SUMMARY RECORD OF THE FIFTH MEETING

Grand Ballroom, Westin Chosun Hotel, Seoul
Wednesday, 11 September 1996 at 2 p.m.

CHAIRMAN: Mrs O'Love T JACOBSEN (Niue)

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1. CONSIDERATION OF DRAFT RESOLUTIONS


Dr CHAN (Rapporteur) introducing the draft resolution, stated that the Rapporteurs had been informed by the Secretariat that the resolution, once adopted by the Committee, would provide the legitimate basis for the Regional Director to take forward the proposed programme budget for 1998-1999. The constructive comments and suggestions made by representatives would be reflected in the proceedings of the session, and the Regional Director would take heed of those suggestions when formulating future programme budgets for the Region. It was in the light of that information that the Rapporteurs had prepared the draft resolution before the Committee.

Dr DURHAM (New Zealand) proposed a number of amendments to the draft resolution. At the end of the second preambular paragraph, the words “and the global priorities determined by the Executive Board” should be added. A third preambular paragraph should be inserted, as follows:

“Noting that the World Health Organization faces a financial crisis and needs to focus on fulfilling its comparative advantage in priority areas in order to be the sustainable and effective global international health organization required by the global community in the twenty-first century;”

Her delegation also proposed the insertion of three new operative paragraphs to precede the existing operating paragraphs:

“(1) to undertake rigorous financial planning with a view to protecting priority health activities in the Region, taking realistic account of expected income at global and regional levels and the likely cost increases;

(2) to continuously strengthen the management of the Western Pacific Region to improve the efficiency, productivity and effectiveness of the Region to maximize gains in health status in priority areas;

(3) to report to the Regional Committee on an annual basis on the management steps taken to improve the efficiency, productivity and effectiveness of the Western Pacific
Region, including human resources management and financial management, and implementation of the priority health programmes in the Region;"

She also proposed that the existing operative paragraph 1 be renumbered operative paragraph 4 and amended to read:

“(4) to convey to the Director-General the Regional Committee's wish that the final programme budget for the financial period 1998-1999 will enable full implementation in both financial and programme terms;”

The existing operative paragraph 2 would become operative paragraph 5.

Dr HOWELL (France) proposed the deletion of the words “be realistic so as to” in the first operative paragraph.

Mrs ABEL (Vanuatu) supported that proposal.

Dr WILLIAMS (Cook Islands) asked for the amendments proposed by the New Zealand representative to be submitted to the Committee in writing.

Dr NUKURO (Solomon Islands) supported that request. He stressed the importance of retaining the reference to the level of cost increase, since funds from sources other than WHO for countries such as his own were expected to fall sharply by 1998-1999.

Ms BLACKWOOD (United States of America) expressed support for the amendment to the first operative paragraph proposed by the representative of New Zealand. Her delegation was prepared to accept wording which called for full implementation of the budget, but not the reference to the level of cost increase.

Dr BELLAMY (United Kingdom of Great Britain and Northern Ireland) pointed out that it was impossible to predict whether cost increases would be approved by the World Health Assembly in May 1997. He felt it was more realistic to refer to the final programme budget.

The REGIONAL DIRECTOR, referring to the matter of cost increases, quoted from the letter of guidance he had received from the Director-General: “You should present your programme budget proposals to the Regional Committee in real terms only, i.e. before any provision for cost increases in 1998-1999. Our experience is that this renders the review of the Regional Committee
more programme- and substance-oriented without any distortion for projected cost increases”. That letter of guidance had been reviewed both by the Administration, Budget and Finance and Programme Development Committees of the Executive Board, and by the Executive Board itself. Accordingly, as he had informed the Committee during its discussion of the agenda item, he had included no cost increase component in his budget proposals.

He felt it might be helpful to the Committee to outline the procedure for preparing the programme budget, defining areas of responsibility. When the Regional Director submitted his programme budget proposals to the Regional Committee, it was the task of the Committee to review those proposals. It had no authority to amend the proposals, only to make comments and suggestions. The Regional Director then submitted the proposals to the Director-General, together with the Committee’s comments. The Director-General in his turn prepared the global programme budget proposals and presented them to the Executive Board. Like the Regional Committee, the Board had no authority to change the proposals, only to comment and suggest. The Director-General took those comments into account and submitted his amended proposals to the World Health Assembly, which took the final decision. The Regional Director hoped his explanation would give representatives a clearer idea of the boundaries of each party’s areas of responsibility and authority.

