SUMMARY RECORD OF THE FIFTH MEETING

WHO Conference Hall, Manila
Wednesday, 13 September 1995 at 9 a.m.

CHAIRMAN: Dr Joseph Williams (Cook Islands)

CONTENTS

1. PROGRAMME BUDGET: Item 9 of the Agenda (continued)

1.1 Regional allocations: Item 9.3 of the Agenda (Document WPR/RC46/6)

The CHAIRMAN declared the meeting open, and welcomed the representative of Tuvalu.

The REGIONAL DIRECTOR stated that the item had been included on the agenda in response to a general concern about the erosion of budgetary allocations as a result of the governing bodies' policies on zero-growth and limited cost increases. To allow the Executive Board to consider any decision on reorienting allocations under the regular budget, the Board had requested the Regional Committee to consider the topic in 1995.

Some movement was already taking place to shift resources from headquarters to the regions and countries. For example, the appropriation resolution for the financial period 1996-1997 (resolution WHA48.32, and particularly paragraph 2), approved the use of casual income, if available, up to the amount of US$10 million in each of the years 1996 and 1997 for expenditure on priority country programmes. In addition, resolution WHA48.26 called for the Executive Board and the Director-General to take steps to transfer allocations to priority health programmes at country level starting with a 2% transfer in the 1998–1999 programme budget, with that need being reviewed every biennium. He hoped that that amount would be allocated to regional offices, and would not be allocated from headquarters to countries directly nor kept at headquarters for direct operations.

Document WPR/RC46/6 had been prepared to present to the Regional Committee some aspects of the process of regional allocation of funds and the effect, on the Western Pacific Region and individual countries, of the erosion of available funds over the past 20 to 25 years.

The document contained two parts. The first part was an extract from the report presented by the Director-General to the Executive Board in May 1995. The second part provided information on the factors that, in the view of the Regional Office, should be considered in the review of the allocations.

He said that, in order to provide a complete picture, he was obliged to make some comparisons with other WHO regional offices, although he would have preferred to avoid doing so.

The Western Pacific Region was responsible for the largest population of any region (28% of the world) but had the lowest per capita regular budget input. The first table in Part II of

the document showed the range of regional allocations per capita among the regions. That ranged from 27 US cents for the African Region and 20 US cents for the Eastern Mediterranean to 6 US cents for Europe and only 5 US cents per capita for the Western Pacific Region.

Over the last 25 years, the Region had experienced the greatest percentage increase in number of Member States, with an increase of 125% from 12 in 1970 to 27 in 1995. In addition, there were eight non-independent areas, and one Associate Member (Tokelau). Of those, eight had budgetary allocations and the ninth, Wallis and Futuna, had received collaboration from the intercountry programme. In terms of actual numbers, that increase was second only to the European Region, whose membership had moved from 31 to 50 in the same period. Details of the movements for all regions were shown in Table 2 of the document.

A comparison had been made between the larger countries in the South-East Asia Region and the Western Pacific Region, to illustrate the relatively low amounts allocated in the latter Region. Each of the individual country planning figures allocated by the South-East Asia Region to three of its most populous countries was greater than that for China, whose population was equivalent to the total of those three countries combined. Furthermore, the total of the three country planning figures amounted to more than 50% of the entire regular budget for the Western Pacific Region.

Although the health situation in most countries of the Region had improved over the past few years, there were still urgent health issues to be addressed, such as the eradication of poliomyelitis, the control of tuberculosis, malaria and leprosy, and reduction of the unacceptably high maternal and infant mortality rates in some countries. In addition, the increasing importance of noncommunicable diseases and diseases related to lifestyles was becoming apparent in many countries and areas. Member States and WHO should not reduce their efforts now, nor their financial commitments.

Under the existing situation, the proportion of the budget available to countries of the Region was reduced each time a new Member State joined WHO in the Region. Thus, while the relative amounts of the funds allocated to the various regions had altered very little over recent years, there had been significant shifts in allocations for countries within the Region. That was also true for some other regions. In addition, as the overall allocation decreased in real terms, the proportion required to fund the Regional Office became higher. Taking all those factors into consideration, a strong case existed for the Western Pacific Region not only to maintain its overall share of WHO funds but in fact to increase its share substantially. The Regional Committee might also wish to express its support for the practical application of resolution

WHA48.26, and the transfer of allocations to priority health programmes at country level, with that need being reviewed every biennium.

Those facts were important as a basis for any recommendations the Regional Committee might wish to make on the subject. He felt that it was important that the Region's position was made clear in respect of the distribution of resources from the regular budget, and he asked the Committee to give its views in that regard.

