting' in operative paragraph 1(1); the insertion of the words 'and strengthen' after the words 'to secure' in the original operative paragraph 1(8) (now operative paragraph 1(9)); and the insertion of the words 'policies and' before 'programmes' in the new operative paragraph 1(5) proposed by the representative of Papua New Guinea.

Dr OTTO (Palau) pointed out that, if the new amendments were adopted, 'resource mobilization' would be mentioned in both of the last two subparagraphs. He suggested, therefore, that the words 'and increase resource mobilization' be dropped from new operative paragraph 1(10).

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC51/R3).

4. PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES: Item 14 of the Agenda (Document WPR/RC51/8)

The REGIONAL DIRECTOR, introducing the report, recalled that, in the past, noncommunicable diseases (NCD) had been regarded as diseases of affluence limited to developed countries. WHO could no longer afford to take that view, since the major burden of NCD now lay with developing countries. Limited resources, the low priority assigned to NCD and low awareness of risk factors meant that many developing countries had been unable to respond effectively to the global NCD epidemic.

It was well known that NCD were often caused by unhealthy lifestyles, which were in turn heavily influenced by social, economic, cultural and educational environments. The problem for the Western Pacific Region was that urbanization, industrialization and globalization were increasing the exposure of many people to unhealthy lifestyles and behaviours.

WHO believed that its main strategy to combat NCD must be to modify the lifestyles that gave rise to them. The major NCD in the Region – cardiovascular diseases, cancer and diabetes - had common lifestyle-related risk factors, such as unhealthy diets, smoking and physical inactivity.

As the Secretariat had argued in the regional policy document *New horizons in health*, personal behaviour change was critical if risk factors were to be reduced. However, WHO could not expect individuals to change their behaviour on their own; there had to be changes to the context in which they lived, brought about by effective public policy, health promotion, and enactment and enforcement of legislation. For example, if fish, fruit and vegetables were widely and cheaply available, it would be easier for individuals to make healthy dietary choices. More parks and sidewalks would encourage walking, recreation and play. Effective information, education and communication programmes would give people the information they would need to choose healthy lifestyles. Whenever there was a choice, WHO must help people to make healthy decisions and ensure that policies were in place to support those decisions.

He strongly believed that WHO must continue to focus on prevention. Medical interventions during the clinical stages of noncommunicable diseases, particularly high-technology approaches, had only a limited impact on the health of the general population and were expensive, even for the richest countries.

Since experience had shown that single-disease programmes were less cost-effective and were also not feasible in many developing countries, WHO promoted an integrated approach to NCD. Such an approach would enable the integration of primary, secondary and tertiary disease prevention and health promotion, and would ensure that programmes in different sectors and disciplines worked closely together.

WHO's primary role was to provide leadership in the campaign against NCD. In 1999, NCD had been identified as one of the 17 focuses for WHO in the regional policy document A framework for action, which had been endorsed by the Regional Committee. The fact that NCD had been tabled for discussion by the Regional Committee at the current session was an indication of the seriousness with which Member States regarded the issue. NCD had last been discussed by the Committee in 1985. In the intervening 15 years, the epidemiological transition had progressed very significantly, to the extent that there was now a global NCD epidemic.

Turning to diabetes, he said that, despite rising levels of the disease in the Region, prevention and care of diabetes were still low priorities in most national health plans and among the international community. To heighten awareness of the disease, WHO, the International Diabetes Federation (IDF) Western Pacific Region and the Secretariat of the Pacific Community (SPC) had formed a regional strategic alliance. At a meeting in June 2000, the alliance had developed a Western Pacific Declaration on Diabetes, which was set out in Annex 2 to the report, and a regional plan of action for 2000–2005. He urged the Committee to endorse the Declaration as an important landmark in WHO's campaign to raise awareness of the extent of the diabetes burden in the Region.

He stressed that strong and committed political leadership was a prerequisite if WHO and its Member States were to stem the rising tide of NCD in the Region. The road was long, however, and it was essential that the journey be begun as soon as possible.

The CHAIRPERSON said that, in informal discussions with the Regional Director and the Country Liaison Officer in Tonga, he had suggested that it was important to make representatives attending the Regional Committee aware, in a more practical way, of the importance of physical exercise, particularly for those with sedentary occupations. He had therefore requested the Secretariat to arrange for a representative of the College of Human Kinetics, University of the Philippines, to be invited to give a short demonstration to the Committee.

