WPR/RC54/SR/4

SUMMARY RECORD OF THE FOURTH MEETING

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CHAIRPERSON: Dr Manuel DAYRIT (Philippines)

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1. EXPANDED PROGRAMME ON IMMUNIZATION: MEASLES AND HEPATITIS B: Item 11 of the Agenda (Document WPR/RC54/5)

The REGIONAL DIRECTOR said that on 29 October 2000, in Kyoto, Japan, the Western Pacific Region had been declared poliomyelitis-free. That historic achievement showed what the Region could do when the Member States and WHO all worked together. Today, two new initiatives for the Expanded Programme on Immunization (EPI) were being proposed, to build on its achievements to date. Those two new initiatives could strengthen health services as well as the EPI. Immunization services needed to reach every child, and to keep reaching every new birth cohort indefinitely. Thus immunization could provide the foundation for other basic health services.

Measles was likely to be the next target for global eradication once global eradication of poliomyelitis had been achieved. Earlier in 2003, the World Health Assembly had adopted a resolution to reduce measles mortality, which was attached to document WPR/RC54/5 as Annex 1. He believed that WHO and its Member States could eliminate measles from the Region. Three other regions had already established elimination goals. In fact for brief periods, the Region of the Americas had even achieved elimination. However, without global elimination, the re-introduction of the disease was inevitable, and if immunization coverage was not maintained, virus transmission would become re established. That was why global coordination of efforts was so important.

WHO and its Member States would not need to wait for global efforts to eliminate measles in the Region. If they could reduce the current disease burden, the benefits to the Region would be immediate. Immunization had already reduced the number of measles cases in the Region by 90% and the number of deaths by 95%. However, it was possible to prevent all of them and for the Region to once again show leadership in disease elimination.

To succeed in eliminating measles would require three key strategies: immunization, surveillance and laboratory support. A group of experts had helped WHO to devise a Regional Plan of Action for elimination, which was attached to document WPR/RC54/5 as Annex 2. The experts had recommended that regional elimination should be the goal for measles control, but, since measles control was at very different stages in different countries, it was proposed that the target date for elimination be set at a future date – based on an annual review of progress.

The second proposed new pillar to strengthen the EPI was hepatitis B control. There was a very large burden of disease from hepatitis B in the Region. Although only a quarter of the world's population lived in the Region, it was estimated that more than half of all the hepatitis B-related deaths occurred in the Western Pacific. Every two minutes someone died from hepatitis in the Region, usually from liver cancer in later life as a result of chronic infection acquired in early

childhood. Those deaths could be prevented by hepatitis B immunization, although it would take decades before the full benefits of such immunization were realized. Hepatitis B vaccine was the only anticancer vaccine currently available.

The Western Pacific was so far the only WHO region where hepatitis B vaccine was included in every national immunization programme. However, more work was needed to make sure that every newborn infant in the Region was protected from hepatitis B infection by the highly effective vaccine. So far, the hepatitis B control initiative had largely concentrated on strengthening routine immunization services, and making sure that every child received timely immunization. It was particularly important that the quality of routinely reported immunization coverage data be maintained in order to monitor the programme. Hepatitis B was unlike other EPI diseases, as the impact of immunization on the disease was not easily measured, so coverage was the main way of monitoring the programme.

He hoped that Member States would agree with WHO's proposal that measles and hepatitis B be selected as the two new pillars to strengthen the EPI, and looked forward to hearing about their experiences in measles and hepatitis B control, and their support for the new initiatives, including their readiness to establish a target date for regional measles elimination.

Dr WAQATAKIREWA (Fiji) endorsed the proposal to include elimination of measles and control of hepatitis B in the EPI. The objective of the hepatitis B control programme – a hepatitis B surface antigen (HBsAg) prevalence of less than 1% in five-year olds – was challenging, but achievable.

In view of a recent outbreak of rubella, Fiji had changed its immunization schedule so that measles and rubella vaccine could be administered to all infants at 12 months. Rubella vaccination could also be included in the EPI, reflecting new patterns of disease occurrence and control efforts.

Dr SULEIMAN (Malaysia) said that his country was fully committed to elimination of measles and control of hepatitis B. The measles elimination programme had been given high priority; a national plan had been established and targets set. Children would have a second opportunity for measles vaccination and surveillance systems would be improved through laboratory confirmation of suspected cases. Routine vaccination services were being strengthened in order to control hepatitis B, adhering to the strategies outlined in the regional plan.

Mr UNTALAN (United States of America) applauded the inclusion of measles elimination and hepatitis B control in the EPI. Achieving and maintaining high immunization levels in all communities was in the interest of national security and social equity, and his country strongly

supported the efforts of the Regional Office to raise vaccination levels. He urged other Member States to endorse the initiative, and to assure the political commitment and financing needed for a successful immunization programme.