Dr TAPA (Tonga) pointed out that, in the past, the corresponding resolution had contained only one operative paragraph, namely the second operative paragraph of the draft resolution before the Committee. He felt that the request in the first operative paragraph exceeded the authority of the Committee, and proposed the deletion of that paragraph.

Dr OTTO (Republic of Palau) concurred with Dr Tapa’s proposal, and said it would be helpful if representatives could be informed in advance of their areas of authority.

Dr CHAN, Rapporteur, thanked Dr Tapa for his comments and proposal. She suggested that the Committee might revert to its previous practice and retain only the second operative paragraph of the draft resolution. In that paragraph the words “Regional Committee’s proposals” should be amended to “Regional Director’s proposals”.

Professor LI SHICHUO (China), Dr NUKURO (Solomon Islands), Dr HOWELL (France), Dr TAITAI (Kiribati), Mr ROKOVADA (Fiji), Dr WILLIAMS (Cook Islands), Dr DURHAM (New Zealand), Dr ADAMS (Australia), Ms BLACKWOOD (United States of America) and
Dr BELLAMY (United Kingdom of Great Britain and Northern Ireland) supported the proposal made by Dr Tapa and Dr Chan.

The REGIONAL DIRECTOR suggested that the Committee accept Dr Durham's proposal to add the words "and the global priorities determined by the Executive Board" to the second preambular paragraph. Of the amounts allocated in the proposed programme budget for 1998-1999, 77.6% met the global priorities and 74.8% met the regional priorities.

**Decision:** The draft resolution, as thus amended, was adopted (see resolution WPR/RC47.R1).

1.2 **WHO Western Pacific Environmental Health Centre (EHC) (Document WPR/RC47/Conf. Paper No.3)**

Dr TEE (Malaysia) proposed that operative paragraph (4) be amended so that the words "to ensure the continued viability of a strong environmental health programme in the Region" became subparagraph (1) and to add subparagraph (2) to read:

"(2) to maximize the use of technical resources available in the Region, such as the Environmental Health Research Centre to be established in Malaysia, and the WHO collaborating centres in environmental health."

Dr ADAMS (Australia) agreed with the suggestion of the representative of Malaysia to include WHO collaborating centres as a source of technical expertise.

**It was so agreed.**

**Decision:** The resolution, as amended, was adopted (see resolution WPR/RC47.R2).

1.3 **Report of the Regional Director (Document WPR/RC47/Conf. Paper No.1 Rev.1)**

Revision 1 of WPR/RC47/Conf. Paper No.1 Rev.1 with the proposed amendments as discussed during the fourth meeting (see section 3.1) was circulated to the representatives for decision.

**It was so agreed.**
Decision: The resolution, as amended, was adopted (see resolution WPR/RC47.R3).

2. AIDS: Item 10 of the Agenda

2.1 Annual report on AIDS, including sexually transmitted diseases: Item 10.1 of the Agenda (Document WPR/RC47/6)

The REGIONAL DIRECTOR introduced his report on the HIV/AIDS epidemiological situation, describing the present and future activities in the prevention and control of sexually transmitted diseases as the entry point for HIV/AIDS control in the Region.

The report covered the last six months of the Global Programme on AIDS, which ceased operation in December 1995, and the activities of the regional programme on sexually transmitted diseases and AIDS, which had been in operation since 1 January.

The REGIONAL DIRECTOR presented a summary of the epidemiological situation of HIV/AIDS in the Region. In Australia and New Zealand, where there had been intensive prevention programmes, incidence of HIV infection was decreasing. In addition, most of the islands of the South Pacific did not seem to be experiencing a substantial increase in HIV infections and AIDS cases. Unfortunately, epidemics were emerging or were already established in many other countries in the Region. It was projected that those upward trends would continue in the coming years.

Transmission of the infection had predominantly been through sexual contact in most countries. The high prevalence of sexually transmitted diseases in certain countries, in conjunction with the use of commercial sex workers, had played an important role in the spread of HIV infection. That had been the principal reason for the close focus on the prevention and control of sexually transmitted diseases in the Region.

He noted that it was generally agreed that HIV/AIDS was primarily a health issue, but with serious socioeconomic and political implications. Each cosponsor of UNAIDS should use its strengths and expertise, in close consultation with each other, to deal with HIV/AIDS, which was a multifaceted issue.

