

SUMMARY RECORD OF THE NINTH MEETING

(WHO Conference Hall, Manila)
Friday, 12 September 2003 at 09:00

CHAIRPERSON: Dr Manuel DAYRIT (Philippines)

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1. CHILD HEALTH: Item 17 of the Agenda (Document WPR/RC54/11)

The REGIONAL DIRECTOR said that child survival was one of the most important measures of global development. The goal of a two-thirds reduction in childhood mortality by 2015, from 1990 levels, was therefore one of the key Millennium Development Goals.

Every year more than 1 million children in the Western Pacific Region died before their fifth birthday, which meant that about 3000 children were dying unnecessarily every single day. There was overwhelming evidence that simple and tested interventions could easily prevent at least 60% of those deaths, but such services were not accessible by many of the children and carers in greatest need.

Integrated Management of Childhood Illness (IMCI) was a technically sound, comprehensive and evidence-based strategy that focused on the major threats to children's health in a systematic and integrated way. It provided standard guidelines, adapted to local conditions, on interventions to prevent and manage the common conditions that kill children, combining them with nutritional interventions and immunization. IMCI improved the skills of health professionals, strengthened health systems and empowered families through interventions within the community. It had been ranked by the World Bank as among the most cost-effective health interventions in low- and middle-income countries and as the "best buy" in child health.

IMCI had already been successfully introduced in the Region. Its implementation had been monitored and evaluated thoroughly from the outset, and reviews had consistently shown that it empowered health workers to provide improved quality of care to sick children. It also equipped mothers and other child carers with new knowledge on how to care for children, in sickness and in health. The reviews had also pointed out that strong policy and health system support, including significant increases in human and financial resources, and firm coordination of actions would be needed if large-scale improvements in child health were to be made and long-term gains in childhood mortality reduction were to be achieved.

It was time to examine critically the way in which obligations to improve children's chances of survival were being implemented. Piecemeal offerings and pilot projects were not enough. Children were particularly vulnerable to the effects of inequity, poverty, hunger and social and economic injustice. Their well-being should be at the forefront of efforts to reduce inequities in health.

WHO and its Member States were committed to achieving the Millennium Development Goals. They knew what the challenges were, and they had the tools to address them. Interventions that had already been successfully implemented in many countries must be intensified and scaled-up and the unmet needs of children placed high on the political and development agenda. With dedication,

strong support and coordinated action, he was confident that WHO and its Member States could take a big step towards improving children's survival, growth and development in the Western Pacific. He therefore urged Member States to embrace IMCI as an opportunity for child mortality reduction and as an effective and cost-efficient way of achieving the Millennium Development Goal for reducing childhood mortality.

Dr IWAMOTO (Japan) agreed that it was time to put into practice action to reduce child mortality if the Millennium Development Goal was to be achieved. The IMCI strategy would be central to that effort. There were a number of reasons why the reduction in child mortality had stagnated or even been reversed since the mid-1990s: IMCI was a complex strategy, which was difficult for donors and decision-makers to understand; there was a lack of scientific evidence that its introduction had contributed to a reduction in child mortality; and there had been resource constraints, in particular for training. As an initial step to remedy the situation, the Regional Office should develop essential indicators to monitor the impact of the strategy. She endorsed the incorporation of child health interventions into national health policies as a priority for health system reinforcement.

Children's health should be given the highest priority. WHO, in collaboration with other organizations, should therefore make every effort to ensure intensification of the effectiveness of IMCI. She would be interested to hear the Regional Director's views on the attainability of the Millennium Development Goal.

Dr TANGI (Tonga), emphasizing the importance of child health programmes, pointed out that during the present session of the Regional Committee some 15 000 children in the Region had died. Yet it was the death of a single soldier in Iraq or of a few people as the result of a terrorist bomb that made the headlines. He urged the mass media to pay greater attention to the fate of the world's children. WHO should make a greater commitment to child health in the Region and at the global level. More resources should be invested in that area and more time should be devoted to discussion of the various issues involved.

Dr SAFURA (Malaysia) reported that child health status in Malaysia had improved over the past decade, with substantial reductions in infant and child mortality, achievement of the Universal Child Immunization target and mid-decade goal, and an increase in breast-feeding. In addition, all government hospitals were now accredited as baby-friendly hospitals.

