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WESTERN PACIFIC REGION

REGIONAL COMMITTEE

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AN HISTORICAL OVERVIEW

CONTENTS

ABBREVIATIONS

APO	Asia Pacific Observatory on Health Systems and Policies
APSED	Asia Pacific Strategy for Emerging Diseases
CD	Communicable disease
CSR	Communicable disease surveillance and response
DOTS	Directly Observed Treatment Short-Course for tuberculosis treatment
EB	Executive Board
EMR	Eastern Mediterranean Region of WHO
FAO	Food and Agriculture Organization of the United Nations
GMS	Global Management Systems
GPW	General Programme of Work
HiTs	Health Systems in Transition
HO	Health Organization of League of Nations
HQ	WHO headquarters in Geneva
ILO	International Labor Organization
Global Fund	The Global Fund for AIDS, Tuberculosis and Malaria
LON	League of Nations
MS	Member States
NCD	Non-communicable disease
PAHO	Pan American Health Organization
RACMR	Regional Advisory Committee on Medical Research
RC	Regional Committee
RCM	Regional Committee Meeting of WPT
RC	Regional Committee of WPR
RD	Regional Director
SDGs	Sustainable Development Goals
SPC	Secretariat of the Pacific Community
TAB	Technical Assistance Board
TCDC	RCM Sub-Committee on Technical Cooperation among Developing Countries
UHC	Universal Health Coverage
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNOG	United Nations Office in Geneva
UNRAA	United Nations Relief and Rehabilitation Agency
USA	United States of America
WHA	World Health Assembly
WHO	World Health Organization
WPR	Western Pacific Region of WHO
WPRO	Western Pacific Regional Office of WHO

EXECUTIVE SUMMARY

This paper gives an historical overview of the evolution of and influences that shaped the Regional Committee Meetings (RCM) of the Western Pacific Region (WPR) and its deliberations since it began in 1951. The purpose is that a shared understanding of the past may usefully inform the future[1] and that a *'…a realistic view of the future requires an informed understanding of the past…'.[2]* The methodology largely focused on analysis of key documents. A limitation of the paper is that a systematic capturing of oral history was not possible. Regular historical analysis each five years, capturing oral and written history, could be invaluable to assist ongoing shared understanding.

International Health Cooperation
International health cooperation of the modern era started in 1851 in Europe with the aim of agreeing quarantine regulations in response to the plague, the 1832 Europe cholera epidemic and their threat to international trade. There has been broad technical continuity since despite changing organizational arrangements and political factors including war. The World Health Organization (WHO) was constituted in 1948 as part of the United Nations (UN) with a regional structure and proscribed boundaries. In 1948 there were eight WPR members, twelve in 1951 and there are 37 in 2016[3].

Context
WPR's geographical area is large and the cultures, economies and health needs diverse. In 1965 the Regional Director said there were *'…few health problems in the world which are not to be found in some of the Western Pacific Region'*.[4] WPR's context has changed to that underpinning its foundation including demographics, technology, geopolitics and socioeconomic issues. There is also a more crowded international and regional health cooperation stage and an overall accelerating pace of change.[5] Increasingly sophisticated understanding of public health is reflected in the *Health for All* declaration in 1978, the *Ottawa Charter* in 1986 and the HIV/AIDS epidemic highlighted the need to think differently. In 2016 the SDGs reflect greater understanding of the importance of socio-political and economic influences and a consideration for RCM is how to strategically engage with new actors on the increasingly crowded health co-operation stage.

Regional Committee Meetings
RCM met twice in 1951, in May in Geneva when it was constituted and in September, and has met annually since. RCM Rules of Procedure were iteratively changed from 1954.[6] Budget uncertainty has been a constant since 1951. There have been technical sessions of various formats since 1952, originally triggered by an EB resolution, including five Ministerial Round Tables in 2001-2006 and technical panels with expert moderators in the current era.

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[1] www.studentsfriend.com *The uses of history* and see also Stearn, Peter N., *Why Study History*: https://www.historians.org/about-aha-and-membership/aha-history-andarchives/archives/whystudyhistory-(1998)

[2] The late Dr Lee Jong-wook, Director-General of WHO from 2003-2006, in his foreword to *Engaging for Health. Eleventh General Programme of Health. A Global Agenda* at the 59th WHA in 2006: http://apps.who.int/iris/bitstream/10665/69379/1/GPW_eng.pdf or http://apps.who.int/iris/bitstream/10665/69379/1/GPW_eng.pdf

[3] Including an Associate Member and seven Areas

[4] WP/RC16/5: http://iris.wpro.who.int/handle/10665.1/8943

[5] Two examples from technology alone are the 1953 invention of the transistor radio to today's nanotechnology and increasingly pharmacogenomics

[6] RC5 in 1954 amended Rules 26 and 28 on voting and election of Regional Directors; there have been at least thirteen amendments since the last by RC63 in 2012

The mature RCM customs and practices were written for the first time in 2013, important given annual rotation of Chairs. RCM accelerated its adoption of technology from 2010 including electronic transmission of documents and live streaming in 2014. Virtual attendance could thus be a future consideration. Interventions rather than debates are the norm and other than in the very early years[7] decision-making was largely by consensus. There were incremental improvements in planning, budget development and presentation and Regional Director reports over the years. From 2009 improvements were rapid. In 1995 RCM46 referred to *'…its commitment to continuing to review its own methods of work in the light of changing circumstances and the health needs in the Region'*.

No health ministers attended the first RCM in 1951. Ministers attend now from time as do heads of health ministries, with usually around 50% each from the Pacific. In the last two decades there was an increase in Ministers attending in the election year of the first term of Regional Directors[8]. There is no gender-disaggregated data on attendees.

Planning and priorities

Planning and priority setting including to guide the RCM technical agenda is a focus of WHO current reforms as it was in 1951, when the first four RCMs wanted a five-year regional plan based on national plans. In 1968 WHA and EB proposed long term regional planning and projections to the end of the 20th century and new biennial planning and programme budgets.[9] In 1976 RCM27 resolved to cease the previous WPR-specific four-year GPWs and adopt the WHA-set GPWs which had been extended to six years to allow wider consultation with countries for a 'bottom up' planning process. At RCM66, some forty years later, the Regional Director[10] affirmed that the *'…bottom-up approach employed in the 2016-2017 budget planning process…'* was the appropriate approach to identify MS needs and priorities. RCM20 noted its satisfaction that future GPWs would be five years not four.[11] GPW11 was 10-years to coincide with the MDGs; the current GPW12 is six years.

The purpose of GPWs has been described variously. RCM1 said the purpose was to provide '*…a broad general policy…framework...'* for annual plan development. In 2006 the definition was that the GPWs were to guide WHO work of WHO and action by all *'…the world health community…'.* [12] For GPW12 the purpose is *'…a high level strategic vision for the work of WHO…'* with the intent to *'…drive the…work (of WHO)…across and between different levels of the Organization'.*[13]

RCM Technical Agendas and Resolutions

WHO is both a technical agency and part of the UN. This suggests that public health and politics may both be influencing factors when setting RCM agendas. Pragmatism suggests that the importance of a health issue as measured in objective or evidence-based public health terms may be tempered by the strength and persuasiveness of key actors; the prevailing political, cultural, social and economic contexts; timing; the interest, capacity and capability of institutions and countries to lead and implement change; and the human emotions aroused. While these influences cannot necessarily be discerned from the RCM minutes and other formal documents they can be assumed in varying degrees.

