SUMMARY RECORD OF THE THIRD MEETING

WHO Conference Hall, Manila
Wednesday, 14 September 1993 at 9 a.m.

CHAIRMAN: Mr S. Naivalu (Fiji)

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1. ADDRESS BY THE INCOMING CHAIRMAN: Item 4 of the Agenda

The CHAIRMAN addressed the Committee (see Annex).

2. PROGRAMME BUDGET, 1992-1993: BUDGET PERFORMANCE (INTERIM REPORT): Item 9 of the Agenda (Document WPR/RC44/4)

The REGIONAL DIRECTOR drew attention to document WPR/RC44/4, which contained an interim report on budget performance during the biennium 1992-1993. The report summarized the difficulties faced prior to and during implementation stages and the actions taken to resolve the situation. The various changes in the 1992-1993 regular budget were shown in Annex 1. The interim financial implementation of the regular programme budget as at 31 May 1993, listed by major programme and programme, was contained in Annex 2. Annex 3 provided more detailed remarks on the financial implementation.

The 1992-1993 regular programme budget estimates of US$ 63 901 400 referred to in Annex 1 and itemized in column (1) of Annex 2 were those reviewed by the Regional Committee at its forty-first session in 1990. Subsequent changes in the regular budget were shown in Annex 1 and further reflected in Annex 2 under columns 2 and 3. The effect of those changes could be seen in the resulting adjusted programme budget of US$ 57 140 400.

Annex 2 showed that expenditures and obligations incurred as at 31 May 1993 had amounted to US$ 44 446 200 (column 7), resulting in an implementation rate of 78% in dollar terms (column 8). The budget was expected to be fully implemented by the end of the biennium.

The interim report was intended to provide information on progress in implementation. It explained fully the many problems and the measures taken to overcome them. He thanked all the Member States for their cooperation and understanding.

The final report on budget performance 1992-1993 would be presented to the Committee at its forty-fifth session in 1994, at which time it was expected that discussion would take place on the final implementation results. Nevertheless, he would be pleased to answer any questions on the interim report.

Ms BLACKWOOD (United States of America) expressed appreciation of the manner in which the interim report on budget performance had been presented. It was very informative, and, she believed, unique in the WHO system. It showed not only how much of each budget line had been

implemented or obligated to date, but also gave explanatory comments on variations between the obligations and the original budget allocations. Several factors outlined in the report revealed that the Region was operating under constraints not anticipated at the time of adoption of the 1992-1993 programme budget. The financial challenges were a reminder that the Committee needed to make hard decisions in order to determine the Region's priorities in the use of scarce resources. It was hoped that the Secretariat would continue to modify future biennial budgets in ways that would assist Member States in understanding and making such difficult choices. The United States delegation would be interested to know how the target activities for reduction had been determined in consultation with Member States, which had resulted in a reduction of US$ 7.4 million. In addition, the Regional Director's comment on the significant increase under programme 15 (Support services - column 5, page 11 of the report) was requested.

Mr KOIMANREA (Papua New Guinea) congratulated the Regional Director on handling the budget changes both in a financially sound and compassionate manner. The implementation rate of 78% for the adjusted 1992-1993 programme budget was noted with satisfaction. That indicated not only the Secretariat's ability to utilize funds in a timely manner, but also reflected the increasing needs of countries in the Region. He welcomed the agreement during the previous day's session to allow reprogramming of resources to a few selected areas where the most gains could be achieved. The Regional Director's vision for a more proactive and entrepreneurial Western Pacific Region had much to commend it. Health systems needed reform, which should be done in response to changing social, economic, and political conditions. Health systems, and in particular financial resources, could be used to achieve the maximum benefits possible. His Government looked forward to a fuller discussion of the programme budget during the Committee's session in 1994.

