World Health Organization
Organisation mondiale de la Santé

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Ninety-seventh Session

EB97/SR/1
15 January 1996

PROVISIONAL SUMMARY RECORD OF THE FIRST MEETING

WHO Headquarters, Geneva
Monday, 15 January 1996, at 9:30

Chairman: Professor LI Shichuo

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Note

This summary record is **provisional** only. The summaries of statements have not yet been approved by the speakers, and the text should not be quoted.

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The final text will appear subsequently in **Executive Board, Ninety-seventh session: Summary records** (document EB97/1996/REC/2).

FIRST MEETING

Monday, 15 January 1996, at 9:30

Chairman: Professor LI Shichuo

1. OPENING OF THE SESSION: Item 1 of the Provisional Agenda

The CHAIRMAN declared open the ninety-seventh session of the Executive Board and welcomed all participants. He took it that, in the absence of any objection, the Board would wish Dr Hamadi to assume the office of Vice-Chairman in the place of his predecessor, Dr Zahi.

It was so decided.

2. ADOPTION OF THE AGENDA: Item 2 of the Provisional Agenda (Documents EB97/1 and EB97/DIV/9)

The CHAIRMAN indicated that items 10.2, 12 and 15.3 should be deleted from the provisional agenda in document EB97/1.

Dr LEPPO welcomed the provision of a preliminary daily timetable, contained in document EB97/DIV/9, as being a helpful innovation. He was concerned that the subject of personnel should be discussed as a whole and asked how that could be achieved, given that personnel policy (item 4.5 of the provisional agenda) was scheduled for discussion on Tuesday, 16 January, whereas the statement by the representative of the WHO Staff Associations and personnel matters (items 14 and 15, respectively, of the provisional agenda) were expected to be discussed on Tuesday, 23 January.

Dr PIEL (Cabinet of the Director-General) said that the Board could raise specific personnel matters during its broad discussion of personnel policy and vice versa.

The agenda, as amended, was adopted.

3. PROGRAMME OF WORK

The CHAIRMAN, announcing the dates and times of meetings, said that three days had been allocated to the review and evaluation of specific programmes by subgroups of the Board. He proposed that subgroup meetings should be open only to Board Members and their alternates and advisers, together with Secretariat staff whose direct participation was requested, and to representatives of Member States who might wish to attend in the diplomatic gallery.

It was so decided.

Dr BOUFFORD, supported by Dr DEVO, suggested that the time expended by the Board on programme reviews could be shortened by half a day in order to leave more time for discussion of core agenda items.

Dr PIEL (Cabinet of the Director-General) said that various options would be considered to that end.

4. STATEMENT BY THE DIRECTOR-GENERAL

The DIRECTOR-GENERAL expressed his sadness at the tragic loss of three world leaders, Yitzhak Rabin of Israel, Dame Nita Barrow of Barbados and François Mitterrand of France, who had each worked to promote peace, international understanding and cooperation. On behalf of all, he offered his condolences to their families and friends.

Illustrating his comments with overhead projections, he said that over the past three years, WHO's reform had concentrated on structures and procedures, priority being given to enhancing coherence, efficiency and accountability. During the first phase of reform, determining the main course of action (mainstreaming) had been the rule in all programmes and activities. Having designed and put in place improved management tools, which would have to be evaluated and adapted in the light of experience, the next task was to rally the necessary human resources and the social and political support to ensure that reform could succeed and be sustained.

Achieving health for all with the participation of all, based on the principles of equity and solidarity, required more than good managerial procedures. It required the development of new health partnerships, open to all sectors of society, allowing for the broad and equal participation of all, in a spirit of mutual respect and responsibility.

Most Member States were having to operate within tight budgetary constraints, with potentially serious consequences for their own public services. International agencies had to share that burden, especially through making savings and setting priorities. The budgetary crisis experienced by so many governments and, as a consequence, by all United Nations agencies, provided an opportunity to raise some fundamental questions about WHO's vision of international cooperation, global governance and solidarity for health. How those questions were answered would determine the vision of WHO and its future. His own vision was that access to health care and services was a human right; that the commitment to achieving health for all had to be renewed in spite of economic uncertainty; and that the contract with the peoples of the world had to be honoured through new health partnerships.

Far-reaching changes were taking place in disease profiles, population trends and the social, political and economic environment of health work. At the same time, the number and types of institutions involved in international health work were constantly increasing, while WHO itself was operating within severe financial constraints. In the face of changing demands, WHO had done its utmost to preserve its inclusive approach to health and to emphasize the continuity between prevention, care, rehabilitation and health promotion for all people through the different stages of their lives. Health care coverage had improved in respect of immunization, child care, family planning, control of diarrhoeal diseases, acute respiratory infections and essential drugs. The eradication or elimination of specific communicable diseases, including poliomyelitis, leprosy, dracunculiasis and measles, was going well and targets would be achieved by the year 2000. The revolution in information technology and services, with electronic mass media and information highways providing universal and non-selective health information, while raising health awareness, was not without its negative effects. Increased international trade and marketing in food had, in general, improved nutritional status worldwide, although the effects of marketing some commodities had been negative. New and old communicable diseases posed problems: there had been outbreaks and epidemics of plague, Ebola, cholera, dysentery, hepatitis B and C, HIV/AIDS and sexually transmitted diseases. Population structure was changing, with an increasing proportion of the elderly. Flows of refugees and migrant workers, along with increased international travel, all contributed to greater population movement. There had been environmental changes regarding water resources, sanitation including solid waste, chemical and nuclear substances, and air and water pollution. There had also been climatic changes. The development of diagnostic, curative and rehabilitative technologies had been unbalanced, and there had been misuse, abuse and non-rational use of drugs. Lifestyles had changed; more women and young people were using tobacco, and the problems posed

by alcohol, drugs, food, accidents, violence and suicide were also of concern. Finally, both developed and developing countries were experiencing a serious health-financing crisis.