WHO had a constitutional mandate to coordinate public health work. Therefore, the programme on sexually transmitted diseases and AIDS in the Regional Office was working closely
with Member States, within the framework of UNAIDS, focusing on public health issues. The following were the four main areas of work:

Activities that reinforced prevention and control of sexually transmitted diseases through the promotion of syndromic case management, and advocacy to encourage health-care-seeking behaviour. Syndromic case management had been an inexpensive but highly effective method of sexually transmitted disease treatment that could be provided by basic health care workers. It did not rely on laboratory support which was costly, and often inaccessible.

Activities would continue to support and encourage individuals with sexually transmitted diseases to seek appropriate services. Programme management skills would also be promoted.

The second main area included activities which reinforced epidemiological surveillance of HIV/AIDS and sexually transmitted diseases. Securing data of sufficient accuracy to support rational planning, targeting, implementing, and monitoring of the programme would be possible through strengthening sentinel serosurveillance of HIV and sexually transmitted diseases. Through collaboration with national epidemiologists, the Regional Office would continue to reinforce the sentinel serosurveillance, support estimation and projections of the numbers of HIV infections, AIDS cases and sexually transmitted diseases, as well as monitor gonococcal antibiotic susceptibility.

The third area of action focused on activities targeting individuals most exposed to HIV/AIDS and sexually transmitted diseases. Those were primarily individuals involved in commercial sex work or injecting drug use. Specific programmes would be supported for the reduction of sexually transmitted diseases and HIV in commercial sex workers, primarily through peer education activities for them, and through harm reduction programmes for injecting drug users.

Finally, the Regional Office would actively collaborate with key decision-makers in Member States to mobilize support for appropriate national responses for prevention and control of sexually transmitted diseases.

In all such activities, WHO would rely on the cooperation and support of the Member States. The regionwide effort to prevent and control the spread of sexually transmitted diseases, including HIV infection, could not be managed alone. There was evidence that intervention measures could work, and it was up to all of the Member States as well as WHO, to ensure that the most effective means of preventing those diseases were effectively followed.
Dr TAPA (Tonga) commended the Regional Director on the report and his clear introduction. He endorsed the focus of future activities and the four important aspects indicated in section 5 of the document.

In Tonga, there was an increasing trend in the number of sexually transmitted diseases, especially gonorrhoea, with 81 cases in 1995 compared to 60 in 1994, 32 in 1993, 45 in 1992 and 38 in 1991. Non-gonococcal urethritis, however, had decreased dramatically from 17 reported cases in 1991 to zero in the years 1992 to 1995. There was good reason to believe that there was a direct correlation between the number of reported sexually transmitted disease cases and the number of confirmed HIV/AIDS cases. He gave the latest statistics for Tonga. The first AIDS case was confirmed in 1987. Since July 1996, three adult HIV/AIDS cases were further confirmed. Formal notification of the cases should have been made by now to WHO through official channels. That would bring the cumulative total to nine, with five having died from the disease. His government was committed to strengthen measures to prevent sexually transmitted diseases and HIV infection. It would continue to collaborate with WHO and UNAIDS.

Dr ADAMS (Australia) said that although table 6 of the document showed that the HIV prevalence in his country had decreased considerably so that it was no longer at the top of the table, it was discouraging to note that figures in the Region had grown to a total of over 200,000 in 1994, and had gone probably higher in 1996. He urged everyone to continue the strategy of linking HIV infection and sexually transmitted diseases for management of both diseases. That was reflected in the Region’s decision to set up a new unit for sexually transmitted diseases and AIDS and the approach to treat sexually transmitted diseases on a syndromic basis. The principal source of transmission remained through sexual contact and injecting drug use. His country endorsed the Region’s priorities outlined under the “Future Activities” section of the report. His delegation commended the inclusion of programmes for injecting drug users in the Region which was a major contributing factor in the control of HIV/AIDS in his country. Australia was always willing to share its experience with any country. Like the representative of Tonga, he would also be interested in learning more about the collaboration of countries with UNAIDS.

Dr CHHEA (Cambodia) said that his Government was seriously concerned at the continued increase of HIV/AIDS cases in Cambodia since the virus’ appearance in 1991. In fact, it was the most serious situation in the Region, in spite of control measures initiated by the Government in collaboration with various organizations. The rapid spread of the epidemic was a result of many
factors: the demographic movement through the border, and within the country for the last few years; the lack of knowledge and prophylaxis against the disease, coupled with the poverty of populations who had to emigrate to towns for jobs. Control measures were based on three main components: education for groups at high risk, promotion of the use of condoms and increase in screening centres and free treatment of sexually transmitted diseases. Through collaboration with WHO, and his government’s political commitment, a structured network for control measures had been developed. However, there was a serious lack of technical and financial resources. He made a special plea to all agencies, including WHO, to support his country in containing the epidemic before it was too late.

