REPORT OF THE REGIONAL DIRECTOR

The work of WHO in the Western Pacific Region
1 July 2010–30 June 2011

World Health Organization
Western Pacific Region
THE WORK OF WHO IN THE
WESTERN PACIFIC REGION

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Report of the Regional Director to the
Regional Committee for the Western Pacific
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Contents

Introduction iv

Combating Communicable Diseases 2
  1. Expanded Programme on Immunization 4
  2. Malaria, other vectorborne and parasitic diseases 10
  3. HIV/AIDS and STI 16
  4. Stop TB and leprosy elimination 18

Health Security and Emergencies 22
  5. Emerging disease surveillance and response 24
  6. Food safety 28
  7. Emergency and humanitarian action 30

Building Healthy Communities and Populations 34
  8. Environmental health 36
  9. Maternal and child health and nutrition 40
  10. Noncommunicable diseases and health promotion 46
  11. Mental health and injury prevention 50
  12. Tobacco Free Initiative 54

Health Sector Development 58
  13. Health services development 60
  14. Health care financing 62
  15. Human resources for health 68
  16. Essential medicines and health technology 70
  17. Health information, evidence and research 74

Division of Pacific Technical Support 78
Programme Management and Coordination 82
Administration and Finance 86
This report to the Regional Committee for the Western Pacific highlights WHO’s work in the Region for the year ending 30 June 2011. While I will touch upon the highlights of our work across the Region and at the country level, I would also like to discuss some of the challenges facing WHO and our Member States.

Since our Regional Committee last met, the Western Pacific Region—the largest and most diverse of all WHO regions—has faced a year of change and a year of challenge. WHO’s global reform process and the need for effective and efficient management in times of financial crisis have led to some difficult choices.

But those challenges have also presented unique opportunities—to refresh our core mandate, to focus on what we do best, and to create an Organization that can best meet the needs of the 21st century.

The regional reform programme we launched two years ago is holding the Western Pacific Region in good stead in these turbulent times. Investments in staff learning and development, in staff rotation and mobility, and in organizational development have resulted in a greater focus on priority public health areas and higher quality technical assistance to Member States.

With the structures, systems and people we now have in place, we are better positioned to do the one thing that matters most—improve health outcomes at the country level, particularly in areas where health disparities are at their greatest.

Last year, at the sixty-first session of the Regional Committee for the Western Pacific, I made a commitment to focus on three areas. First, I promised to continue to push forward with several priority issues, including the health-related Millennium Development Goals, noncommunicable diseases, health security and health systems strengthening. Secondly, I pledged to pull some neglected issues back into focus. And finally, I committed to reaching out and working in greater partnership with others. We have, in fact, made much progress in these areas, and details of that work can be found in this report.
Despite those achievements, WHO and its Member States continue to face a number of tough challenges. As a Region, we can take heart in progress towards the achievement of the health-related Millennium Development Goals. For example, expanded immunization programmes at the country level and a renewed focus on newborn care are contributing to a reduction in child mortality. But poor access to antenatal care and a lack of skilled birth attendants in many parts of the Region are hampering further success.

Continued hard work on malaria control means that elimination of the disease is now feasible in many countries in the Region. Tuberculosis control programmes have been strengthened across the Region, and successes have been reported in the prevention and treatment of HIV/AIDS. Our Member States must be applauded for their hard work in these areas.

Despite progress in fighting HIV/AIDS, malaria and other diseases, experts are concerned that the rise in antimicrobial drug resistance in many parts of the Region could threaten these achievements. In fact, the theme of this year’s World Health Day was antimicrobial resistance, and the rally cry from the WHO Director-General was clear: No Action Today, No Cure Tomorrow. WHO and our Member States must work even harder in the coming year to fight antimicrobial resistance.

Noncommunicable diseases—cancer, cardiovascular diseases, chronic respiratory ailments and diabetes—now feature prominently on the political agenda. The work undertaken by Member States, with support from WHO, to produce the Nadi Statement and the Seoul Declaration, as well as the communiqué from Ministers of Health for the Pacific Island Countries to the leaders of the Pacific Islands Forum, means that as a Region, leaders will be well prepared to voice concerns and make commitments during the United Nations High-level Meeting on Noncommunicable Diseases that will take place in New York in September 2011.

A number of important achievements in addressing noncommunicable disease risk factors have also occurred this year throughout the 37 countries and areas that make up the Western Pacific Region. For the first time ever, the Director-General awarded World No Tobacco Day Awards to two individuals in our Region. Achievements across all aspects of tobacco control—from legislation to health education to cessation services—are continuing to grow. Work on other risk factors, on the social determinants of health, and support for healthier lifestyles through Healthy Cities and the Healthy Islands initiatives have also accelerated this year. Once again, our Member States can take pride in their achievements in these areas.
The tragic earthquake, tsunami and nuclear incident in Japan on 11 March 2011 tested all aspects of our emergency response programme and demonstrated the importance of preparedness and an integrated approach to disaster management. Lessons learnt from that experience, as well as the February 2011 earthquake in Christchurch, New Zealand, and other national disasters, are being used to strengthen further our regional resilience to health threats and to improve health security.

In order to achieve the Millennium Development Goals, address rising health care needs for noncommunicable diseases and ensure that health services will be available when disasters strike, strong health systems must be in place. Much work has been done this year to help Member States strengthen various aspects of their health systems. But the lack of universal health insurance coverage and inequitable access to integrated, comprehensive and quality health services remain significant challenges in many parts of the Region.

I am pleased to report that this year we were able to turn the spotlight on a number of previously neglected issues that are concerns for several of our Member States.

Work to eliminate three debilitating diseases that should no longer exist—yaws, leprosy and lymphatic filariasis—is progressing rapidly. An Action Framework for Leprosy Control and Rehabilitation in the Pacific Island Countries has been developed and is being implemented in Kiribati, the Marshall Islands and the Federated States
of Micronesia. A similar action framework will soon be available to support yaws elimination in Vanuatu. Country-specific plans for lymphatic filariasis have been developed and are being implemented so that this disease can be eliminated from our Region.

Attention to dengue, a somewhat neglected disease, has also increased this year, culminating in the successful observance of Dengue Day, which drew support from many WHO Member States.

Another priority over the past year has been our effort to mainstream a gender perspective into all of our technical work, and a report on those efforts will be available during the October 2011 session of the Regional Committee in Manila, Philippines.

None of this could have been achieved without the hard work of our Member States and strong global partnerships. In fact, this year has seen significant efforts in reaching out and in partner engagement. Collaborative agreements specifically focused on country needs have been reached with UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the International Federation of Red Cross and Red Crescent Societies.

One of the greatest successes this year has been the strengthening of WHO support to the Pacific. The creation of the Division of Pacific Technical Support has allowed us to better understand and better address the specific needs of the Pacific island countries and areas. WHO, working with the Secretariat of the Pacific Community, helped develop a new structure for the biennial Meeting of Ministers of Health for the Pacific Island Countries, affording a unique opportunity to better understand the concerns of our Member States in the “Blue Continent” and to work side by side with our key technical partners to explore how best we can support Pacific countries to meet those needs.

It was a year of change and a year of challenge. But it also was a year of achievement. The key challenges—seriously addressing maternal health issues, combating antimicrobial resistance before it reverses our achievements, tackling noncommunicable diseases, ensuring universal access to quality health systems, and continuing to shine a light on neglected issues—remain ahead of us. Let’s continue to work together to improve health and reduce the disparities as we strive to achieve our shared goal of good health for all people of the Western Pacific Region.

Regional Director
INTRODUCTION
Communicable diseases continue to be a serious public health problem in the Western Pacific Region, exacerbated by a rise in noncommunicable diseases in most countries and areas. Pockets of extreme poverty, coupled with subtropical and tropical climatic conditions, favour transmission of many communicable diseases, including dengue, Japanese encephalitis, malaria and Chikungunya, not only in the least-developed countries but also in more developed ones. Weak health systems, international donor fatigue and other limiting factors are forcing public health professionals and organizations, WHO included, to rethink how best to approach the combined threat of communicable and noncommunicable diseases affecting most Member States in the Region.

This past year, the Division of Combating Communicable Diseases, and its network of Country Office focal points, scaled up inter-programmatic cooperation at the regional and country levels to establish more cost-effective, coherent and sustainable technical support in four important areas of work.

The first area is immunization. The Division supported Member States in achieving targeted disease-reduction goals, introducing new and underutilized vaccines, and strengthening routine and supplementary immunization.

Within the Regional Office, the Division collaborated on a number of cross-cutting issues, including maternal and child health, disease surveillance, health information, evidence and research, environmental health, and health technologies. Specifically, it provided technical input into the WHO/UNICEF Regional Child Survival Strategy, the Regional Information Observatory, and the Country Health Information Profiles, and assisted in the development of web-based data management applications for vaccine-preventable disease surveillance. The Division has worked with staff from the field of the emerging disease surveillance and response (ESR) in stepping up Japanese encephalitis surveillance, developing training courses on vaccine-preventable disease (VPD) surveillance and event-based surveillance, participating in the Regional Surveillance Coordination Group, and sharing information on VPD outbreaks and importations using EPI’s case-based VPD surveillance and ESR’s syndromic surveillance reports and International Health Regulations (2005) notifications. The Division also contributed to waste management activities and safe injection device strategies, and preparedness, procurement, deployment and vaccination activities for pandemic influenza A (H1N1) 2009 vaccine. Finally the Division played a part in strengthening health and immunization systems using supplementary immunization activities to address health systems deficiencies and combine multiple health interventions, building laboratory capacity partly through participation in the Regional Laboratory Working Group, and introducing the human papillomavirus (HPV) vaccine in Cook Islands to prevent cervical cancer.
The second important area of work is HIV/AIDS and sexually transmitted infections. At the regional level, the Division collaborated with maternal and child health colleagues on the prevention of mother-to-child transmission, elimination of congenital syphilis, and execution of a “linked response” to HIV, sexually transmitted infections and maternal, child and reproductive health. Joint efforts with the Stop TB unit resulted in the adoption of standard operating procedures for managing TB/HIV collaboration and health in prisons.

At the country level, joint programmes and projects focused on harm reduction in Malaysia, methadone maintenance therapy for opioid dependence in Cambodia, pharmacovigilance for surveillance of antiretroviral therapy (ART) drugs in Viet Nam, and the elimination of congenital syphilis in China.

The third area is malaria, other vectorborne and parasitic diseases. At the country level, experts in this field collaborated with immunization staff in Kiribati, the Lao People’s Democratic Republic, the Federated States of Micronesia, Vanuatu and Viet Nam on the integrated distribution of deworming tablets, vitamin A capsules and bednets during immunization campaigns. Other inter-programmatic projects involved distributing bednets through antenatal care and HIV clinics; increasing access to treatment and prevention services for migrant populations and ethnic minorities; addressing climate change and vectorborne diseases in Cambodia, Mongolia and Papua New Guinea, with support from the Korea International Cooperation Agency; and phasing out DDT in Papua New Guinea, the Philippines, Solomon Islands, Vanuatu and Viet Nam, with support from the Global Environmental Facility. Research capacity, strengthened through scientific writing workshops and technology transfer, was critical to the success of all of the programmes, as it cuts across most of the technical units.

In the coming years, the Division will intensify collaboration with relevant units and divisions on the above-listed initiatives. It will also work more closely with countries on increasing coverage of malaria interventions in pregnancy, strengthening laboratory networks to ensure the quality of parasite-based diagnosis, strengthening surveillance systems and tracking progress towards diseases elimination, and managing, publishing and promoting the use of routine data.

The final area is tuberculosis (TB) and leprosy elimination. Managing TB/HIV collaboration is a core function of WHO, especially among the United Nations agencies working on HIV/AIDS. Both HIV and TB staff participate in cross-cutting meetings and workshops at the regional level. At the country level, collaboration between TB and HIV programmes is well under way in Cambodia and the Lao People’s Democratic Republic. Screening—for HIV among TB patients and for TB among people with HIV—has resulted in early case detection and treatment for the two diseases.

In collaboration with health systems staff in the Regional Office, the Stop TB unit has made progress in infection control and laboratory strengthening, and will intensify efforts to integrate TB infection control and laboratory capacity-building into general infection control and laboratory services to avoid duplication. Intensified TB case detection in prisons is a potential area for further collaboration.

More needs to be done to lessen the impact of HIV infection on TB control and of TB infection on HIV prevention and care, especially at the country level. For tuberculosis patients co-infected with HIV, early HIV diagnosis and provision of ART need to be strengthened to lower mortality. The new WHO policy on the symptomatic screening for TB among people with HIV should be widely promoted for intensified TB case detection and facilitation of isoniazid preventive therapy in some countries. Multidrug-resistant tuberculosis is currently at the forefront of challenges faced by the Stop TB team and will require concerted collaborative efforts with other units to successfully tackle this public health problem.
Expanded Programme on Immunization

Strategic issues

Immunization is a cost-effective public health intervention that has dramatically reduced disease, disability and death in the Western Pacific Region. As of 2011, the Region has remained free of poliomyelitis, regional measles incidence has decreased to 19 cases per 1 million population, more than 87% of the Region’s population live in countries and areas with less than 2% prevalence of chronic hepatitis infection among children, and 31 countries and areas have eliminated maternal and neonatal tetanus as a public health problem.

Demand is mounting for new and underutilized vaccines that prevent major causes of cervical cancer, diarrhoea, encephalitis, meningitis and pneumonia, accompanied by a growing need to assure vaccine quality, safety and adequate supply-chain management. Programme monitoring and high-quality surveillance, supported by an accredited laboratory network, are increasingly needed to demonstrate progress toward or achievement of disease eradication, elimination or control. Systematic expansion of surveillance for diseases targeted by new or underutilized vaccines is essential to guide decision-making and monitor impact.

Despite many successes, disparities remain in immunization coverage between and within countries, threatening the achievement of the regional goals of measles elimination and hepatitis B control, placing at risk the Region’s polio-free status and the achievement of maternal and neonatal tetanus elimination, and limiting the impact of new and underutilized vaccine introduction. To fully realize the benefits of immunization and help achieve the Millennium Development Goals, WHO has developed a strategic framework in line with the Global Immunization Vision and Strategy that has five objectives: (1) ensure equitable access to vaccines of assured quality, including pandemic vaccines; (2) achieve targeted disease eradication, elimination or control; (3) promote the rational introduction of new vaccines; (4) strengthen vaccine-preventable disease monitoring and surveillance systems, laboratory capacity, and data use; and (5) strengthen communications, partnerships and advocacy to support immunizations and promote integration of immunization with other health interventions.

Action and results

A strong routine immunization system is the foundation for achieving the objectives of an immunization programme. To strengthen vaccine management systems, WHO organized and supported the installation of vaccination supplies stock management software and training for national and provincial immunization programme staff in the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam. Intercountry training on effective vaccine management was conducted for five priority countries to help them assess their vaccine supply chains and improve performance. Vaccine management training for national and provincial immunization programme staff and temperature-monitoring studies using data recording devices were conducted in Mongolia. A vaccine procurement assessment was conducted in Fiji in 2010, and a special session on vaccine security (forecasting and procurement) was conducted during the Sixth Pacific Immunization Programme Strengthening Workshop for 20 Pacific island countries and areas.
A WHO-led assessment of the national regulatory authority in China, which was carried out by experts from six countries, concluded in March 2011 that all of the functionality requirements of a vaccine regulatory system had been met. Pre-assessments were conducted in Japan and Viet Nam. WHO conducted training on surveillance and response for adverse events following immunization in the Philippines. A nationwide assessment of injection safety (including therapeutic injection) was conducted in the Lao People’s Democratic Republic. WHO also provided support to develop a policy on injection safety for Mongolia.

In response to pandemic influenza A (H1N1) 2009, WHO provided technical support to 17 low- and middle-income countries for the deployment and administration of 8.7 million doses of donated pandemic vaccine, and published a periodic bulletin providing feedback to Member States on the status of vaccine deployment. A workshop was conducted in May 2011 to review and share lessons from pandemic vaccine deployment and to update deployment plans to respond to new or recurring pandemics.

Inequities in routine immunization coverage were addressed through WHO-supported training on district-level immunization strengthening and development of national multi-year immunization plans that aspire to vaccinate hard-to-reach children. WHO also spearheaded efforts to observe Vaccination Week in the Western Pacific Region in April 2011. More than 30 countries and areas participated in the week-long event that included targeted outreach clinics, expanded clinic hours, and social mobilization and media campaigns.

WHO support helped the Region maintain its polio-free status and make progress towards measles elimination, hepatitis B control and maternal and neonatal tetanus elimination. To achieve universally high immunization coverage, supplemental immunization activities were conducted for polio in Cambodia, China and Mongolia, and for measles in Cambodia, China, Japan, the Federated States of Micronesia, Papua New Guinea, the Philippines, Tuvalu and Viet Nam. A routine second dose of measles vaccine is now administered in 31 countries and areas. Supplemental immunization activities using tetanus toxoid for women of childbearing age were conducted in Cambodia and the Lao People’s Democratic Republic. Most countries combined multiple vaccines during their supplemental immunization activities and integrated other health initiatives such as vitamin A supplements and deworming tablets.

Surveillance for acute flaccid paralysis (AFP) and measles was strengthened through training, national reviews, financial support for operational costs, ongoing monitoring of surveillance performance and feedback through bulletins. However, surveillance performance still needs improvement. In 2010, out of 17 countries and areas (the Pacific island countries were considered as one epidemiologic block), nine achieved a non-polio AFP rate of at least 1 per 100 000 children under 15 years old, and seven achieved a discarded measles rate of at least
Measles Elimination in the Western Pacific Region

Before the licensing of measles vaccines in the 1960s, virtually every child was likely to be infected with measles. On average, 1 in every 100 infected infants died from the disease or its complications. Concerted efforts beginning in the 1990s to reduce measles mortality, and—following a resolution by the Regional Committee for the Western Pacific in 2003—to eliminate measles have had dramatic results.

WHO-recommended measles elimination strategies include high coverage with two doses of measles-containing vaccine, either through routine or supplementary immunization; high-quality, case-based measles surveillance; and an accredited and accessible laboratory network. In 1980, approximately 1.3 million cases of measles were reported in the Region, but the actual number of measles cases was undoubtedly many times greater. Thanks to successful implementation of these strategies by Member States, only 48,471 cases were reported in 2010, a 96% decrease over three decades.

The Region has been making extraordinary efforts to achieve its 2012 measles-elimination goal. China’s historic campaign in September 2010 reached over 102 million children, and the country has continued to target areas with residual measles virus transmission in 2011. Japan’s five-year plan to eliminate measles by 2012 is proceeding well: coverage with a second dose of measles vaccine at 5–7 years of age steadily increased to 97% by 2010 following its introduction in 2006, and annual immunization of successive 13- and 18-year-old cohorts continues to reduce transmission among adolescents and young adults. Large-scale immunization campaigns have been conducted recently in Papua New Guinea, the Philippines and Viet Nam. Cambodia will conduct a second campaign in October targeting older children and the Lao People’s Democratic Republic will conduct an intensified measles and rubella immunization.

Joint efforts between WHO and Member States are bringing the Region closer to its 2012 goal; projections for 2011 indicate that regional measles incidence will decrease by more than two thirds compared to 2010. China is on track to reach its measles incidence target of less than 10 cases per million population in 2011 and elimination by 2012. Ongoing implementation of Japan’s five-year measles elimination plan has reduced measles incidence to 5 per million in 2011 on an annual basis. In Papua New Guinea, no confirmed measles cases have been reported in 2010 or 2011. Viet Nam’s 2010 campaign reduced measles incidence to less than 2 per million in 2011 on an annual basis, with only 13 laboratory-confirmed cases. While the impact of the high-quality campaigns conducted in Cambodia and the Philippines remains to be seen, the very high coverage achieved in both countries suggest drastic reductions in measles incidence are likely.

The Region’s 2012 goal of measles elimination is within reach. Future generations may not thank us for eliminating a disease they never knew. That in itself will be our reward.
2 per 100,000 population. Adequate stool specimens were collected from at least 80% of AFP cases in five countries, and adequate serologic specimens were collected from at least 80% of measles cases in five countries. Supplementary polio surveillance activities included environmental surveillance in Australia, China and Malaysia, and stool surveys of healthy children in China and Mongolia.

Risk assessments for the spread of potentially imported wild poliovirus were conducted for all countries and areas, and wild poliovirus importation preparedness plans were updated in almost all Member States. District-level risk assessments for maternal and neonatal tetanus were conducted in China and the Lao People’s Democratic Republic to guide elimination strategies.

The Regional Certification Commission for Polio Eradication continued its active oversight of Member States and concluded at its 16th meeting that the Region remained free of circulating poliovirus in 2010. The Regional Hepatitis B Expert Resource Panel continued its work of verifying achievement of the hepatitis B control milestone and goal. Verification has been completed for the Republic of Korea and Macau (China), and the process has been initiated in Hong Kong (China), Malaysia and Mongolia. As of 2010, 27 countries and areas that represent 87% of the Region’s population have achieved immunization coverage levels consistent with achieving the 2012 milestone of chronic hepatitis B infection rates of less than 2% among 5 year olds.

All low-income countries and areas in the Western Pacific Region were providing Haemophilus influenzae type b (Hib) vaccine as part of their national immunization programmes. WHO assisted four Member States in applying to the GAVI Alliance for pneumococcal conjugate vaccine and second-dose measles vaccine. Surveillance for meningitis and encephalitis in Cambodia, Mongolia, Papua New Guinea, the Philippines and Viet Nam found that 12%–30% of cases had vaccine-preventable causes. This surveillance will allow countries to measure the impact of Hib and pneumococcal conjugate vaccination in the next few years and to carry out the planned expansion of Japanese encephalitis vaccine use in several countries. In collaboration with the WHO South-East Asia Regional Office, a Fifth Biregional Workshop on Japanese Encephalitis Prevention and Control was held in May 2011 to develop action plans to strengthen surveillance and vaccination programmes for Japanese encephalitis. WHO-supported surveillance for severe rotavirus diarrhoea in eight priority countries continued in 2010. Some 25%–65% of the diarrhoea cases requiring hospitalization in these countries were caused by rotavirus, indicating a potentially significant impact if the rotavirus vaccine were to be introduced. In 2010 and 2011, four middle-income countries introduced vaccination against human papillomavirus, providing adolescent girls with protection against the cause of 70% of cervical cancer cases. WHO also supported national decision-making for immunization programme policies and new vaccine introduction by conducting a Workshop on National Immunization Technical Advisory Groups.
WHO support for programme monitoring and vaccine-preventable disease surveillance included supportive and corrective feedback on the WHO/UNICEF Joint EPI Reporting Form; development of and training on data management tools for traditional and new vaccine surveillance; development of models for monitoring/assessing low performance at national and subnational levels and epidemiological risk for diseases like polio and measles; and continuous supportive and corrective feedback on surveillance data quality. Divisions and units within the WHO Regional Office collaborated to improve various aspects of vaccine-preventable disease surveillance. Surveillance sensitivity was enhanced by integrating vaccine-preventable disease surveillance with event-based surveillance training in collaboration with the Emerging Disease Surveillance and Response unit at the Regional Office. Monitoring and surveillance feedback to countries was increased by publishing data in collaboration with the Health Information, Evidence and Research unit. Furthermore, countries were provided an opportunity to publish research on vaccine-preventable diseases through the online Western Pacific Surveillance and Research journal.

Laboratory networks for poliomyelitis, measles and rubella, and Japanese encephalitis continued to provide timely and reliable laboratory confirmation and virus identification. All poliomyelitis network laboratories and almost all measles and rubella network laboratories in the Region were fully accredited in 2010. The polio laboratory network introduced a new algorithm protocol that will shorten the interval between specimen collection and virus isolation. Real-time polymerase chain reaction for intratypic differentiation and the screening of vaccine-derived polioviruses was successfully implemented by the laboratory network during 2010. The WHO measles regional reference laboratory in Hong Kong (China) provided genotyping results for Cambodia, the Lao People’s Democratic Republic, Malaysia, Mongolia, the Philippines and Viet Nam. Regional capacity to conduct measles genotyping was enhanced after conducting two hands-on laboratory training sessions for measles network laboratories in November 2010.

The Japanese encephalitis laboratory network, established in 2008, continued to provide laboratory confirmation and implement quality assurance measures, such as proficiency and confirmatory testing. Following the polio and measles laboratory model, WHO accreditation of Japanese encephalitis laboratories using the WHO checklist has been in place since 2010. A second intercountry hands-on training workshop was held in Hong Kong (China) in November 2010 to further improve quality assurance of laboratory diagnosis for all network laboratories. Similarly, regional laboratory networks to support rotavirus and vaccine-preventable invasive bacterial diseases (VP-IBD) surveillance were formally established in September 2010 and measures to monitor quality assurance were introduced. In March 2011, the first regional laboratory training course on VP-IBD pathogens was held and an external quality assessment panel for rotavirus and bacterial meningal pathogens was distributed to regional reference laboratories.

The Second Meeting on Vaccine Preventable Diseases Laboratory Networks for polio, measles and rubella, and Japan encephalitis was organized in Manila in February 2010 to review the performance and identify challenges of network laboratories, and to identify ways to improve the quality of their performance. For all network laboratories, strengthening communications between network laboratories and immunization surveillance programmes was emphasized.

**Future directions**

WHO will continue to work with national counterparts to build capacity at the country level to improve immunization performance, describe and respond to epidemiological risk of vaccine-preventable diseases, and enhance synergies between immunization and other health programmes. WHO will support Member States in strengthening their routine immunization systems and in achieving global and regional disease eradication, elimination and control goals as well as Millennium Development Goals and goals contained within the Global Immunization Vision and Strategy. External certification and
verification commissions and expert resource panels will be used increasingly to monitor and validate progress towards global and regional immunization goals, and to provide added technical support for Member States. Introduction of pneumococcal and rotavirus vaccines and the prevention of measles infection will help decrease the burden of pneumonia and diarrhoea, moving the Region towards success in implementing the joint WHO/UNICEF Regional Child Survival Strategy.