The world needed a global intergovernmental organization which could act as an honest broker for information exchange, dialogue and cooperation on all health matters involving governments, communities, health professions and institutions, nongovernmental organizations and businesses; carry out impartial assessments of health needs, policies and technology; and be in a position to set and harmonize ethical and technical standards, helping countries to formulate their health policies and to monitor health-related products and practices. In that connection WHO must take full advantage of its links with the other parts of the United Nations system. Its mission should be to support Member States in formulating, implementing and evaluating health policies; to ensure technical cooperation with Member States to help them build and strengthen their own capacity for health development; to set ethical and technical standards in support of national health policies; to ensure global accountability for health, including strategy monitoring and evaluation; to collect, validate and disseminate information on health-related research, products and activities; and to ensure the effective promotion and coordination of international health work, including resource mobilization and the creation of health partnerships in support of health for all.

The constitutional provisions relating to WHO's mission had been supplemented by the commitment entered into at the Alma-Ata Conference in 1978 to achieve health for all by the year 2000 through primary health care. That commitment had necessitated reforms both in WHO and in Member States. Recently such reforms had had to be carried out by many Member States at a time when the changing circumstances of the post-Cold War period had given rise to democratization, the observance of human rights, a transition to a market economy and a certain degree of regionalization. All those factors had had an effect on the work done by WHO in setting and coordinating international technical and ethical standards in health matters and in promoting technical cooperation among Member States, especially among developing countries.

WHO's overall global programme was largely based on normative activities, but it was also concerned with policy and strategy development. Individual global and intercountry activities included programmes and initiatives for malaria, tuberculosis, emerging diseases, vaccine and immunization, drug action, the eradication of leprosy and poliomyelitis, the provision of safe drinking water in Africa, food regulation, an intergovernmental forum on chemical safety, onchocerciasis and other tropical diseases, human reproduction, and AIDS.

As a reflection of the acute financial crisis, the resources which WHO derived from voluntary contributions now more or less equalled those derived from assessed contributions. The Board would have to review how the Organization should face up to current and future realities, bearing in mind the possibility of mobilizing certain new resources, both human and financial. Much information on health matters was being provided to other organizations and institutions and to governments and the general public, and was currently accessible to all through the Internet. The Organization's technical resources were focused mainly on disease control and public health infrastructure programmes, as well as on policy formulation and management and evaluation.

The difficulties involved in sustaining policies for the achievement of health for all by the year 2000 and in removing the obstacles encountered in reducing illness and premature deaths were well known. They included the economic recession and inadequate health infrastructures, and human resource constraints, especially in developing countries; the cost and inappropriate use of new technologies; the opportunities and problems associated with the information explosion; the lack of awareness or actual denial of global change; the lack of political commitment at central, provincial and district levels; the diversion of resources to political priorities, including complex emergencies; and emerging diseases. In order to cope with that situation, the Organization had developed a strategic orientation covering health and development, including the eradication of poverty; the rational use and application of technology; health information for all; a general mobilization of resources and actors in new partnerships; and health system development based on primary health care.

International cooperation must be extended to all people and countries in order to promote peace and social development. It should be based on equal partnership and be conducted in a spirit of mutual respect and responsibility. It should aim at fostering peoples' and countries' independence and their ability to develop and sustain their own resources and human potential. Emphasis should therefore be placed on self-

help and capacity-building, especially through technical cooperation among developing countries and the exchange of information and experience between people. At the local and national levels in particular, people must be recognized as partners in their own right and empowered to become actively involved in health development and priority-setting. In that spirit, WHO must establish new partnerships for health that would give the public in all countries a sense of ownership of the Organization, its objectives and programmes. WHO must open itself up to all sectors of society, including nongovernmental organizations and the private sector. Those new partners would bring new challenges, but by meeting them WHO could significantly enhance its ability to mobilize social, political and therefore financial support for health development and international health cooperation.

Mainstreaming had been the managerial answer to the Organization's strategic dilemmas. It had made it easier to focus on priorities, to coordinate cross-sectoral activities and to pool human and financial resources. It had also improved cost-effectiveness and complementarity of action and had reduced the risks of duplication at the various levels of WHO's decentralized structure. When restructuring programmes and activities, the main concern had been to meet the most pressing needs in the following order of priorities: (1) those which presented a health emergency; (2) those which affected the poorest countries and the most vulnerable groups; (3) those which produced the heaviest burden of death, suffering and disability; and (4) those which represented a major impediment to social and economic development.

