SUMMARY RECORD OF THE THIRD MEETING

Sonic City Building Conference Hall, Omiya, Japan
Wednesday, 11 September 1991 at 9.00 a.m.

CHAIRMAN: Dr S. Tani (Japan)

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1. ADDRESS BY THE INCOMING CHAIRMAN: Item 5 of the Agenda

The CHAIRMAN addressed the Committee (see Annex).

2. RULES OF PROCEDURE OF THE REGIONAL COMMITTEE: Item 8 of the Agenda (Document WPR/RC42/3)

The REGIONAL DIRECTOR explained that, as document WPR/RC42/3 pointed out, article 47 of the Constitution of the World Health Organization provided for the participation in regional committees of territories or groups of territories within the Region, which were not responsible for the conduct of their international relations and which were not Associate Members.

Resolution WHA2.103, in operative paragraph 3.(1) dealt with the rights and obligations of such territories in the regional organization.

However, the Rules of Procedure of the Regional Committee did not make any specific provision for the participation of territories or groups of territories, or, as they were called in the Region, areas, in the activities of the Regional Committee. An amendment to Rule 1 of the Rules of Procedure was therefore proposed for the Committee's consideration and approval.

The proposal was to add to Rule 1 the phrase "and areas participating pursuant to Article 47 of the Constitution". That would bring the Rules of Procedure of the Regional Committee for the Western Pacific into line with the Constitution.

Dr TAPA (Tonga) said his Government agreed to the proposed amendment to Rule 1 of the Rules of Procedure. The amendment was important because it would enable areas of the Region to participate fully in the work of the Regional Committee. He therefore encouraged Member States with responsibility for certain areas in the Region to accept the proposed amendment if they had no particular difficulties with it. As there was no sub-committee to submit a report on the proposed amendment, he agreed to the suspension of Rule 53 of the Rules of Procedure.

In the absence of further comments, the CHAIRMAN asked the Rapporteurs to prepare a draft resolution.

3. AIDS: Item 9 of the Agenda

3.1 Annual report on AIDS, including sexually transmitted diseases: Item 9.1 of the Agenda (Document WPR/RC42/4)

The REGIONAL DIRECTOR drew attention to document WPR/RC42/4, which showed the updated global and regional AIDS figures as at 1 July 1991. The total number of AIDS cases reported from countries in the Western Pacific Region as at 1 September 1991 was 3569. Although that was less than 1% of the global total, the number was steadily increasing in all parts of the Region.

Seroepidemiological studies had also shown that the number of HIV-infected drug abusers in several Asian countries was on the rise.

Also of special concern were the high rates of sexually transmitted diseases in many countries, especially in the Pacific. Besides being an indicator of risk-taking behaviour,

sexually transmitted diseases were seen as important co-factors in the transmission of HIV. Countries with high STD rates might, therefore, soon be facing a very serious HIV problem.

By August 1991, the regional staff of the Global Programme on AIDS had completed technical visits to 31 countries and areas in the Region. Short-term plans had been formulated in 21 and medium-term plans in 16 of them in cooperation with WHO teams. To date, four resource mobilization meetings had been held.

Dr KURISAQILA (Fiji), congratulated the officers on their election, the Marshall Islands, the Federated States of Micronesia and Tokelau for their admission as Members and Associate Member of WHO, respectively, and Dr Tapa for his award. He observed that the current representatives of the Marshall Islands, the Federated States of Micronesia and Tokelau, as well as Dr Tapa, were all graduates of the Fiji School of Medicine, previously known as the Central Medical School. The Fiji delegation itself included the Head of the Fiji School of Medicine, Dr Samisoni, who was also the first indigenous South Pacific islander to have held the post since the School's establishment in 1886.

Speaking in his capacity as Fiji's Minister of Health and Chairman of the National Committee on AIDS, he noted that WHO, as leader in the global battle against AIDS, along with organizations such as UNDP, the South Pacific Commission and UNESCO, had provided resources and expertise to assist countries in formulating suitable national plans for the control and prevention of AIDS. Specific strategies, as embodied in short-term and medium-term plans, were developed both to benefit the country concerned and to make an impact at the global level. Cooperation was provided in the epidemiological surveillance and trend assessment in each country. Prevention strategies and ways to implement them were recommended. Blood testing requirements were met by providing hospital laboratories with the necessary supplies and equipment, and training personnel.

Educational materials on the subject had been developed for inclusion in the school curriculum in order to allow children a better understanding of their sexuality and possible problems that could arise from their lack of such knowledge. All those programmes had been provided with mechanisms for monitoring and evaluation to make them more responsive to the changing needs of countries.

Given the magnitude of collaborative activities provided by those organizations, how had the countries responded? Current statistics on the disease make it impossible for governments to remain complacent or to procrastinate. Organizations for controlling AIDS could only function properly with the committed cooperation of the countries expressed in terms of a strong political will. Governments must be perceived both by the public and the other Member States as a committed partner in combating the disease.

