SUMMARY RECORD OF THE SEVENTH MEETING

WHO Conference Hall, Manila
Friday, 12 September 1980 at 9.00 a.m.

CHAIRMAN: Mr J. Jaminan (Papua New Guinea)

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1. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolutions:

1.1 Reimbursement of travel costs of representatives to regional committees (Document WPR/RC31/Conf. Paper No. 5)

Decision: The draft resolution was adopted without comment (see resolution WPR/RC31.R14).

1.2 Seventh General Programme of Work covering a specific period (1984-1989) (Document WPR/RC31/Conf. Paper No. 15)

Dr MINNERS (United States of America) proposed that, in order to convey the Committee's feeling as to the importance of the Seventh General Programme of Work, a phrase along the following lines should be added immediately before operative paragraph 1: "The Regional Committee notes that the Seventh General Programme of Work is very strongly related to strategies to achieve health for all and should effectively guide the Organization's resources towards this priority objective".

Dr NICHOLSON (United Kingdom of Great Britain and Northern Ireland) supported that proposal.

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC31.R15).

1.3 Health 2000 Resources Group (Document WPR/RC31/Conf. Paper No. 16)

Dr SENILAGAKALI (Fiji) proposed that the word "elects" should be substituted for "nominates" in the operative paragraph.

Dr ACOSTA (Philippines) preferred the word "nominates".

Dr GENTILE (France) supported the proposal of the representative of Fiji.

Dr CHRISTMAS (New Zealand), on a point of procedure, asked whether adoption of the resolution would mean that the Committee would need to hold a formal election of a member of the Health Resources Group every three years.

Dr VIGNES (Director, Legal Division, WHO Headquarters) said that that procedure would not necessarily be permanently binding. It would always be possible for the Committee to change its method of selection in three or four years' time.

The CHAIRMAN noted that there was a majority in favour of the proposal by the representative of Fiji.

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC31.R17).
1.4 **Provisional agenda of the sixty-seventh session of the Executive Board** (Document WPR/RC31/Conf. Paper No. 17)

Decision: The draft resolution was adopted without comment (see resolution WPR/RC31.R18).

1.5 **Resolutions of regional interest adopted by the Thirty-third World Health Assembly** (Document WPR/RC31/Conf. Paper No. 18)

Decision: The draft resolution was adopted without comment (see resolution WPR/RC31.R19).

1.6 **Regional programme for disability prevention and rehabilitation** (Document WPR/RC31/Conf. Paper No. 19)

Dr CHRISTMAS (New Zealand) fully supported the resolution but had some reservations as to the use of the phrase "by way of primary health care" in operative paragraph 1. It was true that a primary health care system could contribute substantially to educational programmes on disability prevention, but most rehabilitation programmes required complex and sophisticated training centres, often attached to hospitals, which could provide specialized care. In many countries, disability prevention was the responsibility of a central organization dealing with health education. He therefore proposed that the phrase "by way of primary health care" should be deleted.

Dr RIDINGS (Samoa) supported that proposal. It was important not to adhere too slavishly to the concept of primary health care as the main means of achieving health for all. Secondary health care could also make an important contribution, and that fact should be admitted.

Dr SENILAGAKALI (Fiji) saw some merit in leaving the reference to primary health care in the draft resolution. He proposed that in the first line of the first operative paragraph, the phrase "primary health care" should be added before "programmes" and that in the second line the phrase "by way of primary health care" should be deleted. Primary health care had become a key element in the attempt to attain health for all by the year 2000, and was useful as a means of attracting public attention and raising funds.

Mr VAUGHN (Australia) said it would be possible to include a reference to primary health care while still taking account of the criticisms made by the representatives of New Zealand and Samoa. He proposed that the phrase "including, where appropriate" should be added after "rehabilitation" in the second clause of the first operative paragraph.

Dr CHRISTMAS (New Zealand) supported that proposal. He had not intended to imply that primary health care was not a significant contributor to health services, but the paragraph as now worded implied that all efforts made towards disability prevention and rehabilitation should be at primary health care level, which was not likely to lead to an efficient programme.
Dr MINNERS (United States of America) supported the proposal of the representative of Australia. Referring to sub-paragraph (2) of operative paragraph 2, and in fact to this type of operative paragraph in all the resolutions, it was his understanding that the support provided would be within the limitations of resources now available, or of such extrabudgetary resources as could be arranged; there would be no question of an increase in the budget.

Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC31.R20).


Decision: The draft resolution was adopted without comment (see resolution WPR/RC31.R21).

1.8 Development of health research (Document WPR/RC31/Conf. Paper No. 21)

Dr MINNERS (United States of America) noted that the title of the draft resolution was "Development of health research", whereas the title of the agenda item, which was longer, referred to "biomedical and health services research". The change in the title of the draft resolution was no doubt intentional and he thought that it made good sense. He suggested that the phrase "and in particular those relating to career structures in research" should be added to operative paragraph 3.

Asked by Dr CHRISTMAS (New Zealand), why he wished to introduce that change, Dr Minners explained that the subheading, in parentheses, of document WPR/RC31/23 made reference to "research strengthening and career structures". He believed that some or all strengthening of research would be lost if those so strengthened returned and had no opportunity of a career in research. There was thus a reciprocal relationship between strengthening research capability and strengthening career opportunities.

Dr NICHOLSON (United Kingdom of Great Britain and Northern Ireland) seconded the amendment moved by the representative of the United States of America.

Dr PAIK (Chief, Research Promotion and Development) explained that the change of title from "biomedical research" to "health research" was intentional, because many members of the ACMR were in favour of the latter term. Furthermore, that term had been used in the document on the medium-term programme for research promotion prepared by WHO Headquarters. "Health research" now included conventional biomedical research, health research, and the new concept of health behavioural research.

Decision: The draft resolution, as amended, was adopted without further comment (see resolution WPR/RC31.R22).

1.9 Acute respiratory infections (Document WPR/RC31/Conf. Paper No. 22)

Decision: The draft resolution was adopted without comment (see resolution WPR/RC31.R23).
1.10 Development of the regional mental health programme (Document WPR/RC31/Conf. Paper No. 23)

Decision: The draft resolution was adopted without comment (see resolution WPR/RC31.R24).

1.11 Biennial World Health Assemblies (Document WPR/RC31/Conf. Paper No. 14)

Mr VAUGHN (Australia) read out resolution WPR/RC31.R4 adopted by the Regional Committee at its current session which, as requested by Dr Acosta (Philippines), was being placed before the Regional Committee at the same time as the draft resolution tabled by the Delegation of Australia contained in document WPR/RC31/Conf. Paper No. 14. In the view of the Australian delegation, biennial health assemblies would require the role of the regional committees to be strengthened. The Australian draft resolution did not contradict, but reinforced, resolution WPR/RC31.R4. He then read out the draft resolution before the Committee.

In reply to a question from Dr ACOSTA (Philippines), the REGIONAL DIRECTOR said that the final text of resolution WPR/RC31.R4 incorporated the revision recommended by the Sub-Committee on the General Programme of Work (WPR/RC31/16 Corr.1).

Dr ACOSTA (Philippines) said that, though he did not question the value of the draft resolution proposed by Australia, he doubted the advisability of adopting, at the same meeting, two resolutions expressing different degrees of concern about the same subject. In his opinion, the two resolutions needed to be combined.

Dr VIGNES (Director, Legal Division, WHO Headquarters) pointed out that resolution WPR/RC31.R4 had already been adopted, and therefore could not be incorporated into a draft resolution unless it had been rediscussed by the Committee and a formal decision made to combine the two resolutions.

Dr RIDINGS (Samoa) considered that the Australian resolution could be regarded as separate, merely giving added emphasis to a very important subject.

Dr MINNERS (United States of America) could see no objection to two resolutions being considered on the same subject. There were ample precedents.

Dr ACOSTA (Philippines) stated that he had not made a formal proposal, only an observation.

Decision: The draft resolution was adopted without further comment (see resolution WPR/RC31.R15).

1.12 Abuse of narcotic and psychoactive substances (Document WPR/RC31/Conf. Paper No. 24)

After Dr MINNERS (United States of America) had read out the resolution, Dr NICHOLSON (United Kingdom of Great Britain and Northern Ireland) congratulated him on an excellent initiative. The only change he would propose was the substitution of the word "detrimental" for the word "negative" in the first line of the fourth preambular paragraph.
Dr FOLIAKI (Tonga) proposed the deletion of operative paragraph 4, since what it suggested was normal administrative procedure.