The DEAN, COLLEGE OF HUMAN KINETICS, UNIVERSITY OF THE PHILIPPINES, with the assistance of three colleagues, demonstrated a programme of simple bending and stretching exercises that could be undertaken while sitting at or standing by a desk. All participants in the session took part in the programme.

The meeting rose at 12 noon.

ANNEX

MINISTERIAL ROUND TABLE MEETING ON HEALTH AND POVERTY

Summary by Dr Phua Kai Hong, Moderator

The Ministerial Round Table focused on the subject of health and poverty. Thirty-two Member States took part in the Round Table, and comments and country experiences were provided by 22 Ministers or their representatives. Those experiences reflected the Committee's concern about the topic and its commitment to poverty reduction. The meeting served to raise awareness about the linkages between health and poverty, resulting in a sharing of experiences and recommendations as to WHO's role.

Several comments reflected important general concerns. Health leaders have long known that much of the burden of disease lies in poverty and improvements in health can lead to economic gains. That admission is significant, implying the recognition that health policy-makers need to do more to obtain support from political leaders. At the same time, it was suggested that the health sector could take the lead in placing health at the centre of both development and poverty reduction efforts.

Differences in culture and levels of economic development have increased the difficulties in defining and measuring poverty across the region. It is important to take into account how different communities perceive their own poverty or well-being. A positive outlook and strong social support structures, despite an obvious lack of material wealth, as in the Pacific Islands, should also be recognized as assets for development.

The following summarize comments related to the discussion of policy options. First, it was noted that even countries that are relatively wealthy would still need a national policy on social and economic development with appropriate safety nets. One aim of the policy would be to shift from giving handouts to empowering the poor.

A positive approach should be followed and care should be taken to avoid negative connotations and stigmatizing the poor. That can be done through more acceptable means of addressing inequalities. Country experiences show that, with the increase in the activities of the private health sector, governments need to be more proactive in regulating that sector to protect the poor. It was noted that high health care expenses could lead families into poverty.

Several countries emphasized the importance of a multisectoral approach. The health sector can take the lead in identifying issues and getting partners on board for intersectoral collaboration. All levels of government - national, provincial and local - have to be involved in poverty reduction, in

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a consistent manner, from policy formulation to implementation. Greater integration is needed from all levels and sectors concerned with health and poverty.

Interagency partnership is also required at the international level. At the same time, a prime guiding principle in the efforts of the international development community in promoting health for poverty reduction should be based on the priorities of the specific country. Development programmes should be planned and implemented as country-led efforts rather than being donor-led.

The role of NGOs was recognized, as those organizations are often closer to the poor than governments. It is important that the people be mobilized to participate in and take ownership of health and poverty reduction programs. Schemes that include provision of credit with support of other social services have proved to be an effective community-based strategy for poverty reduction.

With regard to access to health care, the goal of universal coverage has been reached in some countries in the region. Clearly, in those countries, a mix of financing mechanisms, including tax-based and social insurance systems, has removed financial barriers to access and given the necessary protection to all population groups, including the poor. It was reiterated that user charges for health care at the time of illness may deter the sick from seeking care. In such situations, there is a case for social assistance to target vulnerable individuals and groups. The responsibility to assure that lies with government.

The very low level of government spending on health in many countries in the Region was acknowledged. There were requests for WHO to develop standards for the appropriate level of health care expenditure. However, comments from the Pacific island countries, which had relatively high proportions of the national budget allocated to health, highlighted the need for a country-specific approach. That analysis should consider the true costs of health care in the country. It should also aim to ensure more equity and efficiency in resource allocation and utilization. That would need to emphasize the allocation of resources for more intensive efforts to combat diseases that disproportionately affect the poor.

Following the endorsement of WHO's initiative in selecting the topic for the Round Table discussion, several suggestions were made for the future work of WHO in the area of health and poverty. It was suggested that the Regional Office should develop a framework for action in poverty reduction that also identified the non-health components and essential social services. The framework should allow the formulation of criteria on how to implement strategies in the country-specific context and include the monitoring of implementation. It was also proposed that NGOs and other partners

should be included in the framework. Several countries requested WHO support in developing alternative health care financing mechanisms.

WHO's advocacy role was seen as critical, both in assisting Ministries of Health to obtain the broad political support needed, and in achieving intersectoral cooperation required to achieve better health outcomes for all population groups. WHO's advocacy-related work could include a focus on inequalities. With WHO's initiative, the integrated approach to poverty reduction including health, education and income-generating activities, could be a useful and practical model, involving new partners and strategies.

In concluding the meeting, participants recognized that people are the Region's most valuable resource, and health is a critical asset in achieving development goals.