(WPR/RC46/SR/8)

SUMMARY RECORD OF THE EIGHTH MEETING

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CHAIRMAN: Dr Chhea Thang (Cambodia)

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1. REPRODUCTIVE HEALTH: Item 16 of the Agenda (Document WPR/RC46/15)

The REGIONAL DIRECTOR drew the Committee's attention to document WPR/RC46/15, on reproductive health.

The subject had recently been taken up in several United Nations' forums and had very recently been a focus of interest at the Fourth World Conference on Women, held in Beijing, China in September 1995. It was appropriate, therefore, to look carefully at that aspect of WHO's health work, as the implications of reproductive ill-health were far-reaching, from both a demographic and an economic point of view.

The document gave a brief overview of the "reproductive health" situation in countries and areas of the Region and suggested the most relevant and urgent interventions to be undertaken by the health sector, in order to improve the reproductive health outcome. It took into consideration the complex range of social and economic aspects of reproductive health considerations, including the "human rights" dimension.

From whichever perspective reproductive health was considered, it was and would continue to be mainly a health issue, to be dealt with by the health professions, and for which programmes and activities had to be developed by the health sector.

In the Western Pacific Region, large disparities in the outcome of human reproduction still existed between and within countries. In parts of some of the developing countries of the Region, the maternal mortality ratio was more than 50 times higher than in the most developed countries. Likewise, infant mortality rates varied from 6 to 120 per thousand live births.

The majority of infant deaths occurred during the early neonatal period, indicating that an improvement of obstetric services and delivery practices could be effective in reducing mortality.

Better quality of medical services, increased access by women and couples to such services, and the application of inexpensive tools and simple technologies, could dramatically reduce the tragedy of maternal and infant mortality. Those measures could also reduce the long-term pathological consequences which often followed a badly managed delivery.

The expansion of family planning services, including provision of a wider choice of safe contraceptive methods, remained a principal means to improve reproductive health outcomes, and to reduce complications from unwanted pregnancies and the unsafe abortion which often followed.

Furthermore, the provision of safe contraceptives allowed young couples to delay the first pregnancy. In that way the woman and the couple could decide if and when to have children, how many children to have, or to stop the childbearing process in older age or in cases where there were medical or other risks.

The direction and content of the reproductive health programme were country and area-specific and responded to local situations. In order to review the reproductive health programme in different areas, and to revise regional and country objectives and targets, a regional reproductive health workshop would take place in Kuala Lumpur, Malaysia, from 11 to 15 December 1995.

It was WHO's hope that, through discussion on the current status of reproductive health in the Region, Member States would review what was available, and, in cooperation with other sectors, would identify and implement the most cost-effective and appropriate interventions to improve the outcome of human reproduction.

Dr ADAMS (Australia) said a number of Australian reproductive health experts would be interested in receiving invitations to the regional workshop that was to take place in Kuala Lumpur, Malaysia, in December 1995.

Dr SHAFIE (Malaysia) said that reproductive health was one of the health care areas requiring attention in Malaysia over the next decade, in particular the issues of contraception for adolescents, unsafe abortions, and contraception for high-risk groups. Family planning in Malaysia was presented not primarily as a birth control measure but as a means of birth spacing and of preventing high-risk pregnancies. The decline in the total fertility rate and population growth rates had been the result of improvements in the reproductive health of women as well as of other factors such as the improvement in education, the socioeconomic status of the country and women's access to effective family planning methods. It was expected that those factors would lead to a further improvement of women's reproductive health in the coming decade. The Malaysian Ministry of Health had committed resources to family health care which included family planning and maternal mortality reviews, as well as increased coverage of high-risk women through the Quality Assurance Programme and greater attention to disadvantaged groups and geographical areas.

Mr ZHANG (China) said the Government of China treated reproductive health as an important issue, and had managed to bring down maternal and infant mortality rates, and raise the rate of contraceptive use. China was still a developing country and there remained a disparity

between its achievements and those of some developed countries, and it wished to strengthen its cooperation with the Regional Office in respect of that.

Dr NOGUEIRA DA CANHOTA (Macao) said that Macao regarded family development as a fundamental task and had passed a family policy law in August 1994 which provided a legal basis for families to care for their members' health, nutrition, education, shelter and physical and emotional development. Strong support services had been provided to help them do that. In order to exchange information and experience on family-related issues, an international conference on women was to be held in Macao from 18 to 20 September 1995, in cooperation with the International Union of Family Organizations.