Economic growth and lifestyle changes had led to further improvements, which in turn had affected the definition of health priorities. With strong political commitment from the Government at national, state and community levels, the Ministry of Health had focused on noncommunicable causes

of mortality, including screening of newborn infants, early child care and development, safe environments, water and sanitation, mental health, safety and injury prevention, and nutrition.

IMCI was an important component of strategies to attain the Millennium Development Goal and had been adapted and implemented in selected districts. Additional courses would be conducted to train health care providers so that IMCI could be further expanded. Training in IMCI was also being integrated in curricula for nurses and medical assistants. She was confident that Malaysia would achieve the Millennium Development Goal.

Ms CAO (China) endorsed the Regional Office analysis of the regional and global child health situation and supported the proposed actions. The Chinese Government attached great importance to ensuring the well-being of its population together with improvements to the economy, the environment and use of resources, as the basis of sustainable development. During the 1990s, it had pursued the commitments made at the 1990 World Summit for Children and formulated an action plan focusing on child health. For the new century, a ten-year child health plan had been launched. The rights of children were enshrined in the constitution and protected by legislation.

Although conditions for children were gradually improving, China was a developing country with a vast population and many children. Preventable diseases represented 60% of total deaths in children. However progress was restricted by the slow pace of socioeconomic development in certain areas and by the many disparities across the country, in particular between urban and rural areas and between richer and poorer groups in the community. Health services were often underused, owing to lack of awareness as well as economic reasons. The achievement of the Millennium Development Goal represented a considerable challenge, especially in the west of the country. Surveys had shown that congenital abnormalities, low birth weight and premature births were increasing, so efforts would be needed to reduce the neonatal mortality rate. The number of people living with HIV/AIDS was increasing so mother-to-child transmission of HIV was another factor.

IMCI had been introduced in 1998 and incorporated into the guidelines on childhood development in 2001. Implementation was now expanding, with increased financial allocations at central and local levels. It was hoped that WHO would continue to provide technical and financial support, in particular to developing countries, to ensure that child health was given the priority it deserved and that IMCI was extended across the Region.

Dr LO Veasna Kiry (Cambodia) commended the inclusion of the item on the Committee's agenda. Cambodia had ratified the United Nations Convention on the Rights of the Child and those rights were enshrined in the constitution. It was also committed to the attainment of the Millennium

Development Goals and recognized its responsibilities for child survival. Cambodia had the highest rates of infant and child mortality in the Region despite considerable progress in controlling vaccine-preventable diseases. Acute respiratory infections, diarrhoeal disease, perinatal conditions and malnutrition were the main killers.

The national health sector strategic plan for 2003-2007 gave the highest priority to mortality reduction and the fight against childhood malnutrition. External support would be needed, however, if the ambitious targets set out in the plan were to be achieved. He therefore hoped that the focus being shown by the Regional Office would be echoed by other international organizations.

The knowledge to improve child survival was available – the difficult task was to translate that knowledge into large-scale action. IMCI, which brought all the relevant interventions together, had the potential to provide the solution. To date implementation of IMCI had been limited to small-scale projects supported by external donors and greater efforts were needed to strengthen child health programme infrastructures.

Experience in the elimination of poliomyelitis and leprosy reduction in Cambodia had shown that key elements of success included: setting of clear targets, political commitment from the government and donors; clear attribution of responsibilities; and adequate funding. In the area of child survival, the first two of those elements were already in place and, given the interest shown by the Regional Office and the Regional Committee, it should be possible to mobilize additional support from donors. However, improvements in IMCI management, monitoring and evaluation were needed to strengthen implementation and enhance accountability. In addition, greater attention should be given to health outcomes directly linked to child mortality. WHO's efforts should be targeted on countries and regions within countries with high mortality rates.

Dr UNTALAN (United States of America) expressed strong support for the WHO global strategy on child and adolescent health adopted at the Fifty-sixth World Health Assembly. It provided an integrated, science-based framework centred on the family and adopted a lifecycle approach to health and development. It was incumbent upon Member States to translate the strategy into public policy. Child and adolescent health should be a top priority on political and health agendas, and there should be national commitment to adequate levels of financial, human and technical resources. IMCI, with its focus on proven and cost-effective interventions, was a means of strengthening and sustaining activities. In that context, he commended regional efforts to reduce measles morbidity and mortality and looked forward to the establishment of a target date for elimination of the disease in the near future.