As WHO works to realize the synergies of mutually reinforcing strategies and cross-programme collaboration, it must also address challenges in human and financial resources. Partnerships among governments, multilateral and nongovernmental organizations are critical. The Global Polio Eradication Initiative, the Measles Initiative, and the GAVI Alliance, among others, are key partnerships through which WHO will continue to support Member States to achieve global and regional goals.
Malaria

Strategic issues

Remarkable progress has been made in reducing the malaria burden in 10 endemic countries in the Western Pacific Region, with a few steadily progressing towards elimination. Levels of external funding for malaria programmes in the Region have been unprecedented, and good accountability to donors has been demonstrated with all countries moving to the next phase of donor funding. Nonetheless, daunting challenges remain. Overall, weak health systems have limited advancements. Effective mechanisms to reach the most vulnerable population groups—pregnant women, children, ethnic minority groups and mobile populations—have yet to be finalized. Some countries have yet to adapt regional frameworks to country situations. Collaboration with other programmes and coordination between the formal and informal private health sectors have to be strengthened. And even though the battle against artemisinin-resistant falciparum malaria along the Cambodian-Thai border appears to have been successful, the possible emergence of artemisinin-resistant malaria in neighbouring countries and the proliferation of counterfeit and substandard drugs have become major concerns. Deficiency of the glucose-6-phosphate dehydrogenase (G6PD) enzyme remains a major obstacle to the effective cure of vivax malaria in many countries in the Region. While access to malaria diagnostic testing and treatment, as well as malaria prevention using insecticide-treated mosquito nets, has increased in most countries, universal access still has not been achieved. Eight out of 10 malaria-endemic countries in the Region have changed their national goals from malaria control to elimination, with Cambodia and Viet Nam as the most recent countries to do so in 2011.

Action and results

WHO was instrumental in providing technical cooperation to the 10 malaria-endemic countries in the Western Pacific Region. Areas of support included developing and updating tools, tracking progress and documenting and disseminating information, conducting research and articulating evidence for decision-making. Based on the Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015), which was endorsed by the WHO Regional Committee for the Western Pacific in 2009, national malaria strategies have been updated in seven countries. Furthermore, the draft Biregional Malaria Indicator Framework has informed the development and updating of national surveillance and monitoring and evaluation plans in Cambodia, China, the Lao People’s Democratic Republic and Viet Nam. WHO is collaborating with Member States and development partners to build country programme capacity in surveillance and monitoring and evaluation.

WHO successfully supported Member States in mobilizing resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other donors for use in national malaria programmes. The Global Fund has committed US$ 854 million in six of the 10 malaria-endemic countries. Despite this level of funding, additional resources will be needed to sustain current efforts.

WHO led a major initiative along the Cambodian-Thai border to contain and eliminate artemisinin-resistant falciparum malaria parasites, with excellent support from national and local authorities. Efforts were
supported by funds from the Bill & Melinda Gates Foundation, the United States Agency for International Development and other partners in Cambodia. Recent funding from the Global Fund will sustain these efforts for another five years. Data show that falciparum malaria in the epicentre of the problem area, known as Containment Zone 1, has been significantly reduced. However, further foci of suspected artemisinin resistance have been detected along the China-Myanmar border and the Thailand-Myanmar and Thailand-Viet Nam borders. Efforts, including resource mobilization, were intensified to support containment operations in those areas and at the regional level.

Further efforts to prevent development of artemisinin resistance included engaging the private sector in malaria diagnosis and treatment, especially in Cambodia and the Lao People’s Democratic Republic. In Cambodia, a national policy pertaining to private-sector malaria diagnosis and treatment has been implemented, a ban on the marketing of oral artemisinin monotherapy has been issued by the Ministry of Health, and initiatives involving collaboration with Interpol to combat counterfeit medicines have been intensified. An initiative to improve access to

Village workers team with technology to fight malaria

At just 21 years of age, Chou Khea is on the frontlines of Cambodia’s battle against falciparum malaria, one of the most dangerous of all malaria infections. As a village malaria worker in remote Ou Nonoung village in western Cambodia’s Ta Sanh district, she was trained as part of the Containment Project, with support from WHO and other partners.

Khea and her fellow village malaria workers prepare blood slides from those who test positive for falciparum malaria in rapid diagnostic tests and ensure that they take their medicine. The proportion of patients who still carry malaria parasites on the third day of treatment, so-called Day 3 positives, is currently the best measure of effective treatment and serves as a warning system for confirmation of resistance to artemisinin, the preferred treatment for falciparum malaria.

“Immediately after a villager tests positive for falciparum malaria in a rapid diagnostic test, I prepare the blood slides,” says Khea. “Then I give the drugs, which the villager has to take in front of me.”

“On Day 2 and Day 3, I go to the houses of villagers and make sure that the drugs are again taken while I watch,” she says. “After 72 hours from the first intake of the antimalarial drugs, I’ll be at the villager’s house again to take his or her blood sample for preparing another blood slide.”

She then takes the Day Zero and Day 3 slides, together with the used rapid diagnostic test, to the Ta Sanh Health Centre, 30 kilometres away. At the centre, the Day 3 slides are examined by microscope for asexual malaria parasites, which confirm a positive result. The microscopist immediately sends out a text message on a mobile phone to a database indicating the village code and the sex of the patient.

This mobile phone alert system and associated web-based technology help pinpoint potential outbreaks of the vectorborne disease and allow public health officials to target interventions to spots where mosquito parasite reservoirs are likely present.

The Containment Project pioneered the use of this alert system in Ta Sanh, with support from Cambodia’s National Centre for Parasitology, Entomology and Malaria Control in partnership with the Malaria Consortium.

The use of text message alerts and the mapping of Day 3 positives in real-time on Google Earth using open-source software enables groups of health workers to share information and react quickly. In essence, this system turns a mobile phone and a laptop into a central communications hub that interfaces with a database, which automatically provides validation on the data received.

A script in the database interfaces with Google Earth to map the locations of the Day 3 positives based on village codes, providing a clear visualization of the terrain that helps the National Centre for Parasitology, Entomology and Malaria Control, WHO and other partners plan coordinated interventions, follow up on cases, and carry out epidemiological and entomological investigations.

This joint effort is making a real difference in the fight against falciparum malaria in Cambodia and is providing a model for how local health workers can be supported with the latest technology to serve even the most remote communities.
malaria diagnosis and treatment to mobile and migrant populations has been launched in Cambodia.

Efforts to improve malaria diagnosis in the Region have continued in collaboration with WHO Headquarters and the Foundation for Innovative New Diagnostics. Two regional laboratories in Cambodia and the Philippines now conduct quality testing of malaria rapid diagnostic tests. Significant progress was made in improving quality assurance of malaria microscopy, including expansion of the regional slide bank, production and dissemination of manuals on quality assurance, and implementation of microscopy training as well as implementation of the WHO external competency assessment of the microscopists programme in the majority of malaria endemic countries, in collaboration with the Australian Army Malaria Institute, a WHO Collaborating Centre. Work to improve the treatment of vivax malaria has progressed, with assessments being carried out in five countries, a trial under way to assess primaquine sensitivity in people with G6PD deficiency in preparation.

An informal consultation on non-malaria febrile illnesses was held in Vientiane, Lao People’s Democratic Republic, in January 2011 to review the results of research in Cambodia and the Lao People’s Democratic Republic and to determine the causes and the best treatment strategies. Another consultation was convened in Kuching, Malaysia, in February 2011 to review the public health implications of Plasmodium knowlesi, a monkey malaria parasite that can cause malaria in humans, and develop recommendations for a public health response. A project proposal was submitted to the Global Environmental Facility in collaboration with WHO’s environmental health programme to support the phasing out of DDT in five countries: Papua New Guinea, the Philippines, Solomon Islands, Vanuatu and Viet Nam.

Future directions

The Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015) will continue to serve as the road map for malaria-endemic countries in the Region, and WHO will support Member States in the adaptation and implementation and the monitoring of progress. WHO will also support national programme reviews in Cambodia and Papua New Guinea, the stepping up of malaria elimination efforts throughout the Region with emphasis on China, Malaysia and the Republic of Korea, the intensification of the monitoring of antimalarial drug efficacy throughout the Region, including through the launch of a Pacific Malaria Drug Resistance Network, and the detection and elimination of artemisinin-resistant malaria parasites throughout the Region. Countries such as Papua New Guinea, Solomon Islands and Vanuatu are being supported to move to the next phase of funding from the Global Fund.

High priority will be placed on improving the national quality assurance of microscopy through support for strengthening of national quality assurance systems including external competency assessments and good procurement practices. WHO will collaborate with other programmes to facilitate health systems strengthening, using malaria resources in routine surveillance, quality-assured laboratory diagnosis and community human resources for health. Relevant operational research will continue to fill in programmatic gaps, especially in improving access to malaria treatment and prevention for migrant and mobile populations and the radical treatment of vivax malaria. WHO will also step up efforts to document and disseminate successes and lessons learnt throughout the Region.
**Dengue**

**Strategic issues**

Dengue emerged as a serious public health problem in the Region in the last two to three decades. As a consequence of unplanned urban growth, inadequate clean water supplies and increased human mobility between urban and rural settings, dengue has spread to new geographic areas and the frequency of dengue outbreaks has increased. Many countries find their capacity to respond to outbreaks is severely constrained by limited infrastructure and a lack of human and financial resources. To prevent dengue, its mosquito vector *Aedes* must be denied access to water containers and other potential breeding grounds. This requires careful local planning, blanket coverage of interventions and conscientious execution with community involvement to have a sustained effect.

**Action and results**

Since 2010, dengue prevention and control has been placed under the umbrella of the Asia Pacific Strategy for Emerging Diseases, or APSED (2010), to foster sustainability and integration. The areas of work specified in the Dengue Strategic Plan for the Asia Pacific Region (2008–2015) have been shared within WHO between the Emerging Disease Surveillance and Response unit, which is now responsible for surveillance, outbreak response and case management, and the Malaria, other Vectorborne and Parasitic Diseases unit, which now focuses its efforts on vector control and community mobilization to prevent and reduce the impact of outbreaks. Innovative collaboration between the two units is essential to the success of WHO’s technical support programme in dengue.

Vector control is the basis for dengue transmission control and should be applied using the key principles of integrated vector management, including: advocacy; social mobilization; legislation; public health policies to promote basic sanitation and hygienic environments for households and communities; collaboration within the health and other sectors; integrated multi-disease approaches; evidence-based decision-making; and capacity-building. WHO in collaboration with ACTMalaria organized a training course on integrated vector management in Manila in October 2010, for entomologists in the Region. WHO also joined forces with the Singapore National Environment Agency in holding the Second Asia Pacific Dengue Workshop in Singapore in August 2011 to strengthen dengue surveillance and control.

WHO provided technical support to a two-year dengue project in Cambodia and the Lao People’s Democratic Republic, funded by the Asian Development Bank. The pilot project supports community-based dengue prevention by combining biological mosquito control interventions (introduction of guppy fish to household water containers) and traditional source reduction methods (physical removal of breeding sites), along with a strong behaviour-change component. A midterm review showed that the project has been taken up enthusiastically by the involved communities and that vector density was reduced by over 75% in the intervention areas over the first six months of the trial. This project is expected to contribute to the development of more sustainable evidence-based dengue vector control strategies.

A video produced for dengue advocacy was launched during the sixty-first session of the WHO Regional Committee for the Western Pacific in 2010. WHO also supported ASEAN Dengue Day on 15 June 2011 to raise public awareness of the risks of dengue in the Region.

**Future directions**

Continued advocacy, strengthened commitment and resource mobilization are required for dengue prevention and control. Sustainable and community-based vector control with strong partnerships at different levels is needed. Integrated vector management offers the opportunity of multi-disease approaches, but further capacity-building and support for development of national integrated vector management plans will be required. Integrated vector management includes the rational use of public health insecticides for vector control, intensified vector surveillance, and the monitoring of insecticide resistance, which is a serious threat to dengue vector control in the Region.
Neglected tropical diseases

Elimination of lymphatic filariasis as a public health problem in the Western Pacific Region has progressed steadily. Several Asian countries, including Cambodia, Malaysia, Viet Nam and many parts of the Philippines, have completed five rounds of mass drug administration (MDA) and are now conducting post-MDA surveillance surveys; preliminary reports show remarkable progress towards elimination of the disease from these countries. In the Pacific, Cook Islands, Niue, Tonga and Vanuatu are carrying out post-MDA surveillance, while seven countries and areas are still implementing additional rounds of nationwide MDA and five are conducting surveys to confirm their infection status. In order to maximize resources, lymphatic filariasis elimination activities will be conducted jointly with leprosy elimination activities in Kiribati, the Marshall Islands and the Federated States of Micronesia—the three countries in the Region where leprosy has yet to be eliminated as a public health problem.

Yaws is endemic in at least three Pacific island countries—Papua New Guinea, Solomon Islands and Vanuatu, affecting particularly poor populations in remote areas. Mass treatment campaigns in the 1950s reduced yaws dramatically, but the disease has since resurged due to initially incomplete intervention coverage. In Vanuatu, the last mass treatment campaign against yaws, which was conducted in one province in 2001, reached 92% coverage; however, its longer-term effect remains unknown. In 2008, a seroprevalence survey in another province showed 17% prevalence, warranting a new mass treatment campaign. Vanuatu has recently developed a detailed national plan of action towards intensified control and elimination of yaws. The prevalence of clinical yaws across provinces is being assessed in conjunction with a countrywide malaria indicator survey conducted in 2011, which will inform the way forward in terms of targeting new mass treatment campaigns and enhancing routine surveillance. For Solomon Islands and Papua New Guinea, an assessment of the current situation is required.

Regarding soil-transmitted helminths, deworming programmes in Cambodia, Kiribati, the Lao People’s Democratic Republic and Tuvalu sustained treatment coverage rates of 75% among primary schoolchildren. The Philippines and Viet Nam reached approximately 50% of primary schoolchildren. Most Pacific island countries have implemented mass drug administration for lymphatic filariasis. Over a decade of mass drug administration based on the use of two drugs, one of which is albendazole, is expected to have had an impact on soil-transmitted helminths, especially in the Pacific island countries.

A Regional Programme Managers Meeting on Lymphatic Filariasis and other Selected Neglected Tropical Diseases took place in Nadi, Fiji, in May 2011. It brought together national programme managers of 24 countries and areas. Valuable data were provided, progress of neglected tropical diseases programmes was reviewed, national action plans were finalized, and feasibility of synergies with other programmes were discussed, for example lymphatic filariasis and malaria in Papua New Guinea.

Limited funding for scaling up mass deworming of high-risk population groups continues to impede progress in the control and elimination of neglected tropical diseases in the Region. However, an increasing number of organizations and donors are showing interest and beginning to invest in neglected tropical diseases. One of these organizations is currently supporting a WHO staff member in the Region and has offered to share funding for a second post. The United States Agency for International Development is supporting operations at the country level. WHO continues to work closely with countries and partners to advocate on behalf of neglected tropical diseases, exchange information, network and mobilize resources.
Multi-disease, intersectoral actions

In line with its multi-disease approach, WHO has taken steps to integrate malaria and dengue control with other programmes. A climate change and vectorborne diseases project, which is being conducted in Cambodia, Mongolia and Papua New Guinea with funding from the Korea International Cooperation Agency, has fostered cooperation with the WHO environmental health and emerging diseases surveillance programmes and has provided an excellent opportunity to bring this objective forward in a strategic manner. The project is expected to contribute to health systems strengthening and to minimize the consequences of vectorborne diseases for populations in areas that are prone to climate change.

WHO has developed an intersectoral, multi-disease strategy to address neglected tropical diseases in a sustainable way. Informal consultations and discussions with leading experts in different sectors were organized to determine the feasibility and cost-effectiveness or cost savings of such interventions. Proposals will be developed and submitted to bilateral agencies beyond the health sector, thus placing neglected tropical diseases under a sustainable development or poverty reduction agenda while accessing new funding opportunities.

Research on infectious diseases of poverty

Significant knowledge and programmatic gaps still exist on the prevention and control of infectious diseases of poverty, which include dengue, HIV/AIDS, neglected tropical diseases, malaria, sexually transmitted infections and tuberculosis. Individual and institutional research capacity is a key issue that cuts across these diseases. A regional research strategy that addresses all of these diseases is needed to effectively tackle the gaps.

The Regional Office for the Western Pacific has been working closely with the WHO Special Programme for Research and Training in Tropical Diseases Research (TDR) to promote research on infectious diseases of poverty. WHO developed a Regional Research Plan of Action on Infectious Diseases of Poverty through a series of consultations with TDR, research networks and researchers in and beyond the Region. The plan highlights regional strategies to promote research capacity-building, tools and strategies development, and introduction of novel approaches to fill the programmatic gaps for the prevention and control of infectious diseases of poverty. As part of the plan, WHO and TDR jointly supported various activities of regional research networks such as the Regional Network for Asian Schistosomiasis and other Helminth Zoonosis (RNAS+) and ASEAN Network for Drugs, Diagnostics and Vaccines Innovation.

WHO continued to support innovative research through the WHO Joint Small Grants Programme for Operational Research in Communicable Diseases. Four research projects from the Lao People’s Democratic Republic, Papua New Guinea and the Philippines were funded in 2010. WHO also conducted a proposal writing workshop on infectious diseases of poverty, including tuberculosis, which targeted research institutions and disease control programme staff.
HIV/AIDS and Sexually Transmitted Infections

Strategic issues

In the Western Pacific Region, the HIV situation has stabilized. The overall prevalence in a majority of countries remains well below 1%, but the number of people living with HIV increased from 680 000 in 2001 to 1 300 000 in 2009, according to 2010 estimates prepared by the Joint United Nations Programme on HIV/AIDS.

Around 90% of HIV infections in the Region were concentrated in five countries—Cambodia, China, Malaysia, Papua New Guinea and Viet Nam. Only Papua New Guinea has a generalized HIV epidemic. In the majority of countries, the HIV epidemic is primarily driven by most-at-risk populations, including men who have sex with men, sex workers and people who inject drugs.

Sexually transmitted infections (STI) are an important risk factor in HIV transmission. Prevalence of STI varies across the Region, with high rates reported in Mongolia and Pacific island countries. Overall, however, data are lacking.

Scaling up health sector interventions to achieve universal access for the prevention, treatment, care and support of HIV/AIDS has been rapid in the Region. However, the goal of universal access (80% coverage and uptake) remained unachievable in 2010. Reported condom use by sex workers is more than 80% in most countries, though data are limited to establishment-based sex workers. Interventions for men who have sex with men are increasingly available, but far beyond sufficient, giving rise to the rapid spread of HIV among this population in some countries.

Harm reduction interventions for people who inject drugs reached 40% as of 2009.

The number of people receiving antiretroviral treatment (ART) jumped to around 160 000 as of December 2009. In that year alone, about 38 000 people started HIV treatment, a 31% increase over the previous year. However, overall, only 33% of those in the Region who needed ART were receiving it. Paediatric ART coverage was significantly better. Sixty-one percent of children in need—about 8300 children younger than 15 years old—were receiving ART in 2009. The number of pregnant women living with HIV who received ART for preventing mother-to-child transmission was 4300 in 2009, which accounted for 32% of the estimated number who needed HIV treatment.

Action and results

The World Health Assembly in May 2011 endorsed the Global Health Sector Strategy for HIV (2011–2015). A joint workplan is being developed with UNAIDS Regional Support Team for Asia and the Pacific, in order to maximize the harmonization of technical support to countries, in line with the new global strategy.

Countries were supported to adapt and implement the new WHO 2010 guidelines on antiretroviral treatment for HIV infection in adults and adolescents as well as in infants and children and on antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Four of the five countries with a high burden of HIV have revised their national ART guidelines based on the WHO recommendations. Treatment 2.0, an initiative launched by UNAIDS and WHO in November 2010 to optimize drug regimens, simplify laboratory platforms for diagnosis and monitoring, reduce costs, adapt delivery systems, and mobilize communities, is being piloted in China and Viet Nam.

Together with United Nations partners, the 8th Asia Pacific United Nations Prevention
of Parents-to-Child Transmission Task Force Meeting was held in November 2010 in the Lao People’s Democratic Republic. This meeting endorsed the development of a biregional framework for the elimination of paediatric HIV and congenital syphilis in Asia and the Pacific. This framework provides guidance for countries to develop their national plans and targets for the elimination of paediatric HIV and congenital syphilis. Countries were supported technically to move forward with this elimination initiative. A joint mission to Viet Nam to review the prevention of mother-to-child transmission programme was conducted to accelerate effective responses to eliminate paediatric HIV and congenital syphilis.

WHO organized a Global Consultation on the Development of Guidance for the Prevention and Treatment of HIV and other Sexually Transmitted Infections among Men who have Sex with Men and Transgender People in September 2010 in China. The guidelines will provide a comprehensive framework for action for these two population groups. A case study supported by WHO was developed on the health sector response to HIV among men who have sex with men in China.

Because of the evolving nature and context of sex work, evidence has been compiled on current targeted interventions for sex workers in Cambodia, China, Mongolia and Viet Nam. This evidence has informed the development of a regional guidance document on priority health sector interventions to address the changing environment and needs of sex workers.

After the publication of the Regional Strategy for Harm Reduction in Asia and the Pacific (2010–2015) in July 2010, countries were supported to implement the strategy. In Malaysia, the Government has shifted from detention centre-based drug education to community-based harm reduction for people who inject drugs. A joint publication of WHO and the Ministry of Health highlights this best practice.

A midterm review of the Regional Strategic Plan for the Prevention and Control of Sexually Transmitted Infections (2008–2012) was organized in October 2010 in Mongolia. Progress in STI control was reviewed and three priority areas were identified, namely, STI surveillance, elimination of congenital syphilis and repackaging of targeted interventions for sex workers. Progress was made in integrating syphilis surveillance into HIV surveillance, and in integrating the elimination of congenital syphilis into the elimination of paediatric HIV initiative. In addition, WHO continued to support the gonococcal antimicrobial surveillance programme to monitor the increasing threat of resistance to extended-spectrum cephalosporin.

Capacity-building for strategic information for HIV/AIDS and STI has been continuously supported and improved at the national level, particularly on behavioural surveillance, monitoring health sector responses, surveillance and monitoring of HIV drug resistance. Fifteen countries reported on health sector progress towards universal access, nine countries maintained integrated HIV surveillance systems and four countries maintained HIV drug resistance surveillance following WHO technical recommendations. A systematic review of the HIV drug resistance assessment in the Western Pacific Region has been published in a peer-reviewed journal.

Operational research finalized over the last year included a validation study on HIV testing algorithms in Pacific island countries and a cost-effectiveness analysis of linking HIV services with sexual and reproductive health services. WHO provided technical and financial support to the Philippines to conduct an HIV outbreak survey among people who inject drugs.

WHO continued to guide and technically support the WHO Network for HIV and Health, with 20 members from WHO collaborating centres and technical partners. The network has been consistently providing Member States with quality technical support.

Future directions

Responding to evolving epidemics, changing political and financial environments, and increasing evidence on the effectiveness of HIV interventions and approaches, WHO will continuously support Member States to implement the regional HIV health sector action plan based on the Global Health Sector Strategy for HIV (2011–2015). WHO will support countries to scale up cost-effective prevention, treatment, care and support strategies, to increase links with other programmes such as maternal and child health and sexual and reproductive health, to promote greater efficiencies, to build strong and sustainable systems, and to reduce vulnerabilities and increase community involvement.

WHO has identified the following priorities: ensure universal access to antiretroviral treatment and availability of effective ART; support the elimination of new paediatric HIV infections and congenital syphilis; ensure provision of comprehensive health services for most-at-risk populations and people who are affected and infected with a continuum of services; link HIV services with STI, tuberculosis and sexual reproductive health services including maternal and child health; and strengthen strategic information for evidence-based HIV programming.
**Stop TB and Leprosy Elimination**

### Tuberculosis

#### Strategic issues

Significant progress has been made in tuberculosis (TB) control in the Western Pacific Region in the past decade. The number of prevalent TB patients fell from 3.6 million in 2000 to 2 million in 2008. During the same period, more than 10 million patients were diagnosed and treated and an estimated 800,000 deaths were averted. According to the latest WHO estimates, the Western Pacific Region is likely to achieve the Millennium Development Goals (MDGs) relevant to TB, due in large part to the successful expansion of directly observed treatment, short-course (DOTS).

Despite these successes, TB control programmes in the Region face significant challenges. The TB epidemic tends to concentrate in vulnerable and marginalized populations that are difficult to reach and often have limited access to health care. Further exacerbating the situation are increases in the TB-HIV co-infection and the emergence and spread of drug-resistant TB, particularly multidrug-resistant TB (MDR-TB). In fact, the Region reports 120,000 incident MDR-TB cases annually—28% of the world’s MDR-TB burden. At present, however, existing laboratory capacity and overall TB programme management are insufficient for early TB diagnosis and for an effective response to MDR-TB and TB-HIV co-infection.

#### Action and results

In order to address these strategic issues, the Regional Strategy to Stop Tuberculosis in the Western Pacific (2011–2015) was developed in consultation with Member States and endorsed by sixty-first session of the Regional Committee in 2010. The new Strategy builds upon the previous two regional strategic plans and introduces new, evidence-based interventions and technologies in response to the new and emerging challenges. The Strategy provides a reference for action to be taken, focusing on five core objectives: (1) promoting universal and equitable access to quality TB diagnosis and treatment for all people; (2) strengthening TB laboratory capacity; (3) scaling up programmatic management of drug-resistant TB; (4) expanding TB/HIV collaborative activities; and (5) strengthening TB programme management capacity.

**Universal and equitable access to quality TB diagnosis and treatment.** Since TB disproportionately affects the poorest and most marginalized populations, such as migrants and prisoners, TB control strategies need to target these vulnerable groups in order to increase the impact of TB programmes. To this end, WHO, national TB programmes and the International Organization for Migration embarked on a project to provide systematic TB services to repatriated migrants in two border provinces in Cambodia that are tailored to their specific situation. Further to this, WHO began conducting health assessments in prisons in various countries with a high burden of TB. In 2010, a health assessment was conducted in prisons in Mongolia. The exercise revealed significant progress in TB control and has provided useful insight for other countries that are targeting this high-risk group.
**Strengthening TB laboratory capacity.** In 2010, WHO endorsed a revolutionary new TB diagnostic test that will make it possible to decentralize the diagnosis of drug-resistant TB, to reduce the turn-around time of MDR-TB diagnosis from months to hours, to increase the sensitivity of TB diagnosis compared to conventional methods, and to share equipment and technicians with other disease programmes. In order to accommodate new diagnostic tools, however, countries need technical support to develop appropriate diagnostic algorithms. In anticipation of these needs, WHO held a consultation meeting with the Supra-National Reference Laboratories (SRLs) in the Philippines to discuss the approach. Two regional laboratory workshops, attended by seven countries with a high burden of TB, were then held at the Research Institute of Tuberculosis in Japan in August 2010 and at the Korean Institute of Tuberculosis in February 2011, and were facilitated by the SRLs and the Global Laboratory Initiative.