The restructuring of WHO's programmes and staff had been achieved in close consultation with senior management both at headquarters and in the regions and with the participation of all concerned. Its implementation would require a considerable effort to clarify programme objectives and the setting of quantifiable targets against which performance and outcomes could be evaluated. The restructuring process had been an extremely painful exercise for all which had caused justifiable anxiety and frustration among all staff members, including those who had responded wholeheartedly to the challenge of reform, working extra hours and days to ensure that ongoing activities and support to countries would not suffer. In fact, WHO's staff had done some remarkable work and had shown great dedication in very difficult circumstances.

The Organization's approaches and partnership arrangements emphasized solidarity and equity, equal partnership and mutual respect, mainstreaming and prioritization, securing governmental commitment in health matters, enhancing cooperation and coordination with other United Nations agencies, international organizations and nongovernmental organizations, and establishing new alliances with civil society, including the private sector and health-related industries. In that connection, programmes had been directed to focus more particularly on the control and eradication of major diseases and epidemics of global implication; nutrition for food security and safety, in close cooperation with the World Trade Organization and other United Nations agencies; continuous health-situation and health-status monitoring; health ethics and quality of care; health research, on which a very interesting proposal had been put forward for consideration by the Board; development-oriented environmental health systems; health care systems to meet societal changes and problems such as mental health, substance abuse and violence; building new health care systems to meet economic reality and social demands and needs; new health care strategies to meet changes in population structure and population movements, including components for reproductive health, family health, women's health, adolescent health, industrial health and the health of the elderly; health care system financing and infrastructure to meet new urban and rural development, especially in developing countries; and health systems to meet emerging diseases and complex emergencies.

As far as the 1998-1999 programme budget was concerned, the Programme Development Committee had recommended that priority should be given to the eradication of specific communicable diseases; the prevention and control of other specific communicable diseases, including emerging diseases and the most burdensome diseases; the promotion of primary health care, including family health, women's health, reproductive health, essential drugs, vaccines, nutrition, and the development and application of relevant knowledge and technology; the promotion of healthy behaviour, with emphasis on school health as an integral part of primary health care; and the promotion of environmental health, especially community water supply and sanitation. The Board's guidance in respect of those matters would be greatly appreciated, since it was important that WHO should be accountable to both donors and Member States, especially those which really needed its services. The extent of the Organization's commitment to health as a human right, to democracy and to solidarity and equity would be reflected in the type of partnerships it entered into and in

the kind of programmes it established, bearing in mind that health for all would be achieved only with the active participation of all concerned.

Professor BERTAN thanked the Director-General for his comprehensive report but felt that more emphasis might have been placed on health economics and the need to consider cost-effectiveness at every stage of operations.

5. REPORTS OF THE PROGRAMME DEVELOPMENT COMMITTEE AND THE ADMINISTRATION, BUDGET AND FINANCE COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (documents EB97/2 and EB97/3)

Dr DEVO (Chairman, Programme Development Committee) reported that the Programme Development Committee (PDC) had met from 9 to 11 January 1996. One day had been devoted to a joint meeting with the Administration, Budget and Finance Committee (ABFC). He would restrict his comments to those matters which had been discussed by PDC but would not be considered elsewhere under the Board's Agenda.

In discussing the assignment of programmes to Executive Board members, PDC had recognized that the development in individual members of familiarity with specific programmes and with the functioning of the Organization would benefit the Board as a whole, but had expressed concern that such involvement might lead to distortions unless common criteria and evaluation procedures were developed to ensure consistent and uniform reporting to the Board. Another option would be to replace the programme reviews by subgroups of the Executive Board by in-depth reviews by PDC at each of its sessions. PDC had recommended that the Board should consider that option during its discussion of the outcome of the programme review process at the current session.

Resolution WHA47.14 had called for the introduction of a provision for a time-limit for the validity of all resolutions, both retroactively and prospectively, in order to streamline and update the work of the governing bodies. PDC had proposed that a summary document should be prepared listing the relevant resolutions and their reporting requirements. Following an internal review, the Secretariat would make proposals to PDC concerning those resolutions for which reporting requirements could be discontinued. PDC had recommended that the Board should determine for which resolutions reporting requirements should be discontinued, on the basis of a review by PDC of the Secretariat's analysis.

In considering methods for evaluating the work of PDC and AFBC, in pursuance of resolution EB93.13, PDC had proposed that a small working group composed of the Chairmen and Secretaries of PDC and ABFC and two members of the Board should be established to develop suitable approaches and criteria. The results of the evaluation would be presented in 1998-1999, once the guidance had been reviewed by the Committees and the Board. PDC had re-emphasized that the evaluation criteria should be directed towards improving efficiency, which was the intention of resolution EB93.13. For example, the evaluation should ascertain whether the duration of Board sessions had been reduced as a result of the work of the two Committees. Strict criteria would allow a meaningful revision of the terms of reference of both Committees in the light of experience. Members of the working group should communicate mostly by correspondence in order to keep costs to a minimum. PDC had recommended that the Board should instruct both Committees to develop specific criteria and finalize methods for the evaluation of their work by January 1997.

Dr NGO VAN HOP (Chairman, Administration, Budget and Finance Committee) reported that ABFC had met on 10 and 11 January 1996, one of the two days being devoted to a joint meeting with PDC.