While there were no conventional weapons to fight the disease, education could be a powerful tool. However, education required communication, which was not easy in certain sectors of society where the discussion of sex was traditionally taboo. Such barriers could prevent valuable information from reaching its target audience, and governments should face the challenge of using political means to surmount them. The task was not an easy one and would require the modification of established customs. However, change was necessary, since the reality was that the present generation lived sexually active lives, and ignorance of the dangers could be disastrous.

Mr SUPA (Solomon Islands) added his congratulations to the elected officers, the new Members and the Associate Member, and to Dr Tapa.

Information given in document WPR/RC42/4 showed that Solomon Islands faced the danger of HIV infection and AIDS being brought into the country through its growing tourism

industry. That threat was aggravated by factors such as rapid urbanization, changing attitudes and behaviour among those of reproductive age, who formed a significant proportion of the population, the increasing rate of population growth, and low per capita income. No case of AIDS had yet been reported in the country. However, priority was being given to controlling sexually transmitted diseases through the development of laboratory diagnostic capabilities in that area. The scarcity of resources hampered those efforts, and consideration was being given to training malaria microscopists to perform gram stain tests for sexually transmitted and other diseases such as tuberculosis and leprosy. The cooperation of nongovernmental organizations was essential.

He had made a study tour to the Philippines and Thailand in May 1991, and the opportunity to learn from the experience of other countries in the implementation of their AIDS and STD prevention and control programmes had been very beneficial. It would be useful for countries with identical situations to meet regularly to exchange information and experience on the subject.

The medium-term plan for the prevention and control of AIDS in Solomon Islands had been drawn up in 1989 and funding had been obtained for its initial two-year activities. The WHO Global Programme on AIDS was, therefore, requested to consider funding the remaining activities contained in the Plan.

Dr TINIELU (Tokelau) joined the others in congratulating the elected officers and Dr Tapa. He also thanked the Director-General, the Secretariat and his fellow representatives for their warm welcome.

Referring to document WPR/RC42/4, he commended the Secretariat for the informative report on the status of AIDS and sexually transmitted diseases in the Region, which was a source of both gratitude and concern. While WHO's efforts to combat the disease were encouraging, the newness of the AIDS phenomenon and its intricacies were a source of concern. Many countries of the Region, particularly the least developed ones, were perhaps hopeful of keeping the HIV onslaught in their countries to manageable levels through their collaborative efforts with WHO and other international agencies. Such efforts could provide a false sense of optimism for the future. It should be remembered that HIV infection and sexually transmitted diseases were regional and global concerns. Therefore, everyone must do their share in collaboration with WHO. Only then could the Region as a whole have a sense of security.

The financial requirements for the task could pose a problem. In that regard, cooperation on AIDS and sexually transmitted diseases should be extended to other countries, particularly Tuvalu, Niue and Tokelau, which faced the constant threat of those diseases being imported from neighbouring islands. It was also noted from the Regional Director's report that Cambodia did not yet have any ongoing programme of cooperation with WHO.

Dr ADAMS (Australia) said that figures in Table 1 of document WPR/RC42/4 showed that Australia had now lived for nearly ten years with the epidemic. The first case had been diagnosed in 1981 and while his country had unfortunately contributed the largest number of AIDS cases in the Region, some optimism was in sight. The table showed that in the early years, the number of AIDS cases in Australia had more than doubled each year, but the increase had slowed down in 1989 and 1990. The number of new AIDS cases had, in fact, dramatically decreased in 1991. Therefore, he was cautiously optimistic that the epidemic could be controlled.

Countries that were faced with the epidemic had to spend a tremendous amount of money and resources. If there had been success in controlling AIDS in Australia it resulted

from programmes aimed at modifying the sexual habits of male homosexuals, the courageous willingness of politicians to introduce sex education for the general public and the introduction of such schemes as needle and syringe exchange to prevent the spread of infection among intravenous drug users. However the struggle had to continue since a new generation of young people approaching sexual maturity had to be reached unless a miracle were to occur and the virus was eradicated.

Australia's experience was fairly unique in that about 90% of the cases had been in the homosexual population and, unlike other countries, had not spread to the heterosexual and intravenous drug populations. He thought that that could be the result of not merely luck but the success of some of the programmes.

While over 2500 AIDS cases were reported in Australia, that was probably only a small percentage of the actual cases, since the incubation period of the disease was 9 - 10 years. Therefore, the AIDS cases reported in document WPR/RC/42/4 could have been 9 or more years ago. It was important to build up in all countries the capacity to ascertain where the virus was spreading. In Australia, about 14 000 persons were reported to be infected with HIV, most of whom had not developed AIDS but the correct number was probably about 20 000 persons. In order to prevent the spread of infection in Australia, the country had to develop sentinel HIV surveillance mechanisms through STD clinics, antenatal screening, screening of drug-addiction treatment clinics, etc. It was necessary to identify areas in which the virus could spread in order to take preventive measures. He hoped that representatives could share information on their surveillance systems for HIV infection as distinct from AIDS.

