# SUMMARY RECORD OF THE FOURTH MEETING

Hotel Shilla, Seoul
Wednesday, 23 September 1981 at 2.30 p.m.

CHAIRMAN: Mr Doo-Ho Rhee (Republic of Korea)

## CONTENTS

1. STRATEGY FOR THE ACHIEVEMENT OF HEALTH FOR ALL BY THE YEAR 2000: REVIEW AND UPDATING: Item 12 of the Agenda (Documents WPR/RC32/6, WPR/RC32/6 Add.1, WPR/RC32/6 Add.1 Corr.1, and WPR/RC32/6 Add.2) (continued from the third meeting, section 3)

1.1 Review and updating of the Regional Strategy in the light of the Global Strategy

Chapter 1: Main Health and Health-related Problems
Chapter 2: Health and Socioeconomic Policies

Dr CHRISTMAS (New Zealand) asked whether the problem of translating "toddler mortality" into French had been resolved.

Dr HAN (Director, Programme Management) said that no similar term existed in French, but the final French text would be amended to show that mortality among children aged 1-4 was meant.

Chapters 1 and 2 were approved without further comment.

Chapter 3: Conceptual Framework for Action

Dr ACOSTA (Philippines) asked why the Sub-Committee had added the qualifying phrase "notwithstanding the downward trend of population growth" in sub-paragraph (b) of the second paragraph of Chapter 3. An increasing population in any case meant that certain adjustments had to be made in health services.

Dr AHN (Republic of Korea), speaking as Rapporteur for Part II of the report of Sub-Committee on the General Programme of Work, said that the Sub-Committee had felt that the added phrase gave a more precise picture of the conditions that must be taken into consideration.

Dr TAPA (Tonga) suggested adding the word "rate" after "growth" in the underlined phrase.

Dr CHRISTMAS (New Zealand) agreed with Dr Ahn's comments. Although the population of the Region was increasing, there were certain countries in which the rate of population growth was decreasing.

Dr CHEW (Singapore) felt that the revised text was no clearer. He would prefer to dispense with the added phrase.

The REGIONAL DIRECTOR said that the general feeling was that the addition was not necessary and it should therefore be deleted.

In the absence of further comment, Chapter 3, as amended, was approved.

Chapter 4: Long-term Objectives, Targets, and Approaches

There were no comments.

Chapter 5: Development of the Health System Based on Primary Health Care

Dr ACOSTA (Philippines) found the new chapter commendably pertinent to the needs of the regional programmes but felt that health plans should have been mentioned. If systems of health delivery were to be modified with a view to achieving health for all by the year 2000, national health plans would have to be adjusted and directed along new lines.

Dr AHN (Republic of Korea), speaking as Rapporteur for Part II of the Report of the Sub-Committee on the General Programme of Work, said that Dr Acosta's point was specifically dealt with in paragraph 6.4 Managerial and Administrative Support, which was the term used in the Regional Strategy document for what the Global Strategy referred to as "the managerial process for health development".

Dr CHRISTMAS (New Zealand) suggested that Dr Acosta's objection might be met by adding "and consistent with the country health programme" after the words "Chapter 3" in line 4 of the first paragraph.

Dr SUNG-WOO LEE (Republic of Korea) said that emphasis was rightly placed in the Chapter on the importance of training in health management and administration.

Dr HAN (Director, Programme Management) suggested that "managerial process for national health development" would be appropriate if Dr Christmas had country health programming in mind in his proposed amendment, but if he meant programmes the wording could stand.

Dr CHRISTMAS (New Zealand) said he was willing to adjust his amendment to the latest WHO technical terminology.

In the absence of further comment, Chapter 5, as amended, was approved.

Chapter 6: Regional Support Measures

Dr TAPA (Tonga) noted that, in paragraph 6.1, page 31, a statement on the regional development advisory council had been deleted. He would like to know what the situation was in regard to the setting up of a global development advisory council, since the two subjects were connected.

