SUMMARY RECORD OF THE SEVENTH MEETING

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

CONTENTS

page

1. Prevention and control of noncommunicable diseases (continued) 162

2. Coordination of the work of the World Health Assembly, the Executive Board and the Regional Committee 174

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

Dr BENJAMIN (Federated States of Micronesia) said that in his country the issue of diabetes was exacerbated by a number of other factors, including hypertension, heart disease, lack of appropriate treatment modalities and insufficient access to adequate health services. Research and field studies had shown that the high rates of diabetes could be attributed to genetic susceptibility to the disease and also to the transitional economic situation, which prevented the implementation of comprehensive prevention and management programmes.

Multidisciplinary integrated intervention strategies were needed to counteract common risk factors for NCD, such as sedentary lifestyles and poor diet. Attention should be given to both primary and secondary prevention, since it had been shown that effective preventive techniques could extend life expectancy and make lives more productive. The strategies should involve all stakeholders, including health care workers, religious organizations, influential community members, business leaders and people with NCD and their families.

From 1991–1997, about 44% of all adult deaths were due to diabetes, stroke, hypertension and heart disease taken together.

As it faced increasing reductions in health care resources, his country would continue to face difficulties in providing adequate health care services. The outlook for comprehensive care for diabetes and other NCD remained bleak, since the health care delivery system focused mainly on curative services, despite the need to emphasize prevention as a long-term investment.

He fully endorsed the Western Pacific Declaration on Diabetes.

Dr VILLAGOMEZ (United States of America) also endorsed the Declaration and supported the development of a regional plan of action for its implementation. It was evident that many chronic diseases were preventable, and that a reduction in common risk factors would significantly limit the socioeconomic and health burdens resulting from them. Prevention was therefore the key, and the Regional Office strategy, which emphasized surveillance, the development of norms and standards, and organizational models of care, supported that goal. For maximum impact, WHO should focus its energies on strategies directed at three major risk factors: tobacco use, unhealthy diets and physical inactivity. It was therefore entirely appropriate that NCD activities were included under the theme Building healthy communities and populations.

He supported WHO's recognition of the critical role played by regulatory authorities in controlling tobacco products. That was especially important to protect young people. Regulation was also crucial in respect of dietary guidelines, food labelling and the safe use of medicines, and it would be interesting to hear about Regional Office collaboration with national regulatory authorities in those areas.

The Regional Director's report indicated that the absence of regional databases and lack of training were barriers to efficient surveillance. He asked how those problems would be addressed.

It was clear that many of the determinants of better health, such as better education, cleaner environments and sustained reductions in poverty, lay outside the health sector. Partnerships with a variety of health and non-health stakeholders would therefore be essential. Member States must recognize that increasing numbers of people, in developed and developing countries, would suffer from NCD, and that it would be important for everyone to work together towards a balanced community health system that gave due weight to health promotion and prevention and early detection.

Professor MATHEWS (Australia) endorsed the report and the Western Pacific Regional Declaration of Diabetes, and welcomed the emphasis on poverty reduction, improving access to health services and enhancing awareness of risk factors. WHO had a vital role to play in those areas.

Prevention and effective control of excess weight and obesity were essential given their links with type 2 diabetes and hypertension. Other risk factors were less well understood, for example low birth weight, which appeared to be related to a predisposition to diabetes and to cardiovascular and renal disease. In addition, there was some evidence to indicate that type 2 diabetes might also be linked with rotavirus infection, which suggested that the distinction between communicable and noncommunicable diseases might not be entirely clear cut.

At the international level, Australia recognized the importance of NCD through its bilateral and multilateral support. Within the country, due emphasis was given to NCD through the National Health Priority Council. Australia was working towards integrated chronic disease and behavioural risk-factor surveillance and would be interested in collaborating with the Regional Office and Member States on the development of appropriate NCD surveillance tools and systems. An international workshop on prevention and control of chronic NCD would be held in November 2000 in conjunction with the Sixth International Congress of Behavioural Medicine.

He recognized the importance of alcohol misuse and tobacco use as risk factors for chronic NCD and supported the Regional Office action in those areas.