Mr KEO (Australia) said that his Government acknowledged the 10.8% reduction in the 1992-1993 programme budget, and recognized the need to accommodate a roll-over deficit of US$ 1 million for the previous biennium. A uniform reduction of about 12% throughout the 15 programmes, including support services, would have been expected, but the wide variation of programme changes during implementation as shown in Annex 2 was a source of concern. For example, programme 6 (Public information and education for health) had been reduced by 42%, while programme 15 (Support services) showed an increase of 37%, which included an increase of 72% in personnel costs. In the interest of transparency and good governance, the Secretariat was requested to indicate, as a standard budgeting practice for current and future bienniums, the number of staff allocated against each programme together with their corresponding costs. While appreciating the difficulties encountered by the Secretariat during implementation of the budget, national and budgetary realities were such that it was important to adhere to the actual budget regardless of the amount of the overall deficit before or during implementation. Based on available

documentation, the Regional Director should be complimented on his managerial ability to implement the biennial activities within the budget. That achievement should be applauded as it would no longer be possible to support the practice of rolling over the current biennium's deficits to a future biennium.

Mr Doa-Young CHEONG (Republic of Korea) congratulated the Secretariat on the smooth implementation of the programme budget for 1992-1993 despite the difficult financial situation. Its collaboration in such programmes as development of district health management, and implementation of primary health care was particularly appreciated.

The REGIONAL DIRECTOR thanked the representatives for their expressions of concern over the financial difficulties that WHO had faced in the implementation of the 1992-1993 programme budget. Likewise, he thanked the Member States for their cooperation and understanding during the two exercises undertaken in order to adjust the 1992-1993 programme budget, which had actually been reviewed in 1990. The Director-General had withheld 10% of the budget allocation for the current biennium as a result of the non-payment by some Member States of their assessed contributions. Moreover, as agreed with Member States, certain essential activities in the preceding biennium had had to be carried over to the current biennium. In February 1992, following a recosting of the various components of the programme budget that had revealed a deficit, the first budget reduction exercise (referred to as "Priority C" adjustment) had been undertaken. Although it seemed to be an across-the-board reduction between programmes, a very critical review of country programmes had been undertaken with the aim of reducing those which were considered a lower priority. The exercise had resulted in a budget reduction of approximately 21%-22% spread over country (20%), intercountry (22%) and Regional Office (30%) levels. It had been hoped that the reduction would result in sufficient savings to allow implementation of the remaining activities within the reduced budget allocation. Unfortunately, further cost escalations and improved implementation rates through the use of the regional information system had necessitated that Member States, through the WHO Representatives and Country Liaison Officers, again be requested to consider further adjustments (referred to as "Priority X") in the revised programme budget. That had resulted in a further reduction of US$ 2.9 million. That had proved insufficient, and a deficit remained of around US$ 1.3 million. It was hoped that that could be covered by non-implementation of certain activities. However, it was hoped that the lessons learnt from previous exercises in terms of prioritizing activities could be useful in the implementation of the 1994-1995 programme budget since in the next three months, consideration might have to be given to that. That experience would be borne in mind during the formulation of the 1996-1997 programme budget.

In reply to questions from the representatives of Australia and the United States of America concerning the 37% increase in the operating budget for support services, the REGIONAL DIRECTOR explained that there had been a general escalation of costs, but the rise had been mainly due to increased salary costs. The 42% decrease in the operating budget for public health information and education for health was largely accounted for by the freezing of posts, in particular the post of a public information officer. He agreed it was illogical to freeze a vacant post in a high-priority area while retaining staff working in low-priority areas, but he was often compelled to do so by the staff management policies, which applied throughout the United Nations system. He had asked the Programme Committee and Senior Staff Selection Committee at the Regional Office to look into the distribution of posts at the Regional Office and country offices and to consider what posts might be abolished in the course of the next two bienniums. The freezing of posts was an interim measure prior to the thorough reorganization of the structure of the Regional Office.

Responding to the Australian representative's question about the ratio between the staff component of the budget and other programme components, he emphasized that the Regional Office required a wide range of staff with the expertise and experience to advise Member States. Permanent staff accounted for 38.8% of the total budget and short-term consultants for 6.3%. It was important to make a distinction between the technical staff and administrative support staff.

Dr TAPA (Tonga), pointing out that resources available for WHO activities in the Region were constantly dwindling, asked what were the realistic prospects for the next biennium. Perhaps Member States were making things more difficult for themselves by failing to pay their assessed contributions in time.

