WORLD HEALTH ORGANIZATION | **ORGANISATION MONDIALE DE LA SANTE**

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL COMMITTEE WPR/RC57/11

Fifty-seventh session 24 July 2006
Auckland, New Zealand
18–22 September 2006 ORIGINAL: ENGLISH

Provisional agenda item 16

PROGRAMME UPDATES

Measles elimination, hepatitis B control and poliomyelitis eradication

The Western Pacific Region is committed to minimizing the morbidity and mortality related to vaccine-preventable diseases by expanding the coverage of current and new vaccines in line with the regional goals of the WHO Expanded Programme on Immunization and the Global Immunization Vision and Strategy 2006–2015. The Region also has taken concrete steps to achieve the twin regional goals of measles elimination and hepatitis B control by 2012, which were endorsed by Member States at the fifty-sixth session of the Regional Committee for the Western Pacific. Member States have continued to make strong efforts towards the maintenance of polio-free status in the Region by improving immunization coverage and disease surveillance.

Tobacco control

Tobacco use is one of the largest and fastest-growing causes of death globally. If current consumption patterns persist, about 1 billion people in the 21st century will be killed by their addiction to tobacco, with more than 300 million deaths in the Western Pacific Region alone. The WHO Framework Convention on Tobacco Control is the world's first tobacco control treaty. It has been ratified by 26 of the 27 Member States in the Western Pacific Region. Many Member States are making significant progress in implementing the measures contained in the Convention.

Mental health, including Patient at the Centre of Care Initiative

The WHO regional programme for mental health and the control of substance abuse is guided by three goals contained in the Regional Strategy for Mental Health in the Western Pacific:

(1) to reduce the human, social and economic burden produced by mental, neurological and substance use disorders; (2) to promote mental health; and (3) to give appropriate attention to the psychosocial aspects of health care. This programme update focuses on three initiatives: the Pacific Islands Mental Health Network; suicide prevention; and the Patient at the Centre of Care Initiative.

Environmental health

Rapid and encouraging progress has been made in strengthening the capacity to tackle environmental health problems in the Western Pacific Region. WHO has collaborated with a number of Member States in strengthening their national capacities for health risk assessment and the management of various environmental health issues including water quality and sanitation; indoor and outdoor air quality; health care waste; toxic chemicals; and climate change. The Regional Office for the Western Pacific has worked in close collaboration with other WHO offices, Member States and partner agencies on a series of environmental health issues.

Detailed updates on the four above-mentioned programmes are attached. The Regional Committee is asked to review progress made in these areas and note the report.

MEASLES ELIMINATION, HEPATITIS B CONTROL AND POLIOMYELITIS ERADICATION

1. BACKGROUND AND ISSUES

The Regional Committee at its fifty-sixth session in September 2005 set a regional goal of 2012 to eliminate measles and reduce the seroprevalence of HbsAg to less than 2% in 5-year-old children.[1] The Committee also urged Member States to maintain poliomyelitis-free status by sustaining high-quality acute flaccid paralysis surveillance and high immunization coverage with polio vaccines. The resolution by the Regional Committee provided tangible goals to revitalize efforts to sustain, further strengthen and monitor immunization services.

The performance of immunization services in the Region continues to improve with several countries and areas having likely interrupted endemic measles transmission and reduced hepatitis B chronic infection rates to less than 2%. But challenges remain.

Firstly, some Member States, such as Cambodia, the Lao People's Democratic Republic and Papua New Guinea, are struggling to achieve a sustainable high level of immunization coverage—a prerequisite to achieve measles elimination, to control hepatitis B and to safeguard the Region from the risk of a poliomyelitis outbreak. Poor routine immunization coverage for polio vaccines in several areas was the main factor in the recent circulation of vaccine-derived poliomyelitis virus (cVDPV) in some Member States in 2005–2006.

Secondly, countries and areas that have interrupted measles transmission remain under threat of fresh outbreaks following an importation of the virus because they have failed to sustain high measles vaccine coverage. This was demonstrated by a measles outbreak in March 2006 in Fiji. In addition, constraints in human and financial resources are keeping many Member States from instituting case-based laboratory surveillance for measles as required in the elimination phase.

Only four countries in the world are classified as poliomyelitis endemic, but other countries and areas remain at risk of a polio outbreak, either from an imported wild poliovirus, or the emergence of a vaccine-derived poliomyelitis virus. However, it is becoming increasingly difficult to maintain the

[1] Resolution WPR/RC56.R8.

quality of acute flaccid paralysis surveillance. It would be better to integrate poliomyelitis surveillance, where feasible, with surveillance for other communicable diseases.

Thirdly, many Member States have not put in place viable action plans to reduce mother-to-child-transmission of hepatitis B required to achieve chronic infection rates of less than 2%. Although prices of hepatitis B vaccine have fallen substantially, some Member States are not providing regular funding to finance hepatitis B vaccinations through the routine immunization programme.

Continuous efforts are needed along with sustained funding and political commitment to address the low routine immunization rates and surveillance gaps in some countries and areas.