In reviewing WHO procurement policy, ABFC had noted the efforts made by the Organization in regard to expanding local purchases and using modern technology to streamline the supply process. It had welcomed the intention to reduce the duration of the supply cycle and had agreed with the suggestion that procurement issues should be taken into account early in programme planning. The Committee had therefore recommended that the Board should request the Director-General to study the alternative approaches outlined

in paragraph 16 of its report (document EB97/3) with a view to developing a more proactive and supportive approach to supply services.

The other matters covered by ABFC would be considered by the Board under other agenda items.

Dr REINER regretted that as the reports of the two Committees had only just been made available to Board members, it had not been possible to study them thoroughly. He suggested that, as a way of overcoming the problem, PDC and ABFC should meet well in advance of the Executive Board.

Professor BERTAN, supported by Dr BLEWETT, recalled that the decision to schedule sessions of PDC, ABFC and the Executive Board in close succession had been taken in order to reduce costs. Perhaps the Board could consider the issues concerned at the beginning of the second week of its session, to allow members sufficient time to study the documentation.

Dr PIEL (Cabinet of the Director-General) gave an indication as to when the items covered in the reports of PDC and ABFC (documents EB97/2 and EB97/3 respectively) would be dealt with under the Board's agenda. For those matters that would not be considered by the Board, members might wish to proceed straightaway to consideration of the recommendations of the two Committees.

Dr BOUFFORD suggested that consideration of the recommendations should be deferred to allow Board members adequate time to study the documentation.

It was so agreed.

6. **WHO REFORM AND RESPONSE TO GLOBAL CHANGE:** Item 4 of the Agenda (document WHA48/1995/REC/1, resolution WHA48.15)

REPORTS OF REGIONAL DIRECTORS: Item 4.1 of the Agenda (documents EB97/DIV/3, EB97/DIV/4, EB97/DIV/5, EB97/DIV/6, EB97/DIV/7 and EB97/DIV/8)

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) said that the Regional Committee for the Eastern Mediterranean had discussed quality assurance of health care within the primary health care approach, and a dialogue had begun with Member States on the implications of broadening the focus of quality assurance from its more traditional context of pharmaceuticals and laboratories to the newer areas of services and primary health care.

Member States considered that in view of technical and economic considerations it was time for ethical values in medical practice to be strengthened; to permit thorough discussion of the subject, he had been requested to organize a meeting to which representatives of religious authorities and physicians and other health workers would be invited. There was already an impetus in the Region to develop a code of health ethics, and he wished to invite interested parties from other areas of the world to participate in that undertaking.

Resurgent malaria in several countries of the Region gave rise to concern, but he was pleased to say that 11 countries were reporting no cases of poliomyelitis. The Region was following closely the evolving UNAIDS programme, with most of the WHO representatives having been nominated to chair their respective country theme groups. The Regional Committee had also called for more balanced regional representation on the governing bodies of UNAIDS. The Region had taken the initiative regarding emerging diseases, having recently hosted a major international meeting on the subject.

Priorities in the Region remained the development of human resources, with particular attention to the training of nurses and other paramedical personnel, and the use of national languages in medical and paramedical education.

There was excellent collaboration with UNICEF, great attention being given to the monitoring of joint achievements with respect to mid-decade goals.

Developmental needs in terms of the basic minimum needs for development and the quality-of-life concept had expanded both among and within countries of the Region, 11 countries having embarked on basic developmental needs programmes, albeit at different rates. Replicability was crucial to such programmes, and replication of basic developmental needs schemes was increasing. Replication had taken place in both urban and rural settings with many and varied partners, including local nongovernmental organizations, United Nations bodies such as UNICEF in Egypt and Jordan, IFAD in Somalia and UNDP in Morocco, as well as universities and medical schools; the number and range of such partners was expected to increase.

Technical cooperation between countries especially with respect to the areas of basic developmental needs and primary health care, was growing. Missions and study tours had considered the achievements of countries with special experience in those areas, and the successes of the Islamic Republic of Iran and Jordan had led to consideration of the establishment of regional training centres for primary health care and for basic developmental needs respectively in those countries. The Regional Centre for Environmental Health Activities had proved itself to be a respected technical resource, with its computerized information network serving as a model for many Member States of the Region.

Stagnation of the regular budget meant that increased efficiencies were being pursued, with expenditure being repeatedly examined for its relevance to programmes, and reduced. The point had been reached where programme growth would very soon be largely dependent upon extrabudgetary resources. Donors, however, were looking increasingly at expenditure and overheads and at programme support costs, and it might be worth reviewing that change of focus sooner rather than later in order to be in the best position to compete for available resources. The manner in which technical expertise was made available to Member States should also be re-examined; for example, greater use could be made of the Region's relationships with collaborating centres of excellence.

Although the reorientation of resources from global and interregional activities to those in countries was not scheduled to occur until 1998-1999, he wished to promote the idea of using those funds for the final push to eradicate poliomyelitis in countries that were found at the time to be lagging behind schedule. It would be an achievement on the part of WHO deserving the fullest support.

Finally, he informed the Board of the generous gift by the Government of Egypt of land in Cairo for the construction of a new Regional Office. More details would be available for discussion under item 13 of the Board's agenda dealing with the Real Estate Fund, but he wished to urge the Board to give favourable consideration to an adequate allocation from that Fund to enable the project to be undertaken and completed.