Dr REID (United States of America) joined others in congratulating the Chairman and other officers of the Regional Committee on their election, Dr Tapa on his award and the new Members and Associate Member for joining WHO. He commended the Regional Director on the report. Although the report had not described HIV infection in the Region in great detail, it was apparent that there was a continued increase. His delegation, therefore, would be interested in learning about ongoing activities, problems encountered in the development of short-term and medium-term plans for national programmes, the countries with the biggest problems and future directions expected. He wondered what different approaches were being utilized in so vast an area with such different population groups, and whether the Regional Director had an opinion on the real status of HIV transmission in the Region and the directions in which the virus was travelling in terms of mini-epidemics in certain risk groups.

It would appear that reporting of incidence in sexually transmitted diseases had not improved since the previous year. Was the Regional Office taking steps to improve such reporting? His delegation would also be grateful for more information on the integration of sexually transmitted disease and HIV prevention and control activities, particularly its effectiveness.

Dr ABDULLAH (Malaysia) gave some historical information on AIDS in Malaysia. In 1980, his country had considered AIDS to be a disease of the West and of Africa. In 1985, after their closest neighbouring country had reported an AIDS case, there had been some alarm. In 1986, the first AIDS case had been reported in Malaysia but the disease had been contracted outside the country.

In the next years there had been additional cases, first among homosexuals, then among heterosexuals, bisexuals and drug addicts. Cases had also been detected among people who had received blood transfusions, haemophiliacs, and prostitutes. However, in prostitutes, the disease had been confined to those who had come from neighbouring countries.

Although AIDS cases in Malaysia were only about 0.08% of the total in the Region, vigorous efforts were being made to control and prevent the disease. The main concern was that of the 28 cases almost all had occurred in the economically and socially productive age groups of 20 to 50 years. Therefore there was a danger that if the epidemic continued to spread, the economy of the country would be affected.

In order to prevent the newly emerging problem of AIDS, Malaysia had decided to concentrate on changing lifestyles. Starting in 1991, a six-year campaign had been launched which would cost 10 million Malaysian dollars. It was aimed at six diseases related to lifestyles: AIDS, cardiovascular diseases, cancer, diabetes, the childhood diseases and food poisoning. It was hoped that the campaign would be able to contain AIDS before it became an epidemic in Malaysia.

Since most of the AIDS cases and carriers in the country were found among the young, efforts had been exerted towards health education of schoolchildren and training of teachers.

The Government had supported promotion of the use of condoms through the mass media and interpersonal education, especially for those who still had a preference for unsafe sex. Certain religious groups and moralists had been against such a campaign.

Strict legislation was being prepared concerning prostitution, which would enable the country to deport foreign prostitutes with AIDS and punish prostitution practised by those infected with HIV.

A medical scheme for local prostitutes was being established so that regular medical examinations, screening and treatment could be undertaken. An educational campaign to promote safe sex among prostitutes through the use of condoms was also being initiated.

To cope with the anticipated increase in AIDS cases, Malaysia, with the assistance of WHO and other bilateral agencies, had developed a training programme for medical personnel in the diagnosis, treatment and care of AIDS patients.

The hospitals in the country were equipped to diagnose AIDS. Confirmation tests were now being done by the Institute for Medical Research in Kuala Lumpur and only doubtful cases were still being tested for confirmation by Fairfield Hospital in Adelaide.

Dr SIALIS (Papua New Guinea) said that in Papua New Guinea, the first AIDS case had been reported in 1987 but the probability was that the disease had been in the country earlier. The AIDS problem was a source of concern and Papua New Guinea welcomed the assistance it had received, especially in the identification of the disease through appropriate tests. He thanked WHO for providing financial and technical assistance to the country and expressed his gratitude to New Zealand for running a workshop on AIDS some weeks previously. The European Economic Community had also assisted Papua New Guinea in the development of the country's short-term plan. He agreed with the report that awareness through health education was necessary and it was important to be persistent in combating such a serious disease.

Dr OSAWA (Japan) noted that according to the report, the Region now had the equipment and trained personnel to conduct tests on HIV infection. Most areas were now routinely testing more than 90% of their blood donors for HIV. He congratulated WHO for that outstanding achievement which was the result of the Organization's strong support and the hard work of each country.

As of 30 June 1991, there were 397 AIDS cases in Japan, and 1810 persons carrying the virus. It was essential to strengthen appropriate control measures for AIDS since the numbers were gradually increasing.

He hoped that WHO would continue to strengthen its support of various AIDS programmes in the future. For its part, the Japanese Government would continue its technical cooperation efforts, such as the provision of experts to other countries. Japan would continue to contribute US$2.5 million annually to the Global Programme on AIDS.