2. ACTION TAKEN

The awareness of the rationale for measles elimination and hepatitis B control remains high in all Member States, with inclusion of these goals in the national multi-year plans for immunization and in plans for the entire health sector. Twenty-two countries and areas have reported more than 80% coverage for the first dose of measles vaccine for more than five years. Twenty-one countries did so for three doses of the hepatitis B vaccine. China and Viet Nam, which account for 76% of all births in the Region, made great progress in hepatitis B control activities with the substantial expansion of birth dose coverage to reduce mother-to-child transmission. In addition, Guizhou province in China, with technical and financial support from WHO, has moved from the highest measles incidence rate among all China provinces in 2002 to the lowest incidence rate in 2005. Special interventions focused on a province-wide measles vaccination campaign, followed by a successful school programme to check immunizations.

A biregional workshop was organized in September 2005, followed by regular visits to priority Member States, to develop comprehensive multi-year plans of action for measles elimination and hepatitis B control, with full cost estimates. Almost all Member States now have plans to provide a second opportunity for measles vaccinations either through the introduction of a routine second dose or by conducting periodic supplementary activities. The WHO Regional Office for the Western Pacific developed two guides, *Field Guidelines for Measles Elimination* and *Operational Guidelines for Prevention of Mother-to-Child-Transmission of Hepatitis B,* to help Member States develop relevant programme strategies. To improve surveillance, regular technical support is being provided

to strengthen the laboratory capacities within countries. In addition, WHO is collaborating with Member States in the development of emergency preparedness plans for the potential importation of a wild poliovirus. WHO helped mobilize funds to assist Cambodia in responding to a recent outbreak of a vaccine-derived poliovirus.

As routine immunization services are central not only to achieve current goals but also to exploit future opportunities presented by the availability of new vaccines, extensive assistance was provided for comprehensive EPI reviews in Cambodia, China and the Philippines, as well as for strengthening EPI data systems in the Lao People's Democratic Republic. In addition, as requested by the Regional Committee, continuous efforts are being made at national, regional and global levels to mobilize additional resources through the strengthening of regional and subregional immunization partnerships. Measles elimination efforts in the Western Pacific Region will be greatly facilitated by the commitment of Phase II of the Global Alliance for Vaccines and Immunization intended to support the introduction of a second dose of measles as well as periodic supplementary activities in countries where per capita income is less than US$ 1000.

3. ACTIONS PROPOSED

The following actions by Member States are proposed for consideration by the Regional Committee:

(1) Maintain commitments made at the fifty-sixth session of the Regional Committee to strengthen, develop and implement national plans of action to meet the 2012 twin goals of measles elimination and hepatitis B control and to maintain polio-free status.

(2) Make all efforts to improve routine immunization services to reach all people eligible for vaccinations and to quickly introduce new vaccines in an effort to achieve current goals and further reduce vaccine-preventable morbidity and mortality. Progress in the improvement of immunization services in Member States will be monitored by progress in achieving measles elimination and hepatitis B control and in maintaining polio-free status.

(3) Mobilize sufficient internal and external funding for immunization services to facilitate implementation of national multi-year plans for EPI.

The Regional Committee is asked to note this report.

TOBACCO CONTROL

1. BACKGROUND AND ISSUES

Tobacco use imposes an enormous and growing public health burden that could be avoided if evidence-based tobacco control measures called for in the WHO Framework Convention on Tobacco Control were implemented in low- and middle-income countries, especially in the Western Pacific Region. Some countries continue to believe that tobacco control measures will harm their economies, without understanding that resulting public health costs more than offset tobacco industry profits and government revenues from taxation. This lack of awareness and action remains the foremost challenge in the Western Pacific, a greater concern perhaps than the fact that the Region has the largest number of smokers, the highest rate of male smoking prevalence, and the fastest increase of tobacco use uptake by women and young people.

Reflecting on these concerns, the Regional Committee at its fifty-sixth session encouraged Member States to ratify the Convention no later than 1 November 2005 in order to participate in the first session of the Conference of Parties and maintain commitments made at the fifty-fifth session of the Regional Committee, including implementing tobacco control measures beyond those required by the Convention and its protocols, and to use the Convention and the *Regional Action Plan 2005-2009 for the Tobacco Free Initiative* to guide national tobacco control policies and programmes.

2. ACTIONS TAKEN

2.1 WHO Framework Convention on Tobacco Control

The Convention has now been ratified by 131 countries globally and 26 of 27 Member States in the Western Pacific Region. Twenty-five Western Pacific Member States participated as Contracting Parties at the first session of the Conference of Parties (COP1) held in February 2006 in Geneva. The Conference adopted Rules of Procedure and Financial Rules for the Conference of the Parties. It determined timeframes and workplans for elaboration of guidelines for certain Convention Articles, with priority given to protection from exposure to tobacco smoke (Article 8) and regulation of the contents of tobacco products (Article 9). It began development of protocols on cross-border advertising, promotion and sponsorship (Article 13.8), and on the illicit trade of tobacco products (Article 15). Further, the Conference decided that the permanent Convention Secretariat will be

established within WHO in Geneva, and be responsible and accountable to the Conference of Parties for technical and treaty activities and to the WHO Director-General for administrative and staff management matters, and set the Convention Secretariat's 2006–2007 budget at US$ 8 010 000 to be funded entirely from voluntary assessed contributions.

In addition, in accordance with *Article 21—Reporting and Exchange of Information*, Member States are required to report on their progress within two years after the Convention enters into force for them. A reporting instrument was developed during COP1 that provides information on how Parties to the Convention are progressing with respect to implementation of the Convention. Guidelines on the use of the reporting instrument have also been subsequently developed. Understanding the reporting instrument and consultations are important as many parties in the Western Pacific Region are due to provide their first report in February 2007.