Dr HIDDLESTONE (Chairman, Executive Board) explained that it had been thought that, the Regional Committee having the task of overseeing the policies and strategies, a regional advisory council would be subservient to overall planning by the Regional Committee. The Regional Committee covered the need, so that to establish another body would be a duplication.

Mr TOVADEK (Papua New Guinea) asked whether the South Pacific had been included in error in paragraph 6.4, page 33, where a list was given of countries where health development centres were proposed.

Dr HAN (Director, Programme Management) explained that in fact it was intended to create a sub-regional centre or network for the small countries or areas of the South Pacific.

In the absence of further comment, Chapter 6 was approved.

Chapter 7: Generation and Mobilization of Resources

Dr ACOSTA (Philippines) asked why the previous section 6.1 had been replaced.

Dr AHN (Republic of Korea), speaking as Rapporteur for Part II of the Report of the Sub-Committee on the General Programme of Work, said the Sub-Committee had noted that the original section 6.1 had dealt chiefly with the health manpower development programme and had made very little reference to mobilizing human resources. It had therefore been suggested that it should be transferred to a new Chapter 5, and replaced by a new section (7.1) based on Chapter V, paragraphs 2-8 of the document "Global Strategy for Health for All by the Year 2000".[1]

Mr DHILLON (Chief, Human Resource Development) said the previous section 6.1, which had concerned health manpower training, had now been moved, and replaced by the new section 7.1 on human resources development, consistent with the Global Strategy document. The only part of it that concerned health manpower development was paragraph 7.1(6) on health personnel.

Dr NICHOLSON (United Kingdom of Great Britain and Northern Ireland), referring to paragraph 7.2(2), pointed out that bilateral agencies responded to formal requests from overseas governments. However, whether or not the assistance they provided was channelled into the health sector in fact depended on how much influence health ministries had with their governments. Unfortunately, they often had lower priority than other ministries.

Dr RIDINGS (Samoa) said it should not be left to individual governments to make requests, since in many Member States the health sector was not as strong as other sectors. When bilateral aid was given, donor countries should make clear that the condition was that it must be specifically earmarked for health purposes.

Dr ACOSTA (Philippines) recalled that one of the most important recommendations of the Sub-Committee on Techni al Cooperation among Developing Countries had been that health ministries should strengthen their influence on government bodies in charge of bilateral and multilateral programmes.

The REGIONAL DIRECTOR said the conflict over whether donor countries should support the health or the development sector in the receiving country was a perennial one. According to the "classic" pattern as embodied in the terms of multilateral or bilateral agreements, donor countries should respect the receiving countries' priorities. In practice, however, it was well known that the health sector was no as effective as other sectors in making its voice heard, and therefore health was always given lower priority. He saw WHO's role in the Region as that of a catalyst, endeavouring to orient donor-recipient relations more towards health and

[1] "Health for All" Series No. 3, WHO, Geneva, 1981.

social objectives, but the task was a difficult one. There had been some discussion in the Executive Board on whether one of the indicators or targets for the draft global strategy should be that 0.6% of the resources of developed countries should be transferred to developing countries for the health sector.

Dr HOWELLS (Australia) supported that view. However, he could not agree that a donor country should insist that whatever aid it gave must be devoted to health, since that would amount to patronage.

In the absence of further comment, Chapter 7 was approved.

Chapter 8: Collaborative Mechanisms

Chapter 8 was approved without discussion.

Chapter 9: Monitoring and Evaluation

The CHAIRMAN, referring to paragraph 9.3.1, said the secretariat would reply to questions raised earlier on the revised list of indicators, and give the explanations requested by the Sub-Committee on the General Programme of Work in Part II of its report (document WPR/RC32/6 Add.1, Section 6).