**Scaling up programmatic management of drug-resistant TB (PMDT).** WHO implemented a variety of activities to support countries to start and expand PMDT efforts with access to quality MDR-TB drugs through the global Green Light Committee (GLC) mechanism. WHO coordinated and participated in several GLC country reviews, facilitated MDR-TB training in Cambodia, organized a regional workshop on MDR-TB recording and reporting, assisted Papua New Guinea in preparing a GLC application, and helped the Lao People’s Democratic Republic to receive GLC approval for the first time. In addition, WHO contributed to international normative guidance and policy development, through its participation in key global committees, thus ensuring input from the Western Pacific Region into global WHO guidelines and donor initiatives. More recently, WHO assisted Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam in aligning MDR-TB diagnostic and treatment capacities and planning PMDT scale-up. This is crucial to ensure access to adequate treatment for all identified MDR-TB patients.

**Expanding TB/HIV collaborative activities.** To coordinate the scale-up of the TB/HIV response, WHO published *A Revised Framework to Address TB-HIV Co-infection in the Western Pacific Region* (2008), which emphasizes early diagnosis and recommends that HIV tests and TB screening be provided at TB and HIV clinics, respectively. Since then, progress has been observed in countries such as Cambodia, the Lao People’s Democratic Republic and Viet Nam. Especially in Cambodia, HIV testing coverage among TB patients increased from 13% in 2006 to 70% in 2009. In addition, Cambodia took the lead in implementing the Three I’s (i.e. infection control in health facilities, intensified TB case finding and isoniazid preventive therapy among people living with HIV), a key public health strategy to decrease the impact of TB on people living with HIV. Infection control inventory missions conducted by WHO in 2010 will also support these positive developments in TB/HIV activities.

**Strengthening TB programme management capacity.** Countries often have insufficient capacity to acquire and manage donor grants, and to implement new and complicated programme operations. In response, WHO continued to assist countries to develop adequate human resource development strategies and to improve monitoring and evaluation systems. WHO also provided guidance on advocacy, communication and social mobilization plans, and assisted countries in developing comprehensive national technical assistance plans and coordinating timely and quality technical support. To improve the quality of TB surveillance systems in Member States and obtain reliable information on the disease burden, WHO organized a Regional Workshop on TB Surveillance and Impact Monitoring in the Western Pacific in June 2010. Country data, which were extensively analysed during the meeting, have since been used for the global estimation of TB disease burden. In 2010, WHO provided technical support to three countries in the Region, namely, Cambodia, China and the Lao People’s Democratic Republic, to conduct TB prevalence surveys. Epidemiological evidence extracted from these surveys will reveal the programmatic impact of the TB control strategy in the last decade.
Future directions

Moving forward, innovative, country-specific approaches to TB care are needed to break the cycle of TB transmission and eliminate TB as a public health problem. In this spirit, WHO will continue working with and providing support to Member States as they implement the new Regional Strategy. Notably, WHO will focus its efforts on the introduction of more sensitive diagnostic algorithms and targeted active case finding among high-risk populations, including people suffering from noncommunicable diseases such as diabetes. Increased attention will also be given to childhood TB, particularly through the systematic implementation of contact investigation. In addition, WHO will tailor country-specific technical support to help national TB programmes develop urgently needed laboratory scale-up plans and will pilot MDR-TB interventions and address related human resources needs.

WHO will also provide increased support for operational research (and country capacity-building to conduct research) that assesses barriers to TB control as well as the feasibility and cost-effectiveness of actions to address these barriers. In December 2010, WHO launched the Western Pacific TB Operational Research Grant, which will annually request research proposals from countries for funding.

Leprosy

Strategic directions

Leprosy or Hansen’s disease is an ancient infectious disease responsible for tremendous suffering, disability and stigma. A critical milestone, agreed upon by the Forty-fourth World Health Assembly in 1991, was the resolution to eliminate leprosy as a public health problem by the year 2000, defined as a prevalence rate of less than 1 case per 10 000 population.

While elimination was achieved in the Western Pacific Region as a whole in 1991, three countries have not yet achieved the goal, namely Kiribati, the Marshall Islands and the Federated States of Micronesia. American Samoa, Nauru and Palau have been reporting prevalence above the elimination threshold with fewer than 10 cases annually, and in Papua New Guinea, the leprosy prevalence is just below the threshold. Meanwhile, China and the Philippines still report more than 1000 new cases every year. According to the latest estimates for 2009, 5367 new cases were reported in the Western Pacific Region, with a case detection rate of 0.3 per 100 000 population.

Action and results

WHO continued to support countries in implementing the Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy (2011–2015). Several joint missions and workshops were conducted by WHO in Pacific island countries and in Papua New Guinea. However, in order to achieve and sustain elimination in all countries, the Regional Director, during the sixty-first session of the Regional Committee in Malaysia in October 2010, committed to significantly scaling up leprosy activities, particularly in those countries that have not yet achieved elimination. As a result, the Action Framework for Leprosy Control and Elimination was launched during the meeting of the Pacific Island Health Officers Association in April 2011 in Palau. As an initial step, a technical assistance mission was conducted in the three targeted Pacific island countries in March and April 2011, which resulted in a detailed elimination plan.

Despite the progress made in sustaining elimination in the Region, the need to maintain quality leprosy services is paramount. Efforts are being made to facilitate the integration of leprosy services into general health services and to intensify case detection through systematic contact tracing and mass screening in high-prevalence areas. Comprehensive, accessible leprosy services need to be provided not only for newly detected cases, but also for previously diagnosed and treated patients. A considerable number of cured patients with disabilities rely on rehabilitative services.

Future directions

In the coming years, WHO will support not only the three countries and areas that have not yet reached leprosy elimination, but also those countries reporting a substantial number of new annual cases of leprosy through workshops, training and monitoring missions. In the Pacific region, WHO will continue to closely collaborate with technical partners such as the Pacific Leprosy Foundation, the United States National Hansen’s Disease Program and the United States Centers for Disease Control and Prevention.
The new Division of Health Security and Emergencies works towards ensuring public health security in the Western Pacific Region through a collective approach for preparedness planning, prevention, early detection and rapid response to emerging diseases, acute public health events and emergencies. The Division is comprised of three units: Emerging Disease Surveillance and Response; Emergency and Humanitarian Action; and Food Safety.

In line with the International Health Regulations, or IHR (2005), the updated Asia Pacific Strategy for Emerging Diseases, the draft Western Pacific Regional Food Safety Strategy (2011–2015) and other relevant policy frameworks, the Division supports countries and areas in strengthening their systems and capacities for preventing, detecting and managing public health threats arising from emerging infectious diseases, food safety hazards, disasters and emergencies. Meanwhile, the Division also works to improve the regional preparedness, alert and response system with the participation of Member States and through existing networks such as the Global Outbreak Alert and Response Network and the Regional Clinical Network on Emerging Infectious Diseases.

Preparing for and responding to health security threats—in order to mitigate their negative impact on health, socioeconomic development and political stability—depends on active participation by all countries and areas in the Region and regional partners in both the public and private sectors. Health security threats do not observe international borders. As such, a functional regional surveillance and response system benefits all.

The Division was established in July 2010. Since then, it has directed the development of two critical regional strategies—the updated Asia Pacific Strategy for Emerging Diseases, or APSED (2010), and the draft Western Pacific Regional Food Safety Strategy (2011–2015)—to better guide countries and areas in the Western Pacific Region. Building on the foundation of the original APSED, the Division developed a common approach to surveillance, information sharing, risk assessment and response for emerging diseases and other public health emergencies. Moving forward,
APSED (2010) continues to focus on emerging diseases but has widened its scope to include other acute public health threats such as food safety events, disasters and emergencies. The launch in 2010 of *Western Pacific Surveillance and Response (WPSAR)*, a journal dedicated to the surveillance of and response to public health events in the Western Pacific Region, marked a significant development in the strengthening of regional information sharing for public health action.

The unanimous endorsement of APSED (2010) by the Regional Committee for the Western Pacific in October 2010 marked a historic moment in the battle against emerging disease challenges. Implementation of this strategy in a timely, effective manner is paramount, given the uncertainty of emerging diseases, the dynamic nature of disease trends, and the complexity of factors contributing to disease emergence. The Emerging Disease Surveillance and Response unit, working with the two other units within the Division and the country offices, has coordinated the development a draft five-year workplan for implementing APSED (2010). The draft workplan will be presented to the Sixth Meeting of the Asia Pacific Technical Advisory Group on Emerging Infectious Diseases for review and finalization in July 2011.

The central focus of the Food Safety unit over the past year has been the development of the *Western Pacific Regional Food Safety Strategy (2011–2015)*. The draft strategy, which focuses on the strengthening of national food control systems, will be submitted to the Regional Committee for consideration of endorsement in October 2011. The Food Safety unit is working with the Emerging Disease Surveillance and Response unit to identify and strengthen common elements between the two programmes, including surveillance of priority foodborne diseases, event detection, reporting and sharing information on food safety incidents and emergencies through the International Food Safety Authorities Network and IHR communication channels, outbreak investigation and emergency response planning, risk communications, and zoonoses risk reduction.

The Emergency and Humanitarian Action unit aims to support Member States in building their capacity for risk reduction, emergency preparedness, response and recovery. As the lead organization for the United Nations Health Cluster, WHO works to strengthen the mechanism for coordinating the health sector response to emergencies and disasters. The WHO Regional Office for the Western Pacific convened the First Regional Health Cluster Forum in May 2011 to develop an operational framework for health responses. A common operational platform for outbreak and emergency response within the Division has been created to facilitate rapid information flow, streamlined communications and coordinated response. The unit works closely with other Division units, especially Emerging Disease Surveillance and Response, to provide emergency response support to Member States.
Strategic issues

Emerging diseases represent a predominant threat to health security in the Western Pacific Region. More than 350 acute public health events were detected, assessed and monitored by the WHO Regional Office for the Western Pacific over the past year. More than 58% were related to infectious diseases, including avian influenza A (H5N1), cholera and dengue.

It is not possible to predict what, where, when and how new infectious diseases will emerge; however, it is certain that emerging diseases will continue to occur and possible that they will result in substantial negative impacts on health, social and economic development and stability. Working collectively to improve preparedness and readiness is the single best solution to mitigate the potential impact.

Effective preparedness requires a technically sound, up-to-date strategic framework that provides clear strategic directions and priorities for investment and action. The updated Asia Pacific Strategy for Emerging Diseases, or APSED (2010), will guide the Western Pacific Region in moving towards a better prepared and more secure Region through a collective approach.

Action and results

The central focus and most notable achievement in 2010 was the development of APSED (2010) through an intensive country- and regional-level consultative process and a review of responses to recent pandemics. The draft strategy was revised at the Fifth Meeting of the Asia Pacific Technical Advisory Group (TAG) on Emerging Diseases in July 2010 and was endorsed by the Regional Committee for the Western Pacific in October 2010. APSED (2010) serves as a common strategic framework for countries and areas, WHO and partners to further strengthen the collective approach, thus contributing to national, regional and global health security in line with the International Health Regulations, or IHR (2005).

A draft five-year workplan for APSED (2010) was reviewed at the sixth TAG meeting on emerging diseases in July 2011. The workplan sets down a clear vision for the focus areas of work, expected results and priority activities. In harmonization with the IHR (2005) monitoring tool, a monitoring mechanism with proposed indicators was developed to monitor APSED (2010) implementation.

Surveillance, risk assessment and response continued to be a priority this past year. Technical support was provided to a number of countries to review and strengthen their national surveillance and response systems. Pacific syndromic surveillance was set up with participation of the Pacific island countries and areas. An assessment tool was developed for the modified Field Epidemiology Training Programme at an annual forum in 2010. And a risk assessment tool for acute public health events was developed to guide a systematic process for gathering, assessing and documenting information to determine risks that inform public health actions. Technical and logistic support was provided to respond to outbreaks of cholera in Papua New Guinea, dengue in the Lao People’s Democratic Republic and the Philippines, and avian influenza A (H5N1) in Cambodia.

A regional review of pandemic preparedness and response in 2010–2011 resulted in the identification and documentation of
A feast on the meat of sea turtles is not uncommon on tiny Murilo island, home to just 250 people in the northern stretches of Chuuk, one of four states that make up the Federated States of Micronesia. So on 15 October 2010, when two brothers began to butcher a Hawksbill turtle for a feast with family and friends, nothing seemed amiss.

But then, something went terribly wrong.

Within a few hours of slurping the turtle soup late that Friday afternoon, islanders young and old started to fall ill. Some became nauseated; others began to vomit.

By Sunday afternoon, 17 October, word reached the Department of Health and Social Affairs and WHO’s Country Liaison Office of the sudden death of three children and the severe illness of at least 20 other people on Murilo.

A rapid response team left immediately to set up a field hospital to treat surviving victims. Concerns about a potential outbreak of a new or emerging disease also led to the dispatch an epidemiological investigative team with two members from the Department of Health and Social Affairs and two members from the WHO Country Office.

The International Health Regulations (2005) and the Asia Pacific Strategy for Emerging Diseases (2010) call on Member States and WHO to work closely to assess and respond to any acute public health event including disease outbreaks that might be of international concern.

By the time the investigative team arrived, six people had died—four children and the adult brothers who had prepared the turtle stew; 88 others had become ill, including a child who had been breastfed by a mother who had eaten the stew. Six dogs that had begged for leftovers also were dead.

But was the meat of the critically endangered marine reptile to blame? Could the culprit have been an environmental contaminant? The islanders recalled that just a year before a foreign vessel had been using氰ide to catch fish just off their shores.

Only the turtle’s shell and skeleton remained after the feast. WHO helped arrange laboratory tests on those samples, as well as human, canine and algae samples. But they yielded no conclusive results. And the investigative team found no evidence of acute environmental contamination. But interviews on the island revealed that four out of every five islanders who ate turtle meat became ill.

Unfortunately, this wasn’t the first incident of turtle-meat poisoning. Just six months earlier, there were reports of poisoned turtle meat on Sapwuahfik island in Pohnpei State, and two previous incidents on the same island in 1997 had led to three deaths.

There is no antidote to counter the effects turtle-meat poisoning, also known as chelonitoxism. No medicines can treat it. All turtles, particularly Hawksbills, can be poisonous.

The investigative team shared its initial findings with the Department of Health and Social Affairs in Pohnpei and with experts in the Food Safety and the Emerging Disease Surveillance and Response units in the Division of Health Security and Emergencies at the WHO Regional Office for the Western Pacific in Manila, Philippines.

In the end, WHO found no reason to single out Murilo island for increased risk of poisoning from turtle meat, since any turtles or their eggs, anywhere, can be toxic. But the Department of Health and Social Affairs and WHO did recommend a ban on the consumption of all species of sea turtles and their eggs throughout the Federated States of Micronesia. While current laws restrict the capture of these marine reptiles, those laws need to be updated to better protect public health. And they must be enforced. Local traditions may make a total ban impossible. But a ban on Hawksbills, thought to be more toxic, and restrictions on other turtles and their eggs would be a good start.

The outbreak serves as a reminder of the importance of collaboration between WHO and Member States to assist in outbreak response and also in improved preparedness for outbreaks. Both concepts are part of the new draft Western Pacific Regional Food Safety Strategy (2011–2015).
key lessons that can guide future actions. A 2011 meeting of National Influenza Centres in the WHO Western Pacific and South-East Asia Regions facilitated the development of a five-year workplan for strengthening influenza surveillance. The Chinese National Influenza Center was designated as a WHO collaborating centre to support influenza-related work in the Region and globally.

Dengue is a priority emerging disease in the Western Pacific Region. In collaboration with the Association of Southeast Asian Nations (ASEAN) Secretariat, a dengue action paper was developed and used to advocate and advise appropriate approaches for managing the dengue threat, including utilizing existing strategies, such as APSED (2010), for surveillance and response.

Laboratory capacity was strengthened in coordination with the implementation of the Asia Pacific Strategy for Strengthening Health Laboratory Services (2010–2015).

In partnership with the Food and Agriculture Organization of the United Nations, the World Organisation for Animal Health and ASEAN Secretariat, WHO co-hosted a Regional Workshop on Collaboration between Human and Animal Health Sectors on Zoonoses Prevention and Control in December 2010 in Japan that reinforced countries’ commitment to strengthening and identifying ways to sustain the coordination mechanism.

WHO provided technical support to Mongolia and Viet Nam to strengthen capacity in infection prevention and control. In Mongolia, national policy was updated and a national resource centre for infection prevention and control was established to provide timely services. Also a risk communications package was developed through a consultative process and tested to support rapid containment operations. Meanwhile, Viet Nam developed a draft national infection control master plan (2011–2015).

An annual scenario-based IHR event communication exercise, named “IHR Exercise Crystal 2010”, was conducted in December 2010 with the participation of National IHR Focal Points from 20 Member States. The exercise demonstrated the importance of National IHR Focal Points in detecting, verifying, assessing and responding to public health events of international concern and the need to strengthen their role.

Strengthening preparedness for evidence-based points-of-entry responses to public health emergencies of international concern was a priority for IHR (2005) implementation over the past year. As such, WHO developed an interim guide for public health emergency contingency planning at designated points of entry. Technical support for this activity was provided to Brunei Darussalam, Japan and the Philippines.

Intensive scenario-based training was offered to technical institutions of the Global Outbreak Alert and Response Network to improve regional preparedness for outbreak response. The Regional Clinical Network on Emerging Infectious Diseases met in 2010 to review and advise clinical management of dengue, pandemic influenza A (H1N1) 2009, and hand, foot and mouth disease.

**Future directions**

WHO will work with Member States and partner agencies to strengthen the national and regional systems and capacities required for managing emerging disease threats through implementation of APSED (2010).

Preparedness for appropriate responses to emerging disease and health security threats, including pandemic influenza and other acute public health emergencies, will continue to be a top priority.

The Emerging Disease Surveillance and Response unit will work towards a more secure Western Pacific Region through a collective and common approach to surveillance, risk assessment and response operations.
**Strategic issues**

Food safety touches the lives of everyone—young and old, rich and poor. Diarrhoeal diseases alone, a considerable proportion of which are foodborne, kill 2.2 million people every year worldwide. However, the full burden of foodborne diseases arising from biological, chemical and physical contamination is much larger.

Contributing to the burden of foodborne disease is the globalization of the food supply. Local outbreaks now have implications in many other countries due to travel and trade, creating significant challenges for those who manage food safety.

Food safety also contributes significantly to the prevention and control of noncommunicable diseases and dietary-related undernutrition. Through the development of food standards and the strengthening of food inspection capacities to enforce such standards, national food control systems can help reduce the extensive public health, social and economic consequences of these dietary-related diseases.

**Action and results**

Support for the development of food legislation to address food safety and dietary-related concerns in the Pacific was a high priority, with progress made in several Member States, including Cook Islands, Fiji, Kiribati, the Federated States of Micronesia, Nauru, Niue and Samoa.

A new food safety law was enacted in Viet Nam, along with two decrees defining the roles and responsibilities of ministries involved in food safety. China took steps to implement the Food Safety Law passed last year, suchas designating the Ministry of Health as the coordinating agency for food safety issues in China.

The Centre for Food Safety of the Food and Environmental Hygiene Department in Hong Kong (China) was designated as a WHO Collaborating Centre for Risk Analysis of Chemicals in Food. Also, several national institutes were designated as collaborating institutions of the Global Environment Monitoring System – Food Contamination Monitoring and Assessment Programme, which shares information on food contamination and food consumption so that the dietary exposure to food contaminants can be estimated.

As new legislation and policy are developed, food inspectors’ capacities to implement and enforce such requirements must also be strengthened. As such, training was conducted for food inspectors in Fiji and the Lao People’s Democratic Republic.

Promotion of the WHO “Five Keys to Safer Food” during Expo 2010 in Shanghai, China, was undertaken by the WHO Country Office. Approximately 120,000 people visited the exhibition. The five keys messages were later translated into five minority languages in China’s western provinces, bringing the total number of translations to more than 70 languages, making it a truly universal WHO product.

Acknowledging that food safety is a regional health security issue and that countries have a collective responsibility to develop food safety control systems, several mentoring visits were coordinated by the WHO Regional Office to facilitate sharing of expertise between countries. For example, the New Zealand Food Safety Authority hosted a delegation from Papua New Guinea and explained how they audit food businesses. The Malaysian Ministry of Health
hosted officials from Mongolia and shared expertise on Codex Alimentarius, and Japan’s National Institute of Health Sciences shared expertise with a visiting team from Malaysia on conducting burden of foodborne disease studies.

While the prevention of food contamination is the aim of national food controls systems, it is important for countries and areas to be able to effectively detect, assess and manage food safety incidents and emergencies. Following a workshop held in collaboration with the Food and Agriculture Organization of the United Nations, the WHO Regional Office has been advocating the development of food safety emergency response plans in Member States and sharing of urgent food safety information through the International Food Safety Authorities Network (INFOSAN). Agreement to develop or strengthen such food safety emergency response plans has been reached in Cambodia, Fiji, the Lao People’s Democratic Republic, Mongolia and Viet Nam.

Additionally, several countries and areas have taken steps to improve their participation in INFOSAN.

Despite the vital importance of food safety and the success of projects undertaken over the last year, many countries and areas in the Western Pacific still fall short when it comes to food control systems and human, financial and technical resources for food safety. WHO must continue to work with national governments to develop national food controls systems to prevent foodborne disease.

**Future directions**

During the Sixty-third World Health Assembly in 2010, Member States agreed to further develop and implement the core capacities set forth in the International Health Regulations (2005), as they relate to food safety. Additionally, a recent review by the WHO Regional Office highlighted its responsibility to support Member States in implementing the expanded multi-hazard mandate of the International Health Regulations (2005) to support the strengthening of cross-border protection.

In consideration of the need for food control systems in many of the Western Pacific Member States, WHO reviewed progress made under the existing Western Pacific Regional Strategy for Food Safety. Work commenced through an expert meeting, in-country consultations and a technical consultation involving many countries and areas of the Western Pacific Region. The review identified how Member States can best take action to strengthen food control in the next five years not only to reduce the risk of food contamination and foodborne diseases, but also to address the double burden of undernutrition and noncommunicable diseases. The outcome of this review was the draft *Western Pacific Regional Food Safety Strategy (2011–2015)*, which will be considered for endorsement by Member States during the sixty-second session of the Regional Committee in October 2011.

The draft *Western Pacific Regional Food Safety Strategy (2011–2015)* provides guidance to country and regional approaches to strengthening food control systems. Topics covered include coordination throughout the food chain continuum and adequate funding, risk-based regulatory frameworks, food safety data to guide policy and risk analysis, inspection services, food safety training and education, and food safety incidents and emergencies.
Strategic issues

The United Nations International Strategy for Disaster Reduction reported that 2010 was “one of the worst” years on record for natural disasters. In the Western Pacific Region, natural hazards such as earthquakes, typhoons, floods and landslides affected several countries, namely Australia, Cambodia, China, Japan, New Zealand, the Philippines, Vanuatu and Viet Nam. Of the 373 disasters recorded last year, 22 were in China and 14 were in the Philippines.

February 2011 was marked by a tragic 6.3 intensity earthquake that hit Christchurch, New Zealand, killing 166 people and incurring major damages to infrastructure. An unprecedented 9.0 magnitude earthquake and tsunami occurred on 11 March 2011 in Japan and caused serious casualties and infrastructure damage, especially damage to the Fukushima Nuclear Power Plant. Both of these disasters had huge impacts on health and economic development.

Reflecting on these and other recent emergencies, WHO decided to take the following strategic actions: (1) increase the level of preparedness of Member States in responding to acute emergencies; (2) step up risk reduction efforts to ensure the resilience of the health sector to disasters and emergencies; (3) develop seamless mechanisms for coordination and delivery of health emergency services; and (4) better prepare itself to support Member States when emergencies strike.

Action and results

The integration of the Emergency and Humanitarian Action unit into the new Division of Health Security and Emergencies, together with the Emerging Disease Surveillance and Response unit and Food Safety unit, has enabled WHO to more coherently monitor potential disasters and to respond to them with a single operational platform.

To strengthen the capacity of the Organization, the Western Pacific Region Emergency Response Procedures were developed for WHO staff as guidelines for providing technical, administrative and coordination support to Member States in disasters and crisis situations. A training curriculum was also designed to be used for WHO staff to become more sensitized to emergency response and to be skilled in operational activities for disasters and crises.

In May 2011, the First Regional Health Cluster Forum on Humanitarian Emergencies was convened by the WHO Regional Office and the WHO Kobe Centre in Japan. The aim of the forum, which promoted “One Health Cluster Response” as its unifying theme, was to formulate an operational framework for national response. Attendees included United Nations agencies, bilateral and multilateral agencies, international nongovernmental organizations and representatives from Member States. It is anticipated that international agencies working in a particular country will now work as “one” when an emergency occurs.

Technical support to Member States. WHO provided support to Cambodia, China and the Lao People’s Democratic Republic to further strengthen policies and guidelines for emergency preparedness and response. In Cambodia, a national policy for health was finalized as part of the new legislation for emergency response. In the Lao People’s Democratic Republic, a new health response plan was finalized with support from WHO. And, in China, a workshop was conducted with WHO support to develop technical guidelines...
on emergency response for the Chinese Center for Disease Control and Prevention.

