SUMMARY RECORD OF THE THIRD MEETING

Room A of the Kyoto International Conference Hall
Tuesday, 17 September 2002 at 2 p.m.

CHAIRPERSON: Dr Hideo SHINOZAKI (Japan)

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1. PROPOSED PROGRAMME BUDGET 2004-2005: Item 9 of the Agenda (Document WPR/RC53/4) (continued)

Dr SELUKA (Tuvalu) requested the Regional Director to provide further details on the increase in WHO's presence in countries, and asked if that would mean that WHO staff would be located in each Member State. In view of the reductions in country budgets, he wondered whether the Regional Director would reconsider the proposed allocation to disadvantaged countries. He understood that there was a minimum allocation for least developed countries that had not changed despite their rising burden of disease. In Tuvalu that included HIV/AIDS, diabetes, cardiovascular diseases and stroke.

Dr DAYRIT (Philippines) suggested that it would have been more appropriate to discuss the proposed programme budget 2004-2005 after the debate on the final report of the programme budget 2000-2001. An indication of how a previous budget had been implemented would provide a sounder basis for discussion of the future budget. He proposed that in future the order should be reversed.

Given that budgets were blunt instruments for achieving objectives, he requested an explanation of increases and decreases for specific budget lines. For example, did the decrease in allocation to the Expanded Programme on Immunization or for control of tuberculosis mean that those areas now had lower priority? Conversely, the allocation for programme planning, monitoring and evaluation had increased considerably and he wondered how that should be interpreted.

Although it was sound practice to present budgets in terms of goals, objectives, strategies, results and indicators, he requested information on the activities being funded to reach those targets. Such activity-based budgeting would provide a clearer idea of the way in which resources were being used. More important than the actual figures for country allocations was the way in which those funds were employed.

Dr MANN (Papua New Guinea) took the opportunity to congratulate the Director-General for her excellent leadership and vision on global health issues and to thank her for the consideration she had accorded to the Region, especially in regard to the gradual application of budget reductions.

In comparison with the current budget, he noted that for 2004-2005, allocations to certain regions had increased whereas to others, including the Western Pacific, they had decreased. He felt that any reduction in country allocations should take account of the disease

burden and priorities of Member States. The greatest concerns of Papua New Guinea were malaria and other communicable diseases, whereas noncommunicable diseases were of higher priority in more developed Member States. He was confident, however, that the Regional Director would be able to manage the situation and find ways to compensate for the reductions.

He observed that the proposed programme budget indicated an increase in WHO's presence in countries and wondered whether that would mean more opportunities for experts from Pacific island nations to be recruited to WHO.

Mr KALPOKAS (Vanuatu) also thanked the Director-General for her inspiring leadership for global health development. During her term of office Vanuatu had been fortunate enough to serve on the Executive Board, and its member had been appointed Chairman of the Board. He appreciated that indication of confidence in and respect for his country and for all Pacific island nations.

Noting that for the next biennium reporting on programme outcomes would be based on expected results and indicators, he requested the support of local WHO offices in preparation of the budget.

Dr THORNE (United Kingdom of Great Britain and Northern Ireland), observing that the budget was based upon an expected increase of 37% in extrabudgetary resources, asked how firm was the expectation of such a large increase, and whether there was a mechanism for prioritizing between different activities in case that level of funding did not materialize.

Dr TANGI (Tonga) said that he strongly supported the view expressed by previous speakers that the provisions of resolution WHA51.31 related to the decrease in the regional allocation for the Western Pacific should expire in 2005.

The REGIONAL DIRECTOR said that, for the benefit of new representatives, he would start by explaining the process of results-based budgeting. This started with the global approach, although regional input was assured through such mechanisms as the Global Cabinet and meetings of the Directors, Programme Management.

Second, and in reply to the question of why expected results were not included in the regional overview, he explained that, at the global level, the Executive Board and the Health Assembly had only one opportunity each to discuss the proposed programme budget. At the regional level, however, the Regional Committee had two opportunities to examine the

budget. In this case, the proposed programme budget 2004-2005 would be re-examined by the Regional Committee at its fifty-fourth session next year. Thus, the information provided in the regional overview at this time was only an initial outline. After the current session, countries would prepare their budgets in more detail, taking account of the present debate, and this would lead to more detailed information, which would in due course be presented to the Committee. At its next session, the Regional Committee would examine the budget more thoroughly, including mobilization of extrabudgetary resources and expected results at country and regional levels.