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[7] For example, Rule 7 was debated in the 1950s on the size of a quorum citing travel difficulties within the region and two votes were required to gain agreement

[8] Particularly in 1998 and 2008 for the last two Regional Director elections; see Table 4 in full report

[9] WHA21.49 and 22.53; EB43.R.19

[10] Dr Shin Young-soo

[11] WPR/RC20.R1: http://iris.wpro.who.int/handle/10665.1/9066

[12] op. cit. see footnote 2 above

[13] whttp://www.who.int/about/resources_planning/twelfth-gpw/en/

Other influences included the RCM program budget and technical sub-committees from the mid-1950s to 1998 and MS perceptions of their own needs. An early example of the latter is at RCM2 when MS saw that the advisor roles of technical analysis, advice and support did not match their priorities of materials, equipment and funds. Other influences included new significant health issues, geopolitics[14], regionally-relevant WHA resolutions[15], relevant UN declarations[16], Regional Director leadership[17] and the Secretariat with its technical expertise and regional perspective. Notwithstanding these influences, all RCM technical resolutions since 1951 reflect a significant regional health need. Whether each was the actual strategic priority at the time is unclear. In recent years the proportion of RCM technical agenda items and resolutions with regional action plans has significantly increased.

Progress and Achievements

RCM has over-sighted some remarkable achievements since 1951 that are reflected in the annual Regional Director reports.[18] [19] One of the lessons of history is the visionary leaders whose ambition and foresight reverberated through the decades such as for polio eradication. WPR often either led global thinking or responded with fresh conceptual approaches[20] (while some issues lagged[21]). A pattern in RCM resolutions is the intense focus on a particular issue for discrete periods reflecting the sustained focus needed for health gains.[22] RCM generally found the balance between globally driven strategies and those specifically regionally responsive.[23] These examples illustrate the critical importance of RCM leadership, effort, insight and persistence from 1951 until today.

The 1st Annual Report in 1951 presented, inter alia, plans for the eradication of endemic and epidemic diseases[24], relocation of WPRO from temporary offices in Hong Kong to Manila and a malaria and insect control programme in Cambodia. RCM11's included '…*that …no logical and rapid development of health services will be possible without technically strong central administrations'.* RCM27 in 1976 heard that (then Western) Samoa was considering introducing primary health care and governments were being encouraged to expand immunization programmes.

At RCM47 the report included the future of small island countries linked to environmental issues, *New horizons in health* and a new priority, the management and control of new, emerging and re-emerging issues.[25] RCM47 also wanted a new approach to Regional

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[14] For example, support to Viet Nam, Cambodia and Laos in the 1970s

[15] For example, tobacco control through WHA31.6, 33.5, 42.19, 52.18, 54.18 culminating in WHA56.1, the *Framework Convention on Tobacco Control* and AMR adopted by RMC in 2011

[16] For example *The Human Rights to Water and Sanitation* declaration in 2010 and the *Sustainable Development Goals* in 2015

[17] For example *Healthy Islands* from 1995 and continuing; tuberculosis, EPI and people-centred care in the 2000s; and now ageing, AMR, UHC, NCDs, emerging diseases and continuing and renewed vigilance on ongoing issues including Neglected Tropical Diseases and Emergency Responses

[18] The Regional Director reports are a rich source of information about issues and progress in WPR and worthy of a separate study

[19] There have been six WPR Regional Directors: Dr Fang (1951-1966), Dr Francisco J Dy (July 1966-June 1979), Dr Hiroshi Nakajima (July 1979-June 1989), Dr Sang Tae Han (1989-1999), Dr Shigeru Omi (February 1999-Jan 2009), Dr Shin Young-soo (Feb 2009-current)

[20] For example people-centered care in the 2000s which was eight years ahead of its time and Universal Health Cover now and other issues; ageing and violence are two issues which lagged and were addressed in the last three years

[21] For example, UHC and the double burden of nutrition in this decade

[22] For example, 11 Resolutions on malaria 1951-1960 driven by it being one of WHA's six priorities; 12 on training 1961-1970;10 1971-1980 on health system strengthening

[23] For example the *Healthy Islands* initiative as a regional-specific response to *Health for All*

[24] Malaria, tuberculosis, diphtheria and yaws

[25] To which RCM47 agreed after reviewing the PB

Director reports that were *'…more focused…'*.[26] From this came short annual reports in even-numbered years covering significant issues and developments and more comprehensive reports in odd-numbered years, resulting in *Fifty Years in the Western Pacific 1948-1988* as part 2 of the Regional Director's report to RCM49.[27] RCM59[28] heard that lessons learned from SARS were being applied to the avian influenza virus and internet-based training for Pacific health workers was being implemented. The reports up until 2009 were large framed on WHOs technical programs and included considerable detail. From 2009 significant effort was made to an integrated approach to reporting on key issues, themes and highlights focused on keeping countries at the centre, with detail such as training courses contained in background papers. Also newly incorporated was powerful imagery to support the keeping countries at the centre focus.

The Regional Director's[29] 2015 annual report shows the extraordinary achievements from sustained effort by many over years. Measles was now eliminated in seven countries and areas.[30] Hepatitis B prevalence was reduced to less than 1% in five year olds in American Samoa. Niue, Palau and Vanuatu were seeking validation of the lymphatic filariasis elimination. Cambodia had eliminated maternal and neonatal tetanus. The report also highlighted the increasing understanding of public health complexities and the resultant new and innovative approaches on continuing and emerging issues such as health systems through UHC, the newborn, Neglected Tropical Diseases, antimicrobial resistance and violence.

WPR commenced reforms in 2009 *'…aimed at improving results at country level'*.[31] Reviews in 2012 and 2014[32] provided qualitative and quantitative evidence of significant and continuing progress. Strategic links between WPR and the current overall WHO reforms[33] include through the Regional Director's joint chairing of the global reform Task Force and two MS are on the reform governance committee[34].

RCM resolutions also reflect the increasingly sophisticated understanding of public health and, in recent years, a more transparently strategic approach with resolutions linked to documented action plans within a newly streamlined approach to technical agendas. Country presentations as RCM side events from 2016 are being progressed as are rolling agendas and further strategies to increase Member States' input to setting RCM agendas. Setting RCM strategic priorities may, however, be problematic in the absence of a shared strategic vision for the future.

In the last three years 100% of RCM technical resolutions have specific regional plans and actions. This is a powerful strategic change and is illustrated in Table 1 below.