The REGIONAL DIRECTOR assured the representative of Tonga and other representatives that their comments and concerns would be taken fully into account when planning future operations. For several bienniums the Region had been obliged to resort to underbudgeting, as it had been unable to make adequate provision for increases in real costs. He had told the Committee at its previous session that, despite an improved budgeting process for the 1994-1995 biennium, there would still be a budget shortfall of US$ 4.3 million at the start of that biennium; and that he had endeavoured to budget for the actual cost of country programmes, and to confine underbudgeting to intercountry programmes, the Regional Office and WHO Representatives' Offices. During the past year further escalation of costs had occurred in many areas. In particular, Manila had been classified as a hardship duty station, as a result of which Regional Office staff had to be paid a hardship allowance. The post adjustment at some other duty stations had also been increased. As a result of those and other developments, it was currently estimated that the budget shortfall at the start of the next biennium in January 1994 would be US$ 9.4 million. Even that

figure did not take into account the possibility that the Director-General might find it necessary to withhold further funds in the next biennium. He was accordingly taking measures to cut expenditure sharply in Manila and in WHO Representatives Offices, by freezing posts and conducting other cost-cutting exercises in many areas. He hoped that some of the shortfall could be made up by implementing activities somewhat later than scheduled.

Regarding the programme budget for 1996-1997, he had just received instructions from the Director-General to prepare that budget without taking any cost increase factor into account. In the past the real increase in costs in the Region had been of the order of 20%, but it had only been possible to apply a cost increase factor of about 8%. It was impossible to foresee what cost increase factor might be allocated to the Region in 1996-1997 by the governing bodies of WHO. The Director-General had also instructed that 3% of each region's budget for 1996-1997 should be withheld at the global level for priority activities. The Regional Director strongly urged that the funds withheld from the Region be used for priority activities in that Region. The Director-General acknowledged the Regional Director's wish.

Mr DURAND-DROUHIN (France) reaffirmed his Government's belief in the principle that, in allocating financial resources, priority should be given to intensified cooperation with countries in greatest need.

The interim report on budget performance showed clearly where it had been found necessary to make savings. It would be useful to know what principles or criteria were applied by the Regional Office in allocating resources to individual countries.

The DIRECTOR-GENERAL said it was not yet clear what the Organization's financial situation would be in 1994-1995.

He had been obliged to withhold 10% of regional budgets in the current biennium because a major contributing country was some two years in arrears in the payment of its contributions. In budgeting for the next biennium, therefore, he was obliged to aim for zero or even negative growth and to concentrate more on priority areas.

The decision to withhold 3% of regional allocations had arisen out of his discussions with the regional directors and assistant directors-general. Such an across-the-board cut had many pros and cons, but the majority had felt it was the only way to reorient activities and ensure that funds were available for priority programmes and countries.

He agreed with the representative of France on the importance of intensified cooperation with countries in greatest need. That approach was accelerating the flow of resources to such countries,

not just from the WHO regular budget but from all sources of international cooperation in health. It aimed to reform the countries' health care systems towards primary health care. Many countries of the Region had benefited from the approach, and the total flow of funds from bilateral and multilateral sources was increasing. Disbursements by some multilateral agencies were still conditional on structural adjustment, but it was hoped such constraints would gradually disappear in the Region.

To sum up, the Organization's financial prospects for 1994-1995 were still no better, but he hoped the situation would improve as economic recovery got under way in the major contributing countries.

He shared the Regional Director's concern at the critical situation created by increases in the salaries and allowances of long-term staff. Under the common system, salary scales and post adjustment rates were determined by the United Nations; WHO had no control over them, but had to foot the bill. Moreover, judgements of the ILO Administrative Tribunal were increasingly favourable to staff who appealed against their conditions of service.

The recommendation not to include a cost increase factor in the 1996-1997 budget at the present stage emanated from the Executive Board Working Group on Global Change. That recommendation in turn reflected the resolution on budgetary reform adopted by the Forty-sixth World Health Assembly, which called for a shorter period between the recommendation and implementation of the programme budget. Rather than indicate a "phantom" cost increase two or three years before implementation, it had been decided to wait at least one more year so as to obtain a more realistic figure. For similar reasons, it was intended to wait as long as possible before setting the exchange rates for the United States dollar. Those matters would be discussed by the Executive Board, possibly within a specially created committee on budget and finance, and by the World Health Assembly.