Professor HOANG DINH HOI (Viet Nam) expressed support for the points raised in the Regional Director's report in favour of a reconsideration of regional allocations and requested him to raise the matter with the Director-General.

Although the Western Pacific had the largest proportion of the world population (28%), the per capita allocation was lower at 5 US cents than for any Region. The per capita figure for the South-East Asia Region by comparison was 7 US cents, the average for all regions being 10 US cents.

He noted further that the Western Pacific used its allocation fully, whereas other regions did not. A more equitable allocation would be compatible with budgetary reform in WHO.

Professor LI (China) expressed appreciation for the report. He noted a number of aspects relating to the budget. After many years of no budget growth, the 1996-1997 budget showed a negative trend. Some major contributors were not paying their dues to WHO in full. Meanwhile the overall membership had increased. With continued adjustments in allocations the situation had not improved much for the Western Pacific Region. Figures had been quoted to show that it was at a serious disadvantage, despite the fact that the economic situation was similar to that in other regions. The population was the largest of any of the regions and he added that China's population accounted for the major portion of the Region's total. The regional allocation should reflect the Region's population size more directly.

Ms NESBITT (Australia) agreed that a review of the regional allocation was consistent with reform. The increase in membership in the Region had resulted in allocation shifts within the Region but the regional allocation had not substantially altered. However, while the document brought out apparently significant disparities with other Regions, other criteria should be taken into consideration before conclusions as to the real level of disparity were drawn. Many of the factors favouring increased allocation applied to all the regions, not only to the Western Pacific; the issue of criteria therefore called for a global, multifaceted approach. The matter should also be considered in the context of health-for-all strategies, the consolidation of

budgetary reform, other overall priorities in WHO as recommended by the Executive Board, and particularly programme priorities at country level.

The outcome of a review should be consistent with strategic budgeting and be sufficiently flexible to ensure a continuous assessment of priorities.

Mr SAKAI (Japan) said that, in spite of substantial improvements in health in the Western Pacific Region, a wide range of problems remained which required adequate financial resources for appropriate action. The inequity of its allocation could not be overlooked, and the Regional Committee should request a fair share. Japan would join other Members concerned in the submission of a resolution to the next World Health Assembly with the cooperation of the Secretariat.

Mr BOYER (United States of America) said the question was a difficult one on which his views once again were likely to be seen as dissenting. The limitation of zero real growth in the budget over the last 10-15 years made the issue of reallocation all the more difficult to justify. The fact that Africa had many of the poorest countries was an argument for an increased allocation to that region; other regions would also have their reasons and would no doubt be submitting similar resolutions. The Executive Board had considered the matter, but there was no easy solution. No region was likely to be prepared to have its allocation reduced. The question that should be addressed, therefore, was that if one region was to receive an increased percentage of the budget available, which region was to receive a corresponding decrease? He agreed with the representative of Australia that the analysis in the report, based on a per capita distribution, according to the population of a region, was not sufficient to make an informed judgement. The per capita argument was not particularly appropriate for WHO in his view since, unlike UNICEF, whose operations were directly related to population, WHO dealt with ministries of health. Population was just one of many factors, as outlined by the representative of Australia, that should be taken into account.

Rather than submit a regional proposal or resolution, it would be preferable to have a proposal from the Director-General.

Dr DURHAM (New Zealand) expressing appreciation of the clear presentation in the document, said that she agreed with Australia and the United States that population size was a crude basis on which to allocate budgetary resources. New Zealand would support the development of a global population-based funding formula which would include technical adjustments in accordance with programme and country priorities. There should be a phased progression to greater equity, which should also extend to the use of resources at country level.

Dr ROXAS (Philippines) supporting a review of allocations, requested information about the criteria for allocation between and within Regions. He suggested that the criteria should be population (on a per capita basis), magnitude of health problems, national development index and absorption capacity.

Dr MONTAVILLE (France) said he wished in the presence of the Director-General to recall that the purpose of resource allocation was to close the gaps in health status between peoples, whether at global, regional or country level. Other factors given in the document had also to be taken into consideration, bearing in mind particularly the needs of the poorest and least developed countries and those with the poorest health indicators. He felt that a review was feasible, even if purely statistical considerations were not sufficient.

Dr RODGERS (Solomon Islands) commending the document's clear presentation, supported it in the interests of equity, although comparison between regions of allocations per capita might seem simple. The concern expressed by Australia, New Zealand and the United States had already been taken into account in the existing system of allocation. This was indicated in the table on page 5 of the report, which was presumably why Africa, with 10% of the world population and a major AIDS/HIV problem, had 28.6% of the total budget — almost as much as the South-East Asia and the Western Pacific regions together (31.6%), with their combined 53.2% of world population. He noted that malaria was a serious problem, for example, in his country.