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[26] RCM47 Record of Meeting

[27] WPR/RC49/3

[28] Dr Shiagaru Omi was the Regional Director

[29] Dr Shin Young-soo

[30] Australia, Brunei Darussalam, Cambodia, Macao SAR (China), Mongolia, Republic of Korea and Japan

[31] *Fit for the Future* as cited in *Strengthening country support in the WHO Regional office of the Western Pacific*. WHO. 2014. P 10

[32] Op Cit

[33] The WHO reforms started in 2010 with an informal consultation in the future of financing; EB128 in 2011 and a special EB session in 2011 advanced the thinking to the current reforms; http://www.who.int/about/who_reform/process/en/

[34] Australia and China

Table 1 RCM Resolutions Related to Regional Action Plans 1970-2015

Intention of Regional Committee technical resolution, 1970-2015

Legend:
- Urging commitment or action on a technical issue
- Endorsing a technical strategy or goal

(Chart showing 100% stacked bar graph with years 1970, 1975, 1980, 1985, 1990, 1995, 2000, 2005, 2010, 2011, 2012, 2013, 2014, 2015 on x-axis and 0% to 100% on y-axis.)
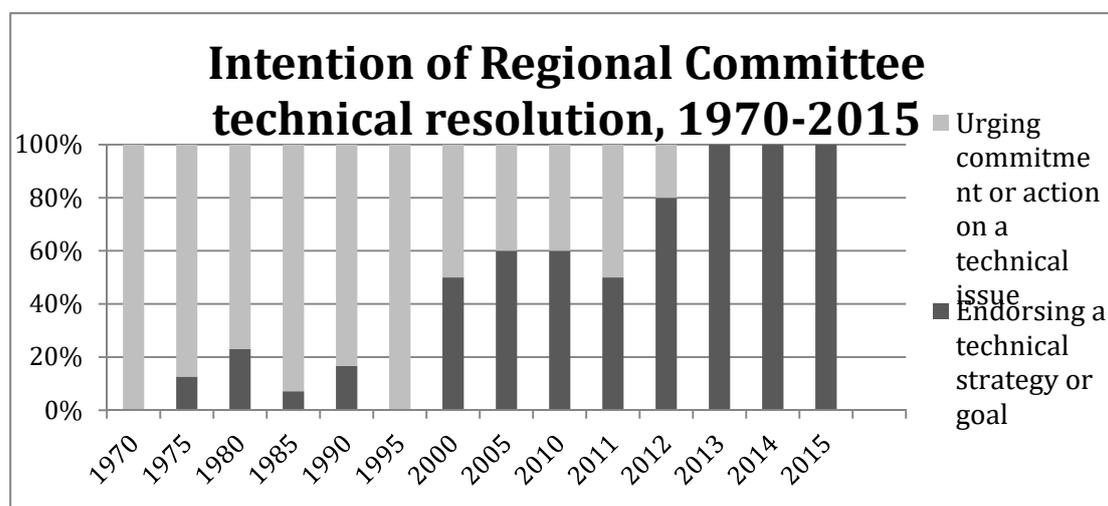
Possible RCM Considerations

RCM history and the recent rapid improvements position RCM well for the future. RCM may like to consider that its setting of strategic priorities may be enhanced by there being a shared vision for the future health of the Region. MS high-level decision-makers, drawing on their national, regional and global experience, could meet together each five years to first set - and then each five years refresh - the strategic vision, direction and priorities for the future health of the Western Pacific Region.

Inter-sectoral coordination has been a feature since WPRO's co-location with UNICEF in 1951 and was further emphasized with *Health for All*.[35] The SDGs place new urgency and emphasis for working differently including engaging strategically with the socio-political aspects of public health and working with new constituents. The Regional Director reinforced this in his annual report to RCM66 where he stressed the importance of *'…working across sectors, across borders and across societies'*.[36]

Knowing the future vision and direction and the strategic priorities to achieve them would be a vehicle for engaging with new and continuing actors and also equip WPRO to ensure it has future capacity and capability to fulfill its mission, including having the bold, innovative, technically excellent and strategic thinkers needed to shape and lead to the future in response to country needs.

RCM may like to consider these and other powerful lessons from history through:

1. Encouraging bold and innovative thinking in RCM;
2. Developing a shared understanding and vision for the desired future health of the Region through high-level decision makers, refreshed each five years, within which to set strategic priorities for the RCM agenda and the Secretariat;
3. Defining information needed not only to respond to scientific and technological changes but also to anticipate and lead change;
4. Assessing risks and opportunities of virtual attendance at RCM;

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[35] Declaration of Alma Ata in 1978: http://www.who.int/publications/almaata_declaration_en.pdf
[36] RC66 Record of Meeting on the Regional Director's annual report

5.   Identifying and strategically engaging with new and continuing constituents and other socio-political aspects of public health;

6.   Eliciting from MS views of RCM cultural mores and their impact on effectiveness;

7.   Assessing of efficacy and impact of the revised RCM agenda consultation and briefing processes including on RCM attendance of high-level decision makers

8.   Maintaining effort towards increased budget flexibility;

9.   Initiating facilitated country presentations at side events at RCM;

10. Testing the agreed new approaches for MS input to provisional agenda items before embarking on additional processes such as sub-committees, virtual or otherwise;

11. Requesting regular five-year retrospective analyses of RCM agendas and resolutions (desk analysis and oral history);

12. Gathering gender-specific data on RCM attendees;

13. Developing a technical taxonomy for further categorization of all technical resolutions;

14. Commissioning an historical analysis on Regional Director reports since 1951;

15. Strongly encouraging ongoing WPRO reforms to ensure capacity and capability to meet the future and keep countries at the centre.

INTRODUCTION

This paper gives an historical overview of the overview of the evolution of and influences that shaped the Regional Committee Meetings (RCM) of the Western Pacific Region (WPR) since it began in 1951.[37] The purpose is that a shared understanding of the past may usefully inform future decisions.[38]

Some postmodernist scholars say that truth is ultimately unknowable, that real objectivity is unattainable.[39] Thomas Jefferson and Woodrow Wilson's views were different with Woodrow saying that history provides people *'…with the invaluable mental power we call judgement'.*[40] Other current and past scholars reinforce Woodrow's view saying that history helps inform us towards making better future decisions, contributes to better thinking and supports a sense of identity and common understanding and that history enables better, more thoughtful, more useful contemplation and reflection.[41] The late Dr Lee Jong-wook, Director-General of WHO from 2003-2006, said in his foreword to the WHO Eleventh Programme of Work[42] that *'…a realistic view of the future requires an informed understanding of the past.'*

There are of course caveats. Firstly, history is not an inanimate mechanism. Historical developments frequently unfold in an unplanned and at times erratic fashion.[43] Secondly, history is reflected through the eye of the beholder. Where there are many eyes the perceptions may differ. Lastly, documents such as minutes of RC meetings (RCM) tell us much but cannot tell us all. They do not usually show the influences of changing political environments nor informal influences. These can be deduced from other sources such as consultations with those who were there at the time. Much valuable oral history and insights about WPR and the RCM have been lost over the years. Regular analysis each five years or each decade could be invaluable in capturing history efficiently and accurately to enable ongoing reflection to inform future thinking.

The structure of this paper is in four parts from the contextual to the technically specific and finishes with some issues for consideration by RCM. Part 1 describes the global context from 1851 when formal international health cooperation of the

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[37] APW 2016/622876-0

[38] www.historytoday.com/peter-furtado/uses-history and see also Stearn, Peter N., *Why Study History* (1998) through https://www.historians.org/about-aha-and-membership/aha-history-and-archives/archives/why-study-history-(1998)

[39] Southgate, Beverly. *Why Bother with History: Ancient, Modern and Postmodern Motivations (2000)* see synopsis and comments at http://www.abebooks.com/9780582423909/Why-Bother-History-Ancient-Modern-0582423902/plp

[40] https://www.wilsoncenter.org/about-woodrow-wilson

[41] op. cit. Stearn

[42] *Engaging for Health. Eleventh General Programme of Health. A Global Agenda 11th Programme of Work 2006-2015:* http://apps.who.int/iris/bitstream/10665/69379/1/GPW_eng.pdf or whqlibdoc.who.int/publications/2006/GPW_eng.pdf

[43] http://www.theaustralian.com.au/arts/books/a-necessary-shock/story-e6frg8nf-1225998508451

modern era began. It shows that international cooperation agencies segued one to the next and the influence of geopolitics and health crises. Technical continuity was maintained through the years and there were lessons learned that informed the decision for WHO to have a regional structure. It also demonstrates the slow pace of international agreement and evolution of scientific knowledge that continues, on occasion, today. Part 2 presents contextual changes and other drivers that influenced RCM work since it began in 1951. Part 3 focuses on trend analysis of RCM technical resolutions since 1951 and influencing factors. Part 4 extracts key points and considerations for RCM.