Ms NORA'ALIA (Brunei Darussalam) expressed strong support for WHO's strategic directions for improving the health and development of children and adolescents. Her country was fully committed to disease prevention and health promotion targeted at children at the primary, secondary and tertiary health care levels. At the primary level, immunization coverage was more than 95% and services were decentralized to improve accessibility. Proactive early screening was undertaken at the secondary level, and a new hospital for women and children was planned. Tertiary level services included early rehabilitation programmes for children with special needs and referral abroad, with full government support, for children requiring further specialized care.

Brunei Darussalam was a signatory of the United Nations Convention on the Rights of the Child and had enacted The Children Order Act in 2000 to protect the health and general well-being of every child.

Dr SIPELI (Niue) recalled that representatives had emphasized the need for political commitment in respect of most of the subjects discussed by the Committee at the present session. Countries would decide, however, on their own priorities – for example, as to whether they favoured child health or material gains for the general public. Politicians were the key players in determining those priorities and should be proactive in ensuring that the simple, effective and technically sound interventions that were available were provided in order to protect children against disease and premature death. He therefore supported WHO's renewed global commitment on child health.

Mr JORÉDIÉ (France) endorsed WHO's approach to child health. His country's priority was the integrated management of childhood illness, particularly by assuring the autonomy of families within a community approach. School health programmes were also a useful means of providing health education to individual children.

Health services in the French overseas territories had focused on developing human resources for maternal and child care within the different public health structures. The number of maternal and child health centres around Noumea had increased, and the number and ratio of midwives was very high. Further, the range of their skills had officially been extended to include prevention activities, particularly vaccination. A thorough study was under way to identify the reasons for premature births and low birth weight, which still amounted to 7% of total births in New Caledonia.

Mr NAIVALU (Fiji) said that Fiji had officially launched the Integrated Management of Childhood Illness in August of the current year during the observance of World Breast-feeding Week in a joint ceremony with the Ministry of Health, UNICEF and WHO.

In January 2004, Fiji would launch an iron fortification and enrichment of wheat flour programme in collaboration with UNICEF, the Government of Fiji and a local business entity. That initiative would be a milestone in public health, since iron deficiency anaemia had been a chronic public health problem in his country. It was hoped that the iron fortification programme would reduce the problem by 30%.

In view of the importance of the annual session of the Regional Committee he said that it would be helpful if other relevant UN agencies could be present to share their views.

Dr KUARTEI (Palau) pointed out that the term "Integrated Management of Childhood Illness" appeared to promote the idea of dealing with child health indicators from an illness standpoint. He agreed with the representative of Japan that IMCI indicators must be drawn up and said that these should include not only treatment and prevention of illness, but also health protection and promotion. Such integration would lead to a broader intersectoral approach, encompassing economic strategies, the legal system and cultural participation. These were part and parcel of the approach to the management of child health.

Mr VAEVAE PARE (Cook Islands) said that since the 1960s the Cook Islands Ministry of Health had placed child health high on its agenda and therefore supported the proposed actions contained in the IMCI strategy. He also supported Japan's request for WHO to develop tools that could be used to monitor the progress of IMCI progress in the Region.

In his country the school curriculum was being developed with the Ministry of Education, other relevant government ministries had been co-opted to address areas of concern. Support would be sought for the establishment of a databank as part of efforts to ensure 100% coverage of all children in Cook Islands.

Dr GALON (Philippines) agreed with the Regional Director that now was the time to focus on the unfinished agenda of child survival, growth and development. Although there had been a significant reduction in child mortality, children still died of the same illnesses that had afflicted them 20 years ago. Efforts had to be intensified to attain the Millennium Development Goal of reduction of childhood mortality by two-thirds by 2015.

Dr CHAN (Macao, China) supported the new strategy for child health. Following WHO guidelines, Macao had started a healthy school project with the cooperation of the Education Department. He was confident that more schools would join the initiative.

Dr ENOSA (Samoa) explained that Samoa had recently taken a step forward by requesting New Zealand to fund a three-year programme called Family and Child Welfare, which would end in July 2004. He hoped that New Zealand would continue to fund future projects. Samoa's Education Department had been involved in incorporating the health awareness programme into school curricula.

He joined other countries in calling for further involvement from donor partners such as UNICEF, AusAID and JICA, in providing assistance to Pacific island countries.