The Macao maternal and child health programme had been intensified since 1993 with special attention being given to family planning and prenatal care; in 1994 an average of more than seven prenatal consultations was provided for each pregnant woman in Macao. As a result of promotion activities by health centres, the birth rate had fallen; services were also provided for infertile couples. During routine check-ups, information was provided on breast-feeding, nutrition, birth control and planning, and infant care. As a result of that and related measures, the infant mortality rate in 1994 had fallen to 6.2 per thousand live births.

Ms RUIZ (Philippines) commending the Regional Director on the report, said that improvement in the welfare of families, with the focus on the health of women, safe motherhood and child survival, was a government policy in her country. The provision of quality family planning had been identified as one of the most effective ways of improving women's reproductive health and child survival. It was also recognized that effective family planning allowed women to avoid unwanted pregnancies, illegal abortions and childbearing in circumstances that threatened the child's and their own health.

Mr RODRIGUEZ (United States of America) acknowledged the Regional Director's prompt and effective response to the mandate given by the International Conference on Population and Development held in Cairo, Egypt, in September 1994, to support countries' enhancement of reproductive health services.

Mr HIRAI (Japan) commended the emphasis in the report on the importance of sexual behaviour and access to appropriate family planning methods. Japan had stressed the importance of reproductive health both at the International Conference on Population and Development, and at the Fourth World Conference on Women. One example of an initiative to reduce maternal and infant mortality rates was a maternal and child health handbook which provided Japanese women with guidance on pregnancy, childbirth and child care. As a country which had achieved very

low levels of infant and maternal mortality, Japan wished to continue its contribution to improving reproductive health elsewhere in the Region.

Dr WORKMAN (New Zealand) said that reproductive and sexual health had been a particular policy focus in New Zealand government agencies following the International Conference on Population and Development. Among the reasons why reproductive health improvements were required in New Zealand were that fertility rates for women between the ages of 15 and 19 were high, and within the countries of the Organisation for Economic Co-operation and Development, second only to those in the United States of America; that unprotected sexual intercourse was common; that 11 460 induced abortions were performed in 1992, nearly half of them for women aged 24 or under, with Pacific island women living in New Zealand having particularly high abortion rates; and that genital wart infection had, since 1988, been the most common sexually transmitted disease diagnosed in clinics, with numbers continuing to increase.

The Government of New Zealand had proposed initiatives for public health programmes to improve the reproductive and sexual health of Pacific island people, for an investigation into the level of implementation of reproductive and sexual programmes and policies in schools, for a reduction in the cost barriers to contraceptive use, and for the development and monitoring of targets for reducing rates of induced abortion. The Programme of Action of the International Conference on Population and Development should be the base document for New Zealand's position on matters relating to reproductive health. Among other outcomes, the Conference recognized the vital importance to development of the empowerment and autonomy of women, and the need to improve their political, social, economic and health status.

Dr TAUFA (Papua New Guinea) said her country had high rates of infant, child and maternal mortality, and had received support from WHO, UNFPA and a number of nongovernmental organizations. A population policy had been approved in 1991, and was being supported with the joint support of the Asian Development Bank and AusAID. With reference to the penultimate paragraph of section 5 of document WPR/RC46/15 regarding the systematic application of simple and inexpensive technologies, she said that she would like to see more support for projects for village birth attendants and community-based distributors of contraceptives in an attempt to reach women in the more remote rural areas.

Ms HOMASI (Tuvalu) said that reproductive health had been discussed in various forums at the Fourth World Conference on Women, which she had herself attended. The WHO technical group had raised the subject of the increasing incidence of cervical cancer in most Pacific countries and Tuvalu had given a presentation at the nongovernmental organizations forum in

Huairou, China, on its recently introduced cervical screening programmes, which had been a national women's initiative.

The REGIONAL DIRECTOR, replying to points raised by Committee members, said that invitations to the workshop in Kuala Lumpur had been sent out on 29 August 1995, and that countries had been asked to nominate one participant each.

For the information of the representative of Papua New Guinea, he was pleased to announce that approximately US$500 000 from UNFPA for a maternal and child health project in that country had recently been approved and would include one staff member post.

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

2. INTERNATIONAL DECADE OF THE WORLD'S INDIGENOUS PEOPLE: Item 17 of the Agenda (Document WPR/RC46/16)

The REGIONAL DIRECTOR said that the United Nations was actively promoting the International Decade of the World's Indigenous People, which had begun in December 1994, in order to increase the participation of those often-disadvantaged people in social and economic progress. WHO was focusing on the health needs of indigenous peoples in the context of the Decade. The Government of New Zealand had made a special request to the Regional Committee that the issue be explicitly addressed in the forty-sixth session.