Dr PERIQUET (Philippines) thanked the Regional Director for the update on AIDS in the Region and acknowledged with appreciation WHO's collaboration in drawing up a national plan of action and mobilizing resources to address the problem in the Philippines. Tables 1 and 2 of document WPR/RC42/4 showed a decrease in the number of AIDS cases. He wondered whether that was an indication of some success in the health education and prevention and control activities of the countries concerned. Perhaps an in-depth analysis could be done for future use.

In the Philippines, the delicate and sensitive nature of the AIDS problem, the lack of baseline information and country-specific patterns of behaviour had resulted in a number of research studies to provide information on which to base project activities. In the area of health education and communication, for example, the Government had had to make certain assumptions about the incidence of HIV infection in the country, based on limited testing. Among those assumptions was the probability that certain populations such as male and female commercial sex workers, young adults, Filipinos working overseas and male homosexuals were more likely to be infected with HIV. Knowledge, Attitude and Practices surveys had therefore been using samples from the high-risk groups, and a survey of the general population regarding AIDS had also been conducted. The results were then used to develop communication campaigns. Since the initial activity had been successful in the Metro Manila area, the campaign would be extended to other cities in the country.

An AIDS hot line had also proven to be effective, and it was probable that people preferred to seek advice from "unknown" counsellors. The hot line service had therefore been expanded to meet the demand for information.

Since it was difficult and costly to reach the target population, HIV surveillance had been limited primarily to female commercial sex workers in high-risk areas. However, the Philippines was currently developing a national AIDS surveillance system which would include the conduct of HIV serosurveys in selected sites nationwide among female sex workers, male patients with sexually transmitted diseases and pregnant women.

Dr CHAN (Hong Kong) said that Hong Kong had always taken a very active and aggressive attitude to the prevention of AIDS. Although Hong Kong's first case of AIDS was not diagnosed until 1985, the Government had as early as 1983 set up an organizational framework for a Territory-wide AIDS prevention programme to deal with a potentially very serious problem. That attitude had served Hong Kong well; for example, by 1990, as a result of integrating the AIDS programme with control of sexually transmitted diseases, the number of new cases of syphilis had dropped to nearly half the 1982 figure and the number of new cases of gonorrhoea was 30% less than it had been in the early 1980s.

Hong Kong, however, agreed that, as stated in the report, further work was needed in the fight against AIDS, particularly in the area of resource mobilization and the involvement of other agencies and community groups. To that end, a Hong Kong AIDS Foundation had been established, with Government encouragement and assistance, in early September 1991 for the purpose of mobilizing public resources and support and opening avenues for community participation in the prevention and control of AIDS. Prominent persons from various sectors

of the community had shown their support for the Foundation by becoming founding members or by serving on its executive and its Advisory Board. The Hong Kong Government had demonstrated its political commitment by allocating a seed fund of Hong Kong $15 million to the Foundation and providing it with initial accommodation. The Foundation's activities would include research, health promotion and education, publicity and counselling services. A particular aim was to promote community awareness and participation, including greater tolerance towards and less discrimination against HIV-infected persons.

"Sharing the challenge" was the theme of AIDS Day in 1991. The collaboration under way between the Hong Kong Government, the AIDS Council and the AIDS Foundation clearly showed how different sectors of the community could work together towards a common goal.

Mr BUILLARD (France), paying tribute to the efforts of the Regional Director and his staff to promote health and the relief of physical and mental suffering in the peoples of the Region, said the technical and financial assistance given by WHO to French Polynesia and New Caledonia in their fight against AIDS was greatly appreciated. Those territories had been visited by WHO experts to assist in finalizing national AIDS control programmes. The medium-term plans for AIDS prevention and control for both French Polynesia and New Caledonia had now been completed and that fact should be reflected in Table 7 on page 11 of the document WPR/RC42/4.

He welcomed the Regional Office's work in combating discrimination against persons with HIV infection. A particularly useful and courageous contribution had been made in that area by the regional workshop on legal and ethical aspects of AIDS and HIV infection held in Seoul in July 1990, which it was hoped would have a practical effect in reducing discrimination.

Dr PALAFOX (Marshall Islands), while welcoming the report, said his country was somewhat concerned by one aspect of WHO practice in the reporting of AIDS cases. In the interests of obtaining an accurate epidemiological picture of the incidence and prevalence of AIDS and HIV infection, there were perhaps grounds for distinguishing between indigenous and imported cases in small countries such as his own where indigenous cases were few or nonexistent. For example, the total of 5 HIV (+ AIDS) cases reported for the Marshall Islands in Table 3 had occurred in expatriate civilians working on an air base. Distinguishing indigenous from imported cases would also ease country sensitivities about reporting AIDS cases. The possibility of this causing discrimination should be weighed against the need for more accurate statistics. That had, in fact, been the general opinion at recent sub-regional meetings on AIDS in Samoa and Australia.