2. National action

Many Member States of the Western Pacific Region are making excellent progress in implementing Convention provisions, and some are seeing decreases in smoking prevalence through the enforcement of evidence-based tobacco control measures. Unfortunately, in some countries action has been delayed or stalled completely.

The Republic of Korea's repeated cigarette tax increases, effective health communication campaigns and improved access to quitting services have resulted in almost immediate decreases in male smoking. Male smoking prevalence dropped from 57.8% in September 2004 to 52.3% in 2005 and 49.2% in early 2006. Female smoking rates, although low, appear to be rising.

Australia introduced new graphic health warnings on all tobacco products imported and manufactured for retail sales in Australia. New legislation banning smoking in areas of bars, restaurants and clubs, backed by extensive communication campaigns, has led to rapid, significant and unexpected decreases in smoking among young women and a reduction in overall smoking prevalence to just 20.1%.

Guam, Hong Kong (China), New Zealand and Singapore are pursuing the strongest smoke-free policies, providing good regional models and contributing valuable lessons learnt. Guam is now enforcing a new law that makes restaurants and most enclosed public places smoke free. Hong Kong (China) is planning new legislation banning smoking in all public places. New Zealand, one of the world's first smoke-free countries, has actively enforced its smoke-free legislation and has seen a huge increase in the number of people seeking help in quitting. In Singapore, smoking is now

prohibited in schools, courts, all public transport, pools, open-air stadiums and air-conditioned public places.

Others countries such as Cambodia, Niue, Papua New Guinea and Viet Nam are developing new legislations and programmes to meet requirements of the Convention.

3. Tobacco Free Initiative support

With support from the Japanese Government and the United States Centers for Disease Control and Prevention, the Regional Office's Tobacco Free Initiative (TFI) unit focused resources on high-quality, rapid-response technical assistance and support for countries, as well as critical surveillance and research projects. This work was facilitated by WHO country office technical officers.

WHO conducted subregional workshops in November 2005 to help prepare Member States to effectively implement the Convention, prepare for the first session of the Conference of Parties in February 2006, strengthen networks and information exchange, and facilitate donor and partner collaboration in the Region. It has also supported several national workshops to develop legislation, build capacity and gain provincial support for tobacco control measures

WHO published the Global Information System for Tobacco Control, an online regional database of country-specific information on smoking prevalence, smoking-related disease burdens, agricultural and economic data (www.wpro.who.int/gistc/main/default.aspx). It further expanded the Global Tobacco Surveillance System, which includes the Global Youth Tobacco Survey and other standardized, comparable global surveys. More than 20 countries have now completed one or more of the global surveys. WHO is also partnering with the Secretariat for the Pacific Community to study the use of betel nut with tobacco in the Pacific islands, South-East Asia and China, and to recommend effective intervention strategies.

WHO is also supporting healthy lifestyle communication and tobacco-free/smoke-free policies for the 2007 South Pacific Games in Samoa, and implementation of smoke-free policies for the 2008 Beijing Olympics.

3. ACTIONS PROPOSED

Member States are asked to continue to make progress on strategies and action detailed in the *Regional Action Plan 2005-2009 for the Tobacco Free Initiative* and to continue to make progress to ratify, accept or approve the Convention, at the earliest opportunity, if they have not already done so.

Further, Member States are asked to reinvigorate commitments made at the fifty-fifth session, including implementing tobacco control measures consistent with and beyond those required by the Convention. Further, priority should be given to increasing tobacco tax increases, strengthening smoking restrictions, implementing comprehensive bans on advertising and promotion, effectively communicating the health risks from smoking to include stronger health warnings on tobacco products, and where possible, increasing access to cessation therapies. Member States also are requested to consider the draft Progress Report for the Conference of Parties: Guidelines—Group 1 Questionnaire (Annex 1). Copies of the accompanying draft reporting instrument's step-by-step guidelines will be made available at the fifty-seventh session of the Regional Committee.

The Regional Committee is asked to note this report.

MENTAL HEALTH, INCLUDING PATIENT AT THE CENTRE OF CARE INITIATIVE

1. CURRENT SITUATION

The burden of mental and neurological disorders accounted for 11% of global disease burden in the Western Pacific Region in 1990 and is expected to account for 15% by 2020. However, in half of the countries and areas in the Region, the resource allocation for mental and neurological disorders is less than 1% of the total health budget. There are several obstacles that often make it difficult to provide mental health services: the widespread stigma and discrimination against people who are mentally ill; poor community awareness of the nature and determinants of mental health and mental illness; the lack of legislation and policy on mental health; and a failure to value mental health as a community resource.

The Regional Committee for the Western Pacific, at its fifty-second session in September 2001, endorsed the Regional Strategy for Mental Health.[2] In this resolution, the Regional Committee urged Member States to use the Strategy as a framework for the development of national mental health programmes. It also requested the Regional Director to support Member States in building capacity, to facilitate the exchange of knowledge and experience in the field of mental health, to produce an analysis of the mental health situation in the Region, to continue to work with Member States and other development partners to raise awareness of mental disorders as a priority area, and to advocate for greater resources to improve mental health in the Region.