Third, the expected results and corresponding indicators would enable WHO and Member States to evaluate performance. The global priorities had already been established, but that did not prevent the Region from pursuing regional issues, nor countries from pursuing country-specific ones.

Turning to World Health Assembly resolution WHA51.31, the Regional Director reminded the Committee of the provisions of paragraph 3(a), which recommended that the regional, intercountry and country allocation in future programme budgets should for the most part be guided by a model that drew upon UNDP's Human Development Index. He explained that, inevitably, this meant some would gain and others lose in the process. He also pointed out the resolution specified that any reduction "can be implemented gradually so that the reduction for any region would not exceed 3% per year and would be spread over a period of three bienniums". He stressed that the resolution did not specify that the reduction should be exactly 3%, but rather a maximum of 3% per year, over three bienniums, beginning in 2000-2001. In his view, the intent of the resolution was that any reduction should be completed by the end of 2005. Posts in the Region had already been cut, affecting provision of support to Member States; he would not want to see that process continue.

In response to queries on expenditure on global priorities, he noted that, of the US$ 31 million allocated to the Western Pacific Region in the 2004-2005 budget, US$ 12 million - 38% of the total regional budget – had been allocated to global priorities. The proportion in the previous biennium had been 24%. Tobacco was now a global priority; its allocation had increased by 180% and the mental health allocation by 192%. Mental health should be given still more, but since resources were limited, unfortunately that could not happen.

Many Member States had asked why the funding for certain programmes had been reduced; the main reason was that the budget for the Region had been reduced by 11% over

three bienniums, which meant that funding for some activities had to be cut. Nevertheless, 11% was better than the 18% on which the Director-General might have insisted, by virtue of resolution WHA51.31, and he thanked her for her support in mitigating the negative effects of the resolution on the Region.

The Regional Director asked representatives to recall resolution WPR/RC50.R1 whereby the Regional Committee had requested that 60% of the total country allocation should be decided in accordance with the UNDP Human Development Index. The remaining 40% was to be allocated at the discretion of the Regional Director, but the Committee had insisted that least developed countries should not suffer. In effect, such countries tended to have larger allocations than in previous biennums. It had been decided that, at the other end of the scale, affluent countries, should be allocated US$ 50 000 or less; Australia, indeed, had forgone its right to even that allocation. He understood that the Western Pacific was the only WHO region to use such objective criteria.

Regarding additional allocation to WHO's presence in countries, discussions on regional allocations after the end of the period covered by resolution WHA51.31 would provide a good opportunity to look at that issue.

Some countries had asked whether more national professional staff could be recruited, rather than expatriate staff. In some countries, like China, WHO had already recruited national staff – perhaps not enough for some Member States, but he believed that that would be an increasing trend.

Some Member States had asked why WHO Headquarters structured the budget around the 30 or so areas of work, while the Regional Office budget was structured around 17 focuses. He said it was simply a matter of scale, as there were a smaller number of divisions in a smaller office, but he emphasized that the two were clearly linked. Regarding the question on zero allocations, he said two areas had been given zero allocation: research and product development for communicable diseases, which was part of a global programme run by Headquarters with collaboration from the regional offices, and sustainable development, which was linked to the regional focus on health systems reform.

In global terms, extrabudgetary funding had increased by 77% between 1998 and 2000. The problem raised by Member States was that the benefit of that increase had not been equally enjoyed. The Western Pacific Region's share had amounted to 6.3% in 1998, but only 4.1% in the following biennium. The main reason was that many globally mobilized funds were earmarked to programmes such as onchocerciasis control, Roll Back Malaria and

poliomyelitis eradication, which were greatly needed in countries in other regions. Thus the Western Pacific Region carried a double burden: cuts in both regular and extrabudgetary funding. He hoped that Executive Board members would take the opportunity to explain this issue when the Executive Board came to re-examine resolution WHA51.31.

In response to further specific questions, he regretted that strengthening the presence of WHO in countries would not mean that each country would get one new WHO staff member, though some countries in need would.

Discussion of the report of a previous biennium before an examination of the forthcoming one, as suggested by the distinguished representative of the Philippines, was a good idea and would be adopted at the next session of the Regional Committee. Regarding the recruitment of staff from Pacific island countries, he said there had been some progress in this regard but gave his assurance he would try to improve the situation further.

The DIRECTOR, PROGRAMME MANAGEMENT, in response to some of the points raised, said that the budget cuts in certain focuses were indeed significant. However, there had also been a certain amount of shifting of posts from one focus to another.