Dr CHEN (Singapore) explained that numbers of cases of HIV infection were rising in Singapore, despite a vigorous national AIDS prevention programme, which complemented a successful programme for control of sexually transmitted diseases. The national strategy for AIDS prevention included public education campaigns as the main focus, legislation which made it an offence for a person with HIV infection knowingly to spread the disease, management of infected people, counselling for people at high risk, screening of blood products, disease monitoring, and involvement of health and community workers.

The chief message for the public was prevention of AIDS and sexually transmitted diseases through mutually faithful sexual relationships and avoidance of casual, unprotected sex. The main challenge was how to change people’s behaviour and to encourage those who had been at risk to go for early screening.

Dr YU (China) said that in the past year the number of HIV infections in China had increased considerably, and that the country urgently needed international support. He hoped that WHO would support a national HIV/AIDS programme using control and prevention of sexually transmitted diseases as an entry point. Aside from HIV transmitted by sexual contact, research was needed on prevention of iatrogenic transmission in order to provide guidance to countries.

As noted in section 3 of the report, WHO had provided technical consultancies on prevention and management of sexually transmitted diseases, for which he expressed his appreciation. HIV/AIDS, whatever the means of transmission, was a disease and as such needed care and treatment. WHO should therefore continue to play a leading role in mobilizing resources and contributing to programme implementation.
He fully supported the unit set up in the Regional Office for the prevention and control of sexually transmitted diseases - a major factor in HIV transmission. He hoped that WHO would support China with regard to harm-reduction programmes for injecting drug users, especially for drug control and for rehabilitation, because of the large part that injecting drug use played in HIV transmission.

With regard to strengthening of prevention and control of sexually transmitted diseases through promotion of syndromic case management, he hoped that WHO would be able to provide material for use by the health sector. Last year, WHO had supported a study visit by Chinese nationals to Thailand, where the health authorities had provided very useful reference material for diagnosis and treatment.

Dr DANIEL (Cook Islands) affirmed that as yet no one had been identified as having HIV or AIDS in Cook Islands, and that the incidence of several sexually transmitted diseases had declined. Activities were aimed at minimizing the factors that contributed to transmission of HIV/AIDS and sexually transmitted diseases, including extensive distribution of health education materials in both the local dialect and English. Education about HIV/AIDS was a component of the school curriculum.

Despite cuts in the health budget as a result of reform, the Ministry of Health had reserved one quarter of its budget for health promotion and protection. Although the programme on HIV/AIDS and sexually transmitted diseases was being maintained, it needed support from WHO for effective implementation. As Cook Islands had not received an allocation for that programme, he requested the Regional Director to look into the matter.

Dr ITO (Japan) observed that although HIV infection was declining in some countries of the Region, others were experiencing a considerable, even dramatic, increase. The future activities of the Regional Office as described in the report were effective measures that deserved priority attention.

The Government of Japan would be making a more active contribution to efforts to tackle the problem of HIV globally, and would be contributing, from 1994 up to the year 2000, US$ 3 billion for control of HIV infection, and population programmes in developing countries up to the year 2000. It had supported the creation of an epidemiologist post in the Regional Office, in addition to bilateral projects and activities. It intended to strengthen further such efforts, while ensuring optimal use of its contributions to UNAIDS.
Dr TAITAI (Kiribati) stated that eight new cases of HIV had been identified in Kiribati in the past three months. Young local seamen had good employment opportunities abroad. That also meant that foreign diseases were being imported into the country. The Government was concerned by the rising incidence of HIV/AIDS, and was requesting technical and financial support from WHO under the programme for sexually transmitted diseases and AIDS. He also suggested that an additional Country Programme Adviser could be posted to Fiji or to the country liaison office in Kiribati.

Mr EMBEL (Papua New Guinea) observed that his country had experienced exponential growth in the number of HIV/AIDS cases since 1987. It had requested Australia to provide support for a special HIV prevention project, which had been in operation since the beginning of 1996.

He endorsed the activities carried out under WHO's programme for sexually transmitted diseases and AIDS, in particular health education. Educational efforts faced particular difficulty in his country, where more than 850 languages were spoken.