Dr PAIK (Chief, Research Promotion and Development) said the representative of the Republic of Korea had queried the usefulness of so-called "totals" of child mortality, and had asked why neonatal, post neonatal and perinatal mortality had been included. The list of indicators proposed was not intended to be definitive, but should rather be seen as a kind of shopping list, from which Member States could select, according to their appropriateness for generating the necessary data at national level. It had been felt that child mortality (the number of deaths per year per 1000 children in the age-group 1-4) was a more sensitive indicator of social and economic development in a community than infant mortality, since, whereas the infant mortality rate might be 100 times higher in least developed countries than in developed countries, the child mortality rate might be 250 times higher. Neonatal, post neonatal and perinatal mortality had been included for their usefulness for in-depth study of antenatal and post-natal care, and would be applicable chiefly to the developed countries.

Regarding the clarification requested by the Sub-Committee in paragraph 6 of its report (WPR/RC32/6 Add.1), endorsement "at the highest official level" meant that there should be a policy statement in favour of health for all at the highest level of authority (Head of State, Cabinet, Party Committee, etc.). By "involving people" was meant community involvement, though that indicator was one which was very difficult to quantify, and might need more research. As to the phrase "resources are equitably distributed", averages of resources utilized were less useful than figures showing actual distribution of resources as between, for example, urban and rural areas, and showing what proportion of the health budget went to primary health care by region, province or district. A "well-defined" strategy meant well-defined according to such principles as those set out on

page 15 of the publication "Formulating Strategies for Health for All in the Year 2000" as well as the principles defined in the Alma-Ata Declaration on Primary Health Care and in the main publication "Global Strategy for Health for All by the Year 2000".

The Sub-Committee had also asked how the criterion of at least 5% of gross national product to be spent on health had been arrived at. If world economic growth trends continued, it was expected that even the least developed country would eventually be able to reach a level of US$500 GNP. A rough estimate, based on projections for the various elements of primary health care and its supporting components, had therefore been that the minimum spent on health should be around US$25 per head by the year 2000, which was 5% of US$500.

In the absence of further comment, Chapter 9 was approved.

Chapter 10: Role of WHO with Respect to Regional Strategy Issues

Chapter 10 was approved without discussion.

Chapter 11: Tentative Plan for Implementation of Regional Strategies, Including a Timetable

Dr HAN (Director, Programme Management), in answer to a question from Dr ACOSTA (Philippines) said the years indicated in the right-hand column of the timetable were revised dates. The annotation in the left-hand column gave the original dates.

In the absence of further comment, Chapter 11 was approved.

1.2 Plans of action for implementating Global and Regional Strategies for health for all by the year 2000 (Document WPR/RC32/6 Add.2)

Dr AHN (Republic of Korea), Rapporteur, Part II of the Report of the Sub-Committee on the General Programme of Work, went on to introduce that part of the report relating to the draft plans of action for implementing the Global and Regional Strategies for health for all by the year 2000 (document WPR/RC32/6 Add.2). In resolution WHA34.36, the World Health Assembly had requested the Executive Board to prepare a draft plan of action to implement the Global Strategy, which would be reviewed by the regional committees at their 1981 sessions, finalized by the Executive Board in January 1982 and submitted to the Health Assembly in May 1982.

The draft plan of action for the Global Strategy had therefore been prepared and had been used by the Sub-Committee as a guide in preparing a draft plan of action for use at regional level. The regional plan of action had been integrated within the global one and both were being presented to the Regional Committee as one document (Annex 1 to document WPR/RC32/6 Add.2).

The plans of action were divided into five sections:

(1) a section on strategies, which indicated the action proposed to be taken with respect to their formulation, their implementation through plans of action, and their monitoring and evaluation;

(2) a section on developing health systems, which proposed the action to be taken in reviewing health systems and reorienting them to achieve the goal of health for all by the year 2000;

(3) a section on promotion and support, which referred to the strengthening of ministries of health or analogous authorities;

(4) a section on generating and mobilizing resources, in which Member States requiring external resources were asked to identify their needs clearly. Intercountry cooperation was recommended, and the catalytic role of WHO in the mobilization of funds was noted. Mention was also made of the possible involvement of the two subcommittees of the Regional Committee, one in identifying the needs of Member States and the other in reviewing them; and

(5) a final section on monitoring and evaluation.