Dr EVANS (Australia) could see no reason for the resolution at that juncture. Alcohol caused far more problems in the Region and drug abuse was still of minor importance. Moreover, it had already been mentioned in the resolution on the regional mental health programme. Operative paragraph 3 was unrealistic, as no country in the Region could provide hard statistics, only guesses.

Dr KOH (Singapore) disagreed strongly and fully supported the United States resolution. There was no more objection to having references to drug abuse in two different resolutions than to having two resolutions on biennial health assembles. Drug abuse was a considerable problem in Singapore and some other countries in the Region. He could furnish reliable statistics on drug abuse cases in Singapore.

The REGIONAL DIRECTOR said that he had been delighted when the United States had proposed submitting a draft resolution on abuse of narcotic and psychoactive substances because it gave him some hope of attracting extrabudgetary funds from that country and other industrialized countries to help combat what was becoming a major problem in newly developed and even in some developing countries. The Region possessed great expertise on matters of drug abuse. Regular budget funds had to go to the alcohol programme, however, since alcoholism was in general a greater problem in the Region.

Decision: After incorporation of the two proposed amendments, the draft resolution was adopted (see resolution WPR/RC31.R25).

2. CONTROL OF MALARIA IN THE WESTERN PACIFIC REGION: Item 26 of the Agenda (Document WPR/RC31/26)

Dr CHRISTMAS (New Zealand), introducing the item at the invitation of the CHAIRMAN, said that although New Zealand was a protected country, the only cases of malaria being those imported – mostly by New Zealand nationals returning from malarious areas abroad – the Government was concerned about the need for a concerted effort by countries of the Region to stop the recrudescence of the disease in some of them, where the vectors were on the increase, and to control the danger represented by growing traffic between countries.

It was proposed therefore that greater priority should be given to malaria control in the Region, and that guidelines should be established by the Regional Office for general prevention and control, with emphasis on chemoprophylaxis.

Dr KOH (Singapore) said that the report was most timely, in view of the resurgence of malaria in many countries. Singapore was in a very vulnerable position, and the risk was increased by the influx of workers from malarious areas, including some from further away than before, as could be seen from Annex 1 to the report. The cooperation with Malaysia in
intercountry border meetings was valued, as well as other joint activities for prevention and control. Thus far it had been possible to keep the disease at bay; there had been no indigenous cases in recent years, but continuous vigilance was necessary to prevent deterioration of the situation.

Dr DIZON (Philippines) noted that his country was not among those listed in Annex 1 to the document, presumably because most traffic was between major cities, and in the Philippines these were malaria-free. However, there were malarious areas, and he supported the proposal that travel agencies and organizations might be involved in measures for preventing the import or export of malaria.

The population at risk in the Philippines was 15 million; with some 40% in the attack phase and another 40% in the maintenance phase. Insecticide spraying was limited to areas of continuous transmission, and areas of low transmission were covered by the general health services. Malaria morbidity and mortality had fallen considerably in 1979 and the first half of 1980, and considerable efforts were being undertaken to maintain the gains achieved.

Dr TALIB (Malaysia) confirmed that cooperation with Singapore was close; intercountry border meetings were also held with Thailand and Indonesia in the South-East Asia Region of WHO, but the borders with those neighbouring countries were very long and it was difficult to control transmission between them, especially at unofficial entry points. WHO's guidance was therefore sought on additional measures for control.

Since 1968, up to which time control had been limited to the larval form of the vector, attack measures against the adult mosquito had reduced the incidence of malaria to about 5% of the original level; but the situation was now stationary.

Dr DA PAZ (Portugal) said that malaria had recently been eradicated in the territories under Portuguese administration including Macao, and there was now a surveillance system; but the same problems were being faced as in Singapore. Portugal would be happy to share its experience with countries of the Region.