The need for efficiency and accountability was recognized, but on these criteria good management should also be rewarded in situations where comparable health problems were faced. Any formula used by WHO should not work out to the disadvantage of small island nations. He favoured the submission of a resolution by the Regional Committee to request an increase in the Region's allocation.

Dr TAPA (Tonga), wishing to help reconcile conflicting views on the need for a review, observed that any reorientation of allocations would have to be based on all the factors outlined in the report. However, he felt that the population criterion was rightly given first place in the document, since the health of populations was the primary concern of WHO, according to Article 1 of its Constitution. The other criteria deserved support, and the proposals from other regions should also be heard, but the Western Pacific Region should not be prevented from putting its strong case.

The World Health Assembly Resolution WHA48.32, the appropriation resolution for the financial period 1996-1997, provided an opportunity to request that the US$10 million in each of

the years 1996 and 1997 for expenditure on priority country programmes should also be shared equitably amongst the six regions with per capita measurement being the main consideration.

Professor LI (China) said that although the delegations had different views regarding reconsideration of regional allocations under the regular budget, he felt that the concern about the need for more funds for priority health programmes was shared by all. There were still major health problems that could not be addressed without additional financial resources. For example, under the eradication of poliomyelitis programme in China, 80 million doses of vaccine had to be provided yearly.

He recognized the difficulty of an equitable regional allocation, but adjustment of allocations within the regions was not impossible. Although population was not the only criterion for regional allocations, it was an important one. He agreed that a review of the criteria for regional allocation was needed.

Dr ENOSA (Samoa) noted that the health outcome of the small island countries may not reflect their budgetary allocation in the same way as the larger countries. Nevertheless, whatever the size of population, the basic requirements for life were the same for small countries as for large countries. It was important to obtain funds for the country level, but it was more important that the funds allocated to the country enabled it to set achievable goals. He requested an explanation from the Director-General on the criteria for the regional allocations and how these were reflected in country allocations.

The REGIONAL DIRECTOR said that the subject was a difficult one, especially since there were two divergent viewpoints. As Regional Director, he was convinced that the Western Pacific Region deserved an increase in allocation. Whatever terminology might be used to denote programme priorities he would plead for a larger share of the allocation available.

Substantiating his argument for increasing the regional allocation on the basis of population, he said that when China became a Member State in 1972, the Regional Office had received only US$250 000 more to address the health needs of such a large population. When operations had been resumed in Cambodia in 1994-1995, the Region had received an additional US$480 000. The existing regional allocation had then had to be reapportioned at country level to meet the health needs not only of those two countries, but also of other Member States.

Given some time, the Region would be able to justify the request for reallocation based on health needs. The Executive Board, if it wished, could compare that justification with the needs of other regions. It was a difficult task, and he had therefore concentrated on the five factors

outlined in the document for consideration by the Regional Committee, rather than detailing the countries' specific health needs. He thought the Regional Committee should request an increase in regional allocation. It might not be approved by the Executive Board but the criteria would at least be reviewed. He also supported the suggestion of the representative of Tonga, which was in line with resolution WHA48.26 where the 2% set aside for country activities should again be allocated on the basis of equity.

Clarifying the percentage allocation to the Region he referred to the table on page 3. In 1986-1987, the Region had had 9.34% of the total WHO budget; in 1988-1989, it had had 8.76%; in 1990-1991, it had shown a slight increase to 8.89%; in 1992-1993, there had been a slight decrease to 8.56%; and in 1994-1995, it had been 8.70%. In 1996-1997 the share would have been 8.70%, but Mongolia's entry into the Region had increased the percentage to 9.10%.

He understood the difficulties that faced the Director-General at the global level, which he himself had encountered when determining country planning figures. He acknowledged the complexity of the factors that had to be taken into account and that a simple mathematical model could not be applied. However, he still felt that a plea could be made for a larger share for the Region.

The DIRECTOR-GENERAL said that, like the Western Pacific Region, the African Region would request an increased regional allocation while the European Region and the Eastern Mediterranean Region had made such a request in 1994.

In October 1995, the Global Policy Council, composed of the six regional directors and the assistant director-generals with himself as Chairman, would consider the issue of regional allocations. The Council had previously considered the issue but had not reached a solution because each region wished for an increase. Two steps had been taken: to reduce the headquarters allocation and increase the share of a region in particular need (that had been done for Africa in 1996-1997); the second was the allocation of US$3 million to supplement the deficit for the Americas Region.

He said that the Western Pacific Region had not made any reduction in force. That was very fortunate, and very good financial management. In the case of headquarters, 140 posts had been cut with a probable maximum of 50 reduction in force. The European Region was also facing reduction in force. Despite the increase referred to, the Americas Region was also now in the same situation because the major contributor had indicated a significant reduction in its payments.