With regard to the third section, he drew attention to paragraph 17(1), in which it was suggested that regional committees should consider the adoption of regional health charters. As its third comment on page 1 of the report indicated, the Sub-Committee had concluded that there would be no definite advantage for the Region in developing such a charter, and that the Regional Strategy contained in much greater detail all the elements that might be incorporated. It had therefore not accepted the suggestion.

The CHAIRMAN said that the Committee would now consider the plans of action contained in the document paragraph by paragraph, beginning with paragraph 5.

Paragraphs 5-16

There were no comments.

Paragraph 17

Dr CHRISTMAS (New Zealand) said that the idea behind sub-paragraph (2) was very sound but he felt that the text should be amended in such a way as to take account of countries which did not belong to any particular grouping.

The REGIONAL DIRECTOR fully agreed and said that the secretariat would revise the text accordingly.

Paragraphs 18-20

There were no comments.

Paragraphs 21-23

Dr SUNG-WOO LEE (Republic of Korea) said that his delegation fully supported the proposed regional plan of action contained in paragraph 23; however, it would like WHO to support training activities through the effective utilization of the Organization's experts and advisers.

Paragraphs 24-26

There were no comments.

Paragraphs 27-29

Dr RIDINGS (Samoa), commenting on the "international flow of resources in support of the Strategy" mentioned in paragraph 27, asked for some up-to-date information regarding the Health Resources Group, since there appeared to be some conflict between the Group and the Executive Board.

Dr HIDDLESTONE (Chairman, Executive Board) said that the Health Resources Group had had a very unfortunate start in that it had seemed to develop separately from both the Executive Board and the Health Assembly, thus arousing a certain amount of suspicion as to the way in which it would mobilize extrabudgetary resources. However, those early worries had been resolved and the group was now proceeding in such a way that its activities would be carried out under the oversight of the Executive Board, so the fears expressed at the Health Assembly probably no longer had any foundation. The Group was due to hold a further meeting later in the year, where it was expected to embark upon a series of pilot studies to illustrate the fact that it was now well within the mainstream of oversight by both the Executive Board and the Health Assembly. The information given in paragraph 27 illustrated quite clearly the fact that the Executive Board would regularly review the Group's activities.

Dr CHRISTMAS (New Zealand) requested some further information on the trilateral cooperation mentioned in paragraph 29, and in particular whether countries other than Tonga were involved in such arrangements in the South Pacific area.

Dr NICHOLSON (United Kingdom of Great Britain and Northern Ireland) informed the Committee that his Government was carrying out a trilateral malaria control project with WHO in the Solomon Islands. There were also at least two examples of even broader coordination in which the government of the country concerned was working with WHO and three bilateral agencies on the same project.

The REGIONAL DIRECTOR said that Tonga was an experimental case and that the Government of Japan had sent missions to three countries. In any case, it was often extremely difficult for donor countries to hold regular discussions with every small country in the South Pacific because of the absence of diplomatic missions. WHO had extensive information on the particular requirements of the small countries in the area, which it could usefully pass on to potential donors, thus initiating a dialogue in which special emphasis would be placed on the health sector. The Organization could also seek to attract new donors. However, small countries in the South Pacific usually had a traditional donor. That donor's support might be limited, might be reduced because of budgetary constraints, or might be oriented to development sectors other than health, possibly because it was under the impression that health needs were already being met by WHO or by voluntary organizations. The result was that health support was sometimes

reduced after independence. Furthermore, bilateral aid was often directed by commercial firms with a view to stimulating a given economic activity. In such cases WHO had a role to play in explaining the importance of health as an integral part of overall development. In any event, a flexible approach to the problems of small newly independent countries was essential, and emphasis might well be placed on efforts to obtain increased assistance from their traditional donors.