Mrs KHO VANI (Democratic Kampuchea) thanked New Zealand for having placed the item on the agenda. Malaria was still endemic in Democratic Kampuchea. Between 1975 and 1978, during the liberation, the Government had made tremendous efforts to eradicate malaria, but as a result of foreign aggression the people had fled to unsanitary forest and mountainous areas, and the situation had again become very serious. During the 1979 rainy season thousands of people already weakened by hunger had died of malaria, and during the present rainy season there had been new outbreaks of the disease and chloroquine resistance had been noted. The Government had made tremendous efforts to solve the problem and some fifty medical centres had been established in all the liberated zones of the country. There was, however, a lack of medicaments, and some 90 to 95% of the population was at risk. In view of the lack of technical and financial resources, the Government had appealed to WHO to provide help as soon as possible.
The CHAIRMAN (speaking as the representative of Papua New Guinea) said that some doubt had risen in Papua New Guinea about the effectiveness of malaria control programmes.

Dr TURNER (United States of America) said that, fortunately, American Samoa, Guam and Trust Territory of the Pacific Islands did not have a malaria problem. In view of large-scale international air travel, however, it was essential to maintain surveillance, and the Government of the United States would be pleased to participate if WHO developed a surveillance programme for the Western Pacific Region.

Dr NICHOLSON (United Kingdom of Great Britain and Northern Ireland) referred to Annex 2 to the document - in particular, prophylaxis for non-immunes. He noted that the combination of sulfadoxine or sulfalene and pyrimethamine was not recommended for prolonged use, and asked whether that was on account of teratogenic effects. He also noted that pyrimethamine or proguanil were recommended for use in areas where P. falciparum was not chloroquine-resistant; he asked whether any local resistance to those compounds had been noted in the Region. He also asked whether it was not true that a combination of a sulfonamide and pyrimethamine, whilst very effective against P. falciparum, was less effective against P. vivax. In areas where there was both chloroquine resistance and a high P. vivax incidence was the sulfonamide and pyrimethamine combination sufficient, or should either chloroquine or proguanil be taken against P. vivax?

Dr DIZON (Philippines) said that at the first meeting of Ministers of Health of ASEAN countries it had been urged that border conferences should be held to discuss specific health problems. The Philippines would be pleased to cooperate in any border conferences that might be called regarding malaria transmission.

Dr CHANG (Republic of Korea) referred to the statement contained in section 2.3 of the document regarding malaria in the Republic of Korea. He said that, although malaria had been endemic in the Republic of Korea before the Second World War, there had been no cases since 1968, and an intensive surveillance programme had been carried out with technical cooperation from WHO. The disappearance of malaria was probably attributable partly to improved living and sanitary conditions and partly to the use of pesticides in agriculture.

Dr EVANS (Australia) appreciated the suggestion made by the representative of New Zealand regarding the production of pamphlets concerning prophylaxis and treatment. Strict adherence to the International Health Regulations regarding vector control at airports would contribute greatly to malaria control, and the spraying of aircraft before landing would also help to control the spread of vectors.

Mr MILENG (Papua New Guinea), referring to Annex 1 to the document, noted the very high proportion of imported cases of malaria coming from Papua New Guinea. A WHO-assisted programme for malaria control was under way in Papua New Guinea, but chloroquine resistance had been noted, and there were also financial problems. Further cooperation from WHO would be welcomed.
Dr VAN DIJK (Regional Adviser in Malaria) said that the most important measure for the entire anopheline-free part of the South Pacific would be the prevention of importation of vectors through appropriate measures at airports and international ports, as the representative of Australia had mentioned. It was equally important for the non-malarious areas to be updated regarding the diagnosis and treatment of imported malaria cases and given appropriate advice on prophylaxis for departing travellers.

Replying to the representative of the United Kingdom, he said the combination of sulfadoxine and pyrimethamine was known as Fansidar and the combination of sulfalene with pyrimethamine was known as Metakelfin. Maloprim - a combination of dapsone and pyrimethamine - was not included in the table. As far as was known, those drugs seemed equally effective. So far as P. vivax was concerned, they seemed to be effective for prophylaxis, though perhaps not for treatment. Owing to the side-effect of suppression of the bone marrow function, they were not recommended for use for more than half a year - which would in fact cover virtually all international travel.

Reference had rightly been made to the role of the airlines and travel agents, although the latter might be reluctant to emphasize that certain countries were malarious. An announcement might, for example, be made during flights that a malarious area was being entered, and prophylactic measures could be described.

