



**REGIONAL COMMITTEE FOR THE WESTERN PACIFIC
SIXTY-THIRD SESSION
Hanoi, Viet Nam
24–28 September 2012**

FINAL REPORT OF THE REGIONAL COMMITTEE

**Manila
December 2012**



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PREFACE

The sixty-third session of the Regional Committee for the Western Pacific was held in Hanoi, Viet Nam, from 24 to 28 September 2012. Associate Professor Dr Nguyen Thi Kim Tien (Viet Nam) and Dr Mark Jacobs (New Zealand) were elected Chairperson and Vice-Chairperson, respectively. Dr Madeleine de Rosas-Valera (Philippines) and Dr Jean-Paul Grangeon (France) were elected Rapporteurs.

The draft meeting report of the Regional Committee is in Part III of this document, on pages 13 to 33.

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I. INTRODUCTION

The sixty-third session of the Regional Committee for the Western Pacific was held in Hanoi, Viet Nam, from 24 to 28 September 2012.

The session was attended by representatives of Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, Hong Kong (China), Japan, Kiribati, the Lao People's Democratic Republic, Macao (China), Malaysia, the Marshall Islands, the Federated States of Micronesia, Mongolia, Nauru, New Zealand, Niue, Palau, Papua New Guinea, the Philippines, the Republic of Korea, Samoa, Singapore, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu and Viet Nam, and by representatives of France and the United States of America as Member States responsible for areas in the Region; representatives from the United Nations Food and Agriculture Organization, the United Nations Children's Fund and the World Food Programme; representatives of 24 nongovernmental organizations; and observers from the Flour Fortification Initiative, GAVI Alliance, Hong Kong Economic and Trade Office, International Baby Food Action Network and the Chinese University of Hong Kong.

The resolutions adopted and decisions taken by the Regional Committee are set out below in Part II. Part III contains the report of the plenary meetings. The agenda and the list of participants are contained in Annexes 1 and 2.

An opening ceremony and cultural performance were held at the Hanoi Opera House. Remarks were made by the Minister of Health and the Vice President of Viet Nam as hosts of the event, the WHO Regional Director for the Western Pacific and the Chairperson of the sixty-second session of the Regional Committee. The Director-General of the World Health Organization delivered a video address (see Annexes 4 to 8).

II. RESOLUTIONS ADOPTED AND DECISION MADE BY THE REGIONAL COMMITTEE

WPR/RC63.R1 DRAFT PROPOSED PROGRAMME BUDGET 2014–2015 AND
DRAFT TWELFTH GENERAL PROGRAMME OF WORK

The Regional Committee,

Having examined the draft Twelfth WHO General Programme of Work and the Organization-wide draft Proposed Programme Budget 2014–2015 to be initially budgeted based on more realistic projections of income and expenditure;

Appreciating the presentation of the draft Proposed Programme Budget 2014–2015 grouped in six categories and according to the principles of results-based budgeting;

Commending the Secretariat's efforts to base strategic planning processes more firmly on individual countries' priorities and needs, and the agreed collective regional technical agenda, and to improve results-based management and accountability through the simplified and robust planning framework of the Twelfth WHO General Programme of Work,

1. THANKS the Secretariat for the comprehensive presentation of the Organization-wide draft Proposed Programme Budget 2014–2015 and the draft Twelfth WHO General Programme of Work 2014–2019;
2. APPRECIATES the commitment of the Secretariat to the continuous improvement of the draft Proposed Programme Budget;
3. REQUESTS the Regional Director:
 - (1) to convey to the Director-General the comments of the Regional Committee on the draft Twelfth WHO General Programme of Work and the Organization-wide draft Proposed Programme Budget 2014–2015, so that these comments can be taken into consideration when the Twelfth WHO General Programme of Work and the Programme Budget 2014–2015 are finalized by the Director-General and submitted to the global governing bodies;
 - (2) to present to the Regional Committee, at its sixty-fourth session, the Programme Budget 2014–2015, taking into account discussions at the sixty-third session of the Regional Committee, the 132nd session of the Executive Board and the Sixty-sixth World Health Assembly in 2013.

Fourth meeting, 26 September 2012

WPR/RC63.R2 SCALING UP NUTRITION IN THE WESTERN PACIFIC REGION

The Regional Committee,

Aware of the critical importance of good nutritional status in achieving public health and development goals;

Mindful that exclusive breastfeeding is the best source of nutrition in the first six months of life and that appropriate nutrition in the first years of life has a lasting effect on health, intellectual development, productivity and earning capacity;

Having considered the report on Maternal, Infant and Young Child Nutrition: Comprehensive Implementation Plan, resolution WHA65.6 on Maternal, infant and young child nutrition adopted in May 2012 and the United Nations General Assembly resolution 66/2 on the *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*;

Recalling the global and regional commitments for a world free of malnutrition and related deaths and disabilities, including: resolutions WHA30.51 and WHA31.47 on the role of the health sector in the development of national and international food and nutrition policies and plans; WHA46.7 on the follow-up action to the International Conference on Nutrition; WHA34.22 on the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions on infant and young child nutrition; Regional Committee resolutions WPR/RC44.R6 on Nutrition in the Western Pacific Region, WPR/RC46.R13, WPR/RC48.R8 and WPR/RC50.R10 on infant and young child nutrition and subsequent resolutions on noncommunicable diseases (NCDs);

Recalling that the Seventh Meeting of Ministers of Health for the Pacific Island Countries (2007) recognized that micronutrient deficiencies and other forms of undernutrition are public health problems in many Pacific island countries and areas, along with inappropriate nutrition, obesity and NCD, and considering the recommendations of the Pacific Food Summit and the Framework for

Action on Food Security in the Pacific, endorsed by Pacific island leaders at the 41st Pacific Islands Forum (Vanuatu, 2010),

1. ENDORSES this Call to Scale Up Nutrition in the Western Pacific Region, based on the WHO comprehensive implementation plan on maternal, infant and young child nutrition endorsed by the World Health Assembly in May 2012;
2. URGES Member States:
 - (1) to commit the resources needed to achieve by the year 2025 and as appropriate to each country's situation, the global targets endorsed at the Sixty-fifth World Health Assembly through resolution WHA65.6;
 - (2) to implement the measures recommended in the comprehensive implementation plan on maternal, infant and young child nutrition, considering country contexts;
 - (3) to ensure good coordination and alignment of national nutrition and food security programmes with NCD interventions and targets;
3. REQUESTS the Regional Director:
 - (1) to support countries in implementing the WHO comprehensive implementation plan on maternal, infant and young child nutrition;
 - (2) to strengthen collaboration with United Nations agencies and all other partners, through sustainable mechanisms, at regional and country levels, to scale up nutrition interventions, including food security;
 - (3) to report regularly on progress in achieving the targets.

Fourth meeting, 26 September 2012

WPR/RC6.R3 VIOLENCE AND INJURY PREVENTION

The Regional Committee,

Recognizing that Member States in the Region suffer a significant burden of violence and injuries resulting in millions of deaths and injuries with considerable social and economic costs to victims and families;

Acknowledging the efforts of Member States to adopt a public health approach that promotes national and community-based multisectoral actions to reduce all types of violence and injuries through advocacy, support for appropriate legislation and enforcement of laws and regulations, education, and establishment of trauma care systems and rehabilitation services;

Recalling resolutions WHA56.24 on Implementing the recommendations of the World report on violence and health; WHA57.10 on Road safety and health; WHA60.22 on Health systems: emergency-care systems; WHA64.27 on Child injury prevention; United Nations General Assembly resolutions 61/143 on intensification of efforts to eliminate all forms of violence against women and 64/255 on Improving global road safety; and resolutions WPR/RC48.R9 on Women, Health and Development and WPR/RC58.R2 on Progress Towards Achieving the Millennium Development Goals;

Realizing that road traffic injuries, falls, child injuries and violence against women and children account for the majority of violence and injuries in the Region and that concerted multisectoral action can result in reductions in violence and injuries,

1. URGES Member States:

(1) to establish or strengthen national and intersectoral coordination mechanisms for violence and injury prevention;

(2) to give high priority to the strengthening or development, implementation and evaluation of multisectoral national policy and action plans for violence and injury prevention;

(3) to strengthen or develop surveillance systems and coordinate data collection on violence and injuries among sectors—including health, transport, police, justice and social welfare—in order to obtain a better understanding of the burden, risk factors and consequences of injuries, so that programmes for prevention, care and rehabilitation can be better planned, monitored and evaluated;

(4) to strengthen their capacity to manage the consequences of violence and injuries along the continuum of trauma care, from the pre-hospital phase through hospital care to rehabilitation;

2. REQUESTS the Regional Director:

(1) to support Member States in their efforts to strengthen or develop and implement national policy and action plans to strengthen violence and injury prevention;

(2) to provide assistance in building technical capacity at all levels in order to strengthen the response to violence and injuries, including surveillance, evidence-based practice and evaluation;

(3) to facilitate sharing of best practices across sectors and countries, and to promote networking among international and regional partners, including nongovernmental organizations;

(4) to monitor progress made in the prevention of violence and injuries in the Region and report to the Regional Committee.

Sixth meeting, 27 September 2012

WPR/RC63.R4 REGIONAL ACTION PLAN FOR NEGLECTED TROPICAL DISEASES
IN THE WESTERN PACIFIC (2012–2016)

The Regional Committee,

Concerned that neglected tropical diseases (NTDs) remain a significant public health problem in the Region, especially affecting those living in poverty and in remote areas;

Recognizing the need to combine disease-specific plans into an integrated NTD framework;

Acknowledging the progress made by several Member States in reducing the NTD burden as a result of strong political commitment, improved access to preventive chemotherapy¹ and quality case management, and the integration of NTD control into health and education systems;

Aware of the continued high burden of NTDs in some countries;

Recognizing the need to consolidate success in leprosy, lymphatic filariasis and schistosomiasis programmes to meet the elimination goals, and the need to fill gaps in knowledge of the burden of trachoma and yaws in order to start elimination interventions;

Acknowledging the need to scale up national and regional interventions for soil-transmitted helminthiases and foodborne trematodiases;

Acknowledging the need for sustained funding for NTD interventions in endemic countries and areas;

Recognizing the importance of the Regional Action Plan for Neglected Tropical Diseases in the Western Pacific, in line with relevant World Health Assembly resolutions,² to serve as a road map for the Region;

Having reviewed the draft Regional Action Plan for Neglected Tropical Diseases in the Western Pacific (2012–2016),

1. ENDORSES the Regional Action Plan for Neglected Tropical Diseases in the Western Pacific (2012–2016);
2. URGES Member States where NTDs exist:
 - (1) to use the Regional Action Plan for Neglected Tropical Diseases in the Western Pacific (2012–2016) to update or develop national NTD plans of action and use the regional action plan as a framework for monitoring implementation, documenting success and mobilizing resources;
 - (2) to ensure that sufficient human and financial resources are made available to implement and sustain national NTD control and elimination programmes, and incorporate health system strengthening whenever feasible;
 - (3) to work towards universal access for all populations at risk for NTDs to appropriate preventive chemotherapy interventions, quality case management and transmission control activities;
 - (4) to strengthen national surveillance, monitoring and evaluation systems to monitor NTD trends, assess programme impact, provide data for verification of elimination and report annually to WHO on key regional indicators;
 - (5) to identify and implement research priorities to fill NTD programmatic knowledge gaps, while building regional research capacity;

¹ Preventive chemotherapy stands for the large-scale preventive treatment against helminthiases and trachoma with safe, single-dose, quality-assured medicines.

² Elimination of lymphatic filariasis as a public health problem (WHA50.29, 1997), Global elimination of blinding trachoma (WHA51.11, 1998), Elimination of leprosy as a public health problem (WHA51.15, 1998), Schistosomiasis and soil-transmitted helminth infections (WHA54.19, 2001), Control of leishmaniasis (WHA60.13, 2007), and Elimination of schistosomiasis (WHA65.21, 2012).

(6) to support interprogrammatic and intersectoral collaboration, and encourage partnerships with nongovernmental organizations and technical agencies—including involvement of the private sector when appropriate—to address NTDs comprehensively and optimize use of resources;

3. REQUESTS the Regional Director:

(1) to use the Regional Action Plan for Neglected Tropical Diseases in the Western Pacific (2012–2016) to advocate with key international stakeholders and development partners for increased support for NTD programmes in the Region;

(2) to provide technical support to Member States to develop or update integrated national NTD plans of action; support scaling up of NTD programmes; build national capacity, particularly in surveillance, monitoring and evaluation; define programmatic gaps that need to be addressed through operational research;

(3) to continue to monitor and assess the NTD situation in the Region;

(4) to report regularly to the Regional Committee on the progress made in implementing the Regional Action Plan for Neglected Tropical Diseases in the Western Pacific (2012–2016).

Sixth meeting, 27 September 2012

WPR/RC63.R5 ELIMINATION OF MEASLES AND ACCELERATION OF
RUBELLA CONTROL

The Regional Committee,

Recalling resolutions WPR/RC54.R3 that called for measles elimination, WPR/RC56.R8 that established the target year of 2012, and WPR/RC61.R7 that reaffirmed the 2012 measles elimination goal and called for acceleration of rubella control;

Recalling the May 2012 resolution WHA65.17 endorsing the Global Vaccine Action Plan that calls for achieving and sustaining high and equitable vaccine coverage;

Acknowledging the dramatic decline in the number of measles cases from almost 146 000 in 2008 to 21 000 (an 86% reduction) in 2011; and that measles transmission continues in few countries in 2012 and continues to decrease;

Recognizing the Region is now on the verge of eliminating measles and could be the second Region to achieve measles elimination;

Noting the Western Pacific Regional Verification Commission on Measles Elimination has been established, and the verification mechanism has been elaborated in consultation with Member States;

Aware that three years will be required for national and regional verification from the last endemic measles case, to demonstrate the achievement is sustainable;

Mindful of various opportunities to synergize measles elimination and rubella control activities,

1. REAFFIRMS its commitment to eliminate measles and accelerate rubella control in the Western Pacific Region;
2. URGES Member States:
 - (1) to interrupt all residual endemic measles virus transmission as rapidly as possible, through ensuring high population immunity with measles vaccine;
 - (2) to implement effective immunization strategies to identify and reach all vulnerable underserved communities in both rural and urban settings;
 - (3) to enhance systems and capacity for preparedness, rapid detection and response to measles outbreaks whether caused by an endemic or imported virus, to prevent the spread and re-establishment of measles virus transmission;
 - (4) to improve sensitivity and performance of epidemiological surveillance and laboratory capacity to identify the source of infection, and demonstrate the absence of endemic transmission, for eventual verification;
 - (5) to establish national verification committees that develop regular progress reports for submission to the Regional Verification Commission;
 - (6) to further accelerate control of rubella and prevention of congenital rubella syndrome through integration of measles and rubella immunization and surveillance activities;
3. REQUESTS the Regional Director:
 - (1) to continue supporting Member States in their efforts to eliminate measles;
 - (2) to continue advocating for measles elimination, seek additional resources to achieve and sustain measles elimination and accelerate rubella control;
 - (3) to enhance international collaboration in measles elimination across regions and national borders;
 - (4) to report progress to the Regional Committee.

Sixth meeting, 27 September 2012

WPR/RC63.R6 IMPLEMENTATION OF THE INTERNATIONAL HEALTH
REGULATIONS (2005)

The Regional Committee,

Recalling resolutions WHA61.2 and WHA65.23 on Implementation of the International Health Regulations (IHR), resolution WPR/RC58.R3 on Avian and Pandemic Influenza, IHR (2005) and the Asia Pacific Strategy for Emerging Diseases (APSED 2005), and WPR/RC61.R5 on the Asia Pacific Strategy for Emerging Diseases (2010) and IHR (2005);

Aware that the deadline for Member States to meet the IHR core capacity requirements was 15 June 2012, and that only in exceptional situations, and supported by a new implementation plan,

extensions to the deadline may be obtained for 2014, taking into account the technical advice of the IHR Review Committee;

Commending a joint effort made by Member States, WHO, donors and partners over the past five years in ensuring good progress in developing the national capacities and in meeting IHR core capacity requirements in the Western Pacific Region through APSED (2005);

Recognizing efforts by technical programmes to contribute to IHR (2005) core capacity strengthening through implementation of strategies and activities such as those relating to food safety and environmental health;

Noting the challenging time frame for meeting IHR core capacity requirements and the fact that many countries, including 14 countries in the Western Pacific Region, have requested an extension of the 15 June 2012 deadline, reiterating their commitment to meet IHR core capacity requirements by 15 June 2014;

Recognizing the commitments made by Member States and WHO in further enhancing the national and regional core capacities through a consultative process of developing and implementing APSED (2010) and other technical activities;

Noting the development or update of national workplans for emerging diseases and public health emergencies, including the use of the APSED (2010) Workplan as a guide or tool and other technical activities, in line with IHR (2005);

Aware that regional IHR implementation requires further efforts and collaboration among governments, WHO, donors and technical partners, and that subregional and regional forums, including the Asia Pacific Technical Advisory Group on APSED (2010), facilitate regional progress monitoring, prioritization of country and regional activities and coordinated efforts;

Reconfirming the unique opportunities in using the global IHR monitoring tool and in implementing APSED (2010) and other technical activities to meet the IHR (2005) core capacity requirements, and the need for a tailored approach for Pacific island countries and areas;

Recognizing the importance of enhancing and sustaining a regional system for public health event and emergency management through collective efforts and participation of the countries and areas of the Region,

1. REAFFIRMS its commitment to implement APSED (2010) and its workplan as a key tool, supplemented by other technical and institutional strategies and activities, to help meet and maintain IHR core capacity requirements;
2. URGES Member States:
 - (1) to further invest and mobilize financial and technical resources to ensure effective implementation of updated national plans for emerging diseases and public health emergencies;
 - (2) to establish and enhance regular stakeholder planning and review processes as a sustainable mechanism for national core capacity monitoring and programme improvement, and to utilize the core capacity monitoring questionnaire and indicators;
 - (3) to strengthen subregional and regional collaboration and approaches to meet IHR core capacity development needs, including a tailored approach for the Pacific;

3. REQUESTS the Regional Director:

- (1) to further advocate and facilitate compliance with IHR (2005) including through implementation of APSED (2010) and other technical strategies and activities, such as the Western Pacific Regional Food Safety Strategy 2011–2015;
- (2) to support countries in their implementation of national workplans for emerging diseases and public health emergencies through provision of technical and financial assistance;
- (3) to facilitate support among Member States and across relevant sectors;
- (4) to facilitate monitoring and reporting of IHR (2005) implementation through utilization of the core capacity monitoring tools and indicators, and the regional and subregional mechanisms.

Sixth meeting, 27 September 2012

WPR/RC63.R7 NOMINATION OF THE REGIONAL DIRECTOR: CODE OF CONDUCT¹

The Regional Committee,

Recalling the discussions held by the Committee since its fifty-ninth session on modalities to increase the fairness and transparency of the process for the nomination of the Regional Director;

Also recalling its resolution WPR/RC61.R3, by which the Committee amended its Rules of Procedure in order to improve the effectiveness of the procedure for nominating the Regional Director;

Convinced that the overall process of nomination, including the activities carried out by candidates and by Member States nominating or supporting those candidates, will benefit from agreed principles of good conduct;

Recognizing at the same time that the nomination of the Regional Director is an intergovernmental process and that Member States have the sovereign right to conduct their foreign policy;

Having considered the report by the Legal Counsel and the draft Code of Conduct annexed to it (WPR/RC63/8),

1. ADOPTS the Code of Conduct for the Nomination of the Regional Director of the Western Pacific Region of the World Health Organization, as amended by the Committee (annexed);
2. CALLS UPON Member States to implement and abide by the Code of Conduct, to make it widely known and easily accessible, and to bring it to the attention of persons they wish to propose for the post of Regional Director in future nomination processes;
3. REQUESTS the Regional Director to support the implementation of the Code of Conduct as envisaged in the Code;

¹ See Annex 13.

4. FURTHER REQUESTS the Regional Director to impress upon the Secretariat of the Regional Office the importance of complying with the obligations laid out in the Staff Regulations and Rules with regard to the conduct to be observed during the process of nomination of the Regional Director, as provided in Section V of the Code of Conduct.
5. DECIDES that the Code of Conduct will become effective at the end of the sixty-third session of the Committee.

Seventh meeting, 27 September 2012

WPR/RC63.R8 AMENDMENTS TO THE RULES OF PROCEDURE OF THE REGIONAL
COMMITTEE

The Regional Committee,

Having considered decision WHA65(9), by which the Sixty-fifth World Health Assembly decided *inter alia* that the Regional Committee should harmonize their practices in relation to the nomination of regional directors, the review of credentials and the participation of observers;

Having considered the report of the Secretariat,

1. DECIDES to amend Rule 2 of its Rules of Procedure concerning participation of observers in the work of the Regional Committee by adding the following at the end of the current text of the Rule:

“The Regional Director, in consultation with the Regional Committee, may invite States not members of the Committee to participate without vote in the sessions of the Committee. The Regional Director, in consultation with the Regional Committee, may also invite nongovernmental organizations to participate in the deliberations of the Committee as provided in the *Principles governing relations between the World Health Organization and nongovernmental organizations*.”

2. DECIDES to replace Rule 3 of its Rules of Procedure with the following text and to add a new Rule 3 bis as provided below:

“The Members shall communicate to the Regional Director (hereinafter referred to as the Director), if possible 15 days before the date fixed for the opening of the session of the Committee, the names of their representatives, including all alternates and advisers. Similarly, the States and organizations referred to in Rule 2 invited to be represented at the session, shall communicate the names of the persons by whom they shall be represented. The credentials of representatives shall be delivered to the Director, if possible not less than one day before the opening of the session of the Committee. Such credentials shall be issued by one of the following: the Head of State, the Head of Government, the Minister for Foreign Affairs, the Minister of Health or any other competent authority.