Immunization programmes had notably reduced measles morbidity and mortality, bringing the Region close to elimination, and he looked forward to the setting of a target date. Lessons learnt from experience in different parts of the Region would guide future control efforts, including the need for adequate surveillance mechanisms.

Dr YU (China) reported that, in 2002, the incidence rate for measles in China had been 4.76 per 100 000, with some 64 000 reported cases. China was currently conducting a project to strengthen routine immunization services, including measles control, in poor areas of the country, which should provide valuable experience. It had established a national measles surveillance plan in 1999, which had been amended in 2000 to set out specific regulations, including strengthening of the surveillance system through laboratory confirmation.

China fully endorsed the strategies and activities set out in the regional plan of action for measles elimination. However, even though the plan indicated that target dates would be determined on the basis of annual reviews of measles control in each country, other factors needed to be considered. China's large population, its huge surface area, imbalances between regions at different stages of development, efforts needed to maintain polio-free status, and lack of funding, all made it difficult to set a target date for elimination.

China also agreed with the proposal to include hepatitis B immunization in the EPI. The Ministry of Health and Ministry of Finance of China had issued joint instructions in 2001 to include hepatitis B immunization in the routine immunization programme. Together with domestic financing, the programme was receiving strong support from the Global Alliance for Vaccines and Immunization (GAVI), particularly for providing supplies to the poorer provinces. China had recently redefined its targets for hepatitis B vaccination and control, including a HBsAg rate of less than 2% in children under three years old at provincial level. As the targets had been determined after careful study of the actual situation in China, the proposed regional objective represented a considerable challenge.

Dr RAHMAH (Brunei Darussalam) welcomed the consensus that measles elimination was technically feasible and agreed with establishment of the target date through a process of annual review. She also fully supported the regional plan for hepatitis B control and the requirements defined to achieve the regional objective.

Both measles and hepatitis B vaccination had been included in her country's national immunization programme for many years, resulting in coverage of over 95% and a significant reduction in the number of clinical cases. None the less, areas in need of further strengthening had been identified, with a view to achieving elimination.

Dr SELUKA (Tuvalu) endorsed the regional action plans for measles elimination and hepatitis B control. The last outbreak of measles in Tuvalu had occurred in 1998 and had caused five deaths. The establishment of the Pacific Public Health Surveillance Network would make it possible to respond effectively to future disease outbreaks through the sharing of information. In that regard, an outbreak manual had been designed to enable staff in peripheral health clinics in Tuvalu to identify and respond to suspected outbreaks.

His country had one of the highest hepatitis B prevalence rates in the Region, despite high vaccination coverage. Research was required, with the support of WHO, to uncover the underlying contributing factors.

Professor NYMADAWA (Mongolia) fully endorsed the regional action plans for measles elimination and hepatitis B control. However, a developing country could not eliminate measles alone, even with high vaccination coverage. Mongolia had long experience with measles immunization. Following the introduction of measles immunization in 1973, the number of cases had dropped to zero, but this had not been sustained and outbreaks had returned to pre-vaccine-era levels. Since 1987, Mongolia's policy had been to provide a first dose after nine months and a second six months later. However, his country would be unable to meet the regional elimination target without strengthening its laboratory services. In order to achieve the target, a collaborative effort was needed, especially through a network of laboratories. Moreover, Mongolia's experience showed that the results of many years' efforts could quickly be destroyed if the vaccination schedule was not maintained every year. GAVI had calculated that US$ 30 was sufficient to protect a child for life. However, on average, immunization programmes accounted for only 3.2% of total health expenditures and less than 0.2% of GDP. GAVI was, therefore, requiring all countries eligible for funding to draw up a five-year financial sustainability plan.

Mr JORÉDIÉ (France) supported WHO's proposal to eliminate measles in the Region and to reduce the incidence of hepatitis B through high immunization coverage. The same method been used to eradicate poliomyelitis. The French territories in the Pacific had always been very anxious to have immunization coverage higher than 90% and they were near to achieving their goal for measles immunization.

In New Caledonia, vaccination against hepatitis B at birth had been compulsory since 1989. The measles virus had been absent from the territory for the past 10 years, thanks to the very active immunization policies carried out by public health authorities. Four years ago, a mass immunization campaign had been carried out, enabling the country to avoid epidemics such as that in 1986, following which more than 16 cases of sclerotic sub-acute encephalitis had been recorded.