Annex 1 was not intended to be exhaustive. It indicated, however, that a large proportion of imported cases came from neighbouring countries. Hence the importance of coordination of antimalarial measures along common borders, including epidemiological studies of imported cases. A number of border coordination meetings had been held regularly, and the collaboration had been valuable.

Even in countries where good progress had been made with antimalaria programmes, there were areas where it had been less satisfactory, especially where considerable population movements created residual foci of resistance. A certain flexibility was required in such cases, and he was pleased to note that such flexibility had been introduced in the programme in Malaysia.

Dr PAIK (Chief, Research Promotion and Development), replying to the representative of the United Kingdom, said that resistance of some local strains of P. falciparum to pyrimethamine had already been noted in Solomon Islands in 1973.

The REGIONAL DIRECTOR, referring to international travel, stressed the difficulties arising from the fact that malaria was not considered to be a quarantinable disease. Airline companies had not been cooperative, despite resolutions adopted by the Health Assembly on the subject; nor had the International Civil Aviation Organization taken up the subject seriously. The lack of cooperation from the airlines was due to economic reasons; spraying of aircraft needed to be carried out before departure - involving considerable delay and, hence, cost. Moreover, an announcement that the aircraft was entering a malarious area might well frighten passengers.
Dr CHARPIN (France) questioned the effectiveness of the spraying of aircraft, and stressed the importance of health education of the public regarding malaria, through primary health care programmes.

Dr SELF (Responsible Officer, Vector Biology and Control) recalled that some six years ago there had been a regional resolution dealing with airport sanitation and aircraft disinsection. WHO had provided guidance on safe aerosols to use inside aircraft. At first those aerosols had included DDT, but there had then been a change to pyrethoid compounds and eventually to a chemical known as D-Phenothrin. Indications were that, if properly used, the latter was both safe and effective.

It was recommended that the spray should be used in aircraft after the doors were closed and before take-off. That recommendation had caused problems, because it meant that disinsection could not be carried out by quarantine officials of the country of departure and had to be carried out on arrival, often not very effectively. WHO was doing its best to combat that problem and had received useful advice, notably from Australia and New Zealand, on improved methods. One possibility was the use of a residual spray during servicing. Efforts were being made to improve vector control at airports, and also in areas where there was a primary health care network, notably by having the community participate in larval control.

In answer to a question from Dr Senilagakali (Fiji), he said that aircraft doors should remain closed for at least five minutes after spraying.

Dr SENILAGAKALI (Fiji) said that, from his observations, it appeared that quarantine measures at airports were not stringent enough. Fiji was free from malaria vectors but still maintained surveillance.

Dr RIDINGS (Samoa) said experiments being carried out on residual spraying had given encouraging results. He was sure that that method would provide the answer to the problem.

Noting that there were no further comments, the CHAIRMAN asked the Rapporteurs to prepare a suitable draft resolution. (For consideration of the draft resolution, see the eighth meeting, section 2.1).

3. CONTROL OF TUBERCULOSIS IN THE WESTERN PACIFIC REGION:
Item 27 of the Agenda (Document WPR/RC31/27)

Dr CHRISTMAS (New Zealand) said all would agree that tuberculosis was one of the major public health problems of the Region. A number of countries had made considerable advances in the control of the disease, but others had made less progress. The purpose of the paper (document WPR/RC31/27) was to highlight a disease that had been known for centuries...

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but which was still prevalent. Unlike malaria, there was not the problem of a vector; efficient methods of diagnosis and treatment existed, and measures had been introduced via the primary health care network which should make it possible to eradicate the disease as effectively as had been done with smallpox. He urged all countries of the Region to cooperate in a determined effort to control, if not to eradicate, tuberculosis by the year 2000. Those countries which had more advanced or effective control programmes should work more closely with their neighbours in that effort, by means of sharing services and expertise and by a series of sub-regional control programmes. WHO should be asked to facilitate the effort, which would be in keeping with the proposal regarding the future functions of world health over the next two decades.

Dr RIDINGS (Samoa) said his country was grateful, both to New Zealand and to WHO, for their help in tuberculosis control programmes. It was important that there should be technical cooperation between countries of the Region, because although Australia and New Zealand had managed to control the disease, they suffered from constant re-infection. The final aim should be to eradicate tuberculosis in the area.