Rule 3 bis. The officers of the Regional Committee shall examine the credentials of representatives and report thereon to the Regional Committee. Any representative to whose admission a Member has made an objection shall be seated provisionally with the same rights as other representatives, until the officers have reported and the Regional Committee has rendered its decision.”;

3. DECIDES that the foregoing amendments will become effective at the end of the sixty-third session of the Committee.

Seventh meeting, 27 September 2012

WPR/RC63.R9 SIXTY-FOURTH SESSION OF THE REGIONAL COMMITTEE

The Regional Committee,

CONFIRMS that the sixty-fourth session of the Regional Committee shall be held at the Regional Office in Manila.

Seventh meeting, 27 September 2012

WPR/RC63.R10 RESOLUTION OF APPRECIATION

The Regional Committee,

EXPRESSES its appreciation and thanks to:

1. the Government of Viet Nam, for:
 - (a) hosting the sixty-third session of the Regional Committee for the Western Pacific;
 - (b) the excellent arrangements and facilities provided;
 - (c) the generous welcome and hospitality received;
2. the Chairperson, Vice-Chairperson and Rapporteurs elected by the Committee;
3. the representatives of the intergovernmental and nongovernmental organizations for their oral and written statements.

Seventh meeting, 27 September 2012

DECISION

WPR/RC63(1) **SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND
RESEARCH TRAINING IN HUMAN REPRODUCTION: MEMBERSHIP
OF THE POLICY AND COORDINATION COMMITTEE**

The Regional Committee, noting that the period of tenure of the representative of the Government of the Philippines as a member of Category 2 of the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction expires on 31 December 2012, selects the Lao People's Democratic Republic to nominate a representative to serve on the Policy and Coordination Committee, under Category 2, for a period of three years from 1 January 2013 to 31 December 2015.

(Seventh Meeting, 27 September 2012)

PART III. MEETING REPORT**OPENING OF THE SESSION: Item 1 of the Provisional Agenda**

1. The sixty-third session of the Regional Committee for the Western Pacific, held in Hanoi, Viet Nam, from 24 to 28 September 2012, was declared open by the Chairperson of the sixty-second session.

ADDRESS BY THE OUTGOING CHAIRPERSON: Item 2 of the Provisional Agenda

2. At the first plenary meeting, the outgoing Chairperson addressed the Committee (See Annex 9).

ELECTION OF OFFICERS: CHAIRPERSON, VICE-CHAIRPERSON AND RAPPORTEURS: Item 3 of the Provisional Agenda

3. The Committee elected the following officers:

| | |
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| Chairperson: | Associate Professor Dr Nguyen Thi Kim Tien (Viet Nam) |
| Vice-Chairperson: | Dr Mark Jacobs (New Zealand) |
| Rapporteurs: | |
| in English | Dr Madeleine de Rosas-Valera (Philippines) |
| in French | Dr Jean-Paul Grangeon (France) |

ADDRESS BY THE INCOMING CHAIRPERSON: Item 4 of the Provisional Agenda

4. The chairperson of the sixty-third session of the Regional Committee addressed the Committee (See Annex 10).

**ADOPTION OF THE AGENDA: Item 5 of the Provisional Agenda
(document WPR/RC63/1 Rev. 2)**

5. The Agenda was adopted (See Annex 1).

ADDRESS BY THE DIRECTOR-GENERAL: Item 6 of the Agenda

6. The Director-General was unable to attend the Regional Committee in person. A copy of her address was therefore distributed to the Committee (See Annex 11).

**ADDRESS BY AND REPORT OF THE REGIONAL DIRECTOR: Item 7 of the Agenda
(document WPR/RC63/2)**

7. The Regional Director addressed the Committee (See Annex 12).

8. Representatives commended the progress over the previous year, noted the significant challenges remaining, and outlined the progress in various areas in the countries in the Region. It was generally agreed that control of infectious diseases, such as malaria and tuberculosis, and the ever-present threat of resurgent polio, together with maternal and child mortality, were still ongoing challenges in the Western Pacific Region. Better targeting of WHO technical support to remote and impoverished areas was requested as a priority. Representatives said the newly established Division of Pacific Technical Support was a good example of the WHO Regional Office seeking to align its coordination and assistance efforts as closely as possible with priorities at the country level.

9. A number of representatives expressed their desire for cooperation with WHO to strengthen national health systems, especially at the primary care level through training of the health workforce. Representatives also expressed keen interest in the reform of health financing and the achievement of universal health coverage, and numerous speakers made offers to share their national experiences and expertise in both fields. There were many requests for assistance in order to maintain the momentum towards achievement of the Millennium Development Goals.

10. The speakers were of the view that noncommunicable and chronic diseases would be the major health issue of the future as populations age and increasing affluence results in unhealthy lifestyles. Health systems across the Region evidently need to take account of the likely implications, for example by developing patient-centred care for the elderly in home settings or residential institutions, or by undertaking health promotion efforts with a social rather than a narrowly medical focus. There were many requests for assistance from WHO to develop a national noncommunicable disease (NCD) strategy.

11. Speakers from Pacific island countries and areas said that their region faces a common issue of unhealthy diets and a resulting epidemic of obesity. In one country, the problem was mitigated by officially promoting the cultivation of healthy local produce in an effort to discourage the importation of unhealthy foods. In another a programme was launched to reduce salt intake. Another problem peculiar to small-island states is over-reliance on an expatriate health workforce because of the difficulties faced by islanders in gaining admission to medical schools. Negotiations with training institutions are required to offset the disadvantages faced by islanders, who have only limited local educational resources at their disposal and are ill-prepared to satisfy the entry requirements specified by such institutions.

12. The representative of Australia acknowledged the congratulations of other delegations on Australia's recent enactment of legislation to prohibit the display of branding or marketing on tobacco-product packaging. She urged other countries to pursue their efforts towards the same goal. Several representatives referred to the importance of legislative initiatives in their countries to curb tobacco use and tobacco marketing.

13. Replying to comments that the WHO reform agenda needed to be discussed during the current session of the Regional Committee, the Regional Director said that the Committee would have an opportunity to debate the issue under agenda items 9 and 17. At the regional level, he said he had endeavoured to foster responsiveness to Member State concerns, for example by establishing the new Country Support Unit, designed to deal with urgent national public health issues as and when they arose. The Regional Office has taken measures to respond to countries' requests for more technical assistance in the area of NCDs by deploying professional staff specializing in that field to country offices. A number of representatives also mentioned the disproportionate burden of preventable blindness in the Western Pacific Region, which has 90 million visually impaired people. In 80% of those cases, blindness is avoidable or curable. There appeared to be a groundswell of opinion among Member States that preventable blindness should be placed on the Regional Committee's agenda, possibly at the following session.

**PROGRAMME BUDGET 2010-2011: BUDGET PERFORMANCE (FINAL REPORT):
Item 8 of the Agenda (document WPR/RC63/3)**

14. The Director, Programme Management, introduced the item, presenting the final financial implementation of assessed contributions and voluntary contributions for the biennium 2010–2011 by source of funding, strategic objective and category of expenditure. He noted the continued trend of higher implementation in countries, which is due partly to the creation of the new Division of Pacific Technical Support. He also noted that the increase in the overall implementation rate as compared to the previous biennium reflected strengthened financial management and improved operation of the Global Management System.

15. Representatives commended the 94.5% financial implementation rate, an improvement on the previous biennium. Despite reduced funding, the Regional Office managed to increase allocations at the country level. There was praise for the detailed information on achievement of strategic objectives, though there was a call for country-level information on them and for information on the achievement of indicators, in addition to that on expected results.

16. Representatives noted with satisfaction that all but three of the 99 regional expected results had been fully achieved, and commented on the three that had been only partially achieved—all of them having been noted as “fully achieved” in the previous biennium. Two were under Strategic Objective 5, on the reduction of the health consequences of emergencies, disasters, crises and conflicts. The report suggested that the necessary strategic framework was lacking. It was proposed that the International Health Regulations (IHR 2005) and the *Asia Pacific Strategy for Emerging Diseases* (APSED 2010) be amalgamated into a single strategic framework for that purpose.

17. The other partially achieved result was in health research, a field in which most low-income countries did not spend the recommended 2% of the health budget; that goal was perhaps unrealistic. Concern was expressed that 11 of the 13 strategic objectives were in deficit and thus increasingly exposed to the vicissitudes of voluntary contributions. Three suggestions were made: to take a less aspirational and a more realistic approach to budgeting; to merge some strategic objectives so as to reduce structural overlap; and to focus more on the top priorities of each country, since WHO is a technical agency that can provide only limited budgetary support.

18. Representatives reported achievements in communicable disease control; nine countries had drawn up plans for the progressive elimination of malaria. More should be done to control yaws and trachoma. Attention was drawn to the importance of health and the environment, and particularly to the need to devote sufficient human and financial resources to the control of NCDs, beginning with the WHO Package of Essential Noncommunicable Disease Interventions (PEN) and drawing on the declaration of a NCD crisis by the Pacific Islands Forum leaders.

19. The Director, Programme Management, thanked representatives for their guidance, which would be used in future budget preparations. On the need for a strategic framework in Strategic Objective 5, he said that although APSED provided generic components for management of emerging diseases and hazards, there were still specific issues in which the Organization wanted a more proactive than reactive approach. WHO is a research organization, so national health research is a priority. But it has been underfunded, especially at the country level in low- and medium-income countries. The regional research strategy would need to secure resources. WHO was starting to see better use of indicators in the strategic framework and was looking to achieve further improvement. He acknowledged that the Organization was spread too thin and risked duplicating work at the country level—and not only in the Western Pacific Region. The reduction from 11 technical strategic objectives to five technical categories should help to reduce overlap within the Organization, and a new commitment to country performance was emerging at the highest level. The thinking was to

continue using country cooperation strategies as platforms for biennial budgeting, but at the same time to ask WHO Representatives and staff to agree with health ministries on one or two priorities for each country, and to allocate additional resources accordingly.

20. He fully agreed that some strategic objectives were underfunded, but too much voluntary funding was earmarked, which prevented the Organization from switching resources to those objectives. It was ironic that, while donors were prepared to allocate billions of dollars to the Global Fund to Fight AIDS, Tuberculosis and Malaria without earmarking, funding for WHO was closely and rigidly attributed. He hoped that, with the increase in accountability and transparency that Member States had praised, the necessary flexibility in funding would follow.

**DRAFT PROPOSED PROGRAMME BUDGET 2014–2015: Item 9 of the Agenda
(document WPR/RC63/4)**

21. The Director, Programme Management, introduced the item, presenting the draft Proposed Programme Budget 2014–2015 of the Western Pacific Region. It was developed in conjunction with the draft proposed Twelfth General Programme of Work 2014–2019. He noted that the budget includes a new “results chain” that reflects ongoing WHO reforms. The model of the results chain was introduced in 2010 in the Western Pacific Region with the development of strategic frameworks. Unlike previous programme budget presentations, which focused on the Programme Budget for the Western Pacific Region, the draft Proposed Programme Budget 2014–2015 was an Organization-wide Programme Budget based on the new results-based planning structure applicable to the Organization at all three levels—country, regional and headquarters. He said the draft Proposed Programme Budget 2014–2015 and the draft Twelfth General Programme of Work 2014–2019 will be further developed and refined in 2013, in close consultation and collaboration with WHO country offices, regional offices and headquarters.

22. The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters, followed up with a presentation on how the draft proposed Twelfth General Programme of Work 2014–2019 and draft Proposed Programme Budget 2014–2015 had been devised and were being shaped, with iterative input from Member States.

23. Representatives commended the documents and the clear manner in which the new process had been presented. There was general appreciation of the six new categories, which could enhance flexibility in funding; specific proposed budget figures would be needed in the next versions. A number of suggestions were made about the actual categories: neglected zoonotic diseases should be covered by category 1; adolescent health should be extended to cover more than sexual and reproductive health; category 4 should say more on the funding of human resources for health as the basis for autonomous national response to health problems; category 3—promoting health through the life course—seemed to overlap considerably with other categories; more was needed on climate change and health; NCDs in particular, and especially in the Western Pacific Region, needed more attention than they seemed to get in the documents. While it was agreed that the social determinants of health constituted a cross-cutting priority rather than an autonomous category, the subject was not adequately explained in the document. In the discussion of access to medical products under category 4, the concept of access was linked to price, while price was not the only factor that governed access to such products; more work was needed on the regulatory process. The idea of a binding treaty that would devote 0.02% of gross domestic product to neglected tropical diseases was seen by more than one speaker as unreasonable and unworkable. On category 6, more specifics were needed on the enhancement of leadership, governance, dialogue, knowledge management and country focus.

24. In more general terms, the two documents should be more clearly differentiated, and information was needed on how ongoing activities and programmes would be evaluated when their categorization was being so radically changed. Speakers warned against spreading the Organization too thin, and proposed that it concentrate on efficiency, on setting priorities and on its comparative advantages, which included normative and standard-setting roles, and privileged access to governments.

25. The Director, Planning, Resource Coordination and Performance Monitoring, thanked representatives for their encouragement and took note of their suggestions, touching once again on the honing of priorities; outputs to encompass existing commitments; and how to further develop outcomes by reducing their numbers, standardizing and using outcomes already being measured. Monitoring and reporting would follow current arrangements, with midterm review then performance assessment after two years. He noted that the two documents before the Committee had to be better differentiated, and that the budget for the reform process ought to be specified. There would be a stronger emphasis on NCDs. More attention would be paid to emerging zoonotic diseases, adolescent health as a whole and health information, and to environmental health and climate change. Although it was agreed that the social determinants of health were not quite a category but rather a priority with outputs, more clarity was needed in the formulation of that area. Category 4 would be aligned with outcomes of the Working Group meeting of Member States on Substandard/spurious/falsely-labelled/falsified/counterfeit Medical Products and of the Consultative Expert Working Group on Research and Development.

26. Budget figures in the current versions of the documents used the actual expenditure for 2010–2011, and the 2012–2013 budget as an indication of current programmatic emphases, but the financial aspect would be better defined in their next iterations for the January Executive Board and the May World Health Assembly.

27. The Director, Programme Management, assured the Committee that its proposals and observations would be forwarded to the Director-General as input to the next steps in the process. He acknowledged that what were now referred to as priorities could more accurately be described as the scope of work. Priorities should be set within that scope, stating what WHO would and would not be doing. He thanked the representative of the Republic of Korea for the country's pledge to support the agreed priority areas. At the country level, WHO Representatives would be asked to help select one or two priority areas to focus on. Work remained to be done on indicators, of which there should not be a profusion. The intention was to use tracer indicators of outputs that would be easier to measure and monitor.

28. One representative had sought assurance that academic research was not being overlooked, and cautioned against duplication of effort among international agencies at the country level. The Director, Programme Management, assured her that the Regional Office fostered better management and governance of research done in countries in the Region by supporting national health research in Member States.

29. The Regional Committee considered a draft resolution on the draft Proposed Programme Budget 2014–2015 and draft Twelfth General Programme of Work.

30. The resolution was adopted (See resolution WPR/RC63.R1).

VIOLENCE AND INJURY PREVENTION: Item 10 of the Agenda (document WPR/RC63/5)

31. The Director, Programme Management, pointed out that violence and injuries accounted for 1.2 million deaths a year and enormous morbidity in the Region. He proposed that the meeting should focus on road traffic injuries, childhood injuries—especially drowning—violence against women and children, and falls, given the high mortality, morbidity and social impact of these problems in the Region.

32. Since 2004, WHO, in conjunction with the United Nations regional commissions, has been the global coordinator of United Nations Road Safety Collaboration, a consortium of international partners. In 2011, the United Nations launched the Decade of Action for Road Safety and called for multisectoral action to prepare national plans and implement cost-effective measures. The United Nations called for a Road Safety Week in May 2013. The health sector must work together with a broad range of partners to reduce deaths on the road.

33. Childhood injuries, especially drowning, continue to be a major threat to child survival in the Region. In 2008, WHO and UNICEF launched the *World Report on Child Injury Prevention*, highlighting the need to integrate child injury prevention with other child health efforts to achieve Millennium Development Goal 4. Member States had to renew their commitment to the United Nations campaigns to eliminate violence against women and children. Finally, falls remain a significant problem, particularly as a threat to safe and healthy ageing.

34. Representatives welcomed the opportunity to discuss a subject which, according to statistics cited by several countries, ranked very high indeed among causes of preventable mortality and morbidity, particularly among young people. Especially prominent were violence against women and domestic violence in general, as well as road traffic injuries, often exacerbated by the harmful use of alcohol. There were repeated calls for reliable data so that interventions could be prioritized. Several representatives discussed the institutional context in which action could best be taken, governed by instruments such as the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. Regional guidance was needed for country-specific responses that would entail legislation and, for each topic, intersectoral coordination of the appropriate entities within countries. Those would include various government ministries, nongovernmental organizations and law enforcement. With such arrangements in place, injury prevention and treatment could be better targeted and deployed. The Organization was called upon to provide technical assistance.

35. The Director, Violence and Injury Prevention, WHO headquarters, welcomed the response from countries of the Region and spoke of multisectoral activity taking place and of data collection in the health sector. He referred to cost-effective preventive steps such as helmet-wearing and the prevention of drink-driving. He called upon health ministries to appoint a focal point on violence and injury prevention, and mentioned the imminent World Conference on Safety Promotion and the Week on Protection of Pedestrians, 6–11 May 2013.

36. The Regional Committee considered a draft resolution on violence and injury prevention.

37. The resolution was adopted (See resolution WPR/RC63.R3).

NEGLECTED TROPICAL DISEASES: Item 11 of the Agenda (document WPR/RC63/6)

38. The Director, Programme Management, presented the item and a short video on the subject was shown. The draft Regional Action Plan for Neglected Tropical Diseases in the Western Pacific (2012–2016) presented a five-year road map for neglected tropical diseases, focusing on seven key diseases: lymphatic filariasis, foodborne trematodiasis, leprosy, schistosomiasis, soil-transmitted helminthiasis, trachoma and yaws. It was the first such action plan in the Region.

39. Tropical diseases are diseases of poverty and neglect that afflict the most vulnerable people in society in 28 countries and areas in the Region. Although not usually fatal, they cause distress, lasting disability and stigma. While medically diverse, many have low-cost and proven solutions that are readily available. It is a good time to act on neglected tropical diseases, with recent commitments by pharmaceutical companies, donors, nongovernmental organizations and endemic countries to reach the global goals set for 2020: elimination of leprosy, lymphatic filariasis, schistosomiasis, trachoma and yaws, and reducing morbidity from soil-transmitted helminthiasis and foodborne trematodiasis. The Regional Committee was therefore requested to review and consider for endorsement the draft Regional Action Plan for Neglected Tropical Diseases in the Western Pacific (2012–2016).

40. Every speaker praised the draft Regional Action Plan for Neglected Tropical Diseases in the Western Pacific Region. Many reported on the progress they had made on control of those diseases, and on difficulties encountered. China voiced its willingness to share experience, citing its support to African countries in schistosomiasis elimination. There was a call for zoonotic diseases to be added to the plan.

41. Several speakers called for work beyond health ministries, with collaboration between institutions and ministries in research, public–private partnerships for drug supplies, and a greater use of networks to put those diseases higher on the health agenda, perhaps in connection with the resurgence of primary health care, concentrating on vulnerable populations. There was a need for training in supply management.

42. The Director, Combating Communicable Diseases, observed that although there was no global fund for neglected tropical diseases, there were donors and WHO would continue to garner resources. Some zoonotic diseases were covered, and there was a food safety element in the plan.

43. The Assistant Director-General, HIV/AIDS, TB, Malaria and Neglected Tropical Diseases, praised the great assets of the Western Pacific Region: expertise, industry that produced drugs for the treatment of neglected tropical diseases, and the instance of interregional collaboration between China and countries of Africa. WHO was ready to provide assistance as needed. He observed that public–private partnerships had already secured drug donations for the treatment of more than 7 million people.

44. The Regional Director concluded that, in order to meet the targets, a major effort in resource mobilization would be required.

45. The Regional Committee considered a draft resolution on the Regional Action Plan for Neglected Tropical Diseases in the Western Pacific Region (2012–2016).

46. The resolution was adopted with minor amendments (See resolution WPR/RC63.R4).

MEASLES ELIMINATION: Item 12 of the Agenda (documents WPR/RC63/7 and WPR/RC63/7 Corr. 1)

47. The Regional Director, introducing the item, observed that the Western Pacific Region was very close to the goal of elimination, having set a 2012 target date in 2005.

48. The Chairperson, Technical Advisory Group on Immunization and Vaccine-preventable Diseases in the Western Pacific Region, recounted the history of progress towards measles elimination. From 81.6 cases per million per year, incidence had fallen to as low as 5.7 per million according to preliminary findings this year—a reduction of 92%. Surveillance was now excellent, as was vaccine coverage. Virological surveillance showed that, increasingly, existing cases were imported from beyond the Region.

49. In 2000 measles had caused 25 000 deaths, and in 2008 there were 2000. Now, up to the month of September, there had been only 12 measles deaths in 2012. Although that represented a major advance towards the Millennium Development Goals, there was still work to do. The objective was feasible and within reach, and the strategies were good. The campaign was now poised, as the Region's polio elimination campaign had been, close to the goal and slightly behind the timeline. He exhorted countries to maintain their efforts.

50. The ensuing discussion showed the range in national situations, from countries where endemic measles transmission was interrupted years ago to others where transmission continues. Some countries in the Region have experienced measles cases or outbreaks caused by importation of measles virus. For this reason, Member States must develop and implement strategies to close existing or emerging immunity gaps to prevent future outbreaks. The discussion also emphasized the need to improve and maintain sensitive surveillance to monitor the evolution of measles epidemiology and to guide response actions.

51. Several countries shared experiences regarding synergizing measles elimination activities with the management of other diseases—such as control of rubella and prevention of congenital rubella syndrome—by integrating measles supplementary immunization with other low-cost interventions, such as distribution of vitamin A, deworming medicine and malaria bednets and hand washing. The activity also fits into the Integrated Management of Childhood Illness.