Using the criterion of a per capita allocation was not a good method of determining regional allocations. Indeed, some of the representatives of South Pacific island countries had pointed out that some small countries had a higher per capita allocation compared to countries with a larger population. He was extremely sympathetic to the Region's request and had, in fact, raised the issue when he was Regional Director of the Region. However, WHO's financial policy had always been one of fiscal conservatism.

He assured the representatives that he would discuss with the Global Policy Council the criteria for the Committee's request. In return, he requested the major contributors like Australia, Japan and the United States of America, to contribute to defining which countries were most in need of WHO technical cooperation and which countries were less in need of such cooperation. If basic health indicators were used for that exercise, regions like the Western Pacific would receive a reduced allocation because of its success in management of disease programmes.

Major donors like the United Nations, World Bank, UNICEF and other, bilateral agencies used certain traditional indicators, such as gross national product and infant mortality, to define countries in need. Those would also result in a lower allocation of financial resources to countries that had been more successful. That led to the use of disparate indicators by countries between different agencies in order to secure support. WHO, however, allocated country resources based on health needs, not on indicators.

Furthermore, it was mandated to extend technical cooperation to all Member States. Recalling the WHO Constitution, he reminded the Regional Committee that WHO's functions included acting as the directing and coordinating authority on international health matters, and extending technical cooperation to all countries. The balancing of resources for these functions between headquarters, the regional offices, intercountry activities, and country needs was a complex exercise.

By way of illustration, he noted that some countries in other regions had a proportionally high country allocation compared to some Western Pacific countries, despite having a smaller population. That was owing to the relatively high priority of certain programmes, such as poliomyelitis eradication and leprosy elimination, which were not progressing as fast as in other countries. The Eastern Mediterranean Region had only two countries that required direct technical cooperation with WHO. The oil-rich countries channelled their country allocation to intercountry programmes and the Regional Office would extend, on occasion, advisory services or support for intercountry activities. Countries of the European Region were suffering enormously, particularly in Central Asia and to some extent, Eastern Europe. Nevertheless, in order to build up WHO's image, the European Region was extending considerable resources,

particularly emergency assistance, to the former Yugoslavia. The allocation of three major countries for the Americas Region was more than the country allocation for all of the Western Pacific Region.

He had submitted a basic document on regional allocations to the Global Policy Council, but the regional directors had been unable to reach an agreement. The issue would then be considered by the Executive Board but the representation from the Western Pacific Region was small and that could present a disadvantage. He agreed that some kind of a solution should be found, although that was no longer possible for the 1996-1997 programme budget. He would try to raise the issue during the discussion of the regional budget allocation for 1998-1999. He warned the representatives that success was not certain since the issue was an extremely sensitive one.

He recalled the WHO Constitution, article 50, paragraph F, which stated that the function of the Regional Committee was "to recommend additional regional appropriations by the Governments of the respective regions, if the proportion of the central budget of the Organization allotted to that Region is insufficient for the carrying-out of the regional functions." That meant that Member States had a role to play in the country allocation.

He urged the identification of the country priority programmes which should be reflected in the proposal. That was a most important matter which should be addressed by the Regional Committee. He hoped that the Regional Director would bring to the Global Policy Council as well as to the Executive Board the priority needs of countries in the Region and that its Executive Board members would actively participate in the discussion. It was disappointing that there had been little input from the representatives of the Western Pacific Region when the 1996-1997 budget appropriation was being considered by the drafting committee. In fact, one country of the Region was in the forefront of those who were for a reduction in the budget. Support for a reconsideration of regional allocation had, however, been expressed by another representative from that country during the present meeting. The only way to ensure that regional allocations would be reviewed was to identify the Region's priorities at country level and at regional level and to be unanimous in supporting the proposal before the Executive Board.

Dr ENOSA (Samoa) thanked the Director-General and the Regional Director for their clarification.

Dr SIPELI (Niue) endorsed the comments of the representative of Solomon Islands, emphasizing the needs of the small island states.

The CHAIRMAN requested the Rapporteurs to prepare an appropriate draft resolution.

2. CONSIDERATION OF DRAFT RESOLUTIONS

The Committee considered the following draft resolutions.

2.1 New horizons in health (Document WPR/RC46/Conf. Paper No. 1)

Dr DURHAM (New Zealand) proposed with respect to operative paragraph 3(1) that the words "health outcome" be inserted after the word "achievable", and that "at the regional level to enable monitoring and reporting on the state of the Region's health" be added after the word "targets". In operative paragraph 3(2), she proposed the addition after the word "requirements" of the phrase "and to establish a minimum set of regional indicators". Finally, she proposed a new operative paragraph 3(3) to read as follows: "to present the indicators in a form which differentiates between the health of the indigenous population and the health of the rest of the population".