Australia's indigenous people were particularly vulnerable to NCD, including cardiovascular, renal and chronic lung disease, hypertension and diabetes, and a number of strategies had been implemented to tackle that problem, including emphasis on provision of health services administered and managed by indigenous people themselves.

Dr KIENENE (Kiribati) said that the report before the Committee highlighted the complexity of the development of NCD, which involved lifestyle factors such as stress at work, diet, exercise, tobacco and alcohol consumption. By their nature, those determinants were not easy to address, ranging as they did from the privacy of home to the workplace, and across cultures and traditions to retailers, price control policies and legislation, and the giant multinational tobacco companies. NCD prevention and control would require an integrated and multisectoral approach by WHO and other relevant partners. A strong political commitment from countries was needed, and efforts should be made to enhance the awareness of politicians regarding lifestyle changes, encouraging them to lead by example.

He endorsed the Western Pacific Declaration on Diabetes.

Dato Haji AHMAD MATNOR (Brunei Darussalam) endorsed the Western Pacific Declaration on Diabetes and the proposed actions set out in the Regional Director's report.

His country had undergone an epidemiological transition from communicable diseases to NCD, and heart disease, cerebrovascular disease, cancer and diabetes mellitus had become the leading causes of mortality. Brunei Darussalam had embarked on a national programme for the prevention and control of NCD, focusing on the common lifestyle risk factors for those diseases. A National Committee on Health Promotion had been established, with members representing relevant government agencies, nongovernmental organizations and the private sector. The Committee had identified seven priority areas: nutrition, food safety, tobacco control, physical fitness, mental health, healthy environment and women's health. Members were reviewing public policies to promote healthy lifestyles, evidence-based programmes and integrated approaches.

Diabetes mellitus was a growing problem in the country. Diabetes prevention and care had therefore been strengthened, with the establishment of diabetic clinics in hospitals and primary care settings, and workshops and seminars had been conducted for health care personnel and people with diabetes and their families.

Dr CHAN (Macao, China) said that NCD and injuries together had been the major cause of mortality and morbidity in her country for several decades. In 1999 they had caused 98% of all deaths. Cardiovascular disease and tumours caused 61% of all deaths and lung cancer alone 7.8%.

Smoking was the main common risk factor, and the Department of Health had therefore identified prevention and control of tobacco use as its first priority for action. Comprehensive legislation, emphasizing protection of the young and non-smokers, had been revised in 1997, and tobacco advertising in all media had been banned. Education programmes, particularly those targeted at the young, had been strengthened and emphasis had been given to promotion of healthy lifestyles. A healthy environment was being emphasized in the health system and other sectors.

Despite intensive preventive activities, early detection and treatment of NCD and the prevention of disabilities resulting from them was the most frequent activity in primary care facilities, and chronic NCD such as cardiovascular disease, diabetes and chronic obstructive pulmonary disease were the major adult diseases seen in health centres. Emphasis was being given to screening for cervical and breast cancer.

Essential drugs and diagnostic procedures were available free of charge to all residents, and elderly, psychiatric and cancer patients were treated without charge in all government facilities and in some private facilities, with government support. A new hospice care centre had been established early in 2000 through a government/private sector partnership.

Dr CHEN (China) said that China accounted for two-thirds of diabetes cases and half of cancer cases in the Region. It had launched a project for community-based prevention and control some 30 years ago, which had since been extended to 24 provinces. None the less, noncommunicable diseases had not been effectively controlled, and prevalence was rising.

He fully endorsed WHO's strategies for combating such diseases in the Region and supported the Western Pacific Declaration on Diabetes. On the basis of China's experience, he suggested that a key aspect of prevention and control of noncommunicable diseases was raising awareness of the problem at the highest level, particularly in developing countries. To that end, WHO should convene meetings of high-level decision-makers, encouraging them to take part in national prevention and control activities.

Developing countries encountered greater difficulty in preventing and controlling noncommunicable diseases than industrialized countries, because their resources were limited and they tended to give priority to communicable diseases. Developing countries should understand that noncommunicable diseases laid a heavy burden both on the individual and on society. He suggested that WHO should launch a cost-benefit study on the impact of noncommunicable diseases on socioeconomic development, as a basis for framing policy and for mobilizing society as a whole.