A brief statement on the subject was contained in document WPR/RC46/16. He stressed that the working document and its terminology were not intended in any way to be definitive on the subject. The document was an initial outline of the situation in the Region from a public health standpoint for the purposes of discussion. WHO's primary interest was in the health needs of underserved groups, emphasizing equity of access to services and attention to special needs, as the WHO Constitution stated, "without distinction of race, religion, political belief, economic or social conditions". He also pointed out that the definition of the term "indigenous people" was still under review by various bodies in the United Nations, and therefore the wording contained in the document did not enjoy formal status in the United Nations context. The information in the document had been gathered by means of a brief questionnaire, to provide a framework for the issues presented. The main intention of the document was to provide a simple basis from which discussion of the points of interest to Member States might proceed.

The Committee might wish to discuss whether the Regional Office should play a particular role in coordination or promotion of activities for the Decade's programme.

The CHAIRMAN reminded members of the Committee that because work was under way in the United Nations human rights organs with regard to indigenous people they should concern themselves only with the role they wished the Regional Office to play in the International Decade and the scope of activities Member States might wish to consider with regard to the health issues of indigenous people.

Mr WORKMAN (New Zealand), speaking also as a member of the indigenous Maori people, stressed that improving the health of the Maori population was one of the major challenges faced by his Government. There was a gap in health status between the Maori people and the remainder of the population, and that gap must be closed. The Government was endeavouring to design strategies to improve Maori health, with emphasis on responsiveness to the needs of Maori as individuals and as communities. The special health needs of Maori were specifically recognized in the new Health and Disability Services Act passed as part of the reorganization of the New Zealand health system in 1993. The attendant health sector reforms had given Maori people more opportunity to participate in and control their own health and to purchase and provide their own health services. The Government was working on policies designed to eliminate barriers to access, acknowledging that services must be culturally appropriate, culturally effective, affordable, accessible, equitable and include risk management strategies. The policy would accommodate indigenous healing practices, herbal medicine, and the holistic view of human beings in relation to nature. The National Advisory Committee on Core Health and Disability Services was considering how to establish Maori traditional healing as a core health service. Only a month before, a regional health authority had signed a contract for the provision of Maori traditional healing as a primary health care service. It was important to ensure that the reconciliation of mainstream and Maori health practices did not erode the integrity of Maori traditional healing, where knowledge was held exclusively by certain people in each generation. The speaker noted with interest from the Regional Director's report that several other Members of the Region had significant programmes for reconciling traditional and modern health practices, and would welcome the opportunity to learn more about them.

His Government believed that, when Member States began to calculate health indicators in the new form developed in *New horizons in health*, the indicators should differentiate between the indigenous population and other groups. For its part, it would henceforth ensure that its fellowships programme reflected the importance it attached to improving the health of indigenous people.

Resolution WHA47.27 requested regional offices "to work, along with the governments of the Member States concerned, with indigenous people, including by establishing a core advisory

group of indigenous representatives with special knowledge of the health needs and resources of their communities". He looked forward to hearing what progress the Regional Office had made in that respect. He would also be interested to hear from other representatives about their activities for promoting a social and physical environment that would improve and protect the public health of indigenous people.

He understood that the United Nations Working Group on Indigenous Populations was currently working on a definition of an indigenous person, and he felt that such a difficult issue was best left to that body to deal with. He believed it was preferable for countries to decide for themselves whether and how the International Decade of the World's Indigenous People applied to them.

The New Zealand delegation had circulated a draft resolution on the International Decade to representatives of other Member States and the responses received had proved most helpful in preparing a revised version, which he wished to submit to the Regional Committee for its consideration.

Dr ADAMS (Australia) said his country regarded the International Decade of the World's Indigenous People as providing an excellent framework within which to achieve measurable and sustainable progress in health, in partnership with indigenous communities. In Australia, the States and Territories had primary responsibility for the planning and delivery of health care for all citizens, including the aboriginal and Torres Strait islander people. The available data showed a consistent picture of significantly poorer health status for indigenous Australians than for non-indigenous Australians. Significant differences had been shown in terms of death rates, life expectancy, hospital admission rates, and morbidity levels for diabetes and preventable communicable diseases.