The methodology for this paper included qualitative and quantitative analysis of relevant documents and consultations and discussions with senior Secretariat staff.[44] [45] There was no opportunity for consultations with Member States or systematically with a range of people involved with this and earlier eras. This is a limitation of this report and could be a consideration for any future historical overviews. Documents analyzed included minutes and resolutions of the WPR Regional Committee since it began in May 1951; relevant records of meetings, session minutes and resolutions of the World Health Assembly (WHA) and the Executive Board (EB); the Fifty-year History of the Western Pacific Region[46] and the series of ten year histories of WHO to 1987[47] and other documents as relevant.

Part 1   CONTEXT 1851-1951

1.1   International Sanitary Conference

The first formal international health cooperation mechanism of the modern era was the International Sanitary Conference (ISC) in 1851. The French Government convened the ISC, attended by twelve countries[48], to standardize quarantine regulations between countries. The catalysts for the ISC were the recurring incidences of the plague and the 1832 Europe cholera epidemic. It was the era of the Industrial Revolution and trade was potentially compromised lending urgency. The United States of America (USA) for example sought to have European boats and ports quarantined before they set sail.

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[44] References are presented in the footnotes
[45] Royal Overseas League Literary Series 2016: Writing History. ROSL Newsletter, June, 2016
[46] Part 2 of the Regional Director's annual report to RCM
[47] *The First Ten Years of the World Health Organization, 1948-1957:*
http://apps.who.int/iris/handle/10665/37089
The Second Ten Years of the World Health Organization, 1958-1967:
http://apps.who.int/iris/handle/10665/39254
The Third Ten Years of the World Health Organization, 1968-1977:
http://apps.who.int/iris/bitstream/10665/43924/1/9789241563666_eng.pdf
The Fourth Ten Years of the World Health Organization, 1978-1987:
http://apps.who.int/iris/bitstream/10665/44644/1/9789241564298_eng.pdf?ua=1
Fifty years of the World Health Organization in the Western Pacific Region, 1948-1988: Report of the Regional Director to the Regional Committee for the Western Pacific. Forty-ninth session:
http://iris.wpro.who.int/bitstream/handle/10665.1/10212/WPR_RC049_03_RDRep_1998_en_full.pdf
[48] The twelve countries were Austria, Great Britain, Greece, Portugal, Russia, Spain, France, the Sublime Port (Turkey) and the four Italian powers of Papal States, Sardinia, Tuscany and the Two Sicilies. *The first ten years of the World Health Organization* op. cit.

Despite political, economic and social urgency it was 41 years before the first International Sanitary Convention was agreed in 1892. Scientific disagreement contributed to the delay.[49] It was not until 1903 that the eleventh ISC agreed the cause and mode of transmission of cholera. Scientific disagreement manifests through the decades, for example in discussions on the cause and prevention of HIV/AIDS in the 1980s through to the 2000s.[50]

1.2   Office International d'Hygiene (OIHP)

In 1907 the Office International d'Hygiene Publique (OIHP) was established in Paris. It was the result of ISC members seeing the need for a permanent international health organization to oversee international quarantine rules for ships and ports and to administer other public health agreements. A revised convention incorporating smallpox and typhus was ratified in 1926 and in 1933 a convention for aerial navigation. In 1948 OIHP ceased operating and its functions were handed over to the newly created World Health Organization.

1.3   League of Nations

The League of Nations (LON) was established on 10 January 1920 after the Paris Peace Conference (1919) and the Treaty of Versailles that ended World War l. The LON's purpose was *'…to develop cooperation among nations to guarantee them peace and security.'*[51] It was to be a forum for resolving international disputes to prevent any future world war.[52] In this it failed, powerless to prevent World War Two (WWll) and the preceding annexation of Manchuria by Japan, the annexation of Ethiopia by Italy in 1936 or Austria by Hitler in 1938 and weakened by the withdrawal of key countries from membership.[53]

The LON also had a secondary objective of technical cooperation including in health, social affairs, refugees, financial affairs, education and other areas. The LON had a Health Organization (HO) with three programmes in epidemiology, technical studies and technical advice.

As with ISC in 1851 and the creation of WHO in 1948, the rationale for the LON HO was driven by health crises and geopolitics. These included the global influenza pandemic of 1918-1919 that killed 15-18 million people (estimate), the 1919-1920 European typhus epidemic and the human and environmental devastation from World War 1.

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[49] This was despite the separate scientific work of Max von Pettenkeffer, John Snow and Filippo Pacini in the 1850's and the later work of Robert Koch. It was not until 1965 - 82 years after Pacini's death - that he was formally acknowledged as discovering the cholera-causing organism

[50] For example at RCM57 in Auckland in 2006 a resolution on HIV/AIDS was not put because of differing views on harm minimization versus abstinence for prevention

[51] www.**un**.org/en/about-**un**/

[52] http://avalon.law.yale.edu/20th_Century/leagcov.asp

[53] Brazil in 1928, Japan and Germany in 1935, Guatemala and Honduras in 1938, Italy and Chile give notice of withdrawal in 1937 and 1938 respectively

The United Nations Office in Geneva (UNOG) asserts LON HO was successful in its objective of technical cooperation.[54] The United States of America (USA) however continued its membership of OIHP, did not join the LON seeing it as unnecessary and it blocked formal cooperation between the two. OIHP remained responsible for the International Sanitary Convention.

Geopolitics further influenced international health cooperation when WW ll broke out and LON activities reduced to a weekly epidemiological bulletin and some advice. The LON was replaced by the United Nations (UN) in 1945 and its Health Organization functions were handed over to the World Health Organization in 1949.

1.4   United Nations Relief and Rehabilitation Agency

In 1942 the term 'united nations' was first used when the USA, Britain and the Soviet Union drafted the original UN declaration, signed by 26 countries, to continue as allies in WW ll. In 1943 the British Prime Minister and USA President[55] led the creation of the United Nations Relief and Rehabilitation Agency (UNRAA) to which forty countries agreed. Its purpose was to provide economic assistance to countries after WW ll and to assist war victims under allied forces control including providing food, shelter, medical and other essential services.[56] Its scope was later expanded to include other displaced persons.

UNRAA only existed for three years to 1946. By 1946 it employed 15,000 international staff and 35,000 local staff and had distributed US$4 billion of food, medicines, farm tools and other goods. In June 1945 there were 450 UNRAA health teams including 380 doctors and 435 nurses to care for the millions of people displaced by WW ll.

The UNRAA used current knowledge and tools to successfully combat typhus and cholera including in China. In 1947 China was consequently able to assist Egypt with cholera vaccine made with UNRAA-supplied equipment[57] reflecting not only evidence-based approaches but also bilateral cooperation, both of which continue today.

The UNRAA also collaborated or cooperated with hundreds of volunteer and charitable agencies of the era. WHO continued this approach establishing official relationships with non-government organizations from the beginning, in 1948.