The WHO regional programme in mental health and the control of substance abuse aims to contribute to achievement of three goals proposed in the Regional Strategy for Mental Health:

(1) to reduce the human, social and economic burden produced by mental (e.g. depression), neurological (e.g. epilepsy), and substance use disorders (e.g. alcohol dependence);

(2) to promote mental health; and

(3) to give appropriate attention to the psychosocial aspects of health care.

The programme has been planned and implemented under six basic approaches: advocacy; policy and legislation; service provision; mental health promotion; development of a research culture and capacity; and suicide prevention. This update is focusing on selected initiatives.

2. UPDATE ON THE SELECTED INITIATIVES

2.1 Pacific Islands Mental Health Network

Given the character of the Pacific region, with many small islands making up countries and areas, innovative approaches are needed to achieve improved mental health among populations through the development of mental health services, policy and planning, as well as better treatment and care. Numerous and competing demands on already limited country health resources mean that achieving these goals also will rest on a reduction in the duplication and fragmentation of activities and greater cooperation and collaboration. It also is important that new approaches build sustainable

[2] Resolution WPR/RC52.R5.

national and regional capability and capacity in relation to mental health. At the meeting of Ministers of Health for the Pacific Island Countries held in March 2005 in Apia, Samoa, the concept of a Pacific mental health network, as a means of overcoming geographical and resource constraints, was discussed. With support from the New Zealand Ministry of Health, WHO began to consult with Pacific island countries and areas on conducting a regional situational analysis on mental health.

A framework for the network was drafted and presented to 20 Pacific island countries and areas. Consultation was undertaken with 11 of the 20 that expressed interest in the proposal. New Zealand's International Aid and Development Agency has pledged funds for three years to support the network, as well as clinicians working in mental health in the Pacific island countries and areas.

A workshop was organized by WHO in Auckland in May 2006 to establish an implementation plan for the next three years. The priority areas identified by countries and areas within the network are: advocacy for mental health within Region and in countries; human resource training; strategy, policy, legislation, planning and service development; research and information; and access to psychotropic medicines. An official launch of the network could help raise its wider profile and status. There was a suggestion to tie the launch to the next meeting of Pacific Ministers of Health scheduled in March 2007 in Vanuatu.

2.2 Prevention of suicide

The Regional Office for the Western Pacific held its first meeting on suicide prevention in August 2005 in Manila, with the participation of representatives from 22 countries and areas. There is a shared view that mental health and suicide are major public health concerns in the Western Pacific Region, which has 28% of world's population. WHO estimates that there were approximately 331 000 suicides in the Region in 2002, comprising 38% of the world suicides. Suicides in the Region account respectively for 33% of all violent deaths among men and 57% of all violent deaths among women worldwide.

Although the magnitude of the suicide situation in the Region is acknowledged, the participants of the meeting were concerned that little is known about the specific situation in most of the low- and middle-income countries and areas in the Region. The meeting therefore recommended that, among other actions, the countries and areas:

(a) set up a morbidity and mortality data surveillance system for suicide;

(b) develop human resources, such as epidemiologists and statisticians, needed to maintain a valid and reliable data collection system on morbidity and mortality including suicide;

(c) set up periodic monitoring of the quality of the surveillance system; and

(d) complement the surveillance system with research on the causes, risk and protective factors for suicide.

As a follow-up to these recommendations, the WHO START (Suicide Trends in At-Risk Countries and Territories) project was launched in March 2006 with support from the Australian Institute for Suicide Research and Prevention (AISRAP), a WHO Collaborating Centre for Research and Training in Suicide Prevention. Representatives from 15 countries received training at AISRAP to create national databases, to understand the various types of suicidal behaviour, to certify suicide deaths and develop effective interventions.

The START project will help establish and strengthen surveillance systems for suicidal behaviour and hopefully support the development and implementation of national strategies for the effective management and prevention of suicidal behaviour.

2.3 The Patient at the Centre of Care Initiative

Concerned that the orientation of health systems and the quality of health services are generally not able to meet the needs and expectations of the public, the Regional Committee at its fifty-fifth session in September 2004 adopted resolution WPR/RC55.R1. It requested the Regional Office for the Western Pacific, in collaboration with the Regional Office for South-East Asia and Member States, to draft a policy framework reflecting the significance of psychosocial factors affecting health outcomes. WHO was further requested to support Member States in ensuring that health policies lead to improvements in the quality of health care and that they take into account issues of human dignity, patient rights and needs, and the role of family, culture and society.

In accordance with resolutions WPR/RC54.R2 and WPR/RC55.R1, the Regional Office for the Western Pacific is pursuing a more patient-centred and rights-based approach to health care in the Region and has embarked on the Patient at the Centre of Care Initiative as a biregional effort with the Regional Office for South-East Asia. A document outlining the pertinent issues has been prepared and work on a draft policy framework is under way. The process includes a reference group of experts to provide guidance to the initiative, as well as a series of in-depth stakeholder consultations in selected countries in the South-East Asia and Western Pacific Regions.

The reference group met from 4 to 5 July 2006 in Manila, to discuss the background paper, suggest priority areas to be included or given emphasis in the policy framework, and provide feedback and advice about the stakeholder consultation process. The meeting validated and reinforced WHO's thinking that there is an urgent need to re-orient health systems in the 21st century to a patient-centred and rights-based approach to health care. It supported and endorsed the direction and content of the planned processes and products of the initiative and made many constructive suggestions to guide and inform further work, especially in the policy framework and domains.