Dr XU SHOUREN (China) said that tuberculosis was a serious health problem in the Region and he appreciated the Government of New Zealand's initiative. In the past three years there had been improvements in the prevention and control of the disease in China. Three national conferences had been held on control and treatment, and there had been a number of research seminars. National criteria had been established and nationwide programmes launched. A survey, involving random sampling of various population groups, had been carried out in counties and provinces, covering 880 locations and 1.5 million people. The survey had taken six months to prepare and a year to carry out. 3000 people had been organized into more than 200 teams; 95% of the population had been covered and the margin of error was as low as 5%. Work was now proceeding on the analysis of the results of the survey. In the choice of methods used to conduct the survey, particular attention had been paid to sputum examination. All methods were in conformity with the standard control methods laid down by the Western Pacific Region. Short-term chemotherapy, the identification of strains, and research on drug resistance had been carried out. China's intention was to cooperate with other countries in research and training and in the exchange of experience.

He suggested that the criteria for the evaluation of tuberculosis control should include the morbidity rate. Case-finding and guaranteed treatment for identified cases should also be stressed.

Dr TANAKA (Japan) said tuberculosis control had been discussed at the last Health Assembly and a resolution (WHA33.26) adopted. His Government had been paying great attention to the issue, notably its health manpower development component. In collaboration with WHO, it had established training courses for different categories of workers. Advanced group training courses in tuberculosis control were designed for higher-level administrators engaged in the operational and epidemiological aspects of the work, which it was hoped would strengthen the impact of nationally-controlled programmes in developing countries. One group training course
was designed for physicians who were key organizers of national programmes, and another for senior technicians and doctors with experience in laboratory work in bacteriology. The course included work in essential clinical laboratory techniques and the general strategy of tuberculosis control. The courses were conducted in English by the Research Institute of Tuberculosis of the Japan Anti-Tuberculosis Association in Tokyo. They represented a cooperative effort between multilateral and bilateral organizations which he was sure would help to improve the quality of tuberculosis control programmes in most developing countries.

Dr TABLAN (Philippines) said that, as a demonstration of its determination to combat tuberculosis, her country had accelerated its national tuberculosis programme, particularly in the rural areas. Crash programmes of one or two months had been introduced in certain areas, making use of all available personnel and resources. Targets for BCG vaccination case-finding had been increased by sputum microscopy, and subsidized treatment of infectious sputum-positive cases with a two-drug regimen for a year introduced. Economic constraints precluded the use of short-course chemotherapy on a nationwide basis. BCG vaccination was part of a package deal including compulsory basic immunization of Filipino children up to 8 years. The vaccination target was 6 million per year for the next three years, as part of the expanded programme on immunization carried out by rural health service teams. The managerial aspects were covered by the National Institute for Tuberculosis which dealt with training and research. A survey was to be made the following year, with WHO's cooperation, to assess the impact both of past efforts and of the current year's accelerated programme, which it was hoped would produce updated epidemiological information on which to base new targets and strategies.

Her delegation appreciated the new call to fight tuberculosis spearheaded by New Zealand. The Philippines expected to implement its tuberculosis control programme at community level the following year, via the medium of primary health care.

Dr PALACIOS (United States of America) said that the emphasis on management aspects in the report was commendable. The United States delegation wished to emphasize that tuberculosis could only be controlled through efficient case-finding, treatment and interruption of transmission.

This had been achieved in the Northern Marianas with its population of 16 500 living on four small islands, where, if a period of eight years could be considered sufficient, tuberculosis was eradicated. He was willing to share the experiences gained with interested representatives.

Dr FOLIAKI (Tonga) said that the disease was still a major public health problem in Tonga, in spite of the control programme and BCG vaccination. WHO was also cooperating in related training, and the regional tuberculosis team was currently in Tonga. The Government was keen to support any move to strengthen control, and he assured the representative of New Zealand of its support for the initiative he proposed.
Dr SENILAGAKALI (Fiji) said that tuberculosis was no longer a problem in his country, although it had been a major problem 20 years earlier. An immunization programme, radiodiagnosis and chemotherapy had had their effect.