Training activities. Working with partner agencies and Member States, WHO helped to conduct several training activities in health emergency management. In October 2010, an Interregional Public Health and Emergency Management for Asia and the Pacific Training Course was convened in Ha Noi, Viet Nam, by the WHO Regional Offices for South-East Asia and the Western Pacific Region and the Asian Disaster Preparedness Center. A Regional Training Course on Mass Casualty Management and Hospital Preparedness was conducted in October 2010 in Ho Chi Minh City, with the support of the Southeast Asian Ministers of Education, Tropical Medicine and Public Health Network (SEAMEO TROPMED). A Regional Training Course on Mass Casualty Management and Hospital Preparedness was conducted in October 2010 in Ho Chi Minh City, with the support of the Southeast Asian Ministers of Education, Tropical Medicine and Public Health Network (SEAMEO TROPMED).

A Regional Training Course on Mass Casualty Management and Hospital Preparedness was conducted in October 2010 in Ho Chi Minh City, with the support of the Southeast Asian Ministers of Education, Tropical Medicine and Public Health Network (SEAMEO TROPMED).

National-level training courses on safe hospitals and public health and emergency management in Asia and the Pacific continued to be offered through academic institutions and the Ministries of Health of Cambodia, China, the Lao People’s Democratic Republic, the Philippines and Viet Nam. National-level training courses on safe hospitals and public health and emergency management in Asia and the Pacific continued to be offered through academic institutions and the Ministries of Health of Cambodia, China, the Lao People’s Democratic Republic, the Philippines and Viet Nam.

Together with WHO Headquarters and the Global Health Cluster, the WHO Regional Offices for South-East Asia and the Western Pacific offered a Health Cluster Field Coordinators Training Course in Jakarta. Existing and prospective health cluster coordinators from China, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam participated in this training. Together with WHO Headquarters and the Global Health Cluster, the WHO Regional Offices for South-East Asia and the Western Pacific offered a Health Cluster Field Coordinators Training Course in Jakarta. Existing and prospective health cluster coordinators from China, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam participated in this training.

An internship/volunteer programme was launched in the Western Pacific Regional Office for public health officials from the Chinese An internship/volunteer programme was launched in the Western Pacific Regional Office for public health officials from the Chinese

Japan tsunami tests new emergency response platform

The 9.0 magnitude earthquake in Japan on 11 March 2011 triggered a tsunami and nuclear accident of nearly unimaginable severity in the Tohoku region of Japan. The resulting nuclear accident at Fukushima, caused by the earthquake and tsunami, eventually reached Level 7, the highest rank on the International Nuclear Event Scale.

The Japan disaster was the first major test of the newly established WHO Western Pacific Region Division of Health Security and Emergencies (DSE). The Division already had established a system to detect, monitor, assess and, when required, respond to acute health security events in the Region. Immediately after the earthquake, an Event Management Group including a communications team was formed in the WHO Western Pacific Regional Office.

The DSE Emergency Operation Centre was activated to collect information, monitor the situation, conduct risk assessments and coordinate response operations on a 24/7 basis. The response to the Japan disaster involved all three technical programmes within the Division: Emerging Diseases Surveillance and Response; Emergency and Humanitarian Action; and Food Safety. DSE served as a common operational platform for emergency response and also mobilized support of other technical programmes within the Regional Office, including mental health, noncommunicable diseases and health systems.

Situation monitoring, including the close monitoring of tsunamis in the Pacific, and information-sharing were vitally important. A field mission was undertaken, 38 situation reports were prepared, and “frequently asked questions” were produced to provide public health advice. This was done in close collaboration with the WHO Kobe Centre in Japan and the WHO Headquarters in Geneva.

Following the official notification of the explosion event at the Fukushima Daiichi Nuclear Power Plant through the International Health Regulations (IHR) National Focal Point on 12 March, WHO in the Western Pacific communicated with all the Member States in the Region through IHR National Focal Points and the Regional Director’s contact with Member States. Since then, updated information and data have been shared through an IHR mechanism, including an Event Information Site. Information and technical assistance on the contamination of food was provided to national food authorities through the International Food Safety Authorities Network (INFOSAN).

In close coordination with the WHO Headquarters, which liaised with other agencies including International Atomic Energy Agency and the Food and Agriculture Organization of the United Nations, joint public health risk assessments were conducted and technical advice was provided to address the health concerns of Member States and the international community. They included evacuation and sheltering, travel advice to Japan, border-control measures, the use of potassium iodide tablets, food safety, environment contamination and other issues.

The response to the Japan event clearly demonstrated the need and essential role of a common operational platform for emergency response. While the DSE response proved to be effective, there also were important lessons learnt that will ensure the system is better prepared for future emergency responses.
Center for Disease Control and Prevention and the Health Emergency Response Office of the Ministry of Health, China. A similar programme for foreign public health graduate students is being considered.

**Events and activities.** With support from the European Commission Humanitarian Aid department, WHO continued to run a regional campaign to make health facilities and hospitals safer from emergencies. Key achievements of the campaign have included: evidence-based assessments of hospital vulnerability; provision of technical resources for health sector disaster management planning; enhancement of capacity for disaster preparedness and response in small and medium-sized cities; development of technical resources for structural integrity, safety and functional capacity of health facilities; and the conduct of advocacy and awareness activities on the benefits and importance of disaster response and preparedness.

Similar to the first phase of the campaign, the safe hospitals campaign targeted the priority countries of Cambodia, the Lao People’s Democratic Republic, the Philippines and Viet Nam. Other activities included countries from the Pacific, as well as China and Mongolia, especially for training.

Emergency response. China’s southern provinces suffered the brunt of floods and landslides that hit the country from the end of May to early August 2010. WHO provided support for transporting medicines and supplies to the affected communities. Cyclones and floods further affected the Philippines (July 2010, January 2011), Tonga (January 2011), Viet Nam (October 2010) and Vanuatu (January 2011). Early in 2011, Australia also had severe flooding, something that the country has not experienced in the past 30 years.

Lessons from recent emergencies taught us that preparedness, including intact response plans and trained workforces, standard procedures for operations, and sound coordination mechanisms will make response activities more effective and efficient. Furthermore, strong preparedness will pave the way for early recovery.

In southern Philippines, an ongoing armed conflict prompted a unified United Nations response to support humanitarian activities for the affected population groups, particularly in the Autonomous Region of Muslim Mindanao. WHO set up an office in Cotabato City to provide surge capacity for acute emergencies and to support efforts for recovery.

The **Western Pacific Health Cluster Toolkit** was updated. This handy reference for health field personnel is available on compact disc and can also be accessed online (http://www.wpro.who.int/internet/files/eha/toolkit/web/home.htm).

**Partnerships and networking.** Training activities were carried out in partnership with educational institutions throughout the Region, the most active partners being the University of the Philippines, the Hanoi School of Public Health and the Ho Chi Minh City School of Hygiene and Public Health.

Units within WHO collaborated on events throughout the year, including the annual conference of the Asia Pacific Emergency and Disaster Nursing Network, held in New Zealand in October 2010. Another co-organized event was the annual meeting of Pacific Health Team, held in December 2010 in Suva, Fiji, during which a contingency plan for the health sector was developed. WHO also participated in the Asia-Pacific Humanitarian Network monthly meetings held in Bangkok.

**Future directions**

Recent extreme weather disturbances and natural disasters have made it clear that an all-hazards approach to disaster preparedness, response and recovery is needed. Although most countries have achieved progress in preparedness, more should be done to promote a culture of disaster preparedness.

There is also room for further development and evolution of the “health cluster” approach to health emergency planning and response. Thus, WHO as the leading United Nations agency in the Global Health Cluster will play a very crucial role in setting the future directions of emergency and humanitarian action in the Western Pacific Region.
Countries and areas of the Western Pacific Region are facing enormous public health challenges, many of which are closely related to the priorities of the Division of Building Healthy Communities and Populations. To maximize limited financial and human resources, the Division identifies its priority areas of work in collaboration with Member States to provide timely responses to local situations and to further develop broad public health programmes in the Region.

Building Healthy Communities and Populations

The Division’s first priority is to reduce child mortality and improve maternal health, thereby progressing towards Millennium Development Goals 4 and 5. In line with the Global Strategy for Women’s and Children’s Health, launched by the United Nations Secretary-General in September 2010, WHO has supported countries in achieving universal access to a core package of essential interventions and services for children, adolescents and women across all levels of the health system. In collaboration with the Division of Health Sector Development, cross-cutting approaches to health systems strengthening for maternal and child health programmes, and the broader issues of women and health, have been established, including the Regional Office Working Group on Women and Health.

In support of its second priority, to reduce malnutrition, the Division is pressing forward in its efforts in support of Millennium Development Goal 1, which calls for the eradication of extreme poverty and hunger. Support has been provided to expedite the implementation of the Global Strategy for Infant and Young Child Feeding, to review current policy frameworks addressing malnutrition, to scale up interventions to improve the nutrition of women, infants and young children, and to strengthen nutrition surveillance.

The Division’s third priority is mental health and injury prevention. The Division is providing support and technical advice in addressing mental, neurological and behavioural disorders, which are common to all countries. The WHO Pacific Islands Mental Health Network is an important mechanism by which mental health services are provided and mental health is promoted in the Pacific. The Division also is providing close collaboration to Member States in their efforts in suicide prevention and to enact alcohol policy legislation.
The Regional Framework for Action on Injury and Violence Prevention continues to provide guidance to countries on cross-cutting issues like road safety, child injury prevention and violence prevention. As a part of the launch of the United Nations Decade of Action for Road Safety, the Division strengthened its support for the development of national action plans for road safety.

The fourth priority area is environmental health. The Division provides effective, continuous support to the Ministerial Regional Forum on Environment and Health in Southeast and East Asian Countries and helped to establish a task force to improve the governance, partnerships and impact of the regional forum. WHO supported 20 countries in the Region in assessing health vulnerability to climate change, developing national strategies and action plans for the health sector response to protect health from the effects of climate change, and implementing capacity-building activities for health sector adaptation. Water safety plans have become a popular tool to ensure safe drinking-water in many countries of the Region, and a WHO-led Asia-Pacific Water Safety Plan Network was initiated. To address emerging occupational health concerns, such as exposure to asbestos and limited access of workers to occupational health services, a Regional Framework for Action for Occupational Health (2011–2015) was launched.

Preventing and controlling noncommunicable diseases is the fifth priority. The Division provides support to Member States as they prepare for regional and global events on noncommunicable diseases. A United Nations High-level Meeting on Prevention and Control of Noncommunicable Diseases is planned for September 2011. A cross-cutting and integrated approach to noncommunicable diseases has been adopted by the Division and has resulted in collaboration among a number of WHO teams, including health systems, tobacco, nutrition and environmental health. Strengthening multisectoral collaboration will be a key area of work.

The sixth priority is health promotion. Healthy Cities, one of the cross-cutting programmes, has been widely implemented in the Region. The vision of Healthy Islands has been promoted by Pacific island health ministers and implemented in all the Pacific island countries. The Division has given high priority to the development of the Regional Framework on Scaling up and Expanding Healthy Cities, and has provided support for the development of the Healthy Islands: Framework of Action for Revitalization. Two guiding documents will serve to strengthen institutional arrangements, build capacity for action, advance national policy and action, and support networking among cities and islands.

The final priority is tobacco control. Steady progress has been achieved in implementing the WHO Framework Convention on Tobacco Control (FCTC). The key challenge for the Division is to achieve 10% reduction in prevalence of smoking from the most recent baseline over the next five years. Convincing national decision-makers as well as local political leaders to support full implementation of the WHO FCTC has been a powerful strategy. Capacity in the health sector needs to be further strengthened to make national tobacco control programmes more effective and to ensure that support for quitting is affordable and accessible at every level of health service delivery. Technical support will be provided to the Republic of Korea as it prepares to host the FCTC Fifth Conference of Parties in 2012.
Environmental Health

Strategic issues

In the Western Pacific Region, it is estimated that annually 2.9 million deaths, or 24% of the total deaths, are attributable to environmental risks. Environmental risk factors include unsafe water, sanitation and hygiene, indoor and outdoor air pollution, toxic and hazardous chemicals and wastes, radiation, climate change and occupational conditions.

In line with Regional Committee mandates, WHO support is extended to Member States to strengthen human resources and institutional capacity in environmental health risk assessment and management, to establish and strengthen multisectoral coordination mechanisms, to develop national and local action plans on environmental health, to increase health sector input to the implementation of international agreements related to environmental health, and to participate actively in intercountry initiatives such as the Regional Forum on Environment and Health in Southeast and East Asian Countries and the Pacific Framework for Action on Drinking Water Quality and Health.

The Regional Committee for the Western Pacific in 2008 endorsed the Regional Framework for Action to Protect Human Health from the Effects of Climate Change in the Asia Pacific Region. WHO support is provided to Member States to develop national strategies and plans to protect health from the effects of climate change, strengthen existing health infrastructure and human resources for responding to potential health risks resulting from climate change, establish programmes to reduce greenhouse gas emissions by the health sector, and advocate the decisions made by other sectors on climate change that protect and promote health.

Action and results

WHO, through the Regional Offices for South-East Asia and the Western Pacific, and the United Nations Environment Programme (UNEP) Regional Office for Asia and the Pacific, convened the Second Ministerial Regional Forum on Environment and Health in Southeast and East Asian Countries in July 2010 in Jeju, Republic of Korea. The forum reviewed progress in developing and implementing national environmental health action plans and policy briefs on regional environmental health priorities prepared by thematic working groups. The Regional Forum adopted “health impact assessments” as a new regional priority, and approved the workplans of the working groups. It also established a task force to recommend ways to improve the governance, partnerships and impact of the Regional Forum. With WHO support, the working group on health impact assessments met to discuss the implementation of its workplan in November 2010 in Dunedin, New Zealand, in conjunction with the Third Asia Pacific Regional Health Impact Assessment Conference. National environmental health action plans were approved by governments in the Lao People’s Democratic Republic and the Philippines, and were in the process of approval in Cambodia, Malaysia and Viet Nam.

WHO continued to support countries in assessing health vulnerability to climate change and in developing national strategies and action plans for the health sector response to climate change. With financial support from the Republic of Korea and Japan, WHO collaborated with 11 Pacific island countries to conduct health vulnerability assessments and develop their national strategies and action plans for health sector response. A similar activity was initiated in the Lao People’s Democratic Republic. With funds from the Government of the Republic of Korea, WHO initiated two projects to support
the implementation of national strategies and action plans, involving Cambodia, Mongolia and Papua New Guinea: one focusing on vectorborne diseases and the other on waterborne diseases. China, Fiji, the Philippines and Viet Nam continued to implement capacity-building projects for health sector adaptation to climate change. WHO continued to advocate for urban transport systems that would reduce greenhouse gas emissions while protecting and promoting people’s health.

Environmentally Sustainable and Healthy Urban Transport (ESHUT), an initiative that started in 2009 to promote non-motorized transport (e.g. bicycling and walking) and efficient public transport systems, was promoted at regional forums.

Under the Water Quality Partnership with the Australian Agency for International Development (AusAID), WHO led the advocacy and implementation of water safety plans in six countries. WHO support in partnership with the Secretariat for the Pacific Community’s Pacific Applied Geoscience Division has advanced water safety plans in countries in the Pacific, including Fiji, the Marshall Islands and Samoa. The WHO Regional Office for the Western Pacific hosted a stakeholders’ meeting in October 2010 to discuss project progress and water safety plans. WHO also co-sponsored a session on water safety plans at the Third Southeast Asian Water Utilities Network Convention in December 2010, during which the WHO-led Asia-Pacific Water Safety Plan Network was presented. Phase 2 of the WHO/AusAID Water Quality Partnership ended in June 2011, before which a proposal for Phase 3 was developed.

WHO continued to provide technical support for water and sanitation sector assessments in the Lao People’s Democratic Republic, the Philippines and Viet Nam. WHO continued its advocacy and capacity-building efforts on household water treatment and storage. Training modules were developed and training courses were conducted in Cambodia and Viet Nam, in partnership with the United States Agency for International Development (USAID)-funded Water, Sanitation and Hygiene Enterprise Development (WaterSHED) project.

Asbestos has become an emerging concern in many developing countries in the Region. WHO has continued to support the Asian Asbestos Initiative and participated in its third international seminar organized by the WHO Collaborating Centre for Occupational Health at the University of Occupational and Environmental Health in Fukuoka, Japan, in November 2010. At the seminar, WHO held a consultation to sound out a regional strategy for occupational health, and subsequently developed the Regional Framework for Action for Occupational Health 2011–2015. With funds from the Japanese Government, WHO continued to support a project on workers’ health protection in Viet Nam with the objectives to expand occupational health services, to reduce asbestos-related diseases and to protect health care workers from occupational hazards.

WHO continued to support the development of national plans and policies for health care waste management in Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam, and expert guidance was provided to Fiji to ensure specific health care waste disposal practices were implemented. Technical support was provided for the elimination of mercury in health care in China, Mongolia, the Philippines and Viet Nam. WHO continued to support the development of national policies on health impact assessment in Cambodia and Viet Nam. With WHO support, Cook Islands, Kiribati, Samoa, Solomon Islands and Tonga embarked on a two-year project to establish a poison information network in the Pacific.
Healthy settings for healthy lives

For nearly three decades, WHO has prioritized work in healthy settings—physical and social settings such as schools, workplaces, marketplaces, hospitals, villages and communities that serve as supportive environments for health protection and health promotion.

By creating environments that make it easier for people to make healthy choices, for example in choosing healthier foods or working in smoke-free offices, people can lessen the impact of many of the risk factors that contribute to ill health.

Healthy settings generally require interdisciplinary approaches that crossover into a variety of fields. Noncommunicable disease is a case point.

Public health officials have long understood that doctors, nurses, clinics and hospitals alone can’t solve the burgeoning problem of noncommunicable diseases such as cancer, cardiovascular diseases, chronic respiratory ailments and diabetes. These chronic diseases, which claim more than 30,000 lives every day in the Western Pacific Region, are driven in large part by four common risk factors—tobacco use, alcohol abuse, poor diets and physical inactivity.

But these risk factors can’t be solved by the health sector alone. A coordinated effort among various sectors, including educators, food processors, traders and importers, government and community-based organizations, is needed.

In an effort to address these concerns, Member States in the Western Pacific Region have embraced the healthy settings approach not only in combating noncommunicable diseases, but also in promoting healthier urban environments, better food safety and healthier ageing.

In the Western Pacific, Healthy Cities and Healthy Islands initiatives have been actively pursued since the mid-1990s. Today, various national health promotion programmes of our Member States emphasize supportive environments, including Health-promoting Schools, Healthy Marketplaces, Healthy Workplaces, Health-promoting Hospitals and Healthy Restaurants.

WHO assists Member States in setting up models and demonstration sites, in deriving and disseminating best practices, and in evaluating healthy settings. WHO has also developed regional guidance for the different settings, taking into account local culture and traditions.

In an effort to recognize exemplary work, the Alliance for Healthy Cities in conjunction with WHO, announced awards for a variety of best practices and proposals in 2010.

Eleven different cities in the Region received awards for areas ranging from best practices for environmentally sustainable, healthy urban transport and safe cities to best proposals for smoke-free workplaces and health-promoting schools.

The Regional Director’s Outstanding Healthy City Award for 2010 was presented to Ichikawa City, Japan, which initiated its Healthy Cities programme in 1998 and has participated in the Alliance for Healthy Cities as a founding member since 2003.

For the 22 Pacific island countries and areas in the Western Pacific Region, the vision of Healthy Islands was first envisioned as an ideal by the Ministers of Health for the Pacific Island Countries meeting on Yanuca Island, Fiji, 1995.

In 2011, Best Practice Recognitions were given to the Tafea Local Government Council in Vanuatu for Community-based Efforts in Noncommunicable Diseases Elimination and to the Bureau of Public Health in Palau for government support for a Healthy Workplace Programme.

Best Proposal Recognitions were given to the Pacific Foundation for the Advancement of Women in Fiji for hygiene and to the Community College of Micronesia, Chuuk, Federated States of Micronesia, for the Adopt-a-Community Approach for a Healthy and Clean Chuuk.
Future directions

In preparation for the Third Ministerial Regional Forum on Environment and Health in Southeast and East Asian Countries to be held in Malaysia in 2013, WHO, in collaboration with UNEP, will complete the work of the task force and support the various thematic working groups in the implementation of their respective workplans. WHO support will be extended to countries to implement their national environmental health action plans.

Following the completion of national strategies and action plans for the health sector response to climate change, WHO will collaborate with Member States to implement the national strategies and action plans and where necessary explore possible financial resources to support activities. WHO will continue to promote the development and implementation of ESHUT activities in countries and at regional forums.

The WHO-led Asia-Pacific Water Safety Plan Network is expected to be officially launched in July 2011 during the Singapore International Water Week. WHO will continue to provide technical support to Member States for water and sanitation sector assessments and health care waste management, and will work with Member States to build their capacity in household water treatment and storage through the development of training materials and conduct of training courses. WHO will support the participation of Member States in the Third East Asia Conference on Sanitation and Hygiene to be held in Indonesia in 2012.

WHO will continue to work with Member States and international partners to develop national policies and programmes to reduce asbestos-related diseases, improve the coverage of occupational health services, and promote healthy workplaces.
Maternal and Child Health and Nutrition

Making pregnancy safer, women and reproductive health

Strategic issues

About 13,000 women die from complications related to pregnancy or childbirth each year in the Western Pacific Region. Most of these deaths occur in developing countries, particularly China, the Philippines and Viet Nam, and most are avoidable. In Millennium Development Goal 5 (MDG5), countries have committed to reducing the maternal mortality ratio (MMR) by three quarters between 1990 and 2015. In this Region, MMR has been reduced by 60%, from 130 per 100,000 live births in 1990 to 51 per 100,000 live births in 2008. Three countries—Cambodia, the Lao People’s Democratic Republic and Papua New Guinea—are still reporting high MMR and may not be able to achieve MDG5 by 2015. Less than 50% of deliveries in these countries are assisted by health personnel. And although Kiribati, the Federated States of Micronesia, Solomon Islands and Vanuatu are reporting low absolute numbers, they are experiencing high rates of maternal mortality. Progress must be accelerated to achieve MDG5.

Progress in universal access to reproductive health also varies among countries. The contraceptive prevalence rate ranges from 30% to 50% in Cambodia, the Lao People’s Democratic Republic, the Philippines and some of the Pacific island countries, with a reportedly high unmet need for family planning. Low contraceptive prevalence rates indicate that many pregnancies are unintended and may be unwanted. Some of these pregnancies may lead to unsafe abortions. Adolescent birth rates are highest in Cambodia, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines and some of the Pacific island countries, ranging from 52 to 110 births per 1000 girls aged 15–19 years.

Sexually transmitted infections, breast cancer, cervical cancer and other gynecological morbidities continue to be public health problems. Strengthened health systems, including adequate human and financial resources, are necessary for countries to implement existing policies and strategies, while addressing social determinants of health.

Action and results

Countries with high MMR or high numbers of maternal deaths, namely Cambodia, China, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines and Viet Nam, were supported in addressing key issues of maternal, women and reproductive health.

In the Lao People’s Democratic Republic, WHO supported the expansion of the integrated package of maternal, neonatal and child health services to 10 districts. The initiative, financially supported by the Korea Foundation for International Healthcare, focused on building the capacity of governmental staff at all levels, especially at the district level and below, to formulate annual plans, to organize training, to collect village-produced data and to make supervision visits. Through the initiative, clinical skills were strengthened, maternal death reviews were implemented, and basic medical equipment and delivery beds were donated to health facilities. Community mobilization through village health volunteers was also carried out to advocate proper self-care and delivery in a health facility. As a result of this initiative, the country has experienced improved service coverage and quality of care.
Papua New Guinea was supported in translating relevant portions of its National Health Plan (2011–2020) into a national strategic plan for reducing maternal and neonatal mortality, and in finalizing the strategic plan in collaboration with the National Department of Health. WHO also contributed to the preparation of a pre-service training project for midwives, funded by the Australian Agency for International Development, which will strengthen the four midwifery schools in the country. It is expected that the project will strengthen the health system and will produce competent midwives with essential midwifery and life-saving skills. These activities have enabled Papua New Guinea to improve its programme planning and to upgrade the clinical skills of health providers.

In the Philippines, audiovisual materials for training health providers on essential newborn care were developed.

WHO continues to support maternal death surveillance in Cambodia in an effort to reduce the number of maternal deaths in the country. As part of the initiative, maternal death audits are being conducted to determine the causes of, and circumstances surrounding, all maternal deaths. The information is being used by the Government to understand the factors that lead to death and to take necessary actions to prevent maternal deaths in the future. Support was provided by WHO in evaluating the progress of the initiative and its effectiveness.

China was supported in implementing reviews of maternal “near-miss” cases to improve quality of care, as well as in promoting natural childbirth to respond to the high rate of caesarean deliveries. Mongolia was also supported in improving quality of maternal, neonatal and reproductive health care, as well as in introducing a comprehensive cervical cancer control programme. Viet Nam was supported in disseminating evidence-based information provided in the *The WHO Reproductive Health Library 2011* on CD-ROM. Malaysia carried out a survey of knowledge and attitudes of medical students about induced abortion. The above activities have contributed to country efforts in improving quality of care.

Women’s health received high-level political visibility during the sixty-first session of the Regional Committee in Putrajaya, Malaysia, in October 2010. Most of the government representatives from the Region supported the issues raised in the working paper on women’s health. It was agreed that a report on women’s health in the Western Pacific Region will be prepared, following the publication of a global report on the same subject. A cross-cutting working group that addresses gender and women’s health issues was set up in the Regional Office to provide oversight on how to improve equity in the efforts of improving women’s health.

Involvement of the maternal and child health community in the development and implementation of an operational framework for the prevention of mother-to-child transmission was strengthened. Conceptual and monitoring frameworks were prepared in collaboration with government counterparts and are being used as a basis for United Nations interagency support to 10 priority countries in Asia and the Pacific.

**Future directions**

WHO will continue to provide technical support to Member States on various key issues related to maternal, neonatal and reproductive health. In the area of maternal and neonatal health, three countries will continue to be given special attention. WHO will support Cambodia in strengthening its maternal death surveillance and audit system, and the Lao People’s Democratic Republic in expanding integrated maternal and child health service delivery, strengthening district programme management and enhancing the maternal death audit system. Papua New Guinea will be supported in similar areas.