Specifically, there had been a reduction in the immunization programme due to the reduction in some activities and the cutting of one post. Healthy settings covered four different areas of work, the most affected being health promotion, where a post and some activities had been cut. That was not to be interpreted as a cut in commitment to health promotion, which would be carried out in specific technical programmes such as noncommunicable diseases, environmental health, child and adolescent health, mental health and the Tobacco Free Initiative.

The focus of noncommunicable diseases comprised two areas of work: noncommunicable diseases and mental health. There had been a reduction in activities in both areas, and some reduction in general service staff.

In health systems development and financing, the reduction was primarily because of a shift of two posts, one based in the South Pacific, the other a regional adviser in nursing, from that focus to Human resources for health, which more accurately reflected their work. There was also a slight reduction in activities. There had been a very minor reduction in tuberculosis control activities.

In relation to the question from the representative from New Zealand regarding the potential for a comprehensive framework for the control of noncommunicable diseases; as the Regional Director had said, there were major efforts in diabetes – the Western Pacific Declaration on Diabetes and the plan of action. The Regional Office had tended to use diabetes as an entry point for noncommunicable disease control where appropriate, especially in Pacific island countries. In other parts of the Region, there was a much more integrated approach to noncommunicable diseases. In due course, a comprehensive framework for noncommunicable disease control for the Region would be produced, but the time was not yet ripe.

With regard to the request for information on the timetable requested by the representative of China, he said the guidance for preparation of the 2004-2005 proposed programme budget would be sent to countries in October or November 2002, while the date for submitting the strategic country budget to the Regional office would be end of March 2003.

A complete guideline for managerial process including training materials had been developed. The first training workshop for regional and country staff would take place shortly. Following that training, a series of subregional training workshops would be conducted and these would also involve selected national counterparts. Because of the experience in preparing budgets for 2002-2003, it was expected that there would be a much improved process in 2004-2005.

The DIRECTOR, ADMINISTRATION AND FINANCE, assured the representatives that the Regional Office shared their desire to cut administrative costs and he believed that that had been achieved. He agreed that there had been an increase in the allocation to the personnel department, but explained that the principal reason for this was the transfer of the staff development and training programme, which used to be part of human resources for health, to personnel. In financial terms, this represented a shift of some US$ 200 000. If that amount were disregarded, administrative costs had in fact been reduced by about 1% in comparison with the previous biennium. He assured representatives that the Regional Office would continue to make every effort to drive administrative costs down.

Mr Larsen (speaking on behalf of the EXECUTIVE DIRECTOR, GENERAL MANAGEMENT, WHO Headquarters) clarified some issues related to part 1 of the proposed programme budget 2004-2005. He explained that, historically, the Organization had underestimated the level of extrabudgetary funding, which had been increasing steadily since

the 1998-1999 biennium. The amounts projected for 2004-2005 were the outcome of a results-based budgeting approach. He believed that the figure for extrabudgetary resources in part 1 would prove to be realistic.

In response to the question of the representative of the United Kingdom as to what would happen in the event that the Organization was not successful in attracting the projected amount, he responded that, since a significant amount of extrabudgetary funding was earmarked for specific programmes, those areas of work where funding did not reach the anticipated level would, as a consequence, also have to bear the brunt of any shortfall.

Regarding the 10% shift in the regular budget at country level to "WHO's Presence in Countries", he referred to the Director-General's speech during the morning session, where she had outlined her policy in that regard. Furthermore, he argued that there were a number of WHO project staff who provided a range of functions not easily attributable to any one area of work, e.g. staff in the WHO Representative's office providing support to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Such posts would be classified against "WHO Presence in Countries" in 2004-2005 rather than against any single technical area of work.

With regard to the suggestion of the representative of China that the budget should list the funding for major disease control programmes, as in the documents for the previous two bienniums, he assured the representative that the Director-General would consider this when she came to prepare the document for the Executive Board.

Supplementing the response of the Regional Director, he explained that some of the areas of work in part 1 with a zero allocation for the Region of the Americas were in fact funded through the budget of the Pan American Health Organization.

With regard to the further suggestion by the representative of China that there should be a more detailed breakdown of the budget according to expected results, he said that this would be possible as the budgeting process moved into the operational planning stage. The discussion at the next session of the Regional Committee would be a part of that stage.

He had taken note of the suggestion by the distinguished representative from Palau that the allocation to mental health should be increased. That matter would also be taken into consideration when all comments from regional committees were assessed by the Director-General.