He urged the Secretariat to intensify control activities, which he felt had relaxed, in order to prevent the disease from becoming a new major threat in the Region. He suggested that a regional collaborating centre should be established, and that exchange of information should be promoted.

Dr EVANS (Australia) sought support for continuation of BCG vaccination in the Region, where he said the findings of the trial in India, tending to show the inefficacy of such vaccination, as reported in the Lancet and elsewhere, did not apply. Other studies indicated that the conditions were peculiar to a given region.

Dr ENDO (Regional Adviser in Chronic Diseases) said that the remarks of representatives had been noted, and spoke of the collaborative efforts of all countries of the Region in the programme according to the policies recommended by WHO; the accumulated experience had been reported in the World Health Assembly and the Executive Board, as well as in the Regional Committee. A regional meeting of research workers and tuberculosis control officers was planned, to discuss further development of the programme. The regional tuberculosis control team was unique to the Western Pacific, and its services had been widely appreciated.

The BCG trial in southern India conducted jointly by the Indian Council for Medical Research, the United States Public Health Service and WHO had failed to show the effectiveness of BCG to prevent pulmonary tuberculosis. WHO study groups had concluded that the results of the trial reflected an epidemiological situation peculiar to the area, which had a high prevalence of atypical mycobacterial infection - giving some protection and diminishing BCG effectiveness - and low virulence of bacilli, with low incidence of tuberculosis among newly infected persons. Furthermore, the study had not been designed to measure protection against childhood tuberculosis. It was therefore recommended that the results of the trial should not be extrapolated to other areas, and that WHO should continue to apply the policies recommended by the last Expert Committee on Tuberculosis, however adjusting them according to the changing epidemiology in individual countries. The Regional Director had attached importance to forming a regional study group for the adaptation of policies accordingly. The group had reviewed policies in almost all countries of the Region and sent experts to investigate their epidemiological situations in relation to BCG vaccination. The evidence suggested that it was effective, although some data were weak or inconclusive. An overwhelming majority believed that BCG was effective, and that the WHO policy should continue to be applied. Even so, the target age group should be adjusted according to the situation when the prevalence of tuberculosis declined further, and a mechanism should be established for the collection of relevant information on type of disease by age-group in relation to vaccination, on cost, and on serious complications.
Tuberculosis prevalence would decrease with improved socioeconomic conditions, but specific control measures certainly accelerated the decrease. It would probably, as stated in the report, be two decades before tuberculosis ceased to be a significant public health problem.

He looked forward to continued cooperation with Member States, and said that the suggestion of the representative of Fiji concerning establishment of a collaborating centre in the Region deserved careful attention. He stressed that cooperative programmes between Member States should follow the principles recommended by WHO and be integrated with general health services, avoiding direct application of the sophisticated methods used in more developed countries.

Noting that there were no further comments, the CHAIRMAN asked the Rapporteurs to prepare a suitable draft resolution. (For consideration of the draft resolution, see the eighth meeting, section 2.2).


The CHAIRMAN explained that the document before the Committee contained suggestions by the Secretariat, but representatives were free to suggest other topics or to select the topic that would be discussed at the Thirty-fifth World Health Assembly following the thirty-second session of the Regional Committee.

Dr DIZON (Philippines) said that, while all four suggested topics were significant for the Region, his delegation felt that the Expanded Programme on Immunization was perhaps of the greatest importance, since communicable diseases were still a major problem. His own country was implementing an expanded programme on a nationwide scale and it would be happy to exchange experience with other countries during the 1981 Technical Presentation.

Dr SENILAGAKALI (Fiji) thought that, in view of the forthcoming International Drinking-Water Supply and Sanitation Decade, the most pertinent topic would be "Health education and rural water supply and sanitation". The scope for discussion offered by the health education component of the topic was very wide and would dovetail neatly with the subject they would be discussing that very afternoon.

Dr CHRISTMAS (New Zealand) said that all the topics were important and the idea of discussing the topic of the Thirty-fifth World Health Assembly's Technical Discussions also had merit, but he would suggest "Health needs of the disabled" as the most appropriate, in view of the fact that 1981 was the Year of Disabled Persons.

There being no other proposals, the CHAIRMAN put the question of the topic for the Technical Presentation to the vote.