The REGIONAL DIRECTOR said that, where the regular budget was concerned, the regional programme budgeting policy determined in 1986 was applied whereby national and intercountry programme formulation took into account for each country its population and other biostatistical data such as birth and death rates as well as health problems and health service infrastructure; the rate of development, particularly the plight of the least developed countries and countries in special need; and the capacity of Member States to absorb funds - an important factor, since even in the countries most in need, if that capacity was low, direct cooperation might not be productive.

Concerning indicative country planning figures, he had to say in the presence of the Director-General that when China had replaced Taiwan as a Member State, the Region had received only

US$ 500 000 more to cope with programmes for a population of some 1000 million; although that allocation had increased over the years to about US$ 9 million it was still a drop in the ocean compared with the problems requiring solution. In Cambodia the special situation was involving WHO in cooperation that exceeded the extra million dollars provided. Indeed many of the least developed countries were in the Western Pacific Region, and the extrabudgetary funds and support under WHO initiative for intensified cooperation with countries in special need were also brought to bear for Cambodia, Viet Nam and certain Pacific island countries, for example.

"Savings" was not a very apt term to describe the measures applied to reallocate resources in the Region. He preferred the concept of "slippage". Such savings could only be made when, for an activity that could not be implemented with the resources available, the Regional Office had to rely on economies in large fellowship provisions, or on funds becoming free owing, for example, to the inability of a consultant to take up duties, or to the non-implementation of a fellowship due to the candidate failing a language proficiency test, or when the temporary freezing of a post became possible.

Dr TAPA (Tonga) thanked the Director-General and the Regional Director for their frank explanations. The information they provided on the challenges to be faced was essential; he was convinced that with a proper appreciation of the facts and with the collective wisdom of the Regional Office and Members of the Region it would be possible to meet the situation. The special needs of some countries had to be recognized on humanitarian grounds, together with the need for extrabudgetary support to cope with them. Tonga, with its population of some 100 000 and a minimum assessment of 0.01% of the budget, relied on such support to increase cooperation some fiftyfold.

He appealed to major contributors to pay on time. WHO had faced up to non-payment realistically so far, but the reports on status of contributions showed that the list of Members in arrears was growing.

He had every confidence in WHO's leadership, but all should be aware of the consequences of continued non-payment.

Mr KOIMANREA (Papua New Guinea) asked in regard to resources contributed to the regular budget by Member States of the Region, what was their total financial contribution, what were the consequences for their programmes with WHO in the case of non-payment, and how non-payment by major contributors affected smaller countries or those paying smaller contributions.

Mr VAIMILI (Samoa) associated himself with the remarks of the representative of Tonga: there was no question of doubting WHO's leadership in financial matters and the World Health Assembly had confirmed that position, but the situation must be stated clearly in regional terms.

He asked whether an appeal could appropriately be made at regional level for major contributors to pay on time, since an unequivocal approach was necessary.

He hoped that the Western Pacific Region was not to be treated as a special case. It was important for responsibilities to be properly recognized and the total budget figure to be covered by Members' contributions.

Mr WAENA (Solomon Islands) said that when so much was spent on warfare and weapons of mass destruction it was essential to insist that health and welfare were being neglected and that proportionally the amount allocated to the good cause promoted by agencies like WHO was minute. He thanked the Chairman for pointing that out. Major contributors to the budget had a special responsibility in that regard.

The REGIONAL DIRECTOR, replying to the representative of Papua New Guinea, said that the contributions of Member States with their seat of government in the Region totalled US$ 109 million, or 15.18% of all WHO assessments. If the contributions of the United States of America (US$ 186 million or some 25%), France (US$ 42.8 million or 6.1%), the United Kingdom of Great Britain and Northern Ireland (US$ 33 million, or 4.7%), and Portugal (US$ 1 338 000, or 1.18%), were added, some 50% of assessed contributions could be said to come from Members represented at the session of the WHO Regional Committee for the Western Pacific.