The proposed policy framework spans four policy domains corresponding to four health care constituencies: patients, families and communities; health practitioners; health care institutions and other care settings; and health systems.

Recognizing that there is a diversity of cultural, socioeconomic and political contexts of health systems in the South-East Asia and Western Pacific Regions, and that a patient-centred and rights-based approach to health care is relevant to all forms of health systems at all stages of their development, the meeting agreed that the stakeholder consultation process may vary across countries. However, it is important to have multisectoral presentation and a mix of individuals and agencies which represent the supply and demand sides of the health care system.

The meeting also explored avenues for promoting the initiative and the health systems re-orientation it espouses. A popular book that complements the policy framework has been proposed to be published and officially launched at an international symposium that is expected to produce a declaration of commitment to patient-centred care. A dedicated website will be developed and further advocacy work will be done through academic and quality circles and similar networks, as well as through a series of articles in selected quality journals.

3. ACTIONS PROPOSED

The Regional Committee is asked to review the progress, recommendations (see Annexes 2 and 3), and proposed priority areas for further actions.

ENVIRONMENTAL HEALTH

1. BACKGROUND AND ISSUES

The countries and areas of the Western Pacific Region face a variety of environmental health hazards. In low-income countries, people still suffer from traditional environmental risks such as unsafe water, inadequate sanitation and poor hygiene, and indoor smoke from domestic cooking and heating. People in rapidly developing countries are exposed to additional, more modern environmental risks such as exposure to urban, industrial and agrochemical pollution, as well as industrial emergencies. More recently, the health impact of changes in climate and ecosystems has become a concern in many countries in the Region. Reducing these burdens of environmental risks to health—an estimated 2.9 million attributable deaths and 58.8 million disability-adjusted life years lost—is a major challenge to the countries and areas in the Region.

Following discussions on these issues at its fifty-sixth session in September 2005, the Regional Committee for the Western Pacific encouraged Member States to strengthen human resources and institutional capacity in environmental health risk assessment and management; establish and strengthen multisectoral coordination mechanisms and organize regular forums on environmental health; identify priority environmental health risks and develop national and local action plans to reduce these risks; increase health sector involvement in the implementation and monitoring of international declarations and agreements related to environmental health; and participate actively in intercountry initiatives on environmental health.[3] The Regional Committee also requested WHO to enhance collaboration with relevant United Nations agencies and regional partners in supporting the development of national capacities in environmental health risk assessment and management; advocate actions that will reduce the health impact of climate change through mitigation and adaptation; and work closely with the WHO Regional Office for South-East Asia to improve environmental health.

[3] Resolution WPR/RC56.R7

2. ACTIONS TAKEN

In response to these decisions of the Regional Committee, the Western Pacific Region and its Member States have made rapid progress in environmental health programmes at the national and regional levels. For example, Cambodia, China, Mongolia, the Philippines and Viet Nam, with WHO support, convened multisectoral national forums on health and environment during which they began to develop national environmental health action plans. These countries collaborated with WHO, the Australian Agency for International Development, the United Nations Children's Fund, the United States Agency for International Development and others to strengthen capacity for water quality risk assessment and management, including such activities as studies on the burden of disease attributable to unsafe water and inadequate sanitation, strengthening of drinking water quality monitoring systems, development of water safety plans, promotion of household water treatment, and the provision of water and sanitation facilities in hospitals and schools.

WHO collaborated with Japan, through the Japan International Cooperation Agency and the Japan International Corporation of Welfare Services, in conducting the Seminar on Water Supply Management with participants from several developing countries.[4] Cambodia, the Lao People's Democratic Republic, Mongolia, the Philippines, Solomon Islands and Viet Nam undertook the development and implementation of health care waste management plans. Cambodia and Viet Nam trained their staff in health impact assessments, and China, the Lao People's Democratic Republic and Mongolia undertook a health impact assessment of indoor air quality and developed management options. With WHO support, Mongolia continued to strengthen the functions of its poison information centre and undertook a study on the health impacts of environmental lead pollution. Also with support from WHO, the Philippines trained staff to deal with chemical emergencies, and Viet Nam prepared a report on the health impacts of pesticides. Several countries provided health sector input into the development of the Strategic Approach to International Chemicals Management.[5] China prepared reports on the health impact of transport sector and of climate change and initiated further studies on these issues. China and Fiji recently embarked on a project for climate change adaptation to protect human health.

[4] Cambodia, the Lao People's Democratic Republic, Myanmar and Viet Nam.

[5] Ministry of Health participants from Kiribati, Papua New Guinea, Vanuatu and Viet Nam participated in the third preparatory meeting of the Strategic Approach to International Chemicals Management in Vienna in September 2005.

At the regional level, WHO in collaboration with the United Nations Environment Programme convened the Second High-Level Meeting on Environment and Health in December 2005 in Bangkok, Thailand, which was attended by directors or officials at the director-general level of both health and environment agencies from 13 Asian countries.[6] The meeting considered a regional charter on environment and health, and agreed to convene a ministerial-level regional forum in late 2006 and to establish regional thematic working groups on priority environmental health issues. The thematic working group on water supply, sanitation and hygiene will be supported by the World Bank Water and Sanitation Program. WHO and UNICEF will jointly organize a ministerial conference on sanitation in China in 2007. The Second High-Level Meeting on Environment and Health was held following the Scientific Conference on Asia Pacific Environmental Health. The Asian Development Bank, the United Nations Development Programme, the United Nations Children's Fund, the United Nations Environment Programme, the WHO Regional Offices for South-East Asia and for the Western Pacific, and the World Bank collaborated in both meetings. Other biregional activities included the Regional Workshop on Human Health Impacts from Climate Variability and Climate Change in the Himalayas Region; the Interregional Training Workshop on Indoor Air Pollution and Household Energy Monitoring; the Biregional Workshop on Health and Environment Linkages in Agriculture; the Clean Air for Asia Training Course; and the AusAID-supported Project to Accelerate Effective Management of Water, Sanitation and Hygiene for Health in Asia.