Dr LOPEZ (Philippines) endorsed the selection of measles elimination and hepatitis B control as the two new pillars to strengthen EPI. In 1998, the Philippines had embarked on a 10-year measles elimination plan, with an initial catch-up campaign targeting children between 9 months and 19 years of age, providing a second opportunity for measles immunization. A follow-up campaign would be undertaken in February 2004, targeting children between 9 months and 8 years. The Japanese Government would donate all vaccine requirements, syringes and needles and safety disposal boxes. The door-to-door strategy, which had been employed in the poliomyelitis eradication campaign in 2001, would be used and would focus on high-risk areas such as urban slums and hard-to-reach places.

In 1991, the Philippines had introduced hepatitis B into its EPI. The eventual aim would be to add receipt of three doses of hepatitis B vaccine by 12 months to the definition of a "truly immunized child". A law on hepatitis B immunization had also been enacted.

Although an allocation for hepatitis B immunization had been made in the national EPI, the allocation for the more expensive hepatitis B vaccines had been reduced to cover the requirements for other vaccines. A proposal had been submitted to GAVI for funding for hepatitis B control efforts.

The Philippines welcomed the two initiatives as a means to strengthen and improve the EPI from the technical as well as the programme management perspective, and as a means of raising financial support. To improve advocacy, there was a need to resolve such technical issues as the birth dose for hepatitis B; the use and availability of monovalent measles vaccines and hepatitis B vaccine versus multivalent vaccines; use of plasma-derived hepatitis B or the more expensive recombinant type; use of autodisable syringes and needles; and disease surveillance and laboratory confirmation.

Ms GO (Republic of Korea) said that her country fully supported the selection of measles elimination and hepatitis B control as the two new pillars to strengthen the EPI in the Region. Every infant needed to be protected from hepatitis B infection to prevent an important disease burden in later life. In the Republic of Korea, a catch-up measles-rubella vaccination campaign had been conducted in 2001 to cope with a severe outbreak of measles. The target date for elimination of measles was 2005 and efforts would continue to eliminate measles in the Republic of Korea. For hepatitis B, the

Government had, since 2002, paid the cost of vaccination and testing of newborn infants whose mothers had acquired hepatitis B in order to prevent mother-to-child transmission.

Dr FUKUDA (Japan) welcomed the proposal that measles elimination and hepatitis B control should be the two new pillars to strengthen the EPI in the Region and said his country fully supported measles elimination as a long-term regional target. However, measles epidemiology and control varied from country to country and WHO should take those differences into consideration when making recommendations for each country.

Every year 100 000 to 200 000 measles cases occurred in Japan, with ten or more deaths reported. Most cases occurred in non-vaccinated persons, especially in the one-year-old group, only half of which had been vaccinated. The report of a technical expert committee for measles control, published in May 2003, had recommended the prioritization of increased immunization coverage in the one-year-old group. Routine immunization provided an opportunity for single dose vaccination to all children throughout the year. The primary strategy was to increase awareness through an advocacy campaign to improve immunization coverage. The National Institute of Infectious Diseases of Japan had been designated as the regional reference laboratory for measles. It was committed to providing technical support for the improvement of measles diagnosis in each country of the region.

In Japan, the HBsAg of expectant mothers was first examined and, upon the birth of the baby, its HBsAg and hepatitis B antibodies were also examined. Immunization depended on the results of these tests. He was confident that the system provided sufficient protection to prevent mother-to-child transmission and for hepatitis B control. He concluded by noting that Japan was fully committed to supporting WHO activities to further enhance EPI, including strengthening the surveillance system and laboratory support.

Dr KOI (Macao, China) said that, in Macao, immunization activities had formerly included only one dose of measles vaccine. Immunization coverage had been low and there had been a large-scale measles epidemic in 1988, with 672 cases reported. After the introduction of second and third doses and increased coverage, the incidence of measles had gradually decreased. Since 1994, only sporadic cases had occurred every year. A measles elimination programme had now been established, according to the recommendation of the Technical Advisory Group. The programme had recommended two doses for 12- and 18-month-old infants since January 2003. Clinical doctors were required to arrange laboratory confirmation for every measles case. Although Macao (China) covered a small geographical area, there was frequent communication with other peoples and countries. To eliminate measles, therefore, efforts had been made to achieve high coverage with two doses of vaccination. Elimination of measles in other regions was equally important. He agreed with the

selection of measles elimination and hepatitis B control as the two new pillars to strengthen the EPI and with measles elimination as a regional goal.

The seropositive rate for HbsAg was about 11% in the adult population, and liver carcinoma was the second major cause of cancer deaths. Chronic hepatitis B infection was an important public health problem. Since 1990, the Macao Government had provided free hepatitis B immunization for newborn infants and for those born after 1985. The immunization rate for newborn infants was over 99%, and exceeded 92% for children aged 12 months with 3 doses. Following the recommendations of the Technical Advisory Group, Macao would carry out a sampling survey of the seropositive rate for HbsAg in children to evaluate the efficacy of the immunization programme. It was hoped that the rate would be less than 1%.