The REGIONAL ADVISER, COMMUNICABLE DISEASE SURVEILLANCE AND RESPONSE, responding to the query from the representative of New Zealand on influenza, said that WHO had recently established a global initiative on influenza; pandemic preparedness was an important component of that initiative. Regarding the supply of influenza vaccine, he noted that the current global capacity to produce influenza vaccine was still limited. Some technical issues needed to be resolved to ensure timely availability of the vaccine for pandemic strains. Efforts were continuing to improve pandemic preparedness at global, regional and national levels, which included developing strategies for supply and use of the vaccine.

The CHAIRPERSON requested the rapporteurs to draft an appropriate resolution.

2. PROGRAMME BUDGET 2000-2001: BUDGET PERFORMANCE (FINAL REPORT): Item 8 of the Agenda (Document WPR/RC53/3)

The REGIONAL DIRECTOR, introducing the item, said that Programme budget 2000 2001: budget performance (final report) provided an account of the financial implementation by focus of the regular budget for the 2000-2001 biennium, which had ended on 31 December 2001. It also included a report on expenditure of extrabudgetary funds.

At the request of Member States, for the first time in a final report, information on programme outcomes was also provided.

The report started with a description of important developments that had affected the level of the budget and delivery of activities during the implementation period. The various changes in the budget were outlined, first in general terms in Annex 1, and then in detail by focus in Annex 2.

A number of changes had been made to the budget after it had been endorsed by the Regional Committee in 1998. In November 1999, the Director-General had established the initial working allocation for the Region at 99% of the approved programme budget 2000 2001 (US$ 759 000, or 1%, had been withheld by Headquarters). This had been necessary because of an anticipated shortfall in the collection of assessed contributions to the regular budget. As a result, the initial working allocation for the Western Pacific Region was US$ 75 130 000.

Further adjustments had been made to the budget because of the difference between the budgeted exchange rate of 38 Philippine peso to US$ 1 and the actual exchange rate of

51.60 Philippine pesos to US$ 1 in December 2001. Additional funds of US$ 255 000 had been allocated by Headquarters for regional activities to be carried out by the focuses on sexually transmitted infections, including HIV/AIDS and reproductive health and for strengthening WHO's presence in countries.

Annex 2 gave the final financial implementation by each focus. Compared with previous final reports, the format of this annex had been simplified to make it easier to understand. A number of changes due to efficiency shifts, cost variances, and other programme changes had been made to the working allocation during the course of the biennium and these were summarized in column 2 of Annex 2.

The appropriation resolution WHA52.20 for the financial period 2000-2001 encouraged the Director-General to identify efficiency savings in the range of 2% to 3% and to reallocate the savings to priority programmes. The Director-General had identified the following as priority areas: health systems, making pregnancy safer, blood safety, food safety, noncommunicable diseases, mental health, and investment in change. For the Western Pacific Region, US$ 2 400 000, or 3.2% of the approved regular budget of US$ 75 889 000, had been established as a target.

The appropriation resolution did not provide for cost increases resulting from inflation. For the Western Pacific Region, such increases had been estimated to amount to US$ 2 500 000. In order to achieve the required level of efficiency savings and to absorb the cost increases, a number of measures had been taken. These had included cuts in duty travel of staff, revised travel and per diem procedures, reductions in country allocations for fellowships, study tours, and supplies and equipment, and a Mutually Agreed Separation exercise.

All of the changes that had occurred as a result of efficiency savings, changes required to absorb cost increases, cost variations and changes due to reprogramming were consolidated in column 2 of Annex 2.

At 31 December 2001, the end of the biennium, US$ 73 915 400, or 100% of the regular budget, had been obligated.

Extrabudgetary funds included US$ 1 343 000 allocated by the Director-General to the Western Pacific Region from the US$ 15 000 000 of casual income funds applied to the high-priority programmes, namely, Roll Back Malaria, Tuberculosis, Tobacco Free Initiative and HIV/AIDS. The total amount of extrabudgetary funds obligated was US$ 45 034 621.

Columns 7 and 8 showed the total implementation of all funds and implementation by focus as a percentage of all funds implemented.