Overall, the priority countries will be supported in strengthening health systems for maternal, neonatal and reproductive health with a focus on strengthening district programme management, improving service delivery and strengthening community participation. These efforts will contribute significantly to the achievement of MDGs 4 and 5. To scale up coverage of the essential package of maternal, neonatal and child health services for target groups, WHO will collaborate with United Nations agencies, development partners and nongovernmental organizations in assisting governments. In countries with large populations, inequity in accessing the essential package of health services needs to be addressed.

In terms of reproductive health, improvement of access to and quality of family planning services is crucial not only for countries with a high MMR but also for Pacific island countries. Promotion of adaptation and use of evidence-based guidelines and tools in the broad areas of reproductive health will be continued according to country situations and needs. At the policy level, when opportunities become available, support will be provided for the development of national health policy and strategic plans, as well as their translation into implementation plans at the district level and below.
Child health

Strategic issues

The latest WHO estimates indicate that the overall under-5 and infant mortality rates in the Western Pacific Region were cut in half between 1990 and 2009, and the estimated total number of deaths among children under the age of 5 years decreased by two thirds during that time. Several countries are on track to achieve Millennium Development Goal (MDG) 4, that is, reducing by two thirds, the under-5 mortality rate.

Despite those achievements, 527,000 children under 5 died in 2009 in the Region. Almost half of all child deaths occur during the first month of life. At least 65% of all child deaths in the Region are caused by neonatal conditions, pneumonia and diarrhoea for which interventions are known. More than 95% of these deaths occur in six countries—Cambodia, China, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines and Viet Nam—where huge disparities in mortality as to gender, urban/rural residence, income levels and ethnicity exist and variations in coverage and access to child survival interventions across populations prevail.

Identifying and addressing key health system gaps will immensely influence progress towards reducing child mortality. The Region promotes integrated programme planning and management focusing on the most important causes of mortality and ensuring that packages of interventions for maternal and child health are delivered through integrated service at all levels of care. Improved financing for maternal and child health, human resource capacity, availability of appropriate medicines and technology, and use of information for action are the key health system developments that will facilitate further gains in saving children’s lives.

Action and results

In the Lao People’s Democratic Republic, implementation of the Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services (2009–2015), which started in two districts in December 2009, was expanded to 17 districts in three provinces with support from WHO and the Korea Foundation for International Healthcare. Over the past year, mother and child health have been improved by strengthening planning and management capacity at the district level, improving the health information system, training health staff and supporting mobile health clinics and health day campaigns. Village health volunteers were equipped with a practical manual and trained to give basic information to mothers and families to facilitate health service utilization and to provide basic services as needed. Also, a voucher scheme was introduced to provide women in poverty areas with free maternity and newborn care in health facilities.

WHO continued to champion the expansion of the Integrated Management of Childhood Illness (IMCI) approach in most priority countries. To support this endeavour, WHO staff in the Western Pacific Region were trained to use the IMCI Computerized Adaptation and Training Tool (ICATT). WHO provided Mongolia with 10 computers and training to set up an ICATT laboratory in the Health Sciences University. Cambodia and the Philippines were instructed on how to improve IMCI pre-service education with the use of ICATT. And the Lao People’s Democratic Republic received support to update its national IMCI guidelines and finalize a five-day agenda for IMCI training of primary health care workers.

Training for community health workers was conducted in three demonstration provinces in the Lao People’s Democratic Republic and in one district in Viet Nam to improve neonatal health and survival. Technical assistance from WHO facilitated the adaptation of community training modules in Mongolia, the Philippines and Viet Nam.

Improvement of referral-level care in the Lao People’s Democratic Republic was supported through the conduct of a hospital assessment in one provincial hospital and one district hospital in each of the three demonstration provinces. The hospital assessments were followed by a four-day training workshop on the Pocketbook of Hospital Care for Children. A National Training Workshop on the Pocketbook of Hospital Care was conducted in the Pacific for participants from Fiji, Kiribati, Samoa, Tonga and Vanuatu.

A review of the child survival programme in Cambodia was supported using data from recently concluded population-based surveys, facility surveys, verbal autopsy and routine health information. Following the review, the five-year national plan was realigned to reflect critical areas for action.

Future directions

WHO will continue to support country actions designed to strengthen policy
and improve availability, accessibility and affordability of quality child health services at all levels throughout the continuum of care. Specifically, WHO will support capacity-building activities that strengthen programme planning at the national and subnational levels. Intensified support will be provided to more countries for the implementation of community-based approaches, including mechanisms to improve the referral care process. Tracking progress towards universal coverage of integrated maternal, neonatal and child health at all levels and key maternal and child health outcomes will be guided by the regional monitoring framework. WHO will provide greater attention to priority countries for achievement of MDG 4. Finally, it will support implementation of integrated plans and investments in maternal, neonatal and child health, and capacity-building for community-based health workers, as well as scaled-up IMCI implementation in Papua New Guinea and other priority countries.

**Adolescent health**

**Strategic issues**

Adolescents, despite being recognized as a vulnerable section of the population by various health policies and strategies, are often overlooked during programme implementation and health system development. Technical support and resources must be allocated to activities that cater to the needs of adolescents.

While useful information on certain aspects of adolescent health such as tobacco use is readily available in some countries, gaps in information on sexual and reproductive health, mental health, and injuries and violence need to be urgently filled. WHO must also help countries to develop viable models and strengthen capacities to deliver adolescent-friendly health services.

**Action and results**

Factsheets on adolescent health were developed for selected countries to assist in advocating to policy-makers and stakeholders and to better inform programming.

A Meeting on a Training Network on Child and Adolescent Health and Tobacco Control in the Western Pacific was jointly carried out with the Tobacco Free Initiative in December 2010. Further, in partnership with the Mental Health unit, an Expert Consultation on Adolescents and Substance Use was convened to discuss the conclusions and recommendations of the regional review on substance use, and to suggest ways to support countries in mounting a strengthened response to the issues and challenges of adolescent substance use.

The Philippines was supported in finalizing standards for adolescent-friendly health services and in compiling laws impacting their utilization. Technical support was provided to Hong Kong Polytechnic University to carry out a summer school programme on adolescent-friendly health services in Suzhou, China; students from more than 40 nursing schools in China, including Hong Kong (China) and Macao (China), participated in the programme. Support was provided to the School of Nursing of the Hong Kong Polytechnic University to develop a certificate programme for school nurses to improve their competencies in adolescent health. Papua New Guinea and the Lao People’s Democratic Republic were supported in developing approaches to adolescent health.

Support was provided to Mongolia to integrate adolescent health into primary health care as a follow-up to the rapid programme review of seven programmes—reproductive health, HIV and sexually transmitted infections, mental health, nutrition, alcohol, tobacco, and adolescent-friendly health services—carried out in June 2010. Support was extended to Viet Nam to carry out a review of its adolescent health programme.

**Future directions**

WHO will support Member States in strengthening the health sector response to adolescent health by assisting with the collation, analysis and distribution of strategic information; supporting the development of policies and strategies; and scaling up the provision of adolescent-friendly health services. WHO will continue to support ongoing initiatives, but will also champion new initiatives, focusing on the mainstreaming of adolescent health into primary health care.
Nutrition

Strategic issues

Many countries and areas in the Western Pacific suffer from a double burden of malnutrition—the persistence of nutrient deficiencies along with a rapid rise in overweight and obesity. While undernutrition rates have decreased substantially between 1990 and 2010, thereby reducing the proportion of people who suffer from hunger, WHO estimates that each year, almost 200 000 children die from causes related to childhood and maternal undernutrition in the Western Pacific Region.

Malnutrition in childhood and adolescence leads to suboptimal growth and development. In adulthood, it can hamper women’s reproductive—as well as productive—roles. In the Western Pacific Region, at least seven countries have low-birth-weight rates greater than 10%, a sign of widespread maternal malnutrition. The prevalence of anaemia, which reduces resistance to infection, restricts learning and school performance in children and lowers productivity in adults, is 30.7% in pregnant women, 21.5% in other women and 23.1% in preschool children. Conservative estimates indicate that food-related diseases affect at least 40% of the people in Pacific island countries and areas, where some of the highest rates of obesity and diabetes in the world are found. At the same time, micronutrient deficiencies, arising from poor food quality, lack of vegetables, fruits and iodized salt, and the persistence of parasitic infections, is still a public health problem in many countries.

The importance of good nutrition is poorly understood by many decision-makers. As such, investments to address nutrient deficiencies and obesity are inadequate. Greater efforts are needed to introduce multisectoral programmes that tackle the multiple determinants of malnutrition; to scale up cost-effective interventions targeting high-risk groups; to periodically conduct nutrition surveys to assess and monitor the extent of nutrition problems; and to improve communications aimed at high-risk groups, stakeholders and decision-makers.

Action and results

Nutrition policy and plans development, implementation and monitoring. Partnership building and resource mobilization were supported in Cambodia, China, the Lao People’s Democratic Republic, the Philippines, Viet Nam and several Pacific island countries and areas. WHO also supported the promotion of integrated approaches for food and nutrition security by participating in an Investment Forum for Food Security in Asia and the Pacific, organized by the Asian Development Bank, the Food and Agriculture Organization of the United Nations (FAO) and the International Fund for Agricultural Development (July 2010); a Regional Consultation on Food Security in the ASEAN Region, co-organized by FAO and the Association of Southeast Asian Nations (November 2010); and a review of the REACH pilot project in the Lao People’s Democratic Republic; and a multicountry project led by the United Nations Children’s Fund (UNICEF) on Maternal and Young Child Nutrition Security in Asia.

Programmes on infant and young child feeding and child malnutrition. WHO supported innovative approaches for implementing the International Code of Marketing of Breast-milk Substitutes and the Baby-friendly Hospital Initiative in China and the Philippines, through the Spanish-funded joint United Nations programme on Millennium Development Goals 4 and 5. Exclusive breastfeeding for six months was promoted through mass campaigns supported by WHO and conducted in Cambodia, China, the Lao People’s Democratic Republic and the Philippines. Training courses on the new guidelines and strategies for the prevention and management of child malnutrition in hospitals and communities, including WHO standards to identify malnourished children, were conducted in Cambodia, the Lao People’s Democratic Republic, the Philippines, Solomon Islands and other Pacific countries. Improved infant and young child feeding in emergencies was promoted through a workshop with UNICEF and partners, and
improved nutritional status for the prevention and treatment of HIV was promoted through a workshop with the United Nations World Food Programme and other partners.

**Programmes to improve micronutrient status.** Anaemia prevalence in women of reproductive age was reduced by scaling up weekly iron and folic acid supplementation in communities and schools throughout Cambodia, the Lao People’s Democratic Republic and Viet Nam. Technical evidence for these programmes, which was first presented at a global consultation, was published, together with a guide on best practices for implementing the programme and developing a communications strategy for scaling up these programmes. Strategies for anaemia prevention throughout the life cycle were promoted through follow-up action after a workshop conducted in Viet Nam. Staff from the Regional Office participated in two meetings of the newly established WHO Nutrition Guidance Expert Advisory Group to contribute to the development of global nutrition guidelines. Furthermore, technical support was provided to the Philippines to revise a manual of operations for its micronutrient supplementation programme.

**Healthy diets and physical activity promotion with the noncommunicable diseases and the food safety programmes.** In collaboration with other units and country offices, support was provided for the implementation of the Framework for Action on Food Security in the Pacific, adopted at the Pacific Food Summit 2010 by the Pacific Islands Forum Secretariat. In addition, national obesity prevention strategies were strengthened through a regional consultation, salt reduction strategies were promoted in Mongolia, and food standards that control fat and salt intake were reinforced in the Pacific. Through collaborative activities with the Government of the Philippines and nongovernmental organizations, healthy school programmes were promoted, including the WHO Urbani School Health Kit and other approaches.

**Assessment and monitoring of nutritional status and nutrition programme evaluation.** Integrated food security information systems were promoted in the Pacific, and nutrition surveillance systems were strengthened in Malaysia, through a workshop and by establishing collaboration with WHO Headquarters and National Institute of Health and Nutrition, Japan. With WHO support, zinc status was assessed for the first time in the Philippines, and surveys on iodine status in Samoa and Guam were promoted and advanced.

**Capacity-building in nutrition.** Technical support was used to conduct an analysis of nutrition training needs and to review pre-service and in-service training curricula in Mongolia, to develop new training programmes in Cambodia, and to review the situation in the Lao People’s Democratic Republic. Participation in the multicountry project on Maternal and Young Child Nutrition Security in Asia promoted the use of partner institutions and WHO collaborating centres. Capacity-building for WHO staff working on nutrition in countries also was promoted.

**Future directions**

Future work will focus on fostering political commitment to prevent and reduce malnutrition in all its forms, scaling up interventions to reduce malnutrition caused by deficient and excessive intakes and strengthening nutrition surveillance. A Biregional Consultation on Scaling up Action to Improve Nutrition will be convened by the WHO Regional Offices for South-East Asia and the Western Pacific in August 2011 to help implement the recommendations of World Health Assembly resolution WHA63.23. The focus will be on supporting countries that need to accelerate progress in achieving the Millennium Development Goals, namely Cambodia, the Lao People’s Democratic Republic, Papua New Guinea, and the Philippines in the Western Pacific Region, and on learning from the positive experiences of countries in both regions. Country progress, gaps and needs will be analysed, and commitments to scale up nutrition will be solicited from government and development partners. The consultation will promote implementation of the policy brief, *Scaling up Nutrition: A Framework for Action*, adopted by over 100 organizations in 2010, based on evidence of cost-effectiveness of interventions published in *The Lancet* in 2008.
Noncommunicable Diseases and Health Promotion

Noncommunicable Diseases

Strategic issues

Prevention and control of noncommunicable diseases (NCD) including cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, with an emphasis on eliminating shared risk factors such as tobacco use, the harmful use of alcohol, unhealthy diets and physical inactivity, are regional and global priorities. The United Nations General Assembly High-level Meeting on Noncommunicable Diseases in September 2011 will provide an unrivalled opportunity to scale up actions. Acting on noncommunicable diseases and their risk factors will lead not only to direct health benefits but also to substantial co-benefits in many areas. Simple, practical and sustainable surveillance systems, a whole-of-government approach for risk reduction, and health systems strengthening based on primary health care values and principles for NCD management are the key areas for advancing the NCD agenda.

Action and results

WHO continued to support NCD advocacy activities to affect change in policy. For example, the importance of breast cancer control was advocated during a side event at the sixty-first session of the Regional Committee in Malaysia in October 2010. Furthermore, NCD policy advocacy briefs, with a focus on risk factor control, were developed and disseminated to support multisectoral actions. A WHO global survey of NCD country capacity showed that more than 90% of Member States and areas have an NCD unit or branch in their ministry or department of health and more than 80% have an integrated NCD policy, plan or programme.

National capacities in NCD prevention and control were strengthened through a series of WHO meetings and workshops. The sixth Japan-WHO Joint Meeting on Multisectoral Interventions for NCD Prevention, held in Saitama in July 2010 and supported by Japan’s Ministry of Health, Labour and Welfare, presented multisectoral interventions and recommended health impact assessment as a tool to facilitate policy-level interventions. The meeting brought together 26 participants from health and non-health sectors from 10 countries. In the Republic of Korea, a one-week course, organized by the WHO Collaborating Centre for Cancer Registration, Prevention and Early Detection at the National Cancer Center in November 2010, provided training for 10 managers of national NCD prevention programmes from five countries in the Region.

WHO provided extensive technical support for NCD prevention and control at the country level. Support was extended to the Philippines to introduce a health promoting campaign, called “Healthier You”. Cambodia published its first national WHO STEPwise approach (STEPS) survey and presented the findings to the Mekong Santé Congress in January 2011. Viet Nam completed its analysis of the national STEPS survey and developed a draft national action plan for NCD prevention and control for 2011–2015. Technical support was provided to Mongolia to strengthen the national cancer registration. In China, WHO participated in technical review meetings of the analytical and advisory activities of the World Bank as they relate to health systems and noncommunicable diseases. Also in China, NCD prevention was promoted as one of the main interventions in the Healthy Cities initiative.
In the Pacific, WHO co-organized a Workshop on Nutrition, Diet and Lifestyle in Guam to strengthen the capacity of United States-affiliated Pacific islands to implement the Framework for Action on Food Security. Global School-based Student Health Surveys (GSHS) were completed in Cook Islands, Fiji and Niue, three out of the eight countries trained in June 2010. Salt reduction was promoted in Fiji, Nauru and Solomon Islands. A video on the Marketing of Foods and Non-alcoholic Beverages to Children was developed to provide guidance for action in the Pacific island countries and areas.

WHO organized technical consultations to identify priority interventions and to develop operational guidance for countries. A consultation on obesity control was held in Melbourne, Australia, in collaboration with Deakin University, a WHO Collaborating Centre for Obesity Prevention, in April 2011. A report of the Regional Consultation on Strategies to Reduce Salt Intake, held in collaboration with the Health Promotion Board, Singapore, in June 2010, was made available.

NCD prevention and control was proposed as one of the new priority areas for the Health Working Group of the Asian Pacific Economic Cooperation at a meeting in Sendai, Japan, in September 2010. WHO organized sessions and made presentations at the UICC World Cancer Congress in Shenzhen, China, in August 2010.

In the area of resource mobilization, WHO supported the Ministry of Health of Mongolia to mobilize additional resources for NCD management from the Millennium Challenge Account of the United States Government to improve the management of acute myocardial infarction and stroke and to demonstrate a care continuum. With financial support from the Australian Agency for International Development (AusAID), the regional programme on prevention of blindness was strengthened and a post for coordinating this activity was created.

Programmes supported by voluntary contributions from the Government of Japan, AusAID, New Zealand’s International Aid and Development Agency, the World Diabetes Foundation, Shinno-en, the Korean Fund for International Healthcare, Korea Centers for Disease Control and Prevention and the Government of Luxembourg were continued.

WHO supported Member States in their preparation for the United Nations General Assembly High-level Meeting on the Prevention and Control on Noncommunicable Diseases. Consultations with WHO country teams and round-table meetings were held to develop the NCD road map for 2011. Senior officials of Pacific island countries and areas met in Nadi, Fiji, in February 2011, and adopted the Nadi Statement on the NCD Crisis in Pacific Island Countries and Areas. Pacific health ministers discussed NCD as an agenda item at a meeting in Honiara, Solomon Islands, in June 2011.

WHO helped Member States to prepare for their participation in the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, in Moscow in April 2011. A regional high-level meeting on scaling up multisectoral actions for NCD prevention and control, held in Seoul, Republic of Korea, in March 2011, adopted the Seoul Declaration as the collective voice of the Region for engaging with the United Nations General Assembly High-level Meeting.

**Future directions**

NCD prevention and control will be scaled up in three major areas. First, the WHO STEPwise approach to surveillance, which has been widely used in low- and middle-income countries, will be expanded to move towards sustainable surveillance with institutional capacity. Second, multisectoral interventions will be promoted through Healthy Cities and other platforms and operational guidance will be developed for a whole-of-government approach. Third, NCD services in health systems will be strengthened through a primary health care focus to expand the coverage of a package of cost-effective interventions. Work in NCD prevention will also be guided by the outcome of the United Nations General Assembly High-level Meeting in September 2011 and the sixty-second session of the Regional Committee in October 2011.
Health promotion

Strategic issues

When combined, the components of health promotion—supportive environment, healthy public policy, community action and strong personal skills—enable people to make healthy choices. A whole-of-government and whole-of-society approach is required to achieve healthier lives through health promotion.

Healthy settings approaches, such as Healthy Cities and Healthy Islands, offer effective ways to address public health priorities and integrate health promotion and health protection. Several factors, including political commitment, community support, multisectoral participation and local ownership, have contributed greatly to the success of these healthy settings initiatives. In recent years, rapid economic, environmental and social changes have called for an expansion of Healthy Cities and a revitalization of Healthy Islands. Scaling up and expanding Healthy Cities will require WHO and Members States to strengthen institutional arrangements, build capacity for action, strengthen the evidence base, advance national policy and action, and support city-to-city learning and networking.

Action and results

Municipal leaders shared their experiences at an International Mayors’ Forum on Health Cities in Dalian City, China, in September 2010. In conjunction with the forum, a Meeting of National Focal Points on Scaling up and Expanding Healthy Cities in the Western Pacific Region reviewed key urban health challenges and identified next steps for action at national and regional levels. The Regional Framework for Scaling up and Expanding Health Cities (2011–2015) was endorsed by the Dalian meeting.

Phasing out mercury in health care

Mercury is a chemical element and the only metal that is liquid at standard temperatures and pressure. It has been used globally in a variety of products from paint to skin-lightening products and batteries to measuring devices, including such health care applications as thermometers, blood pressure gauges and even vaccine preservatives.

But there’s a problem with mercury, which exits in elemental, inorganic and organic forms. It’s toxic to human health, posing a particular threat to the development of the fetus during pregnancy and to children early in life.

In hospitals, clinics and doctors’ offices, mercury can be released unintentionally not only from old-fashioned thermometers and blood pressure devices, but also from products in which it has been intentionally added, including preservatives and laboratory chemicals. Such leaks and spills expose doctors, nurses and other health care workers, as well as patients, to danger. And at room temperature, significant amounts of liquid elemental mercury transform to a gas, exposing workers or patients in the area to potentially highly toxic levels.

Earlier this year, 117 countries met for the second round of negotiations on a legally binding global treaty to manage and reduce the use of mercury. The delegates welcomed the offer of Japan to host a diplomatic conference in 2013 in Minamata, where the convention on mercury is expected to be signed. Minamata holds special significance, as it was the dumping of methylmercury in industrial wastewater in the bay there in the 1950s that created one of the most dramatic and emotionally wrenching cases of industrial pollution in history.

WHO supports and promotes the reduction or elimination of releases of mercury and its compounds in the environment. The Organization participates in the United Nations Environment Programme’s Global Mercury Partnership. And WHO, in partnership with Health Care Without Harm, serves as a co-leader for the group working on mercury in health care settings. The working group’s goals are simple: to work with health partners to reduce mercury exposure; to eliminate the use of mercury wherever possible; and to promote the development of alternatives to the use of mercury.

WHO in the Philippines is collaborating with the Department of Health in the implementation of a project, funded by the Global Environment Facility, on health care waste management. An administrative order from the Department of Health calls for the phasing out of mercury in all hospital devices. With WHO support, the department is updating its existing health care waste management manual.

WHO and Health Care Without Harm–Southeast Asia previously have recognized the first 16 hospitals in the Philippines to have phased out mercury. Six hundred of the more than 1700 hospitals in the Philippines have reported that they had already started implementing the administrative order on mercury. As more hospitals in the Philippines and throughout the Western Pacific Region follow their lead, hospitals, clinics and doctors’ offices will be safer, both for patients and health care workers.
Securing sustainable financing and autonomous infrastructure for health promotion has been a priority of WHO since 2002, through a health promotion leadership training programme called ProLead. In partnership with the Southeast Asian Tobacco Control Alliance, through the Southeast Asian Initiative on Tobacco Tax and the Viet Nam Committee on Smoking or Health, WHO organized a Regional Workshop on Strengthening Health Promotion Foundations and Tobacco Control in the Western Pacific Region in September 2010 in Ha Noi, Viet Nam, with participants from Cambodia, Indonesia, the Lao People’s Democratic Republic, Malaysia, Mongolia, the Philippines, Samoa, Tonga and Viet Nam.

At a Meeting for Developing Technical Networks and Resource Centres for Healthy Cities in the Western Pacific Region, held in October 2010 in Seoul, Republic of Korea, it was recommended to establish and/or strengthen national and regional recognition systems to showcase the best practices of Healthy Cities programmes. Several cities in the Western Pacific Region were recognized by WHO for their innovative and effective approaches to promoting and protecting the health of urban populations at the Fourth Global Conference of the Alliance for Healthy Cities, also in the Republic of Korea, in October 2010. Among 63 proposals, two cities received best proposal awards and 14 received best practice awards. Ichikawa, Japan, received the Regional Director’s award.

In cooperation with the WHO Centre for Health Development in Kobe, Japan, the WHO Regional Office conducted a Training Workshop on Urban HEART Application in the Western Pacific Region, as a parallel session of the Fourth Global Conference of the Alliance for Healthy Cities in October 2010, to assess urban health inequities and to develop a response plan. In collaboration with the WHO Kobe Centre and WHO Country Office in China, it also held a workshop for around 50 officials from nine cities in China to introduce the Urban Health Equity Assessment and Response Tool (HEART) and Healthy Cities programme.

The Global Forum on Urbanization and Health, organized by the WHO Kobe Centre in November 2010, brought together government leaders, city mayors and experts from around the world to address healthy urbanization and urban health inequities. The WHO Regional Office sponsored 30 participants from Cambodia, China, the Lao People’s Democratic Republic, Malaysia, Mongolia, the Philippines, Singapore and Viet Nam.

The Regional Committee, at the sixty-first session in October 2010, noted that progress had been achieved in implementing resolution WPR/RC49.R6 on Healthy Cities and Healthy Islands, and urged the Regional Director to develop regional frameworks for future interventions and programmes. Development of the Regional Framework for Scaling up and Expanding Healthy Cities (2011–2015) was supported by the Regional Committee and will serve as a basis to strengthen institutional arrangements, build capacity for action, strengthen the evidence base, advance national policy and action, and support city-to-city learning and networking to promote healthy urbanization.

The Framework of Action on Revitalizing Healthy Islands was endorsed at a steering group meeting on Healthy Islands in Nadi, Fiji, in February 2011. A WHO Healthy Island Recognition programme was launched, and two best practice and three best proposal recognitions were announced at the Meeting of Ministers of Health for the Pacific Island Countries in June 2011.

During a Regional Seminar on Health Promotion and Active Ageing in Asia and the Pacific in November 2010, organized by the United Nations Economic and Social Commission for Asia and the Pacific and Help Age International, the prevention and control of noncommunicable diseases was presented as part of health promotion and healthy ageing.

**Future directions**

Health promotion programmes will be expanded to intensify implementation of Healthy Cities, Healthy Islands and other healthy settings approaches such as health promoting communities, schools, and workplaces; strengthen health promotion policy, build leadership capacity and explore more options for innovative financing through ProLead projects and support for establishment of more health promotion foundations; build and strengthen multisectoral and multi-disciplinary partnerships and approaches for promoting health; and strengthen advocacy for healthy ageing.
Mental health

Strategic issues

Mental, neurological and behavioural disorders are common and cause immense suffering. While expenditures on mental and behavioural disorders in developed countries vary from 5% to 20% of overall health expenditure, most low- and middle-income countries devote less than 1% of their health expenditure to mental health. During the last decade, these same countries have reported little progress in mental health care.