Mr DAVIES (Australia) stated that Australia recognized and was concerned by the burden of disease attributable to measles and hepatitis B in the Region. His country supported the selection of measles and hepatitis B as the two new pillars to strengthen the EPI. Measles elimination and control of hepatitis B were appropriate goals for the Region to pursue and built on the success of the poliomyelitis eradication campaign. He agreed that the target date for regional measles elimination should be based initially on an annual review of progress, although Australia would like to see a clear, ambitious but achievable target date set at an early stage.

He recognized the importance of the EPI in controlling and eliminating preventable diseases in the Region and believed that such interventions made financial sense. Recent research carried out in Australia suggested that every AUS$ 1 spent on measles immunization could yield savings of more than AUS$ 150 in future health care costs.

AusAID had identified the prevention and control of communicable diseases as a priority area. In 2003-2004, Australia would provide AUS$ 225 million for health assistance to developing countries. A substantial proportion of that assistance was for basic health services, including immunization. Through AusAID, Australia had provided support for immunization and vaccine efforts to Cambodia, Papua New Guinea and 14 Pacific island countries. Funds had also been provided to the International Vaccine Institute for a project covering Viet Nam and China.

Australia urged WHO to give appropriate consideration to the constraints that countries faced in scaling up to plan, managing and delivering immunization services. He asked WHO to provide support for countries' efforts to overcome those constraints.

Dr SIPELI (Niue) said that his country had been carrying out routine measles immunization using the triple vaccine, measles-mumps-rubella (MMR), giving the first dose at 15 months and the

second at four years. Coverage was 100%. Hepatitis B immunization had been offered to all infants since 1986 at four weeks and six months, based on the recommendation of the vaccine manufacturers. Babies were now delivered in hospitals and were routinely immunized 12 hours after birth. Niue endorsed the regional action plans for the elimination of measles and hepatitis B control.

Dr MANN (Papua New Guinea) said the two regional action plans for measles elimination and hepatitis B control would provide countries with the guidelines necessary to develop national implementation plans.

Immunization coverage in Papua New Guinea was very low, and had hovered around 45% and 50% for the last five years, resulting in several measles epidemics among children and young adults.

His country had been continuing efforts to ensure that infants received one dose of measles vaccine soon after birth. In addition, children may receive another two doses and he requested support to determine whether that policy was appropriate. A supplementary immunization programme would be launched next month. He extended thanks to Australia and Japan for their strong support for Papua New Guinea's EPI activities.

Dr ENOSA (Samoa) joined previous speakers in commending the selection of two new pillars to strengthen the EPI in the Region. However, for the Pacific island countries the main constraint in the implementation of such initiatives was always cost. Samoa had started a measles immunization programme some five years earlier but had recently, like Tonga and Fiji, experienced the emergence of rubella. The implications of that development, especially as regards pregnant women, were under consideration, and WHO would be requested to provide support for a survey to determine the extent of the problem. It was likely that the more expensive triple MMR vaccine would be needed. He expressed appreciation for the generous financial support for the EPI in the Pacific island countries provided by the Governments of Australia and Japan.

Dr MALEFOASI (Solomon Islands) also welcomed the timely new initiatives, which accorded with his country's recovery plans. Solomon Islands would support relevant WHO strategies. Implementation would constitute a considerable challenge, however, since immunization coverage was at a low level following the recent civil unrest. It would require a strategic, holistic approach, but he was confident that it could be achieved given the ongoing improvement in primary health care services and the low incidence of measles and hepatitis B. The Ministry of Health, with support from nongovernmental organizations, was preparing action plans to re-establish all aspects of the EPI, which was a key component of the economic recovery plan for the coming decade, to be submitted shortly to potential donors.

Mrs PAUL (Marshall Islands) voiced her country's commitment to the improvement of its immunization programme and to the elimination of measles - a recent outbreak of measles had affected the young in particular and had claimed three lives. However, it was difficult to see how plans to increase immunization coverage and upgrade laboratory facilities could be realized given the proposed cut of around 38% in the WHO country allocation for that area. She, therefore, asked the Regional Office to reconsider that allocation.

Dr CUTTER (Singapore) expressed support for the selection of measles elimination and hepatitis control as the two new pillars to strengthen the EPI, and urged that a target date for measles elimination be set as soon as possible. He outlined the progress made in Singapore's immunization programme. A second dose of MMR vaccine for children of 11-12 years had been included since 1998, following an outbreak of measles the previous year, and had resulted in a dramatic fall in the number of recorded cases. Hepatitis B had been included since 1997, with a three-dose coverage of around 90%, and had substantially reduced the seroprevalence of HBsAg and the incidence of acute hepatitis B. Incidence in children under 15 years of age had been reduced to zero.