52. Representatives called for intensified actions, with more support from international organizations to ensure high-quality surveillance, including a strengthened measles and rubella laboratory network to support national verification committees, which should report to the Regional Verification Commission, except in cases where notification had, for administrative reasons, to go through central governments.

53. The Chairperson, Technical Advisory Group on Immunization and Vaccine-preventable Diseases in the Western Pacific Region, observed that, with good vaccine coverage, epidemic waves were less frequent, so that the age of children to be vaccinated would rise. He predicted a quiet period followed by a wave of new cases. Imported cases should be expected. Measles was very sensitive to immunization, such that lower coverage would let the disease rapidly increase again, while good coverage would result in elimination.

54. The Team Leader, Expanded Programme on Immunization, congratulated countries. He said the Regional Verification Commission for Measles Elimination was to meet in February or March 2013.

55. The Regional Director described the work as one of the most important missions given to the Regional Office by Member States. Since 2010, efforts had been intensified. He thanked the Chairperson of the Technical Advisory Group for his work, which was now nearing completion. It was necessary to maintain momentum and verify elimination. That would be part of a protocol for achieving and sustaining measles elimination, once the job had been finished in the remaining five endemic countries in the Region. He thanked staff for their commitment and congratulated Member States on their achievements.

56. The Regional Committee considered a draft resolution on the elimination of measles and the acceleration of rubella control.

57. The resolution was adopted with minor amendments (See resolution WPR/RC63.R5).

**NOMINATION OF THE REGIONAL DIRECTOR: CODE OF CONDUCT:
Item 13 of the Agenda (document WPR/RC63/8)**

58. The Legal Counsel said that the Regional Committee had discussed various proposals for improving the fairness of the procedure for nominating the Regional Director since its fifty-ninth session. After introducing a shortlisting and interview process at its sixty-first session, the Committee had considered the adoption of a code of conduct as a tool to improve the fairness, openness and transparency of the nomination process. The discussion had been undertaken on the understanding that the code of conduct would be a non-legally binding political statement, essentially regarding the electoral campaign, with compliance expected as a matter of good faith. The draft code currently before the Committee was a revision of the draft presented at the previous session and contained proposed amendments from Member States.

59. The Sixty-fifth World Health Assembly had decided that there should be a code of conduct for the nomination and appointment of the Director-General. The Secretariat, which will be presenting the draft code to the Executive Board in January 2013, had drawn heavily on the work on the code of conduct for the nomination of the Regional Director. If the Committee decided to adopt the code currently before it, it would be the first-ever example of such a practice in the United Nations system. That would be an historic achievement and would place WHO and the Western Pacific Region at the forefront of a general trend among international organizations towards accountability, fairness and transparency in the conduct of their business, including with regard to the election of their most senior officials.

60. It was noted that the draft code of conduct was one of many reforms to improve transparency and process within WHO as a whole. At the same time, it was a novel instrument that might need to be refined in the future. Speakers raised a number of points on how the code would work in practice, specifically the method whereby travel by a sitting Regional Director would be determined to be campaign-free, and on disclosing and setting the boundaries of campaign activities. It would also be important to ensure that the draft code was entirely consistent with the Regional Committee's Rules of Procedure. A request was made for the curricula vitae of candidates to be made available in all the official languages of the Regional Committee.

61. The Legal Counsel said that the code, if adopted, would take effect immediately. For reasons of economy and on principle, the Committee had deliberately chosen not to set up a cumbersome mechanism to monitor compliance; it was expected that Member States would act in good faith. All internal candidates would be subject to the Staff Rules and Regulations of WHO, which specified that they should at all times put the interests of the Organization first. A number of possible solutions

could be envisaged to ensure full disclosure of campaign activities, for example the use of a dedicated, password-protected web page.

62. The Committee considered a draft resolution on nomination of the Regional Director, to which it was proposed to attach the draft code of conduct as an annex.

63. The representative of Australia said that multiple delegations—including New Zealand, Japan and Australia—worked in coordination to produce an agreed amendment to the proposed text of paragraph 7 in the second part of section B. The Director, Programme Management, further proposed the inclusion of an operative paragraph specifying that the Code of Conduct would become effective at the end of the sixty-third session of the Regional Committee.

64. The resolution was adopted with minor amendments (See resolution WPR/RC63.R7). The *Code of Conduct for the Nomination of the Regional Director of the Western Pacific Region of the World Health Organization* is in Annex 13.

INTERNATIONAL HEALTH REGULATIONS: Item 14 of the Agenda (documents WPR/RC63/9 and WPR/RC63/9 Corr.1)

65. The Director, Programme Management, presenting the agenda item on the International Health Regulations (IHR), said that the Asia Pacific Strategy for Emerging Diseases (APSED) was a regional tool to help Member States meet the IHR (2005) core capacity requirements. Despite significant progress, 14 Member States in the Region had requested two-year extensions in which to fulfil their obligations. Effective implementation of national plans, which required sustainable national investment and external support, was vital to success. More predictable financial and technical resources were required not only during emergencies, but also between emergencies to improve preparedness. In addition, Pacific island countries and areas faced unique challenges and needed tailored approaches to implement IHR (2005). Many national capacities could be enhanced at the Pacific subregional level through collective efforts and resource sharing. The Regional Committee was invited to review and consider for endorsement a draft resolution to facilitate compliance with IHR (2005) by using APSED (2010) as a tool for implementation.

66. Two cases of acute respiratory syndrome with renal failure, one of which had been confirmed to be infected with a novel coronavirus, had just been reported in the United Kingdom of Great Britain and Northern Ireland. Both patients had reported recent travel to the Kingdom of Saudi Arabia. Using the IHR mechanism, WHO had alerted national IHR focal points about those cases and facilitated sharing of information through its event information site. It had kept the public informed through the Disease Outbreak News section on the WHO web site. The Organization was collaborating with a network of laboratories with special expertise in coronaviruses. The event was of particular media interest given the reported history of travel to the Kingdom of Saudi Arabia in the context of the upcoming Muslim haj pilgrimage season. WHO was not currently recommending any travel restrictions relating to that event, but was seeking further information to determine the likely public health implications.

67. Representatives were in broad agreement that IHR (2005) had proved its worth in ensuring international health security and that APSED was an invaluable regional road map for helping Member States implement the IHR core capacities. Specifically, it was noted with approval that APSED was tailored to the needs of the Region and advocated sustainable development of generic capacities. Countries needed to implement IHR core capacities more or less in step and demonstrate a commitment to share information, otherwise the effectiveness of the international surveillance mechanism might be compromised. It followed, therefore, that countries which lagged behind should

be offered technical assistance; that the up-to-date status of core capacity implementation in each Member State should be disseminated in a spirit of transparency; and that cooperation should be sought with other regions outside the Western Pacific, specifically the South-East Asian Region.

68. One representative commented that the number of Member States requesting an extension of the deadline for implementing core capacities should actually be viewed as a positive sign, since it showed that countries had undertaken an honest, realistic and responsible evaluation of their individual capacities. Several speakers made the point that putting in place IHR core capacities was a hugely challenging undertaking that went far beyond the traditional confines of the health sector and necessitated substantial investment. Repeated pleas were made for WHO technical support and operational expertise, for example the dispatch of technical officers qualified to offer advice on how best to apply the IHR agenda across the whole of government. Specifically, a plea was made to shorten and simplify the IHR monitoring tool.

69. Representatives from small island countries cited some recurring problems, namely the difficulty of designating a national focal point to cover vast and sparsely inhabited areas that lacked appropriate institutional infrastructure. As a practical solution, it was suggested that WHO should capitalize on the United Nations Joint Presence Office. The point was also made that, while geographical remoteness could be an effective barrier against the spread of disease, once a disease became established, a small island could rapidly become an incubator and disastrous consequences could ensue. The representative of France emphasized that although New Caledonia was an overseas territory of France, it had separate administrative procedures from Metropolitan France with respect to health surveillance and the notification of diseases.

70. The Director, Health Security and Emergencies, said that the Regional Office was well aware of the urgency of the deadline to implement IHR core capacities and the scale of the financial and logistical challenge that implementation represented for many Member States. The Secretariat viewed with interest many of the points raised by speakers, for example the need to review and share the lessons learnt from regional events, which was envisaged under the APSED stakeholder planning and review process; the need to harmonize reporting between APSED and IHR; to accelerate the development of certain technical projects, such as the emergency operations centre; to maintain core capacities in those countries that had not chosen to extend the implementation deadline; and to encourage cooperation with other WHO regions.

71. The Director, Programme Management, said that he fully endorsed the proposal to take advantage of the United Nations Joint Presence Office in the context of implementing IHR core capacities, and the need to ensure that technical staff in country offices were conversant with IHR (2005) and APSED (2010). For the provision of technical assistance, the Regional Office could draw not only on its own resources, but also on headquarters and the Division of Pacific Technical Support in Suva, Fiji.

72. The Committee considered a draft resolution on the implementation of the International Health Regulations (2005) using APSED (2010) and its workplan as a key tool, supplemented by other technical and institutional strategies and activities.

73. The resolution was adopted with minor amendments (See resolution WPR/RC63.R6).

HIGH-LEVEL PANEL DISCUSSION ON JOINT ACTION TO ACHIEVE FOOD AND NUTRITION SECURITY IN THE WESTERN PACIFIC REGION

74. Professor Ian Darnton-Hill, the facilitator for the high-level panel discussion on nutrition, said the event was intended to strengthen collaboration among governments, United Nations agencies and other key partners in order to scale up nutrition interventions through a multisectoral approach and to provide guidance for WHO collaboration at the country and regional levels.

Panellists' presentations

75. Dr Nils Daulaire, United States Department of Health and Human Services, said that many countries were facing a double burden of undernutrition and overnutrition, the latter being defined as too much of the wrong kind of nutrients. Overnutrition was a major problem because of its close association with NCDs. In the Western Pacific Region, the NCD burden has been an economic disaster: studies show that the cost of treating NCDs accounts for a large percentage of total health costs, especially in Pacific island countries. The principal culprit was lack of appropriate nutrition and growing commercialization that made so-called “junk food” the least expensive household choice in the short term. Whether focusing on undernutrition or overnutrition, the primary focus should be on maternal and early-child health, which has immediate impact and sets long-term behaviours. The underlying health of mothers is a critical determinant for the health of their children. Children who were exclusively breastfed for the first six months of life were better protected against communicable diseases in the short term and NCDs in the long term. Approaches to tackling malnutrition should be multisectoral and adopt a “lifespan approach” that starts before birth and continues through the first two years of life and beyond.

76. Mr Hiroyuki Konuma, United Nations Food and Agriculture Organization (FAO), said that FAO sought to achieve its objectives of raising levels of nutrition, improving agricultural productivity and contributing to the growth of the world economy through nutrition-sensitive agricultural development, improvement of food and agriculture governance, bio-fortification, promotion of sustainable diets relying on greater biodiversity, and nutritional education. The future direction of FAO policy would focus on harmonization of agriculture, food, health, education, social protection and nutrition policies; multisectoral coordination; promotion of sustainable food supplies at affordable prices; improving the access of poor and disadvantaged groups to nutritionally balanced foods through poverty alleviation; promotion of nutrition-sensitive agriculture as a sustainable solution; reduction of post-harvest losses and waste; development of resilience to cope with disasters and climate change; placing emphasis on mothers, newborns and young children; and promotion of greater nutritional awareness and social solidarity.

77. Mr Daniel Toole, United Nations Children’s Fund (UNICEF), commenting on the huge disparities in stunting in children by wealth and place of residence, said that children in rural areas were generally more undernourished than those in urban areas, but in recent years the gap had narrowed owing to the prevalence of unhealthy urban settings. It was possible to address stunting through complementary feeding between the ages of 6 and 24 months, but in many cases the quality of food provided to young children was very poor. The problem stemmed from a mixture of ignorance, lack of support to caregivers and limited household access to nutrient-rich foods. The practice of breastfeeding, one of the most cost-efficient nutrition interventions, was currently subjected to considerable commercial pressures to switch to breast-milk substitutes, including through aggressive advertising. In its work, UNICEF focused on multisectoral approaches on early nutrition to reduce stunting and anaemia, on identifying and targeting the neediest groups, on influencing policy through compelling evidence in order to ensure effective legislation and on knowledge sharing. To keep their promises to children, governments needed to enact legislation and take cost-effective nutrition measures such as food fortification, salt iodization and the adoption of a strong code on the

marketing of breast-milk substitutes. Ministers of health should also seek to exert stronger influence on budgets to achieve sustainable financing for nutrition, health and education.

78. Mr Kenro Oshidari, World Food Programme (WFP), said that the underlying cause of stunting was inadequate dietary intake during critical periods of life, such as the first 1000 days. Direct food assistance was only part of the equation; health, sanitation, education and agriculture were other vitally important elements. An investment in nutrition had to be seen as an investment in the future. To that end, nutrition needed to be taken seriously by policy-makers at the highest level. It was important to impress upon donors that good nutrition would help to eradicate poverty and was thus a sure foundation for future development.

79. The Regional Director, speaking on behalf of WHO, said that over the years the focus of nutrition programmes had changed. Initially United Nations agencies had been more concerned with famine and hunger; today they were more likely to emphasize the importance of better diet, exercise and improved food security. He said by far the most pressing problem is that of stunting, which is a strong indicator of future growth and development problems; it also correlates directly with educational success and earning power. Stunting also leads to diminished economic growth. Most countries in the Western Pacific Region now had national plans of action for nutrition, which together with breastfeeding and complementary feeding efforts, prevention of vitamin and mineral deficiencies, improving women's nutrition and health, and promoting physical activity, were central components of the WHO platform for action in the field of nutrition. In the future, WHO would urge its Member States to put nutrition higher on the development agenda and scale up their nutrition programmes based on long-term intersectoral plans and sustainable financing.

Panel discussion

80. A representative of one Pacific island country cited a common predicament, namely that poor, sandy soil meant that the vast majority of food products had to be imported. The intensive use of fertilizers to grow fruit and vegetables locally would moreover cause environmental damage. Mr Konuma accepted that some countries faced adverse soil and terrain conditions, and FAO therefore advocated a return to indigenous food resources. In the Pacific islands, examples were taro, yam, breadfruit and sago palm. He recognized that, over time, dietary tastes had changed and those foods had fallen out of favour, in which case they would require a degree of processing to make them palatable to the younger generation. Hydroponic cultivation solutions were another possible avenue of exploration.

81. Another common problem cited in small island countries is the very small pool of skilled professionals. It was not realistic to release a mother on six months of maternity leave and find someone to replace her while she was away. The problem could be offset by creating baby-friendly spaces in workplaces, thus enabling mothers to return to work after two months. Mr Toole said that six months of maternity leave was an ideal that would obviously not work in all settings; the most important thing was for governments to support and facilitate breastfeeding, including by banning the marketing of breast-milk substitutes.

82. The representative of the Federated States of Micronesia asked why her country was not eligible for assistance from WFP, especially with regard to the milk fortifiers for malnourished mothers who were trying to breastfeed. The Regional Director should also explain why no north Pacific countries had been included in the WHO survey on malnutrition and stunting. Mr Oshidari, replying to the first point, said that the criterion for WFP assistance was food insecurity. The Federated States of Micronesia was not considered to be at risk, although in the event of a natural disaster WFP was always willing to assist when invited to do so by national governments. The

Regional Director, replying to the second point, said that the data in question had been generated by the WHO Global Health Observatory at WHO headquarters and he would pass along the concern.

83. One representative said that it would be helpful to gauge the extent of implementation of the International Code of Marketing of Breast-milk Substitutes throughout the Region. Mr Toole said that implementation had been strong, despite concerted industry attempts to weaken it. The technical secretariat could provide more detail.

84. Replying to an enquiry about interagency collaboration at meetings of the World Trade Organization (WTO) regarding the impact of trade on nutrition, Dr Daulaire said that the issue concerned not just WTO, but trade agreements in general. It was generally true that trade negotiations were the exclusive preserve of the relevant ministries and of commercial interests. Within government, ministries of health should therefore engage more proactively with their counterparts in trade departments on critical health issues, as they had done in the case of tobacco regulation.

85. Finally, responding to a question on the conversion of agricultural crops into biofuels in the context of food shortages in some countries, Mr Konuma stressed the need to harmonize food security and biofuel development policy so as to ensure that the latter did not compromise the former. Land use planning or agro-zoning—the allocation of different zones to different crops with distinct end uses—was a practical means of achieving that end.

86. Professor Darnton-Hill, summing up the panel discussion, said that countries in the Region were affected by a double burden of undernutrition and overnutrition. It was generally agreed that better nutrition was a good investment for the future, and that the focus should be on the nutritional health of mothers, infants and young children. Poverty and malnutrition were a double-sided problem, that is to say there should be an equal focus on causes and results. Efforts to address malnutrition should be channelled through governments, and governments, donors and international agencies should speak on nutrition with a single voice.

NUTRITION: Item 15 of the Agenda (document WPR/RC63/10)

87. The Director, Programme Management, presenting document WPR/RC63/10 on the prevention and control of malnutrition in the Western Pacific Region, said that the aim of the agenda item was to explore ways to expand areas for action, scale up multisectoral nutrition interventions, strengthen collaboration and partnership, and consider a draft resolution for the prevention and control of the double burden of undernutrition and nutrition-related NCDs.

88. Representatives noted a range of challenges they faced in the area of nutrition, including unbalanced diets and the wide availability of processed foods with high fat, salt and sugar, resulting in high rates of obesity, diabetes and tooth decay; the impact of climate change on food crop cultivation; aggressive marketing of infant formula; worm infestations; anaemia; micronutrient deficiencies; and the difficulty of ensuring that legislation and guidelines to encourage healthy lifestyles are actually followed in practice. They said the challenges were partly due to resource constraints and partly to ignorance and resistance to behavioural change. Diverse patterns of food consumption attributable to geographical, genetic, cultural and income factors were noted.

89. Good efforts leading to improved nutritional status in some countries of the Region were also cited: higher rates of breastfeeding; legislation to comply with the International Code of Marketing of Breast-milk Substitutes; extension of paid maternity leave and greater flexibility for working mothers; efforts to restrict advertising of certain foods to children; selective taxation of unhealthy foods and drinks; encouraging people to grow their own fruits and vegetables; nutritional supplements for

women and children, leading to a significant decrease in anaemia in some students and rural populations; food fortification; better labelling of food products; negotiations with manufacturers to reduce the fat and salt content of certain foods; school-based programmes to educate young people about the importance of diet and physical activity; and nutrition packages for pregnant and lactating mothers and newborns.

90. Many speakers noted that their governments had adopted action plans and strategies focusing on nutrition directly or in the context of NCDs and chronic diseases. In some cases nutrition indicators had been integrated into national social and development agendas.

91. One representative said that the document prepared by the Secretariat would have been even more informative had it provided details about folic acid and other micronutrient deficiencies, the incidence of severe malnutrition, and nutrition in the context of emergencies and climate change.

92. Another speaker commented that the comprehensive implementation plan on maternal, infant and young child nutrition endorsed by the World Health Assembly had used nutritional data from just one country in Asia and did not therefore reflect the diversity of the Region. Considering the Region's diverse dietary habits and customs, it would be interesting to know how WHO had collected and analysed its data. In response, the Regional Adviser in Nutrition, Maternal and Child Health and Nutrition unit, said that at the time of the multicountry study to establish the growth curves for children, only one Asian country had fulfilled the protocol criteria. However, it was interesting to note that the growth curves of children who were exclusively breastfed and had grown up in relatively comfortable circumstances were almost identical regardless of country of origin.

93. Countries use internationally agreed protocols to help to determine the safety of genetically modified foods. Genetically modified food can be considered safe if it passes testing in accordance with these protocols. Many issues with genetically modified food are outside of WHO's purview.

94. One representative made the point that healthy locally grown food was seasonal and could not therefore be consistently relied upon as a source of nutrition. The Director, Division of Building Healthy Communities and Populations, admitted the difficulty but said that WHO, in collaboration with its regional partners at UNICEF and FAO, was fully committed to applying country-specific solutions that sought a balance between health, agriculture and trade in the context of implementing the commitments made at the 2010 Pacific Food Summit.

95. Statements were made on behalf of the International Council for Control of Iodine Deficiency Disorders, World Vision International and the International Life Sciences Institute.

96. The Regional Committee considered a draft resolution on scaling up nutrition in the Western Pacific Region.

97. The resolution was adopted with minor amendments (See resolution WPR/RC63.R2).

**PROGRESS REPORTS ON TECHNICAL PROGRAMMES: Item 16 of the Agenda
(document WPR/RC63/11)**

Tobacco control

Healthy settings

Noncommunicable diseases

Health-related Millennium Development Goals

Health financing

Malaria and artemisinin resistance

Expanded Programme on Immunization

HIV/AIDS prevention and treatment

98. The Director, Programme Management, presenting document WPR/RC63/11 on progress in eight areas of the work of WHO in the Region, said that tobacco control efforts in the Western Pacific were guided by the *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific Region (2010–2014)*, which had set a target of a 10% reduction in tobacco use in adults and adolescents for smoked and smokeless tobacco by 2015. Despite progress, more effort was needed on demand-reduction measures, promotion of smoke-free indoor policies, and banning of tobacco advertising, promotion and sponsorship. Member States needed to resist tobacco industry interference in the implementation of the WHO Framework Convention on Tobacco Control.

99. Healthy Cities and Healthy Islands initiatives were increasingly being used by Member States as effective multisectoral approaches to address the social determinants of health, promote healthy lifestyles and prevent NCDs. NCDs had become both global and regional priorities over the past year; in fact the Pacific subregion was experiencing a full-blown NCD crisis. The Sixty-fifth World Health Assembly had adopted the global target of a 25% reduction in premature mortality from NCDs by 2025 and had requested broader consultations with Member States to develop voluntary global targets and indicators for NCDs.