In a WHO survey of international experts, a number of barriers to mental health services were identified, namely the prevailing public health priority agenda and its effect on funding; the complexity of and resistance to decentralization of mental health services; challenges to implementation of mental health care in primary care settings; the low numbers and few types of workers who are trained and supervised in mental health care; and the frequent scarcity of public health perspectives in mental health leadership.

Action and results

The WHO Pacific Islands Mental Health Network is an important mechanism for advancing mental health services and mental health promotion in the Pacific. Encouraging progress has been observed in many Pacific countries in terms of mental health policy, plans and legislation, human resources development, and partnership building. Fiji and Vanuatu endorsed their mental health policy, and nine other countries have drafted national mental health policies. Fiji adopted a new Mental Health Decree 2010. The decree stipulates that mental health treatment, including preventive and rehabilitative services, should be provided in the community by public health services and general health systems. Progress also has been achieved in drafting new mental health acts in Vanuatu and Solomon Islands. Training for physicians and other health workers on diagnosis and treatment of mental disorders was organized in Cook Islands, Solomon Islands, Tokelau and Vanuatu.

WHO has been running the Suicide Trends in At-Risk Territories (START) project for the past few years. The key goals of the study are to develop systematic recording of fatal and non-fatal suicidal behaviours, and to develop flexible and cross-culturally appropriate interventions for suicidal behaviours. A meeting of START investigators took place in Brisbane during the 4th Asia Pacific Regional Conference of the International Association for Suicide Prevention in November 2010. The meeting was an opportunity to update START researchers on the current status of the study across the Western Pacific and beyond. The conference included a START symposium, with presentations from Australia, French Polynesia, Guam and Tonga.

In response to rising concerns of rates and patterns of suicide in the Region, a review was conducted to evaluate the impact of mass media on suicidal behaviours and the effects of media-centred interventions on suicide prevention. Following the review, journalists, mental health professionals and other stakeholders were consulted in China, Hong Kong (China), Japan and the Republic of Korea. The consultations aimed to engage media professionals and other stakeholders in discussions of suicide, and to mobilize the media to actively promote suicide prevention.

WHO continued to collaborate with governments and health professionals in China, the Lao People’s Democratic Republic,
Mongolia and the Philippines to develop and implement information-based mental health policy. Based on findings from the WHO Assessment Instrument of Mental Health Systems (WHO-AIMS), systematic efforts were made to build capacity for mental health in the Lao People’s Democratic Republic, through domestic and international fellowships, short-term training courses and a psychiatric resident programme. Also, national workshops and training of provincial heads of health authorities and provincial hospitals were organized, as a first step to establishing mental health units in all provincial hospitals throughout the country.

**Future directions**

Mental health remains a low priority in most low- and middle-income countries. To overcome barriers, greater efforts are needed to explore innovative approaches to enhance political commitment, to raise public awareness, and to motivate and empower health professionals to provide much-needed mental health services.

**Injury prevention**

**Strategic issues**

Injuries and violence account for about 5 million deaths globally and 1.2 million deaths in the Region annually. Road traffic injuries contribute to approximately 280 000 deaths in the Region, accounting for 22% of the global road deaths, and are among the top two causes of death for people between 5 and 44 years of age. Drowning is the leading cause of death among children 5 to 14 years in the Region.

The United Nations Decade of Action for Road Safety 2011–2020 was launched globally on 11 May 2011. Several Member States, including Cambodia, China, the Lao People’s Democratic Republic, Mongolia, the Philippines, Tonga and Viet Nam, launched their national action plans on or shortly after that date. The Decade of Action provides a unique opportunity for all countries to implement multisectoral interventions to reduce the toll due to road traffic crashes and injuries. Member States are encouraged to enhance their national response to the prevention of road traffic injuries through strategic partnerships with relevant sectors and communities.

The *World Report on Disability* was launched on 9 June 2011. Jointly published by WHO and the World Bank, the report summarizes the best available scientific evidence on disability and calls for increased political support to develop national policies and plans in the areas of disability and rehabilitation. Member States are recommended to harness resources to scale up implementation of a comprehensive package of strategies and programmes that covers health, education, employment and other elements of community-based rehabilitation.

**Action and results**

A Regional Meeting on Road Safety was held in April 2011 to share recent progress in road safety in the Region, to agree on next steps for the second Global Status Report on Road Safety and to discuss proposed country-level activities for the Decade of Action for Road Safety. Twenty-eight countries participated in the meeting, which addressed data issues, institutional settings, and national policies and interventions on road safety.

With funding from Bloomberg Philanthropies, WHO supported multisectoral road safety interventions in Cambodia, China and Viet Nam that strengthened road safety legislation and enforced helmet and seat-belt use, and drink-driving and speed controls. WHO also supported meetings of road safety stakeholders, public education and capacity-building in Cook Islands, Fiji, the Lao People’s Democratic Republic, Mongolia, the Philippines and Tonga. In Guimaras province, Philippines, WHO supported local, multisectoral initiatives to reduce road traffic injuries, such as data
gathering, capacity-building and provision of breath analysers, all of which have contributed to preparations for a new ordinance for road safety in the province.

WHO provided support for drowning-prevention activities, such as data gathering and implementation of model community-based interventions, in Cambodia, Malaysia, the Philippines and Viet Nam. WHO provided technical guidance to develop child injury data systems in the Lao People’s Democratic Republic and Mongolia. In November 2010, WHO supported the participation of professionals from Cambodia, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam at the Second Asia Pacific Convention on Community-based Rehabilitation.

In December 2010, WHO collaborated with the Malaysian Institute of Road Safety Research to organize a course on injury prevention research. Participants from Cambodia, the Lao People’s Democratic Republic, Malaysia, the Philippines and Viet Nam were trained in research methods in the field of injury and violence prevention. WHO supported violence prevention activities, which included situational analyses and pilot interventions, in Fiji, Mongolia and the Philippines. In Mongolia, WHO assisted a one-stop hospital-based centre for victims of violence, which has become a model for the country. WHO provided technical guidance for the development of a national plan for community-based rehabilitation in Cook Islands and Mongolia and the pilot-testing of wheelchair guidelines in Solomon Islands.

Future directions

WHO will work with Member States to scale up activities pertaining to road safety, child injury prevention, violence prevention and community-based rehabilitation. Each of these areas provides unique challenges in setting up surveillance systems, providing services for victims and implementing intersectoral interventions for prevention. WHO will focus on building the capacity of health and related sectors in these areas. A key priority will be to integrate injury and violence prevention into national development plans and to make them disability-inclusive.
Alcohol-related harm

Reducing the health burden caused by the harmful use of alcohol, thereby reducing disease and preventing injuries, is a public health objective of WHO. The harmful use of alcohol is a major contributing factor to death, disease and injury: to the drinker through health impacts, such as alcohol dependence, liver cirrhosis, cancers and injuries; and to others through the dangerous actions of intoxicated people, such as drink-driving and violence, or though the impact of drinking on fetus and child development.

Over the past year, since the World Health Assembly adopted resolution WHA63.13 and endorsed the Global Strategy to Reduce Harmful Use of Alcohol, this area of work has received growing attention and focus internationally. A global meeting of government-nominated counterparts, including representatives from the Western Pacific Region, took place in early 2011 in Geneva. The global meeting provided a forum for the launching of Addressing the Harmful Use of Alcohol: A Guide to Developing Effective Alcohol Legislation. The recently published Global Status Report on Alcohol and Health presents global and regional data on the consumption of alcohol, patterns of drinking, health consequences and policy responses, including country profiles of Member States in the Western Pacific Region.

Based on an earlier review of adolescents and substance use in the Western Pacific Region, an expert consultation was held in Manila in March 2011 to provide guidance to WHO to strengthen the health sector response in this previously neglected area.

WHO supported both government- and nongovernment-led activities in Cambodia and Mongolia, such as national stakeholders’ workshops, projects designed to regulate alcohol use in schools, interventions for repeat drink-drivers and community action.

A number of advocacy and technical materials were developed, such as four technical notes on amphetamine-type stimulants, an alcohol advocacy kit for nongovernmental organizations, and a technical note on alcohol and health consequences.
Strategic issues

Tobacco control is a cost-effective way of preventing premature death and unnecessary suffering from noncommunicable diseases, but only if policy-makers are convinced of its importance. Tobacco-control initiatives—raising prices and taxes; banning advertisements, promotion and sponsorship; enforcing 100% bans on indoor smoking in public places; empowering parents to prevent exposure of children to second-hand smoke in homes; requiring graphic health warnings on tobacco products; offering help for smokers to quit; and prohibiting the sale of cigarettes to minors—do not cost very much. Yet, when combined, they can significantly lower mortality, morbidity and expenditures related to cancer, cardiovascular disease, diabetes and strokes.

Despite the overwhelming evidence of health and economic benefits from strong tobacco control measures, governments struggle to overcome barriers and obstacles posed by the tobacco industry as it relentlessly and aggressively tries to derail the momentum created by the WHO Framework Convention on Tobacco Control (WHO FCTC). This year marked the fifth anniversary of the WHO FCTC coming into force. Advocacy and mobilization of partners in political, social and economic sectors who share responsibility for full implementation of the treaty are key in making progress.

Action and results

Momentum for full implementation of the WHO FCTC has been steadily increasing. Through successful advocacy, legislators and parliamentarians have been convinced of the importance of aligning laws with the Convention. The American Samoa Smoke Free Environment Act was signed into law in October 2010. Fiji amended its existing legislation to comply with the WHO FCTC and put into effect the new Tobacco Control Decree 2010 in December. Kosrae State in the Federated States of Micronesia banned the sale of single cigarette sticks. Cambodia approved a comprehensive ban on cigarette advertising, promotion and sponsorship in February 2011. Hong Kong (China) has extended its smoking ban to 130 outdoor public transport facilities since December 2010. Furthermore, the fixed penalty system introduced in 2009 (fine of US$ 193 for lighting up in no smoking areas) was successfully enforced in 2010 with 8000 penalty notices.

An unprecedented flurry of action was taken by leaders in cities, municipalities, institutions and other local settings to support smoke-free settings in the priority countries of the Bloomberg Initiative to Reduce Tobacco Use, namely China, the Philippines and Viet Nam. In China, the declaration by health officials of a smoke-free World Expo 2010 in Shanghai inspired action toward the launch of a global movement for tobacco-free mega events. The Asian Games held in Guangzhou were also smoke-free. Following a ministerial decision to make all health facilities in China smoke-free, results of official monitoring have been reported to media. Seven cities are aggressively pursuing smoke-free policies: Chongqing, Harbin, Nanchang, Lanzhou, Shenyang, Shenzhen and Tianjin. In the Philippines, the Department of Health and the Department of Interior and Local Government endorsed a memorandum circular for all provinces, cities and municipalities to enact a model smoke-free ordinance that is consistent with the WHO FCTC. Successful implementation was noted in four major provinces: Misamis Oriental, Negros Oriental, Nueva Vizcaya and Romblon. In Viet Nam, a gender and tobacco project was expanded to cover the whole of Than Mien district in Hai Duong province.
major project on smoke-free transportation was also started in Ho Chi Minh City.

Several Member States have successfully convinced economic and finance officials to raise prices and taxes of tobacco. Australia announced a 25% increase in tobacco excise tax. Brunei Darussalam successfully increased tax and excise duty on tobacco products resulting in a tripling of the price of cigarettes. In Tonga, duty for tobacco increased in July 2010.

Paediatricians and child health care providers have taken the lead in public advocacy for the prevention of youth smoking and protection of children against second-hand smoke. In December 2010, WHO convened a Meeting on a Training Network on Child and Adolescent Health and Tobacco Control. Participants included experts and advocates from Australia, China, Japan, Fiji, Malaysia, Mongolia, the Philippines, Singapore and Viet Nam and resource staff from the American Academy of Paediatrics and its Julius B. Richmond Center of Excellence. The Philippine Ambulatory Paediatric Association presented pioneering work on the development of training modules for paediatricians. Participants agreed to establish an informal network that will continue to enhance the knowledge and skills of child and adolescent health care providers.

National focal points on tobacco control have also stepped up efforts for stronger tobacco control programmes within ministries of health. In support of the Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2010–2014), which was endorsed by the WHO Regional Committee for the Western Pacific in September 2009, a workshop on establishing indicators for tobacco control was held in August 2010 in Manila with participation of national focal points on tobacco control from 32 countries and areas. Workshop participants used the most recent available data to determine their targets, priority actions and indicators for progress toward reduction of prevalence of tobacco use by 10% of the current baseline by 2014. It was agreed that indicators on the following were the highest priority: (1) protection against second-hand smoke exposure; (2) taxation; (3) surveillance systems; and (4) training health workers.

Based on the results of a meeting on betel nut and tobacco use, it was also agreed that chewing tobacco would also be included in national action plans of countries where this is a problem.

WHO strongly supported initiatives for sustainable tobacco control. In September 2010, WHO, in collaboration with the Southeast Asian Tobacco Control Alliance and the Viet Nam Committee on Smoking or Health, convened a Regional Workshop on Strengthening Capacity for Health Promotion Foundations and Tobacco Control. Building on the previous work on health promotion leadership training (ProLead), the capacity-building interventions were conducted with executives from health promotion foundations and boards in Malaysia, Mongolia and Tonga and teams composed of finance and health officials of countries that are trying to secure a percentage of tobacco taxes for health promotion foundations and tobacco control—Cambodia, the Lao People’s Democratic Republic, the Philippines, Samoa and Viet Nam.

Tobacco surveillance continues to be the backbone of tobacco control. China, the Philippines and Viet Nam successfully completed implementation of the Global Adult Tobacco Survey, which enables them to compare adult data with other countries in the world. The Global Youth Tobacco Survey was implemented in Cambodia, Guam, the Lao People’s Democratic Republic, Macau (China), the Philippines and Viet Nam. WHO participated in the Asia Pacific Conference
on Tobacco or Health in Sydney, Australia, in October 2010 and shared how the Region has developed innovative methodologies to help countries use data for policies and action.

A Global Health Professions Surveillance System Policy and Programme Workshop was convened in May 2011 with participation from six countries—China, Fiji, Mongolia, the Philippines, the Republic of Korea and Viet Nam. Institutional plans of action were developed to incorporate tobacco control policies and practices in the training of health professionals.

The Fourth Conference of Parties (COP4) of the WHO FCTC was held in Uruguay in November 2010 with the participation of 22 parties from the Western Pacific Region. Partial guidelines on Article 9 (regulation of tobacco products) and Article 10 (regulation of tobacco product disclosures) were endorsed. Guidelines on Article 12 (education, communication, training and public awareness) and Article 14 (demand reduction measures concerning tobacco dependence and cessation) were adopted. The mandate of the working group on Article 17 (provision of support for economically viable alternative activities) and Article 18 (protection of the environment and health of persons) was extended. The Parties agreed to create a working group to draft guidelines on Article 6 (price and tax measures). Negotiations on the Protocol on Illicit Trade in Tobacco Products will continue until 2012. The reporting cycle for Parties has changed, effective 2012, so that all reports will be synchronized with the Conference of Parties. The Republic of Korea won the bid to host the Fifth Conference of Parties in Seoul in 2012.

Future directions

WHO will continue to work with Member States in advocating for full implementation of the WHO FCTC, emphasizing the health, economic and social benefits. Linking tobacco control to overall efforts to curb the noncommunicable disease epidemic will be the key. Tobacco control indicators need to be reflected in updated national action plans and should also be expressed in national health plans. Policies, legislation, enforcement of laws and changing of social norms will continue to be crucial strategies for regulating tobacco use.

WHO will continue to organize technical support for raising taxes and prices and setting up health promotion foundations using a percentage of tobacco taxes.

Protection against exposure to second-hand smoke will continue to be a high priority. Localized and targeted work on smoke-free policies and settings will be emphasized. This includes advocacy for smoke-free mega events in China and in other countries, smoke-free world heritage sites and public education campaigns to recognize institutions, organizations, provinces, cities and municipalities that are mobilizing communities to endorse and demand smoke-free environments as a public health measure.

Smoking cessation and treatment of tobacco dependence are high on the agenda. WHO will continue to encourage and support Member States in training health professionals to give brief cessation advice to patients, in establishing quitlines or telephone-based cessation services, and in developing comprehensive cessation systems.
Strong health systems are vital for addressing public health challenges in the Western Pacific Region. Whether tackling communicable disease, responding to the burgeoning noncommunicable disease burden, or ensuring the survival of mothers and children, stronger health systems hold the key to improved health outcomes. The mission of the Division of Health Sector Development is to support countries in their progress towards universal coverage and equitable access to quality health services.

The Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care, developed during a two-year consultative process, was endorsed by the Regional Committee for the Western Pacific in October 2010.

Over the past year, national health policies, strategies and plans have become more prominent on the global health agenda. Robust plans foster aid effectiveness because countries can use them to guide and coordinate external partners’ work in support of national priorities and objectives. WHO in the Western Pacific has been conducting a region-wide learning programme to upgrade the quality of staff participation in policy dialogues and national health planning processes.

A key area of work has been to support countries to apply for, negotiate, implement and monitor grants from the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Similarly, the Division worked with the maternal and child health programme in the Regional Office to identify the health systems bottlenecks in the delivery of health packages, and further work was done on the interface between noncommunicable diseases and strengthening health systems.

Many households in the Region suffer financial hardship because of high health care costs, or go without treatment because they cannot afford to pay. Both the World Health Report 2010 and the Health Financing Strategy for the Asia Pacific Region (2010–2015) outline the main strategic directions for health financing. Several countries have established targets for more equitable health spending. WHO formulated health financing profiles for all Member States in the Region to assess health expenditure trends and key health financing policies during the period 1997–2007, and to allow countries to compare their experiences.

The World Health Report 2010, titled Health Systems Financing: the Path to Universal Coverage, was launched in the six Asian countries with the most inequitable health outcomes: Cambodia, China, the Lao People’s Democratic Republic, Mongolia, the Philippines and...
Viet Nam. These countries also received training to assess the impact of health payments on households, and then were supported to apply these methods to their own countries.

WHO continued its efforts to raise awareness of health inequities and build the skills and political commitment needed to address these issues. This follows on from the work of the Commission on Social Determinants of Health, and on an initiative from the Government of South Australia. In 2010, a new area of work was initiated to improve health in prisons. A draft framework to assess health in prisons was piloted in Mongolia and the Philippines.

Health workforce challenges in the Region include a shortage of health workers, especially in rural and remote areas, an unbalanced distribution of skills and low-quality training. A mid-term review of the Regional Strategy on Human Resources for Health (2006–2015) assessed progress made to date. To scale up operational implementation of the strategy, an updated Human Resources for Health Action Framework (2011–2015) was developed.

Improving the quality of health professionals’ education and training was a key focus in 2010. The Regional Director launched a special initiative to establish education development centres for health professionals in Cambodia and the Lao People’s Democratic Republic.

Strong health information systems help policymakers, planners and providers understand challenges and assess progress. Decisions such as where health centres should be located, what kinds of medicines and equipment health centres need, and whether or not services are too expensive for the poor should be guided by high-quality information and evidence. Over the last year, WHO worked with regional and country partners to improve national vital registration systems, an important source of information for measuring progress towards the health-related Millennium Development Goals. An analysis of progress made by countries in the Region towards these goals was published. WHO’s Country Health System Surveillance (CHeSS) tool was used to monitor the performance of health systems in countries such as Cambodia and China.

WHO is committed to building a sound evidence base on health and health systems issues in the Region that can inform the development of policies and programmes and ensure efficient use of available resources to achieve the best possible health outcomes. In 2010, WHO significantly scaled up its investment in an ethical review process, establishing a regional committee and a network of national committees.

The Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2015) was developed, through a consultative process with Member States and experts, to improve access to essential medicines and provide a platform for regional-level actions that benefit individual countries. It establishes a strong monitoring mechanism, with 19 core indicators for which baseline data will be collected in 2011. A Price Information Exchange for selected medicines in the Western Pacific Region was launched this year.

In 2010, WHO supported Fiji, Kiribati, Malaysia, Mongolia, Nauru, Papua New Guinea, Solomon Islands and Tuvalu to develop their national laboratory policies and plans, strengthen their capacity to plan and manage resources, and ensure quality control in laboratory services. To improve the quality of laboratory services, WHO supported the Pacific Paramedical Training Centre in New Zealand to conduct a standardized quality assessment in 19 national laboratories; mostly in Pacific island countries. Training materials on quality management were disseminated across the Pacific and regional guidelines developed.
Strategic issues

Universal coverage is an important goal for both developed and developing countries in the Western Pacific Region. Inequity, in terms of access to integrated, comprehensive and quality health services, remains a significant and widespread challenge both between and within countries.

National health policies, plans and strategies have taken a more prominent role in the global health agenda over the past year. A major impetus was the decision by external funders, such as the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank, to consider using national health plans as platforms for funding. However, it was also recognized that the aid effectiveness agenda, particularly country ownership, is better achieved if countries have robust strategic health plans and policies that serve as a means of guiding and even controlling input from external partners.

In planning for the health of their populations, countries need to examine a wide range of challenges including the growing burden of noncommunicable diseases coupled with the continuing threat of communicable diseases; rapid demographic, political and economic changes with resulting effects on the social and environmental determinants of health and the services needed; marketization of service delivery; dependence on user fees; and a heavier reliance on technology and specialization than on primary care.

Action and results

The Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care was endorsed and adopted by the Regional Committee for the Western Pacific in October 2010. This strategy summarizes and merges a series of topic-specific health system strategies into one guiding document that was developed through a two-year consultative process with all Member States and a range of health system experts and researchers.

WHO worked directly with Member States to support national health policy dialogues through plan development, sector monitoring and reviews, sectoral coordination, development of service delivery models and packages, hospital reform, and proposal development. Support was provided by WHO staff from the country offices with back-up from the Regional Office and at times Headquarters. Direct support was provided by WHO in Cambodia, China, Fiji, Kiribati, the Lao People’s Democratic Republic, Malaysia, Mongolia, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Vanuatu and Viet Nam. Recognizing the increasing importance of health policy dialogue, WHO has embarked on a global effort to upgrade the quality of its participation in these processes at the country level, with financial support from the WHO Global Learning Programme. Considerable regional staff time has been invested in supporting this initiative.

Support to countries in their dealings with GAVI and the Global Fund has been provided in proposal development and grant negotiation, as well as implementation and monitoring processes. In Cambodia, a consultation on the joint Health Systems Funding Platform by GAVI, the Global Fund and the World Bank was held, with WHO as lead facilitator, to discuss alignment of donor requirements with the national system. In Viet Nam, a Joint Assessment of National Strategy was undertaken with national counterparts as part of the process for GAVI and Global Fund support. Three of the five countries that received assistance in preparing health systems strengthening proposals for
the Global Fund were successful, namely Papua New Guinea, Mongolia and Viet Nam.

Support for small-size quality assurance projects was provided to six Asian countries and 12 Pacific island countries and areas. Patient safety, particularly use of the safe surgery checklist, was fostered and a subregional workshop to introduce the checklist was held in conjunction with a surgical society meeting in Viet Nam for participants from Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam. Follow-up activities are planned for the coming year.

A review of public health legal processes in the Lao People’s Democratic Republic was accomplished as part of the introduction of various legal instruments dealing with health care financing and human resources. In addition, a meeting of experts on public health law with an emphasis on Pacific island countries was held. Relevant documents and tools were reviewed to promote a more unified and harmonized approach in providing technical assistance on public health law to countries.

**Future directions**

WHO will continue to work directly with countries to strengthen the quality of policy dialogue and planning-related processes, linking its work on governance, aid effectiveness, service delivery models, quality and patient safety.

Country office staff will engage at strategic levels in health sector and system performance reviews and health-related policy dialogue with other sectors. A strategic and pragmatic approach is needed to the work on health in all policies. WHO staff need to acknowledge, and be supported to act on, their mandate to work with other sectors on health-related issues.

The burden of noncommunicable diseases is placing strain on the health systems of countries in the Region at all levels of development. Identifying evidence-based innovative service delivery models that meet the needs of patients and communities in an integrated and cost-efficient manner across the continuum of care and life cycle will be a strategic priority for the Region in coming years. Operational research and country case studies will be important in building up the evidence base on what works, in what circumstances, and what is needed to bring service delivery to meaningful scale. Strengthening managers in the effective use of available resources for responsive service delivery is needed. Additional support to subnational health system development is needed in many settings. There is also a need for stronger engagement with the hospital sector in regards to management, quality, safety, accreditation and support to lower levels of care.
Health care financing

Strategic issues

Universal health care coverage remains the overarching goal of health financing policies in the Western Pacific Region. The World Health Report 2010, launched globally in November 2010, gives governments practical guidance on ways to finance health care so more people get the care they need. It stresses that all countries, at all stages of development, can make important steps to move towards universal coverage. This is consistent with the Health Financing Strategy for the Asia Pacific Region (2010–2015).

There are three fundamental and interconnected health financing challenges. First, sufficient funds need to be raised to cover at least the cost of delivering essential health interventions. Second, these funds should be raised in such a way that they minimize financial risks and barriers to access. This means minimizing reliance on direct out-of-pocket payments for health care, particularly for the poor and other vulnerable groups. Third, resources for health should be spent more efficiently and equitably, so that health outcomes for all are maximized given available resources.

Action and results

With the World Health Report 2010 and the Health Financing Strategy for the Asia Pacific Region (2010–2015), the main strategic directions for health financing in the Region are now well elucidated. The regional strategy is available in Chinese, French, Khmer, Lao, Mongolian and Vietnamese. Further, health financing country profiles covering the period 1997–2007 have been developed for all Member States in the Western Pacific Region. These profiles analyse trends in health expenditures and provide snapshots of key health financing issues in each country. Given the widespread interest in these profiles by countries and partner agencies, the profiles will be updated and expanded to cover the period 1995–2009.

Region-specific health financing experiences and achievements provided important input for the World Health Report 2010. After its official release, the report was launched in six countries where priority on health financing reform is supported by WHO. These countries were Cambodia, China, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam; countries where, despite some recent improvements, government spending on health remains relatively low and reliance on out-of-pocket payments correspondingly high. Following these activities, a WHO action plan to support countries in implementing universal coverage was developed.