Mrs PIERANTOZZI (Palau) also supported the proposals. Palau had succeeded in maintaining immunization coverage above 90% thanks to its small population and to a policy of administering vaccines at birth, with good follow-up. However, migration across the Region posed a challenge in respect of both immunization and surveillance. WHO support was requested to ensure better regional coordination of the EPI, especially in migrating populations. WHO support for the development of regional laboratory diagnostic facilities and safe blood services was also needed.

WHO had paid considerable attention to maternal and child health. She proposed the development of initiatives to improve men's health and to involve men as partners in family health actions, for example, by encouraging them to support the immunization of their children.

Dr LAM (Hong Kong, China) reported that Hong Kong provided the MMR vaccine, free of charge, to all children as part of its EPI, with a two-dose schedule. The first dose was given at 12 months and a second opportunity was provided at six years. Children who had missed the first dose could receive free vaccination at health centres before the second dose was due. Hepatitis B immunization had been introduced in 1985, with a first dose administered within 24 hours of birth for most babies. Coverage with three doses was more than 88%, and children aged one to four years showed zero seroprevalence for HBsAg. Hong Kong was fully committed to continuing its efforts to eliminate measles and to control hepatitis B, under the guidance of the Regional Office.

Dr KIENENE (Kiribati) supported the proposal to select two new pillars to strengthen the EPI. The reduction of HBsAg seroprevalence to 1% was an ambitious target given the high rates currently observed in some Pacific island countries such as his own, where it was 25%-30%. However, he was sure that, with support from WHO, that objective could be achieved.

Mr TEOKOTAI (Cook Islands) supported the proposals to strengthen the EPI and to adopt the objective of measles elimination. The effectiveness of the programme was illustrated by the lack of incidence of the diseases concerned in his own country. Immunization coverage was 96% for children under 12 years for measles, with a second dose given at school entrance, and 99.7% for hepatitis B. The ongoing objective was to maintain that high coverage. He agreed with the representative of Fiji that immunization against rubella should also be included in the EPI, as it would be only a matter of time before the disease emerged elsewhere in the Pacific island countries. It was important to give due attention to surveillance and to the capacity of diagnostic laboratory facilities in Pacific island countries.

Dr DUONG HUY (Viet Nam) supported the selection of the proposed new pillars to strengthen the EPI and commended the two regional plans. Viet Nam had developed a strategy for the elimination of measles by 2010. Coverage for children under one year of age had been maintained at more than 90% for many years, and the number of measles epidemics had declined in northern provinces following the first national immunization campaign. A second dose would be offered as a routine component of the EPI from 2006. Thanks to the provision of vaccines by GAVI, Viet Nam had introduced hepatitis B immunization in 44 provinces since 2002, but coverage remained a problem in remote and mountainous areas. WHO and the Program for Alternative Technology in Health (PATH) had supported the preparation of a plan for incorporation of immunization against hepatitis B in the EPI. Viet Nam was constructing facilities for local production of vaccines against measles, with support from the Government of Japan, and hepatitis B. He expressed appreciation for the support provided by WHO and others and looked forward to further cooperation in the future.

At the invitation of the CHAIRPERSON, the representative of the Global Alliance for Vaccines and Immunization made a statement to the Committee.

The REGIONAL DIRECTOR thanked representatives for their support for the proposal to use immunization against hepatitis B and measles as twin pillars to strengthen the EPI. He recalled that up to 800 people died each day in the Region from conditions related to infection with hepatitis B virus. The death toll was similar to that of tuberculosis, but less attention had been paid to hepatitis B. The representative of China had suggested that, even though he supported the proposed initiative, the target of reducing the prevalence of hepatitis B virus infection to 1% was somewhat ambitious. That

goal could, however, be achieved in coming years as the cost of the vaccine decreased. He agreed with the representative of Japan that the situation differed from country to country, and that comprehensive screening of mothers for hepatitis B surface antigen and immunization could be effective in reducing mother-to-child transmission.