Dr MATHESON (New Zealand) said that his country endorsed the goal of reducing under-five mortality rate by two-thirds by 2015. His country focused especially on support for primary health care and on reducing the underlying causes of health inequalities that had an impact on children. The Maori health strategy emphasized the central role of families in the provision of a safe and supportive environment for children. An annual review ensured that the strategy was effecting improvements in child well-being.

In response to the comment by the previous speaker, he assured him that New Zealand was fully committed to maintaining collaboration with its Pacific neighbours.

Mrs PAUL (Marshall Islands) commented that child health was particularly important for her country, where over half of the population was under 20 years of age. A recent study conducted in the Marshall Islands on children's social, educational and health problems had identified child neglect as one of the root causes. It was an overlooked problem, but an important one.

Dr KIENENE (Kiribati), agreeing with the representative of Fiji, asked why other organizations involved with children's welfare, such as UNICEF, UNFPA and ILO, were not represented in the discussions.

He was also pleased that the Regional Director's report included many important issues, such as water and sanitation, which, while not under the Ministry of Health's mandate, were nevertheless areas where it could work in partnership with other ministries.

He observed that in his country, they were concentrating on traditional birth practices, since some many births attended by traditional birth attendants were not registered. This was a vicious cycle, since, if the babies had not been registered, they would not receive immunization. These children were then vulnerable to vaccine-preventable diseases, which meant that the infant mortality rate increased. IMCI had not started in Kiribati but his country was addressing child health in the broadest way possible, taking these issues into account.

Dr MANN (Papua New Guinea) pointed out that the high rate of infant and child mortality in his country was attributable to malaria and vaccine-preventable diseases, which was a matter of considerable concern.

With the cooperation of WHO and UNICEF, IMCI programmes had been launched in pilot areas and were beginning to show results in terms of child welfare. His country was therefore fully supportive of that initiative.

The REGIONAL DIRECTOR, referring to the query from Japan as to whether the child mortality target of the Millennium Development Goal was achievable, replied that earlier success had demonstrated that with determination, sufficient resources, effective strategies and appropriate programmes, targets could be met. IMCI was a cost-effective intervention that was already contributing to reductions in child mortality, although on a small scale.

In reply to Fiji's suggestion that other agencies involved in the child health should be invited to the session, he confirmed that invitations had been issued, but recipients had been unable to attend.

China had raised the point of the disparity between rural and urban areas in terms of child health, and he agreed that that was a matter on which the Region as a whole would have to focus in the future in order to meet the needs of marginalized groups.

He agreed with speakers that special efforts were needed to mobilize additional resources. When secured, extra funds would be channelled to child health and to activities at country level. He also drew attention to a recent article published by WHO in *The Lancet* which analysed all the issues related to child health.

The MEDICAL OFFICER IN CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT, responding to the issue of the scientific evidence for IMCI and the proposed development of indicators, which had been raised by the representative of Japan, said that IMCI was based on interventions for which sound evidence had been established, such as oral rehydration therapy to save children from dying of dehydration and antibiotics to avert deaths from pneumonia. Exclusive breast-feeding for the first six months of life would provide good protection against childhood illnesses and malnutrition. She agreed with several representatives that there was a need to better demonstrate the progress towards mortality reduction. The request for better indicators was in line with the findings of a recent meeting and this would, as the Regional Director had said, be looked into as a matter of priority.

The WHO ASSISTANT DIRECTOR-GENERAL FOR FAMILY AND COMMUNITY HEALTH, WHO HEADQUARTERS, noted the concern that had been expressed about the rates of child mortality in the Region. She assured the meeting that the challenge was not peculiar to the Region: 30 000 children died throughout the world every day and 10.9 million children under the age of five died every year. That figure could be compared with the 2.8 million people who died from AIDS each year. The depletion of global potential due to the deaths of children was thus more than three times greater than that due to the HIV/AIDS epidemic, yet the cost of interventions to reduce the carnage by 60% was only 10% of the cost of controlling HIV/AIDS. Ironically, a child saved now could promote economic growth and contribute to development for about 40 years, whereas the adults who were being saved from the HIV/AIDS epidemic would contribute for only 10 or at most 20 more years. By combining the forces of all global partners, all national stakeholders and the community to address prevention, case management, nutrition and immunization, 1800 young lives in the Region could be saved daily. That could be achieved only with commitment. The children of the world wanted a place fit for them to live in, with adults who were fit to be their parents. In order to justify their confidence, indicators were needed. Partnerships should be created, national plans of action developed, resources mobilized and allocated, not only by WHO but also by countries and donors. She supported the vision of the Director-General and the Regional Director of an environment that was safe and healthy for children.