In the Pacific, WHO formed partnerships with the Australian Agency for International Development, the New Zealand International Aid and Development Agency, the New Zealand Ministry of Health, and the South Pacific Applied Geoscience Commission to support the implementation of the Framework for Action on Drinking Water Quality and Health in Pacific Island Countries. The collaborative work includes the development and implementation of water safety plans, the establishment of systems or plans for monitoring drinking water quality, and the building of national capacity in microbial analysis of drinking water supplies. WHO participated in the regional meeting on solid waste management organized by the Secretariat of the Pacific Regional Environment Programme where the Strategy for Solid Waste Management in Pacific Island Countries and Territories was formulated.

[6] Brunei Darussalam, Cambodia, China, Indonesia, Japan, the Lao People's Democratic Republic, Malaysia, Mongolia, the Philippines, the Republic of Korea, Singapore, Thailand and Viet Nam.

3. ACTIONS PROPOSED

The following actions by Member States are proposed for consideration by the Regional Committee:

(1) enhance resources and capacity to make further progress towards the development and implementation of national action plans on significant and emerging environmental health issues, such as indoor and outdoor air quality, water supply, sanitation and hygiene, management of chemicals and wastes, the health impact of climate and ecosystem changes, preparedness and response to industrial emergencies, including chemical spills and radio-nuclear incidents, through multisectoral national forums; and

(2) continue to participate actively in the various regional programmes on environmental health, including the ministerial Regional Forum on Environment and Health in ASEAN and East Asian Countries, the first of which will be held in December 2006; the ministerial East Asia Sanitation Conference in early 2007; the implementation of the Framework for Action on Drinking Water Quality and Health in Pacific Island Countries; and the regional meetings and country activities in the management of solid waste, particularly health care waste in Pacific island countries and areas.

WHO will further enhance collaboration with other United Nations agencies and regional partners to support the capacity-building of Member States and the various regional initiatives on environmental health.

The Regional Committee is asked to note this report.

ANNEX 1

Framework Convention on Tobacco Control (FCTC)

Progress Report for the Conference of the Parties (COP)

GUIDELINES – GROUP 1 QUESTIONNAIRE

The Progress Report for the Conference of the Parties (COP) provides information on how Parties to the WHO FCTC are progressing in respect of implementing the Convention.

Completion of the progress reports are required under *Article 21 – Reporting and Exchange of Information.*

OBJECTIVE OF THE PROGRESS REPORT FOR THE COP:

To understand and learn from each other's experiences in implementing the WHO FCTC through the provision of progress reports from each member country.

FREQUENCY AND TIMING OF THE REPORTS:

As agreed at the first COP (6 – 17 February 2006) a graduated reporting system will be implemented. As such, reports will be separated into three (3) Groups.

Group 1 (for which questions have been developed) – relates to core data items including legislation, taxation and funding for implementation activities.

GROUP 1: Parties are to report against all Group 1 **core** questions within **two years** of entry into force of the Convention for that Party. This is the minimum reporting requirement. Parties may choose to report against selected optional questions.

Group 2 and Group 3 (questions will be developed at Session 2 of the COP) – and will expand on Group 1 questions.

GROUP 2: Parties report against all Group 2 **core** questions within **five years** of entry into force of the Convention for that Party. This is the minimum reporting requirement. Parties may choose to report against selected optional questions.

Annex 1

GROUP 3: Parties are to report against Group 3 **core** questions within **eight years** of entry into force of the Convention for that Party.

All reports are to be submitted to the Secretariat to the COP.

This process allows reports to be staggered in their submission to the Secretariat, rather than all Parties' reports being due at the same time.

When preparing reports, Parties should be mindful of the opportunities for shared learning and are required to submit examples of best practice and/or contact details for further information.

SUBMISSION OF THE REPORT:

Parties will provide reports in one of the **six designated languages**[1], and shall not expect the Secretariat to provide translations. However, it is expected that the Secretariat, in considering the reports, will make available summaries or analysis of reports which focus on significant achievements or areas where information sharing could be valuable.

ASSISTANCE TO DEVELOPING ECONOMY COUNTRIES AND COUNTRIES WITH ECONOMIES IN TRANSITION (SECTION 7: TECHNICAL AND FINANCIAL ASSISTANCE):

In this section of the report, Parties should report on:

• their ability to provide assistance, both financial and technical, in the case of development partners, as well as assistance already provided; or

• their assessed areas of need and the extent to which these are being met (or otherwise), and estimates of assistance, both technical and financial required to enable them to move to the next reporting group, in the case of developing economies and economies in transition. This could also include relevant information about any constraints or barriers to implementation as well as the assistance already received/provided.

In addition, the Secretariat will operate as a clearinghouse seeking to facilitate coordination of available skills and resources with identified needs. In the first instance, the Secretariat will manage this process within regions, to allow more efficient operation and greater understanding within regions.