The Government had decided to increase its efforts to improve the health of the indigenous populations, and one of the first steps taken had been to transfer responsibility for aboriginal health matters at the federal level to the Department of Human Services and Health on 1 July 1995. The Department acknowledged the need for culturally appropriate delivery of health and substance abuse services to indigenous communities, and the vast majority of such services were now run by organizations controlled by the local community.

A number of new initiatives had been announced in the 1995 budget. In the next four years an additional A$103 million would be allocated to the funding of specific indigenous health initiatives, bringing total Government spending on the health of indigenous people to A$482 million during that period. A total of A$3 million had been allocated for the coming year

to establish a national indigenous health workforce agency, and A$1 million for enabling aboriginal health services to employ extra staff while permanent staff were attending training. A national indigenous health advisory council was being established, to serve as a focal point for all health-related decisions affecting indigenous people.

The data on indigenous communities' health were deeply disturbing, and during the International Decade Australia would aim for real gains in indigenous health and lasting improvements to health infrastructure. Nevertheless, it must be borne in mind that the problems of indigenous health were due to a large number of factors associated with social, cultural and economic deprivation, and could not be resolved simply by improving health and substance abuse services.

Ms RUIZ (Philippines) expressed her Government's support for the International Decade of the World's Indigenous People. Although there was still no consensus on the definition of "indigenous people", the Government of the Philippines recognized that there were communities which, by virtue of history or culture, had special health needs. Accordingly, the Community Health Service of the Department of Health was to implement the Indigenous People's Health Programme, which aimed to provide indigenous people with the same access to health care as the rest of the population. Health care must be available to all Filipinos, regardless of their cultural or historical background.

Mr McCUDDIN (United States of America) said that American Samoans were responsible for running the health care system and determining health policy in their territory. As United States nationals they were able to travel freely, and more of them now lived in the United States than in American Samoa. Although the same resources were available to Samoans resident in the United States as to other citizens, their health status was significantly lower because of problems of access, economic difficulties and insufficient knowledge of English. The problem was being addressed in various forums, and it was hoped that American Samoans and similar groups living in the United States would soon achieve parity in health status and access to health care with other citizens.

Dr ABU BAKAR (Malaysia) said that, ever since achieving independence in 1957, his country had been sensitive to the needs of minority groups, including indigenous people. It had placed emphasis on integration, and as a result only a small minority of indigenous people still suffered inferior health status, namely the groups that continued to lead a nomadic life. Special programmes had been developed by the Department of Aboriginal Affairs and the Ministry of Health to look after the health needs of indigenous people.

The REGIONAL DIRECTOR, referring to the draft resolution submitted by New Zealand, suggested it would be more appropriate for him to report to the Executive Board at its ninety-seventh session in January 1996 than to the World Health Assembly.

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

3. SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION: MEMBERSHIP OF THE POLICY AND COORDINATION COMMITTEE: Item 18 of the Agenda (Document WPR/RC46/17)

The REGIONAL DIRECTOR said that the Policy and Coordination Committee (PCC) was the governing body of the Special Programme of Research, Development and Research Training in Human Reproduction. It was composed of four categories of membership, with a total of 32 members. One of the categories, category (2), had 14 members. Three of those memberships were allocated to the Western Pacific Region. The members were elected by the Regional Committee for three-year terms according to population distribution and regional needs. In electing members, due consideration should be given to a country's financial or technical support for the Special Programme, and its interest in that field, as reflected by national policies and programmes.

At present the three countries elected under category 2 were Fiji, the Philippines and New Zealand. The period of tenure of the member from Fiji was due to expire on 31 December 1995.

In order to maintain the full representation of the Western Pacific Region on the Policy and Coordination Committee, the Regional Committee was requested to elect one Member State to nominate a member whose three-year term would start on 1 January 1996. The Regional Director suggested that the Committee might wish to elect Japan.

The nomination was approved.

The next meeting of the Policy and Coordination Committee would be held from 19 to 21 June 1996.

4. SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES: MEMBERSHIP OF THE JOINT COORDINATING BOARD: Item 19 of the Agenda (Document WPR/RC46/18)

The REGIONAL DIRECTOR stated that paragraph 2.2.2 of the Memorandum of Understanding on the Administrative and Technical Structures of the Special Programme for Research and Training in Tropical Diseases provided for the selection by the WHO regional committees of two Member States from among those directly affected by the diseases dealt with by the Special Programme, or from among those providing technical or scientific support to the Special Programme.