Dr HAN (Regional Director for the Western Pacific) introduced his report in the context of the policy framework, document "New horizons in health", which constituted the basis for renewal of the regional "health-for-all" strategy, and which had been made available to the Executive Board at its ninety-fifth session. He said that the health situation in the Region requires WHO to be responsive to well-recognized problems and to be prepared to react quickly to the resurgence of disease and to newly emerging problems. There were, therefore, task forces for cholera control and also to cope with emergency requests related to other urgent disease outbreaks or crises, such as the recent epidemic of dengue haemorrhagic fever in Cambodia. Experience had shown that there was an important support role to be played by headquarters and other regions.

The Region was now practically free of poliomyelitis, with only 11 wild poliovirus-associated cases being reported in 1995, all of them in the Mekong Delta region of Viet Nam and Cambodia; it was expected that wild poliovirus would be completely eradicated from the region within the next two years.

It was essential for regional interventions to be country-sensitive and issue-specific. There was a regional policy for the elimination of leprosy as a public health problem by the year 2000 involving multidrug therapy; although the prevalence had dropped to 0.25 per 10 000 people, well below the elimination target set, the reality was that there were still countries and areas within countries with levels which the average figure did not reflect, and the challenge was to identify why those areas still had a high prevalence of leprosy and to implement activities to improve the situation through specialized projects.

WHO had been very active in the field of women's and family health. Maternal mortality rates in Cambodia, the Lao People's Democratic Republic, Papua New Guinea and Tuvalu were still higher than the regional target of 300 per 100 000 live births, which itself was too high and which the Region was considering lowering to 100 per 100 000 live births; in that case the Philippines and Mongolia could also be considered as target countries for intensified action. Likewise, the infant mortality rate was above the regional target of 50 per 1 000 live births in 10 countries of the Region, and it was regarded as an important area for concerted action with partners such as UNFPA.

Relationships with funding partners and other collaborating groups were crucial to the achievement of results, and discussion of the ideas expressed in "New horizons in health" was helping to bring together that coalition of forces. Governments in the Region were already using the document, and some had already incorporated aspects of its policy framework into their long-term plans; others were considering doing so. The Declaration resulting from the Conference of the Ministers of Health of the Pacific Islands, held in Yanuca Island, Fiji, in March 1995, had been given top-level political support in each of the 14 participating countries. Following the Conference, the Region planned to implement "healthy-islands" projects in conjunction with the Governments of Fiji, Niue, Papua New Guinea, Samoa, and Solomon Islands.

There was a need to focus activities further on priority health issues, and the Regional Office was therefore endeavouring to restructure programmes and staff resources to meet the requirements of Member States. That would require a radical approach which amounted to a "re-engineering" of the Region. The Region had to ask itself what it should be focusing on, what resources it needed, and how it should be structured to meet those needs; some very hard decisions would be required. Some programme areas would be markedly reduced in order to address the new priorities; others would require expansion and the appropriate personnel.

Dr SAMBA (Regional Director for Africa), referring members of the Board to his report in document EB97/DIV/4, said that he would focus on what had been done in the African Region to address the recommendations of the Executive Board Working Group on the WHO Response to Global Change. Fifteen of the 47 recommendations had been identified as being of particular relevance to the African Region.

In connection with recommendation 18, all senior staff had been urged to pursue closer cooperation with WHO headquarters in order to improve policy planning by setting out clear priorities. Such cooperation was facilitated by direct contacts, where possible, between the staff of the Regional Office and that of headquarters.

With regard to recommendation 21 on personnel matters, staffing procedures had been reviewed and recruitment was carried out in strict accordance with the relevant rules - namely, publication of information on vacant posts and establishment of a selection committee to consider applications on the basis of competence and bearing in mind equitable geographical distribution and gender. He had asked certain national authorities to refrain from applying political pressure, and was pleased to say that those efforts had borne fruit.

In the context of recommendation 22, the Regional Office was preparing an inventory of technical experts in Africa to assist in selecting consultants, establishing review committees, and the like.

The recommendations on WHO country offices had been duly noted, and the Regional Office was firmly committed to implementing them. In connection with recommendation 25, the performance of WHO Representatives was being improved by selecting them for technical, managerial and diplomatic competence and giving them the necessary support. In response to recommendation 26, regular training of WHO Representatives was to be intensified and was being carried out in close collaboration with WHO headquarters, UNDP and the World Bank. Concerning recommendation 28, more authority had been delegated to WHO Representatives in such areas as recruitment and fund-raising and they were being encouraged to take initiatives more often. In connection with recommendation 30, alternative forms of WHO representation at the country level, where relevant, were being explored with Member States.

Turning to the recommendations on communication, specifically recommendation 29, he said that communication within the African Region had been greatly improved. A satellite system had been installed to facilitate telephone contacts and e-mail was in use and would be extended to as many countries in the

Region as possible. In the context of recommendation 45, the capability to use modern communication techniques to facilitate health promotion and disease prevention was being improved.

Regarding recommendation 41, an inventory of centres of excellence was being drawn up with a view to increasing the number of collaborating centres; work with existing centres was being intensified. In line with recommendation 42, research activities were being included in major programmes. Special attention was given to priority health areas, with particular reference to primary health care and health for all.