Mr McCUDDIN (United States of America) proposed that the words "and budgets" be deleted from the first preambular paragraph; that in operative paragraph 3(2) the phrase "individual country requirements" be replaced by "health-for-all monitoring requirements and individual country capabilities"; and that the words "health for all, *New horizons in health* and" be inserted after the words "implementation of" in operative paragraph 3(4).

Mrs HONG TIY (Fiji) proposed, with respect to the new sub-paragraph 3(3) proposed by the representative of New Zealand, that the words "where applicable" be added at the end.

The REGIONAL DIRECTOR said he had been uneasy about the proposed new paragraph because the Committee had not yet discussed the subject of indigenous populations, and in any event there was still no firm United Nations definition of the term. However, the amendment proposed by the representative of Fiji satisfied him.

Dr OTTO (Republic of Palau) proposed that the words "and budgets" should not be deleted from the first preambular paragraph, as the representative of the United States had proposed, because *New horizons in health* indicates that the strategy should be within the financial resources of countries. Without this phrase it would be difficult for countries to use the resolution when making recommendations to departments of finance.

Mr LEE (Republic of Korea) wondered whether the targets referred to in operative paragraph 3(1) should be specified as health outcome targets, as the representative of New Zealand had proposed, given that not all *New horizons in health* targets were related to health outcomes.

Mr McCUDDIN (United States of America) accepted the proposal of the representative of the Republic of Palau.

Dr DURHAM (New Zealand) said it was important to emphasize improvements in health outcomes, and that not all the *New horizons in health* indicators necessarily led to them. She proposed a further amendment to operative paragraph 3(1), replacing the phrase "setting achievable targets" by "setting achievable health outcome and other targets".

Mr LEE (Republic of Korea) said that the proposed further amendment met his concerns.

Ms NESBITT (Australia), Rapporteur, said that the various amendments to operative paragraph 3(2) would be more satisfactorily accommodated in two separate paragraphs.

The REGIONAL DIRECTOR proposed a further amendment to operative paragraph 3(2), inserting the words "and evaluation" between the words "health-for-all monitoring" and "requirements".

> Decision: The draft resolution, as amended, was adopted (see resolution WPR/RC46.R2).

2.2 Changes in the 1996-1997 programme budget (Document WPR/RC46/Conf. Paper No.2)

Dr ADAMS (Australia) proposed the addition of a new operative paragraph (3) reading as follows: "to ensure prioritization of the health needs of the Region as set out in *New horizons in health* and to reflect these closely in the allocation and implementation of all available resources as well as in the monitoring of the impact of these allocations on gains in health status". The existing paragraph (3) would then become paragraph (4).

Dr DURHAM (New Zealand) supported the amendment proposed by the previous speaker and suggested that paragraph (1) should be amended by replacing "the programmes despite the budgetary constraints" with "priority programmes while maximizing gains in efficiency".

Mr SAKAI (Japan) supported the amendments proposed by the representatives of Australia and New Zealand which covered important aspects of budget allocation and implementation.

Mr McCUDDIN (United States of America) also supported the two proposed amendments and suggested the addition of a further operative paragraph at the end of the draft resolution to read as follows: "to prepare future regional budgets for presentation to the Regional Committee on the basis of a full breakdown of programme categories to ensure an informative format and also to include information on extrabudgetary contributions in each programme category".

The REGIONAL DIRECTOR suggested that since the amendment proposed by the representative of Australia covered two different aspects it could be split into two operative paragraphs, the first reading "to ensure prioritization of the health needs of the Region as set out in *New horizons in health*", and the second reading "to reflect these health needs closely in the allocation and implementation of all available resources as well as in the monitoring of the impact of these allocations on gains in health status". If the amendment was approved, it might be appropriate to add a fifth preambular paragraph reading "Noting also the relevance of *New horizons in health* to programme development and implementation", to introduce the document mentioned in the operative paragraph.

He further suggested that in the amendment proposed by the representative of New Zealand "maximizing gains" should be replaced by "optimizing gains", to avoid repetition.

He expressed concern that the amendment proposed by the representative of the United States of America might cause some difficulties since it might be in conflict with the Director-General's guidelines on programme budget preparation. He sympathized with the proposal and could understand that the Regional Committee might wish to revert to a more detailed programme budget, as mentioned by the representative of the United States of America at an earlier meeting. However, he was required to comply with the Director-General's instructions for the Organization as a whole, as well as responding to the requests of Member States in the Region.