But the question was not only one of non-payment; some countries were in understandable difficulties, which it was hoped would be relieved so that they could resume normal payment. The main problem was with Members outside the Region that could not meet their obligations.

Countries that did not pay were eventually subject to the provisions of Article 7 of the WHO Constitution for suspension of voting privileges and services, applicable at the World Health Assembly, but not at Regional Committee level.

There was the additional problem of late payment, which could continue for several years before such provisions became applicable.

Contributions still to be paid in 1993 by eight Member States in the Western Pacific Region amounted to US$ 2 887 000, and it would be advisable that all contributions due were received before non-payment by Members in other Regions was criticized.

The implications for smaller contributing countries in the case where larger contributors did not pay raised the question of priority-setting.

The DIRECTOR-GENERAL said that the Western Pacific Region shared the worst situation resulting from non-payment by major contributors with the European Region whose Members contributed over 50% of the total regular budget. In that region the fragmentation of the former USSR and former Yugoslavia had resulted in several new Members - and a significant proportion of the total population of some 1400 million (the largest regional population) - falling into the category of developing countries. Many of their peoples were among those in greatest need.

All regions indeed had claims to special consideration. In the circumstances he wished to remind representatives that WHO was one of the most successfully decentralized agencies, also financially. Over 60% of the budget went to the regions and - through the regional mechanism - to countries for their people in the form of technical support and cooperation.

So if a major contributor, say, one which contributed over 10% of the assessed total regular budget - had not paid its contribution since the second part of 1991, creating a correspondingly large deficit, and if in addition another country with a large population and responsible for a considerable proportion of contributions became fragmented, while at the same time yet other countries in the Middle East and in the Americas, for example, faced serious economic difficulties, representing some 5% of unpaid contributions, what was to be done? Until 1990 - leaving aside exceptional non-payment or delayed payment by one or the other major contributors that had resulted in a 25% deficit - no such difficulty had had to be faced. It was indeed only after 1987, where WHO could still count on receiving about 95% of total assessed contributions, that receipts had fallen below 90% to about 83%, and the rate of payment was now below 80%.

If in 1993 the largest contributor did not make the payment which it usually made in October, the situation would become so serious that a significant reduction in WHO's normative function and direct technical cooperation with Member States would have to be considered. If the major contributor did not make its payments, WHO was obliged to face complete structural change. There were only three choices: either abolish headquarters, abolish the Regional Office, or abolish technical cooperation with countries. WHO was currently in a borderline situation.

However, he had been assured by major contributors in verbal communications that arrears would be paid. One such contributor had already made good part of its arrears. Other Members in arrears had also started to pay. It was hoped that a normal financial situation with regular contributions from fully-fledged contributors would be re-established in one or two years.

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/RC44/5 Rev.1)

The REGIONAL DIRECTOR said that for the previous six years, he had presented an annual report on AIDS, including sexually transmitted diseases, in conformity with resolution WPR/RC38.R5 of the Regional Committee at its thirty-eighth session. The report presented an analysis of the scope and trend of the spread of the AIDS epidemic in the Region.

For the current year, in response to a request for a comprehensive report on the programme, a more detailed review had been prepared. It presented the epidemiological situation of HIV infection, AIDS and sexually transmitted diseases in the Region, and the history, development and future direction of the regional AIDS programme. The evaluation did not simply present the statistics of incidence or mortality but drew reasoned and very carefully considered conclusions about the implications, or omissions of the statistics gathered.

The objective of the report remained, as before, neither to alarm nor to threaten but to inform, guide and provide a balance in adopting proper prevention and control measures and defining target areas.

The major factors which facilitated HIV transmission were known. The approaches to minimize risk behaviour had been discussed and decided upon. All countries in the Region had established national AIDS committees to oversee the management of national programmes. Nine of the 35 countries and areas had not reported any cases of AIDS or HIV infection. None the less, when the documents before the Committee were prepared, there had been only 5058 cases of AIDS reported from countries in the Region, whereas, the number of cases was, as at 1 September 1993, 5549. WHO estimates were that between 50 000 and 100 000 people were already infected with HIV in the Region.