In connection with recommendation 27, the Regional Office and WHO Representatives were supporting governments in coordinating in a sustained manner health inputs from multilateral, bilateral and nongovernmental organizations. In pursuance of recommendations 32 and 33, he had been in contact with the heads of all United Nations agencies, especially those working in the fields of health and emergency situations, in order to improve collaboration with them.

The budgetary constraints had not made things easy. Staff numbers at the Regional Office had been reduced and cash payments for overtime replaced with compensatory time off. Efforts had been made to privatize, where relevant, the activities of the Regional Office. Country performance regarding staff quantity and quality had improved overall, as demonstrated by greater support for normative functions and technical cooperation, and especially preparedness for and control of epidemics.

Dr ALLEYNE (Regional Director for the Americas) said that in the Region of the Americas the reform process was regarded as a continuous one rather than as an end in itself; interested members could be provided with documentation on the regional response to each of the recommendations made by the Executive Board Working Group on the WHO Response to Global Change.

A major component of the Region's managerial strategy was to have the entire Pan American Health Organization become truly involved in achieving overall objectives. That goal was to be achieved by ensuring the provision of adequate information on local situations, communicating decisions throughout the Organization, and applying transparency and consistency in decision-making. As no mission of an organization could be crafted by the few for the many, he had begun his tenure by promoting the participation of all staff in defining PAHO's mission. The result had been an emphasis on technical cooperation with Member States and on collaboration among them so that, while maintaining a healthy environment and pursuing sustainable human development, the peoples of the Americas could achieve health by and for all.

Much effort had been devoted to renewing the call for health for all with an emphasis on the strategy of primary health care. PAHO had initiated consultations at all levels with the objective of rekindling enthusiasm for the basic principles of equity and social justice that had underpinned the original ideal of health for all; such efforts were to be intensified in 1996. As the Organization's mandate called for technical cooperation with Member States, an intensive process of redefining the approach to such cooperation had been launched. It was encouraging that representatives of governments, other agencies and other bodies within WHO itself had joined in that process.

In 1995, every effort had been made to ensure that the Strategic and Programmatic Orientations approved by the Pan American Sanitary Conference in 1994 would serve as the framework for health activities and programming. Those five orientations were all-important, and had been reflected in an adjustment of the Regional Office's structure. Five technical divisions had been created to deal with health and human development, health systems and services development, health promotion and protection, environmental protection and development, and disease prevention and control. In addition, a special programme on vaccines and immunization had been set up. In connection with the first division, whose title might raise questions as to how technical cooperation in that area could be implemented, he said the Regional Office considered that health was one of the five major indicators and components of human development, along with a healthy environment, economic growth, education, and human rights. It had set out to show that health had an important role to play in the quest for sustainable human development. The programme on women, health and development was part of that quest.

In order to enhance coordination in policy and practice, the Senior Management Committee had been reformulated as a Director's Cabinet and a Committee on Programmes in order to ensure better articulation of regional and country programmes. The American Region Planning, Programming, Monitoring and Evaluation System (AMPES) had continued to be improved, incorporating more fully the Logical Framework

for project formulation and management, for it was believed that only in that way could the basis for evaluation of technical programmes be established.

A series of seminars had been started to enhance the leadership and managerial capability of senior staff in order to prepare them to deal with the new challenges ahead. The Region's management of information had been rationalized: the data needed for corporate functions were being separated from data needed for technical cooperation in establishing local health systems and for providing information on health conditions in the countries of the Americas, with due emphasis always being placed on dissemination of information produced through the various media offered by new technology.

Turning to matters of technical cooperation, he said that in 1995 PAHO had carried out some of the activities assigned to it by the Summit of the Americas, held in Miami, Florida, in November 1994. Such activities included holding meetings on health sector reform and on environmental health and sustainable human development, the development of a regional plan of action for AIDS, and the follow-up to the decision taken by the wives of the presidents at the Summit to emphasize the health of children and women. On the occasion of World Health Day, PAHO had received a visit from Mrs Hillary Rodham Clinton, First Lady of the United States of America, who had pledged her Government's financial support for the partnership to eliminate measles in the hemisphere by the year 2000.

The year 1995 had been the fourth without poliomyelitis in the Region; measles was on the decline; and neonatal tetanus was disappearing. In the past three years, no new and confirmed case of measles had occurred in the Caribbean. In the past year, no case of measles had been transmitted to North America from South America or the Caribbean. That situation was the result of enormous efforts by the countries in the Region.

The elimination of *Triatoma infestans*, the major vector of the trypanosome causing Chagas' disease, was progressing as planned. The programme for eradication of foot-and-mouth disease had made significant strides, with Uruguay and many parts of Argentina and Brazil becoming free of the disease; that achievement had tremendous economic implications for those countries. PAHO had provided material and logistic support and helped mobilize external aid for countries afflicted by natural disaster, and was always ready to share its experience with others. The movement towards focusing on healthy communities as a geographical and political locus for health promotion had continued, together with efforts to strengthen the organization of local health systems. A programme on mental health had been received favourably by PAHO's governing bodies.