In order to improve prevention and control, WHO should, on the one hand, foster the sharing of experiences in order to develop appropriate methodology and technology in developing countries and, on the other, mobilize the flow of technical and financial support from developed countries

Moreover, in view of financial constraints and weak infrastructure in developing countries, there was an urgent need to establish a simple, appropriate, and affordable system of information on noncommunicable diseases that would provide a basis for making decisions on prevention and control.

Experience in developing countries had demonstrated that information on healthy living was an effective strategy for preventing noncommunicable diseases and promoting healthy behaviour. Nevertheless, a number of developing countries had not yet undertaken suitable action. Technical strategies still remained at the stage of simple health education; both policy development and the supportive environment were weak. Moreover, resources allocated to health promotion were limited by financial constraints; WHO should provide support to strengthen that aspect of prevention.

Dr ISMAIL ABU TAT (Malaysia) reported that cardiovascular diseases and cancer were the leading causes of death in Malaysia, and that the prevalence of diabetes was rising. His Government had launched a healthy lifestyle campaign related to specific diseases, and was advocating healthy eating, physical exercise, and smoke-free public premises. It had also started to integrate prevention and control of noncommunicable diseases into primary health care.

Traditional approaches that targeted a single disease were not cost-effective. The provision of specialized services for the treatment of noncommunicable diseases was costly and unlikely to meet the needs of the population at large. The design and adoption of a comprehensive approach that targeted all major risk factors common to cardiovascular diseases and diabetes was the most cost-effective way to prevent, control and manage them. Further, he suggested that WHO should provide support and technical input for research on the economic impact of noncommunicable diseases in developing countries.

His Government fully supported the Western Pacific Declaration on Diabetes and would participate in implementation of the regional plan of action.

Mr ROKOVADA (Fiji), endorsing the Western Pacific Declaration on Diabetes, said that prevention and control of noncommunicable diseases had been identified as a priority by the Ministry of Health of Fiji. Adequate financial resources had been allocated for that purpose and a forthcoming restructuring would form the basis for a more integrated approach.

Tobacco taxes in Fiji had been raised and a portion of them channelled to the Ministry of Health to support health promotion. However, enforcement posed a challenge and he would appreciate information on how that aspect had been handled elsewhere. The Government had also imposed restrictions on imports of low-grade, high-fat meat. However, such measures had been circumvented and, again, he would appreciate learning about the experience of other countries in that regard.

Fiji had also been involved in a community-based programme that had raised awareness of the risk to health represented by obesity. It was expected to produce results in the medium term.

Professor TRUYEN (Viet Nam), endorsing the Western Pacific Declaration on Diabetes, noted that noncommunicable diseases were no longer "diseases of affluence", and that the number of people suffering from cardiovascular disease, diabetes and cancer cases was rising in Viet Nam. Hypertension was the eighth leading cause of death, although a survey had revealed that most patients were not receiving any kind of medication.

Efforts so far had concentrated on curative interventions, but his Government would shortly be drawing up a national plan for prevention and control. It would be geared to primary prevention of noncommunicable diseases through a healthy lifestyle, and would integrate prevention and control into primary health care.

Dr ALCANTARA (Philippines), expressing support for the Western Pacific Declaration on Diabetes, said that her Government accorded high priority to the prevention and control of noncommunicable diseases. Programmes were under way to combat noncommunicable diseases throughout the country and, with the support of WHO, a pilot project was being conducted on community-based, integrated prevention in both urban and rural settings.

Prevention and control activities focused on a population approach to primary prevention, geared to modifying unhealthy lifestyles and behaviour. A further project was being implemented at both national and local levels, known as the Movement for Centers of Vitality, which aimed at making quality health services, including those for the treatment of noncommunicable diseases, available to the whole population. The expansion of health insurance benefits to include cost-effective screening for noncommunicable diseases was also being examined.

Mrs SURENCHIMEG (Mongolia) reported that cardiovascular diseases and cancer were among the leading causes of death in her country. Integration of programmes to combat different noncommunicable diseases was the most cost-effective way to tackle prevention and control and was essential in a developing country like Mongolia, where health promotion was in its infancy.

However, health professionals needed training in the best way to handle integration. Integration should also take account of the special requirements of prevention of specific diseases at secondary and tertiary levels.