The two Member States of the Western Pacific Region thus selected were Malaysia and Papua New Guinea. Since the three-year period of tenure of Malaysia expired on 31 December 1995, the Committee would need to appoint a Member State to represent the Region from 1 January 1996. It might wish to consider China as a replacement for Malaysia.

The nomination was approved.

The exact dates and place of the 1996 meeting of the Joint Coordinating Board would be conveyed to Member States in due course.

5. CORRELATION OF THE WORK OF THE WORLD HEALTH ASSEMBLY, THE EXECUTIVE BOARD AND THE REGIONAL COMMITTEE: Item 20 of the Agenda

5.1 Consideration of resolutions of the Forty-eighth World Health Assembly and the Executive Board at its ninety-fifth and ninety-sixth sessions: Item 20.1 of the Agenda (Document WPR/RC46/19)

The REGIONAL DIRECTOR said that document WPR/RC46/19 referred to resolutions adopted earlier in 1995 by the World Health Assembly and the Executive Board which were of significance to the Western Pacific Region. It commented on their implications, and provided some information on relevant activities in the Region. The resolutions themselves were attached to the document. Other resolutions adopted by the Health Assembly that needed to be brought to the attention of the Committee were related to other items on the agenda and were included in the documentation on those items.

He drew the attention of the Committee particularly to those operative paragraphs pertaining to activities that Member States in the Region could undertake to implement the resolutions.

5.1.1 Resolution WHA48.1 - Transfer of Mongolia to the Western Pacific Region

The CHAIRMAN invited the Regional Director to explain the position.

The REGIONAL DIRECTOR, drawing attention to the short analysis of the general situation of transfer between regions in document WPR/RC46/19 (page 2), said that there was no set procedure for transfer. In the case in point the Government of Mongolia had made its request through headquarters and the decision for transfer had been taken at that level. The wider issue was whether and in what way the two relevant regional committees should become involved. He drew the attention of the representatives to three aspects. First, would it be appropriate to determine rules of prior consultation of the two concerned regional committees? Second, should certain criteria be used in a decision on such a matter: size of population, geographical and political situation, shared or special health problems, etc? Third, should there, in fact, be no change to the procedure?

Dr TAPA (Tonga) favoured no change to the procedure.

It was so agreed.

5.1.2 Resolution WHA48.2 - Emergency and humanitarian action

There were no comments.

5.1.3 Resolution WHA48.3 - Intensified cooperation with countries in greatest need

There were no comments.

5.1.4 Resolution WHA48.7 - Revision and updating of the International Health Regulations

There were no comments.

5.1.5 Resolution WHA48.8 - Reorienting medical education and medical practice for health for all

There were no comments.

5.1.6 Resolution WHA48.9 - Prevention of hearing impairment

There were no comments.

5.1.7 Resolution WHA48.12 - Control of diarrhoeal diseases and acute respiratory infections: integrated management of the sick child

There were no comments.

5.1.8 Resolution WHA48.13 - Communicable diseases prevention and control: new, emerging and re-emerging infectious diseases

There were no comments.

Dr DURHAM (New Zealand) expressed concern that resolution WHA48.11 on an international strategy for tobacco control, had not been included in document WPR/RC46/19. The Regional Director's biennial report (document WPR/RC46/2) indicated that per capita tobacco consumption continued to increase in the Region. In her intervention during discussion of the report (item 7 of the Agenda), she had noted recent information that one in two smokers would die prematurely of tobacco-related causes - in fact some 14 years early on average. Further, it was projected that, at the beginning of the twenty-first century, lung cancer would overtake breast cancer as the leading cause of death from cancer among women in New Zealand. She had therefore proposed that the Region should contribute proactively to consideration of the feasibility of developing an international instrument for tobacco control - in the form of guidelines, a declaration or an international convention - and that the Regional Director should be requested to facilitate the regional contribution. Given the importance of tobacco control, it might be appropriate to consider a draft resolution to that effect under the item currently under discussion.

The REGIONAL DIRECTOR replied that in his introduction to the current discussion he had indicated that resolutions related to other items on the Agenda had been included in the documentation on those items. Accordingly, resolution WHA48.11 had been included under item 12.1, Country visits: Report of the Sub-Committee, Part I, and was reproduced, in part, in Annex 3 of document WPR/RC46/10. Further, the Regional Action Plan on Tobacco or Health for 1995-1999 had been presented to the Committee at its previous session. That Plan, together with certain other activities, would form the basis of the Region's contribution to subsequent plans and strategies at the global level.