100. The 2015 deadline for achieving the Millennium Development Goals (MDGs), six of which are health-related, is rapidly approaching. The Western Pacific Region was making good progress, although the goals of reducing child mortality and improving maternal health still required attention. Many countries in the Region needed to make greater efforts if they were to fulfil the MDGs on time. On the issue of health-care financing, WHO actions had focused on evidence-based policy-making and a shift towards universal health coverage. The Regional Office had worked closely with ministries of health and other government departments to raise the priority of health and health financing on national political agendas.

101. Malaria was still endemic in 10 out of the 37 countries and areas in the Western Pacific Region. Despite significant progress, the biggest challenge to malaria control and elimination was the development of resistance to artemisinin derivatives, which had the potential to spread outside the Region and become a global problem. A country-by-country approach alone would not work: cross-border cooperation with support from the Region and the international community was essential to safeguard the gains made over the past 30 years.

102. The Expanded Programme on Immunization (EPI) had continued to report progress towards achieving the Regional Committee's goals of measles elimination and hepatitis B control and maintaining the Region's poliomyelitis-free status. The Region's EPI Technical Advisory Group and Hepatitis B Expert Resource Panel had recommended 2017 as the target year for a less than 1% infection rate.

103. HIV infection rates were stabilizing in the Region. Scientific breakthroughs in treatment could potentially reduce transmission and mortality, but achieving high coverage remained a significant challenge against a backdrop of declining national and donor funding. Political leadership, country ownership, community involvement and expanded prevention and antiretroviral therapy (ART) were all required. HIV would remain endemic in certain key populations for many decades, with increasing public health and economic costs. Member States needed to make strategic investments in HIV now in order to halt new infections.

104. On tobacco control, representatives outlined the action taken by their countries in banning the sale and promotion of tobacco products, instituting cessation programmes, taxing tobacco products and regulating tobacco pricing, winning public support for tobacco control through health communication measures, negotiating with trade and commercial interests sympathetic to tobacco industry, enforcing existing tobacco legislation, and using revenue from tobacco taxation to encourage the cultivation of non-tobacco crops. WHO was requested to continue to provide technical and financial assistance, for example to help counteract tobacco industry interference in regulation efforts, to prevent dumping of cheap tobacco products, and to boost epidemiological monitoring capacity. One representative urged health ministers to impress upon their counterparts in trade ministries who were engaged in negotiations at WTO the health significance of plain packaging of tobacco products. It was widely agreed that multisectoral action that went beyond the narrow jurisdiction of health ministries was essential to implement effective tobacco-control measures.

105. Regarding healthy settings, speakers described a wide variety of Healthy Cities and Healthy Islands initiatives across the Region. Priorities needed to be reformulated, focusing on primary health care, water, sanitation and NCD risk factors. Encouragement and promotion of sports initiatives were frequently cited as an excellent starting point for campaigns to encourage healthy lifestyles. Family vegetable plots, disaster preparedness plans and breastfeeding advocacy campaigns were also noted. Healthy Cities and Healthy Islands approaches needed to be supplemented by a recognition of the importance of health workforce recruitment and retention, the unique geographical barriers faced by cities and islands that made them uniquely vulnerable to climate change, and the fact that the magnitude of the problems facing cities and islands could be obscured by disaggregated data that potentially masked disparities among populations. Representatives of Pacific island countries and areas urged WHO to recommit to the vision and principles of the Healthy Islands approach to afford protection against NCDs.

106. Following up on the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Disease, which had called upon WHO to develop a comprehensive global monitoring framework and prepare recommendations for a set of voluntary global targets for the prevention and control of NCDs, a number of representatives commented on the relevant background document prepared by the Secretariat. Although the majority of delegations expressed support for the list of targets and indicators contained in the background paper, some concerns were voiced about the very large number of targets and indicators, the cost of collecting information about them and certain technical and methodological issues. The set of indicators should be well-rounded and take into proper consideration all four major NCD risk factors, striking a balance between prevention, treatment and care.

107. One representative urged a common regional response to tackling NCDs, given that some of the underlying determinants such as marketing of food and non-alcoholic beverages to children were transnational issues. At the same time, regional action plans and comprehensive monitoring frameworks needed to be substantiated by evidence-based technical data that took adequate account of regional diversity. Mental disorders and chronic habits were not currently included among NCDs, yet they represented a major disease burden and needed to be addressed. Another speaker made the link between the harmful use of alcohol and domestic violence. Rather than dealing with the symptoms of

the problem head on, alcohol-triggered domestic violence could be addressed more effectively through strategies to boost the dignity and self-esteem of women, for example by guaranteeing gender parity and women's financial independence.

108. Several representatives recommended that the health-related MDGs should be reflected in social and development goals at the national and subnational levels to ensure commitment and leadership. Additionally, policy-makers should start thinking about action after the deadline for achievement of the MDGs in 2015. Specific areas hampering progress towards the various MDGs were cited, for example weak primary health care and the high price of medicines.

109. On malaria, several representatives urged the continuation of strenuous efforts including cross-border cooperation to tackle the problem of artemisinin resistance in the Greater Mekong Subregion by decreasing usage of monotherapies. Effective malaria containment relied on certification of geographical areas with a high risk of transmission, early diagnosis and prompt treatment, vector control, active and passive detection and epidemic management. One speaker urged WHO to accelerate the prequalification of new antimalarials. With regard to the Expanded Programme on Immunization, speakers described developments in their respective countries and broadly endorsed the recommendation by the Hepatitis B Expert Resource Panel that 2017 should be the target year for a less than 1% infection rate. One representative inquired whether countries with a current hepatitis B rate of less than 1% rate would need to request verification again for the target year.

110. On HIV/AIDS prevention and treatment, representatives described their different national programmes. Throughout the Region, particular attention was paid to high-risk and marginalized populations such as men who have sex with men, female sex workers, transgender populations, and intravenous drug users. Educational campaigns tended to focus on the primary drivers of HIV epidemics, such as low levels of condom use and sharing of injecting equipment, but safe sex campaigns were also targeted at young people. A few speakers emphasized that health systems needed to be more sympathetic to the situation of marginalized and vulnerable groups. In a context of financial crisis and with expectations of better management and tangible results, governments need to develop domestic funding mechanisms based on a reliable estimate of the resources required and the strategic use of antiretrovirals should play an important role. Specifically, much of the evidence used in planning HIV/AIDS control activities had been based on research from Africa, but the profile of the disease in the Western Pacific Region was completely different. One representative said that the categorization of her country as having low HIV prevalence had in fact diverted resources and attention from the issue and had led to continued acceleration of the HIV infection, especially in high-risk populations. The representatives of several Pacific island countries reported that the prevalence of the HIV infection in their countries was fortunately low, while sexually transmitted infections (STIs) were a much bigger problem.

111. One representative said that the progress report on HIV prevention and treatment failed to refer to the link between HIV and the promotion of human rights, which was a key aspect of the strategies advocated by the Joint United Nations Programme on HIV/AIDS (UNAIDS). In addition, mother-to-child transmission of HIV was not considered a priority target for HIV prevention and control interventions; it would perhaps be preferable to establish collaborative mechanisms with the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) in the context of reproductive health. Nor did the progress report before the Regional Committee mention the work of civil society organizations in HIV prevention and control, particularly the role they played in isolated and remote communities.

112. Statements were made on behalf of the Union for International Cancer Control, Alzheimer's Disease International, the International Bureau for Epilepsy, the International Agency for the

Prevention of Blindness, the International Alliance of Patients' Organizations, the World Hepatitis Alliance and Medical Women's International Association.

**COORDINATION OF THE WORK OF THE WORLD HEALTH ASSEMBLY,
THE EXECUTIVE BOARD AND THE REGIONAL COMMITTEE: Item 17 of the Agenda
(document WPR/RC63/12)**

World Health Assembly decision WHA65(9) WHO Reform

113. The Director, Programme Management, said that the governance reforms of the Organization envisaged under World Health Assembly decision WHA65(9) concerned methods of work and the role of the Governing Bodies. Among the proposed enhancements of the alignment between the Regional Committees and the Executive Committee was the proposal that the chairpersons of the Regional Committees should submit a summary report of their respective Committees' deliberations to the Executive Board. Regional Committees had also been asked to review the credentials of Member States attending Regional Committees and the participation of observers. It was proposed to replace Rule 3 of the Committee's Rules of Procedure and entrust the task of reviewing credentials to the officers of the Regional Committees. It was further proposed that the participation of observers should be stipulated through an amendment to Rule 2 of the Rules of Procedure to enable the Regional Committee to invite observers to attend its sessions, for example Member States from other regions, intergovernmental and nongovernmental organizations.

114. A key area of the managerial reforms would be to clearly define the roles and responsibilities of the Secretariat at the headquarters, regional and country levels. Improving WHO human resources policies and practices was another ongoing area of work, focusing on staff development, learning and performance management. It was hoped to build a more flexible and mobile workforce and increase the effectiveness of current recruitment processes.

115. Predictability and flexibility of financing had been the starting point of WHO reform, and the views of the Regional Committee on how to enhance the transparency, predictability and flexibility of WHO financing would provide valuable input to the discussion to be held at the Second extraordinary meeting of the Programme, Budget and Administration Committee of the Executive Board in December 2012 and the Director-General's report on that topic to the Executive Board in January 2013.

116. One representative said that the balance between voluntary and assessed contributions, as well as contributions from Member States and non-Member State donors, would be hard to change in the short term. It would be more useful to authorize the Director-General and Regional Directors to move funds between programmes in order to address areas with critical shortfalls. Governing body mechanisms for engaging with non-Member State stakeholders needed to be improved. There needed to be clarity of roles to avoid duplication and to ensure that resources effectively matched tasks. And finally, it should be acknowledged that jobs at WHO were not static, so consideration should be given to the increased use of fixed-term appointments for time-limited tasks, and academic requirements should be tailored to suit individual positions. Finally, the schedule of Governing Bodies meetings should be maintained as any change would disproportionately penalize the Western Pacific Region, where the holiday season differed from that in Europe.

117. The Committee considered a draft resolution on amendments to the Rules of Procedure of the Regional Committee.

118. The resolution was adopted (See resolution WPR/RC63.R8).

World Health Assembly resolution WHA65.4 Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country

World Health Assembly resolution WHA65.7 Implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

World Health Assembly resolution WHA65.8 Outcome of the World Conference on Social Determinants of Health;

World Health Assembly resolution WHA65.19 Substandard/spurious/false-labelled/falsified/counterfeit medical products

World Health Assembly resolution WHA65.20 WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies

World Health Assembly resolution WHA65.22 Follow up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

119. The Director, Programme Management, introduced discussion of various resolutions adopted by the World Health Assembly at its sixty-fifth session. On mental health, representatives called for the establishment of a regional mental health programme to give practical support to health services in Pacific island countries. On social determinants it was pointed out that in the Rio Declaration of 2011, the environmental dimension had been added, a point taken up in the Rio+20 conference earlier in 2012. The Organization should therefore consider the social and environmental determinants of health. The Regional Office was already working to enhance and extend the provision of mental health care with the WHO Representative in Fiji, and that work would continue. The Secretariat had taken note of the point about the environmental determinants of health.

120. One representative welcomed the work on counterfeit drugs, linking the subject to the earlier discussion on artemisinin resistance. It had been wise to decouple the subject from trade and intellectual property rights. Several countries focused on the Consultative Expert Working Group on Research and Development, encouraging the coordination of research by WHO while expressing certain reservations about the idea of a binding global instrument with compulsory levels of contribution from countries. It was clear, nevertheless, that the current mix of market incentives and funding arrangements did not work to the advantage of developing countries; and there was particular concern for least developed countries. A pooled funding mechanism might be tested on a small scale. National consultations should feed into expert meetings convened by the WHO Regional Office for the Western Pacific, which could guide funding for priorities selected on the basis of evidence.

121. The Director, Programme Management, noted the views of Member States and undertook to communicate them to the Director-General; the subjects would then be discussed at the Executive Board and the Health Assembly.

SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION: MEMBERSHIP OF THE POLICY AND COORDINATION COMMITTEE: Item 18 of the Agenda (document WPR/RC63/13)

122. The Director, Programme Management, said that the three Member States from the Region on the Policy and Coordination Committee of the WHO Special Programme of Research, Development and Research Training in Human Reproduction were currently Malaysia, the Philippines and Viet Nam. The term of office of the Philippines would expire on 31 December 2012, and the Regional Committee was requested to elect a Member State to succeed the Philippines.

123. The Regional Committee selected the Lao People's Democratic Republic to replace the Philippines (see decision WPR/RC63(1)).

TIME AND PLACE OF THE SIXTY-FOURTH AND SIXTY-FIFTH SESSIONS OF THE REGIONAL COMMITTEE: Item 19 of the Agenda

124. The Regional Director reminded the meeting that the Government of the Philippines had offered to host the sixty-fourth session of the Regional Committee. However, he said that since 2013 would be an election year for the post of Regional Director, it would be preferable to hold the sixty-fourth session at the Regional Office to avoid any appearance of a conflict of interest. It was agreed that the dates of the sixty-fourth session would be decided in further consultations with Member States, with a decision to be reached within two months.

125. The Regional Director had asked whether the Philippines might defer its hosting to the sixty-fifth session in 2014.

126. The representative of the Philippines noted the request that her country host the Regional Committee meeting in 2014 rather than in 2013 and said she would relay it to the appropriate officials.

127. The Committee agreed that its sixty-fourth session would be held at the Regional Office, in Manila (See resolution WPR/RC63.R9).

CLOSURE OF THE SESSION: Item 20 of the Agenda

128. After the usual exchange of courtesies, the sixty-third session of the Regional Committee was declared closed (See resolution WPR/RC63.R10).

AGENDA

Opening of the session and adoption of the agenda

1. Opening of the session
2. Address by the outgoing Chairperson
3. Election of new officers: Chairperson, Vice-Chairperson and Rapporteurs
4. Address by the incoming Chairperson
5. Adoption of the agenda

Keynote address

6. Address by the Director-General

Review of the work of WHO

7. Address by and Report of the Regional Director
WPR/RC63/2
8. Programme budget 2010–2011: budget performance (final report)
WPR/RC63/3

Policies, programmes and directions for the future

9. Proposed programme budget 2014–2015
WPR/RC63/4
10. Violence and injury prevention
WPR/RC63/5
11. Neglected tropical diseases
WPR/RC63/6
12. Measles elimination
WPR/RC63/7
WPR/RC63/7 Corr. 1
13. Nomination of the Regional Director: code of conduct
WPR/RC63/8
14. International health regulations
WPR/RC63/9
WPR/RC63/9 Corr. 1
15. Nutrition
WPR/RC63/10

Annex 1

Policies, programmes and directions for the future (continued)

16. Progress reports on technical programmes
 - 16.1 Tobacco control
 - 16.2 Healthy settings
 - 16.3 Noncommunicable diseases
 - 16.4 Health-related Millennium Development Goals
 - 16.5 Health financing
 - 16.6 Malaria and artemisinin resistance
 - 16.7 Expanded Programme on Immunization
 - 16.8 HIV/AIDS prevention and treatment

WPR/RC63/11
17. Coordination of the work of the World Health Assembly, the Executive Board and the Regional Committee

WPR/RC63/12

Membership of Global Committee

18. Special Programme of Research, Development and Research Training in Human Reproduction: Membership of the Policy and Coordination Committee

WPR/RC63/13

Other matters

19. Time and place of the sixty-fourth and sixty-fifth sessions of the Regional Committee
20. Closure of the session

LIST OF REPRESENTATIVES**I. REPRESENTATIVES OF MEMBER STATES****AUSTRALIA**

Professor Jane Halton, Secretary, Department of Health and Ageing, Canberra, *Chief Representative*

Mr Hugh Borrowman, Australian Ambassador to Viet Nam, Hanoi, *Alternate*

Mrs Jan Bennett, Principal Adviser, Australian Government, Department of Health and Ageing, Canberra, *Alternate*

Mr Simon Cotterell, Assistant Secretary, International Strategies, Australian Government, Department of Health and Ageing, Canberra, *Alternate*

Mr Michael Wilson, Minister-Counsellor, Mekong and Regional, Australian Agency for International Development, Hanoi, *Alternate*

Mr Chris Bedford, Director, International Health Policy, Australian Government, Department of Health and Ageing, Canberra, *Alternate*

Ms Amber Cernovs, Policy Manager, Australian Agency for International Development, Canberra, *Alternate*

BRUNEI DARUSSALAM

Mr Pehin Dato Adanan Yusof, Minister of Health, Ministry of Health, Bandar Seri Begawan, *Chief Representative*

Dr Norlila Abdul Jalil, Deputy Permanent Secretary (Professional and Technical), Ministry of Health, Bandar Seri Begawan, *Alternate*

Dr Khalifah Ismail, Director General of Health Services, Ministry of Health, Bandar Seri Begawan, *Alternate*

Ms Zahrah Hashim, Director of Policy and Planning, Ministry of Health, Bandar Seri Begawan, *Alternate*

Dr Anie Haryani A. Rahman, Senior Medical Officer, Ministry of Health, Bandar Seri Begawan, *Alternate*

Mr Shamshul Bharine Sabtu, Public Health Officer, Ministry of Health, Bandar Seri Begawan, *Alternate*

Dr Fandy Osman, Health Facilities Officer, Ministry of Health, Bandar Seri Begawan, *Alternate*

CAMBODIA

Dr Mam Bun Heng, Minister of Health, Ministry of Health, Phnom Penh, *Chief Representative*

Dr Lo Veasnakiry, Director of Planning and Health Information Department, Ministry of Health, Phnom Penh, *Alternate*

Annex 2

- CAMBODIA (continued) Dr Or Vandine, Director of International Cooperation Department, Ministry of Health, Phnom Penh, *Alternate*
- CHINA
- Dr Ren Minghui, Director-General, Department of International Cooperation, Ministry of Health, Beijing, *Chief Representative*
- Dr Mi Yanping, Division Director, Health Emergency Office, Ministry of Health, Beijing, *Alternate*
- Dr Song Li, Division Director, Department of Maternal & Children Health and Community Health, Ministry of Health, Beijing, *Alternate*
- Mr Yang Zhiguang, Deputy Division Director, Bureau of Disease Prevention and Control, Ministry of Health, Beijing, *Alternate*
- Ms Han Jianli, Deputy Division Director, Department of International Cooperation, Ministry of Health, Beijing, *Alternate*
- Ms Ru Lixia, Program Officer, Department of International Cooperation, Ministry of Health, Beijing, *Alternate*
- CHINA (HONG KONG)
- Dr Ko Wing-man, Secretary for Food and Health, Food and Health Bureau, Government of the Hong Kong Special Administrative Region, *Chief Representative*
- Dr Chan Hon-ye, Constance, Director of Health, Department of Health, Government of the Hong Kong Special Administrative Region, *Alternate*
- Mr Ho Siu-hong, Francis, Administrative Assistant to Secretary for Food and Health, Food and Health Bureau, Government of the Hong Kong Special Administrative Region, *Alternate*
- Ms Cheung King-sing, Estrella, Principal Assistant Secretary for Food and Health (Health), Food and Health Bureau, Government of the Hong Kong Special Administrative Region, *Alternate*
- Dr Lam Chau-kuen, Yonnie, Principal Medical and Health Officer, Department of Health, Government of the Hong Kong Special Administrative Region, *Alternate*
- Mr Tang Kwok-keung, Press Secretary to Secretary for Food and Health, Food and Health Bureau, Government of the Hong Kong Special Administrative Region, *Alternate*
- Dr Lee Ka-yin, Karen, Senior Medical and Health Officer, Department of Health, Government of the Hong Kong Special Administrative Region, *Alternate*
- Dr Cheung Yung-yan, Terence, Senior Medical and Health Officer, Department of Health, Government of the Hong Kong Special Administrative Region, *Alternate*

- CHINA (HONG KONG)
(continued) Dr Pang Fei-chau, Chief Manager, Hospital Authority, Department of Health, Government of the Hong Kong Special Administrative Region, *Alternate*
- CHINA (MACAO) Dr Cheang Seng Ip, Deputy Director, Health Bureau, Government of the Macao Special Administrative Region, *Chief Representative*
- Dr O Heng Kin, Medical Consultant in Public Health, Tobacco Control Office, Health Bureau, Government of the Macao Special Administrative Region, *Alternate*
- Dr Lam Chong, Head, Unit for Communicable Diseases, Center for Disease Control, Health Bureau, Government of the Macao Special Administrative Region, *Alternate*
- Dr Chan Tan Mui, Head, Unit for Non-communicable Diseases Prevention and Health Promotion, Health Bureau, Government of the Macao Special Administrative Region, *Alternate*
- Dr Li Tak Ming, Specialist of Internal Medicine, Macau Government Hospital, Health Bureau, Government of the Macao Special Administrative Region, *Alternate*
- Mr Wong Cheng Po, Research and Planning Office, Health Bureau, Government of the Macao Special Administrative Region, *Alternate*
- COOK ISLANDS Mr Nandi Tuaine Glassie, Minister of Health, Ministry of Health, Rarotonga, *Chief Representative*
- Mrs Elizabeth Iro, Secretary of Health, Ministry of Health, Rarotonga, *Alternate*
- FIJI Dr Neil Sharma, Minister for Health, Ministry of Health, Suva, *Chief Representative*
- Dr Pablo Romakin, Divisional Medical Officer, Northern Health Services, Ministry of Health, Labasa, *Alternate*
- FRANCE Dr Charles Tetaria, Ministre de la Santé et de la Solidarité de Polynésie française, en charge de la protection sociale généralisée, Papeete, *Chief Representative*
- Ms Sylvie Robineau, Membre du gouvernement de Nouvelle-Calédonie, chargée de la santé, de la protection sociale, de la solidarité, du handicap et de la formation professionnelle, Nouméa, *Alternate*
- Ms Brigitte Arthur, Chef du bureau international santé et protection sociale, délégation aux Affaires européennes et internationales, ministère des Affaires sociales et de la Santé, Paris, *Alternate*
- Mr Jean-Alain Course, Directeur des affaires sanitaires et sociales de Nouvelle-Calédonie, Direction des affaires sanitaires et sociales, Nouméa, *Alternate*