Measles outbreaks had occurred in the Region in the recent past, as vaccine coverage as high as 80% or 90% still meant that 20% or 10% were not immunized, in addition to those who did not become immune after vaccination. Those percentages accumulated over time, until a threshold for periodic resurgence of the disease was crossed. Both theory and experience showed that an immunization rate of 95%, with two doses, would be required to interrupt transmission of indigenous wild virus. The representative of Mongolia had clearly expressed the need for regional collaboration, laboratory systems and sustained financial support to eliminate the highly infectious measles virus. Despite the differences in country situations described by the representative of Japan, it was therefore essential that there be an overall regional strategy, although he fully agreed that this should not be imposed inflexibly. Although the representative of Australia had proposed that a target date for elimination of measles be set as soon as possible, there were a number of reasons why this was problematic at present. Poliomyelitis had not yet been entirely eliminated, and the introduction of immunization against measles might overstretch the available international immunization capability and financial support. Furthermore, immunization programmes in Member States were currently at very different stages. Once poliomyelitis had been eradicated, a target date could be set for elimination of measles.

The REGIONAL ADVISER IN COMMUNICABLE DISEASE SURVEILLANCE AND RESPONSE said that, in order to counteract the lack of adequate laboratory capacity for confirmation of measles cases in the Region, the LabNet system had been set up within the Pacific Public Health Surveillance Network. The first meeting of LabNet was being held in Suva, Fiji, concurrently with the present session of the Committee. That meeting was discussing various issues related to the strengthening of laboratory capacity in Pacific island countries and he believed that it would represent a milestone in efforts to improve such capacity.

The REGIONAL ADVISER IN EXPANDED PROGRAMME ON IMMUNIZATION said that the measles elimination programme would provide a good opportunity to reduce or eliminate congenital rubella syndrome. As mentioned by the Regional Director, at least 95% coverage would be needed for a measles elimination programme, and rubella vaccine could safely be given with the measles vaccine. As rubella was less infectious than measles, it would be easier to eliminate. The drawbacks to combined immunization were the additional cost and the different age ranges covered. As long-term funding for immunization against measles had not yet been secured, it would be

premature to add rubella vaccine in most countries. When that was possible, however, as in Tonga, combination immunization was preferable. The situations in individual countries should be reviewed, so that programmes could be drawn up for the addition of rubella immunization when appropriate.

2. SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV/AIDS: Item 12 of the Agenda (Document WPR/RC54/6)

The REGIONAL DIRECTOR, introducing the report, said that WHO continued to have a very active HIV/AIDS programme in the Western Pacific Region. The promotion of condom use had led to significant reductions in the prevalence of HIV infection among sex workers, particularly in Cambodia. The "100% condom use" strategy was being extended to a number of countries with low HIV prevalence, such as the Lao People's Democratic Republic and Mongolia. The rates of condom use were increasing significantly among individuals at high risk of infection in many countries.

Injecting drug use remained a major path of transmission in China, Malaysia and Viet Nam. In collaboration with WHO Headquarters and the South-East Asia Region, the Regional Office had developed a strategic framework for a harm reduction-based approach to HIV prevention among injecting drug users in Asia, which was described in Annex 2 of document WPR/RC54/6.

Partnerships among governments, United Nations agencies, bilateral and multilateral partners and nongovernmental organizations to fight HIV/AIDS in the Region continued to be good. One example was the success of proposals from the Region to the Global Fund to Fight AIDS, Tuberculosis and Malaria. In January 2003, the Global Fund had approved three more proposals addressing HIV/AIDS, from Cambodia, from Mongolia and from 11 Pacific island countries. Those had brought the total support from the Global Fund for HIV/AIDS projects in the Region to US$ 53.5 million. Excellent, close collaboration among countries, UNAIDS and WHO had contributed greatly to the high success rate of proposals to the Global Fund from the Region.

Despite those positive developments, he said that WHO and its Member States should not be lulled into a false sense of security. Although the regional prevalence rate was relatively low, the large populations of several countries in the Region meant that the regional rate masked large numbers of infections and significant human costs.

There was also a danger that increasing levels of HIV infection among highly vulnerable populations could lead to spread of the epidemic to the wider community. In some countries, up to half of all new cases of HIV infection were among wives of infected men. In Cambodia, about one-third of new cases were in children infected by their mothers. Efforts to reach those most at risk for

infection with large-scale interventions of proven effectiveness should continue and indeed be increased.

WHO and its Member States should work together to reduce the burden on individuals with AIDS, their families and communities and health services. Broader access to antiretroviral therapy and its rational use were needed where HIV testing and counselling were available, as part of comprehensive HIV/AIDS care. Annex 3 to the document gave details of WHO's work to expand antiretroviral therapy in the Region. The Region was facing the risk of a general HIV/AIDS epidemic, and WHO and its Members States should do everything possible to prevent it. The REGIONAL DIRECTOR urged Member States to address carefully the four proposed actions listed in document WPR/RC54/6: political commitment, prevention, surveillance and HIV/AIDS care.

Looking back over the many excellent achievements in the Region since the emergence of HIV/AIDS, he was confident that WHO could continue to prevent a general HIV/AIDS epidemic in the Western Pacific Region.