In addition to improving the overarching strategic directions in health financing, many countries have been actively reforming their health financing systems with the support of WHO. In China, important strides have been made towards universal coverage. The Government has invested substantially to not only expand health insurance membership, but also increase the share of costs covered by health insurance. Further, public health programmes have been expanded and more equitably financed through the use of equalization grants and fiscal transfers.

In the Lao People’s Democratic Republic, a national health financing strategy is under revision, based on the National Health Sector Development Plan. The strategy consolidates various policy initiatives related to health financing, including a free maternal and
The financial burden of health payments

Each year, millions of families in the Western Pacific Region fall into financial hardship due to the cost of health care. An estimated 80 million people suffer financial catastrophe and 40 million are impoverished each year in the Region because they have to pay for health care, according to a 2007 study. And this is happening despite the Region’s impressive economic growth.

But even more powerful than the numbers are the individual stories. Take the case of the Aguila family in the Philippines. One of their sons complained of joint pain and inflammation. Self-medication and a traditional healer offered no relief. The family finally brought their son to a regional hospital. After no improvement, they visited a private hospital, which undertook a CT scan, X-rays and consultations with various specialists. Finally, he was diagnosed with rheumatic fever and rheumatic heart disease. The family had to spend US$ 600 on the various tests, consultations and transportation for an illness that could have been diagnosed by a general practitioner with minimal lab tests.

A similar story is that of Dou Huhai from China, as reported in the WHO Bulletin. Dou, a factory worker, caught his left hand in a punching machine, crushing two of his fingers. Taken to hospital, a doctor told him it was going to be possible to salvage most of his fingers. But when he discovered that Dou could not pay for the operation and had no insurance coverage, the doctor performed a simple amputation. In China, substantial investment in the health system is improving access to care. In the Philippines, spending increases are limited, but there are promising signs that health is being pushed higher up the government’s agenda.

Having a better understanding of how households are affected by health payments is critical, so that precise policies can be designed to stop health care from causing financial difficulties. That is why WHO has been working with countries and other development partners to improve country capacities in analytical financing work. As part of this support, Cambodia, China, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam have been conducting studies on the financial burden of health payments, having previously completed training activities. These studies not only estimated absolute figures, for instance, about 1.15 million families in Viet Nam faced financial catastrophe in 2008 because of health care costs. But they also showed that key determinants of financial hardship or lack of access to care, such as households caring for the elderly and young children, as well as poor and near-poor families, were typically the most at risk.

The six countries have started to use this evidence to influence policy in the form of policy briefs and discussions with key stakeholders. These have been consistent with recommendations from the WHO Health Financing Strategy for the Asia Pacific Region (2010–2015) and the World Health Report 2010, both of which emphasize the need to move away from heavy reliance on direct out-of-pocket payments if universal coverage is to be achieved.
child health care policy. Further, there are ongoing policy discussions on options to reduce the fragmentation of existing social health protection mechanisms (various health insurance schemes and health equity funds) by merging them into a single scheme.

WHO continued to support the implementation of the hospital financial management system in Mongolia, and supported actions to strengthen social health insurance coverage and to improve health service benefit and quality.

Equitable access to quality health service by all people is an important goal of the national development plan of the Philippines. The new administration aims to attain universal coverage in the next three years. In December 2010, the Department of Health issued an administrative order to implement the Aquino Health Agenda: Achieving Universal Healthcare for all Filipinos. It focuses on expanding social health insurance coverage especially to the poor and vulnerable with public subsidies. In May 2011, WHO together with development partners organized a senior policy seminar in support of the universal health care agenda.

Over the past year, progress was made in developing and applying WHO tools and methodologies. The WHO methodology for analysing the financial burden of health payments was introduced and applied in the six priority countries of Cambodia, China, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam. This assessed access to care, catastrophic health expenditure and impoverishment incidences associated with ill health. A particular focus was on capacity-building, with countries taking the lead in such analyses. The studies suggest that despite some reductions in out-of-pocket payments, health care remains as the likely leading cause for households falling into financial hardship. For example, in Viet Nam, it is estimated that 1.15 million households faced catastrophic health expenditure and over 740,000 households were impoverished due to direct out-of-pocket health payments alone in 2008. These numbers are high compared to similar estimates made in 2006. The results of the six-country studies were discussed between countries and with other development partners during a workshop held in Manila in March 2011. Following the workshop, policy briefs on the reduction of direct out-of-pocket payments, catastrophic health expenditure and impoverishment were developed and disseminated for policy use in different country settings.

Complementing this work on evaluating the financial burden of health payments, training was provided to assess the organizational and institutional aspects of health financing, using the Organizational Assessment for Improving and Strengthening Health Financing approach developed by Headquarters. It was introduced to the Region during an intercountry workshop held in Viet Nam, with subsequent technical support to implement this tool in Mongolia.

Health financing support to the Pacific islands focused on developing National Health Accounts (NHA). This was done in partnership with the Asian Development Bank (ADB), where NHA tools, technical notes and reference documents guiding NHA development in the Pacific were developed. A framework to institutionalize NHA in Fiji, the Federated States of Micronesia and Vanuatu was developed and implemented with the
production of a second round of NHA reports covering 2006–2007. Further, NHA experts in Pacific island countries agreed to expand opportunities to share country- and region-specific expertise, skills and experiences. More broadly, the region has contributed to the revision of a System of Health Accounts that aims to set global standards for NHA development and production of reports applicable for all countries.

WHO continued to monitor the health impacts of the recent global economic crisis, notably in Cambodia, China, Fiji and the Philippines. The results suggest that the global economic crisis has not had serious negative impacts on the health sector in Asia, as of 2010, due to timely responses from governments, including the protection of government health budgets.

In consultation with countries and experts, the WHO Regional Office developed MacroHealth, a simulation tool for assessing the fiscal space available for the health sector, given macroeconomic and public finance constraints. The software has been used in the Lao People’s Democratic Republic, Malaysia and the Philippines, and following interest will be applied in other countries. Policy briefs on health investment, fiscal space and budget support were derived from this tool.

The work of the Health Care Financing unit was expanded to other technical units, divisions and institutions. For example, a regional training workshop on tobacco taxation was co-organized with the Tobacco Free Initiative. Technical input was also provided on cross-cutting work related to health system bottlenecks to delivering essential interventions for noncommunicable diseases. Together with the Health Services Development unit, technical input was provided to discussions on Malaysia’s health sector transformation. Contributions were also made to discussions on health systems strengthening and attainment of Millennium Development Goals 4 and 5 in Cambodia, China, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam.

The unit contributed to the publication of an ADB book on poverty and sustainable development in Asia and social health protection in the Asia Pacific region. Technical support was provided to increase national capacities in health care financing and social health protection through various activities, including social health insurance training courses.

**Future directions**

WHO supports countries to develop adequate, sustainable and equitable health financing contributing to universal coverage. With strategic directions provided by the *World Health Report 2010* and the *Health Financing Strategy for the Asia Pacific Region (2010–2015)*, the focus is now on country-specific activities. Clear road maps to universal coverage, with movement from fragmented to more consolidated social health protection, are necessary for most countries in the Region. In countries with low government spending on health, it is also important to assess the feasibility and returns from increased spending. And for all countries in the Region, there is a need for an increased focus on potential efficiency gains. Of particular importance is the reform of provider payments, such that they create incentives for health workers to deliver appropriate care. More critical assessments of what health services are included in government-funded benefit packages are also needed. All these efforts are expected to be carried out in close partnership with other United Nations organizations and development agencies, and in such a way that national capacities are strengthened.
Equity, poverty, gender, human rights

Strategic issues

The Region has witnessed steady economic progress in recent decades, but benefits of this growth have not been adequately shared across all population groups. Similarly, the benefits of health gains achieved over this period have been unequally distributed, increasingly leaving behind the poor and those from marginalized groups. Health inequities are increasing and are likely to remain a defining challenge in the foreseeable future. Equity, gender and human rights issues in health thus remain critically relevant in the Region.

The Region faces important challenges in reducing inequities in access to health services and in health outcomes. Weak or inefficient health systems continue to put the poor and other socially excluded population groups at a disadvantage.

Some progress has been made, but more is needed. Health must be recognized as central to development. In addition, countries and areas must ensure more equitable access to health services for all sections of the population and address financial or social barriers to access, including poverty, gender and ethnicity.

Action and results

The overall approach of WHO has been, first, to build the awareness, skills and capacity of technical programmes and countries on poverty, equity, gender and human rights issues in health and to develop, disseminate and promote the use of tools to support this work. A regional meeting on social determinants of health was held in Manila in June 2011, as part of the Region’s activities in the lead-up to the World Conference on Social Determinants of Health, to be held in October 2011 in Brazil.

Workshops were held to strengthen the capacity of Ministry of Health staff in Mongolia, the Philippines and Solomon Islands on equity, gender and human rights. Efforts to increase awareness and knowledge of trade and health were supported in the Philippines, in terms trade in health services, and in the Philippines and Viet Nam, in terms of the implications of intellectual property provisions in trade agreements. Cambodia, China, Mongolia and Viet Nam were supported to translate selected technical materials into local languages.

Secondly, implementation support was provided to technical programmes and countries to address poverty, equity, gender and human rights in their policies, programmes and actions. A new area of work was initiated on health in prisons. A draft framework for conducting health assessments in prisons was developed and piloted jointly with the tuberculosis programme in Mongolia and the Philippines, using TB services as an entry point. Gender analysis and actions are being integrated into maternal, child and neonatal health planning at the district level and micro-planning at the health centre level in the Lao People’s Democratic Republic. Work on gender-based violence was supported in Viet Nam and in the Pacific island countries under the UNiTE campaign. In Papua New Guinea, the focus was on gender-based violence, especially sexual violence. Kiribati, Solomon Islands and Viet Nam participated in a workshop on prevention of intimate partner and sexual violence against women. Support on gender mainstreaming was provided to the Division of Health Security and Emergencies, and to the Malaria, other Vectorborne and Parasitic Diseases unit in the Philippines. Joint activities on disabilities were undertaken with the injuries and violence prevention and nursing programmes. Cambodia was supported to review draft legislation to implement certain flexibilities related to TRIPS, the trade-related aspects of intellectual property rights.
A third approach has been to strengthen capacity in equity analysis, monitoring and measurement, as well as the collection, analysis and use of health information that is disaggregated by relevant social stratifiers. In collaboration with Headquarters, financial and technical support was provided to seven participants from four countries in the Region, namely China, Malaysia, the Philippines and Viet Nam, to attend a global policy dialogue meeting in Washington, DC, in October 2010, designed to strengthen evidence to improve women’s health through gender and health statistics. Follow-up activities were developed. The Regional Office participated in and made a presentation at the Global Forum on Gender Statistics, organized by the United Nations Statistics Division. A chapter on equity issues in achieving the Millennium Development Goals (MDGs) was written for inclusion in the regional MDG progress report. In the Philippines, use of the Urban Health Equity Assessment and Response Tool (HEART) was scaled up to seven cities.

An equity focus informs the Region’s work in health systems strengthening and primary health care, with the goal of universal access to quality services for improved health outcomes for all.

Future directions

Awareness, capacity and commitment in Member States and technical programmes on issues related to equity, human rights and gender in health remain relatively weak. Continued support and advocacy are needed.

Future work will include providing technical support for practical solutions to measure, analyse and monitor health inequities. There are several examples of successful collaboration with other units and technical programmes to work on these cross-cutting issues. This approach will be strengthened and continued in the future.
Strategic issues

Quality health services require a strong health workforce. Unfortunately, many countries and areas in the Western Pacific Region are facing a health workforce crisis: absolute shortages of qualified health workers; unbalanced distribution of workers and inefficient skill-mix; unsuitable training and education for patient and population needs; and financial constraints coupled with poor motivation and retention. Although many workforce challenges are common within and across countries, each country’s unique health system and political, socioeconomic and topographical situation necessitates workforce policies and strategic interventions relevant to the national and local context.

Efforts to strengthen political commitments and to foster effective partnerships and collaboration among key health and cross-sectoral stakeholders at country and regional levels have been intensified through the deliberations and action plans of Member States, WHO and partners in addressing human resources for health (HRH) priority gaps. Networks and alliances facilitating these efforts have included the Asia Pacific Action Alliance for Human Resources for Health, the Pacific Human Resources for Health Alliance, the Pacific Islands Health Officers Association, the American Pacific Nurse Leaders Council, and the South Pacific Chief Nursing and Midwifery Officers Alliance. The Second Global Forum on Human Resources for Health, which was attended by countries in the Region, called for concerted actions and coherent policies and plans across sectors, with development partners, for sustainable HRH investments from domestic sources.


Action and results

A five-year Human Resources for Health Action Framework (2011–2015) to scale up implementation of HRH strategic work was updated in 2011. This was preceded by a comprehensive analysis of the current HRH situation and responses to date; a review of case studies in three priority areas of work; an examination of innovative education, leadership and partnerships, management and retention; and consultative meetings with Member States, stakeholders and partners.

Recognizing the need to better utilize information and scale up health workforce capacities to address disasters, a compilation of case studies on the role of nurses and midwives in emergencies and disasters was disseminated, to highlight the health sector response, lessons learnt and potential best practices. Case studies in Cambodia, the Lao People’s Democratic Republic and Vanuatu identified retention strategies best suited to each country’s unique needs.

Improving understanding of human resource systems and workforce databases was the focus of a human resource management course in the Federated States of Micronesia, Solomon Islands and Vanuatu.

Country-specific nursing and midwifery education, workforce and regulatory data were compiled through mapping, institutional studies and surveys to enhance workforce planning efforts and academic-service collaboration.

WHO provided technical support to a number of priority countries to strengthen their evidence base and to develop national health workforce policies and strategies. In the Lao People’s Democratic Republic, WHO and the Ministry of Health convened HRH technical working group meetings that culminated in December 2010 with the adoption of the Health Personnel Development Strategy by 2020, while the Prime Minister endorsed a decree to introduce financial incentives for rural civil servants.

Cambodia continued its review of the health workforce as part of a mid-term review of the Ministry of Health’s Second
National Health Workforce Development Plan 2006–2015. A high-level steering committee was nominated to analyse and address HRH priority issues including workforce deployment in remote and rural areas, guided by WHO technical guidelines, workforce projections and educational reforms. A national nursing taskforce is being formed to produce nursing competencies and standards of practice for service delivery and compile existing legislation on the scope of nursing practice. Nursing assessment and decision-making steps are being given increased attention following the successful National Nursing and Midwifery Conference in November 2010, which placed emphasis on ethical and safe clinical decision-making.

Cambodia and the Lao People’s Democratic Republic, with support from a WHO special initiative addressing the quality of health professional workforce production, established national education development centres. Cambodia launched its Center for Educational Development for Health Professionals in January 2011, a significant milestone in the development of professional councils. The councils are mandated to establish academic standards, regulate and accredit educational institutions and certify health workers competence through national examinations and other requirements for registration and continuing education. Teacher training for educators from these two countries took place in Manila in August 2010 and in Phnom Penh, Cambodia in December 2010, supported by WHO, the University of the Philippines National Teachers Training Center and Seoul National University.

The China Medical Board support, with technical guidance from WHO, facilitated ongoing research studies and initiatives including a Situational Analysis and Policy Evaluation of Deployment and Retention of Human Resources for Health in Rural West China as well as a study on Reform on the Salary System for Health Professionals in Public Hospitals in China.

A two-year Special Fellowship for the Health Leadership Development Initiative was instituted in 2011 by the Regional Director with funding from the Governments of Japan and the Republic of Korea. The objective of the initiative is to prepare mid-level health professionals for leadership roles in public health. A Special Fellow working with the WHO Health Services Development unit is currently working on health systems strengthening in Papua New Guinea.

WHO continued to develop the competencies of health workers in the Region and abroad through the its fellowship programme. In 2010, more than 389 fellowships and group study tours were awarded, 54% to males and 46% to females, amounting to an overall 17% drop from 2009. Regional fellowships were arranged for 53 fellows from the South-East Asia Region and 28 from the Eastern Mediterranean Region. The most common fields of study were public health and research and clinical and curative care. Countries in the Region that received the most fellows were Australia, Fiji and New Zealand.

Nearly 70 health professionals from 16 countries completed the first Biregional Infection Control Training Course in November 2010, through the collaborative efforts of two WHO collaborating centres and the Hong Kong Hospital Authority. Those trained have completed national infection control assessments and are implementing country action plans to improve infection control and patient safety, with technical support from WHO and a number of infection control experts.

System-wide quality improvement for emergency and disaster resilience was addressed by more than 60 nurses and other health professionals from 26 countries during the November 2010 meeting of the Asia Pacific Emergency Disaster Nursing Network in Auckland. The Psychosocial Health and Disaster Training Package, prepared by James Cook University, a WHO Collaborating Centre for Nursing and Midwifery Education and Research Capacity-Building, is now accessible through this network, the Pacific Open Learning Health Network (POLHN) and other networks and institutions.

In November 2010, more than 50 delegates of the South Pacific Chief Nursing and Midwifery Officers Alliance from 15 Member States met to discuss the WHO Strategic Directions for Nursing and Midwifery 2011–2015 in the priority action areas of health systems strengthening and quality improvement. Outcomes of the Australian Leadership Awards programme, which is funded by the Australian Agency for International Development, were presented at the meeting to facilitate the sharing of lessons learnt across borders.

Future directions

Future work with Member States and partners will be tailored to the 2011 World Health Assembly and Regional Committee resolutions, the regional Human Resources for Health Action Framework 2011–2015 and Strategic Directions for Nursing and Midwifery 2011–2015, towards achievement of WHO’s vision for human resources for health:

“Universal coverage for access to quality health services, particularly for the most vulnerable and excluded groups, with improved patient and community health outcomes, through a balanced distribution and efficient skill-mix of a multi-professional, motivated workforce able to prevent and manage a full range of conditions and empower people and communities to manage their own health needs as fully as possible.”
Strategic issues

Essential medicines can save lives, reduce suffering and improve health, but only if they are available and affordable, of good quality, and properly used by both providers and consumers.

Ensuring access to essential medicines of assured quality and their rational use remains a challenge in the Western Pacific Region. In some low- and middle-income countries, public spending on medicines is nominal. Limited availability of essential medicines in the public sector means that patients often have to purchase their medicines from private sector outlets, where prices are higher. Surveys have shown that even the lowest priced generics are often unaffordable for the poor. In high-income countries, the main challenges are related to rational use and cost containment.

Most countries in the Region have established a Medicines Regulatory Authority, though they differ greatly in the level of functionality. Weak regulatory systems and lax and non-transparent enforcement may result in the production, distribution and sale of medicines of doubtful efficacy, safety and quality that can endanger the public. In some countries, counterfeit medicines are still being produced and sold, and unlicensed outlets continue to operate. In addition, small countries often encounter a lack of trained human resources in the medicines sector.

Action and results

Work on the Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016) has been completed. The Framework, which was developed in consultation with experts and Member States, builds on the Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010) and will serve as a basis for country collaboration in the years to come. One of the more salient outcomes of a consultation with Member States in September 2010 was an agreement to set specific targets for the indicators, and to introduce a “traffic light” system to provide quick feedback and alert countries to areas that require more attention.

Last year, the 14th International Conference of Drug Regulatory Authorities (ICDRA) was held in Singapore. It brought together 400 medicines regulators from around the world to review progress and discuss recent regulatory challenges, including new technologies and cost-effectiveness. The conference was followed by a one-day Post-ICDRA Meeting of Medicines Regulators from the Western Pacific Region, which was attended by participants from 16 countries and areas. Discussions touched upon ways to strengthen human resources for medicines regulation and on networking among
regulators in the Region. As a follow-up to this consultation, the Regional Office will explore the development of a repository of relevant training materials and resources that regulatory agencies can adapt to their own context and use for training of their staff.

An end-of-project evaluation of the Partnership on Pharmaceutical Policies with the European Commission, African, Caribbean and Pacific Group of States and WHO was undertaken. It was found that in Pacific island countries the project notably contributed to the development of National Medicines Policies, the strengthening of supply management systems and the acceptance of rational prescription practices.

The information available on the Price Information Exchange website for selected medicines in the Western Pacific Region (www.piemeds.org) was expanded to include prices from 2010, in addition to 2009. Moreover, the range of medicines was expanded to include selected cancer medicines and oxytocin. The website contributes to making actual purchase prices of medicines more transparent.

WHO participated in an assessment of the health care reform process in China in March 2011. The objective was to assess whether the Government’s goals and objectives have been achieved in making essential medicines available and affordable. Considerable progress was noted in the implementation of reform in the medicines area.

WHO collaborated with the State Food and Drug Administration and the National Institute for the Control of Pharmaceutical and Biological Products in China to align national standards with international standards on quality and best manufacturing practices. Several Chinese products are WHO prequalified, and there is an increasing interest among manufacturers to participate in the WHO prequalification programme.

Most countries of the Region have National Medicines Policies, setting out the overall strategic directions for the pharmaceutical sector. WHO supported the updating of the National Medicines Policies of Brunei Darussalam, Cambodia and Mongolia.

WHO intensified its collaboration with Papua New Guinea by hiring a technical officer for medicines in the country office. Support is focused on improving the medicines supply system.

In 2010, as part of the promotion of medicines safety in the Region, a Training Workshop on Strengthening the Network for Safety of Medicines and Pharmacovigilance was organized in Ha Noi by the Ha Noi Pharmacy University in collaboration with WHO, Management Sciences for Health (Washington) and the University of Bordeaux.

In 2011, a training course on pharmacoeconomics was organized in Manila in collaboration with the WHO Collaborating Centre for Training in Pharmacoeconomics and Rational Pharmacotherapy at the University of Newcastle. The aim was to improve evidence-based selection of medicines in the national formulary, which is critical for universal coverage of essential medicines.

The Regional Office also collaborated with professional organizations of pharmacists (such as the Western Pacific Pharmaceutical Forum, International Pharmaceutical Federation and the Federation of Asian Pharmaceutical Associations) to promote best pharmacy practices and access to essential medicines.

Future directions

WHO will continue to work with Member States on improving access to essential medicines. The Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016) will guide that work. The Framework for Action proposes a set of core indicators, for which benchmarks have been set. This will provide quick feedback on areas of strength and areas that may require more attention.

In collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO will develop pharmaceutical country profiles. These will serve multiple purposes, including measuring results and progress over time, as well as supporting applications for Global Fund grants for medicines.

WHO will also reinvigorate its support to countries that are developing insurance schemes that aim at universal coverage, and will advocate for the inclusion of medicines in those schemes.

WHO will expand activities related to medicine safety and continue its efforts to promote and facilitate collaboration between medicines regulators and law enforcement officers in order to combat counterfeit medicines.
Health technology and laboratories

Strategic issues

Laboratories provide vital support in the initiation and monitoring of appropriate clinical and public health interventions. While considerable effort has gone into improving health laboratory services, much of the focus in the Western Pacific Region has been on specific disease-control programmes where adequate funding has been available through global health initiatives.

Within the Regional Office, cross-cutting issues related to laboratories are addressed by a Laboratory Working Group through information sharing, identification of common issues, supporting resource mobilization efforts and coordination action within the framework of the laboratory plan of action.

Screening of all donated blood for infectious agents is a key element of the WHO strategy for blood safety. However, the risk of transmission of disease through transfusions remains unacceptably high in countries where the prevalence and incidence of infections is high and where quality systems are lacking.

Action and results

Recognizing the importance of working across the disease-specific programmes to maximize efficiencies and reduce the duplication and waste of resources, the Asia Pacific Strategy for Strengthening Health Laboratory Services (2010–2015) was endorsed by Member States at the sixtieth session of the Regional Committee in 2009.

A workshop on the implementation of the Strategy for the Pacific Island Countries was held in Fiji in September 2010. Fiji, Mongolia and Papua New Guinea drafted their National Laboratory Policies and Plans in conjunction with their National Health Plans. In addition, 18 Pacific island countries and Papua New Guinea were supported by the Regional External Quality Assessment Scheme (REQAS) provided by the WHO Collaborating Centre for External Quality Assessment in Health Laboratory Services in New Zealand.

Two guidance documents, Development of National Health Laboratory Policy and Plan and Regional Laboratory Quality Standards, were finalized by experts and laboratory managers from 27 countries from the South-East Asia and Western Pacific Regions.

The Laboratory Quality Management Training tool kit, prepared by WHO and the United States Centers for Disease Control and Prevention, was disseminated to laboratory managers from 13 Pacific island countries.

In the area of blood safety, a biregional workshop on blood donor management was conducted. The objectives of the workshop were to discuss the principles of blood donor management and to share experiences in the planning, management and implementation of national blood donor programmes. The proceedings of a series of three workshops on the management of national blood programmes, held annually from 2007 to 2009, were collated, published and distributed to Member States.

In other areas of work, technical support was provided to Mongolia to revise its Organ Donor Law and develop a deceased-donor programme.

Data and information were gathered to support the development of a draft strategy for optimal use of medical devices.

Future directions

Member States will continue to receive technical support for the implementation of the Asia Pacific Strategy for Strengthening Health Laboratory Services (2010–2015) and for the development of their National Laboratory Policies and Plans.

Lack of universal screening for the hepatitis C virus in some countries remains a concern. In addition, lack of sufficient quality assurance systems across the entire blood transfusion process results in safety and quality risks to patients. Member States will receive technical support to address these issues.

WHO will continue to support Member States in the development of policies and plans to ensure equitable access to essential medical devices, including support in strengthening the rational selection, management and use of safe, appropriate and affordable medical devices.
Traditional Medicine

Many populations in the Western Pacific Region continue to use traditional medicine to meet their health needs. Therefore, it is imperative to develop and implement effective policies, regulations and standards for practice and products that will promote traditional medicine within evidence-based framework.

In alignment with the Regional Strategy for Traditional Medicine in the Western Pacific, which expired in 2010, a situational analysis to monitor progress in the Region was undertaken in 24 Member States. The survey results showed that only 19 Member States have national policy or official government documents on traditional medicine.

The draft Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020) was developed and reviewed during an experts consultation meeting held in Hong Kong (China) in November 2010 and an intercountry consultation held in the Republic of Korea in March 2011.