Again in the interest of arriving at an accurate epidemiological picture, it was requested that two reported deaths, one from Kaposi's sarcoma and one from *Pneumocystis carinii* pneumonia, which had occurred in the Marshall Islands in 1984, should no longer be considered AIDS cases and should be removed from the AIDS statistics. The persons concerned had no history of travel to any source of HIV infection and had no relatives or contacts with HIV. Had the cases been of true AIDS, the level of syphilis care and HIV testing in the Marshall Islands was such that any cases arising from transmission would have surfaced by now and been detected. None had, and it was therefore considered that the cases had been caused by immuno-suppression from other causes.

Mr VAIMILI (Samoa) endorsed the views expressed by the representative of the Marshall Islands. Expressing appreciation of the work done at the sub-regional workshop held recently in Western Samoa, he drew attention to the difference between the medical and academic approach to AIDS and the private individual's perception of the problem. Implementation of control measures was thus not always easy. Cultural factors sometimes made it difficult to get messages across, since there was considerable reserve in some countries

such as his own about open discussion on the subject. Like the representative of the Marshall Islands, he considered it vital to success that all countries in the Region should work together and share their information on the disease, particularly in the case of non-nationals travelling through other countries. In some cases some infringement of human rights might have to be considered in the interests of all.

He welcomed the decline in the incidence of AIDS during 1991 that was apparent from Table 1 of the report. It was hoped that incidence could be further reduced in the future and he appealed to the developed countries, whose financial strength put them into a better position to cope with the disease, to come to the support of the small island countries of the Region which were in a critical situation with regard to AIDS.

Mr STRICKLAND (Cook Islands) fully endorsed the comments made by previous speakers. Although no cases of HIV infection had been diagnosed in the Cook Islands, national short and medium-term programmes for AIDS prevention and control had been prepared with WHO assistance. His Government fully recognized the great benefit of such programmes and appealed to WHO to continue to promote and assist them.

Dr LAM (Singapore) commended the Secretariat on its comprehensive report on AIDS. Although the prevalence of sexually transmitted diseases had been falling in Singapore, the same could not be said for AIDS. Since diagnosis of its first case of AIDS in 1985, Singapore had been conducting an intensive control programme. Despite that, the number of cases of AIDS and HIV infection had continued to increase, although the majority of cases were currently of HIV positive persons, perhaps an indication that more people were coming forward for HIV testing. Although initially the cases had occurred among homosexual men, they were increasingly appearing among the heterosexual population - a trend that was causing concern. The national AIDS programme was therefore being further strengthened.

Dr QI (China) said that the spread of AIDS had become a major global health issue. All countries of the Region were making considerable and productive efforts to stem the epidemic. Although China had a low prevalence of HIV infection, the risk factors permitting the spread of the disease existed. The massive rise in recent years in the numbers of sexually transmitted disease cases and in injecting drug users further increased that risk. Preventive measures were not widely used in some parts of the country and also increased the risk of spread. To date, 527 HIV-positive cases, 432 of them indigenous, had been reported in China, most of them among injecting drug users in Yunan province.

Preventive measures undertaken in recent years with WHO and WPRO support had yielded good results. In April 1991, with WHO support, China had completed its medium-term plan for the prevention and control of AIDS, which was principally aimed at directing all resources of the community to the fight against AIDS and to establishing and providing health education to the public as well as consultation and management to AIDS patients and HIV positive persons. 1991 was the first year of operation of the programme and it was hoped it would receive support from other countries, United Nations agencies and nongovernmental organizations as it continued.

HIV infection among injecting drug users had become a very serious problem in some Asian countries. In efforts to provide effective control of the spread of the disease among groups with high-risk behaviour, cooperation and collaboration among countries would need to be strengthened. It was hoped that WPRO would continue to assist in that endeavour.

Dr TAPA (Tonga) expressed his appreciation of the report, which provided much food for thought, as the comments of previous speakers had shown. Some grounds for hope as to the future course of the disease were apparent, but it was imperative that there should be no complacency on the subject of HIV infection, AIDS and sexually transmitted diseases.

Part III of the report was of great interest; the risk of rapid spread of the disease among young heterosexual men and women in four countries of the Region, with its potential impact on family life, was very real. Infants and children would suffer as a consequence.

The shift of emphasis of the programme from the development of short-term plans to the preparation of medium-term plans for national programmes was very encouraging. The fact that all countries in the Region currently had the equipment and trained personnel for HIV testing was very satisfactory. It was gratifying that health education continued to form a major component in the medium-term plans. He fully supported the focus of the Region's AIDS programme on strengthening of national programmes by the three major activities mentioned in the last paragraph of the report. He also endorsed the priority being given to countries with the least resources and to countries with a high proportion of children and young people. He urged WHO to continue and intensify its collaboration in the Region and with individual Member States in the control of HIV infection, AIDS and sexually transmitted diseases.