The UNRAA became part of the United Nations in 1945, largely ceased its functions in 1946 and the formal agreement establishing it ceased on 31 March 1949. Its functions were transferred to WHO, the International Refugee Organization and other UN agencies.

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[54] www.unog.ch/
[55] The British Prime Minister was Winston Churchill and the President of the USA was Franklin D Roosevelt.
[56] *Holocaust Encyclopedia:* https://www.ushmm.org/
[57] op. cit. *Fifty Years of the World Health Organization in the Western Pacific Region, 1948-1998: Report of the Regional Director to the Regional Committee for the Western Pacific. Forty-ninth session.* http://www.wpro.who.int/publications/PUB_9290611227/en/

1.5   The World Health Organization

The UN Charter[58] was signed on 26 June 1945 by 50 countries[59] at the UN Conference on International Organizations in San Francisco. On 24 October 1945 the United Nations officially came into being.[60] There were 51 original UN members.[61] In 2016 there are 193. The UN's objectives and principles include promotion of peace, social progress, human rights and equal rights, better standards of life, freedom and self determination. These principles remain foundations for WHO's work and are reflected in the preamble to its constitution. WHO also has a constitutional mandate to be the *'…directing and coordinating authority on international work…'.* This is a focus of current WHO reforms given the international health cooperation stage is crowded, scientific knowledge has increased and the breadth and depth of health issues widens.

When the structure of the new UN organization was presented to the UN conference in 1945 it did not include health. China and Brazil presented a joint declaration to the conference recommending a further conference on health. This conference was held over 4 weeks in New York in July 1946. From this an Interim Commission was established which did the preparatory work to establish WHO. The 26th ratification of the WHO Constitution[62] was received on 7 April 1948[63] enabling the First World Health Assembly (WHA1) to be convened in June 1948. WHA1 received and ratified the work of the Interim Commission including protocols to hand over OIHP and LON OH functions to WHO.

In 1948 the OIHP responsibilities were handed over to the newly created World Health Organization (WHO). The World Health Assembly (WHA) agreed its first International Sanitary Regulation in 1951. This was a revision and consolidation of the previous 13 OIHP sanitation regulations. In 1956 the regulation was renamed the International Health Regulation (IHR). In 2005 WHA adopted a revised IHR.[64] In 2012 the RCM comprehensively addressed IHR (2005) core capacity requirements, strategies and country support needed[65] continuing the technical continuity begun in 1851.

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[58] The Charter was based on the work of representatives of China, the Soviet Union, the United Kingdom and the USA

[59] Poland was not at that meeting and signed the Charter later, becoming one of the original 51 Member States

[60] The 24 October is celebrated annually to this day as United Nations Day

[61] op. cit. at footnote 2 above

[62] *World Health Organization Constitution, Basic Documents, Forty-fifth edition, Supplement,* October 2006

[63] Celebrated since then as World Health Day

[64] WHA65.23: http://www.who.int/iris/handle/10665/80498

[65] WPR/RC63.R6:
http://www.wpro.who.int/about/regional_committee/63/resolutions/WPR_RC63_R6_IHR_03Oct.pdf

1.6   Regional Cooperation

There were lengthy discussions before WHA decided on regionalization and it was embedded in the WHO Constitution.[66] The decision was informed by existing regional health cooperation organizations and mechanisms that began in the late 1800s and early 1900s in what is now the Eastern Mediterranean Region (EMR) and Pan American Health Organization (PAHO) then called the Pan American Sanitation Bureau. It was also informed by the lessons learned of LON HO and OIHP not having formal cooperation mechanisms. The advantages and disadvantages of regionalization were again raised in the early 1950s, this time by the WHO Executive Board (EB).[67] [68] The Seventh WPR RC meeting (RCM7) in 1956 responded in favor of regionalization saying that any disadvantages were outweighed by advantages including WHO processes.

In EMR there were four inter-governmental committees before the turn of the 19th century in Egypt, Turkey, Morocco and Persia. The Egyptian Quarantine Board was a significant entity and its functions and building became the new WHO regional office for the EMR in 1949.[69] The Pan American Sanitation Bureau was created in 1902 because the Americas recognized that ISC's European-based issues were not always the same as theirs. It agreed to become the WHO Americas regional office (PAHAO) at WHA2 in May 1949, overcoming the potential complexities experienced during the OIHP and LON HO era. PAHO is cited as the oldest continuously functioning international health agency in the world.[70]

The geographical boundaries of the six WHO regions were determined by the Interim Commission and ratified by the First WHA (WHA1) in 1948. Article 44 of the WHO Constitution established regional organizations to meet the needs of each region and regional committees (RC) to oversight the regions. [71] The RC functions are defined in Article 50 of the WHO Constitution.

In 1948 the First World Health Assembly (WHA1) assigned eight countries to WPR.[72] [73] [74] By 1951 when WPR was constituted there were twelve members.[75] In 2016 there are 37 members made up of 27 Member States, one Associate Member and nine areas that are not independent and which are represented by three other

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[66] *WHO Constitution*, Chapter X1
[67] Off. Rec. Wld. Health. Org. 46, page 158
[68] The EB's views on the advantages and disadvantages of regionalization were reproduced in WP/RC7/25 Rev. 1
[69] EMRO is now located in Cairo
[70] *History of the Pan American Health Organization:* www.pitt.edu
[71] In PAHO the Directing Committee is the equivalent of the regional committees
[72] Resolution WHA1.72
[73] The countries were Australia, China, Indochina, Indonesia, Japan, Korea, the Philippines and New Zealand: http://www.wpro.who.int/about/in_brief/history/en/ and http://asiasociety.org/education/korean-history-and-political-geography
[74] Korea attended WHA1 as an observer and was an active participant in establishing WPR; at WHA2 in 1949 Korea sought entry to WHO but geopolitics resulted in a successful roll-call (33 to 39 countries and 9 abstentions); as a result of WHA1 and WHA2 participation Korea is regarded as a founding member of WHO (Ki Dong Park's draft manuscript kindly provided)
[75] Australia, Cambodia, Japan, Korea, Laos, Philippines, New Zealand, the United States of America, France, the Netherlands, Portugal and the United Kingdom of Great Britain and Northern Ireland

Member States.[76] [77] In 1951 there were 14 staff in Manila and 19 in the field. In April 2016 there were 273 staff in Manila and 332 in the field.

The Western Pacific Region was originally to be called the Far East Region but the view prevailed that WHO regions should be called something relevant to them, not someone else's orientation to the world.[78] In 1948 the WPR office (WPRO) was to be in Shanghai. Access was not possible after 1949 and WPRO was temporarily located in Hong Kong. Expressions of interest were sought in 1950 to which Singapore, Korea (Soeul) and the Philippines (Manila) responded. WPRO moved to Manila in 1951 and was first co-located with the United Nations Childrens Fund (UNICEF) in Intramuros.[79] It moved to the current site to purpose-built accommodation in September 1958.

PART 2   RCM OPERATIONS

2.1 Context

The global and regional context for RCM is different now to that underpinning the foundation of WHO including demographics, technology, geopolitics, socioeconomic issues, a more crowded international and regional health cooperation stage, new and old significant health issues and an accelerated rate of change.