Dr KIENENE (Kiribati) said that HIV/AIDS appeared to be here to stay. However, he noted two positive developments mentioned in the report: the launching of the International Treatment Access Coalition and the approval of some proposals to the Global Fund from the Region. His country was one of the beneficiaries of the latest round of approved proposals and was now working hard to complete the formalities so that funds could be released. He recalled that at the Asia Pacific ministerial meeting on HIV/AIDS held in October 2001 in Melbourne, Australia, the Director of UNAIDS had pointed out that the peoples of Asia and the Pacific had been given "the gift of time", but that this was rapidly running out.

Dr RAHMAH (Brunei Darussalam) applauded the support of the Regional Office to Member States in their fight against the escalating HIV/AIDS epidemic. Although few cases had been reported in her country, it was vulnerable to factors associated with the spread of the disease. One area in which difficulty had been encountered was in accurately estimating and projecting the number of cases, which was of paramount importance for assessing the burden of disease and the associated needs. Although she welcomed the development of models such as the Epidemic Projection Package, the specifications for data limited its application by countries with low prevalence or lacking the required data. She therefore urged that alternative tools be developed to overcome that limitation.

Dr DAUD (Malaysia) said that the effects of the HIV/AIDS epidemic extended to the social, economic and cultural sphere. Therefore, not only political commitment but also greater involvement of nonhealth and community-based players was needed. The strategies that had been used to elicit

greater commitment from communities in his country included advocacy on issues related to HIV/AIDS through an interministerial committee; building capacity in the nonhealth sector; collaborative interventions for the prevention and control of AIDS through a multisectoral coordinating committee; financial and technical support to appropriate nongovernmental organizations; coordinated institutional and community-based programmes for prevention, treatment, care and support of women, children and adolescents affected by HIV/AIDS; and provision of diagnostics and affordable antiretroviral drugs through direct negotiations with pharmaceutical companies. The Association of Southeast Asian Nations was guiding national responses to the HIV/AIDS epidemic; promoting a positive environment for confronting stigma, discrimination, denial and silence; ensuring the availability of affordable drugs; helping countries to reduce vulnerability to the disease; and preventing HIV infection among migrant workers.

The Ministries of Health and Education in his country had established a programme to mobilize young people in communities, based on the concept 'action by youth, through youth and for youth' and aimed at remaining healthy within the framework of sociocultural norms and values. The programme had trained 49 000 peer motivators and 820 clubs to sustain the momentum. In 2002, a code of practice for the prevention of HIV/AIDS in the workplace had been formulated by the Ministries of Health and Human Resources and the Malaysian AIDS Council.

Dr KOI (Macao, China) reported that screening of foreigners applying for work permits indicated that most HIV cases reported in Macao belonged to that group. Illegal foreign workers were also cause for concern. Although reported cases of sexually transmitted disease detected by anonymous, non-linked screening were few, they were slowly increasing. The health services were concentrating on educating foreigners working in the entertainment industry, and on harm reduction in other groups, such as young people. Further evaluation of education activities was needed. Treatment of HIV/AIDS was available to residents of Macao free of charge, as it was for any sexually transmitted infection. Since cases were still few, that did not affect resource allocation within the health service.

Dr BILGER (France) praised progress made, particularly in Cambodia, thanks to a proactive prevention strategy aimed at high-risk groups, including sex workers and injecting drug-users. However, more had to be done for those groups in terms of accelerating risk reduction, including such measures as provision of drug substitutes. France endorsed the WHO policy on integrated management of HIV and urged the Organization to establish a forum to address equitable access to treatment, and to set up a programme with the following elements: encouraging countries that had not already done so to put antiretrovirals on their list of essential medicines; promoting a policy for procurement of antiretrovirals at the lowest cost, since cost was a key factor in equitable access;

advocating the adoption of a policy for quality generic drugs; and developing local capacity for production of antiretrovirals. To that end, WHO should gather the information needed to evaluate the situation in the Region. WHO should also continue to coordinate with the Global Fund and to provide it with technical support for implementation of programmes to improve access to antiretrovirals, as the representative of the Fund had requested.

Mr UNTALAN (United States of America) held that few topics were more important to the health of the world and of the Region than HIV/AIDS. His government had been the largest contributor to the Global Fund to Fight AIDS, Tuberculosis and Malaria, with a total pledge of over US$ 1.6 billion until 2008, and US$ 623 million deposited in the trustee account to date. His country's support for the Global Fund and for other multilateral HIV/AIDS initiatives was combined with over US$ 1 billion spent annually on bilateral research, prevention, and care and treatment activities.