At the 1995 meeting of the Regional Committee, more women members of delegations had been present than ever before, and the meeting had been ably presided over by the Minister of Health of Panama, a woman. Perhaps the most important aspect of the meeting, however, was the explicit acceptance by Committee members of their fundamental role in the governance, not the management, of the Organization. It had been clear that they all regarded PAHO/WHO as *their* organization, and that all countries, large and small, had something to contribute to the common quest to improve the health of the American people. Excellent cooperation with many agencies had been achieved in 1995, and an interesting partnership instituted with the major financial bodies which should lead to better allocation of resources in the area of health.

Thus, the balance for 1995 was positive. True, financial restrictions had had to be faced and the necessary managerial processes introduced to deal with them. In that effort, and throughout the year's activities, the staff had responded magnificently. The Organization would have to continue to be alive to and adapt to political and financial currents, but he had no doubt that Member States and the Secretariat remained committed to the Region's collective venture in health.

Dr UTON RAFEI (Regional Director for South-East Asia) highlighted innovative actions taken jointly with Member States to address important health issues. In line with the reforms in WHO, the regional programme-budgeting process had been streamlined, the internal structure and workings of the Regional Office thoroughly reviewed and some changes made.

Encouraged by the discussions at the Regional Committee in 1994, he had initiated practical, action-oriented approaches to the health problems of Member States within the spirit of regional solidarity and cooperation. That initiative was being implemented through three major themes, converted into specific programme activities: advocacy for health development, technical cooperation among countries, and standard-setting and quality of health care. Endorsing that new approach, the Regional Committee had agreed in 1995

to the pooling of resources for an intercountry programme to be implemented in the 1996-1997 biennium and plans of action had been prepared. The least developed countries of the Region were being given high priority. He was confident that the spirit of solidarity among Member States would enhance the impact of WHO's health development activities in the Region.

The Regional Committee, at its meeting in 1995, had reviewed the progress made with the WHO response to global change and had expressed satisfaction with the measures adopted so far. The Committee had examined its own methods of work and had made several changes to improve efficiency. It had been suggested that members of the Executive Board designated by Member States from the Region should attend sessions of the Regional Committee to acquaint themselves with regional health development issues and to advise the Committee on significant policy issues emanating from the Executive Board and the Health Assembly.

The Regional Committee had requested an in-depth study of criteria for regional allocations from WHO's regular budget. He had convened an ad hoc working group of Member States which had reviewed the criteria, taking into account changing conditions throughout the world. It had made recommendations for more specific criteria taking into consideration the public health burden, the socioeconomic status of least developed countries, evidence of commitment to invest public resources in the social sector, and other factors. Those recommendations were now before the Executive Board. The working group had also recommended stronger advocacy for health in order to reach policy-makers in ministries of finance, planning, foreign affairs and other sectors and thus place public health higher on the agendas of national development.

There was strong agreement in the Regional Committee, the Consultative Committee for Programme Development and Management and other regional forums on the need to enhance the awareness of Executive Board members concerning issues of major concern to the Region, specifically the resurgence of malaria and tuberculosis, the need for greater cooperation to control epidemics in border regions, more effective disease surveillance, and timely exchange of information of relevance to public health. He strongly urged members of the Board to give full consideration to those recommendations.

The ministers of health of the South-East Asia Region at their annual meeting in September 1995, had agreed to cooperate in addressing health problems that required joint action, in providing opportunities for training and observation in health institutions of high quality, and in increasing advocacy for health through meetings of high-level officials in the health sector. The appointment of the Chairman of that meeting as Chairman of the Health Ministers' Forum for the ensuing year would increase the efficacity of that forum in implementing the decisions and recommendations of the ministers.

An informal consultation on renewal of the health-for-all strategy had been organized in August 1995. The health secretaries of the countries of the Region were to meet in January 1996 to reinforce the interface between the Regional Office and its Member States and a meeting of parliamentarians was planned in order to enhance political support, both with a view to supporting health development in the Region.

The strategic programme-budgeting exercise had resulted in the identification of priorities in Member States similar to those determined by the Executive Board at its ninety-fifth session - namely, eradication of some communicable diseases, prevention and control of specific communicable diseases, promotion of primary health care and related areas, environmental health, and reproductive, women's and family health.

In a visit to the Regional Office in June 1995 the External Auditor had made a broad assessment of internal controls in key areas and had performed substantive testing of a statistical sample of transactions in 1994, covering all sources of funds. He had made useful suggestions for strengthening the financial procedures for local cost subsidies and inventory control.

In the past, many of the countries of the Region had been obliged by their structural adjustment policies to reduce their activities or keep their allocations for the health sector static. In some countries, the heavy investment in health of multilateral financial institutions, notably the World Bank and the Asian Development Bank, was therefore welcome. The Regional Office had intensified consultation, cooperation, and understanding with those institutions and had helped Member States during their negotiations for credit by formulating projects that were technically sound, ensuring the quality of the development and evaluation of sector plans, and executing specific components of projects. The results of those efforts were reflected in the changing pattern of the flow of external resources in the health sector. Examples of the collaboration between WHO and the World Bank were large health and population projects in Bangladesh and India.

There was a strong commitment to eradicate poliomyelitis, by organizing national immunization days followed up by sustained immunization. The initial success of that approach in some countries had stimulated others to achieve the same goal.

His report in document EB97/DIV/6 described other actions of Member States for renewal of their health-for-all strategies and highlighted the steps being taken to strengthen the management of the Regional Office and WHO country offices so as to ensure maximal work output despite the difficult financial situation.