In the knowledge that much had been done to protect peoples from any further damage by the disease, and with the understanding that so much remained to be done, he urged representatives to respond to the detailed analysis provided, and discuss the future directions.

Dr LEE Shiu-hung (Hong Kong) congratulated the Regional Director on his comprehensive report on AIDS, which underlined the need to sustain efforts at both country and international level. He welcomed the organization during the previous four years of three meetings among health authorities in the neighbouring areas of China, Hong Kong and Macao on the exchange of

epidemiological information and experiences in the prevention and control of major communicable diseases, including AIDS, and looked forward to continuing WHO support.

With the rising prevalence of HIV, it was not surprising that some health care workers were infected with the disease. That was becoming an increasing concern in view of the need to strike a balance between the public's concern for safeguarding the health of people receiving treatment from infected health care workers and the need to protect the rights and privacy of those workers. He urged WHO to prepare up-to-date guidelines on HIV infection among health care workers for national health authorities.

The Government of Hong Kong fully supported WHO's Global Programme on AIDS, and was happy to collaborate in activities, including the holding of seminars or training courses in Hong Kong for health-related workers from other countries and areas. Furthermore, it had recently established an AIDS Trust Fund with a government contribution equivalent to US$ 45 million. Its purpose was to award payments to haemophiliacs infected through blood transfusion or blood products prior to the introduction of blood screening and heat-treated products in 1985; to fund community projects for medical and social support services to HIV-infected persons; and to strengthen Hong Kong's public health education programmes which would promote public awareness and remove prejudice.

Mr SAITO (Japan), recognizing the need for urgent action to stem the explosive spread of HIV infection in Asia, recommended several lines of action for the Global Programme on AIDS in the Western Pacific. It should endeavour to determine the cost-effectiveness of HIV/AIDS interventions; it should transfer rapidly to country level the knowledge gained from successful prevention and care interventions; it should set up a task force for the regional programme on AIDS; and it should expand its support to nongovernmental organizations through provision of technical support at country level.

The Japanese Government had pledged to maintain technical and financial support for the Global Programme on AIDS, especially in the Western Pacific, and in August 1994 it was to host the Tenth International Conference on AIDS. It was essential to ensure participation by the Region in the Conference, which would help to raise awareness of the spread of HIV infection and promote prevention and care. Japan hoped to receive the support and collaboration of Member States and WHO in that activity.

Mr LOVELACE (New Zealand), noting the inadequacy of reporting in some countries with respect to incidence, prevalence and trends associated with the AIDS pandemic, asked what steps might be taken at regional level to encourage higher quality reporting of information. With regard

to such groups as commercial sex workers and injecting drug users, he asked what type of programme might be developed at regional level or encouraged at country level to improve the flow of information to those vulnerable populations.

Dr CLARO (Portugal), updating the figures provided in Table 2, page 4 of document WPR/RC44/5 Rev.1, said that as at June 1993, five people had been diagnosed with AIDS, of whom three had died. Forty-one people had been diagnosed as HIV positive, 31 of whom were women. Two-thirds of the group had been infected through heterosexual transmission, and only one person through blood transfusion.

The policy for AIDS prevention and control in Macao was based on respect and protection of human rights, and several practical measures had been adopted in relation to confidentiality, health care, drug users and immigration. Health education, communication and information on AIDS had been promoted through the media. Special attention had been paid to such higher risk groups as teenagers, both students and those out of school, blood donors and commercial sex workers. Condom use had also been promoted. HIV surveillance had been strengthened. Blood was screened, and pregnant women, prisoners, and police force applicants had been tested. Drug users were tested on a voluntary basis. All results were HIV-negative. Immigrant workers in various entertainment facilities were tested every three months and permission to reside and work in Macao depended on the results. Local workers in the same activities were also being tested.

Official channels had been established with Zhuhai for the exchange of information, and it was hoped that such collaboration could be extended elsewhere. Since most of the information was in Portuguese, he asked whether WHO could cooperate in the work of translation. His Government very much appreciated WHO support in the form of educational materials in various languages and training for staff.

Dr REODICA (Philippines), noting the gradual increase in the number of AIDS cases in the Region and the presence of many factors contributing to the spread of AIDS, urged WHO to give top priority to the Global Programme on AIDS.