Mr UMEMOTO (United Nations Children's Fund), at the invitation of the Chairman, said that, in view of the interest shown in innovative approaches, he would like to quote the example of joint WHO/UNICEF activities with one or more countries or areas of the Region in the South Pacific, particularly Papua New Guinea, Samoa and Solomon Islands: health projects had been drawn up for UNICEF assistance though funding was not readily available. The UNICEF Executive Board referred to these as "noted projects", and approved them for forwarding to interested donor countries, which had included Australia, New Zealand and Canada, with technical support from WHO. He thought that procedure had been found satisfactory.

Referring to the section of the plan of action on monitoring and evaluation, Dr CHRISTMAS (New Zealand) said that these constituted major functions of the Sub-Committee, and a means for Member States to be assisted with assessing programmes with a view to health for all by the year 2000. He hoped the Regional Committee would support that role.

In the absence of further comment, the CHAIRMAN requested the Rapporteurs to prepare a draft resolution. (For consideration of the draft resolution, see the fifth meeting, section 1.2).

## 2. HEALTH SYSTEMS SUPPORT FOR PRIMARY HEALTH CARE: Item 13 of the Agenda (Document WPR/RC32/7)

The REGIONAL DIRECTOR said that health systems support for primary health care had been the subject of the Technical Discussions during the Thirty-Fourth World Health Assembly. Ideally, the subject should have been discussed by the Regional Committee prior to the Health Assembly, either as an item on the agenda or at its own Technical Presentation during the thirty-first session. For various reasons it had not. Nevertheless, since a number of representatives present had taken part in the Technical Discussions during the Health Assembly and since it was considered important to discuss the subject from a regional point of view, the item had been included on the agenda immediately after the item on strategies for health for all by the year 2000, to which it was related.

Some of the principles stressed in the document were:

(1) that primary health care was the basis upon which the health system was developed and that in no way could it be considered a separate programme. The programme classification in the proposed Seventh General Programme of Work was consistent with that view;

(2) the idea of primary health care had to be well understood by the entire health sector, by health-related sectors and by political decision-makers at all levels of administration;

(3) ministries of health had to be strengthened in order to act as the prime movers for primary health care; and

(4) acknowledgement of the principles of self-reliance and community participation did not mean that governments could abandon responsibility for health care. It did mean, however, that the overall returns from investment in health would be greater.

The Regional Director asked the Regional Committee to urge Member States to act on the issues raised in document WPR/RC32/7 and to include a report on the action taken in the reports they would make in 1983 when they reviewed and updated their national strategies.

Dr DONG-MO RHIE (Republic of Korea) said that his delegation had studied document WPR/RC32/7 with great interest. His country had recognized the need to provide equitable health services for all its people, utilizing the primary health care approach. It already had previous experience with the "Saemaul Undong" as part of its national development programme, and fully endorsed section 2 of the document, on political commitment and action.

From the outset, the country's primary health care programme had been closely associated with the "Saemaul Undong" movement in order to enlist community participation. The "Saemaul Undong" had begun in 1962 with the first five-year economic development plan, and had contributed greatly to increased living standards, including better health and nutrition.

Various aspects of the primary health care approach had been reflected in the three "Saemaul Undong" demonstration regions since 1977. Health development committees had been organized to ensure effective implementation of community health care projects. Women health workers were located in each community to stimulate primary health care activities, while community health practitioners were deployed in the primary health care units, of which there were about 30 in remote and other underserved areas.

The Republic of Korea could contribute experience and suggestions on financing, management and supervision, facilities, equipment and supplies. Those supporting functions, though neglected by administrators and research workers, were important and merited more attention from governments and WHO.

Dr TAPA (Tonga) endorsed the report, singling out health education as one of the essential tools required to support the primary health care approach. Since life-style and habits took long to form or change, governments of some countries of the Region were giving increasing attention to health education in schools, and particularly in primary schools.

Dr CRUZ (United States of America) emphasized the need for community involvement and planning. He agreed with the report that central planning must provide support for community efforts, identifying depressed or underserved areas, with a careful assessment of needs and feasibility. It seemed that preventable diseases and conditions that contributed most heavily to early mortality and unnecessary morbidity should be given the highest priority in such efforts. Community participation should be based on existing infrastructures.