Geopolitics have shifted over the decades from the devastation wrought by World War Two and, in WPR, further devastation in the 1970s in Viet Nam and Cambodia, tensions from time to time between countries, political issues influencing aid and development, migration and the many more players on the stage of international and regional health cooperation challenging WHO's constitutional mandate to be *'…the directing and co-ordinating authority on international health'*. Adding to the complexity is that WPR's geographical area is large and the cultures, economies and health needs diverse. In 1965 the Western Pacific Regional Director summarized the breadth of health issues in WPR as there being *'…few health problems in the world which are not to be found in some of the Western Pacific Region'*.[80]

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[76] The first Member States were China & New Zealand in 1946; the last were Niue and Nauru in 1994 and Palau in 1995: http://www.wpro.who.int/about/in_brief/member_states/en/

[77] See www.wpro.who.int/countries Members responsible for areas in the Western Pacific Region are France for French Polynesia, New Caledonia and Wallis and Futuna; United Kingdom for Pitcairn Islands; United States of America for American Samoa, Guam, Commonwealth of the Northern Mariana Islands

[78] Members responsible for areas in the Western Pacific Region are France for French Polynesia, New Caledonia and Wallis and Futuna; United Kingdom for Pitcairn Islands; United States of America for American Samoa, Guam, Commonwealth of the Northern Mariana Islands: www.wpro.who.int/countries

[78] Dr. George Brock Chisholm, Executive Secretary of the Interim Commission (and subsequently the first Director-General of WHO) helped draft the WHO Constitution and is said to have asked in relation to naming the regions '…*but far east of where?';* the names of the WHO Regions were recommended to WHA1 by a Committee established for the purpose and passed by resolution WHA1.72 after complex discussions; the area for the Americas was included later and there have been subsequent membership adjustments http://www.who.int/global_health_histories/first_world_health_assembly/en/ and http://www.searo.who.int/about/history/en/

[79] Known then as the United National International Children's Emergency Fund

[80] WP/RC16/5: http://iris.wpro.who.int/handle/10665.1/9012

In 1951 WPR's health needs were vastly different to those in 2015. In the 1950s the most urgent priorities included strengthening health systems and addressing cholera, plague, small pox, hygiene and sanitation and poliomyelitis. Populations were rapidly increasing and there was a low median life expectancy.[81] The annual population rate declined by nearly 50% between 1950-1975 and continues to decrease. Age distribution across the region was similar in the mid-1970's but there were wide disparities by 2000.

Technological changes have been remarkable since 1951 adding to the complexity. Some examples are illustrative. The transistor radio was invented in 1953, oral contraceptives in 1954 and implantable pacemakers in 1958[82]; the pre-cursor to the internet was invented in 1969[83] and the original hepatitis B vaccine[84], gene-splicing in 1973, post-it notes in 1974, cell phones appeared in 1979 along with the Walkman, the first IBM PC was in 1981 and genetic engineering, cloning and stem cell research came to the fore in the 1990s and nanotechnology in the 2000s. YouTube was only launched in February 2005. The smart phone has been an iterative invention from an IBM prototype in 1992 with an estimated 1.2 billion sold worldwide in 2015.[85]

Within this milieu of change public health knowledge and understanding also became increasingly sophisticated through the decades. This is reflected in RCM agendas and resolutions, increasingly so in the last two decades as change accelerated. There have been extraordinary successes that RCM has oversighted that highlight the importance of sustained and focused public health effort as well as ongoing and new challenges. In 2016 poliomyelitis[86] and small pox[87] are eradicated, measles is eliminated in seven countries and areas, and, while widespread poverty persists, all countries have economically strengthened to at least middle-income.[88] There are also new disease threats including zoo-onotic and the miracle of antibiotics is threatened by antimicrobial resistance (AMR) and many tropical diseases persist[89].

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[81] Median life expectancy was 40-50 but this masked the actual variance reported in 1950 of life expectancy at birth of women – from 72.9 in New Zealand to 34.5 in Papua New Guinea

[82] Wilson Greatbatch: http://www.dailymail.co.uk/news/article-2042741/Wilson-Greatbatch-humble-tinkerer-invented-pacemaker-dies-92.html

[83] ARPNET, the U.S. Defense Department's Advanced Research Projects Agency Network (ARPANET), was developed in 1969; ARPA-funded researchers developed many of the protocols used for Internet communication today: https://www.google.com.au/search?q=when+was+apnet+invented&rlz=1C5CHFA_enAU697PH699&oq=when+was+apnet+invented&aqs=chrome..69i57j0.10879j0j4&sourceid=chrome&ie=UTF-8#q=when+was+arpanet+invented

[84] Invented by doctors Barch Bloomberg and Dr Iriving Millman in 1969; developed further by Merck and licensed in 1981 and vaccinations commenced in 1982

[85] http://www.gartner.com/newsroom/id/2996817

[86] WPR was declared polio free in 2000 and maintained this status when reviewed in 2012; http://www.wpro.who.int/mediacentre/multimedia/photos/features/pf_20130821/en/

[87] WHO declared smallpox eradicated globally in 1990; http://www.who.int/csr/disease/smallpox/en/

[88] The World Bank Group reclassified Cambodia to lower-middle income status from July 1, 2016

[89] With renewed efforts by WPRO under the Neglected Tropical Diseases programme

Urbanization rapidly increased over the decades bringing with it changes in food consumption and physical activity with under-nutrition and obesity paradoxically occurring simultaneously with its attendant chronic disease burden.[90] Urbanization is also a good example of an 'old' issue where new thinking is required to address the complex issues of megacities, social dislocation, poor infrastructure and other challenges. To add to the complexity are overarching goals currently the Sustainable Development Goals (SDGs) which require significant new ways of working, engagement with new constituents for their achievement and illustrate the tension between achieving vertical program success and a systems approach to health gains. These are all significant considerations for RCM.

Notwithstanding these complexities RCM is well positioned to embrace the future. Building on the decades of work before, WPRO has been undergoing significant and groundbreaking reforms since 2009. The strategic focus is to place and keep countries at the centre. There were initial wide consultations under the banner of *'Fit for the Future'* that were *'…aimed at improving results at country level...'.* The reform strategy developed consequently focused on ensuring both responsiveness and pro-activeness to MS needs for better health and WPR technical and organization innovations to support improved country support. A 2012 review found progress and some weaknesses.[91] Key findings included that WHO should adapt its role according to the country circumstances, that health systems support should be strengthened and that productivity was hampered by its culture and systems. Seven action areas were proposed:

- Place the best people in the most demanding jobs;
- Make health systems the main focus in all country offices;
- Be strategic: make tough choices to achieve real impact;
- Assess whether the Regional Office is really country-focused;
- Focus on value for money;
- Beyond convening: be bolder in driving the policy dialogue; and
- Communicate with purpose.

An external assessment in 2014 assessed progress on WPRO's country focus.[92] It found quantitative and qualitative evidence of a significant strategic shift to placing and keeping countries at the centre. Evidence included an increase in the proportion of staff and budget at country offices (CO), a culture of willingness to innovate, WPRO structural reforms[93], programmatic successes, increased budget allocation to health systems and services[94] and open disclosure of continuing challenges[95].