Dr ADAMS (Australia) agreed to the amendment, suggested by the Regional Director, to the additional operative paragraph he had proposed.

Dr DURHAM (New Zealand) said she would prefer paragraph (1) to read "to implement the 1996-1997 programme of collaboration, maximizing both the effectiveness of priority programmes and gains in efficiency".

Mr McCUDDIN (United States of America) explained that the intention of his proposal was to ensure that when reviewing budget proposals the Committee had before it the appropriate information at the required level of detail.

The REGIONAL DIRECTOR suggested that the term "full breakdown" used in the United States amendment required further clarification. Given earlier comments, he assumed that it referred to a breakdown under the 59 categories used in recent programme budgets. That would necessitate the preparation of two separate budgets, since he was required to prepare future programme budgets for headquarters under 19 categories. He suggested that it would be preferable for the draft resolution to be more explicit regarding the level of detail required. Information on extrabudgetary contributions, as far as it was available, was already included in programme budget proposals.

Mr McCUDDIN (United States of America) confirmed that "full breakdown" referred to the 59 categories used in recent programme budgets.

The CHAIRMAN requested the Rapporteurs to prepare a revised version of the draft resolution, taking into account the points discussed.

It was so agreed.

3. AIDS: Item 10 of the Agenda

3.1 Annual report on AIDS, including sexually transmitted diseases: Item 10.1 of the Agenda (Document WPR/RC46/7)

The REGIONAL DIRECTOR presented the annual report on AIDS and sexually transmitted diseases, as requested by the Regional Committee at its thirty-eighth session.

The report described the key focuses of attention in the last year, the current situation, and the projected trends.

He drew attention to the work that had been done on intervention strategies to reduce HIV transmission. The priority programme approaches in the Region had been to control sexually transmitted diseases, to influence changes in behaviour, and to avoid risk. That had been done through health promotion, education, and training, specifically for injecting drug users, commercial sex workers, persons with sexually transmitted diseases and young people. Those approaches were interlinked, and were most effective when implemented in conjunction with each other. WHO had studied which interventions had been most successful, and had sought to introduce those, as appropriate, to specific countries throughout the Region. WHO had noted

with appreciation the increasing political support, which was essential to complement the work being done with the public.

Improving the quality of surveillance systems had also been a focus of activities, since high-quality data were essential to track the development of the disease, and respond promptly. WHO had a clear picture of the different ways in which the disease was being transmitted in different parts of the Region, and thus of the best approaches to halting its spread.

Surveillance showed that, as at 1 September 1995, the total number of of reported HIV infections was 43 650 and the total of reported AIDS cases 8401. Seven countries had reported having no HIV infections or AIDS cases.

The question that faced Member States and WHO, and which he would cover in more detail under the agenda item on the Joint United Nations Programme on AIDS, was what would happen to the programme the following year, and to the initiatives that had been started in the Region, once they fell under the auspices of UNAIDS.

For example, WHO had stressed the importance of the management of sexually transmitted diseases as a simple, cost-effective strategy to prevent the spread of HIV. It would continue to advocate and to support that, in conjunction with whatever sexually transmitted disease element the new programme contained. The Regional Office had budgeted for one professional staff member and one secretary in the Regional Office and had allocated regular budget funds to supplement the extrabudgetary funds, which the Regional Office would continue to administer for sexually transmitted disease prevention and control. However, in that area, as with the whole programme, it was not clear what approaches would be pursued. At present, WHO did not know what exact form the new programme would take in countries, nor what level of funding and management would be available. Those issues would only be reconciled at the November meeting of the Programme Coordinating Board (the governing body of UNAIDS). He had recently had extensive discussions with the Director of UNAIDS on the extent of its collaboration with the Regional Office, and had received an assurance that there would be a smooth transition at the country level. The Regional Office would welcome the strong intervention of the countries which were represented on the Programme Coordinating Board (Australia, China and Japan) in resolving those issues, in communicating the practical implications for the Region of such uncertainties and in determining how important programme activities should be pursued.

Dr ADAMS (Australia) commended the Regional Director's detailed report and expressed concern at the evidence of rising rates of HIV infection in some countries of the Region. Even in Australia, where the infection rate had been declining, it had now levelled off. That suggested

that adequate education and information on the HIV/AIDS risk was not reaching the younger generation, particularly men who had sex with men, and there was certainly no room for complacency. He supported the implementation of syndromic case management of sexually transmitted diseases. Injecting drug use was a cause of increasing concern in the Region, and its control was a difficult issue. He recommended joining forces with nongovernmental organizations to tackle the problem.