Dr KIM (Republic of Korea) said that his Government had been undertaking vigorous activities against AIDS since 1985 and was applying a strict AIDS prevention law under which many high-risk groups had been tested both mandatorily and voluntarily. It was nevertheless facing difficulties in such areas as television advertising of the use of condoms and in school education because of cultural objections and parental opposition. It intended to intensify its programmes further and to give strong support and cooperation to WHO activities against AIDS.

Dr BA (Viet Nam) said that her Government had established a national committee against AIDS, composed of eight different ministries and sectors, to replace the sub-committee which had existed in the Ministry of Health from 1987 to 1990. During that period, some 50 000 blood specimens had been sent for HIV testing in France, Australia, Denmark and Sweden. Only one HIV positive case had been detected in Ho Chi Minh City at the end of 1990.

With the assistance of WHO consultants, a medium-term programme for 1991-1993 had been established, with three objectives: to restrict HIV/AIDS infection to the lowest possible rate; to lessen the psychological impact on the individual and society; and to mobilize the necessary social resources for the campaign against HIV/AIDS infection.

Provincial committees had been established in the nine most exposed provinces, including the frontier provinces. The estimated budget for the medium-term programme amounted to US$2 million. With WHO support, the National Committee had organized an international conference in March 1991 to appeal for assistance from governments and international and nongovernmental organizations. Up to August 1991, only US$780 000 had been pledged: US$509 000 by WHO, US$165 000 by Sweden, US$56 000 by AIDAB (Australia) and US$50 000 by World Vision International. Practically no financing had yet been received, however, although the Ministry of Health had released some funds for the start of the programme in 1991. Based on the medium-term programme, planned activities for 1991 were concentrated on a distribution of responsibilities among the various ministries and sectors; training of personnel and dissemination of educational and information programmes through social agencies and the mass media; mobilization of resources for the prevention of HIV/AIDS infection transmitted sexually and by transfusion, particularly in frontier provinces; organization of a seminar on "AIDS and prostitution" in Viet Nam in September 1991, with the participation of the various institutions concerned; and establishment of an integrated programme against AIDS and sexually transmitted diseases.

Mr MILLER (New Zealand) welcomed the new members of the Committee, congratulated Dr Tapa on his well deserved award and expressed appreciation to the Government of Japan for its generous hospitality and for the concern it had shown for health in the Region.

The report outlining the incidence of AIDS and HIV infection over the past decade left no doubt as to the magnitude of the challenge. New Zealand had already experienced one of the highest incidences of AIDS within the Region. The trend suggested that the growth in reported cases had peaked, but a further 450 new cases were nevertheless expected over the forthcoming three years. The cost of AIDS and HIV related activities for 1991 was estimated at NZ$7.2 million, or roughly NZ$11 000 per reported case. That cost would clearly grow in the immediate future, placing further pressure on a health system already under stress. New Zealand was currently considering a range of options for upgrading its programme of activities, with particular focus on intersectoral activities such as education of children, travellers and immigrants, sentinel testing, prison inmate behaviour and human rights.

New Zealand was aware that it could not solve its AIDS and HIV problems alone, and it therefore welcomed the opportunity to participate in regional discussion and training activities. It particularly appreciated the leadership provided by WHO. The sharing of ideas and information would continue to be of critical importance to the development of future strategies.

Dr BOVORA (Lao People's Democratic Republic) said that his country had launched a more open policy of economic reform. In view of the alarming situation in the neighbouring country of Thailand, his Government realized that it could face similar problems in the future and that prevention activities would be necessary. It was pursuing a programme of health education, particularly through the mass media, and was carrying out systematic blood screening, particularly of migrant workers. Two suspected cases had been identified, but a shortage of diagnostic equipment had made it impossible to confirm them.

The Ministry of Health was implementing its medium-term plan, which was mainly aimed at reducing morbidity and mortality and lessening the social and economic impact of HIV infection. It was also planned to establish a sentinel surveillance system among prisoners and bar girls.

Dr FINAU (South Pacific Commission) said that the Commission housed the WHO/SPC Information Centre for Prevention and Control of AIDS and Sexually Transmitted Diseases, which served some of the purposes mentioned by earlier speakers. In particular, the Centre endeavoured to treat AIDS as a disease of the family rather than a disease of the individual. That was in line with the practice of many countries and with the emphasis placed on the incorporation of other sociological and economic aspects. The Centre also considered it important to deal with AIDS as an international rather than a national problem. That applied particularly to the Pacific islands in view of their highly mobile populations.

In establishing policies and plans it was important, firstly, for countries to recognize the possibility of a higher risk among their migrant populations than among the domestic population, and secondly, for them to incorporate protection of the neighbouring countries as part of their national policy.