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[90]http://www.wpro.who.int/health_research/documents/dhs_hr_health_in_asia_and_the_pacific_08_chapter_3_demographic_trends.pdf

[91] *Placing countries at the centre: a report on a fresh approach to assessing WHO country performance in the Western Pacific Region.* WHO. 2012
http://www.wpro.who.int/entity/country_focus/publications/PlacingCountriesattheCentre_revised.pdf

[92] *External Assessment: Keeping countries at the center: strengthening country support in the WHO Regional office of the Western Pacific.* WHO. 2014
http://www.wpro.who.int/entity/country_focus/publications/externalassessment_2014_inside_v14a__web.pdf

[93] These included the Division of Pacific Technical
Support (DPS) in Fiji; the Country Support Unit in Manila under the Division

Some continuing challenges were finding the balance between vertical and cross-cutting collaboration, expanding partnership work in countries, improving results-based management, further streamlining internal administrative systems and procedures, strengthening priority technical support, lack of coordination in information gathering adding to administrative inefficiency. All these areas are a continuing focus in WPR as the reforms continue in line with recommendations from the review. For example WPR now has a new and ground-breaking approach to health systems (Universal Health Coverage or UHC)[96], there is a rigorous appointment of WRs, mandatory staff rotation to countries has been agreed as a staff and organizational development strategy, there are many efficiency gains including using technology better for RCM[97], bold and innovative thinking is apparent in every Division, staff learning and development strategies are to be further progressed.

As well, WHO globally has embarked on reforms to ensure it is fit for the future as a global entity. The reforms have three aims: programmatic reform to improve people's health; governance reform to increase coherence in global health and managerial reform in pursuit of organizational excellence. As part of this WHO wants better setting of strategic priorities to ensure country responsiveness. There is a strong strategic link between the WPR reforms and the whole-of-WHO reforms through the WPR Regional Director being the Joint Chair of the global Taskforce on the Roles and Functions of the Three Levels of WHO and WPR MS representation on the governance committee[98].

Special care has always been needed to ensure the WPR RC agenda is responsive to the diversity of Member States' needs and priorities and this continues, with ever-increasing complexity. How RCM will ensure its agendas reflect the key regional strategic priorities is an important consideration for the future in the context of continued technical and contextual change and organization reforms.

2.2   Rules of Procedure

Articles 48 and 49 of the WHO Constitution require the RC to develop and adopt its own Rules of Procedures and convene an annual meeting to address public health needs in the region. The first RCM in May 1951 adopted the first WPR RC Rules of Procedures. [99] There have been at least thirteen amendments since[100], the most

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of Programme Management (DPM); links between country cooperation strategies and routine planning; and new Divisional Director appointments

[94] From US$ 24.2 million in the previous biennium to US$ 29.8 million

[95] Such as AMR for malaria and tuberculosis in particular and some tropical diseases

[96] WPR/RC66.R2:
http://iris.wpro.who.int/bitstream/handle/10665.1/12131/WPR_RC066_Res2_2015_en.pdf

[97] For example, electronic transmission of papers, live streaming since 2014, possible use of tablets in the future

[98] China and Australia

[99] RC1/WP/2. Corr.1: http://iris.wpro.who.int/handle/10665.1/8207

[100] The Rules of Procedures of the Regional Committee for the Western Pacific were first amended (Rules 26 and 28 on voting and election of Regional Directors respectively) at RCM5 in 1954 and subsequently amended - at least - at RCM6, 7, 9, 13, 15, 23, 30, 31, 42, 57, 61 and RCM63 (resolutions included

recent in 2012[101]. The iterative nature of the RCM approach to amendments is reflected in the changed definition of a quorum. In 1951 Rule 21 defined a quorum as a majority of members. From 2012, sixty-one years later, Rule 25 defines a quorum as *'…a majority of representatives entitled to vote'*.

The reasons for amendments to the Rules of Procedures varied. Some amendments were to maintain alignment with the rules of WHA and EB. An example is the first amendment in 1954 on Regional Director elections.[102] Some were to streamline RCMS in some way or clarify a matter further.[103] Some were abandoned.[104]

Chinese was made an official language of WHA in 1948. In 1951 RCM1 determined that English and French would be the RCM official languages.[105] Those speaking other languages were required to make their own provisions for interpreting.[106] In 1972 RCM23 amended the rules and Chinese became an official language with interpretation facilities provided. Interpretation provisions for other MS languages remain largely the same in 2016 as in 1951.

2.3   Regional Committee Meetings

The Rules of Procedures have always required an RCM to be convened at least once annually. In 1951 special meetings could also be called at the request of four members in writing unless the Chairman of RCM determined otherwise. In 2016 the Rules of Procedure are that the RC shall hold at least one regular meeting per year and that a special RCM can be called by a majority of the members in writing to the Regional Director unless he, in consultation with the Chairman, does not agree. The Regional Director may, in consultation with the Chairman, also call a special RCM in exceptional events unless the majority of members do not agree.[107]

In 1975 RCM26 considered changing the rules to meet every other year and the Regional Director reported on the implications of this to RCM27. He was not in favor on several grounds. The first was that the RCM must carry out *'…the tasks entrusted to it…'* by the EB and WHA and that included review of the biennial budget that had to be done annually. The matter was made more complex as annual budgets still had to be approved while waiting for WHO Constitutional changes to enable biennial budgeting. The Regional Director said that if a sub-set of RCM met annually to approve the budget while RCM met bi-annually the cost savings would not be great.

WPRC5/13WPR/RC6.21, WPR/RC7.R20, WPR/RC9.R8, WPR/RC13.R3, WPR/RC15.R2, WPR/RC23.R6, WPR/RC30.R1, WPR/RC31.R7, WPR/RC42.R1, WPR/RC57.R3, WPR/RC61.R3, WPR/RC63.R8

[101] The current Rules of Procedure of the Regional Committee for the Western Pacific were revised at the 63rd RC in Hanoi, Viet Nam in September, 2012; WPR/RC63.R7: http://www.wpro.who.int/about/regional_committee/63/resolutions/WPR_RC63_R7_RD_Nomination_code_of_conduct_complete_with_annex.pdf

[102] Amendments to Rules 24 and 25; secrecy of the nomination process was preserved but provision was made for secret ballots to eliminate candidates where there was more than one; the practice of one nomination to the EB was continued

[103] For example in 1961 when Rule 27 was deleted and Rules 11, 25, 33, 35, 44 and 46 revised

[104] Rule 4 in 1951 required the Regional Director to report to the RC any member's absence at two consecutive meetings; that rule no longer exists

[105] Rule 20 of the 1951 Rules of Procedures of the Regional Committee for the Western Pacific

[106] Rule 21 of the 1951 Rules of Procedures ibid

[107] Rules 4 and 5 of 2012 revision op. cit.

The decision was postponed and does not appear to have been formally raised again.[108]

The first meeting of the WPR Regional Committee was scheduled for March 1951. It was postponed by a decision of that year's January Executive Board because of the international situation prevailing at the time.[109] By authority of WHA4 the first meeting of the Regional Committee (RCM1) was convened on 18th May 1951 in Geneva. It met between 0930 and 1145 and constituted the Western Pacific Region.[110]

The second RCM was held in September 1951 and since then there is an unbroken record of annual WPR Regional Committee meetings. RCMs were held mainly in September or October.[111] Their timing is coordinated with the World Health Assembly (May) and Executive Board (January and May after WHA). Members of the Regional Committee are the WPR Member States.[112]

From RCM2 until 1960 meetings were generally spread over a weekend and ranged from six to eight days.[113] The first Monday to Friday RCM was in 1960 in Manila. All meetings held at WPRO in the 1970's were Monday to Friday; weekends continued to be incorporated when meetings were hosted elsewhere. Monday to Friday meetings over five days appear to have become the norm from 1982.[114]

The default venue for RCMs is WPRO. Member States can also host RCM provided the invitation gives sufficient lead time[115], RCM agrees and the host government pays the difference between holding RCM at the Western Pacific Regional Office (WPRO) and the higher cost of it being held elsewhere. This arrangement is said to be unique to WPR and was first agreed by RCM4[116] and reaffirmed as appropriate by RCM19 in 1968.[117] At RCM24 in 1973 there was further discussion on the relative merits of the venue being WPRO or elsewhere. One MS said that having the RCM at WPRO enabled meeting more WPRO technical staff. Another view was that as long as the host was paying the additional costs hosting should continue. Of the 66 RCMs since 1951, 34 have been hosted by Member States.