Dr ITO (Japan) stressed that the importance of HIV/AIDS surveillance could not be overemphasized. He hoped the Regional Office would continue to play a leading role in providing technical support to strengthen the regional surveillance capability. Japan wished to work closely with the Regional Office in that respect by providing experts and equipment. It had assigned the highest priority to its Official Development Assistance scheme, and planned to provide developing countries with support worth US$3000 million between 1994 and 2000. Its technology transfer programmes in the Region had begun in 1991, including an HIV/AIDS diagnostic support and training programme. A seminar held in Tokyo with the participation of senior officials of Member States of the Region to exchange information and transfer expertise had proved successful and was to be followed by another such seminar in a few weeks time. Japan wished to strengthen such efforts in collaboration with the Regional Office and other Member States.

Dr ABDUL LATIF (Brunei Darussalam) drew attention to the large number of HIV-infected persons in his country: as at June 1995, there were 235 infected persons in a population of only 280 000. Of those, 229 were foreign workers. Of the six nationals, two were haemophiliacs who had been infected through contaminated blood products before HIV tests became available, and two had been infected abroad. The predominant mode of transmission was through heterosexual contacts; no infections through intravenous drug use had been recorded. The HIV/AIDS situation in Brunei Darussalam illustrated the vulnerability of a small nation with a large number of foreign workers. It was important to maintain strict surveillance and high public awareness of HIV/AIDS.

Dr SHAO (China) commended the achievements of the Regional Office during the past year, as described in the Regional Director's report. Reported HIV infections in China up to the end of 1994 totalled 1774, of which 65 had progressed to AIDS. In 1994 alone, 531 HIV infections had been reported, almost 30% of the cumulative total for the past ten years, and it was planned to step up surveillance.

China wished to express its gratitude to the international organizations, including WHO, for their vital support in matters relating to AIDS and sexually transmitted diseases. It hoped that

cooperation between China and the Regional Office on the prevention and control of such diseases would be strengthened.

Dr GAKO (Philippines) said that AIDS was becoming a major health problem in his country. In response, the Philippine National AIDS Council, a multisectoral policy-making body for AIDS prevention and control, had been created. It had made progress in securing the integration of AIDS-related activities in the work of the government and nongovernmental agencies. There was good collaboration between the Council, the Department of Health and WHO, particularly in the provision of technical support.

Dr CLARO (Macao) stated that the total number of HIV infections reported from 1986 to August 1995 was 112, of which 85 were females, 26 males, and one unknown. The eight reported AIDS cases concerned seven males and one female, and seven had already died. All the AIDS cases had occurred among nationals, whereas the majority of HIV-infected persons (86) were foreigners.

From November 1992 to the end of August 1995, 13 834 HIV tests had been performed on foreign workers in entertainment facilities. Of these 86 were HIV-positive (73 females and 13 males). The HIV/AIDS programme was running smoothly, and health education and HIV surveillance were being intensified.

Dr GERMAIN (France) thanked the Regional Director for his constant support for the French Pacific territories in the field of HIV/AIDS control, particularly in the preparation and evaluation of the first medium-term plans and in the preparation of the second medium-term plans.

The impending transfer of HIV/AIDS to UNAIDS raised a number of issues. During the changeover it was important to ensure the continuity of technical and financial support so as to safeguard country programmes and the complementarity of activities throughout the Region. At a time of rapidly changing lifestyles and increasing movements between countries, cohesive international programmes were more important than ever before. In view of the forthcoming changes in the organization of HIV/AIDS control at the global and regional levels, his delegation was seeking more information on a number of points: What form would collaboration between the Regional Office and UNAIDS take? What would the Regional Office do to ensure its participation and the continuity of its action at country level? What criteria would be applied to decide which countries should receive financial aid? What would become of the programme for the control of sexually transmitted diseases and how would the changeover between the Global Programme on AIDS and UNAIDS be smoothly effected? He also asked for information on the

project to set up a technical agency for AIDS control in Bangkok and on the envisaged links between the agency and UNAIDS. France wished to see the new coordinated programme carry out its task as effectively as possible.

Dr CHHEA Cambodia) said that his Government was seriously concerned at the continued rapid increase in HIV infection. Up to July 1995 some 1000 HIV infections and 13 AIDS cases had been reported, with three deaths. The Government had initiated control measures in 1991, and a committee to develop a medium-term control programme had been set up within the Ministry of Health in 1992. In 1993, at the Ministry's request, the Government had established a national committee for AIDS control, which had been restructured the following year to deal with other sexually transmitted diseases as well. The recent decision by the heads of Government to chair that Committee themselves was a source of great encouragement, and represented a decisive political commitment. It was hoped that adequate financial and technical support would become available for the effective control of those diseases.