Dr DURHAM (New Zealand) said that it was her understanding from the discussion at the previous Health Assembly that the development of an international instrument went beyond regional plans of action. She did not recall that the Western Pacific Regional Action Plan on Tobacco or Health made any mention of consideration of the feasibility of such an instrument. The Committee might wish to consider the matter prior to the debate of a feasibility study, which she understood was to be submitted to the next World Health Assembly.

The REGIONAL DIRECTOR recognized the concerns expressed by the previous speaker and assured her that the Director-General would pursue resolution WHA48.11 as requested in consultation with his staff at headquarters and in the regional offices and with Member States. It might therefore be inappropriate for the Region to initiate its own action in that regard. However, he would certainly follow up the matter in due course.

EB 96.R1 - Amendments to Articles 24 and 25 of the Constitution: Increase in membership of the Executive Board

The CHAIRMAN invited the Regional Director to explain the position.

The REGIONAL DIRECTOR said he would like to draw the Committee's attention to resolution EB96.R1 requesting the Director-General to propose draft amendments to the Constitution for the consideration of the Forty-ninth World Health Assembly. Those amendments would increase the membership of the Executive Board from 32 to 33. Such a decision would permit a subsequent increase from seven to eight in the number of Member States of the European Region entitled to designate a person to serve on the Board.

Should the above proposed amendments be ratified, the distribution of seats on the Executive Board would be as shown in the table on page 7 of the document.

The Director-General had referred to that situation the preceding day.

Considering that the Eastern Mediterranean Region, with 22 Member States, had five seats on the Board, the Western Pacific Region, with 27 Member States, had a strong case to propose an increase from its current number of four seats, to five. He believed that such an increase could be requested even though the Region's allocation had recently been increased from three to four seats on the Board.

The process of effecting such an increase was lengthy. Some representatives would remember that 11 years earlier, the increase from three to four had been requested by the Regional Committee in September 1984, under resolution WPR/RC35.R10. That request had been considered by the Executive Board at its seventy-fifth session, and forwarded to the World Health Assembly under resolution EB75.R4 of 15 January 1985. The Thirty-eighth World Health Assembly had agreed to the Regional Committee's request under resolution WHA38.14 of 14 May 1985.

The process of ratification took a long time. It was not until 11 July 1994 that the required two-thirds of the Member States had ratified the amendments to Articles 24 and 25 of the WHO Constitution that permitted a fourth member of the Executive Board to be designated from the Western Pacific Region. It had thus taken about nine years. At the time of the Regional Committee's request in 1984, the Western Pacific Region had had 20 members; it now had 27.

Given the length of time taken for ratification of the amendments last time, he urged all Member States to give that matter some attention, if not prompt attention, if such a request should come.

Mr SAKAI (Japan) said that in comparison with the representation of other regions on the Executive Board, the Western Pacific Region was obviously underrepresented in terms of its number of countries.

In addition, in terms of the population covered, the Western Pacific was even more underrepresented.

He therefore asked that a draft resolution be prepared requesting the World Health Assembly to increase the number of seats on the Executive Board from the Region.

Mr BOYER (United States of America) said he understood the purpose of the WHO Executive Board to be as a compact decision-making body working without the more cumbersome formality of the World Health Assembly; it formerly had 24 members, which

worked well. He was afraid that the increase to more than 30 was defeating that original purpose. The Board itself seemed to have recognized the difficulty, as it was forced to subdivide itself for various tasks. He did not wish to see a further expansion in the numbers on the Board, and preferred to see a redistribution of seats among members.

Dr TAPA (Tonga) said that he could not accept the United States' view.

The disproportion was a glaring anomaly, with, for example, the Eastern Mediterranean Region having 22 countries and five members, while the Western Pacific Region had 27 countries and four members.

He supported Japan's proposal.

Mr SAKAI (Japan), responding to the United States' comment, said that he doubted whether a smaller Executive Board could handle the increasing amount of work expected of it, but even if that solution was considered, the question of equality or equity of representation of regions would have to be solved. He suggested that consideration should be given to having a Board of 32 members, with seats divided equally between the regions, resulting in five members from each Region.

Dr RODGERS (Solomon Islands) supported Japan's proposal and agreed with Japan's suggestion of equal representation for all regions.

Mrs RUIZ (Philippines) supported Japan and Solomon Islands.

Mrs HONG TIY (Fiji) calculated that if the regions were to be represented on the Board according to the numbers of Member States, the number of countries represented by each member of the Executive Board would be seven.

The CHAIRMAN said that if it was the wish of the Regional Committee, in accordance with the Japanese proposal, he would request the rapporteurs to prepare a draft resolution.