His country was developing a national response to HIV/AIDS prevention. He requested countries that had been successful in preventing and controlling sexually transmitted diseases and HIV/AIDS to share their experiences. A high-level national delegation was to visit Uganda at the end of the year to gain a perspective on what might be the socioeconomic and political impact of HIV/AIDS in Papua New Guinea if the country did not take immediate steps to counteract the disease. His Government was requesting regional support for preparing a national framework for HIV/AIDS prevention and management.

Dr CLARO (Macao) reported that the incidence of AIDS in Macao had stabilized, and that no new cases had been recorded since January 1995. None the less, health education and HIV surveillance were continuing. Compulsory testing among immigrant workers in entertainment facilities had become routine. As a result of health education and information, awareness of AIDS prevention had risen considerably among the population.

Dr LOPEZ (Philippines) explained that in the Philippines, UNAIDS brought together the efforts of the cosponsors and other agencies and organizations in support of nationally determined needs and priorities. Its overriding goal was to enhance national capabilities to mount an expanded, multisectoral response to HIV/AIDS. The United Nations Theme Group - UNAIDS' main mechanism of action at country level - had recently been granted counterpart status by the Philippine
National AIDS Council. That had significantly strengthened collaboration between bodies of the United Nations system and the Philippines national response to HIV/AIDS. The partnership had already produced a comprehensive country profile on the situation and was contributing to compilation of a database of HIV/AIDS activities throughout the country.

National health authorities were concentrating on policy development, capability building, the syndromic approach to management of sexually transmitted diseases, and training of trainers in activities which might be associated with AIDS.

Dr TEE (Malaysia) was concerned at the estimated prevalence of HIV infection among adults. In July 1996, a meeting of the ministries and agencies concerned had discussed HIV/AIDS prevention and control. Epidemiological monitoring using sentinel serological surveillance had been going on in Malaysia since 1994. Cooperation between government agencies, the corporate sector and nongovernmental organizations was to be strengthened. Projects were integrating sexually transmitted diseases clinics in primary health care services. Health promotion and behaviour change were emphasized, however, in view of the moral principles and religious values of Malaysian society, health services and peer education programmes targeting commercial sex workers and harm-reduction programmes for injecting drug users had been considered with caution. New methods of curbing HIV infection in the latter group had been considered. Malaysia hoped that UNAIDS would provide experts and technical support on programme evaluation, budgeting, financing, and assessment of the economic impact of HIV/AIDS. The representative hoped that social, cultural and religious aspects would be taken into account in decision making.

Dr TUFA (United States of America) noted that the annual report showed HIV/AIDS trends for the Region, but not global figures for comparison. It was clear, even from the available data, that some countries were experiencing considerable rises in the rate of HIV infection. He welcomed the establishment of a sexually transmitted disease unit at the Regional Office, helping countries to develop public health tools and providing epidemiological monitoring and response, also in the provision of condoms. He complimented the Regional Director on the focused approach, with its concentration on commercial sex workers and injecting drug users. WHO had to intensify its support to Member States for control of HIV/AIDS, which was a potential disaster; the window of opportunity to deal with it was closing. In future reports, data on previous years would be welcome, to show secular and gender trends, geographical and risk-factor analysis.
Professor TRUYEN (Viet Nam) said that the first HIV infection in his country had been reported in 1990, and that by August 1996 over 4000 cases had been found in 40 of the country's 53 provinces. Three hundred and forty-two people had developed AIDS, and 195 had died. The epidemic had broken out among injecting drug users and commercial sex workers, spreading into high risk groups and then into the lower-risk population. The HIV/AIDS control strategy for 1996-2000 featured information, education and communication tactics to effect behavioural change. Campaigns were run in schools. HIV/AIDS information was to be given to the general public and to high-risk populations. There was a condom promotion project for young people, and peer education projects for harm reduction. Other measures adopted concerned blood safety, sentinel surveillance in 20 of the 53 provinces and cities, community-based HIV/AIDS management, care and counselling, integration of HIV/AIDS infection surveillance with sexually transmitted disease management, and strengthening of HIV/AIDS prevention, and of scientific research.