Technical support to the Governments of Cambodia and Mongolia to develop and review their traditional medicine policies resulted in the endorsement of a National Policy for Traditional Medicine in Cambodia and a Strategic Plan on Implementation of National Policy on Traditional Medicine in Mongolia.

WHO will continue to collaborate with Member States and partners in the implementation of the draft Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020). Specifically, WHO will promote appropriate, safe and effective use of traditional medicine as well as scientific documentation of traditional medicine knowledge. The evidence-based, multidisciplinary approach of traditional medicine for better and proper inclusion of traditional medicine into the mainstream of health care service will be encouraged.

Essential medicines, such as amoxicillin, a common antibiotic, and mebendazole, effective in the treatment of tapeworms, hookworms and other parasites, are critical elements of successful health care. And governments need to ensure that they are getting full value for the often-limited funds they have to procure these and other medicines.

But how can government procurement agencies know if they are getting the best deal from suppliers? They can’t unless they have benchmarks to use in negotiating the best possible prices.

In an effort to provide these benchmarks, the WHO Regional Office for the Western Pacific, in collaboration with the National Telehealth Center of the University of Philippines, has developed a Price Information Exchange. The exchange, which can be accessed online at http://www.piemeds.com, contains information on actual procurement prices for selected medicines in the public sector. These prices are compared against two benchmarks: an international reference price and the regional median price.

For example, in 2009, it was noted that Malaysia paid only 25% of the price paid by China for the same brand of antibiotic ceftriaxone powder for injection, while in 2010, Palau paid four times more for co-trimoxazole paediatric syrup, used in the treatment of bacterial infections, than the regional median price. The data also show that several countries, including Mongolia, Palau and Tonga, paid significantly less for 25 mg hydrochlorothiazide diuretic tablets in 2010 than in 2009.

One of the unique features of the Price Information Exchange website is that it allows users to click on the bar to view details such as suppliers and quantities purchased. This feature has been particularly useful for procurement agencies in renegotiating prices or in searching for better deals.

The Price Information Exchange and the website have proved extremely helpful to Member States in achieving a goal they share with WHO—the highest possible state of good health for all of their people.
Strategic issues

Sound evidence and reliable information are the foundation of informed decision-making and are essential for health system development. Policy-makers, planners, health care providers and development partners need high-quality information and rigorous evidence to track health system performance, design and evaluate appropriate health interventions or programmes, and develop and support better health policies. Increasing evidence-based decision-making requires strengthening health information systems (HIS) and improving the quality and use of health data and research.

Countries in the Western Pacific Region are diverse in terms of their level of HIS sophistication and health research development. HIS planning, implementation and local coordination are relatively weak in low- and middle-income countries and must be strengthened. Most countries in the Region are dependent on a fragmented HIS that must be improved and made to be more interoperable. More than half of these countries do not have well-functioning vital registration systems. Nearly all of these countries have not harmonized or aligned their monitoring and evaluation framework and core health indicators to monitor health systems performance. The quality of routinely collected health data also continues to be an issue in most countries, along with the capacity to analyse and aptly use these data for decision-making.

Modest investment and inadequate or non-existent governance and management structures are common problems in most low- and middle-income countries both for health information and health research. Most low- and middle-income countries commit nominal domestic funding to health research. Further, the research portfolios are highly imbalanced, reflecting changing global and donor priorities rather than country priorities. Few countries set their own research priorities or allocate domestic or external research funding according to their needs. Lack of transparency and limited access to health research contributes to inadequate awareness, demand and use of research results to inform public health policy and programmes.

Action and results

WHO continued to help countries strengthen their national health information systems by addressing gaps and opportunities identified in recent HIS assessments. A series of workshops and training courses sponsored by WHO and other partners was undertaken to improve national HIS strategic plans, implement international standards, enhance data quality, and improve information use in the Region.

WHO provided support to the Pacific Health Information Network (PHIN), a peer-to-peer network of HIS professionals in 16 Pacific island countries, for training and coordination. It also collaborated with the HIS Knowledge Hub hosted at the University of Queensland to enhance HIS training curriculum for use in the Region. Technical support provided to Cambodia, China, Fiji, the Lao People’s Democratic Republic, the Philippines and Viet Nam focused on HIS improvements through country-led and better-coordinated processes focused primarily on better quality and use of routine health information. In Palau, technical support was used to analyse the information technology architecture of the HIS and produced recommendations to improve efficiency and reliability of the system. The new WHO Collaborating Centre for Health Information and Informatics at the Center for Health Statistics and Information...
within the Ministry of Health in China will aid other countries in the Region by promoting the use of standards and sharing and learning of HIS development and the management of eHealth solutions.

Better vital events systems and improved analysis of disaggregated data from surveys combined with routine HIS in low- and middle-income countries will provide more reliable data for health improvements and directly measure the health-related Millennium Development Goals (MDGs). The Regional Office worked with partners and other levels of WHO to strengthen civil registration and vital statistics systems in the Region. Effective coordination is underway across multiple partners, including the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), the Secretariat of the Pacific (SPC) and partners implementing the new Health Metrics Network Monitoring of Vital Events using the information technology (MoVE-IT) initiative, on activities to improve vital registration and the use of health and vital statistics.

In 2011, the WHO Country Health System Surveillance (CHeSS) framework and multiple tools and techniques for improving health systems performance were introduced to select countries in the Region. Technical support was provided to China by WHO Headquarters, the Regional Office and the country office to apply the CHeSS framework to monitor the progress of health reform based on country requirements. WHO also worked with partners in Cambodia, the Lao People’s Democratic Republic and Viet Nam to improve the monitoring and evaluation of health systems performances in those countries.

To address fragmentation of health information systems and mitigate the overwhelming data demands on countries, WHO is transforming its regional health databank and online data generator into a next generation Health Information and Intelligence Platform (HIIP) for the Western Pacific. HIIP will help maximize data use at both the country and regional levels by extracting, analysing and using more intelligence from available information. Planning and design are well under way to deploy dashboards and dynamic, user-defined analytical and reporting tools starting in 2011 to provide better access to timely information and address priority themes in the Western Pacific.

The Regional Office published the 24th edition of the Western Pacific Country Health Information Profiles (CHIPS 2010)—which compiles statistics and information on the demographic, socioeconomic and political conditions, health situation and trends, and health systems of each of the countries and areas of the WHO Western Pacific Region. Future CHIPS will be fully integrated into the HIIP solution. An analysis of progress towards achieving the health-related MDGs was completed and published in 2010 based on input from different technical units of the Regional Office and data available from global and country sources.

In the area of evidence and research, WHO is helping build capacity for health systems research in countries and is working with other development partners to increase the overall body of knowledge and evidence on health systems issues in the Asia Pacific. With the World Bank and the Asian Development Bank, and in collaboration with interested governments and research institutes across the Region, WHO is in the process of establishing the Asia Pacific Observatory on Health Systems and Policies, which will carry out high-quality research into health systems issues.

On broader research issues, the Health Information, Evidence and Research unit within the Regional Office continues to act as a focal point for the ethical review of research
proposals supported by other divisions in the Regional Office. An Ethics Review Committee for the Western Pacific Region was formally established in November 2010, with standard operating procedures developed and published soon after. A network involving the regional Ethics Review Committee and similar committees functioning in Member States is being set up. An electronic research portal was established to ensure prospective registration, tracking and monitoring of all research conducted and supported in the Western Pacific Region. Efforts were made to establish a similar research portal on pilot basis in two countries, as a governance and management initiative to improve transparency and access to health research undertaken.

Future directions

Health Information Systems

WHO will support countries in strengthening their health information systems and enhancing the quality of their data to improve health systems and health outcomes, and to improve access to and use of high-quality information on health situations and trends at regional and county levels. Technical support will be provided to Member States to introduce and implement global standards, to implement the use of metadata, and to improve data quality and utilization through data analysis. WHO will continue working with the Health Metrics Network, ESCAP, SPC, HIS Hub and other partners to improve the civil registration and vital statistics of countries in the Region.

WHO will also improve health information access, utilization and dissemination at regional and country levels with the development of the Health Information and Intelligence Platform for the Western Pacific. Through the HIIP web interface, user-friendly visualization, analysis and reporting tools will unlock health data in new ways using dashboards, query tools and dynamic reports. Better access to and use of health information through HIIP will better inform policy, planning and programmatic decisions to achieve the health-related MDGs and address other priority areas.

Evidence and Research

In late 2011, WHO will focus on the establishment of the Asia Pacific Observatory on Health Systems and Policies and begin publishing its research. The Evidence Informed Policy Network (EVIPNet) model as a mechanism to promote use of research will be reviewed and alternative mechanisms will be explored to institutionalize the utilization of research.

On broader research issues, WHO will strategically prioritize the strengthening of governance and management structures for health research with particular focus on increasing the transparency, monitoring and accessibility of research undertaken in Member States. Policies will be established for public archiving and access to health research data to maximize use of health research. Institutional mechanisms that oversee and ensure the technical and ethical soundness of research in Member States will be strengthened. Finally, different financing mechanisms will be explored to mobilize additional funding for health research.
To keep pace with the evolving and unique challenges of the Pacific region, WHO established the Division of Pacific Technical Support, based in Suva, Fiji, in September 2010. The previous month, in an effort to better serve Member States in the Pacific, the Regional Director opened the WHO Country Liaison Office for Palau, the Federated States of Micronesia and the Marshall Islands.

The Division of Pacific Technical Support is now providing more focused and timely technical support to the 22 Pacific island countries and areas in the Western Pacific Region.

The Division of Pacific Technical Support adds value in three key areas: building and strengthening the pool of qualified health professionals; providing approaches attuned specifically to the Pacific; and streamlining management of all WHO programmes and activities.

Creating a pool of qualified health professionals

Prior to the creation of the new Division, WHO support was fragmented, with country offices in Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu individually supported by the Regional Office. Now, country support is coordinated with a two thirds increase in resources—from 52 professional and support staff to 86. We anticipate further strengthening of national technical staff in the country offices.

Providing Pacific-specific approaches

The Division’s technical staff members are also Pacific experts, allowing them to tailor responses to local challenges and to apply models that have worked within the Pacific, aligning them with National Health Policies, Strategies and Plans (NHPSP). A more holistic, Region-wide approach, combined with the Pacific-specific approaches, will allow the Division to help coordinate programmes and activities more effectively across the Pacific in keeping with the principles of aid harmonization.
Streamlining management

The Division of Pacific Technical Support is divided into three teams: Combating Communicable Diseases and Health Security and Emergencies; Health Sector Development; and Building Healthy Communities and Populations. The new team structure has opened communication channels among different programmes within and between countries in the Pacific. Budget management is decentralized and is designed to reduce delays in operational decisions, leading to improved responsiveness to country issues.

Priority areas of focus

The Division of Pacific Technical Support focuses on four priority areas of work: (1) Healthy Islands and primary health care; (2) health systems strengthening; (3) health promotion and environment; and (4) communicable diseases and Millennium Development Goals (MDGs).

Healthy Islands and primary health care

The Healthy Islands initiative sets the overarching vision for the Division in the Pacific, and primary health care serves as the key approach in the delivery of programmes and activities to achieve the vision. A draft Healthy Islands: Framework of Action for Revitalization was endorsed at the Meeting of Ministers of Health for the Pacific Island Countries in Honiara, Solomon Islands, in June 2011. One of the first steps in revitalizing the vision and approach is to recognize the best evidence-based public health practices by communities in the different Member States. For 2011, Best Practice Recognitions were given to Palau and Vanuatu, and Best Proposal Recognitions were given to Fiji and the Federated States of Micronesia.

Access to and rational use of quality medicines were facilitated through the development and implementation of sound national medicines policies, improved medicines procurement and supply systems, and standard treatment guidelines. Medical laboratory policies and strategies, including establishment of quality management systems, were supported to improve the quality of diagnostic and clinical care services.

Strengthening human resources for health is crucial in the Pacific region. Towards this goal, the Pacific Human Resources for Health Alliance, with funding from the Australian Agency for International Development, has taken steps to improve the quantity, quality and management of the health workforce, maximizing regional resources, and has developed a regional database of health staff in Pacific island countries and areas.

The Pacific Open Learning Health Network, with funding from the New Zealand Aid Programme, provides continuing professional education to health professionals, many of whom previously had no access to quality training. The Network is comprised of 25 learning centres delivering 165 online courses to 14 Pacific island countries and areas, a dramatic increase from the 26 courses offered in 2009–2010.

Health promotion and environment

At a meeting in February 2011, the Pacific Steering Group on Revitalizing Healthy Islands prepared the Nadi Statement on the noncommunicable disease crisis in the Pacific, which laid the groundwork for the Pacific’s participation in the First Global Ministerial Conference on Healthy Lifestyles and NCD Control in April 2011 in Moscow and prepared for the United Nations High-level Meeting on Noncommunicable Diseases in September 2011 in New York.
The immediacy of the effects of climate change in the Pacific requires special attention, and more global aid is now being dedicated to this area. To assist in the resource mobilization process, the environmental health team supported 14 countries and areas in conducting vulnerability assessments and developing health adaptation policies. WHO continued to work closely with countries and areas on cyclone and disaster management.

**Communicable diseases and MDGs**

The Division of Pacific Technical Support focuses on three neglected diseases—leprosy, lymphatic filariasis and yaws.

Although most of the Pacific region has eliminated leprosy, cases are still being reported by Kiribati, the Marshall Islands and the Federated States of Micronesia. Leprosy elimination plans are being developed in Kiribati and the Marshall Islands, and have been finalized in the Federated States of Micronesia. In all three countries, health care worker training has been initiated.

Elimination of lymphatic filariasis is a renewed priority. Countries and areas with remaining pockets of high prevalence of lymphatic filariasis are American Samoa, Fiji, Samoa and Tuvalu. WHO supported the development of tailored lymphatic filariasis control strategies, with plans to ensure that these countries and areas are on track to becoming filarial-free.

Yaws, which was thought to have been eradicated, was recently detected in some countries, particularly in Vanuatu. The Division is committed to enhance surveillance and ensure intervention is in place.

With limited access to immediate diagnosis by laboratories, syndromic surveillance allows for a real-time response. WHO, in partnership with the Secretariat of the Pacific Community (SPC), rolled out Pacific Syndromic Surveillance (PDS) with weekly reporting. PDS grew out of emergency post-pandemic reporting, at the request of the ministries of health.

Progress in achieving the Millennium Development Goals is another important area of focus for the Division. This year, WHO began working with the United Nations Children’s Fund, United Nations Population Fund and the World Bank to develop a joint United Nations approach towards maternal and child health.

HIV incidence is still low in the Pacific. WHO continued to work with SPC and the joint United Nations group to address HIV and the associated stigma, discrimination and cultural beliefs that compromise screening and prevention activities to prevent HIV transmission in Pacific island countries and areas.

The Division is committed to continuously reducing the malaria and tuberculosis burden in the Pacific. In collaboration with SPC, the United States Centers for Disease Control and Prevention, and other partners, WHO supported national malaria and tuberculosis programmes in the Pacific with funding from of the Global Fund to Fight AIDS, Tuberculosis and Malaria.
The work of WHO in the Western Pacific Region is coordinated by the Division of Programme Management, which provides programme guidance, planning and monitoring for the development, management and coordination of regional, intercountry and national technical cooperation programmes. The Division also fosters cross-programmatic collaboration and partnerships, and works to support mandates approved by Member States and our governing body, the WHO Regional Committee for the Western Pacific.

Working closely with WHO Representatives and Country Liaison Officers in 15 country offices, the Division of Programme Management advises Member States on the overall technical aspects of WHO’s collaborative health programmes. The Division develops the programme budget—more than US$ 323 million for the current biennium—and works to ensure the optimal utilization of those resources through supervision, monitoring and evaluation.

The recent global economic crisis has had a significant impact on WHO’s work in the Western Pacific Region. Declines in government spending and official development assistance have led to reductions in the Organization’s expected revenue. In addition, WHO’s purchasing power...
has declined significantly, as the value of the currencies in which WHO receives significant amounts of income has fallen in relation to other currencies in which WHO has major expenditures.

The Regional Office has initiated a number of cost-saving measures intended to improve efficiency, sustain crucial functions and minimize disruptions of programme delivery. The recently concluded review of the Programme Budget 2010–2011 and Organization-wide Mid-term Review has shown that only a few “expected results” face challenges in achieving full delivery as a result of insufficient funding. However, the crisis has been felt in the area of staff costs, which have been rising despite almost zero growth in staff size over the past two years.

Sound financial and programme management oversight has mitigated the impact of the crisis in the Western Pacific Region. Under the direction of the Regional Office Programme Committee, funding gaps are being monitored with a view to minimize their impact and to mobilize resources to reduce shortfalls. To ensure optimized use of existing resources, the Programme Committee monitors the current budget situation on a monthly basis and reviews the implementation status of workplans funded by different sources of contributions, as well as staff funding shortfalls. The Award Oversight Group monitors income awards very closely to ensure that distribution and utilization are in line with agreements governing these awards.

**Results-based and human resource planning**

The Division of Programme Management plays a critical role in ensuring a close link between resource allocation and utilization on one hand and results-based management and programme delivery on the other. At the direction of the Regional Director, strategic and results-based planning has been enhanced by the development of Strategic Frameworks for WHO’s technical and country work. This has allowed the Regional Office and the country offices to define and articulate their core work and how they contribute to country, regional and global health goals. This strategic planning process, which is complementary to the routine WHO planning process, is intended to enhance the results-based approach by enabling WHO offices to define more clearly the indicators and means to verify achievements. The Technical Strategic Frameworks and Country Strategic Frameworks are now being used as a basis for improving operational planning that is geared towards more effectively linking regional and country work, with a focus on achieving country results.

As part of an initiative to achieve more efficient and long-term human resource planning, the Western Pacific Region staff rotation and mobility policy was launched in 2010. This initiative has provided a model for the entire Organization in encouraging proper staff rotation and mobility.
Country support

The Country Support unit was created to address the Regional Director’s renewed emphasis on responding in a more targeted and effective way to the needs and requests of Member States. The unit was initially tasked with supporting and strengthening the delivery of WHO’s collaborative activities at the country level, including the promotion of comprehensive health systems and strengthened primary health care.

At the heart of the unit’s work is the Country Cooperation Strategies—medium-term visions of WHO’s technical cooperation with Member States in support of their national health strategies or plans. It is the main instrument for harmonizing WHO’s cooperation in countries with that of other United Nations agencies and development partners. Over the past year, Malaysia, Mongolia and the Philippines have launched their updated Country Cooperation Strategies.

In addition, the unit coordinates the implementation of the Regional Office’s Country Focus Policy, part of a global initiative to align the work of WHO with the needs of Member States at the country level. It also works to strengthen cross-cutting public health approaches throughout the Region.

The Regional Office over the past year also strengthened its support to the WHO Country Teams in developing the health-related sections of the United Nations Development Assistance Framework. United Nations Country Teams in Fiji, the Lao People’s Democratic Republic, Mongolia, Papua New Guinea, the Philippines, Samoa and Viet Nam are updating their Assistance Frameworks.

In an effort to strengthen further WHO’s Country Focus Policy, the Regional Office’s extensive engagement in global health partnerships, particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria, has been placed within the Country Support unit.

The Global Fund’s total financing commitment since 2002 in countries in the Western Pacific Region has soared to more than US$ 3 billion. As a result, the Regional Office’s engagement with Global Fund-related activities in countries has also escalated as the Global Fund became the single largest source of funding for HIV/AIDS, malaria, tuberculosis and related health systems strengthening. WHO has enhanced its engagement in these activities by establishing closer collaboration with the Global Fund at the country level and by defining specific plans for joint work related to Global Fund governance, oversight, grant development, implementation and monitoring.

The enhanced work on Global Health Partnerships, especially the Global Fund itself, will build on work that has been well-developed over years of engagement. WHO has so far been successful through its proactive engagement in supporting Member States. For example, Global Fund grants in 2009 and 2010 mobilized over US$ 1 billion for countries in the Region. More than 70 WHO staff members in the Region are engaged in Global Fund-related activities, and about a quarter of those staff members are being funded from Global Fund grants. The Western Pacific Region was the first WHO region to structure its collaboration with the Global Fund through a specific Joint Operational Plan.
External relations and communications

The External Relations and Communications unit has been implementing the new regional resource mobilization workplan, which was developed in close consultation with WHO country offices.

The workplan focuses on five areas: reaching out to established donors and potential donors; improving the management of available financial resources; increasing WHO’s visibility in the Region; fostering productive partnerships; and aligning regional organizational practices with those of Headquarters.

The Organization has been successful in providing effective communications and resource mobilization throughout the Western Pacific Region, with specific intelligence relating to donors’ areas of work and countries of interest. In an effort to attract additional funding, new donors are now being targeted in the private sector, and private-sector mapping of opportunities in the Western Pacific Region has been carried out by the Regional Office. Guidelines on how to engage with the private sector are being developed for use in country offices.

Consolidating the Region’s existing donor base has been a priority. A grant management services support system is now fully functioning to track the timely disbursement and use of funds and to improve reporting. The development of corporate approaches to specific donors, by the establishment of donor interest groups, will inform donor reporting further, thereby allowing for the alignment of donor expectations with clearly defined and articulated organizational needs and priorities.

Funds have been made available to strengthen the capacity of Regional Office and Country Office staff on how to work in partnership with donors on health priorities. Advocacy materials are being prepared in order to effectively articulate the Organization’s core areas of work and competencies.

The Division of Programme Management also coordinates the activities of the Programme Development Office, the Public Information Office, and Translation, Publications and Library.
The Division of Administration and Finance supports the technical work of the Regional Office and country offices through the effective and efficient delivery of services in the areas of budget and finance, personnel, information technology and administrative services. The Division engages in the Region and with Headquarters to help build a stronger Organization that is more capable and adept at serving its Member States.

**Budget and Finance**

The Budget and Finance unit was reorganized this year to provide one-stop financial and budgetary services to all the budget centres in the Regional Office and country offices. With the reorganization, the unit is now responsible for controls, compliance and quality assurance under the Global Management System (GSM) environment.

The electronic imprest (e-Imprest) system was fully implemented in all country offices. This real-time accounting tool in GSM has eliminated the time lag between country offices incurring expenditures in the field and the expenditure being recorded in the financial records.

The unit closely monitored voluntary contributions, in countries as well as in the Regional Office, and offered support to award managers who administer those contributions. Enhanced monitoring and communication with award managers enabled implementation of awards in a timely manner.

Continuing analysis of monthly financial reports allowed budget centres to improve both the quality and quantity of implementation of the Programme Budget.
Personnel

The Personnel unit continued to provide effective and efficient support to the technical units and staff members in various aspects of human resources (HR) management—from establishment of positions, recruitment of staff, contract administration, staff development and performance management to separation from service.

Almost three years after the launch of the GSM, the Personnel unit continued to provide support to staff members throughout the Region to ensure timely administration of entitlements, and selection and recruitment procedures in close collaboration with the Global Service Centre (GSC). Personnel also continued to work closely with GSC and WHO Headquarters on GSM enhancements to align business processes with operations. Training modules on all the GSM streams, including human resources, travel, procurement, programme/workplan, and introduction, were made available to staff members both in the Regional Office and remotely in country offices.

Due to ongoing financial constraints, the Personnel unit worked closely with staff and management to minimize the negative effect on staff. A regional mobility policy for professional staff members continues to be implemented to enhance the development and performance of staff, and to match staff intent with the best interests of the Organization, and a rotation policy for local staff was put in place with the same goals.

As part of the Regional Director’s reforms, the Regional Learning Committee planned and implemented staff development and learning activities in the Western Pacific Region. The learning programmes are in line with the six priority areas of the Global Learning Committee and are made available to all categories of staff.

Information and Communications Technology

The Information and Communications Technology (ICT) unit is responsible for planning and delivering reliable, secure and cost-effective ICT solutions that meet the needs of the Organization. Direct support to the Regional Office and country offices is provided by three teams of experts: the Information Technology Office, Network and User Support, and Application Management and Development.

The Information Technology Office is responsible for devising regional ICT strategies, planning and implementing projects, and coordinating and collaborating on global ICT projects with Headquarters, other WHO Regional Offices and the United Nations system.

The Network and User Support team provides regional staff with remote and on-site support for the workstation environment. It also develops and monitors the regional ICT infrastructure, which includes video, voice and data services running across the regional network.

The Application Management and Development team manages regional applications used to provide Internet and intranet services and information access. In addition, the team develops applications for use in the Regional Office, country offices, Headquarters and other regions. Several external health technical projects have been developed and are supported by the ICT unit.
Administrative Services

Construction and renovation

The Regional Office in Manila has been transformed into a modern, visitor-friendly and eco-conscious facility. Under the direct oversight of the Regional Director, the compound underwent six major improvement projects, including a new drainage and sanitation system, a completely renovated conference hall, reception and lounge areas, an innovative air ventilation system, a new two-storey car park, and enhanced tropical gardens and ponds.

The renovation of the conference hall was necessitated by damage caused by flooding during Typhoon Ondoy in September 2009. While maintaining its original structure, an architectural icon built in the 1950s, the conference hall was fitted with modern audio and video systems, facilities for people with disabilities, energy-efficient lighting and air-conditioning systems, expanded seating capacity, and a reception and coffee break areas. The building now has direct access to an Internet lounge and breakout rooms in an adjacent wing.

The new drainage system will capture, contain and eliminate water during the torrential rains and heavy floods typical of the typhoon season in the Philippines. The improved sanitation system will absorb and process waste water via a new leaching field, septic vault, layers of gravel and perforated pipes under the lawn. The new air ventilation system incorporates state-of-the-art technology to cool and balance air intake and circulation for a healthier working environment.

Reimbursable procurement

From March 2010 to February 2011, reimbursable procurement—a service provided by the Regional Office to Member States, specialized agencies and nongovernmental organizations in official relations with WHO—represented a total amount of approximately US$ 7.8 million of goods procured mainly for supplies and medicines to support national activities related to malaria and other vectorborne and parasitic diseases.

Supplier management

Procurement needs were reviewed with WHO Headquarters to identify frequently purchased items in order to establish long-term agreements with the suppliers in an effort to reduce costs and processing times. Training on supplier management in GSM has been on-going and the scope was expanded to non-staff meeting participants.