Dr THORNE (United Kingdom of Great Britain and Northern Ireland), welcoming the emphasis on noncommunicable diseases, noted that many shared preventable, lifestyle-related, risk factors. However, convincing people to change their behaviour and enabling them to make informed decisions about their lifestyle was a complex process. Success would involve cooperation among a wide range of partners; coordination of that partnership would be crucial.

She expressed support for the Western Pacific Declaration on Diabetes and the formulation of strategies to reduce prevalence.

Dr HARE PAKA (Niue), endorsing the Western Pacific Declaration on Diabetes and the strategies proposed for combating noncommunicable diseases, expressed his concern at the rise of diabetes and hypertension in his country. His Government was drawing up plans for the integration of health promotion and education within the Healthy Islands framework.

In his view, his country had been affected by Westernization, in particular by imported foodstuffs, which had changed people's diet.

Dr OTTO (Palau) reported that noncommunicable diseases were among the leading causes of mortality and morbidity in Palau. Prevention and control of diabetes, in particular, indicated the need for multisectoral coordination. He welcomed the proposal to intensify action against diabetes by promoting and supporting research, including operational and behavioural research. It was often difficult to maintain collaborative relationships with partners; behavioural research into building up and maintaining cooperative relationships was therefore essential. He reiterated his support for the healthy settings approach to diabetes and other noncommunicable diseases.

He commended the support provided to Member States in relation to the proposed Framework Convention on Tobacco Control. Palau had sent comments for the public hearings (Geneva, October 2000), but budgetary constraints might prevent it from participating in the first session of the Intergovernmental Negotiating Body that would follow them. He asked for information on the current position of the Region within the framework convention process.

He was encouraged by the emphasis that was being laid on mental health and on substance abuse. His Government looked forward to receiving technical support in those areas. Referring to section 3.3 of document WPR/RC51/8, he requested that the population-based or hospital-based

registries mentioned should not be limited to cancer alone, but should include other noncommunicable diseases, at least diabetes and certain mental health conditions.

Dr CHAN (Hong Kong, China), expressing her support for the Western Pacific Declaration on Diabetes and the proposed strategies to combat noncommunicable diseases, reported that such diseases were a serious public health concern in Hong Kong, representing collectively the major cause of death.

Among recent prevention and control measures, Hong Kong had enhanced enforcement of smoke-free premises and was preparing to implement recommendations that would stem from the proposed Framework Convention on Tobacco Control. Extra funding had been provided to combat cigarette smuggling.

Recognizing the lack of data and information on which to base decisions regarding the prevention and control of noncommunicable diseases, a public health information system was being built to improve data collection and quality.

Further, an audit had been undertaken to take stock of organizational capacity for health advocacy and promotion, activities which were central to Hong Kong's preventive strategy. As a result, recommendations were to be made on a new organizational framework that would help to mobilize the community, private sector partners and nongovernmental organizations into a strategic alliance. Professional capacity was also being audited, in other words the skills of staff, particularly those involved in health education. Gaps would be identified in order to provide the necessary training for advocacy work. The health sector would then be in a better position to mobilize other sectors to work together to combat noncommunicable diseases.

Dr TEMU (Papua New Guinea), joining other speakers in endorsing the strategies proposed for combating noncommunicable diseases, affirmed his Government's commitment to implementing the Western Pacific Declaration on Diabetes. In that regard, he announced that the National Diabetes Association of Papua New Guinea was to be established within the next two months.

His country would be integrating prevention and control of noncommunicable diseases into the Healthy Islands Plan of Action. In terms of the long-term goal of behavioural change, activities should concentrate on the younger generation, as it was difficult to change behaviour once habits had been formed. Such activities could be carried out within the framework of the health-promoting schools programme, which deserved proactive support within the Region in order to convince young people to adopt healthy behaviour and prevent future cases of disease. The document under review could be geared more to action than to the framing of policy or the conduct of research. He also

recommended that the Healthy Islands approach should be strengthened and fully supported. A number of activities could be effectively implemented within that approach, including the health-promoting schools programme.