Professor LEE (Republic of Korea) said that the first HIV case in the country had been reported in 1985. By June 1996, the total number of HIV cases was 570, with 58 cases of AIDS. Initially, the major source of HIV infection had been sexual contact with foreigners. Since 1992, however, 88% of cases involved sexual contacts among Koreans. The national HIV/AIDS prevention programme in the Republic of Korea entailed (1) education for students and young people, including those in the armed services and sailors; (2) training of physicians and health workers in health centres; (3) HIV screening for high-risk groups and for blood and blood products; (4) the HIV/AIDS case care programme, which included subsidies, and (5) strengthening of nongovernmental organization activity and research and development. Education for the prevention of sexual transmission of HIV infection was a high priority. The Korean Government would cooperate with the WHO Regional Office in AIDS prevention, and UNAIDS programmes and initiatives would be applied to the Korean AIDS policy after careful review.

Mrs HOMASI (Tuvalu) appreciated especially the section of the report on future activities, and hoped for work to cover other groups, such as seafarers, through appropriate settings and work places. While Tuvalu had no cases of HIV infection yet, it was vulnerable. It was through the future activities described in the document that it would be protected. In 1990-1995 there had been 14 cases of gonorrhoea and four cases of syphilis in Tuvalu, most of them in 1994 and 1995, so that it was clear that both diseases were on the increase. Health education and promotion at national levels had been handicapped by the cessation of the funding from the Global Programme on AIDS and UNAIDS support had not yet been received.
Dr NUKURO (Solomon Islands) said that the number of cases of sexually transmitted diseases had increased by 300% between 1990 and 1995, amounting to 344 cases per 100 000 population in the country, which was probably one of the highest rates in the world. While there had been only one documented case of HIV since 1994, it was believed that there were more. Thus, whereas page 2 of the report said that the number of HIV and AIDS cases in many islands of the South Pacific seemed to have stabilized, that could be due to poor surveillance. In his own country, diagnostic kits had to be imported, and confirmatory testing had to be done in Australia. The syndromic approach to diagnosis of sexually transmitted diseases had been introduced recently. Treatment guidelines had been replaced for health workers in rural clinics, since sexually transmitted diseases were now being reported from rural areas also, even among schoolchildren of ten and twelve years of age. More sociological research was needed to account for such changes. School curricula now included family health education from grade six (pre-secondary) onwards. The representative was concerned at the cutback in funding. A UNDP draft report on the impact of AIDS on Pacific island countries would, he hoped, persuade UNAIDS to allocate more funds to Pacific island countries, since although numbers of cases were small, rates were high.

Mr ROKOVADA (Fiji) said that as at 30 August there were 34 cases of HIV infection and 10 cases of AIDS, excluding temporary and permanent residents who had tested positive abroad. Ninety per cent of reported cases were contracted through sexual contact, and control of that mode of transmission was a major priority in the control programme. Health workers were trained in syndromic case management of sexually transmitted diseases. Safe sexual behaviour such as condom usage, early treatment and partner notification were advocated. Training was provided in clinical management and education. Control of sexually transmitted diseases had been integrated with HIV/AIDS control at all levels. HIV screening was compulsory for all blood donations. Universal infection control programmes had been stepped up in hospitals, health centres and nursing stations, through provision of guidelines on training and supplies and equipment. In June, in collaboration with the World AIDS Foundation, a programme for the training of trainers had been conducted for the benefit of health workers.

The CHAIRMAN asked the rapporteurs to draft an appropriate resolution.
2.2 Joint United Nations Programme on AIDS: Item 10.2 of the Agenda

(Document WPR/RC47/7)

As requested by resolution WPR/RC46.R6 adopted at the forty-sixth session of the Regional Committee, the REGIONAL DIRECTOR reported on developments relating to the Joint United Nations Programme on HIV/AIDS (UNAIDS), which began operations in January 1996.

In its first six months, UNAIDS had formed 97 theme groups worldwide, covering 114 countries, which were composed of the representatives of the cosponsoring United Nations agencies in each country. Their objective was to coordinate and plan the United Nations response to HIV/AIDS at country level. In some countries, other United Nations agencies, nongovernmental organizations and donors might also participate in the theme groups. In the Region, 11 theme groups had been established, ten of which were chaired by WHO Representatives. UNAIDS staff had been assigned to Cambodia, China, the Lao People's Democratic Republic, the Philippines and Viet Nam, to support the theme groups. In addition, two country programme advisers were to be assigned in the immediate future to China (a second position) and Fiji, making a total of five country programme advisers.