Decision: "Health education and rural water supply and sanitation" was selected as the subject for the Technical Presentation during the thirty-second session of the Regional Committee.

The CHAIRMAN asked the Rapporteurs to prepare a suitable draft resolution. (For consideration of the draft resolution, see the eighth meeting, section 2.3).
5. **TIME AND PLACE OF THE THIRTY-SECOND AND THIRTY-THIRD SESSIONS OF THE REGIONAL COMMITTEE: Item 30 of the Agenda**

The REGIONAL DIRECTOR said that, at the thirtieth session, the Regional Committee had accepted the invitation of the Government of the Republic of Korea to hold its thirty-second session in Seoul. At that time, the Government of China had expressed a reservation. He was pleased to report that the Government of the Republic of Korea had confirmed its invitation in a letter dated 29 August 1980. He suggested that the dates of the session should be 22 September to 28 September 1981.

As far as the thirty-third session was concerned, the Committee would no doubt wish to abide by the decision that it had reaffirmed in 1973, that every second year its session should be held in Manila at regional headquarters.

Dr CHANG (Republic of Korea) said that his Government would take great pleasure in acting as host to the thirty-second session of the Regional Committee, as indicated in resolution WPR/RC30.R26. Appropriations and arrangements were already being made, with the collaboration of the Regional Office. A cordial invitation was extended by the Government and people of the Republic of Korea to all States in the Region, as well as to representatives of the nongovernmental organizations concerned.

Dr XU SHOUREN (China) reiterated the reservation his Government had expressed at the previous session of the Regional Committee as regards the venue for the thirty-second session.

Mr BOYER (United States of America) thought that time and money could be saved by holding Regional Committee sessions from Monday to Friday instead of from Tuesday to Monday. He therefore proposed that the thirty-second session should begin on Monday, 21 September 1981 and end on Friday, 25 September 1981. The Technical Presentation could be given on Friday morning, the afternoon being reserved for adoption of the report and for the closing ceremony. In 1979, when such a suggestion had been made, it had been argued that a shorter meeting would not allow summary records to be distributed in time for the closing ceremony. However, according to Rule 19 of the Rules of Procedure of the Regional Committee, minutes were to be distributed "as soon as possible after the close of the meetings". It was therefore not necessary to complete these documents for the final meeting. Also, some representatives at the present session could not stay until Monday, which showed that it was difficult for leading health professionals to take so much time. Furthermore, the cost of holding Regional Committee meetings had risen steeply - by as much as 311% in 1979, and the budget for 1982-83 showed a 100% increase over 1980-81.

Dr EVANS (Australia) agreed with part of the proposal made by Mr Boyer. When meetings were held in Manila, they should be held from Monday to Friday, which allowed adequate time for discussions. On the other hand, when Regional Committees were held in another country, that Member State might wish to show Representatives something of the work done in the country. Such sessions might therefore include a week-end.
Mr PECH BUN RET (Democratic Kampuchea) also expressed his Government's reservation against holding the thirty-second session of the Regional Committee in Seoul.

The REGIONAL DIRECTOR agreed with the representative of Australia. The custom of holding the Regional Committee over a week-end dated back to times when the Secretariat had been less experienced in organizing meetings and when WHO Headquarters had provided less support. However, when the Regional Committee was held in non-English-speaking countries, the task of the Secretariat was much heavier. He proposed that, as a compromise, Regional Committee sessions held in Manila should last from Monday to Friday or Saturday, but that, for the time being - and especially in the Republic of Korea, where the English-speaking secretariat might not be fully supported - the Committee should be held as proposed.

In view of the comments made, Mr BOYER (United States of America) did not press his point, since sessions in Manila were to be held from Monday to Friday.

Dr SENILAGAKALI (Fiji) agreed to Seoul as the venue for the next Regional Committee. Though the dates might not be suitable for some representatives who had a long way to travel, he felt that the dates proposed by the Government of the Republic of Korea should be respected.

In the absence of further comments, the CHAIRMAN asked the Rapporteurs to prepare a suitable draft resolution. (For consideration of the draft resolution, see the eighth meeting, section 2.4).

He regretted that pressing business in his country prevented him from attending the closure of the current session of the Regional Committee.

The meeting rose at 12.45 p.m.