Mr BOYER (United States of America) asked whether, on a point of order, as there was no specific item on the agenda under which such a proposal would fall, it would be acceptable to prepare a resolution.

Mr VIGNES (Legal Counsel) said that the motion was acceptable within the context of item 20.1. A further question was whether, since amendments to the Constitution as the subject of resolution EB96.R1 were said to be intended to increase the membership of the Board to 33,

the Western Pacific Region was making a separate proposal, since it might be considered that the increase being sought by resolution EB96.R1 would not be sufficient.

He requested clarification of the representatives' intention in that regard.

Mr SAKAI (Japan) said that his main concerns were that the Western Pacific Region was underrepresented on the Executive Board and that the situation should be improved by increasing the number of Member States of the Region entitled to designate a person to serve on the board from four to five. How that was to be achieved was another matter, and one that would need to be considered by the World Health Assembly in due course. The options appeared to include increasing the total number of members to 34, and redistributing the existing 32 or proposed 33 seats.

Dr ENOSA (Samoa) supported the call for an increase from four to five seats but, like the representative of the United States of America, wondered whether the Regional Committee was the correct forum in which to discuss a request for such an increase. If not the discussion should be closed.

The REGIONAL DIRECTOR said that the Committee was discussing the question of correlation of the work of the World Health Assembly, Executive Board and Regional Committee. The Executive Board had proposed an increase in the number of seats from 32 to 33 and that the Constitution should be amended accordingly. Therefore, in his view, the Regional Committee could legitimately discuss the number of seats under that agenda item. The Committee's wish appeared to be to increase from four to five the number of Member States of the Western Pacific Region entitled to designate a person to serve on the Board. It was his opinion that the Committee was entitled to request such an increase. Representatives had not proposed any change to the Constitution. Consideration of the way such an increase might be achieved was, of course, the prerogative of the Executive Board and the World Health Assembly.

Dr RODGERS (Solomon Islands) suggested that the arguments put forward in the draft resolution on regional allocations (document WPR/RC46/Conf. Paper No. 3) might form a useful basis for the wording of a draft resolution requesting an increase in the number of Board seats.

Dr TAPA (Tonga) supported Japan's proposal that the number of seats allocated for Member States of the Western Pacific should be increased from four to five. That proposal had made no mention of changes to the Constitution. He suggested that the wording of a draft resolution requesting such an increase should be similar to that employed in resolution WPR/RC35.R10, in which the Regional Committee had made a recommendation to the Executive

Board, and through it to the World Health Assembly, that consideration should be given to increasing the number of Member States of the Western Pacific Region entitled to designate a member of the Board from the then three to four.

The CHAIRMAN requested the Rapporteurs to prepare a draft resolution.

5.2 Consideration of the agendas of the World Health Assembly, the Executive Board and the Regional Committee: Item 20.2 of the Agenda (Document WPR/RC46/20)

The REGIONAL DIRECTOR stated that document WPR/RC46/20 showed the relation between the Committee's current agenda and items to be discussed at the forthcoming sessions of the Executive Board and the World Health Assembly. The full draft provisional agendas were shown in Annexes 2 and 3. The correlation was presented for the information of the Regional Committee, and to provide an opportunity for comment on any of the agenda items mentioned there.

Dr BLEWETT (Australia) said that the implementation of WHO reforms, the global change strategy and the programme budget adopted in May 1995 would have a considerable impact on WHO staff, particularly at headquarters. His Government considered that great sensitivity and an open and consultative approach would be required if the objectives were to be achieved without damage to staff morale and confidence. In his personal capacity as an Executive Board member he concurred with that view. Day-to-day staff management was of course, not a matter for the Board but the general morale and confidence of WHO staff was, and the Board should give due attention to that at its next session. At the January 1995 session, the usual statement by the representative of the WHO staff association had been placed well down the agenda and there had been no time for discussion. He would therefore propose that item 13 of the draft provisional agenda for January 1996, Statement by the representative of the WHO staff associations, should be raised under item 4.5, personnel policy. In the past, copies of the statement had only been made available following the oral presentation. Because of the importance of the issue at a time of change and challenge, he would propose that it should to be circulated to Board members prior to the session, together with the usual Board documentation. He was not suggesting any action by the Regional Committee but considered it important to inform representatives of his concerns and the proposals he intended to make.