Annex 3 contained information on progress towards achieving expected results for all 17 focuses during the biennium. The expected results had been developed during the conversion of the programme budget 2000-2001 from 50 programmes to 17 focuses, as instructed by the Regional Committee at its fiftieth session, in resolution WPR/RC50.R3. In future bienniums the reporting on programme outcomes would be based on the expected results and indicators presented in the strategic programme budget. Detailed information on WHO activities in the Region during the biennium was contained in the relevant editions of *The Work of WHO in the Western Pacific Region.*

Dr TANAKA (Japan) said his delegation was pleased at the 100% implementation rate that had been achieved at the end of the biennium, indicating that there had been sufficient volume of programme activities. The report on the progress made was useful and easy to understand. However, he requested further information on the nature of the major actions that had been undertaken to improve efficiency.

Ms BLACKWOOD (United States of America), while congratulating the Region on the successful implementation of the budget for 2000-2001, sought clarification on the discrepancies that appeared to exist between the document under discussion and the global document "Implementation of the Programme Budget 2000-2001: contributions from WHO regions and headquarters" (PME/2002/2). The latter document had shown a different expenditure and percentage of implementation. According to the global document, the overall implementation rate for the Region was 98.3%, as compared to 100% in the document before the Committee.

The REGIONAL DIRECTOR, responding to the query from the representative of Japan, said that the major efficiency measures were revised travel arrangements through negotiated airfares, installation of a global private network to reduce cost of overseas phone calls, use of video conferences in lieu of duty travel to Headquarters, and aggressive bidding to obtain lower prices for supplies and equipment. There had been some reductions in posts, with some staff taking on additional activities. Favourable arrangements with Internet service providers had also been negotiated.

Concerning the question raised by the distinguished representative from the United States of America, he explained that the Region had implemented 100% of its working allocation. The figure in the global document she had referred to had been calculated on the

basis of the original allocation, before the 1% withheld by the Director-General and before any currency exchange rate adjustments had been made. He had been assured by WHO Headquarters that a fuller explanation would be provided in future documentation.

There being no further comments, the Chairperson noted that the Regional Committee had decided to accept the Regional Director's final report for 2000-2001.

Decision: It was so decided (see decision WPR/RC53(1)).

2. TUBERCULOSIS: Item 12 of the Agenda (Document WPR/RC53/7)

The REGIONAL DIRECTOR said that Member States, WHO and partner agencies had made great efforts to combat tuberculosis since the Regional Committee had declared a regional "tuberculosis crisis" in 1999 and requested him to make Stop TB a special project of the Regional Office in order to address the crisis. The impact of the project was already clear, with increases in the number of countries and areas in the Region implementing DOTS and the total reported regional population covered by DOTS. In the Philippines, for example, five years after the introduction of DOTS, almost 100% of the population had access to the strategy, and quality levels had been maintained.

While there had been major advances in countries with a high burden of the disease, the decline in notifications in the seven countries and areas with an intermediate burden and a good health infrastructure had slowed. At its third meeting in Osaka in February 2002, the Technical Advisory Group (TAG) had identified a number of factors responsible for that situation: ageing, the mobility of certain population groups and HIV-tuberculosis co-infection. The TAG had urged the Member States concerned to take account of those issues.

Some parts of the Region were now developing worrying levels of multidrug resistance. Other emerging challenges included rising levels of tuberculosis/HIV co-infection and the need to engage the private sector more actively in tuberculosis control.

The Region's commitment to controlling the disease had been taken up at the global level. In particular, the Global Fund to Fight AIDS, Tuberculosis and Malaria had the potential to make a significant contribution to tuberculosis control. The seven successful proposals from the Region in the first round of grants announced in April 2002 had included tuberculosis projects in China and Mongolia. The project in China had been the seventh largest of the approved projects in the first round and should dramatically reduce the financial shortfall for the nationwide expansion of DOTS. Useful meetings had been held recently in

the Regional Office and Nadi, Fiji to support countries to prepare for the second round of proposals.

The continued progress in expanding and improving the quality of DOTS had been achieved by establishing strong partnerships at national, regional and global levels. However, bold efforts would be needed by all stakeholders, ministries of health and the private sector in order to accelerate the expansion of DOTS if the goal of 100% DOTS coverage by 2005 was to be attained and the quality of tuberculosis services maintained. The human resources devoted to DOTS should be increased, particularly for improved supervision and monitoring, and management of tuberculosis drugs should be strengthened through monitoring, training and planning. Greater attention should be given to combating multidrug resistance. The presence of "hot-spots" of drug-resistant tuberculosis indicated the need to strengthen DOTS implementation and surveillance in those areas. To strengthen surveillance more generally, the regional tuberculosis laboratory network should be reinforced and quality control procedures emphasized. It would also be essential to engage the private sector more fully. The challenge remained great but he was confident that, with increased efforts, the target of "DOTS for all by 2005" would be achieved.