However, although a structure had been established, and human resources planned, there were some concerns about the extent to which the operation was currently functioning. Similarly, although there were financial resources available, they did not appear to be sufficient for the task being faced. For the biennium 1996-1997, UNAIDS would provide just over US$ 1.5 million in support of national AIDS programmes in the Region - a reduction of more than two-thirds from the US$ 4 million received by Member States in the 1994-1995 biennium from the Global Programme on AIDS. There had clearly been a substantial change in funding. In response, active steps were needed to maximize the efficiency and effectiveness of available programme funds. WHO was seeking for sources of additional support to countries. It was essential to maintain a full range of activities focusing on the prevention of HIV infection.

Document WPR/RC47/7 provided a more detailed account of such topics. It also included information on the funding and staff support that UNAIDS would be providing to the Regional Office for sexually transmitted disease and AIDS activities. A plan of action focusing on public health interventions had already been agreed by the Regional Office and UNAIDS.
He assured Member States that, within the UNAIDS framework, the Regional Office would continue to take a leading role in public health-related interventions, particularly through activities that reinforced the prevention and control of sexually transmitted diseases, including HIV. He urged representatives to ensure full commitment to all such activities in their respective countries.

Dr ITO (Japan) said that, as one of the countries to represent the Asia and Pacific Region on the Programme Coordinating Board of UNAIDS, which had 22 members, Japan strongly supported the Joint Programme and commended the efforts of its Secretariat, under the guidance of its Executive Director, Dr Piot, in launching activities since its establishment in January 1996. Although some progress had been made, for example with the establishment of theme groups, it was too early to assess the impact of UNAIDS on the HIV/AIDS epidemic.

The most urgent need was for strong collaboration between the UNAIDS Secretariat and its six cosponsors, including WHO, in order to ensure success in combating the disease. Nevertheless WHO, as a specialized agency devoted to international health issues, must play a leading role, in particular as regards the control of sexually transmitted diseases and dual infections with HIV and tuberculosis, and blood safety. The Government of Japan would continue to support activities in those areas in the Region, in close collaboration with UNAIDS and the Regional Office.

Dr HOWELL (France) recalled the concerns expressed by France regarding the role of WHO following the proposal to disestablish the Global Programme on AIDS and establish UNAIDS. While the change had been requested by the international community itself, the rather unsatisfactory arrangements for the transition had unfortunately brought about a two-thirds reduction in multilateral funding for the implementation of national AIDS programmes, just as the countries of the Region were facing a potential explosion of HIV/AIDS. The arrangements for coordination between the six cosponsoring agencies at country level and the apparent resistance of some agencies to the new Programme also gave cause for concern. In addition, France was worried by the continued progression of the epidemic in the French-speaking countries of the Pacific; in New Caledonia and French Polynesia, respectively there had been an increase from 4 and 17 cases of HIV infection in 1986 to 134 and 144 in 1995. Every effort was being made to halt the spread of the disease. However, countries' individual efforts must be backed by resources, understanding, humanity and solidarity from all Member States. Furthermore, the coordination, technical advice and drive of WHO would be essential to improve activities at country level.
France would continue to provide support through the WHO regional programme for HIV/AIDS activities in Cambodia.

Mr WANG (China) said that as a member of the UNAIDS Programme Coordinating Board, China had attended the third meeting of the Board held in Geneva, Switzerland in June 1996 and had been pleased to note that, since its launch in January 1996, a great deal had been accomplished by headquarters staff and country programme advisers under the guidance of the Executive Director, including the establishment of theme groups, the assignment of programme advisers to key countries, the initiation of studies on policy, strategy and research, the establishment of various administrative arrangements, and the setting of priorities for the next six months. Nevertheless, China was concerned at the financial situation outlined by the Regional Director. Although theme groups had been established at country level, the coordination of prevention and control activities was not yet satisfactory. Some of the cosponsoring agencies continued to implement their own individual programmes; funding was insufficient to enable ministry of health focal points and UNAIDS to play an adequate role in that regard. He agreed that UNAIDS should be involved in the funding of national prevention and control activities as well as playing a coordinating and advocacy role. The substantial reduction of funds had come at a time when China was facing increases in the incidence of HIV/AIDS and sexually transmitted diseases. It would result in reductions in the implementation of planned activities. Nevertheless, his Government had agreed to contribute $100 000 annually to UNAIDS to support its development.

Dr TAPA (Tonga) had supported the establishment of UNAIDS from the outset and therefore noted with satisfaction that it had commenced operations in January 1996. However, that support had been on the understanding that the new arrangements would generate more rather than less funding, at a time when funding through the Global Programme on AIDS was beginning to decline. The substantial drop in funding that had become apparent was therefore a grave disappointment.