Dr ENOSA (Samoa) concurred with fellow representatives that the rates of morbidity and mortality from diabetes mellitus in the Pacific islands were high. The only consolation was that the prevalence of type 1 diabetes mellitus was much lower than that of type 2, and the latter was preventable through dietary measures, such as avoiding a Western diet. A health education and awareness programme had been in place in his country since 1978, but the habits of patients were difficult to change, even though the medication was given free of charge. A health promotion programme in schools had been started in 1995, and it was hoped that changes in attitude might be seen within 10–20 years. The cost of treating patients with renal failure due to diabetes was phenomenally high, and an age limit had had to be placed with respect to the most expensive treatment methods. Legislation on tobacco smoking had been prepared with the help of WHO and AusAID but had still not been presented, in part because most of the legislators were smokers.

He asked for clarification of the relationship between the International Diabetes Federation and the International Diabetes Institute. He further enquired about progress in the development of a vaccine against diabetes and on the feasibility of transplanting islets of Langerhans cells into the pancreas of patients with the disease. His Government endorsed the Western Pacific Declaration on Diabetes.

Mr AUDOA (Nauru) said that diabetes mellitus was a serious problem in his country and was one of the main causes of premature death, with motor vehicle accidents, cardiovascular disease, other smoking-related diseases and the effects of obesity, physical inactivity and alcohol drinking. The declining economy of the country over the past decade had affected the provision of basic health care. That, combined with the high rate of population growth, 4.5% per annum, had resulted in a marked degradation of the health status of the population. Life expectancy in Nauru was 55 years for men and 65 for women. The lack of facilities to treat noncommunicable diseases within the country necessitated overseas referral of critical cases, which represented a huge drain on the economy: annual Government expenditure on medical referrals had reached 30% of the national health budget, equivalent to 2% of the overall budget of the country.

Nauru was fully committed to the fight against diabetes and reiterated its commitment to full implementation of the Healthy Island approach in its public health programme. His country endorsed the Declaration on Diabetes as the first example of partnership among WHO, the International

Diabetes Federation, the Pacific Community and others. He also supported the regional plan of action against diabetes.

Dr SAKAI (Japan) said that the proposed strategy for the prevention and control of noncommunicable diseases was generally appropriate, but he considered that more discussion would be required before a regional strategy could be finalized. A national campaign had been launched in his country, called "Healthy Japan in the 21st Century".

The CHAIRPERSON, speaking in his capacity as representative for Tonga, said that noncommunicable diseases had been a serious problem in his country since the late 1970s, but the Ministry of Health had not known where to start in developing a strategy on NCD. In his own capacity as a surgeon, he had been distressed at the number of cases of diabetic sepsis that required amputation. He had therefore worked with the Ministry of Health to open a diabetes centre. With help from local physicians, WHO and AusAID, the centre had since been enlarged to cover all noncommunicable diseases and the promotion of a healthy lifestyle.

In September 1999 there had been no legislation or policy on tobacco smoking. A policy paper had since been drafted, which would shortly be presented in Parliament.

The REGIONAL DIRECTOR thanked the Committee for its support for the Western Pacific Declaration on Diabetes. He addressed the suggestion of the representative of the United States of America that a regulatory framework be used to control diabetes. As the representative of Papua New Guinea had pointed out, it was difficult to change people's habits. For some time, a spirit of naïve optimism had prevailed among experts in public health and diabetes that behaviour could be changed simply by exhortations to take regular exercise and eat a healthy diet. Now it was recognized that a more comprehensive approach was needed, which would include legislation.

The representative of China had proposed that WHO should organize meetings of high-level decision-makers in order to raise awareness about the control and prevention of noncommunicable diseases. He considered that a pertinent suggestion, as a meeting of political leaders organized by WHO in Amsterdam, the Netherlands, earlier in the year to discuss tuberculosis had convinced many of them of the importance of the issue. He would use the opportunity of the meeting of the WHO Global Cabinet in November to propose that a similar forum be held to discuss noncommunicable diseases. The representative of China had also proposed that a cost-benefit study be conducted of the impact of noncommunicable diseases on socioeconomic development. He thought that was a good idea and WHO would investigate it.

The representative of the Republic of Palau had asked for clarification of the status of the Framework Convention on Tobacco Control. The effort consisted of two stages, the first of which was drawing to a close. In the initial stage, the focal points and working groups had come up with ideas for incorporation into the protocol for the Convention. The second phase would be translation of those ideas into a legal framework in collaboration with political leaders and ministers of finance.