Annex 2

- FRANCE (continued) Dr Jean-Baptiste Dufourcq, Attaché de coopération santé à l'Ambassade de France à Hanoï, *Alternate*
- Dr Jean-Paul Grangeon, Médecin-inspecteur et chef du service des actions sanitaires de la direction des affaires sanitaires et sociales de la Nouvelle-Calédonie, Nouméa, *Alternate*
- Ms Cécile Orosco, Collaboratrice du membre de gouvernement de Nouvelle-Calédonie en chargé de la santé, de la protection sociale, de la solidarité, du handicap et de la formation professionnelle, Nouméa, *Alternate*
- Dr Jean-Marc Pujo, Directeur de la Santé de Polynésie française, Papeete, *Alternate*
- JAPAN Dr Masato Mugitani, Assistant Minister for Global Health, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo, *Chief Representative*
- Dr Naoko Ishikawa, Deputy Director, International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo, *Alternate*
- Dr Hiroyuki Hori, Deputy Director, International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo, *Alternate*
- Dr Haruka Sakamoto, Section Chief, International Cooperation Office, International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo, *Alternate*
- Dr Makiyo Iwata, Section Chief, International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo, *Alternate*
- Dr Masashi Ando, Medical Attaché, Embassy of Japan in Viet Nam, Ministry of Foreign Affairs, Hanoi, *Alternate*
- KIRIBATI Dr Kautu Tenaua, Minister for Health and Medical Services, Ministry of Health and Medical Services, Tarawa, *Chief Representative*
- Mr Elliot Ali, Secretary for Health and Medical Services, Ministry of Health and Medical Services, Tarawa, *Alternate*
- Dr Teatao Tira, Director of Public Health Services, Ministry of Health and Medical Services, Tarawa, *Alternate*
- LAO PEOPLE'S DEMOCRATIC REPUBLIC Dr Inlavanh Keobounphanh, Vice-Minister of Health, Ministry of Health, Vientiane, *Chief Representative*
- Dr Phath Keungsaneth, Director General, Department of Hygiene and Health Promotion, Ministry of Health, Vientiane, *Alternate*

Annex 2

LAO PEOPLE'S
DEMOCRATIC REPUBLIC
(continued)

Dr Bounlay Phommasack, Director General, Department of Communicable Diseases Control, Ministry of Health, Vientiane, *Alternate*

Dr Phasouk Vongvichit, Deputy Director General, Department of Planning and International Cooperation, Ministry of Health, Vientiane, *Alternate*

Dr Chansaly Phommavong, Technical Staff, Department of Planning and International Cooperation, Ministry of Health, Vientiane, *Alternate*

MALAYSIA

Mrs Datuk Rosnah Abd Rashid Shirlin, Deputy Minister of Health, Ministry of Health Malaysia, Putrajaya, *Chief Representative*

Datuk Dr Lokman Hakim Sulaiman, Deputy Director General of Health (Public Health), Ministry of Health Malaysia, Putrajaya, *Alternate*

Dato' Azmil Mohd Zabidi, Ambassador of Malaysia to the Socialist Republic of Viet Nam, Embassy of Malaysia, Hanoi, *Alternate*

Dr Salmah Bahri, Director, Pharmaceutical Practice and Development, Pharmaceutical Services Division, Ministry of Health Malaysia, Putrajaya, *Alternate*

Dr Norhayati Rusli, Deputy Director of Diseases Control (Surveillance), Disease Control Division, Ministry of Health Malaysia, Putrajaya, *Alternate*

Dr Feisul Idzwan Mustapha, Senior Principal Assistant Director, Disease Control Division, Ministry of Health Malaysia, Putrajaya, *Alternate*

Dr Rohani Jahis, Senior Principal Assistant Director, Disease Control Division, Ministry of Health Malaysia, Putrajaya, *Alternate*

Dr Majdah Mohamed, Senior Principal Assistant Director, Family Health Development Division, Ministry of Health Malaysia, Putrajaya, *Alternate*

Mr Mohd Badrie Abd Rahim, Senior Principal Assistant Secretary, Policy and International Relations Division, Ministry of Health Malaysia, Putrajaya, *Alternate*

Mr Kennedy Mayong, Minister Counsellor/Deputy Head of Mission, Embassy of Malaysia, Hanoi, *Alternate*

Ms Azra Firzadh Asangany, Counsellor, Embassy of Malaysia, Hanoi, *Alternate*

Dr Hirman Ismail, Principal Assistant Director, Medical Development Division, Ministry of Health Malaysia, Putrajaya, *Alternate*

Dr Lim Ren Jye, Principal Assistant Director, Traditional and Complementary Medicine Division, Ministry of Health Malaysia, Putrajaya, *Alternate*

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| MALAYSIA (continued) | Mr Imran Idris, Senior Private Secretary to the Deputy Minister of Health, Ministry of Health Malaysia, Putrajaya, <i>Alternate</i> |
| MARSHALL ISLANDS | Mr David Kabua, Minister of Health, Ministry of Health, Majuro, <i>Chief Representative</i> |
| | Mr Russell Edwards, Assistant Secretary of Health, Ministry of Health, Majuro, <i>Alternate</i> |
| MICRONESIA (FEDERATED STATES OF) | Dr Vita A. Skilling, Secretary, Department of Health and Social Affairs, Pohnpei, <i>Chief Representative</i> |
| | Dr Mayleen Ekiek, FSM TB Physician, Department of Health and Social Affairs, Pohnpei, <i>Alternate</i> |
| | Mrs Louisa Helgenberger, Immunization Program Manager, Department of Health and Social Affairs, Pohnpei, <i>Alternate</i> |
| | Mrs Fancelyn Solomon, Administrative Assistant, Department of Health and Social Affairs, Pohnpei, <i>Alternate</i> |
| MONGOLIA | Dr Tugsdelger Sovd, Director, Department of Public Health Policy Implementation and Coordination, Ministry of Health, Ulaanbaatar, <i>Chief Representative</i> |
| | Ms Yanjmaa Binderiya, Director, Division of International Cooperation, Ministry of Health, Ulaanbaatar, <i>Alternate</i> |
| | Dr Munkhtaivan Adiya, Director, Health Project, Millennium Challenge Account-Mongolia, Ministry of Health, Ulaanbaatar, <i>Alternate</i> |
| NAURU | Dr Lepani Waqatakirewa, Health Services Adviser, Ministry of Health and Medical Services, Central Pacific, <i>Chief Representative</i> |
| | Ms Nancy Benjamin, Senior Nursing Officer, Ministry of Health and Medical Services, Central Pacific, <i>Alternate</i> |
| NEW ZEALAND | Dr Mark Jacobs, Director of Public Health, Ministry of Health, Wellington, <i>Chief Representative</i> |
| NIUE * | |
| PALAU | Mr Temengil Temengil, International Health Coordinator, Ministry of Health, Koror, <i>Chief Representative</i> |
| | Mr Yorah Demei, Ministry of Health, Koror, <i>Alternate</i> |
| PAPUA NEW GUINEA | Mr Michael Malabag, Minister for Health and HIV/AIDS, Ministry of Health, Waigani, <i>Chief Representative</i> |

*did not attend

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- PAPUA NEW GUINEA
(continued)
- Mr Pascoe Kase, Secretary, National Department of Health, Waigani, *Alternate*
- Dr Paison Dakulala, Deputy Secretary, National Health Service Standards, National Department of Health, Waigani, *Alternate*
- Mr Enoch Posanai, Executive Manager, Public Health Division, National Department of Health, Waigani, *Alternate*
- Dr Sibauk Bieb Vivaldo, Manager, Disease Control Branch, National Department of Health, Waigani, *Alternate*
- Mr Tino Sariman, First Secretary to Minister, Ministry of Health, Waigani, *Alternate*
- PHILIPPINES
- Dr Madeleine de Rosas-Valera, Assistant Secretary, Health Policy Finance and Research Development Cluster, Department of Health, Manila, *Chief Representative*
- Dr Ariel I. Valencia, Director IV, Center for Health Development – CARAGA, Department of Health, Butuan City, *Alternate*
- Dr Jose Mari C. Fermin, Chief, Western Visayas Medical Center, Iloilo City, *Alternate*
- REPUBLIC OF KOREA
- Dr Lee Tae Han, Assistant Minister, Office of Health Policy, Ministry of Health and Welfare, Seoul, *Chief Representative*
- Dr Jun Byung Yool, Deputy Minister, Korea Centers for Disease Control and Prevention, Ministry of Health and Welfare, Seoul, *Alternate*
- Dr Chang Jae Hyuk, Director General, Bureau of Health Insurance Policy, Ministry of Health and Welfare, Seoul, *Alternate*
- Ms Shin Kkotshigye, Director, Division of International Cooperation, Ministry of Health and Welfare, Seoul, *Alternate*
- Mr Kim Young-Hak, Director, Division of International Cooperation, Ministry of Health and Welfare, Seoul, *Alternate*
- Dr Kim Young-Taek, Deputy Director, Division of Infectious Disease Control, Ministry of Health and Welfare, Seoul, *Alternate*
- Dr Park Young-Joon, Medical Officer, Division of Vaccine-Preventable Disease Control and the National Immunization Program, Korea Centers for Disease Control and Prevention, Ministry of Health and Welfare, Seoul, *Alternate*
- Mr Chu Chae-Shin, Senior Researcher, Division of Epidemic Intelligence Service, Korea Centers for Disease Control and Prevention, Ministry of Health and Welfare, Seoul, *Alternate*

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REPUBLIC OF KOREA
(continued)

Dr Han Sang-Kyun, Director, Tobacco Control Task Force, Ministry of Health and Welfare, Seoul, *Alternate*

Mr Jo Sung-Duk, Assistant Director, Division of International Cooperation, Ministry of Health and Welfare, Seoul, *Alternate*

Ms Kim Ha-Na, Interpreter, Division of International Cooperation, Ministry of Health and Welfare, Seoul, *Alternate*

Professor Moon Chang-Jin, President, Korea Health Promotion Foundation, Ministry of Health and Welfare, Seoul, *Alternate*

Ms Bae Hyunim, Manager, Korea Health Promotion Foundation, Ministry of Health and Welfare, Seoul, *Alternate*

SAMOA

Dr Leao Talalelei Tuitama, Minister of Health, Ministry of Health, Motootua, *Chief Representative*

Mrs Palanitina Tupuimatagi Toelupe, Director General, Ministry of Health, Motootua, *Alternate*

Ms Delphina Taoa Kerslake, Legal Consultant, Ministry of Health, Apia, *Alternate*

Mrs Letelemalanuola Tuitama, Spouse of the Minister, Ministry of Health, Motootua, *Alternate*

SINGAPORE

Mr Gan Kim Yong, Minister for Health, Ministry of Health, *Chief Representative*

Mrs Tan Ching Yee, Permanent Secretary, Ministry of Health, *Alternate*

Mr Ng Teck Hean, Ambassador, Embassy of the Republic of Singapore, Hanoi, *Alternate*

Dr Derrick Heng, Group Director, Public Health Group, Ministry of Health, *Alternate*

Dr Lyn James, Director, Epidemiology and Disease Control Division, Ministry of Health, *Alternate*

Mr Raymond Chow, Deputy Chief of Mission, Singapore Embassy in Hanoi, *Alternate*

Dr Alvin Lee, Assistant Director, Clinical Strategies, Primary and Community Care Division, Ministry of Health, *Alternate*

Ms Wong Lee Ting, Second Secretary (Political), Embassy of the Republic of Singapore, Hanoi, *Alternate*

Mr Chua Yong Khian, Assistant Manager, International Cooperation Branch, Epidemiology and Disease Control Division, Ministry of Health, *Alternate*

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| SINGAPORE (continued) | Mr How Hwee Boon, Personal Security Officer to Minister, Singapore Police Force, Ministry of Health, <i>Alternate</i> |
| SOLOMON ISLANDS | Mr Charles Sigoto, Minister, Ministry of Health and Medical Services, Honiara, <i>Chief Representative</i> Dr Lester Gideon Ross, Permanent Secretary, Ministry of Health and Medical Services, Honiara, <i>Alternate</i> Dr Gregory Loko Jilini, Provincial Health Director - Western Province, National Referral Hospital, Ministry of Health and Medical Services, Western Province, <i>Alternate</i> |
| TOKELAU | Ms Leane Ester Pearce, Director of Health, Tokelau Apia Liaison Office, Apia, <i>Chief Representative</i> |
| TONGA | Dr Siale Akau'ola, Director for Health, Ministry of Health, Nuku'alofa, <i>Chief Representative</i> |
| TUVALU | Mr Taom Tanukale, Minister for Health, Ministry of Health, Funafuti, <i>Chief Representative</i> Mr Uale Taleni, Permanent Secretary for Health, Ministry of Health, Funafuti, <i>Alternate</i> |
| UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND* | |
| UNITED STATES OF AMERICA | Dr Nils Daulaire, Director, Office of Global Affairs, Department of Health and Human Services, Washington, D.C., <i>Chief Representative</i> Ms Erika Elvander, Branch Chief, Asia and the Pacific, Office of Global Affairs, Department of Health and Human Services, Washington, D.C., <i>Alternate</i> Dr James Gillan, Director, Department of Public Health and Social Services, Mangilao, <i>Alternate</i> Ms Judnefera Rasayon, International Relations Officer, Office of Human Security, Bureau of International Organizations Affairs, Department of State, Washington, D.C., <i>Alternate</i> |
| VANUATU | Mr Willie Reuben Abel, Minister of Health, Ministry of Health, Port Vila, <i>Chief Representative</i> Mr Len Tarivonda, Director, Department of Public Health, Ministry of Health, Port Vila, <i>Alternate</i> |

*did not attend

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- VANUATU (continued) Mr Carlot Noel Karie, Political Advisor to the Minister, Ministry of Health, Port Vila, *Alternate*
- VIET NAM
- Associate Professor Dr Nguyen Thi Kim Tien, Minister of Health, Ministry of Health of Viet Nam, Hanoi, *Chief Representative*
- Associate Professor Dr Nguyen Thanh Long, Vice Minister of Health, Ministry of Health of Viet Nam, Hanoi, *Alternate*
- Dr Dau Xuan Canh, Deputy Director General, Cultural and Social Department, Office of the Government, Hanoi, *Alternate*
- Dr Tran Thi Giang Huong, Director General, International Cooperation Department, Ministry of Health of Viet Nam, Hanoi, *Alternate*
- Associate Professor Dr Luong Ngoc Khue, Director General, Administration of Medical Services, Ministry of Health of Viet Nam, Hanoi, *Alternate*
- Associate Professor Dr Pham Le Tuan, Director General, Department of Planning and Finance, Ministry of Health of Viet Nam, Hanoi, *Alternate*
- Dr Tong Thi Song Huong, Director General, Department of Health Insurance, Ministry of Health of Viet Nam, Hanoi, *Alternate*
- Dr Truong Quoc Cuong, Director General, Drug Administration, Ministry of Health of Viet Nam, Hanoi, *Alternate*
- Associate Professor Dr Le Thi Hop, Director General, National Institute of Nutrition, Hanoi, *Alternate*
- Associate Professor Dr Nguyen Tran Hien, Director General, National Institute of Hygiene and Epidemiology, Hanoi, *Alternate*
- Professor Dr Le Quang Cuong, Director General, Health and Strategy Policy Institute, Ministry of Health of Viet Nam, Hanoi, *Alternate*
- Associate Professor Dr Nguyen Manh Hung, Director General, National Institute of Malaria Parasitology and Entomology, Hanoi, *Alternate*
- Associate Professor Dr Nguyen Van Kinh, Director General, Central Hospital for Tropical Diseases, Hanoi, *Alternate*
- Associate Professor Dr Do Nhu Hon, Director General, Viet Nam National Hospital of Ophthalmology, Hanoi, *Alternate*
- Mr Do Hung Viet, Deputy Director General, International Organizations Department, Ministry of Foreign Affairs, Hanoi, *Alternate*
- Ms Nguyen Thi Minh Chau, Deputy Director General, International Cooperation Department, Ministry of Health of Viet Nam, Hanoi, *Alternate*

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| VIET NAM (continued) | Dr Nguyen Manh Cuong, Deputy Director General, International Cooperation Department, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Dr Nguyen Hung Long, Deputy Director General, Viet Nam Food Administration, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Dr Nguyen Hoang Long, Deputy Director General, Department of Planning and Finance, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Dr Le Van Kham, Deputy Director General, Department of Health Insurance, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Associate Professor Dr Bui Duc Duong, Deputy Director General, Administration of HIV/AIDS Control, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Dr Luu Thi Hong, Deputy Director General, Department of Maternal and Child Health, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Associate Professor Dr Tran Thi Ngoc Lan, Deputy Director General, Administration of Environmental Health, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Dr Tran Dac Phu, Deputy Director General, Administration of Environmental Health, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Associate Professor Dr Phan Trong Lan, Deputy Director General, Administration of Preventive Medicine, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Dr Tran Thanh Duong, Deputy Director General, Administration of Preventive Medicine, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Dr Nguyen Minh Hang, Head, Division of Vaccines, Biologicals and Biosafety, Administration of Preventive Medicine, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |
| | Ms Doan Phuong Thao, Officer, International Cooperation Department, Ministry of Health of Viet Nam, Hanoi, <i>Alternate</i> |

II. REPRESENTATIVES OF UNITED NATIONS OFFICES, SPECIALIZED AGENCIES AND RELATED ORGANIZATIONS

| | |
|-----------------------------------|--|
| Food and Agriculture Organization | Mr Hiroyuki Konuma, Assistant Director-General & Regional Director, Food and Agriculture Organization, Regional Office for Asia and the Pacific, Bangkok |
| United Nations Children's Fund | Mr Daniel Toole, UNICEF Regional Director, UNICEF East Asia and Pacific, Bangkok |

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World Food Programme

Mr Kenro Oshidari, Regional Director for Asia, World Food Programme, Bangkok

III. OBSERVERS

Department of Health, Philippines

Dr Juanita Fandiño
Ms Josefina delos Reyes
Ms Laurita R. Mendoza
Ms Maria Cristy Yuson

Flour Fortification Initiative

Ms Karen Codling
Mr Scott Montgomery

GAVI Alliance

Dr Ranjana Kumar

Government of Viet Nam

Dr Nguyen Xuan Truong
Professor Dr Nguyen Cong Khan
Dr Tran Thi Oanh
Dr Pham Van Tac
Dr Nguyen Minh Tuan
Dr Tran Duc Long
Dr Pham Vu Khanh
Dr Dang Van Chinh
Dr Vu Sinh Nam
Dr Tran Van Chien
Dr Tran Van Thuan
Dr Nguyen Quoc Anh
Dr Tran Ngoc Luong
Dr Vu Ba Quyet
Associate Professor Le Thanh Hai
Dr Dinh Ngoc Sy
Dr Nguyen Duy Bao
Professor Dr Le Vu Anh
Professor Dr Nguyen Duc Hinh
Associate Professor Dr Nguyen Thanh Binh
Dr Bui Trong Chien
Dr Pham Tho Duoc
Dr Nguyen Van Chuong
Dr Tang Chi Thuong
Dr Hoang Quoc Cuong
Dr Le Thanh Dong
Ms Tran Thanh Binh
Ms Ngo Thi Hop
Ms Nguyen Hoang Linh
Ms Ha Thi Dung

Hong Kong Economic and Trade Office

Mr Paul Leung Chi Hong

International Baby Food Action Network

Ms Joo Kean Yeong

The Chinese University of Hong Kong

Professor Shiu Hung Lee

IV. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS

| | |
|---|--|
| Alzheimer's Disease International | Dr (Robert) Theam Hock Yeoh Mr Wai Hung Henry Shie |
| Framework Convention Alliance on Tobacco Control | Mrs Viet Hoa Le |
| Helen Keller International | Ms Nancy J. Haselow |
| International Agency for the Prevention of Blindness | Mr Sanjeev Commar Ms Lesley Podesta Ms Komal Ram Dr Leshan Tan |
| International Alliance of Patients' Organizations | Mr Kin Ping Tsang Ms Janette Curtain |
| International Bureau for Epilepsy | Dr Shung-Lon Lai |
| International Confederation of Midwives | Mrs Mary Kirk |
| International Council for Control of Iodine Deficiency Disorders | Dr Gary Ma |
| International Diabetes Federation | Dr Tran Quang Khanh |
| International Federation of Gynecology and Obstetrics | Associate Professor Nguyen Viet Tien |
| International Federation of Medical Students Association | Dr Vincent Khor Mr Po Liang Chen Ms Rachael Purcell Dr Wen Shi Ms Kelly Thompson |
| International Life Saving Federation | Mr Justin Scarr |
| International Life Sciences Institute | Mr Geoffry Lamar Smith Mrs Boon Yee Yeong |
| International Pharmaceutical Federation | Dr Reynaldo Umali |
| International Society of Radiographers and Radiological Technologists | Dr Maria Yy Law |

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| International Special Dietary Foods Industries | Mr Claas Schaberg Mr Thomas Evers Ms Venetta Miranda Mr Tuan Vu Quoc Ms Putri Realita Ms Ziting Zhang |
| Medical Women's International Association | Dr Arino Yaguchi |
| Thalassaemia International Federation | Professor Nguyen Anh Tri |
| Union for International Cancer Control | Professor Ian Norman Olver |
| World Council of Optometry | Professor George Woo |
| World Federation of Hemophilia | Mr Robert Leung |
| World Hepatitis Alliance | Mr Charles Gore |
| World Medical Association | Dr Masami Ishii Mr Yuji Noto |
| World Vision International | Dr Sri Chander |

**LIST OF ORGANIZATIONS WHOSE REPRESENTATIVES
MADE STATEMENTS TO THE REGIONAL COMMITTEE**

Alzheimer's Disease International

International Agency for the Prevention of Blindness

International Alliance of Patients' Organization

International Bureau of Epilepsy

International Council for Control of Iodine Deficiency Disorders

International Federation of Medical Students' Association

International Life Sciences Institute – South East Asia

GAVI Alliance

Union for International Cancer Control

World Vision International

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**ADDRESS BY ASSOCIATE PROFESSOR DR NGUYEN THI KIM TIEN,
MINISTER OF HEALTH, VIET NAM, AT THE OPENING CEREMONY
OF THE SIXTY-THIRD SESSION OF THE WHO REGIONAL COMMITTEE
FOR THE WESTERN PACIFIC**

Her Excellency, Professor Dr Nguyen Thi Doan, member of the Party Central Executive Committee, Vice President of the Socialist Republic of Viet Nam;
Dr Shin Young-soo, World Health Organization Director for the West Pacific;
Ministers of Health from 37 WHO member nations and territories;
Esteemed participants, distinguished guests, ladies and gentlemen:

On behalf of the Ministry of Health, Socialist Republic of Viet Nam, the host agency of the sixty-third session of the World Health Organization's Regional Committee for the West Pacific, I am delighted to welcome you to this sixty-third session of the Regional Committee for the West Pacific, and my best regards and wishes to you all.