[1] Arabic, Chinese, English, French, Russian or Spanish

Annex 1

FEEDBACK ARRANGEMENTS

To facilitate access to examples of best practice in specific areas of tobacco control, all Parties' reports are to be available on a web site and arranged under the headings – Two Year Reports, Five Year Reports and Eight Year Reports to enable Parties to understand the progress being made internationally in implementing the WHO Framework Convention on Tobacco Control. This web site will allow access by non-ratifying countries which may be seeking information to allow them to take effective steps in tobacco control. This is consistent with the objective to learn from each other's experience.

The Secretariat will provide feedback to each reporting Party. The Secretariat will also provide an analysis of the progress being made internationally in implementation of the Convention. Such a summary should be provided annually commencing in 2007 and should seek to:

• reflect international and regional progress;

• highlight significant achievements; and

• reflect the spirit of shared learning.

It is further suggested that existing WHO regional group meetings provide an opportunity to share learning and obtain feedback from other Parties on their progress in implementing the WHO Framework Convention on Tobacco Control.

Progress will be assessed by the Conference of the Parties regionally and globally based on reports received and analysed by the Secretariat.

It should be noted that the items identified in the Annex are not exhaustive, but reflect the spirit and intent of the Convention.

ANNEX 2

CONCLUSIONS AND RECOMMENDATIONS OF THE MEETING ON SUICIDE PREVENTION IN THE WESTERN PACIFIC REGION 15–19 AUGUST 2005, WHO REGIONAL OFFICE, MANILA

Conclusions

There is a shared view that mental health and suicide are major public health concerns in the Western Pacific Region. Available data shows that in 2002, there were approximately 331 000 suicides in the Region, comprising 38% of the world suicides. Suicides in the Region account for 33% of the world total of violent deaths among men and 57% among women. Self-inflicted injury, or suicide, is among the top five causes of injury deaths in the Region, more than road traffic accidents and falls combined, and causing 2.5% of the total burden of diseases. Mental disorders are one of the most relevant risk factors for suicide. From a global perspective, more than 95% of those who committed suicide had mental disorders. Studies from countries in the Western Pacific Region, however, have indicated a somewhat lower percentage, ranging from 63% to 83%. For this reason, the management of mental health problems and suicide should be essential components of the national health agenda in all countries.

Although the magnitude of the suicide problem in the Region is acknowledged, little is known about the specific situation in most of the low and middle-income Member States. Therefore, utilizing and managing existing data, organizing new data sources for surveillance, and eventually establishing a mortality registry system are essential in these countries. The implementation of a valid and reliable monitoring system is necessary for determining the relative importance of all health conditions, and thus, essential to health planning and is a critical first step to the allocation of often limited available resources.

There is diversity in the delivery of suicide prevention services in the Region. Some have well developed suicide prevention programmes while others do not. Australia, New Zealand and Japan, for instance, have their own National Suicide Prevention Strategy while Cambodia struggles with the organization of its basic mental health programme. Suicide prevention services are typically provided through mental health systems, but may also be provided in a variety of other systems, services and/or settings: general health services, school systems, military, nongovernmental organizations,

professional associations, alcohol and drug abuse programmes, accident prevention initiatives, programmes on domestic violence, survivor groups, spiritual leaders, traditional healers, and others.

Finally, recognizing the broad differences in the characteristics and capabilities of various countries in the Region means there is a need for Member States to cooperate and share technical expertise, human resources, and lessons from their experiences with suicide prevention.

Recommendations

(1) There is a need for valid and reliable data to support initiatives for suicide prevention programmes that are relevant to specific countries. Depending on the level of morbidity and mortality data collection systems available, it is recommended that countries:

(a) set up a morbidity and mortality data surveillance system for suicide;

(b) develop human resources (for example, epidemiologists) needed to maintain a valid and reliable data collection system on morbidity and mortality including suicide;

(c) set up periodic monitoring of the quality of the surveillance system;

(d) conduct research on the causes, risks and protective factors for suicide.

(2) Suicide prevention initiatives vary between countries and areas. While some countries and areas have no programme on suicide prevention, there is some advocacy on suicide prevention in others, and comprehensive prevention programmes in a few. In order to initiate and expand suicide prevention activities, WHO should:

(a) encourage countries to move towards the development and implementation of national strategies for effective management and prevention of suicidal behaviours;

(b) provide support to operationalize the strategy, and promote its implementation and evaluation.

(3) As there is a general agreement that mental health and suicide are serious concerns in every country, Member States should:

(a). integrate suicide prevention strategies in their health policy and programmes, including bereavement support for those affected by suicide and suicide attempts;

(b) identify existing systems and programmes through which data on suicide behaviours can be initially generated (for example, hospital admissions, emergency room contacts, police reports);

(c) identify existing systems, programmes, projects or activities in which suicide prevention advocacy could be initially integrated (for example, general mental health promotion activities, school programmes, workplace safety, primary health care, drug and alcohol abuse programmes, help lines, and others);

(d) engage and create partnerships with the media to promote suicide prevention efforts in order to improve the quality and appropriateness of the press reports;

(e) develop and enhance access to and quality of mental health services (for example improving early detection and treatment of depression and other mental disorders);

(f) develop and enhance access to and quality of other health services (for example, equipping emergency rooms with poison antidotes and improving treatment of persons with poisoning symptoms).