It was important to ensure that procedures and methods should be agreed by all concerned. The primary health care approach should be understood by decision-makers at all levels of government and endorsed at the highest. Guam, as part of the United States of America, was happy to be among those having obtained such endorsement. The heads of government at the recent meeting of the Pacific Basin Executives' Association, had adopted a resolution proposed by his Government recognizing the goal of "health for all" and seeking the cooperation of island communities, including the Northern Marianas, the Marshall Islands and the Federated States of Micronesia, to improve the health of their peoples. It also established a health coordinating committee for the area.

Guam was beginning to plan for the community at large, as well as health-related agencies, to be involved in health activities and planning and looked forward to WHO's cooperation, especially in training and through guidance on community participation.

In such work WHO should give more attention to promoting the concept of self-care and improving management methods and organization so as to secure maximum personal involvement in health care.

In the absence of further comment, the CHAIRMAN asked the Rapporteurs to prepare a draft resolution. (For consideration of the draft resolution, see the fifth meeting, section 1.3).

## 3. WHO'S STRUCTURES IN THE LIGHT OF ITS FUNCTIONS: Item 14 of the Agenda (Document WPR/RC32/8)

Dr CHRISTMAS, Chairman of the Sub-Committee on the General Programme of Work, introducing Part III of the Sub-Committee's report (document WPR/RC32/8) in the absence of the Rapporteur, recalled that the purpose of the study had been to emphasize support for strategies for health for all by the year 2000, which should determine the structure and functions of global and regional bodies of WHO. The annex to the report gave details of action taken on operative paragraphs of the relevant resolution of the Health Assembly, resolution WHA33.17.

First, the attempts to correlate the work of the Regional Committee with that of the Health Assembly and the Executive Board in accordance with sub-paragraphs of operative paragraph 1 (on the role of the World Health Assembly); these were continuing. Not reflected in the report was the

desirability of feedback; it was hoped that representatives on the Board would report back on topics discussed at its last sessions. Similarly the Regional Committee would no doubt look forward to hearing a report from the Regional Director on his attendance at the Global Programme Committee. That would further strengthen coordination in accordance with sub-paragraphs 1(4) and 4(3) of the resolution.

The strengthening of monitoring, control and evaluation in accordance with sub-paragraphs 1(7) and 3(8) had already been discussed as far as the Regional Committee was concerned; it had decided that this would best be assured by the Sub-Committee itself.

With regard to sub-paragraph 1(8), he recalled that the Regional Committee, at its previous session, had recommended that the thirty-second session should prepare a draft resolution to increase the number of members of the Executive Board from the Western Pacific Region. That was also the subject of action in response to sub-paragraph 3(1). Sub-paragraph 3(2), also on the role of regional committees, referred to intensification of efforts to develop regional policies and programmes. The Sub-Committee reported that the Regional Committee had adopted the Regional Strategy and had, through its two Sub-Committees, consistently been involved in developing and modifying strategies. The reporting Sub-Committee had, however, envisaged having the Regional Committee request it by resolution to explore the means of further intensifying such efforts.

It had been satisfied with the way the Regional Director and Members of the Region were working, but hoped to see a further increase in the role of both Sub-Committees in the forming of policy.

The CHAIRMAN said that, apart from any other recommendations arising from the discussion of the item, the Committee had to consider three specific comments or recommendations made by the Sub-Committee on the General Programme of Work: firstly, that the most suitable forum for discussion of the role of ministries of health as directing and coordinating authorities on national health work might appropriately first be the Sub-Committee itself; secondly, that the Regional Committee should consider adopting a resolution to increase the number of Members from the Region entitled to designate a member of the Executive Board; thirdly, that the Sub-Committee's membership should be increased by one.