Dr TUKUITONGA (New Zealand) said that tuberculosis remained at a relatively low level in his country and the majority of notified cases were to be found among people born overseas. While DOTS was promoted as a useful strategy it was not used universally in treatment, as there was confidence in the country's own approach to treatment. Multidrug resistance was scarce and found only in imported cases, and the tuberculosis/HIV co-infection rate was insignificant. New Zealand was collaborating on tuberculosis control projects bilaterally with countries in the Region through the New Zealand Agency for International Development. The country had recently updated comprehensive tuberculosis control guidelines, incorporating WHO targets, as part of its integrated approach to communicable disease control. Traditional border screening for tuberculosis was having only a limited effect, as some people were entering the country without passing through established screening routes. He would therefore be interested to learn of further cross-border measures that might be useful in that regard.

Professor NYMADAWA (Mongolia) commended the report, which reflected the hard work undertaken to implement the regional strategic plan and to support Member States in preparing proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria. He fully endorsed the proposed actions for attaining the regional targets. Mongolia continued to experience a high level of tuberculosis. Despite good levels of DOTS implementation, with an

80% cure rate, incidence was continuing to rise. The national control programme had been revised, with particular emphasis on expanding DOTS coverage to remote and vulnerable population groups. He expressed appreciation for the technical and financial support received from the Regional Office, Japan's Research Institute of Tuberculosis and the Danish Agency for Development Assistance and looked forward to continued support to his country's national tuberculosis control programme.

Dr NAKATANI (Japan) endorsed the action taken by the Regional Director to implement the Stop TB project in the Region and commended the progress made in establishing a sound technical basis for controlling the disease, strengthening country programmes and applying for new resources through the new Global Fund. He welcomed the attention being given to countries such as his own where the decline in notification rates had slowed. The third meeting of the TAG held earlier in the year had stimulated Japan to undertake a comprehensive review of its tuberculosis control programme. The recommendations arising from that review, including major changes to relevant legislation, were currently under consideration. He would have liked to see greater emphasis given in document WPR/RC53/7 to the importance of case-finding, from which all other action followed, and trusted that the Regional Office was giving sufficient emphasis to that aspect in the implementation of programmes. Tuberculosis control activities were a good example of the collaboration between the Regional Office, Member States and the international community. Japan was pleased to be able to participate in all three components, including the Global Fund of which it was a founder member and currently Vice-Chair.

Professor LE NGOC TRONG (Viet Nam) said that his country was making considerable progress in controlling tuberculosis, with the expansion of DOTS to cover 99% of the population. Current challenges included the sustainability of the programme and the achievements gained, in particular the implementation of DOTS in remote areas and among vulnerable groups, the involvement of an expanded but largely unregulated private sector, and the growing threat of multidrug resistance and tuberculosis/HIV co-infection. Viet Nam looked forward to further collaboration and hoped to submit a revised proposal to the Global Fund aimed at bridging the resource shortfall for DOTS expansion. Viet Nam was committed to the attainment of the objectives of the regional strategic plan and its own national five-year action plan, and fully endorsed the actions proposed in the report.

Dr QI Xiaoqiu (China) welcomed the positive approach to tuberculosis control taken by the Regional Office and expressed appreciation for the support given to Member States to establish international partnerships, drug-resistance surveillance and institutional capacity-

building. Tuberculosis morbidity and mortality in China remained high and multidrug resistance and co-infection with HIV had intensified control difficulties. China had always attached great importance to the prevention and control of the disease and was committed to the accelerated expansion of DOTS. He expressed support for regional control strategies. Government commitment was vital and decision-makers should be urged to ensure the adoption of vigorous tuberculosis control measures. WHO should seek new partnerships to enhance technical and financial support; strengthen multidrug resistance surveillance; provide guidance for the establishment of improved information systems; and organize relevant training in the design of research on appropriate interventions that could be adapted for use in the various countries of the Region.

Dr YOUNG J. HUR (Republic of Korea) welcomed the progress made in implementing the Stop TB project in the Region. After a substantial decline in tuberculosis over many decades, the decrease in tuberculosis notification rates in his country had slowed. A revised national programme had therefore been instituted in 2000, with emphasis on intensive control and surveillance. The programme was being strengthened and ambitious targets were being introduced. An Internet-based system was monitoring tuberculosis levels and trends countrywide in both public and private sectors. Greater private sector involvement was envisaged in order to establish an integrated national control system.