The REGIONAL DIRECTOR said that he wished to apologize to the Committee for the fact that the report was not comprehensive in its coverage. Since the AIDS situation had been reported upon annually to the Committee it had been thought that the current report could serve as an update to earlier reports. If examined alone, however, it might not give a total picture of what the Region was doing in dealing with AIDS. He would therefore consider

how the report could be prepared in future as a self-contained document including all the relevant information so that there would be no need to refer back to earlier reports.

The basic approaches to the AIDS problem remained unchanged. In order to strengthen national programmes a dual approach was followed: strengthening the surveillance aspect and embarking on education and information activities. In surveillance, emphasis was placed on the need for timely and accurate reporting by Member States based on laboratory confirmation, every effort being made to strengthen national capability and to make full use of the regional reference laboratories for providing accurate diagnosis of cases.

Since there was no cure for AIDS, the only course was to do everything possible to prevent the disease through education and information activities. The various approaches included health education for schoolchildren and information on the use of condoms. A further aspect was the provision of training opportunities. In addition to the case management training provided through the collaborating centre in Australia, it was intended to embark on the training of sex workers as an important future activity. There might be variations in approaches in order to target the most affected groups in individual countries, which in some countries might, for example, be homosexuals or intravenous drug users and in others heterosexuals.

Both short-term and medium-term programmes had been developed. In the initial stages, some governments had shown a certain reluctance, but most countries now had either short-term or medium-term plans or both. One of the most difficult problems was that of mobilization of resources. The total requirement for a medium-term programme (MTP) was a little over US$9 million. A pledging meeting had been held for all donors represented in four countries - China, Papua New Guinea, the Philippines and Viet Nam - for which the MTP requirement was approximately US$8.8 million but WHO was the only agency to have pledged, so only US$1.4 million had been pledged, leaving a shortfall of more than US$7.4 million. Resource mobilization was thus the most difficult problem.

Although the number of cases reported was shown as 3569, the actual number of HIV infection and AIDS cases was estimated at a little more than 20 000 and might well be even higher.

Australia, New Zealand and Singapore had the highest percentage of homosexual and bisexual infection, while Papua New Guinea, the Philippines, French Polynesia, Singapore, Hong Kong and Malaysia had the highest percentage of heterosexual cases, and Japan, followed by Malaysia, French Polynesia, Hong Kong and Australia, were most heavily affected by infection through blood transfusion and haemophilia. The highest rate of infection through drug use was in Malaysia, with nearly 20% of cases.

Efforts had been made in the Region to integrate activities against sexually transmitted diseases and AIDS even before that policy had been instituted at headquarters. The number of cases of syphilis reported in industrialized countries in the Region had been decreasing but the level of gonorrhoea appeared to be constant. Reporting still had to be improved in conjunction with surveillance activities so that Member States could deal with the problems more effectively. Efforts were made to combine the use of resources for AIDS and sexually transmitted diseases. He was unable to say at the present stage how effective the integrated approach was likely to be, since it had only just been initiated; its effectiveness would have to be assessed in the coming years.

On the question of statistics, raised by the delegation of the Marshall Islands, up to 1990 only the cumulative number of AIDS cases reported had been presented. While that had been justified in the early stages as a means of inducing the world to take notice of the high incidence of cases, it would now be appropriate to resort to the acceptable epidemiological

approach to statistics. It could be seen from Table 3 that the current report showed the number of deaths among reported cases (some 2000 out of a total of nearly 3500). The statistical presentation would need to be gradually improved in close consultation with the headquarters global programme. Every effort would be made to increase its relevance to the needs of countries in the future.

Dr PALAFOX (Marshall Islands) asked how the rates for sexually transmitted diseases in the Region compared with those for other regions.

Dr LEE (Director, Disease Prevention and Control) said that he had no precise information on the situation in other regions, but the situation in the Western Pacific Region with respect to sexually transmitted diseases appeared to be relatively favourable. Those diseases had decreased or stabilized, while reported AIDS cases showed an increase following the incubation period after infection.

3.2 Global Programme on AIDS: Membership of the Management Committee: Item 9.2 of the Agenda (Document WPR/RC42/5)

The REGIONAL DIRECTOR explained that as an advisory body to the Director-General of WHO, the Global Programme on AIDS Management Committee made recommendations on matters relating to policy, strategy, finance, management, monitoring and evaluation of the WHO Global Programme on AIDS. It was composed of representatives of countries contributing to the GPA Trust Funds and two members from each of WHO's six regions.

The present elected members from the Region were the Republic of Korea and the Philippines. The term of the latter would expire on 31 December 1991. At the current session the Regional Committee was invited to elect a new member whose term would start on 1 January 1992 and end on 31 December 1994. To replace the Philippines, the Committee might wish to consider Fiji.

Mr SUPA (Solomon Islands) endorsed the nomination of Fiji.

The CHAIRMAN said that if there were no further comments he would take it that the Committee decided to select Fiji to provide a representative to the Global Programme on AIDS Management Committee. He requested the Rapporteurs to prepare a draft resolution to that effect.