Ladies and gentlemen,

Over the years, in line with the Party's Doi moi policy, a socialism-oriented market economy has been set in motion in Viet Nam, with numerous major socioeconomic achievements obtained. In particular, people's health care in Viet Nam has increasingly been a core part of the agenda and a major area of support of the Vietnamese Party, State and government, through various macro policies, schemes and enormous investment. Human development indices in Viet Nam are higher than in many other countries with equal per capita income.

The government of Viet Nam invariably considers people's health care a mission of the entire society and political system. Health care in Viet Nam has consistently enshrined the philosophy of integrating traditional and modern medicine, valuing health education and preventive medicine, giving priority to preventive care, and building a solid population-based health network to lay the ground work for the promotion of primary health care. Added to that, the health sector in Viet Nam has worked tirelessly in achieving Millennium Development Goals, developing a quality health workforce, and building an advanced, hi-tech health system to keep up with other countries in the region and the world, with an outlook for equity, efficiency and development in health.

In the past few years, with ceaseless efforts, numerous impressive health outcomes have been achieved in Viet Nam. The population-based health network has been extensively developed nationwide. To date, 100% of the communes in the country have had a health center and 80% of them now have a village health worker. All communes in remote and hard-to-reach areas now have a village midwife in service. Viet Nam is working hard to maintain on track in achieving its health-related Millennium Development Targets. Primary health care has consistently been promoted and helped improve the quality of primary health care for the people. Viet Nam is also working tirelessly to achieve the set target of universal health insurance coverage by 2020. The government has also demonstrated strong commitments to keep the universal health insurance plan on track, through calling on the public to subscribe to health insurance, financing 100% of the cost for health insurance cards for the poor, children under six years, individuals with patriotic contribution and ethnic minorities, and a major share of the cost of health insurance cards for the near-poor and students.

In addition, the local health sector has been facing bounteous barriers and challenges. One of which is the risk of falling into the poverty trap typical of a country just joining the rank of lower-middle income nations. A gap in access to health services continues to exist between different parts of

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the country. Allocation of health resources remains suboptimal. Out-of-pocket health expenses remain high. Health insurance coverage is still modest, at over 64%. The quality of care has fallen short meeting the people's expectation.

To get to where we are today, the Ministry of Health sincerely appreciates the strong guidance and support of the leaders of the Party, State and government, and close cooperation of central and subnational ministries and line agencies in our mission of people's health care and protection.

The Ministry of Health always values and appreciates the invaluable support of the World Health Organization, the top level agency in charge of health care representing the United Nations and various development partners. The World Health Organization has been supporting Viet Nam for nearly four decades now through technical assistance, technology transfer, assistance in developing health strategies, development of expanded immunization, prevention and control of emerging diseases, including SARS, influenza A H5N1, H1N1, prevention and control of tuberculosis and malaria, non-communicable diseases and other public health programs. The World Health Organization's cooperation and support forms a comprehensive and broad-based supportive partnership, with various approaches introduced and necessary policy advice provided to Viet Nam and other countries in the Region as well. Viet Nam's hosting this regional meeting session demonstrates our commitments in cooperation to achieve health targets of Viet Nam and the entire Region. We hope that the meeting will become a vital hallmark in the health partnership between Viet Nam and other countries in the Region, and take Viet Nam's role to new heights in the full-scale cooperation with the World Health Organization and its member States. This is also an opportunity for regional Member States to share and exchange success stories in health development.

Taking this opportunity, we want to thank United Nations agencies, development agencies of various countries around the world, development banks and international non-governmental organizations for your invaluable cooperation and support to Viet Nam's health sector, both technically and financially. This has played a significant role in the progress to date in health care and protection in Viet Nam over the years.

Ladies and gentlemen,

As seen in the meeting agenda, this meeting session will review the progress of the partnership and discuss various important health issues in the Region. As the host country, we solicit and appreciate your dedicated and effective participation for the ultimate success of the event.

Again, I would like to present my best wishes to Her Excellency Prof Dr Nguyen Thi Doan, Vice President of the Socialist Republic of Viet Nam, Dr. Shin Young-soo, World Health Organization Director for the West Pacific, and each and every one of you. I wish enormous success to the meeting and an effective working day to all the participants. Don't forget to enjoy the grace of our thousand-year capital city of Hanoi, Ha Long bay, a new world natural wonder and capture first hand fond memories of the beautiful country and people of Viet Nam!

Thank you.

**ADDRESS BY HER EXCELLENCY NGUYEN THI DOAN,
VICE PRESIDENT OF VIET NAM, AT THE OPENING CEREMONY
OF THE SIXTY-THIRD SESSION OF THE WHO REGIONAL COMMITTEE
FOR THE WESTERN PACIFIC**

Honourable Dr Shin Young-soo, WHO Regional Director for the Western Pacific;
Honourable ministers of health;
Representatives from international organizations,
Ladies and gentlemen:

On behalf of the Government of Socialist Republic of Viet Nam I would like to warmly welcome all representatives and distinguished guests attending the sixty-third session of the Regional Committee for the Western Pacific hosted by Viet Nam.

Representatives!

Viet Nam has many similarities and close relationships with countries in the Western Pacific. The linkages among our nations have been strongly developing in many aspects, including health sector. Since 1976 when WHO established official cooperation with Viet Nam, the cooperation between the nation and WHO, in general and the Western Pacific, in particular has been advancing successfully. WHO has made great contributions to the achievements of the Viet Nam's health sector and healthcare for the people. As a member country, Viet Nam has been demonstrating its active and responsible role in the World Health Organization. The country's efforts have been highly recognized by the international community. The hosting of the sixty-third session of the Regional Committee for the Western Pacific has partially proven it. We would like to express our special thanks and highly appreciate the trust by WHO and regional countries for Viet Nam. This is an important event, confirming the close and efficient cooperation between Viet Nam and the WHO as well as good relationships between Viet Nam and other countries, which helps the nation to more intensively integrate into the world community.

On this occasion, on behalf of the Government and people of Viet Nam, I would like express my profound gratitude and wish to continue to receive support and cooperation from WHO, member countries and international colleagues and friends in our cause of construction and development for Viet Nam.

Distinguished guests!

President Ho Chi Minh, the great leader of Viet Nam clearly identified: "To build the homeland, to develop new lifestyles, everything requires good health". He also said: "If one people is weak, the whole country is weak; healthy people empower the nation". The Party and Government of Viet Nam have been considering his teaching as important directions to develop orientations and policies on developing health care and protection for the people. Many relevant policies have been timely promulgated, giving priority to health financing, attaching socioeconomic development with social welfare towards equity and sustainability, and considering investment for health as investment for country development. Viet Nam has been making significant strides in cooperating with WHO and the Region to overcome consequences of tens-year warfare, advancing together with WHO member countries in the regions in health care and protection for the people. Therefore, in the past period, especially since the renovation, together with great achievements in the country's reform, Viet Nam has been recognized by the United Nations as one of the examples in implementing the Millennium

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Development Goals (MDGs), especially in reducing poverty, maternal and child mortalities, malnutrition as well as efficiently controlling TB, malaria and HIV/AIDS.

Ladies and gentlemen!

The WHO Western Pacific has the most crowded population (accounting for nearly one third of the world population with 1.6 billion people) and this is the emerging Region with active development. In the past years, the WHO Western Pacific gained notable achievements. However we are facing new challenges that create adverse impacts on the development of each nation's future generations. Many strange diseases appear and treatment mechanisms have not been discovered. The prevalence of some fatal diseases keeps increasing, threatening the human resources development of countries. Besides, increasing traffic accidents and violence cause injuries. Nonetheless the manpower to deal with such issues is a question to answer. At this conference, may I request all representatives to actively seek for a common voice to address cross-cutting issues, work together to study important priorities in the health sector and health care in each nation and the Region such as prevention and control of infectious diseases, non-communicable diseases, violence and injuries, expanded immunization, health financing and health-related MDGs. In my expectation, with goodwill response, the conference will map out effective strategies, resolutions and action plans to bring about great benefits for people in member countries as well as making active contributions to the development of the health sector in the Region.

Representatives!

With all immense significance of the conference, once again, on behalf of the Government of Socialist Republic of Viet Nam, I would like to wish all representative good health, happiness and success to the conference.

I would like to take this opportunity to wish all delegates to have the best possible stay in Viet Nam, enjoy beautiful autumn days in Hanoi, hospitality of the Vietnamese and have many lovely memories of our country.

Thank you very much.

VIDEO ADDRESS BY THE DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION, DR MARGARET CHAN, AT THE OPENING CEREMONY OF THE SIXTY-THIRD SESSION OF THE WHO REGIONAL COMMITTEE FOR THE WESTERN PACIFIC

Excellencies; honourable ministers; distinguished delegates; Dr Shin; ladies and gentlemen:

I wish to thank the Government of Viet Nam for hosting the sixty-third session of the Regional Committee for the Western Pacific.

I deeply regret that my need to attend the United Nations General Assembly prevents me from being in Hanoi to greet you in person. I had been looking forward to speaking to you in Viet Nam. In 2003, while still in Hong Kong, I was a fellow traveller with this country during the SARS outbreak. My conversations with officials in Viet Nam's ministry of health left a strong impression of scientific competence, public health efficiency, and a determination to stop that virus dead in its tracks.

The record of health improvements in this country supports my impressions with solid evidence. Through far-sighted policies, Viet Nam has achieved improvements in health, education, and living conditions that rival those seen in much wealthier nations. Viet Nam is often singled out as one of the best models of poverty reduction.

Perhaps most important, health in this country is regarded as a national asset at the highest level of government. And this is the biggest prerequisite for success in any country, in any region.

WHO reform is on the agenda for this session.

From the outset, the reform process has been in the hands of Member States. You have before you drafts of the next programme budget and the Twelfth General Programme of Work.

These documents let you see how priority setting works in practice.

Member States have asked that these documents be reviewed and discussed by Regional Committees and subsequently revised by the Secretariat.

Please keep in mind that both documents are works in progress.

Ladies and gentlemen,

As I have said before, the job of public health keeps getting harder.

More and more, we are on the receiving end of policies made in other sectors. Our ability to shape these policies is often limited, especially at a time when so many economies are fragile.

If a health-promoting policy is perceived to threaten the profits of an economically important industry, we can expect to have a battle on our hands.

Sometimes we win those battles. Let me mention one encouraging win.

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Last month, Australia's High Court upheld legislation mandating plain packaging, with no branding, for tobacco products. The legislation had been aggressively challenged by several large tobacco companies.

The court ruling was a huge victory for the Australian government, but also for public health. It opens a brave new world for tobacco control.

In this case, concern about protecting the public's health took precedence over issues of intellectual property rights.

As Australia's Attorney-General Nicola Roxon noted, "The message to the rest of the world is that big tobacco can be taken on and beaten."

I think we can all take heart from a game-changing story where the good guys win.

I wish you a productive and successful Regional Committee meeting.

Thank you.

**ADDRESS BY THE WORLD HEALTH ORGANIZATION REGIONAL DIRECTOR FOR
THE WESTERN PACIFIC, DR SHIN YOUNG-SOO, AT THE OPENING CEREMONY OF
THE SIXTY-THIRD SESSION OF THE WHO REGIONAL COMMITTEE
FOR THE WESTERN PACIFIC**

Her Excellency Nguyen Thi Doan, Vice President of Viet Nam;
Honourable Nguyen Thi Kim Tien, Minister of Health;
Honourable Pehin Dato Adanan Yusof, Chairperson of the Regional Committee;
Esteemed representatives of Member States and distinguished guests;
Ladies and gentlemen:

It is my great pleasure to welcome you to the sixty-third session of the WHO Regional Committee for the Western Pacific.

On behalf of our Member States and all the representatives gathered here, I would like to express my sincerest gratitude to the Government of Viet Nam for their gracious hosting of this session of the Regional Committee.

It is indeed a pleasure to be back in Hanoi to witness the remarkable economic development achieved here over the past two decades. Signs of progress are everywhere.

Viet Nam has made tremendous strides on the health front — the result of tireless efforts to address the challenges of rapid development and the transition to a middle-income country.

Viet Nam has strengthened its core capacity to comply with International Health Regulations and has made significant improvements through implementation of the latest Asia Pacific Strategy for Emerging Diseases.

The Government is also to be congratulated for progress on tobacco control. In June the National Assembly passed The Tobacco Control Law of Viet Nam, the first such law aimed at the prevention and control of tobacco harm.

The new tobacco law is a milestone for public health in Viet Nam and for the Region.

Viet Nam is also taking strong steps towards universal health coverage.

As in other countries, rapid economic development has led to an increase in noncommunicable diseases and injuries.

It has also increased population mobility and widened inequalities among the poor and disadvantaged and ethnic minorities.

Viet Nam is responding by upgrading and building a stronger and more resilient health system.

It is a daunting task, but the Ministry of Health is up to the challenge.

They are working hard and fully committed to addressing these issues.

This afternoon we will learn more about this endeavour.

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These issues and challenges are not unique to Viet Nam. We will be discussing many of them in the context of other countries during the coming week.

For the first time in 10 years the Regional Committee will look at new ways of addressing nutrition and food security issues.

To strengthen collaboration among agencies and partners, I have invited several experts and my colleague regional directors from other United Nations agencies for a high-level panel discussion tomorrow afternoon.

We will also review progress on the control of neglected tropical diseases and the implementation of International Health Regulations.

Member States will share experiences in addressing many of the Region's pressing and challenging health issues, such as malaria and artemisinin resistance, injury and violence prevention, and HIV/AIDS prevention and treatment.

We will also discuss the General Programme of Work and the programme budgets of the Organization.

It is a full agenda.

Before I finish, I would like to take a minute to congratulate Australia for their tremendous contribution to the fight against tobacco.

We applaud the recent decision by Australia's High Court endorsing new anti-tobacco marketing laws and dismissing a challenge from cigarette companies.

This is a major turning point in our battle against tobacco and will have a major impact on public health worldwide.

I look forward to this week's session, and hope the discussions and decisions of the Regional Committee will prove useful and instructive for all of our Member States.

Finally, I would like to thank the Government of Viet Nam once again for their gracious hosting of this session of the Regional Committee.

We feel the warmth and sincerity of their hospitality and generosity at every turn and corner

Thank you.

**ADDRESS BY THE OUTGOING CHAIRPERSON, PEHIN DATO ADANAN YUSOF,
MINISTER OF HEALTH, BRUNEI DARUSSALAM, AT THE OPENING CEREMONY
OF THE SIXTY-THIRD SESSION OF THE WHO REGIONAL COMMITTEE
FOR THE WESTERN PACIFIC**

Her Excellency, Nguyen Thi Doan, Vice President of the Socialist Republic of Viet Nam;
Honourable Nguyen Thi Kim Tien, Minister of Health of the Socialist Republic of Viet Nam;
Honourable ministers, distinguished representatives;
Dr Shin Young-soo, Regional Director, WHO Western Pacific Region;
Honourable members of the diplomatic corps;
Representatives of agencies of the United Nations, intergovernmental and
nongovernmental organizations;
Ladies and gentlemen:

As Chairperson of the sixty-second session of the WHO Regional Committee for the Western Pacific, it is my honour to convey to the Government of the Socialist Republic of Viet Nam through Your Excellency Vice President Nguyen Thi Doan, the warm greetings, the sincere appreciation and thanks of the 37 countries and areas that comprise the Western Pacific Region, for the kind invitation to host this sixty-third session of the Regional Committee.

Your Excellency, Vice President Nguyen Thi Doan, we are inspired by your forward looking speech which encourages us the members of the Regional Committee for the Western Pacific to work even harder, strengthen our cooperation in striving to enhance the health and quality of life of our people.

I believe I speak for all of us when I say that sessions of the Committee take on a particularly special significance when held outside of the WHO Regional Office in Manila. Not only are we given this wonderful opportunity to gain first-hand experience of your rich culture and traditions but also to see the beauty of your country and discover a few of Hanoi's wonders, including the famous Vietnamese cuisine.

Viet Nam is an interesting study of contrasts and has always been among the top in the list of places that people would love to visit. The country is one of Southeast Asia's fastest growing economies and yet, it has maintained its deep sense of history and preserved its rich cultural heritage. We only have to look around to feel the charm and elegance of Hanoi.

Like the bamboo, which is one of the symbols of Viet Nam, the people may look so fragile, graceful and may sway with the breeze. But on the contrary, the Vietnamese as a people are strong, firm, focused and determined, very much what a cluster of bamboo represents, that is, solidarity. This shows in the solidarity of the people that propels the country to where it is today. We all look forward to learning and sharing more from your country's experiences about your success and the advances especially in the field of health.

Excellencies, ladies and gentlemen,

The Regional Committee, WHO's Governing Body in the Western Pacific Region, meets each year at this time to discuss health issues and challenges, and to come to a consensus on appropriate policies and actions to be taken, and also to set the direction for the Organization and its Member States for the future.

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As a collegial body, we debate on and resolve health issues of national, regional and global significance. Together, we celebrate our successes. This Region has much to be proud of, thanks to the efforts of all Member States who continue to work hard to address challenges to health and who continually strive to improve health and well-being and quality of life of our people.

The past year saw countries translate into action our regional commitment to address NCDs and scale up their strategies to address their common risk factors. For example, efforts have been intensified to reduce tobacco use and promote healthy living.

The Region has been moving forward in meeting the Millennium Development Goals, while paying special attention to a few who may be at risk but continue to strive to achieve the Goals. Countries continued to strengthen their capacities and regional cooperation enhanced to face the constant threat from health emergencies and natural disasters, and to preserve the gains in the fight against communicable diseases such as measles, poliomyelitis, malaria, tuberculosis and HIV/AIDS.

In the face of continuing challenges, countries of the Region strive not just to improve the quality of health care but more importantly, to develop their health systems to be effective and efficient, responsive, and moving towards universal coverage. This is in line with the theme of this year's World Health Assembly which brings our focus to the utmost importance of universal health coverage. I would like to quote the words of Dr Margaret Chan the Director General of the WHO at the opening of the Health Assembly where she emphasized strongly that 'universal coverage is the single most powerful concept that public health has to offer and it demands solutions to the biggest problems facing health systems'.

Excellencies, ladies and gentlemen,

The work is far from over. I shall soon hand over the task of chairing the sixty-third session of the WHO Regional Committee for the Western Pacific to the new Chairperson. I have every confidence that the good work will continue, that the same spirit of solidarity, regional cooperation, collaboration and partnership shall take us further in our continuous effort to achieve better health for all the people in the Region.

Your Excellency, Vice President Nguyen Thi Doan, allow me once again to thank you and your people for your warm hospitality and graciousness in hosting us and our sixty-third session here in the beautiful city of Hanoi.

**ADDRESS BY THE OUTGOING CHAIRPERSON, PEHIN DATO ADANAN YUSOF,
MINISTER OF HEALTH, BRUNEI DARUSSALAM, AT THE SIXTY-THIRD SESSION OF
THE WHO REGIONAL COMMITTEE FOR THE WESTERN PACIFIC**

Honourable ministers, distinguished representatives;
Dr Shin Young-soo, Regional Director, WHO Western Pacific Region;
Representatives of agencies of the United Nations, intergovernmental
and nongovernmental Organizations;
Ladies and gentlemen:

I am delighted to be with you here in Hanoi for the sixty-third session of the Regional Committee. This morning, I expressed the Committee's appreciation to our host, the Government of the Socialist Republic of Viet Nam for inviting us to this beautiful country. Madame Minister Tien, let me, once again, thank you for your kind hospitality.

I fully understand that the lure of discovering the many excitements that Hanoi offers is strong and tempting. It is not often that we have this opportunity to come and visit Viet Nam. However, we have a job to do this week. I am sure though that our gracious hosts are seeing to it that we will not leave their country without having a taste of the sights and sounds of Viet Nam.

Honourable ministers, distinguished representatives.

This morning, I spoke briefly about progress of our work over the past year. I said that we have many reasons to celebrate. It is true. We can be proud of our Region. At the same time, we cannot and should not rest on our successes. I do not wish to go into details of the year that was.

The report of the Regional Director describes it so articulately and I am sure we shall hear more about it from Dr Shin himself when he addresses the Committee shortly.

As your outgoing Chairperson, I would like to talk on the theme, WHO and Member States on the path to a healthy future. This may sound familiar to you as this has been the purpose of WHO reform. In like manner, many if not most of our countries are reforming our health systems to not only be more responsive, but also more proactive and innovative, in order to better serve our people.