The Republic of Korea was also providing support to other countries in the Region, *inter alia*, through the WHO Collaborating Centre for Research, Training and Reference Laboratory on Tuberculosis at its Institute of Tuberculosis. The Institute was also undertaking bilateral training programmes. The close collaboration between his country and WHO also included support for countries with a high burden of the disease, including the Democratic People's Republic of Korea. International cooperation through WHO and organizations such the International Union against Tuberculosis and Lung Disease was vital for tuberculosis control. He suggested that the definition of DOTS should be updated to permit a broader concept of the implementation of that strategy, for example by including situations where supervision and monitoring capability is carried out by hospitals or community-based public health systems.

Pehin HAJI ABU BAKAR APONG (Brunei Darussalam) welcomed the success achieved by several countries in the Region in obtaining grants from the Global Fund but noted the concerns in respect of the rate of DOTS expansion, a slowing in the decline of notification rates in some countries, multidrug resistance and HIV-tuberculosis co-infection. Brunei Darussalam had established a national tuberculosis committee in 1999 and continued

to develop the national control programme. The Ministry of Health was committed to the use of DOTS, which had been expanded from hospital-based chest clinics to community-based health centres and health clinics. Those efforts were bearing fruit, with a 33% reduction in notification rates in 2001 compared with 2000. He supported WHO tuberculosis control actions, expressed appreciation for the support his country had received from the Organization, and looked forward to the attainment of the regional targets.

Mr MANUOHALALO (France) expressed concern at the current slowing in the decline of tuberculosis notification rates in some countries of the Region, and at the spread of multidrug resistance. New Caledonia and French Polynesia, through their reference laboratories, were in a position to offer support to other countries in the Region in the areas of surveillance, through LabNet, developed in cooperation with WHO and the Secretariat of the Pacific Community. France supported the actions proposed in the document before the Committee, in particular item 7, which called for the improvement of surveillance systems for tuberculosis prevalence and drug resistance through capacity-building at all levels. In New Caledonia and French Polynesia, prevalence of tuberculosis had halved in the last 10 years, thanks to careful supervision of all cases and an increase in human and financial resources devoted to control of the disease.

Dr DAYRIT (Philippines) endorsed the priority being given by WHO to tuberculosis control at the global level and to support for regional control activities. Tuberculosis prevalence was high in the Philippines, although efforts over the last few years had reduced incidence rates by 5%-7% per year. The following approaches had helped those efforts: (1) the Global Drug Facility had provided a valuable option for procuring drugs at low cost; (2) the emphasis on public–private partnerships was encouraging the involvement of private practitioners in the implementation of DOTS; (3) continuous training of health personnel had improved motivation; (4) health system capacity had been enhanced to deal with multidrug resistance; and (5) emphasis on maintaining low rates of HIV infection would assist TB control.

Dr TONG Ka Io (Macao, China) reported that the incidence and mortality rates associated with tuberculosis in Macao had declined steadily in recent decades, and the burden of tuberculosis could now be considered as intermediate. The Health Services of Macao had listed tuberculosis as a priority in the 1990s and had adopted the policy package recommended by WHO, including Government support, passive case detection, use of DOTS, a stable supply of drugs, surveillance and assessment. As a result, all residents of Macao had free access to diagnosis and treatment of tuberculosis, and in practice over 95% of cases were

treated by DOTS. With a view to full coverage with DOTS, the Tuberculosis Prevention and Treatment Centre has been attempting to standardize diagnosis and treatment of the disease and to strengthen patient management and health education. Therefore, whereas only 70% of patients with tuberculosis were cured in the 1990s, the rate had risen to 89% in 2000.

There were some outstanding problems. The reasons for the levelling off in the incidence rate at 100 per 100 000 population had to be established. The new threat of tuberculosis/HIV co-infection, which had been seen for the first time in 2001 had to be assessed, and multidrug resistance countered. He agreed with the eight actions proposed in document WPR/RC53/7 and requested greater technical support to address the two problems he had identified.

Dató CHUA JUI MENG (Malaysia) congratulated the Regional Director on his responses to questions on the proposed programme budget. Tuberculosis remained the most prevalent notifiable communicable disease in Malaysia, with 15 000 cases in 2001, affecting people in all social strata. A national programme for tuberculosis control had been launched in 1961, and all states within the country had been encouraged to formulate their own action plans. His country had been classified as having an intermediate burden of tuberculosis. Like other countries in the Region, it had seen a levelling off of the prevalence of the disease over the past five years, due partly to urban problems and a large population of illegal migrant workers. In order to determine the actual burden of tuberculosis, a population survey was being undertaken by the Ministry of Health in collaboration with the Department of Statistics, involving 80 000 people from all parts of the country. The results were expected at the end of 2003.