The REGIONAL ADVISER IN ENVIRONMENTAL HEALTH explained a map that had been distributed to representatives. Its purpose was to indicate the extent to which countries were prepared for the Framework Convention on Tobacco Control (FCTC). He then outlined the criteria for assessment.

The REGIONAL ADVISER IN HEALTH PROMOTION said that WHO's plans for surveillance of noncommunicable diseases had a number of components: mortality, morbidity and risk factors. Mortality was retrospective, morbidity showed the current burden of disease, and risk factors indicated the future burden and needs in terms of prevention. The strategy for monitoring prevalence entailed both cross-sectional surveys and registries, as the delegate from Palau had said. WHO was supporting countries to improve cancer registration, with standard software developed by the International Agency for Research on Cancer. Guidelines for the monitoring of cardiovascular disease in the Region had just been reviewed and were in press. In collaboration with the Secretariat for the Pacific Community, the Region had also published a manual or standard for the monitoring of diabetes in a clinical setting. In terms of risk factors, the Region had had very many surveys, with various methodologies, for monitoring the prevalence of risk factors and diseases. A concerted effort had been made in the previous year, in collaboration with Member States and WHO Headquarters, to develop a core set of risk factors and perhaps a number of core measurements of prevalence of disease, examples being blood glucose level, and measurement of height and weight at the time of interview. A protocol and questionnaire had been developed and were being finalized. One survey had been conducted in Mongolia using the method and another was to take place in Viet Nam the following year.

The strategy for surveillance, therefore, was to develop simple, standardized tools that could be used at low cost in the Region. In addition to the trials already mentioned, others were being run in China, Fiji, the Federated States of Micronesia and the Philippines.

Regulation and control of low-grade food products and work with national regulatory agencies were limited in the Region, and would have to be improved if the environmental determinants of disease were to be controlled.

Work had been done with national health and other authorities in formulation of national food policies and plans of action. In New Zealand, attempts to work with commercial partners had resulted in a reduction in the fat served up in fast-food outlets, which were becoming very common in the Region.

The following week there would be a regional workshop in Samoa with nutritionists and experts from outside the health sector in Pacific island countries, to consider behavioural and environmental approaches to the control of obesity. It was to be hoped that an incremental approach to work with regulatory agencies would result from the activities described.

In response to the question from Samoa on the difference between the IDI and IDF, he said that IDF, the International Diabetes Federation, was a group of national diabetes associations. The IDI was not a member of the IDF, nor formally associated with it. The IDI was the International Diabetes Institute, based in Melbourne, which happened to be a WHO collaborating centre.

As regards diabetes vaccines and transplants of islets of Langerhans, there was no immediate prospect of vaccines for the Region, while the transplants could be used only in treatment of type 1 diabetes, which was the minority form in the Region and required lifelong immunosuppression.

The REGIONAL ADVISER IN ENVIRONMENTAL HEALTH returned to the question raised by Palau on the Organization's involvement and recommendations on legislation. WHO had provided several countries, including Fiji, the Philippines and Solomon Islands, with legal and regulatory consultancy. WHO had fostered the sharing of legislation among countries, working with the Centers for Disease Control, Atlanta, with the WHO tobacco programme at Headquarters, and with other regions. A legislative database on tobacco control in and beyond the Region was being maintained. There was a need to check overall strategy on implementation of legislation, in terms of the choice between a complete piece of legislation, which might not be entirely enforceable, and a more restricted law, which could clearly be enforced. That dilemma had to be solved by each country.

At the invitation of the CHAIRPERSON, statements were presented by the following nongovernmental organizations:

- International Diabetes Federation
- World Psychiatric Association
- International Society of Radiologists and Radiation Technologists

- World Federation of Mental Health
- World Federation of Neurology.