Dr MINNERS (United States of America) said that the Western Pacific Region had been particularly successful in implementing many of the measures that were identified as themes of the study of WHO's structures in the light of its functions, and in the way that it had maintained unity and correlated its work with the World Health Assembly and the Executive Board. The Chairman of the Sub-Committee had been too modest in recognizing that aspect when describing action taken under the relevant sub-paragraphs of resolution WHA33.17, 1(4) and 4(3). Indeed the Region had the opportunity to provide substantial leadership in the governing bodies of WHO, since others were not so far advanced.

With regard to the resources mobilization committee established at the Regional Office, and its role in the channelling of health resources in accordance with operative sub-paragraphs 1(6) and 3(6) of resolution WHA33.17, he stressed the importance of that role where approaches to funding agencies were concerned. It would familiarize countries with the procedures for such approaches to United Nations and other sources.

He also felt that it should not be mandatory - as he understood was required by the terms of reference of the global Health Resources Group - that funds should be centrally received; channelling of funds direct from voluntary sources to the countries should be recognized as a worthy and important aim.

The effectiveness of the WHO Executive Board was related to its size, which was more manageable than those of many similar bodies; it was realized that the Board's role might become even stronger if Health Assemblies were held biennially, and size would still be a determining factor in its success.

Dr SUNG-WOO LEE (Republic of Korea) expressed approval for the work of the Sub-Committee, and agreed that its membership should be increased in order to meet the needs of its expanded role.

Dr RIDINGS (Samoa) agreed with the representative of the United States of America that the size of the Executive Board was critical. The Board was not democratically representative, however, and a fairer distribution of seats might be achieved by reforming the procedure by which major contributors to WHO were assured of almost continuous representation, being relieved for one year at a time. He thought that although the principle was right, those countries could now designate a person to serve at less frequent intervals, allowing relatively under-represented Regions more seats on the Board.

Dr CHRISTMAS (New Zealand) said he intended to submit his recommendations for more detailed consideration. First, the agenda of Regional Committee sessions should be expanded to allow representatives who were also members of the Executive Board to report back on th Board's deliberations, and the Regional Director to outline discussions in the Global Programme Committee. Secondly, the Sub-Committee should be actively and continuously involved in evaluation and monitoring, and should report annually, with authority to explore ways of developing regional policy in accordance with operative sub-paragraph 3(2) of resolution WHA33.17.

In connexion with operative paragraph 3(1), it should be recommended that the Region's representation among Members entitled to designate a person to serve on the Executive Board should be increased; and, if the Sub-Committee's work was to increase, as the representative of the Republic of Korea had rightly pointed out, its membership should also be increased from seven to eight.

Dr ACOSTA (Philippines) said that the reporting to the Regional Committee by members of the Executive Board might present problems, as members of the Board did not represent their country or their Region in that body.

The REGIONAL DIRECTOR said that preparations had been made for an informal discussion, by representatives at the session, of the question of representativity on the Board - a complicated issue which it might be preferable to leave to the appointed time. He would only remind participants that the decision to increase the number of members of the Board from the South-East Asia Region had still not taken effect after several years because the required ratification of the amendment by two-thirds of the Members of the Organization had not been completed.

Dr ACOSTA (Philippines) said that his doubts concerned not an increase in the size of the Executive Board but the relationship of Board members to their countries and regions. Since Board members were appointed in an individual capacity, and did not represent either their country or their region, the constitutional propriety of asking them to report to the Regional Committee was questionable.

Dr CHRISTMAS (New Zealand) said that the representative of the Philippines had raised an important point. If the Secretariat confirmed Dr Acosta's doubts, he would accept that Board members from the Region could not be asked to report to the Committee.

Mr KAKAR (Director, Support Programme) agreed that Board members were nominated by their countries, but did not represent them, as they served in their individual technical capacity. That being so, they could not be asked to report to the Committee; however, they might be invited to give the benefit of their experience.

The CHAIRMAN said that the Committee would return to the point at its next meeting. (For continuation of discussions, see the fifth meeting, section 2.)

The meeting rose at 5.25 p.m.