A total of 103 AIDS cases had been reported in the Philippines as at June 1993, of whom 69 had died. The male to female ratio for HIV infection was 1:1, and the mode of transmission was primarily heterosexual. Prevalence of HIV infection was estimated at between 5000 and 30 000 cases; it was hoped that the sentinel surveillance programme recently introduced would soon provide a more accurate picture. Knowledge, attitude and practice surveys were currently being conducted among injecting drug users so that education and intervention programmes could be launched. Many of the HIV-positive females were sex workers, and infection rates were rising fast.

The national AIDS programme, institutionally located within the Department of Health, had initially focused on preventing sexual transmission and on protecting the blood supply; its current thrust was to prevent injecting drug users from sharing needles and syringes. Management of the programme was being decentralized, and training was being provided for administrative and medical staff. Local AIDS councils were being set up, comprising local officials and staff of nongovernmental organizations. The recent integration of control of sexually transmitted diseases in the AIDS programme would orient activities towards the prevention of such diseases among the general population and the use of social hygiene clinics for prevention and education activities on both AIDS and sexually transmitted diseases.

The new AIDS communication strategy targeted more specifically policy-makers, health professionals, religious leaders, teachers and entertainers. Education and intervention programmes for groups at risk were being expanded, with the strong participation of nongovernmental organizations and the private sector. The Government staunchly advocated the right of people with HIV-infection to an economically productive life through non-discrimination at the workplace and the provision of an alternative livelihood for sex workers. Congress had given the Department of Health a free hand in drafting a comprehensive bill on AIDS/HIV prevention.

The multisectoral National AIDS Council had been set up to oversee the Philippines response to the threat of AIDS. A national conference would be held in December to coincide with World AIDS Day - National AIDS Awareness Month.

Dr CHEN Ai Ju (Singapore) said that the provision of technical know-how and expertise by WHO was very much appreciated. As the disease was evolving rapidly, the efforts made to keep Member States informed of epidemiological changes and possible treatment and prevention measures were most important.

In Singapore 190 cases had been recorded, most of which were transmitted through casual sex with commercial sex workers. The national AIDS control programme was therefore multipronged, the greatest emphasis being placed on educating the public, reaching out to high-risk groups, strengthening control of sexually transmitted diseases, and protecting the national blood supply. Singapore had successfully protected the blood supply and raised public awareness of the disease and its modes of transmission. It was now focusing on enhancing personal responsibility and modifying behaviour. It looked forward to further collaboration with WHO and to learning from the experience of other Member States.

Dr ADAMS (Australia) reported that since the previous Regional Committee session the national five-year strategy had been evaluated, and the Australian Government had recently agreed

to maintain it. The evaluation indicated that in Australia, as in some other countries in the Region, the epidemic seemed to be plateauing. He hoped that sufficient measures were now in place to control the spread of the virus.

The evaluation concluded that the most cost-effective measures taken in the early days of the epidemic were perhaps the funding of sex worker groups, providing them a small amount of money so that they could organize themselves and insist that all their clients used condoms. As a result, no sex worker in Australia had been infected with HIV through sexual contact during the entire epidemic. The other cost-effective intervention, which took some courage on the part of politicians, was the setting up of needle and syringe exchange schemes in the major cities to prevent the spread of the virus among injecting drug users.

He was fairly confident that the measures in place would continue to contain the epidemic. However, there was no room for complacency as a new generation of children was now reaching sexual maturity. He endorsed the request of the representative of New Zealand for the presentation, possibly at the 1994 Regional Committee session, of specific examples of successful interventions, particularly programmes related to sex workers and injecting drug users.

Mr ZHANG Yuji (China) said that in China the situation concerning AIDS and sexually transmitted diseases was basically that same as that depicted in the report. A total of 1106 cases of HIV infection and 14 cases of AIDS had been reported. HIV infection in China was concentrated in border and coastal areas and large cities; occurred mostly among young and middle-aged people; and affected a range of population groups, but mostly farmers and injecting drug users. The rate of infection from sexual contact was rising fast. Cases of sexually transmitted diseases were also growing rapidly.