On 26 June 1996, a letter of agreement had been signed between UNAIDS and the Government of Tonga for UNAIDS support to the national AIDS programme, for the development of a prevention and control workplan, amounting to US$ 30 000 for the biennium 1996-1997, a considerable reduction from the amount received from the Global Programme on AIDS in 1994-1995. Nevertheless he was grateful, since some funding was better than none at all. The reduction in funding, together with delayed receipt of the amount agreed would undoubtedly make it difficult to maintain, let alone intensify, activities, but he was hopeful that UNAIDS might be able to
provide additional or extrabudgetary funding in due course, particularly since, as he had already
indicated, there had been an increase in the number of cases of HIV infection in Tonga. He requested
the Regional Office to seek additional funds for the prevention and control of HIV/AIDS and other
sexually transmitted diseases.

He noted with satisfaction that 11 theme groups had been established in the Region and that
WHO Representatives had been nominated to chair most of them - a recognition of the role of WHO
as the directing and coordinating agency in international health work which Member States of the
Region had pressed for during consideration of the establishment of UNAIDS.

Dr NUKURO (Solomon Islands) echoed the grave disappointment expressed by the previous
speaker. The reduction in funding levels, which had realized his worst fears, had come just at the
time when sexually transmitted diseases, including HIV/AIDS were beginning to rise sharply in
Solomon Islands, and any delay in initiating prevention and control activities might prove disastrous.
Solomon Islands had not yet been approached by UNAIDS and he was concerned at rumours that
some Pacific Island countries would be offered only US$ 5000. He hoped that UNAIDS would be
able to accelerate its activities and provide additional support.

He wished to take the opportunity to express his appreciation to UNFPA, which had agreed
to the use of some of its funding for the prevention and control of HIV/sexually transmitted diseases
in the context of reproductive health.

Mrs ABEL (Vanuatu) said that, to date, Vanuatu had no reported cases of HIV infection or
AIDS. However, national prevention activities had slowed since the end of the Global Programme
on AIDS, in particular, ongoing health education for the general public, development of information,
education and communication materials and the supply of HIV test kits. The remaining WHO funds
of US$ 10 000 would be used for training 30 health practitioners in the syndromic management of
sexually transmitted diseases. It would therefore not be possible to implement other activities
planned for the remainder of 1996 unless an approach was made by UNAIDS. Although document
WPR/RC47/7 highlighted the structure and operations of UNAIDS, there was no clear indication
regarding its communication system.

Dr ADAMS (Australia) said that Australia, like Japan and China, was a member of the
UNAIDS Programme Coordinating Board and had seen the establishment and development of the
new Programme. Australia strongly supported the concept of the joint effort and had made a
substantial financial contribution to the Programme. Support was needed to help UNAIDS overcome its initial problems, particularly as regards cashflow. WHO and the Region had responded strongly in terms of support for public health aspects and there had been some successes. Member States should respond positively to the crisis in the Region by making others aware of the situation and by encouraging all cosponsoring agencies and partners to provide the necessary support. It was essential that UNAIDS succeeded.

The CHAIRMAN, speaking as the representative of Niue, said that for her small country, which as yet had no cases, it was important to raise awareness, in explicit terms, among all visitors of the dangers of transmitting HIV infection, since the infection could only come from the outside. She hoped that representatives would not weary of their efforts to combat the epidemic, which threatened the survival of mankind.

The REGIONAL DIRECTOR drew attention to the fact that the funding provided so far from UNAIDS for the biennium 1996-1997 had increased since the preparation of document WPR/RC47/7, from US$ 1.3 million to US$ 1.5 million.

Responding to comments by representatives, he agreed that there were many initial problems with UNAIDS. There were clearly reductions in both funding and technical support and it appeared that there might be some resistance to change among the cosponsoring agencies. However the Programme had only been in operation for nine months, and it was perhaps only fair to allow more time before assessing its impact. The representative of Vanuatu had raised the question of communications with UNAIDS. He had offered the Executive Director, free of charge, the use of the Regional Offices channels of communication which functioned effectively. Regrettably, that offer had been refused.

He would do his best to convey the concerns expressed by representatives to UNAIDS and hoped that the Members of the Committee who were also members of the UNAIDS Programme Coordinating Board, would do likewise.

The CHAIRMAN requested the Rapporteurs to prepare an appropriate draft resolution for consideration at a later meeting.

The meeting rose at 5.10 p.m.