Dr HO (Malaysia) said his country's Ministry of Health was deeply concerned at the increasing number of HIV infections, which were mainly among intravenous drug users. It recognized the importance of a good surveillance system, improved laboratory support and a programme to reduce high-risk behaviour. The Ministry was collaborating closely with nongovernmental organizations to support them with their outreach programmes for AIDS and sexually transmitted disease control. The second medium-term plan on AIDS had been incorporated in Malaysia's five-year development plan for 1996-2000. Sex education was being provided in schools, and emphasis was being placed on family values and on moral and religious values.

Mr McCUDDIN (United States of America) shared the concerns expressed about the emergence of additional countries with increasing rates of HIV infection. He welcomed the Region's more aggressive approach in supporting Member States in the development of public health tools to respond to the epidemic and in the provision of condoms. However, the Regional Office should inject a greater sense of urgency into its dialogue and collaboration with Member States to prepare for the full brunt of the epidemic, still to come. There was no room for complacency about the delay in the increase in HIV/AIDS in the Region, and it was unlikely that countries currently reporting few or no infections would enjoy that situation for long. Urgent action was needed at country and intercountry levels to determine the best use of available resources and to develop effective interventions.

Mrs HONG TIY (Fiji) said that Fiji was one of the countries where the number of HIV infections was increasing. The cumulative number of HIV infections totalled 31, with 8 cases of

AIDS; 78% of those infected were aged 20-40 years. Heterosexual contact was the predominant mode of transmission.

Reported cases of gonorrhoea and syphilis had shown a downward trend over the past few years, which was evidence of the success of the programme being put into place. Factors contributing to this included use of the syndromic case management approach at all health care levels, active involvement of certain nongovernmental organizations in public education, the school AIDS programme conducted by the Ministry of Education, and training and retraining of all health care workers.

All Member States should continue to develop public policies to reduce the impact of HIV/AIDS and other sexually transmitted diseases, with increased commitment to interventions that had been shown to be successful.

Professor HOANG DINH HOI (Viet Nam) said that, with the valuable support of WHO and other international organizations, the short-term plan for 1989-1990 and the medium-term plan for 1991-1993 had been successfully implemented in nine provinces. The HIV/AIDS surveillance programme was currently under way in 12 sentinel provinces. Up to 18 August 1995, 2990 HIV infections had been reported; 232 were cases of full-blown AIDS, 70 of which had died. The majority of HIV-infected people were drug users, commercial sex workers and sexually transmitted disease patients. The HIV infection rate was increasing rapidly: only one case had been reported in 1990, but there had been 1124 cases in 1993 and 1041 in 1994. The majority of cases (73.3%) occurred in persons aged 30-49 years. Although the HIV prevalence rate was still low, there was evidence that the epidemic was starting to spread very rapidly in many provinces.

Dr RODGERS (Solomon Islands), referring to the statistics presented in the Regional Director's report, pointed out that in island nations most HIV-positive subjects were from other countries. He requested guidance on the ethical implications of requiring people arriving in a country to declare their HIV status. It was important to strike the right balance between enabling countries to protect themselves and safeguarding confidentiality.

Mr WORKMAN (New Zealand) commending the report, said that the country had had 501 cases of AIDS since monitoring started. Although notifications had fallen over the last two years, HIV infections continued to be identified at a steady rate. The Government was developing a policy on the prevention of sexually transmitted diseases and condom promotion as part of all programmes on sexuality and safer sex. Free distribution of condoms had not yet been accepted by the Government, in spite of support from many community groups.

Measures to improve content and delivery of sex education in schools were under way. The New Zealand Prostitutes Collective, a nongovernmental organization, had been active in efforts to promote health and safe sex among commercial sex workers, although it was acknowledged that there was also a need to address the clients.

Dr WANGI (Papua New Guinea) also commending the report, said that there were 308 HIV infections and 134 AIDS cases in his country. There was an almost equal sex ratio and most of those infected were aged 20-25 years. The transmission was mainly through heterosexual contacts. The rate was increasing, making AIDS a major subject of concern for the Government, which was setting up a National AIDS Council to regulate HIV/AIDS control, by the end of 1995. Meanwhile, health education and promotion among risk groups and the general public were being advanced. He thanked USAID, the Asian Development Bank and the World Bank for their support.

Mr LUI (Tokelau) said that his country was among those that had not reported any HIV infections, and he thought other countries would wish it to remain so. It was reassuring for a country such as his to know that those countries that did have reported cases, also had effective HIV/AIDS programmes. He stressed the need for continuing close collaboration in the Region on health education and promotion relating to the prevention of HIV/AIDS.

The meeting rose at 12.20 p.m.