I did reflect upon the many health challenges countries face every now and then. I note that for various reasons, many of these challenges appear to reinvent themselves and resurrect at some later years. I get to wonder if there could be a way for WHO and Member States to arrive at some lasting solutions to some of these health problems. I am aware that we have been able to eradicate or eliminate many of the diseases, and in fact be on track to eliminating more. But there are other complex health issues that require more fundamental solutions and comprehensive approaches. Efforts that everyone has been doing and continue to do are remarkable and truly appreciated. But you and I know that our work as custodians of our peoples' health is far from being over.

Honourable ministers, distinguished representatives.

The realization of what the WHO Constitution describes as the "attainment of the highest possible level of health as a fundamental right of every human being" requires us to rethink our approaches and embark on broad reforms in our health governance. The complexity of promoting, protecting and maintaining health brought about by the interplay of factors, many of which are clearly beyond the realm of the health sector, makes our work even more challenging. The adoption and

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implementation of the “Health in All Policies” approach is crucial to the success of overcoming this significant challenge.

As the recognized authority on health, our work will require us to provide clear strategic directions; apply solid, evidence-based interventions; develop responsive, efficient, accessible and equitable health systems; and forge creative and effective partnerships. I know that in this Region, we are on the right track.

The work on WHO Reform is a welcome development. I laud the Director-General’s resolve to bring the Organization up to speed, as the saying goes, in the face of the rapidly evolving nature and demands of global health. When the Director-General first embarked on reform, it was principally focused on responding to the big issue of financing the work of WHO. But as work progressed and Member States became more engaged in the process, it became clear that it is more than just the issue of sustainable financing. New health challenges and the increasingly complex landscape of international health demanded a more sweeping reform covering programmes and priorities, governance and management reforms.

As Chairperson, I could say that this Committee has not only provided valuable input to the process, but in fact on some elements, it has already taken the reform process forward. Further, in my previous capacity as a member of the Executive Board, I have seen how our work in the Region has contributed to pushing the global reform agenda. I wish to acknowledge and thank you, Member States, for your cooperation in this and, of course, to the Regional Director, Dr Shin, for your leadership.

To me, WHO reform means that reform should also start with us Member States. We are the Organization. And so I was very pleased that Member States were involved early on in charting the future direction of WHO. This is reflected in our involvement in consultations on the priorities of WHO, the 12th General Programme of Work and the proposed 2014–2015 programme budget. This week, we are given a further opportunity to make our contributions to the process. Both the General Programme of Work and the programme budget, when approved next year, will be a clear statement of the commitment of the Organization for what it intends to do in the coming years. And since I said earlier that we the Member States comprise the Organization, it therefore follows that we are as accountable in implementing what was planned and agreed upon.

Honourable ministers, distinguished representatives.

What should we, as individual Member States do?

Take the case of noncommunicable diseases. In my address last year, I likened NCDs to a slowly but surely raging tsunami that will catch all of us by surprise and test the integrity of our health systems, some of which are still fragile, if we delayed action. We were all party to commitments made at various levels, the strongest by far being that made during the High-level Meeting on the Prevention and Control of NCDs convened by the United Nations General Assembly in September last year.

We shared our ideas and views on the regional and global strategies that should guide action. Countries made progress in addressing specific national concerns. But dealing with the complex and multifactorial nature of NCDs is not that easy. A comprehensive strategy, a whole-of-government approach incorporating health in all policies and nothing less, is what's being called for. Addressing the four common risk factors for NCDs clearly means taking the health agenda on the discussion table with finance, trade, agriculture, local governments, the media, interest groups, civil society and other partners. This is an action that some of us in the health sector may not be comfortable with as yet. But it is something that we have to do. We need to build and strengthen our alliances. The commitment is there, the strategic direction has been laid. There is increasing support from partners. Therefore, there is light at the end of the tunnel, that NCDs can be controlled and prevented.

We need to build and strengthen our health systems starting with appropriate legislations and regulatory framework to enable us not only to provide the means and the facilities to prevent people from getting sick, but also to make it possible for the sick to be cured; not only to save lives, but also to improve the quality of life. Given the escalating costs of health care, we need to adopt cost-effective interventions, more so by placing priority on prevention rather than cure.

Important to our fight against NCDs is the first ever public health treaty, the Framework Convention on Tobacco Control or the WHO FCTC. The FCTC is not simply about stopping individuals from smoking, a major risk factor for NCDs. The FCTC is about creating the policy environment and the legislative framework. It is about modifying physical environments to be conducive to building smoke-free communities as well as enhancing public awareness on the dangers posed by tobacco. Countries continue to experience aggressive interference from the tobacco industry. But the resolve of our countries is so strong that we could be proud of the gains made in this Region's tobacco control efforts.

At this point, I wish to congratulate Australia on having scored a major victory recently in one of her many legal battles with the industry. Australia is an inspiration to us. Brunei Darussalam joins other leading countries in putting tobacco legislation in place, and in vigorous implementation of articles of the FCTC that support effective demand-reduction measures. Early this year, Brunei Darussalam played host to a technical meeting where Australia's bold and historic law on plain packaging was discussed. Brunei will continue its proactive role in tobacco control and looks forward to the fifth Conference of the Parties of the WHO FCTC which will be held in Seoul this November.

Honourable ministers, distinguished representatives.

Meeting our MDG commitments by 2015 is another important focus of our work. While the Region as a whole is making good progress, situation in a few countries for specific MDGs may not look as optimistic. Related to this is the challenge on nutrition. A high-level commitment was made in the early 1990s. It has been acknowledged that unhealthy diet is one of the four most common risk factors for NCDs. We also know that improving nutrition is central to achievement of MDGs; and that it is a key factor in physical and mental development. Furthermore, improved nutrition is crucial for long-term health and productivity. Still, more concerted efforts need to be taken to translate all this knowledge into action.

As with NCDs, nutrition-related problems require a comprehensive approach, a life-course approach that needs engaging sectors other than health and different partners who have their own mandates. Industry interests need to be handled carefully and directed towards enhancing food quality and providing healthier options.

Turning now to the real tsunamis. Each year, this Region has more than its fair share of emergencies which result not only in the loss of lives, displacements, and damage to properties but

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also in destruction of health facilities and disruptions in health services which compromise efforts of health systems to respond in such situations. We are aware of the continuous battering of countries by a wide range of emergencies including hurricanes, floods, earthquakes and droughts. During the past two months, we read about typhoons and floods in China, Korea, the Philippines and Viet Nam. My point is, the outcome or impact of these emergencies usually depends on how well prepared and adequately equipped Governments and health systems are, for these situations. Again, strengthening capacity of health systems for preparedness and response including risk management is crucial in mitigating the impact and minimizing consequences of such events.

The same theme runs across the few examples I have given above. That is, building robust health systems and, a systematic, holistic and evidence based approach to health issues which has a better chance of arriving at lasting solutions and sustaining health gains. From the same examples, I also saw :

Firstly, the importance of true commitment backed by action;

Secondly, the wisdom of continuity, consistency of action and of completing the job; and

Thirdly, the crucial role of strong cooperation and close partnerships.

Honourable ministers, distinguished representatives.

Concrete actions are needed now. Our Region, or the world for that matter, needs more than just articulations of political commitments to significantly impact health and development. The Region has set out on the path towards a healthy future. Let us all travel this path together. With the support and guidance from WHO, and the vaunted regional cooperation this Region is known for, I have no doubt we would succeed in according our people their right to health.

I shall shortly turn over my responsibility to a new Chairperson. I would like to thank you all for your trust and confidence, and for giving me this great honour to be Chairperson of the sixty-second session. It was a privilege and pleasure working with all of you. I also wish to thank my fellow office bearers for their support and hard work. To Dr Shin and his staff, thank you for the guidance. Lastly, I wish you all the best and a fruitful and productive week ahead.

**ADDRESS BY THE INCOMING CHAIRPERSON, ASSOCIATE PROFESSOR
DR NGUYEN THI KIM TIEN, MINISTER OF HEALTH, VIET NAM,
AT THE SIXTY-THIRD SESSION OF THE WHO REGIONAL COMMITTEE
FOR THE WESTERN PACIFIC**

Honourable ministers, distinguished representatives;
Dr Shin Young-soo, Regional Director, WHO Western Pacific Region;
Representatives of agencies of the United Nations, intergovernmental
and nongovernmental organizations;
Ladies and gentlemen:

Good morning.

Once again, I wish to add my own personal greetings and warm welcome to you.

We are honoured to be your host and to provide the forum for discussing important matters of health in this Region.

As our outgoing Chairperson Minister Pehin Dato Adanan Yusof said yesterday, Viet Nam is an interesting study of contrasts – fast growing economy, a deep sense of history and rich cultural heritage. As your host, we will do our best to strike a balance between work, cultural visits and fun during your stay.

Distinguished representatives,

I would like to refer to the great President Ho Chi Minh's famous statement that "unhealthy people make the country weaker and healthy people make the country stronger". This underscores the critical role of the health sector in improving people's quality of life and achieving social equity, and in investing in health which is considered as investing directly in sustainable development.

The work on WHO Reform initiated by the Director-General of WHO is clearly in line with our shared vision of sustainable development and a healthy future for our people. We are glad to see a true partnership evolving and the active engagement of Member States in the work of WHO.

I share some points that were raised yesterday about the need for clear focus and prioritization, given the fact that in this Region we have quite a number of competing priorities.

We are pleased to hear the Regional Director, Dr Shin, give some highlights of WHO's work from July 2011 to June 2012. In the introduction to his report, Dr Shin referred to the past year as "a year of decisive action to tackle the Region's health challenges", a year "of building and fine-tuning tools and systems" to better support Member States. Many of you have spoken to this report yesterday. We appreciate WHO support in achieving our individual global health commitments, in building our health systems so that we are better able to effectively address the health needs of our people. In supporting our work, WHO did so in ways that consider our own unique country situations.

Honourable ministers, distinguished representatives,

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I wish to thank my predecessor, the Honourable Minister of Health Pehin Dato Adanan Yusof, for his able guidance and for leading this Committee through difficult times. I fully agree with the Honourable Minister's call for us to translate our commitments into action and to find lasting solutions to our health problems.

The meeting of the Regional Committee is an important forum where we discuss health and other health-related issues and come up with a collegial decision on the best way forward for this Region. I am glad that we will have time to review progress and further improve our work in malaria control as well as in tobacco control and NCDs, among others. We also have the opportunity to assess how we fare in our commitments towards the achievement of the Millennium Development Goals and discuss what we have to do to improve our performance.

We have many important matters to discuss.

This morning we shall review the final report of implementation of the 2011–2012 programme budget and see how well we have used our resources.

We shall also have the opportunity to review the Twelfth General Programme of Work [12th GPW] spanning the years 2014 to 2019 and the draft Proposed Programme Budget 2014–2015. It is important that we continue to be engaged in the process until both Programme Budget and 12th GPW are finalized. We all have a stake in this and, as Member States, we also have our individual responsibilities in the achievement of the expected outcomes.

With regard to the Committee's unfinished business on the nomination of the Regional Director, I do believe that enough time and effort was spent studying this matter. The Committee's expressed interest in a Code of Conduct was supported and pursued by the Legal Counsel. It is my hope that during this session, we may finally come to a decision and put a closure to this subject.

On the technical programmes, I am very happy that we have nutrition on our agenda. The critical role that nutrition plays in health and development and, in people's quality of life cannot be overemphasized. As with other health issues however, food and nutrition is not simply the responsibility of the health sector. Other sectors play an equally important role as well. The Sixty-fifth World Health Assembly affirmed this and called for a comprehensive approach to address the problem. Later today, heads of agencies working in the field of nutrition and food security will come together to discuss their thrust and priorities.

Violence and injury prevention will be discussed by the Committee. It is about time. Or if I may say, it is long overdue. Violence and injuries account for about 9% of global deaths, with our Region contributing significantly. I am sure you may have experienced for yourselves, or probably heard people's stories about the difficulty in navigating the streets of Hanoi. Yes, Viet Nam has its fair share of road traffic accidents. Government took this matter seriously. The same is true with violence. The Committee's debate and guidance will surely help the rest of the Region facing similar challenges.

Honourable ministers, distinguished representatives,

Looking at the items on our agenda — from the programmes I mentioned earlier to neglected tropical diseases, achieving our MDG commitments, addressing the NCD epidemic, the threats of HIV/AIDS, and malaria — we would see the recurring theme of weak health systems and suboptimal partnership with other stakeholders as hampering our work.

Developing national capacities and strengthening health systems to manage traditional and emerging health problems, public health events and emergencies have been at the core of our efforts to secure a healthy future for our people. An important element is human resource development not only on technical but managerial aspects as well. We hope WHO can establish a program to address concerns related to developing human resources for health.

I appreciate the guidance and support of WHO and our partners who have stood by us in our journey towards universal coverage and a strong, responsive health system. The financing of health care is an important component, generating and mobilizing sufficient resources to make our health system operate effectively, sharing risks so people can have access to quality health care services when needed, thereby addressing and fulfilling the health aspirations of our population. That is why we organized the high-level side event on the topic of universal coverage yesterday afternoon. We have heard how countries are working not only to expand health insurance coverage but also to increase the benefits and to provide better financial risk protection especially to the poor segments of the population. I would like to thank all of you for your participation.

Distinguished representatives,

Our deliberations this week will lay the foundation for our work in the next five years, and determine the future direction of WHO as an Organization, and as a leader in global health. I ask for your cooperation and frank discussions so that we may sharpen our focus and come up with practical outcomes. In the end, it is us the Member States and our collective effort that will determine whether the Region as a whole has indeed made good on its commitment to provide the gift of health to the 1.8 billion people in the Region.

Thank you again for electing me Chairperson. Welcome to Hanoi. We will do our best to make the memories of your stay in Viet Nam something that you would love coming back to.

Thank you for your attention.

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**ADDRESS BY THE DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION,
DR MARGARET CHAN, AT THE SIXTY-THIRD SESSION OF THE WHO REGIONAL
COMMITTEE FOR THE WESTERN PACIFIC (WRITTEN STATEMENT)**

Madam Chairperson; Excellencies; honourable ministers; distinguished delegates; Dr Shin; ladies and gentlemen:

This Region has brought the world some very good news.

In 2003, you resolved to eliminate measles and control hepatitis B, and to use activities for achieving these goals to strengthen routine immunization services.

Your countries have made tremendous progress in reducing hepatitis B infection rates in children to below 2%. Even more ambitious goals have been recommended for 2017.

The drop in measles has been breath-taking: only two measles deaths this year, representing a 99% decline since 2003. The measles initiative is also being used to accelerate the control of rubella and the prevention of congenital rubella syndrome.

Wealthy countries in this Region have provided models for success in other well-off countries well beyond the Region. China has shown the impact of intensified immunization activities on a massive scale. Smaller, less-privileged countries tell us that the hard-to-reach really can be reached when a government is determined.

The Western Pacific is on the verge of becoming the second WHO region, after the Americas, to be certified measles-free. During this session, you will be looking at draft guidelines for the verification of measles elimination. You are doing this job very carefully as well.

In public health, everyone loves to hear about success, about jobs well done.

You are pushing ahead with control of the neglected tropical diseases. You will be considering a detailed action plan for seven priority NTDs. These diseases affect the poorest of the poor. But even in the midst of dire poverty, much of the disease burden can be controlled at a low cost, even before poverty itself is reduced.

This turns the tables. In their long history, these ancient diseases gradually disappeared from large parts of the world as incomes rose and standards of living improved. Your action plan shows how, with good medicines and streamlined strategies, these diseases can be brought to their knees, actually contributing to poverty alleviation on a massive scale.

At the same time, you are not shying away from the operational, financial, and political challenges that face the control of NTDs in this Region. With your eyes wide open to the problems, I am confident that, in this case, too, you will prove that the hard-to-reach really can be reached.

I also welcome the attention you are giving to malaria. At the end of next month, Australia will be hosting a major conference on malaria aimed at saving lives in Asia and the Pacific. This is a

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technical meeting, looking at prospects for control and elimination and at problems and challenges, including the significant threat of artemisinin resistance.

But this is also a political meeting, promoting political as well as technical leadership and looking for ways to ensure sustainable financing, also for the containment of artemisinin resistance.

Considering what is on the horizon, any diseases that we can eradicate, eliminate or get under tight control free resources for tackling the next big challenges.

The relentless rise of chronic noncommunicable disease is among the biggest of these challenges. Meeting this challenge requires new ways of thinking and working. The response, especially concerning prevention, depends heavily on the ability of health officials to persuade other sectors to include health concerns in their policies.

This is a problem that I see, personally, time and time again: the lack of policy coherence within governments, the tendency of the various ministries to stick to strict and narrow mandates.

This kind of compartmentalized thinking loses some of its relevance in a world of radically increased interdependence among countries, but also among sectors. The distinctions between policy spheres have become blurred. What is the net gain if a minister of trade approves an agreement in the interest of national prosperity that ends up flooding the market with tobacco or other unhealthy products?

We talk a great deal about whole-of-government and whole-of-society approaches to health. We know that the health sector, acting on its own, will never be able to counter the rise of NCDs or tackle problems like road safety, the prevention of violence and injuries, or improvements in the nutritional status of populations.

Activities surrounding implementation of the WHO Framework Convention show us how this kind of multisectoral action actually works in practice, how it can be made to happen.

In July, the Philippines hosted a regional consultation on tobacco and trade. Some of the measures in the Framework Convention have implications on trade and investment, making closer collaboration between the health and trade sectors critical to achieving shared goals for economic development and a healthy and productive population.

That consultation brought ministries of trade together with their counterparts in health. It presented evidence showing how the tobacco industry is exploiting international trade and investment agreements, and why and how governments can fight back. The consultation showed how joined up action between health and trade ministries can protect populations from a deadly product and spare governments the related, and enormous, costs.

Once again, let me commend Australia for standing up to the tobacco industry and winning. We hoped for a domino effect in which the good guys start winning. We were all pleased when, earlier this month, a Norwegian court upheld a ban on displaying tobacco products in stores. Norway now plans to follow Australia by requiring plain packaging of tobacco products.

The tobacco industry is not at all pleased, and this pleases me enormously.

The Western Pacific was the first WHO region to have articulated a measurable target for reducing tobacco use. You have before you a report that asks whether countries in this Region can, by 2014, reduce the prevalence of tobacco use by 10% by 2014.

You can and you must. Without question, full implementation of the WHO Framework Convention on Tobacco Control would deal the greatest single preventive blow to noncommunicable diseases.

Let me thank the Republic of Korea for hosting the Fifth Session of the Conference of the Parties to the WHO Framework Convention, to be held in Seoul in mid-November.

Every country in this Region is a party to the Framework Convention. I urge you to keep giving the world uplifting stories where the good guys win.

Ladies and gentlemen,

WHO and its Member States face two big assignments where we absolutely must get things right. The first is WHO reform, which I talked about in my opening video message. The second is placing health on the post-2015 development agenda. I value your guidance as we collaborate on both tasks.

The target date for reaching the Millennium Development Goals is fast approaching. The debate about the post-2015 development agenda is in full swing. Rest assured. WHO is taking a leadership role in moving this debate through procedures aimed at collecting a broad range of views.

As I said, we absolutely must get this right. The MDGs strongly influenced development priorities and directed resource flows. The temptation will be great to expand the number of goals, rather than keep the agenda sharp, focused, and feasible.

The MDGs taught us that health deserves a high place on any development agenda. Health is a precondition of development. It is a powerful driver of socioeconomic progress.

Because its determinants are so broad, health is a sensitive indicator of the impact that policies in all sectors of government have on the well-being of citizens. As just one example, if trade policies, tariffs, and agricultural subsidies cause food prices to soar, the adverse effects will be most visible in the health sector.

Changes in health status will also be the most readily and reliably measured signal that policies need to be adjusted.

We can all be pleased that the final outcome document of the Rio+20 summit gave health a central place as a precondition for development and an indicator of development. That document also stressed the importance of universal health coverage in enhancing health, social cohesion, and sustainable human and economic development.

The MDGs were a compact between developing countries and their needs, and wealthy countries that promised to address these needs through the commitment of funds, expertise, and innovation. In short: a compact between the haves and the have-nots aimed at reducing gaps in living conditions, alleviating poverty and relieving vast human misery.

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When we consider the nature of today's threats to health, a simple compact between the haves and the have-nots fails to capture the complexity of these threats.

I am talking about a changing climate, more emergencies and disasters, more hot zones of conflict, soaring health care costs, soaring food prices, demographic ageing, rapid urbanization, and the globalization of unhealthy lifestyles.

I am talking about an enduring economic downturn, financial insecurity, shrinking opportunities, especially for youth and the middle classes, poverty that keeps getting deeper, and social inequalities that keep growing wider.

These are universal trends, and many of them are driving the relentless rise of noncommunicable diseases.

In my view, one of the best ways to respond to all these challenges is to make universal health coverage part of the post-2015 development agenda. In my view, universal coverage is the single most powerful concept that public health has to offer.

It is the best way to cement the gains made during the previous decade. It is a powerful social equalizer, and it is the ultimate expression of fairness.

It is a unifying concept that puts in place, in a coherent and logical way, the many pieces in the jigsaw puzzle of factors that, together, ultimately determine health outcomes.

It is the route towards two of the most treasured goals in public health: greater fairness in access to care, and greater efficiency in the delivery of services. Traditional economic thinking tells us that you cannot have both. There must be a trade-off between the goals of equity and efficiency. Experience in public health tells us otherwise.

When countries move towards universal coverage, the benefits of interventions, when taken to scale, are value-added. They not only protect health or prevent a disease. They bring down the risks for entire populations.

When coverage levels are high, say, for AIDS, malaria, or tuberculosis interventions, disease transmission goes down, thus amplifying the impact of interventions and improving their efficiency. As another example, high vaccine coverage produces herd immunity, so that even those who have not been immunized benefit from population-wide interventions.

In addition, economists point to tremendous economies of scale in service provision when interventions reach a large proportion of the population.

This week, I am attending a number of health-related events at the United Nations General Assembly. One of these events will launch the Lancet's series of research papers and editorial perspective on universal health coverage.