He commended the evidence-based approach taken by the Western Pacific Regional Office to prevention of HIV and other sexually transmitted infections, blood safety, epidemiological data and coordination with other partners. The Regional Office approach to AIDS care was particularly comprehensive, encompassing palliative care, treatment of opportunistic infections, home- and community-based care, and antiretroviral treatment. Cambodia and other Member States were managing to reduce the prevalence of HIV/AIDS, to keep it stable, or to remain HIV-free. Every country could learn from the experience of others.

His country supported interventions targeted at individuals whose behaviour placed them and those around them at risk of HIV or other sexually transmitted infections; prevention and reduction of transmission should be supported. Nevertheless, he could not fully endorse plans of action that did not include critical behavioural components such as delay of sexual initiation, abstinence, promotion of fidelity and partner reduction. Greater emphasis should be given to mother-to-child transmission. While commercial sex workers were an important target population, male clients also had to be educated. HIV education should neither encourage prostitution nor condone the trafficking of young people and women.

Dr TSANG (Hong Kong, China) welcomed the attention devoted to injecting drug users in the strategic framework. There was a cumulative total of 2000 reported cases of HIV/AIDS in Hong Kong, most of which had contracted the disease through sexual contact. Thus far, only some 2.6% of reported infection had been associated with drug injection. That had been an incidental result of the methadone maintenance programme, which had been introduced in the 1970s. A media campaign had been launched in 2002, based on harm-reduction principles advocated by the Regional

Office; the methadone maintenance programme was one of its essential elements. Universal HIV testing for methadone users had been piloted in 2003 as had an outreach programme, which made 400 contacts with drug users per month. The work on HIV treatment and care, promotion of safer sex, and strengthening of HIV surveillance were in line with the regional framework document.

Mr DAVIES (Australia) acknowledged the need for timely surveillance as a basis for national strategic plans and care for people who were infected. Australia mirrored the goals and guiding principles of the WHO global strategy for health sector response to HIV/AIDS. The country was implementing a six-year, AUS$ 200 million global HIV/AIDS initiative, to assist countries in the Asia-Pacific region to respond to the epidemic. Major programmes were under way in Papua New Guinea, Viet Nam, Indonesia and southern China. Earlier in the year, Australia had approved funding for a four-year AUS$ 12.5 million regional HIV/AIDS project in the Pacific. He agreed that strong political commitment was needed to reduce HIV transmission and other sexually transmitted infections. Australia had provided AUS$ 1 million in seed funding to the Asia-Pacific Leadership Forum, a strategy designed to increase political leadership and action against the HIV/AIDS epidemic, through support for a network of key politicians, leaders and decision-makers.

Dr UEDA (Japan) appreciated the support from the Global Fund for several countries in the Region, which had been obtained with the assistance of WHO, UNAIDS and the respective governments. Japan felt it was important to work with other countries in the Region while dealing with domestic problems in Japan. Examples of such work included capacity-building on HIV/AIDS surveillance in Cambodia, strengthening of diagnosis and research in the Philippines, and support to various workshops on HIV/AIDS. Although HIV prevalence was comparatively low in the Region, new cases were set to increase. Member States had to be reminded of that fact. Large-scale interventions targeted at high-risk groups were to be encouraged, especially since prevalence in the Region was still low. However, it was often hard for governments to approach those most at risk. Support had to be given to nongovernmental and non-profit organizations for that purpose. Experience should be shared and replicated in Member States, and WHO had a role to play in this.

He praised the efforts to improve access to antiretrovirals, but noted that many developing countries did not have the infrastructure to monitor administration of the drugs. A framework was needed to extend the provision of antiretrovirals and achieve the global target of treating 3 million people by 2005. Compliance with drug regimens for HIV/AIDS should be taken into consideration, and guidelines should be developed with partner agencies. Intensive education, counselling, support, treatment and follow-up with families were essential in ensuring compliance with treatment and prevention of drug resistance. It was hard for most hospitals in developing countries to provide such services, since they could not charge for them. The day-care centre approach advocated by the

Regional Office, involving peer support linked with clinical services and the community, should be a key mechanism for encouraging treatment compliance. Such centres, especially at district level, should be used to increase antiretroviral treatment in the Region. Top priority should be given to the provision of antiretrovirals to prevent perinatal transmission of HIV; he advocated a pilot project to study that topic in depth. Harm reduction strategies, such as supply of needles and syringes, could enhance illegal activities, so related measures required careful consideration. WHO should encourage use of condoms for prevention of sexually transmitted diseases.

He regretted that the 7th Asian HIV/AIDS Congress, which had been scheduled for November 2003 in Kobe, Japan, had been postponed for two years on account of SARS. He asked representatives to make it known in their countries that the congress would indeed take place in 2005.