2. COORDINATION OF THE WORK OF THE WORLD HEALTH ASSEMBLY, THE EXECUTIVE BOARD AND THE REGIONAL COMMITTEE: Item 15 of the Agenda (Documents WPR/RC51/9, WPR/RC51/INF.DOC./1 and WPR/RC51/INF.DOC./2)

The DIRECTOR, PROGRAMME MANAGEMENT said that document WPR/RC51/9 referred to resolutions adopted by the World Health Assembly and the Executive Board that were of significance to the Western Pacific Region. The document focused on three subjects: the health of indigenous people, the Framework Convention on Tobacco Control, and infant and young child feeding. The resolutions concerned were attached to the document. Resolutions adopted by the Fifty-third World Health Assembly that were related directly to other items on the agenda had been annexed to the documents covering those items.

He drew the attention of the Committee to the operative paragraphs relating to activities that Member States in the Western Pacific Region could undertake to implement the resolutions

With regard to the resolution on the International Decade of the World's Indigenous People, the Regional Committee was asked to consider whether the Region should develop a regional action plan on the health of indigenous people.

The second resolution covered in the document concerned the Framework Convention on Tobacco Control. He recognized that the issue was of great interest to many Member States in the Region, and he appreciated their request that the topic receive special attention at the current session. At the previous session, the Regional Committee had urged Member States to promote and fully support the proposed convention. Several countries from the Region had been actively involved in the two global working groups on the convention, and the Regional Director was aware that the concern of Member States was particularly important in light of the meeting of the Negotiating Body on the Convention to be held in October 2000.

The third question mentioned in the document was infant and young child feeding. The topic had been discussed at the Fifty-third World Health Assembly in May 2000. As a result of that discussion, WHO Headquarters had prepared a briefing note on a new global strategy for infant and young child feeding. The note was contained in document WPR/RC51/INF.DOC./1. The Committee was asked to comment on the briefing note; its views would be forwarded to WHO Headquarters.

The provisional agenda for the 107th session of the Executive Board in January 2001, contained in document, WPR/RC51/INF.DOC./2, was also provided for information. The Committee would note that the proposed global strategy for infant and young child feeding was among the items listed for discussion.

The CHAIRPERSON invited comments on the first area, the health of indigenous people.

Dr MATHESON (New Zealand) supported the view that the Regional Committee should play an active role in the development of a regional action plan for the health of indigenous people. New Zealand endorsed the concept set out in resolution WHA53.10 that WHO activities relevant to indigenous people be undertaken in close partnership with indigenous people. It would support Regional Office efforts to ensure that the voice of indigenous people in the Region was heard in the development of a global plan of action.

The Chairperson invited comments on the second area, the Framework Convention on Tobacco Control.

Ms CHUNG (United States of America) said that the forthcoming meeting of the Negotiating Body for the proposed Framework Convention on Tobacco Control provided an opportunity for the development of a plan of action that would lead to the Framework Convention itself. WHO should be given strong support in its first efforts at treaty-making.

The United States of America had developed control measures and anti-tobacco legislation that were among the strongest in the world and, over the past four decades, public health controls had been effective in reducing smoking rates by 45%. As a consequence, the public health burden resulting from tobacco use had also declined.

The United States delegation to the Negotiating Body meeting would represent a variety of government agencies and she hoped that other countries would work across the sectors to develop well-informed positions on the range of issue to be considered and would also send multisectoral delegations to the meeting.

She looked forward to the successful negotiation of a strong Framework Convention and related protocols that could be signed and implemented by as many countries as possible. That was an extraordinary opportunity to secure a solid agreement that challenged governments to take coordinated and compatible steps to reduce the harmful effects of tobacco. The Western Pacific Region was clearly among the most affected, as smoking rates in the Member countries were among the highest in the world.

Professor MATHEWS (Australia) reiterated his country's support for the proposed Framework Convention. Australia would be happy to support Member States in developing strong regional support and in contributing to the development of the convention.

The Chairperson asked for comments on the third area, infant and young child feeding.