The Lancet papers published to date present evidence showing the positive impact of universal coverage on health outcomes. They explore the transition to universal coverage in its political and economic dimensions, and offer lessons about how health financing reforms have been enacted in a number of lower income countries.

Editorial comments offer a big-picture view of the historical significance of this evidence. One of these comments suggests that the global movement towards universal coverage may be the third great transition in health, following the demographic transition that began in the late 18th century and the epidemiological transition that began in the 20th century and eventually saw noncommunicable diseases overshadow infectious diseases in every corner of the world.

In the Lancet series, it is extremely helpful to have a respected economist, like Jeffrey Sachs, argue strongly against what he calls “lazy thinking”. This thinking assumes that user fees will reduce overconsumption of health services or increase their value in the users’ eyes. Not true. User fees punish the poor.

You will be considering a report on progress in implementing the Region’s health financing strategy. This strategy contributes to universal coverage as the vision of national health system development in the Western Pacific.

As you are aware, health financing reforms are just one part of the picture. Health insurance raises public expectations. People expect ready access to medicines and services, and they want quality. A commitment to universal coverage means meeting these expectations as well.

Don’t punish the poor, but don’t disappoint them either.

At a time when policies in so many sectors are actually increasing social inequalities, I would be delighted to see health lead the world towards greater fairness in ways that matter to each and every person on this planet.

Thank you.

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**ADDRESS BY THE WORLD HEALTH ORGANIZATION REGIONAL DIRECTOR FOR
THE WESTERN PACIFIC, DR SHIN YOUNG-SOO, AT THE
SIXTY-THIRD SESSION OF THE WHO REGIONAL COMMITTEE
FOR THE WESTERN PACIFIC**

Madam Chairperson;
Honourable ministers;
Representatives from Member States;
Colleagues from WHO and partner agencies;
Ladies and gentlemen:

Welcome to the sixty-third session of the Regional Committee for the Western Pacific. On behalf of the World Health Organization and all of our Member States, I would like to thank the Government of Viet Nam for its gracious hospitality in hosting this year's session.

This is a critical week. We will be discussing the serious public health challenges that confront the Western Pacific Region and reaching a consensus on how to proceed in the coming year.

Our agenda includes issues we've tackled before — such as measles and international health regulations — as well as an issue we haven't considered for some time: nutrition and food security. We will also be discussing injury and violence prevention for the first time.

Since our last Regional Committee meeting, Member States have taken decisive actions that will shape WHO's work at the country level well into the future.

I'm sure you've seen the headlines about Australia's law requiring plain packaging for tobacco products to inhibit marketing efforts. The Government has been a pioneer in confronting this main risk factor for noncommunicable diseases.

On the other side of the Region, China mounted a major immunization campaign to ensure that an outbreak of imported wild poliovirus did not threaten important gains in the fight against that disease.

At the WHO Regional Office for the Western Pacific, we continued to implement innovative approaches to increase efficiency and to sharpen focus on the challenges that you — our Member States — have told us are your priorities.

Soon after I became Regional Director, we embarked on an extensive reform. We identified six areas for improvement and have invested heavily to make the Organization better able to meet the needs of Member States.

Some of these reforms — such as staff rotation and learning and development programmes — worked so well that they have been adopted by WHO at the global level.

But the job is not done. We face even greater challenges in the next phase of our reform, which is called "Making a Real Difference at Country Level". Our focus remains clear: to make a difference where it matters most — at country level.

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The international health arena is now more crowded — which makes WHO's coordinating and convening role more important than ever for countries. In response, we are strengthening our network of offices, as well as their communication and policy-planning capacities.

WHO needs to be more nimble to adapt to rapidly changing realities, not only in public health, but also social and economic situations. This requires that WHO's assistance be tailor-made for individual countries.

You can see this approach in action with the Western Area Health Initiative in China. This represents a new model of WHO engagement at country level. It sets the vision for subnational assistance to achieve better results wherever countries need them.

I was in China in July to personally launch this initiative with Minister Chen Zhu and the leaders from three provincial governments where the initiative is being piloted because of their unique health challenges.

A similar approach is also working for the Philippines in support of the Government's drive for universal access to bring health services to the poorest areas of the country.

In the Mekong area, joint efforts are also under way to maximize synergies between Member States to address common health challenges and promote knowledge-sharing.

With these programmes, we hope to foster a new way of thinking and working to meet the evolving needs of our Member States. We hope to have encouraging updates for you next year on these initiatives.

Our goal remains to ensure greater health opportunities for the people of the Western Pacific Region. There is much to celebrate, but we still face significant health challenges — from immunizing all newborn children to improving the lives of the elderly.

These challenges drive our focus on reform, accountability and country-specific results. The push for results has become such a part of the DNA of the Western Pacific Region that it has put us at the vanguard of the Organization's global reform movement.

For me, reform starts with rethinking how we handle resources.

The Programme Budget 2014–2015 is one of the agenda items for this week. The budget relates closely to the 12th Global Programme of Work, which is the result of extensive consultation with Member States.

The programme budget emphasizes important elements of the Global Reform, such as priority-setting and clearly articulated results in defining and synchronizing work at all levels of WHO.

This results-oriented thinking underpins the new Global Programme of Work and the 2013–2014 Programme Budget — which are the basis for how resources are used to improve performance.

Our annual report — *The Work of WHO in the Western Pacific Region* — provides the details of our achievements and challenges since this Committee last met. Please take time to read the report and raise any questions you may have with me or any of our directors.

As the world's leading authority on public health, our Organization has continued to take the lead in developing cross-cutting, multisectoral approaches to meet today's tough challenges.

Perhaps no issue better demonstrates the need for these so-called whole-of-society and whole-of-government solutions — and the role WHO plays in coordinating that cooperation — than noncommunicable diseases.

As you know, NCDs are responsible for more than four out of five deaths in the Western Pacific Region.

Last year, this Committee directed me to work with Member States and development partners on a road map for action mandated by the September 2011 United Nations General Assembly political declaration on NCDs.

I want to thank the governments of Australia, China — including Hong Kong and Macao — Japan, the Republic of Korea, Malaysia, New Zealand and Singapore, as well as our development partners, for their support of this effort.

We have taken the lead with country-specific action and support, focusing on the many risk factors for NCDs that start early in life. In the Pacific, for example, recent surveys show that more than half of all adolescents are obese or overweight, which puts them at-risk for many NCDs as they age.

In implementation of the United Nations political declaration on NCD prevention and control, we have helped develop multisectoral action plans to address risk factors and their social determinants. We have worked directly with ministries of health and partners throughout the Region to help train health-care workers on essential services for NCDs.

At the request of this Committee and the World Health Assembly, we are assisting countries to develop global targets and indicators for NCD control by the end of this year. We are helping to better monitor NCDs and their risk factors.

Many countries are taking a lesson from the pioneering work on tobacco control. More countries are raising prices and taxes on tobacco products. That money is being used to fund health promotion foundations and boards — as well as anti-tobacco campaigns — around the Region.

On a wider scale, WHO also supports efforts for healthy settings, such as Healthy Cities, Healthy Islands and Health-Promoting Schools — all key elements in the fight against NCDs.

Recently, our support has been intensified to help the more than 90 million visually impaired people in the Region.

We know that 80% of all visual impairment can be avoided or cured. Last year we started a programme to work with Member States to address the main causes — especially cataracts and trachoma — and support governments in integrating eye care into primary health-care systems.

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Now under development is the new Global Action Plan for the Prevention of Avoidable Blindness and Visual Impairment 2014–2019 — which spells out collaboration between WHO, Member States and partners.

On the subject of prevention, perhaps no single intervention we make is more cost-effective than immunization. That's why we are redoubling our efforts to eradicate vaccine-preventable diseases.

As you may have read in your working documents, the regional measles incidence rate has dropped from 82 cases per million in 2008 to a record low of 12 cases per million in 2011. And now that number may now be as low as 5.7 cases per million, according to July results.

Indeed, impressive progress has been made over the past year on the twin goals — set by this Regional Committee — of measles elimination and hepatitis B control.

Thirty-two countries and areas likely have eliminated measles ahead of the 2012 target, but their success still must be verified. And the 2012 milestone for hepatitis B control likely has been met by the Region as a whole and 30 individual countries and areas.

Meanwhile, momentum towards maternal and neonatal tetanus elimination has been maintained in all countries in the Region.

Except for a few countries with high infant mortality rates, most countries in the Region are on track in reducing child mortality. Most countries are also reducing maternal mortality, though challenges remain in several countries in the Region.

We can all take pride in the fact that nine out of 10 malaria-endemic countries have now changed their national goals from control to elimination. Particularly in the Mekong region, countries are gaining the upper hand, even as they simultaneously battle artemisinin resistance.

In the fight against multidrug-resistant tuberculosis, we established a regional support mechanism that offers Member States country-specific assistance.

Sadly, our Region bears more than one-quarter of worldwide burden of multidrug-resistant tuberculosis. If not addressed, these strains could turn into incurable forms of the disease.

Last year, I promised to press the fight against neglected tropical diseases that cause needless suffering for many poor and marginalized people. I am pleased to see so many Member States tackling this issue.

This Region is the global leader in the fight against lymphatic filariasis, with eight countries consolidating successful interventions and now preparing to verify elimination.

Like lymphatic filariasis, most neglected tropical diseases can be eliminated with low-cost and proven solutions. The time has come to make this happen.

As we all know, the Western Pacific Region faces more than its share of health emergencies and natural disasters.

In recent years, we have been at the epicentre of public health events of international concern and disasters of epic proportions, such as last year's earthquakes in Japan and New Zealand.

WHO leads the "health cluster" response to disasters and emergencies. We have led the charge to incorporate lessons learnt from those natural disasters in order to strengthen preparedness and response efforts in the future.

We continue to support Member States in implementing International Health Regulations. The updated workplan for Asia Pacific Strategy for Emerging Diseases (2010) has been a valuable road map for countries in fulfilling their IHR (2005) requirements.

Our new Western Pacific Regional Food Safety Strategy is also providing much-needed guidance for an increasingly globalized world.

Based on the strategy, the Regional Committee directed me to support Member States in capacity-building and strengthening food control systems last year.

Since then, we have worked on a variety of initiatives, including the formation of a Food Safety Cooperation Working Group with partner agencies to ensure the safety of food in the Region.

To sustain past gains while continuing to meet the challenges we face — and prepare for those yet to come — health systems must be strengthened.

We focused over the past year on building capacity to engage countries on these issues and tackle the increasingly important issue of health equity.

I am pleased to see that universal health care has become a priority for many Member States, despite difficult economic times.

We eagerly supported our host, Viet Nam, in the development of its National Health Insurance Initiative. During my visits in November and March, I was pleased to see the country working to expand basic health coverage. Viet Nam wants all of its citizens to have good quality health care, based on need rather than ability to pay.

Other countries in the Region have also initiated health sector reforms to enhance access to care, including Cambodia, the Lao People's Democratic Republic, Mongolia and the Philippines.

As part of expanding primary care, we launched the new Regional Strategy for Traditional Medicine in the Western Pacific last May. We continue to support Member States in implementing the strategy.

I talked earlier about tailoring our engagement at the country level to meet the needs of countries in rapidly changing contexts, not only in terms of public health, but also their social and economic situations.

This tailored approach is even more critical in the Pacific, where small populations scattered over vast areas create special challenges for health programmes.

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Our newest division — the Division of Pacific Technical Support — is coordinating the efforts of all WHO offices to support the Pacific countries to implement your health priorities.

For the first time, the cooperation strategy includes all 21 countries and areas in the Pacific. This will allow Pacific island communities to work together to address common challenges.

At the same time, the country-specific summaries in the strategy clearly outline WHO support for national health plans in each country.

In partnership with Member States, the Secretariat of the Pacific Community and development partners — such as the Australian Agency for International Development and the New Zealand Aid Programme — we have made progress on many fronts.

Let me just highlight a few:

We continue to see promising results on malaria elimination. The evidence shows that scaling up malaria control in Solomon Islands and Vanuatu is having a significant impact as malaria incidence and mortality rates continue to decline.

In the Pacific, the fight against neglected tropical diseases has intensified. Kiribati, the Marshall Islands and the Federated States of Micronesia are making remarkable progress towards controlling leprosy. Solomon Islands was removed from the list of lymphatic filariasis endemic countries last year. Now Niue, Tonga and Vanuatu are next in line to eliminate this disfiguring disease.

Pacific countries are responding to the NCD crisis with country-specific packages of services. So far, seven countries have incorporated this approach into primary health-care systems, allowing better management of NCD risk factors.

Recently I visited one of the remote provinces of Solomon Islands. I experienced firsthand the early impact of these packages of essential NCD services, as they are known. Villagers were delighted because they now know more about their NCD risks and what they can do to control them. They can even receive counselling and drug treatment at no cost.

More countries in the Pacific are ready to implement these packages of services, which we plan to expand across the Region where appropriate.

I've touched on just a few highlights of the past year on the regional level and in the 37 countries and areas that make up the Western Pacific Region.

While many of these accomplishments are significant, they are but a good start. Public health is a highly dynamic field. We must constantly be anticipating and preparing for the next crisis, more than celebrating our successes.

As the Region continues to expand economically, we are tackling health inequities so that robust economies translate into healthy populations. History has shown us that nothing helps countries develop faster overall than improving the health of their people.

But public health goals — especially universal coverage — are long term and require Member States and partners to stay the course. Sustained action and unwavering commitment are the keys to success.

You have seen my commitment firsthand, whether tackling NCDs — which are the leading cause of death and disability in the Region — or neglected tropical diseases.

Even in these trying economic times, our disciplined management in the Regional Office and improved communication with partners and stakeholders have allowed us to expand our presence and support in the Region.

But we do not rest on our accomplishments. We continue to look for ways to strengthen the Organization and improve our ability to meet the public health challenges of tomorrow.

We cannot predict the future, only prepare for it. That's why it pains me when I visit a disaster site and see lives that could have been saved with better preparation.

I feel the same sense of loss when I travel the Region and see people suffering from diseases that could have been cured with basic medicine or prevented with a vaccine.

This is the fourth time I have addressed the Regional Committee, and this year I am more pleased than ever by our progress.

At the same time, I am humbled by the magnitude of the challenges we face.

Going forward together, we must build a stronger, more resilient Region with improved health opportunities for all its 1.8 billion people. They are counting on us.

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**Code of Conduct
for the Nomination of the Regional Director
of the Western Pacific Region of the World Health Organization**

By resolution WPR/RC50.R8, the Regional Committee *inter alia* affirmed that "campaigns for elective office in the Western Pacific Region should be open and fair, and based on the merits of the individual candidates". In resolution WPR/RC61.R3, the Regional Committee also pointed to its intention to improve the fairness of the process for the nomination of the Regional Director. The Regional Committee requested the Legal Counsel to elaborate further on a possible code of conduct on the nomination of the Regional Director.

This Code of Conduct (Code) aims at promoting an open, fair, equitable and transparent process for the nomination of the Regional Director of the Western Pacific Region (WPR) of the World Health Organization (WHO). In seeking to improve the overall process, this Code addresses a number of areas, including the submission of proposals and the conduct of electoral campaigns by Member States and candidates.

The Code is a political understanding reached by the Member States of the Western Pacific Region (Member States). It recommends desirable behaviour by Member States and candidates with regard to the nomination of the Regional Director to increase the fairness, openness and transparency of the process and thus its legitimacy, as well as the legitimacy and acceptance of its outcome. As such, the Code is not legally binding, but Member States and candidates are expected to honour its contents.

A. General Requirements

I. Basic Principles

The whole nomination process as well as electoral campaign activities related to it should be guided by the following principles that further the legitimacy of the process and of its result:

- Fairness
- Equity
- Transparency
- Good Faith
- Dignity, Mutual Respect and Moderation
- Non-Discrimination and
- Merit-based.

II. Authority of the Regional Committee and its Rules of Procedure

1. Member States accept the authority of the Regional Committee for the Western Pacific (Regional Committee) to conduct the nomination of the Regional Director in accordance with its Rules of Procedure and relevant resolutions of the Regional Committee.

2. Member States which propose persons for the post of Regional Director have the right to promote their candidature. The same applies to candidates with regard to their own candidature. In the exercise of that right, Member States and candidates should abide by all rules governing the nomination of the Regional Director contained in the Rules of Procedure of the Regional Committee as well as in relevant resolutions and decisions of the Regional Committee.

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III. Responsibilities

1. It is the responsibility of Member States and candidates to observe and respect this Code.
2. Member States acknowledge that the process of nomination of the Regional Director should be fair, open, transparent, equitable and based on the merits of the individual candidates. They should make this Code publicly known and easily accessible.

B. Requirements concerning the different steps of the nomination process**I. Submission of proposals**

When proposing the name of one or more persons for the post of Regional Director, Member States will be requested by the Director-General to submit the necessary particulars of each person's qualifications and experience using the standard form annexed to this Code as an appendix, in order to improve the comparability of the merits and qualifications of candidates against the criteria adopted by the Regional Committee with resolution WPR/RC50.R8.

II. Electoral campaign

1. This Code applies to electoral activities related to the nomination of the Regional Director whenever they take place until the nomination by the Regional Committee.
2. All Member States and candidates should encourage and promote communication and cooperation among one another during the entire nomination process. Member States and candidates should act in good faith bearing in mind the shared objectives of promoting equity, openness, transparency and fairness throughout the nomination process.
3. Member States and candidates should refer to one another with respect; no Member State or candidate should at any time disrupt or impede the campaign activities of other candidates. Nor should any Member State or any candidate make any oral or written statements or other representations that could be deemed slanderous or libellous.
4. All Member States and candidates should disclose their campaign activities (e.g. hosting of meetings, workshops, visits). Information disclosed will be posted on a dedicated page of the web site of the Regional Office.
5. Member States and candidates should refrain from improperly influencing the nomination process, by, for example, granting or accepting financial or other benefits as a quid pro quo for the support of a candidate, or by promising such benefits.
6. Member States and candidates should not make promises or commitments in favour of, or accept instructions from, any person or entity, public or private, when that could undermine, or be perceived as undermining, the integrity of the nomination process.
7. Member States that have proposed a candidate should facilitate meetings between their candidate and other Member States, if so requested. Wherever possible, meetings between candidates and Member States should be arranged on the occasion of conferences or other events involving Member States of the Region rather than through bilateral visits.

8. Member States nominating candidates for the post of Regional Director should consider disclosing grants or aid funding for the previous two years in order to ensure full transparency and mutual confidence among Member States.

9. Travel by candidates to Member States to promote their candidature should be limited in order to avoid excessive expenditure, which could lead to inequality among Member States and candidates. In this connection, Member States and candidates should consider using as much as possible existing mechanisms (regional committees, Executive Board, World Health Assembly) for meetings and other promotional activities linked to the electoral campaign.

10. Electoral promotion or propaganda under the guise of technical meetings or similar events should be avoided.

11. After the Director-General has dispatched the names and particulars of candidates to Member States in accordance with the third paragraph of Rule 51 of the Rules of Procedure, he/she will open on the web site of WHO a password-protected question-and-answer web forum open to all Member States and the candidates who request to participate in such a forum.

12. After the Director-General has dispatched the names and particulars of candidates to Member States in accordance with the third paragraph of Rule 51 of the Rules of Procedure, the Regional Office will post on its web site information on all candidates who so request including their curricula vitae and other particulars of their qualification and experience as received from Member States, as well as their contact information. The web site will also provide links to individual web sites of candidates upon request. Each candidate is responsible for setting up and financing his/her own web site. The Regional Office will also post on its web site, at the time referred to in the first paragraph of Rule 51 of the Rules of Procedure of the Regional Committee, information on the nomination process and the applicable rules and decisions.

III. Nomination

1. The nomination of the Regional Director is conducted in private meetings of the Regional Committee in accordance with Rule 51 of the Rules of Procedure. Attendance at the private meetings is prescribed by the Director-General and limited to essential Secretariat staff besides Member States. Candidates should not attend those meetings even if they form part of the delegation of their country. The votes in the private meeting are conducted by secret ballot. The results of the ballots should not be disclosed by Member States.

2. Member States should abide strictly by the Rules of Procedure and other applicable resolutions and respect the integrity, legitimacy and dignity of the proceedings. As such, they should avoid behaviours and actions, both inside and outside the conference room where the nomination takes place, which could be perceived as aiming at influencing its outcome.

3. Member States should respect the confidentiality of the proceedings and the secrecy of the votes. In particular, they should refrain from communicating or broadcasting the proceedings during the private meetings through electronic devices.

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IV. Internal candidates

1. WHO staff members, including the incumbent Regional Director, who are proposed for the post of Regional Director are subject to the obligations contained in the WHO Staff Regulations and Rules, as well as to the guidance that may be issued from time to time by the Director-General.
2. WHO staff members who are proposed for the post of Regional Director must observe the highest standard of ethical conduct and strive to avoid any appearance of impropriety. WHO staff members must clearly separate their WHO functions from their candidacy and avoid any overlap, or perception of overlap, between campaign activities and their work for WHO. They also have to avoid any perception of conflict of interest.
3. WHO staff members are subject to the authority of the Regional Director and the Director-General, in accordance with the applicable regulations and rules, in case of allegations of breach of their duties with regard to their campaign activities.
4. The Regional Committee may suggest that Director-General consider applying Staff Rule 650 concerning special leave with or without pay to staff members who have been proposed for the post of Regional Director.

APPENDIX

Standard Form for the Proposal of Names of Persons for Nomination of the Regional Director of the Western Pacific Region of the World Health Organization

1. Please provide details of the qualifications and characteristics of the person proposed by your Government with regard to the criteria contained in Resolution WPR/RC50.R8, para. 2:

a) a strong technical and public health background and extensive experience in international health

b) competency in organizational management

c) evidence of public health leadership

d) sensitivity to cultural, social and political differences

e) a strong commitment to the work of WHO