The DIRECTOR, DEPARTMENT OF CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT, WHO HEADQUARTERS, welcomed the support of the Region for the overall strategy for child and adolescent health and development that had been adopted at the Health Assembly and for the IMCI strategy. He agreed with the Regional Director that it would be possible to achieve the Millennium Development Goal of reducing child mortality. Published articles and evaluations had shown that interventions were available that would reduce mortality rates by 60%-70%. No new vaccines or techniques were needed; the existing interventions (such as oral rehydration, antibiotics and bed nets) would suffice. Ten to fifteen years previously, Member States had urged WHO to integrate the various interventions. The strategy for integrated management of childhood illness did just that, promoting integration for greater efficiency. It was a comprehensive approach based on existing, proven, cost-effective interventions. The stumbling block was the lack of human, health system and financial resources. The tools were available to turn knowledge into action, but global funding for child health had decreased over the past 10 to 15 years. With regard to indicators to monitor progress, he explained that WHO was conducting a multinational evaluation of IMCI, while at the same time evaluating its cost-effectiveness. The study would be completed in 2005. Analytical reviews were also being conducted, and indicators were being identified both for progress in implementing IMCI and for reductions in child mortality.

The CHAIRPERSON asked the rapporteurs to draft an appropriate resolution.

2. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following resolutions.

2.1 Sexually transmitted infections, including HIV/AIDS (Document WPR/RC54/Conf.Paper No. 4 Rev. 1)

The RAPPORTEUR FOR THE ENGLISH LANGUAGE drew the attention of the Committee to the changes to operative paragraphs 1(2) and 2(3)(h). These had been agreed after discussion by the representatives of France, New Zealand, and the United States of America.

Decision: The draft resolution, as amended, was adopted (see WPR/RC54.R5).

2.2 Tuberculosis prevention and control (Document WPR/RC54/Conf.Paper No. 5)

Professor NYMADAWA (Mongolia) proposed that in operative paragraph 2(7) the words “and management of” be introduced after “surveillance for”, in order to cover treatment protocols with second-line drugs.

Decision: The draft resolution, as amended, was adopted (see WPR/RC54.R6).

2.3 Severe acute respiratory syndrome (SARS) and other outbreak-prone diseases (Document WPR/RC54/Conf. Paper No. 6)

Mr BHAT (United States of America) proposed that operative paragraph 1(3) be amended by addition of the words “and sharing of biological samples” after “collaboration between laboratories”. In operative paragraph 1(6), he asked that the words “, including border control measures,” be added after “control measures”. Operative paragraph 2(4) should be amended by addition of the words “and stimulate” after “to coordinate”. He proposed the addition of a new subparagraph 2(6), which would read: “to incorporate lessons learned when working with the Director-General on future travel advisories and with the Member States on border control measures.”

Dr KIENENE (Kiribati) proposed that operative paragraph 2(5) be amended by addition of the words “and shared among Member States” after “properly recorded”.

Dr FUKUDA (Japan) asked that the last part of operative paragraph 1(4) be changed to read “... the SARS coronavirus only in qualified laboratories approved by the appropriate body and with an appropriate level of biosafety;”, in order to allow authorities to decide which laboratories they accredited.

Decision: The draft resolution, as amended, was adopted (see WPR/RC54.R7).

2.4 WHO Framework Convention on Tobacco Control (Document WPR/RC54/Conf.Paper No. 7)

Dr FUKUDA (Japan) recalled that negotiation of a compromise text that addressed the interests of all interested parties had been a long, arduous process. His Government supported the Convention and was doing its best to ratify it. In order to avoid entering into the same discussions again, he suggested that the language upon which compromise had been reached should be retained. In that spirit, he proposed that a new preambular paragraph be added after the seventh existing one, reading: "Acknowledging that agreement to the Convention required a long process to negotiate a compromise to resolve the differences and nuances in the interests of all Member States and interested parties;"

The second proposed amendment was to replace the tenth preambular paragraph, beginning "Noting with profound concern", by the following text, which had been used in the Framework Convention: "Recognizing the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on tobacco control efforts;"

At the end of the last preambular paragraph, he proposed that the word " , regional" be inserted between "global" and "and national".