Dr OTTO (Republic of Palau) said that, given that malnutrition affected first and foremost infants and young children and that breast-feeding was essential to infant and young child feeding, the Committee should express its support for the proposed global strategy. Bearing in mind the commitments made by the Heads of State attending the Millennium Summit, the Committee should also urge the Executive Board to accelerate action on the development of the strategy. Steps should include: the revitalization of the baby-friendly hospital initiative, which had had a very positive impact in the Region and could be expanded; the promotion of exclusive breast-feeding, urging full implementation of related resolutions WHA47.5 and WHA49.15; improvement in timely complementary feeding as recommended by the March 2000 WHO/UNICEF Technical Consultation consensus statement; and strengthening of implementation of the International Code of Marketing of Breast-milk Substitutes. The urgency was such that action should not wait for the full global strategy to be spelt out in 2002. The action points he had mentioned were covered in the briefing note. He urged the Committee to recommend to the Executive Board that, at its 107th session, it should draft an appropriate resolution for submission to the Fifty-fourth World Health Assembly, as requested in the relevant decision adopted at the previous Health Assembly.

Ms CHUNG (United States of America) welcomed the supplementary information provided in document WPR/RC51/INF.DOC./1 on action undertaken to further the development of a global strategy on infant and young child feeding. Building awareness and the commitment of the global community to alleviating malnutrition, strengthening food and nutrition surveillance systems and ensuring adequate nutrition of infants born to HIV-positive mothers were all essential for the overall improvement of infant and young child nutrition.

However, the documents provided did not cover the requests made by the Fifty-third World Health Assembly that: a draft resolution submitted by Brazil should be referred to the Executive Board for consideration at its 107th session; Member States who were not Executive Board members could participate in drafting meetings on the draft resolution held during the session; and the Regional Offices should be encouraged to elicit in-depth technical and scientific discussion on the issue of infant and child nutrition through Regional Committee sessions and other meetings. In-depth technical and scientific discussions were appropriate occasions for the exchange of science-based ideas and policy perspectives among multilateral agencies and experts. Member States should work

together to ensure that the debate was not restricted to WHO's current guidelines on exclusive breast-feeding, as there were other critical aspects of child nutrition, for example, a better understanding of the costs and benefits to mothers and infants of the biological, behavioural and social outcomes of breast-feeding and identification and promotion of large-scale public health interventions to promote exclusive breast-feeding and the appropriate introduction of complementary foods. More effective strategies were needed to tackle the continuing challenges of malnutrition and micronutrient deficiencies through a better understanding of cultural practices and community-based approaches. The discussions must be based on sound science and reliable data.

The Regional Office should be encouraged to facilitate a dialogue among Member States on the draft resolution prepared by Brazil. Member States who were members of the Board should ensure that the Board's debate was grounded in science and would help delineate key elements for a global strategy.

Dr KIENENE (Kiribati) welcomed the briefing note provided. He hoped that any discussions would take into account the use of wet nurses for breast-feeding of infants, in particular in emergencies and where HIV/AIDS was a major problem.

The DIRECTOR, PROGRAMME MANAGEMENT said that he had taken note of the views of the representative of New Zealand in relation to the health of indigenous people and would act on them. The Regional Office planned to work closely with Headquarters in developing a global framework to improve the health of indigenous people and, once that was in place, would move on to develop a regional plan of action. A major meeting had been convened earlier in the year at WHO Headquarters, which had involved a large number of indigenous people's organizations, and further participation of such organizations, including those from the Region, was anticipated as the work progressed.

The comments made in relation to infant and young child nutrition would be passed to the Director-General. The decision taken by the Fifty-third World Health Assembly, referred to by the representative of the United States of America: reaffirmed the importance attributed to WHO activities related to that issue; welcomed the draft resolution proposed by Brazil; requested the Director-General to include the item on the agenda of the 107th session of the Executive Board; further requested that the Board establish a drafting group during the session, which should be open all Member States, not just those who were members of the Board, to prepare a draft resolution based on the Brazilian proposal for consideration by the Board with a view to subsequent submission to the Fifty-fourth World Health Assembly; and encouraged discussion of the topic, including the draft resolution and amendments received, at the Regional level, including at the following sessions of the

Regional Committees, with a view to gathering the broadest possible range of inputs prior to the discussion at the following Health Assembly.

WHO Headquarters had developed a timetable for the development of the proposed global strategy on infant and young child feeding and, together with UNICEF, proposed to convene a joint regional meeting early in 2001, to which regional experts would be invited, to discuss the draft strategy and solicit views from the Region. The revised drafts would be circulated to Member States and other interested parties for information and feedback.

The meeting rose at 5.05 pm.