(4) Acknowledging the differences in the capabilities of the various countries to carry out suicide prevention initiatives on their own, the following collaboration among Member States is highly recommended:

(a) develop a formal network within the Region, and where appropriate, in subgroups of countries (for instance, the Pacific islands). The network should work to continuously disseminate information; promote research; exchange culture-specific understanding of suicides, as well as different approaches for dealing with it; share human resources and technical expertise; and to actively support the implementation and evaluation of mental health and suicide prevention programmes through education and training (including familiarization with ICD-10 categories);

(b) develop a common instrument for suicide surveillance that can be implemented in the Region, or subregions, in order to standardize suicide reporting and thus permit the observation of regional or subregional trends (including trends in attempted suicide and methods of self-injury); and

Annex 2

(c) develop a collaborative research proposal to share current knowledge, generate a better understanding of the suicide problem at country levels, foster advocacy, and establish and evaluate prevention programmes.

(5) A follow-up meeting is necessary in order to sustain the initial efforts and monitor the progress of suicide prevention and management initiatives in the Region. The follow-up meeting should also serve as a venue to discuss the details of future collaboration in the Region.

ANNEX 3

FIRST MEETING OF THE PATIENT AT THE CENTRE OF CARE INITIATIVE REFERENCE GROUP, 4–5 JULY 2006, MANILA

HIGHLIGHTS OF AGREEMENTS AND RECOMMENDATIONS

1. General

1.1 The term "patient-centred" is focused on those who are ill and generally have reason to interact with the health system, especially with health care institutions. The term "people-centred" is recommended since it encompasses personal and population-based health services, including disease prevention and promotion of wellness, in health care institutions and beyond.

1.2 There is a consensus that patient- or people-centred care includes at least the following key elements: culture of care and communication; appropriate services approaches and models; responsive, responsible and accountable services/institutions; and environmental supports through enabling and participatory mechanisms.

1.3 Although there is a diversity of cultural, socioeconomic and political contexts of health systems in the South-East Asia and Western Pacific Regions, a patient-centred and rights-based approach to health care is relevant to all forms of health systems at all stages of development. Thus, the biregional initiative is a welcome development.

1.4 The policy framework should reflect the important role of knowledge management in operationalizing and implementing the framework more effectively. It should address issues related to dissemination of the evidence base, experience documentation and sharing, and lessons from outside the health sector.

1.5 The strength of the evidence base for the menu of policies and interventions could be differentiated so that countries and areas can be guided in assessing their potential effectiveness and in deciding on the policy mix and the timing of implementation that fit their unique situations, through incremental changes or through a revolutionary, system-wide reform package.

1.6 In addition to the development of a dedicated website, a popular publication and the holding of an international symposium to launch the book and generate support for the initiative, other

avenues for promotion and advocacy could be through academic and quality circles, and running a series of articles in selected journals, e.g., *The Lancet*.

1.7 The initiative is not a new, top-up programme or project. A patient-centred and rights-based approach should be embedded in all health programmes, mature and developmental alike. There is a need to map the linkages of the initiative with these programmes, especially with respect to the menu of policy options and recommendations. There are good programme strategy and plan documents that are already in use and relevant recommendations should be incorporated in the patient-centred care policy menu.

2. Specific

2.1 Policy framework and domains

2.1.1 It is recommended that the options for policy reform and interventions be enriched to reflect the wide-ranging evidence base, including country experiences and quality studies.

2.1.2 While the health systems in the Asia-Pacific region use the individualistic Western model of health care, the delivery of health care in the region heavily involves the family. This perspective should be considered in the policy framework, and the individual domain (Domain 1) needs to be more inclusive of family, community, and civil society.

2.1.3 There is a need to link policy interventions at individual, organizational and policy levels, e.g., workforce planning, financial and other incentives, status of primary care services/providers, and roles and contributions of professional bodies.

2.1.4 In addition to the core competencies in knowledge and skills, the formation and reinforcement of positive must be strengthened. The importance of communication and counseling in the curriculum and in continuing professional development must be stressed.

2.1.5 The work environment of practitioners must be conducive to the delivery of safe and responsive care—the organization of the care process, the organizational culture, quality assurance systems, and others.

2.1.6 For the wider health system, the following issues must be addressed: public/private sector regulation, accountability of health insurance sector; selection criteria for professional

education to improve quality and geographical distribution; demand-side interventions to reduce barriers to access/utilization of appropriate care.

2.1.7 All the policy options and interventions must link and contribute to the main desired outcome which is effective health service usage resulting from a partnership of people exercising informed choice in health-related behavior and care, and of skilled, responsive and caring health practitioners.

2.2 In-country consultations

2.2.1 The stakeholder consultation in selected Member States will constitute an integral part of the initiative as it provides important inputs from the field to the process of developing the policy framework and enriching the policy menu.

2.2.2 The stakeholder consultation process may vary across countries, e.g., focused group discussions, key informant interviews, and break-out workshops, among others. It is important to have multisectoral representation and a mix of individuals and agencies which represent the supply and demand sides of the health care system. Funding agencies and other partners could also be invited.

2.2.3 The in-country consultations could initially be done in Malaysia, South Korea, and Thailand where there have been indications of readiness and relevant experience.

2.2.4 There could be a second wave and another mechanism of consultations to be explored and determined in consultation with the WHO representatives in other countries.