The Chinese Government attached great importance to the prevention and control of AIDS and sexually transmitted diseases. It had established a reliable reporting and surveillance network which was operating efficiently. The medium-term prevention and control programme, formulated by the Government in cooperation with WHO, was progressing smoothly. With WHO's support China had promoted and strengthened AIDS information, education and surveillance. A joint China/WHO review of the national AIDS prevention and control programme would be held in October 1993 and he looked forward to further cooperation with the Organization in order to prevent the spread of AIDS in China.

The meeting rose at noon.

ANNEX

ADDRESS BY THE INCOMING CHAIRMAN

Distinguished Representatives, Director-General, Regional Director, Representatives of Specialized Agencies of the United Nations and Nongovernmental Organizations, Ladies and Gentlemen,

I wish to thank the Committee for nominating me as Chairman of the forty-fourth session of the Regional Committee for the Western Pacific. I fully recognize the honour bestowed on me, and even more so, on my country, Fiji. I also thank you on behalf of the Vice-Chairman and Rapporteurs whose support I will be counting on during the deliberations of this session.

As my first task as Chairman, I wish to congratulate Dr S.T. Han on his nomination. The unanimous vote of the Regional Committee speaks for itself. His experienced leadership and guidance are going to be highly valued in the crucial years ahead.

May I also take this opportunity as Chairman of this session to join the other Distinguished Representatives in wishing Dr Nakajima success during his second term as Director-General of the World Health Organization. I fully support the sentiments expressed by my predecessor, Dr Lee.

The next year will be one of particular challenge to WHO as it competes for resources, deals with new directions and new structures and yet continues to address the multiple health problems of the world. When summing up our discussion on the Regional Director's report, Dr S.T. Han has given a clear idea of how he proposes to rise to many of these challenges.

The decade of the nineties and the century to come are often referred to as the era of Asia and the Pacific. While it is true that economic development in this Region has been faster than in other parts of the world, and will hopefully continue at the current rate, the health problems not only remain but multiply. In this Region, there is still unnecessary loss of life from infectious diseases and the manifestation of poverty, there is increasing morbidity due to environmental degradation and accidental injury, and there is, in almost all countries, an increase of incidence of diseases of lifestyle largely due to increasing longevity and affluence.

Annex

Many of our small island nations have their own unique problems because of their smallness in size, limited resources, unstable economies and fragile ecosystems. These problems may be better addressed if they are appreciated and respected by the bigger and more affluent countries in view of continuing collaboration and cooperation.

It has been observed that one of the truly significant health-for-all achievements in the Region has been the ability to manage change on the basis of clearly formulated policies. What is now required is to incorporate the issues of targeting more precisely into national policies. We must learn to focus on priorities to improve efficiency of health care.

In the Western Pacific Region, more countries are going through significant social change which results in evolving health system structures. Most notable among these is the decentralization of responsibility for decisions and resources utilization. Consequently, we would expect that the new health policies will reflect the emerging priority health issues we face. This applies to the larger countries as well as to the smaller island countries in the south. The service structure that will evolve in each country will be characterized by more local responsibility with regard to operational decisions. Many of these structures will be less formal and will link partners involved, which include the government, the private sector, the nongovernmental organizations and the community.

This evolution is necessary. It will need vision and foresight on the part of the governments also. The views expressed by the Regional Director for WHO provide a clear direction to follow. We share his hopes and plans for the future and will be working to realize this in each of our countries. I consider this the basic essence of partnership we all have been talking about.

On a personal note, I know how hard WHO has worked on this in Fiji, the classical example being the 117-year old institution of the Fiji School of Medicine. Dr Han, we are always grateful for your personal efforts in this context.

Distinguished Representatives, on the agenda of this session are many major issues, which require careful consideration and clear decision by the Regional Committee. We have a busy week and a great responsibility before us.

Annex

I am sure we will tackle these issues in the usual business-like fashion for which the Western Pacific Regional Committee is well-known. Let me thank you all in advance for your cooperation and indulgence. I hope all of us will have a fruitful forty-fourth session and an enjoyable stay in Manila.

Thank you.