He suggested that operative paragraph 2(2) be amended to read: "to implement tax policies for tobacco products as a means of reducing tobacco consumption without prejudice to the sovereign rights of the Member States to determine their policies;"

Finally, he asked that in operative paragraph 2(4), the words "by the tobacco industry and its allies" be deleted.

Decision: The draft resolution, as amended, was adopted (see WPR/RC54.R8).

3. COORDINATION OF THE WORK OF THE WORLD HEALTH ASSEMBLY, THE EXECUTIVE BOARD AND THE REGIONAL COMMITTEE: Item 18 of the Agenda (Documents WPR/RC54/12 and WPR/RC54/INF.DOC./2)

The DIRECTOR, PROGRAMME MANAGEMENT explained that document WPR/RC54/12 referred to resolutions adopted by the Fifty-sixth World Health Assembly that were of particular significance for the Western Pacific Region. The resolutions themselves were attached to the document. Resolutions adopted by the Fifty-sixth World Health Assembly that related directly to other items on the agenda had been annexed to the documents covering those items.

He drew the attention of the Committee to the operative paragraphs, which related to activities that Member States could undertake in the Region to implement the resolutions.

Resolution WHA56.19 dealt with prevention and control of influenza pandemics. It was particularly relevant to the Western Pacific Region, since so many new strains of influenza originated there, particularly in southern China. WHO and the Ministry of Health of China were already working closely together on a five-year project to improve influenza surveillance. He drew the Committee's attention in particular to operative paragraphs 1(1) and 1(2) of resolution WHA56.19 on national influenza vaccine policies and to operative paragraph 1(3) on the need for national plans for preparedness for influenza pandemics.

Resolution WHA56.23 dealt with the joint FAO/WHO evaluation of the Codex Alimentarius Commission. He drew the Committee's attention to operative paragraph 3, which invited the regional committees to review regional policies on standard setting and nutrition information.

Resolution WHA56.31 dealt with traditional medicine. The resolution took note of the global strategy for traditional medicine, which was in line with the regional strategy endorsed by the Regional Committee in 2001. With regard to the Health Assembly's specific requests to Member States and to the Director-General, those were also broadly in line with activities already being carried out in the Region in the fields of traditional medicine, pharmaceuticals, human resources, and health systems development.

The multicountry outbreak of SARS earlier in the year had lent a sense of urgency to the revision of the International Health Regulations, which was covered in resolution WHA56.28. He said the Committee might particularly like to note that the Health Assembly had decided to establish an intergovernmental working group open to all Member States to review the draft regulations. Information about that intergovernmental working group could be found in paragraphs 2 and 5 (6).

4. SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION: MEMBERSHIP OF THE POLICY AND COORDINATION COMMITTEE : Item 20 of the Agenda (Document WPR/RC54/14)

The DIRECTOR, PROGRAMME MANAGEMENT explained that the Policy and Coordination Committee, which was the governing body of the WHO Special Programme of Research, Development and Research Training in Human Reproduction, was composed of four categories of members and had a total of 32 members. Category 2 comprised 14 Member States elected by the WHO regional committees for three-year terms; three Member States were to be

selected by the Western Pacific Region. At present, the three from the Western Pacific Region were Papua New Guinea, Viet Nam and Fiji.

The term of Papua New Guinea would expire on 31 December 2003. The Regional Committee was now requested to elect one Member State, whose three-year term would start on 1 January 2004, to succeed Papua New Guinea. In electing members, due consideration was to be given to a Member State's financial or technical support to the Special Programme and its interest in the field of human reproduction, as reflected in its national policies and programmes. The Regional Committee might choose to select the Lao People's Democratic Republic. The next meeting of the committee was scheduled to take place from 30 June until 1 July 2004.

It was so decided (see decision WPR/RC54(1)).

Dr MANN (Papua New Guinea) thanked the Regional Committee for having chosen his country to serve on that important committee and expressed his country's readiness to serve in a similar way in the future.

5. SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES:
MEMBERSHIP OF THE JOINT COORDINATING BOARD: Item 21 of the Agenda
(Document WPR/RC54/15)

The DIRECTOR, PROGRAMME MANAGEMENT said that paragraph 2.2.2 of the Memorandum of Understanding on the Administrative and Technical Structures of the Special Programme for Research and Training in Tropical Diseases provided for the selection by the WHO regional committees of two Member States from among those directly affected by the diseases dealt with by the Special Programme, or from among those providing technical or scientific support to the Special Programme.

The two Member States of the Western Pacific Region who were currently members of the Joint Coordinating Board in this category were the Lao People's Democratic Republic and Cambodia. Since the three-year period of tenure of the representative designated by the Lao People's Democratic Republic would end on 31 December 2003, the Committee would wish to appoint a Member State to send a representative to represent the Western Pacific Region from 1 January 2004. The Regional Committee might wish to consider Mongolia as a replacement for the Lao People's Democratic Republic.

It was so decided (see decision WPR/RC54(2)).

6. TIME AND PLACE OF THE FIFTY-FIFTH AND FIFTY-SIXTH SESSIONS OF THE REGIONAL COMMITTEE: Item 22 of the Agenda

The Chairperson invited Dr Omi to say a few words about the place and proposed dates of the fifty-fifth session.

The REGIONAL DIRECTOR recalled that at its fifty-third session, the Regional Committee had accepted the kind invitation of the Government of China to host the fifty-fifth session of the Regional Committee in 2004.

The Chairperson called on the representative of China to take the floor.

Dr WANG (China) reconfirmed to the Committee that China would host the fifty-fifth session of the Western Pacific Regional Committee of WHO, in Shanghai, China. China would maintain close cooperation with the Regional Office in preparation of the meeting, to ensure complete success.

The CHAIRPERSON thanked the representative of China.

The REGIONAL DIRECTOR proposed the dates of the session, which had to take account of the dates of all the regional committees, both to enable the Director-General to attend part of each session, and to allow time for discussion of those committees to be reflected in documentation for the Executive Board meeting in January 2004. He therefore proposed the dates of 13 to 17 September 2004.

The CHAIRPERSON asked the rapporteurs to draft an appropriate resolution, reflecting appreciation to the Government of China.

7. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following resolution.

7.1 Child health (Document WPR/RC54/Conf.Paper No. 8)

Dr WAQATAKIREWA (Fiji) queried the wording of preambular paragraph 6, since he believed the expression should be not "the United Nations Millennium Development Goals" but "development goals of the United Nations Millennium Declaration".

Mrs BLACKWOOD (United States of America) agreed with the representative of Fiji.

Dr KUARTEI (Palau): suggested that the word "economic" be inserted in operative paragraph 1(1) after "political,".

Dr MATHESON (New Zealand) proposed deletion of the expression “pockets of” from operative paragraph 1, since in some Member States child mortality was of a much higher order than that wording suggested. He further proposed that, in operative paragraph 1(1), “health care” should precede “medical assistance”, since the former was a broader term.

The CHAIRPERSON said that, for the point raised by the representatives of Fiji and the United States of America, the secretariat would ensure the proper terminology was inserted.

Decision: The draft resolution was adopted (see WPR/RC54.R9).

8. CLOSURE OF THE SESSION: Item 23 of the Agenda

Dr TANGI (Tonga) thanked the CHAIRPERSON and other office bearers, all participants, the Regional Director and the secretariat.

Dr THORNE (United Kingdom) seconded the vote of thanks to all concerned.

The REGIONAL DIRECTOR thanked Member States for the trust and confidence they had shown in re-electing him. He pledged to do his best throughout his second term. He thanked the secretariat also for its hard work behind the scenes. He thanked the Chairperson and presented him with the gavel as a token of his appreciation.

The CHAIRPERSON said there were three reasons why the meeting had been memorable. Firstly, because it was the first meeting after the SARS outbreak, which had helped Member States to work more closely together with WHO. The second anniversary of the terrorist attack on New York had also taken place during the session, just as the attack itself had taken place during the fifty-second session. Finally, the meeting had re-elected Dr Omi as regional director. He thanked all participants and the secretariat for their work. He said the draft report of the session would be sent out to all representatives with a covering letter indicating the dates by which comments on the draft should reach the Regional Office. After that date, the report would be considered to have been accepted.

The CHAIRPERSON declared the fifty-fourth session of the Regional Committee closed.

The meeting rose at 12:15.