With regard to the relationship between HIV infection and tuberculosis, it had been found in 2001 that 5% of all new cases of tuberculosis were associated with HIV infection, almost all of which were in intravenous drug users. Thus, all patients with tuberculosis were currently screened for HIV infection, and the managers of the programmes for tuberculosis and HIV and other sexually transmitted infections were working closely to monitor the situation and to develop a plan of action.

DOTS remained the most cost-effective control strategy for tuberculosis, and it was offered free of charge throughout the country. The supply of antituberculosis drugs was adequate, and funding was provided to enable patients and their families to attend for treatment. Multidrug resistance was found in only about 2% of cases.

Questions had been raised in Government meetings about the efficacy of immunization with bacillus Calmette-Guérin (BCG). WHO had concluded that BCG was effective in preventing severe cases of tuberculosis in young populations; however, BCG immunization afforded only 70% protection. Until a vaccine that was effective in 100% of cases became available, tuberculosis would remain a problem. His country was committed politically, socially and economically to acting with the Western Pacific Regional Office against the menace of tuberculosis.

Dr MEAN Chhi Vun (Cambodia) noted that DOTS use in his country had been expanded from hospitals to community health centres. Even though drug resistance was not a major problem in Cambodia, reports of interaction between HIV and tuberculosis infection had increased the urgency of controlling tuberculosis. A plan had been drawn up to ensure effective prevention and care of patients with HIV/tuberculosis within the existing health system. It was important to ensure equitable access to antituberculosis services and to maintain a case detection rate of at least 70% and a cure rate of more than 85% by the end of 2005. That would require strong commitment and sustainable financial support from all partners. In that context, the report of the Regional Director and the document before the Committee indicated increased support for the Stop TB project in the Region. He asked what the overall financial requirement would be to achieve the Regional target with respect to tuberculosis and the current funding gap remaining since the launching of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr HOFSCHNEIDER (United States of America) said that his country welcomed the fact that control of tuberculosis had been made a special project within the Region and supported that effort. The global HIV/AIDS epidemic contributed substantially to the burden of tuberculosis in many countries, tuberculosis being the cause of death of one-third of patients with AIDS worldwide. Given the dual challenge of HIV and tuberculosis, all available resources, including the Global Fund, should be used to bridge the financial gap that impeded expansion of DOTS use. In the Northern Mariana Islands, where the rate of notification of tuberculosis was greater than 100 cases per 100 000 population, an aggressive tuberculosis control programme had been instituted, in which 100% of cases were treated with DOTS.

The REGIONAL DIRECTOR recalled that, immediately after his nomination in September 1998, he had consulted with many Member States to identify a project to replace the eradication of poliomyelitis, which was attained shortly afterwards. Such 'locomotive' projects were useful in raising awareness of the activities of WHO in the Region and thus

benefited other programmes. Tuberculosis had been named unanimously as the disease that affected people in all countries of the Region, causing the deaths of 1000 people in the Region every day.

He agreed with the representative of Japan that greater emphasis should be placed on case detection, in order to increase the rate from 45% to the goal of 70%. That aspect should be reflected in any resolution on tuberculosis that the Committee might adopt.

In response to the query from the representative of Cambodia concerning the funds necessary to reach the goal of 50% coverage with DOTS by 2005, he said that the initial estimate of funding requirements had been US$ 665 million. However, financial commitments from Member States and the international community had reduced the initial shortfall rapidly. Establishment of the Global Fund had decreased the shortfall still further.

The REGIONAL ADVISER, STOP TB AND LEPROSY ELIMINATION, replying to the comment of the representative of New Zealand, said that tuberculosis among migrants and mobile populations was an important problem in countries with a low or intermediate prevalence of the disease. At the third meeting of the Technical Advisory Group in Osaka, Japan, earlier in the year, two points had been emphasized: expansion of the DOTS programme across the Region and even globally in order to control the sources of imported cases, and strengthened screening of migrant and mobile populations, which were considered to be at high risk of infection.

The CHAIRPERSON requested the Rapporteurs to prepare an appropriate draft resolution for consideration by the Regional Committee at a later stage.

The meeting rose at 5:15 p.m.