Dr KURISAQILA (Fiji) thanked the Regional Committee for having selected his country.

The meeting rose at 11.50 a.m.

ANNEX

ADDRESS BY THE INCOMING CHAIRMAN

Distinguished Representatives, Director-General, Regional Director, Representative of Specialized Agencies of the United Nations and nongovernmental organizations, WHO Secretariat, Ladies and Gentlemen,

I wish to thank the Committee for the great honour it has bestowed upon me by electing me Chairman of the forty-second session of the Regional Committee for the Western Pacific. I am well aware that my election expresses the desire of the Regional Committee to honour my country and graciously acknowledge the invitation of the Japanese Government to hold this session in Omiya, Japan.

Permit me to thank you, both personally and on behalf of the Ministry of Health and Welfare, and to welcome all the distinguished representatives who have assembled here today. I hope you will have a fruitful Regional Committee session and an enjoyable stay.

While I cannot say that the task you have entrusted to me will be accomplished with the perfection achieved by my predecessors, I can certainly assure you that I will do my best. The responsibility of chairmanship is always heavy but your cooperation will, I am sure, lighten my burden.

As your newly elected Chairman, I wish to welcome and congratulate the new Vice-Chairman, Mr Zackhras of the Marshall Islands; the Rapporteur in English, Dr Nukuro of Solomon Islands; and the Rapporteur in French, Dr Hop of Viet Nam. We shall work closely together and discharge our duties to the best of our ability.

An international meeting such as this one, of leaders in the field of health, has to deal with very varied problems. Such a task is never easy and we will depend heavily on the support of the Secretariat. This, I am sure, we will receive in the fullest measure from our Regional Director, Dr S.T. Han. I am particularly glad that Dr Nakajima, our Director-General, is also with us right from the first day, both as an international leader and as a man from this neighbourhood.

The fourth session in 1953 and the twenty-eighth session in 1977 of the Regional Committee were held in Tokyo and this is the third occasion Japan has the pleasure to welcome you all.

We are particularly happy to welcome the Federated States of Micronesia and the Marshall Islands as our new members and Tokelau as an Associate Member.

Considerable changes have been occurring in the world and in the Region since the Committee last met in Japan. The pre-Alma-Ata era has passed and we are approaching the threshold of a new century. Times have changed, health problems and needs have changed, and so also have our priorities. The success of WHO's collaboration with countries will largely depend on our willingness to change as necessary and on our determination to be partners in this process.

Annex

When we look back at some of the important issues discussed during our last session, in Manila, we can see the new thrust of health care in the 1990s. Perhaps it could be summed up as building health care systems, developing new policies and technologies, promoting the adoption of proven technologies, training personnel and coordinating disease prevention and control. In particular, management questions received a great deal of attention, and improved information facilities have strengthened collaboration with Member States.

The Committee endorsed the initiative of the Regional Director in selecting certain specific problems that can be solved and then doing everything possible to solve them rather than making a general effort on all fronts. This approach is becoming widely recognized as highly feasible and practical, and our work in this direction must continue and increase.

The Committee also welcomed the high priority given to developing human resources for health, and emphasized the need to reduce diseases related to lifestyle. I think the importance of that emphasis will be very clearly seen in our technical discussions on Monday.

In spite of diversity, we have a great deal in common as Members of this Committee. This was seen clearly last year in the proposed programme budget for 1992-1993, which managed to reflect both the national priorities of Member States and the six regional priority areas.

This year we have an extensive agenda before us. Of particular importance is the second evaluation of the strategy for health for all by the year 2000 as presented in the report of the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation. In reviewing it and the Regional Director's Report we can clearly see the progress we have made in the different sectors of health and in the collaboration between the Organization and its Member States.

We can see great achievement in areas such as the reduction of infant mortality rates, the increase in average life expectancy, and coverage with immunization. At the same time, however, we see the rise of new problems such as noncommunicable diseases and environmental health hazards, which make it impossible to be satisfied with our progress. More is always required of us.

I think that for further improvements, we should make a mutual agreement to expand our investment in health. However, we have limited resources and personnel. Therefore it is very important that we should identify and select the highest priority areas for investment. The Regional Committee provides an excellent opportunity for us to exchange views on this and to make plans for the future in our Region. In this session we will discuss several important programmes such as polio eradication, leprosy control, malaria and environmental health. These are surely very high priority areas for investment.

In the introduction of the Regional Director's report, partnership in health work is emphasized. This is indispensable for the promotion of health because we have limited resources. Now let me reiterate our Prime Minister's assurance that Japan will continue to strengthen its financial, personnel and technological support to WHO and its collaboration with Member States for the further improvement of people's health.

Annex

I look forward to a very fruitful week of discussion and information sharing. Not only will it help to build consensus in the Region; it will also make us better informed about the health problems that confront us and their implications for our national health policies and goals.