The REGIONAL DIRECTOR said that, in the absence of any objections, he would assume that the Regional Committee had endorsed the concerns just expressed and would wish him to convey them to the Director-General. He would raise the matter at the forthcoming meeting of

the Global Policy Council which would discuss in detail the agenda for the January 1996 session of the Executive Board.

Dr BLEWETT (Australia) thanked the Regional Director for that assurance.

6. SELECTION OF TOPIC FOR THE TECHNICAL DISCUSSIONS TO BE HELD IN CONJUNCTION WITH THE FORTY-SEVENTH SESSION OF THE REGIONAL COMMITTEE: Item 21 of the Agenda (Document WPR/RC46/21)

The REGIONAL DIRECTOR announced that, following the closure of the session, the Technical Discussions would be held on the topic "Occupational health risks in the workplace".

In the meantime, the Committee should select a topic for the Technical Discussions in conjunction with the forty-seventh session. Document WPR/RC46/21 contained three proposals for consideration which were: quality of life; health systems reform; and reducing maternal and infant mortality.

The Committee was, however, free to propose alternative topics. In May 1994, the Executive Board had decided, in its resolution EB94.R2, that from the Forty-ninth World Health Assembly in 1996, and on a trial basis, Technical Discussions would be replaced by a limited number of well-organized technical briefings and by informal forums for dialogue. That decision had been endorsed by the Forty-eighth World Health Assembly in its resolution WHA48.17. The Committee might wish to consider following that example.

Mr BOYER (United States of America) said that the idea of the Technical Discussions was to set aside time during the session for a less formal discussion of a selected topic. However, recent Technical Discussions held during World Health Assemblies and Western Pacific Regional Committee sessions had not been particularly well attended, perhaps in the latter case because they were scheduled after the work of the Committee had been completed. The Committee should follow the lead given by the World Health Assembly, and replace Technical Discussions with one or more technical briefings given by a staff member or outside expert, which could be scheduled at times that would attract greater participation, for example during the lunch break or for one or two hours during or immediately after working hours. Many delegates had found the new arrangements at the World Health Assembly to be both more interesting and more useful than Technical Discussions. He pointed out that the Region of the Americas had also stopped holding Technical Discussions. He therefore proposed that the Committee should adopt a suitable schedule of technical briefings for a trial period.

Dr BLEWETT (Australia) supported that proposal.

Dr TAUFA (Papua New Guinea) also supported the proposal but suggested that subjects other than those listed as possible topics for Technical Discussions should be considered.

Dr TAPA (Tonga) supported the proposal with the proviso that it was on a trial basis only. He asked whether it would be appropriate to initiate new arrangements at the next session, which would not be held at the Regional Office.

Dr RODGERS (Solomon Islands) supported the proposal, which would enable more than one topic to be covered at each session. He suggested that any change in the arrangements should be considered in conjunction with a review of country visits, the size of the Sub-Committee and the resolutions adopted in relation to item 12 of the Agenda. Technical briefings, particularly by outside experts, might render country visits unnecessary. Alternatively, the report of a country visit by a small team might form the basis of a technical briefing, which might in turn permit a reduction in the size of the Sub-Committee.

Dr Young-Soo SHIN (Republic of Korea) endorsed the general support for a change and suggested that, when sessions were held outside the Regional Office, it might be interesting to choose topics covering priority issues for WHO that were of particular relevance to the host country, which in the case of the next session was his own. During informal conversations with representatives of Australia, which would host the session in 1997, he had learned that they too would be interested in such an arrangement.

The REGIONAL DIRECTOR noted that the discussion had resulted in some interesting suggestions but said that he would appreciate some guidance on how best any new arrangements might be scheduled, and whether the half day currently given over to the Technical Discussions should be utilized for the proposed briefings, or saved. He suggested that the host countries, for the next two years, in consultation with the Regional Office, might select a topic of interest in place of the technical discussion. If acceptable, the briefing would be scheduled. The fact that representatives received a number of lunch and dinner invitations during Regional Committee sessions should be taken into consideration.

Dr Young-Soo SHIN (Republic of Korea) said his Government would be happy to collaborate with the Regional Director to arrive at a suitable schedule. It might, for example, be possible to arrange a working lunch that would incorporate a technical briefing.

Mr BOYER (United States of America) welcomed the interesting ideas proposed. However, it was becoming clear that for sessions held away from the Regional Office, additional

consultations between Regional Office staff and the host country would be needed to ensure suitable arrangements.

The CHAIRMAN requested the Rapporteurs to prepare a draft resolution.

<u>The meeting rose at 4.55 p.m.</u>