Dr ASVALL (Regional Director for Europe) noted that developments in the western part of the Region had generally been positive, except for health problems in central urban areas, to deal with which a programme had been established. In the eastern part of the Region, however, there were huge problems. Economic development in the countries of the former Soviet Union had continued to decline, with decreases of as much as 15% of the gross national product in 1994, which was creating an increasing health gap in the Region. In one Member State in the east of the Region, life expectancy had fallen rapidly and was now almost five years lower than it had been in 1970. There were now about eight less developed countries in a Region where there had been none a few years previously. There had been a dramatic effect on the prevalence of infectious diseases. In 1994-1995 WHO had supported the development of national plans to reduce the incidence of diphtheria, and that had had some effect in curbing the epidemic in 1995. It had been observed, however, that adults who had lived in areas with a low prevalence of diphtheria were - despite their childhood vaccinations - not immune to the challenge of a strong epidemic in children. WHO had therefore provided new guidance for the protection of adults in such situations.

The endemicity of poliomyelitis had remained at a low level in the Region. The lack of clear improvement had been due to continued infection in the countries in the south-east of the Region. Major action had therefore been launched jointly with the Eastern Mediterranean Region, and, in 1995, 63 million children in 18 countries (10 in the European Region) had been vaccinated. The campaign would be repeated in 1996 and 1997. There had been a poliomyelitis epidemic in one part of one country in the Region, in which there was armed conflict. That would require a specific solution. The Regional Committee had decided in September 1995 to undertake a special action programme to reduce communicable diseases.

The incidence of AIDS had shown little change; however, there had been an alarming increase in the prevalence of sexually transmitted diseases in some countries in the east of the Region. That increase indicated that there might also be an increased danger of AIDS transmission. The AIDS programme at the Regional Office had been severely curtailed at the end of the year, and the new UNAIDS programme would be unable to provide the same level of support to the countries of the Region.

Armed conflict had persisted in the Region. Humanitarian assistance in Bosnia had continued at the same level; however, the Dayton peace agreement had changed the role of WHO, and now a major reconstruction project was being developed. Cooperation with Croatia for the same purpose had also been expanded.

Health policy development had continued in 1995; about eight countries were developing new health-for-all policies. Those policies were increasingly being linked to the development of national master plans for development, particularly in the Newly Independent States and some central European countries, allowing them to set clear priorities and aiming to provide international agencies and donor countries with a rational plan for the coordination of external aid.

A European Conference on Health, Society and Alcohol had been organized by the Regional Office with strong support from France and held in Paris in December 1995. It had involved all the Region's Member States and had been based on six technical publications of the Regional Office. Those had been developed for the conference, the objective of which had been to find ways of dealing with what was one of the most difficult technical, ethical, and political problems in the field of health. Five basic ethical principles and 10 action strategies had been laid down that should be used by countries in establishing their national programmes. The results of the conference would have application beyond the Region.

In the field of environmental health, the decisions of the 1984 conference held in Helsinki continued to be implemented. About 30 countries were developing integrated environment and health action plans on the basis of those decisions. A European Environment and Health Committee had been formed, which

involved all the relevant main agencies and national representatives in Europe, to provide a coordinated European approach.

Health care reform was high on the agenda throughout the Region, not only in central and eastern Europe, where there were economic problems, but also in western Europe, where better means of providing health care were being sought. Preparations were being made for a large conference on health care reform in June 1996 in Ljubljana, which would provide an overview of the field. The World Bank was to be involved. Specific programmes addressed mental health, nursing, and other fields.

The reduction in the WHO programme budget had been an unpleasant surprise for all parts of WHO. At the European Regional Office, the 13% cut had led to an extensive reduction in both staff and programmes: 40 of 225 posts had been cut, resulting in a difficult period for staff members and their families. The process that had been used was the "reduction in force" procedure, whereby all staff members faced a period of uncertainty as to whether they would lose their jobs. The staff had responded well and had decided to present the Member States at the Regional Committee meeting with a Special Programme of Action for achieving work in areas of highest priority for the European Region.

Reform had been under way in the Region for nearly three years, as the process had been begun before the global reforms. The main areas in which reform had been achieved were the governing bodies, programmes, organization, management, and resource mobilization. The need to strengthen the link between WHO and the Member States had been addressed by the creation of a Standing Committee of the Regional Committee, acting rather like a "regional Executive Board", which had increased the interest of Member States in the activities of WHO.

Programmes had been reoriented to the countries of the Region that were in greatest need. In 1992, one-fourth of the programmes had been implemented at the country level, whereas three-fourths of the programmes were now directed to the countries in the eastern part of the Region. A major organizational change had been made to respond to the need for stronger country orientation, by the creation of a new Country Health Department, a reduction in the number of other departments, and a flatter organization to reduce bureaucracy and stimulate more initiative at the level of units and programme managers. New information systems had been introduced, including a programme management information system. New forms of financing had been introduced, such as the creation of special centres financed by Member States (which had, for example, quadrupled the resources of WHO in the area of environment and health) although complete WHO control was maintained over the programme and staffing. New country offices had been created, so that whereas there had been only three locations in 1992 there were now 42 offices, representing a major change in the pattern of management of the Regional Office and a stronger programme orientation to the country level.

The meeting rose at 12:50.

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