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[108] WPR/RC27/ll Rev.l:
http://iris.wpro.who.int/bitstream/handle/10665.1/9238/WPR_RC027_11_RCM_Rev1_1976_en.pdf
[109] WHA4/43.20.2 http://apps.who.int/iris/bitstream/10665/101334/1/WHA4_43_eng.pdf
[110] *Summary of Resolutions and Decisions of the First Meeting of the Regional Committee of the Western Pacific Region* RC1/WP/7:.
http://apps.who.int/iris/bitstream/10665/138657/1/WPR_RC001_Res_Dec_1951_en.pdf
[111] One was held in August (1978); all have been held in October since 2010
[112] In accordance with Article 47 of the WHO Constitution and with Resolution WHA2.103
[113] WP/RC7.R22: http://apps.who.int/iris/bitstream/10665/142954/1/WPR_RC007_Res22_1956_en.pdf
[114] http://www.wpro.who.int/about/regional_committee/archive/en/
[115] Usually two years
[116] WPR/RC4.R3:
http://iris.wpro.who.int/bitstream/handle/10665.1/8439/WPR_RC004_Res03_1953_en.pdf
[117] WPR/RC19.R4: http://apps.who.int/iris/handle/10665/140984

Since 1951 the Rules of Procedures have stipulated that RCMs will be held in public unless the RC decides otherwise.[118] Since 2014 RCM has been live streamed.

RCM records of meetings and session minutes reflect a constant striving to improve efficiency and effectiveness particularly for planning, the programme budget (PB) development and presentation, Regional Director reports and technical discussions.

2.4   Setting the Agendas

There have always been three Rules of Procedures for the RCM agendas and only minor amendments since 1951.[119]

In 1951 Rules 9 and 10 for the RC agenda stipulated:

- The Regional Director draw up the agenda in consultation with the chairman;
- The provisional agenda be sent to members and the Director-General at least six weeks before the meeting;
- Five fixed agenda items while more could be included.[120]

The current agenda-related Rules stipulate:

- The Regional Director draw up the agenda in consultation with the chairman;
- The provisional agenda be sent to members with the notice of convocation in accordance with Rule 4 or Rule 5, as the case may be; [121]
- A minimum of seven agenda items for the Provisional Agenda.[122]

The Rules of Procedures proscribe some agenda items[123] and others are fixed by custom and practice[124]. Table 1 below shows the proscribed agenda items in 1951 and those stipulated by the Rules and Procedures as revised in 2012, the most recent revision. Since 2010 the agenda format has been significantly streamlined while still meeting the criteria.

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[118] Rule 5 in 1951 and Rule 6 now; the precise wording is unchanged
[119] In 1951 they were Rules 7, 8 and 9; by 1962 they had become Rules 7, 8 and 9 and remain so
[120] See Table 2
[121] The Rules require the notice of convocation is sent eight weeks before if a regular RCM session or within 15 days if a special session (subject to a majority of Member States not approving within two weeks)
[122] See Table 2
[123] *Rules of Procedures of the Regional Committee for the Western Pacific Region* (as revised in 2012): http://www.wpro.who.int/about/regional_committee/RulesofProcedureRCM63Sep2012EN.pdf
[124] Until 2012 this applied to the Regional Director annual report and PB agenda items for example

Table 1   RC Agenda Items stipulated by Rules of Procedures 1951 and 2012

1951	*2012*
	The annual report of the Director on the work in the Region
All items the inclusion of which has been ordered by the World Health Assembly	*All items, the inclusion of which has been prescribed by the World Health Assembly*
All items the inclusion of which has been ordered by the Executive Board	*All items, the inclusion of which has been prescribed by the Executive Board of the Organization*
Any item proposed by the Director-General	*Any item proposed by the Director-General or the Director*
	All items, the inclusion of which has been prescribed by the Committee at a previous session
	All items pertaining to the programme budget for the current financial period and all items pertaining to the programme budget for the financial period following the current financial period
Any item proposed by a Member or Associate Member of the Region	*Any item proposed by a Member*
Any item proposed by a member of the Committee	

The RCM agendas appear to meet current international thinking on best practice criteria for agendas of meetings.[125] The criteria, inter alia, are that agendas:

- Improve the effectiveness of meetings;
- Include standing items as well as specific topics of relevance;
- Alert members about issues to be discussed;
- Assist the chair ensuring all matters are dealt with;
- Be prepared by a combination of discussions between the Regional Director and the chair and Member States' input (using WPR as an example)[126].

It is this last point that is a current RCM reform focus: how best to elicit Member States' input.

Since 1951 Rules of Procedures have proscribed when the notice of convocation and provisional agendas must be sent to Member States (MS) but they are silent on how to gain MS input to the RCM agenda other than consultation with the Chairman.[127] Since 1989 - and perhaps before – further MS input to RCM agenda items was a request sent with the notice of convocation with limited responses. If a Member States' suggestion for an agenda item did not have regional bearing then - at least since the 1970s - the matter was negotiated. If it did not become an agenda item

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[125] For example, see the Australian institute of Company Directors (AICD), the New Zealand Institute of Company Directors, the Hong Kong Institute of Company Directors

[126] Australian Institute of Company Director guidelines which reflect those elsewhere are: "The agenda is usually prepared by the chairman with assistance from either the CEO, the board secretary or both. Sometimes the chairman will draft the agenda and the others will review it, sometimes it is done in a meeting with all contributing and sometimes it will be drafted by an executive with the chairman providing comment or revising the draft. Most chairmen will invite the other directors to contribute ideas for the agenda. This may happen annually, before each meeting or both. The chairman, however, has the final say on what appears on the agenda."

[127] In 1951 the notice of convocation and agenda was to be sent to MS this was '…at least six weeks…' before the RC; in 2012 it was '…at least eight weeks…'

then it became either a side technical discussion, was incorporated within a broader technical agenda item or some other mechanism was found for it be dealt with.[128]

Traditionally the Regional Director and his technical staff consulted with, listened to and analyzed country health needs to inform the RCM agenda. RCM24 noted for example *'…the principles and criteria of the Fourth Regional Programme of Work…'* which RCM had adopted *'… were the result of a continuous and fruitful dialogue with governments'*. How internal consultations are done within WPRO to prioritize provisional agenda items is said to have varied with different Regional Directors. Some eras are said to have been more consultative than others. In the current era where oral reflections are more easily obtained the process is inclusive, staff are aware of and expend considerable effort to contribute to thinking for provisional agendas and the development of regional strategies, and are keenly interested in RCM deliberations and decisions. There is also extensive consultation with MS and relevant partners and experts on RCM agenda items requiring a resolution.

Supplementary agenda items have always been subject to certain conditions in the Rules of Procedures. In 1951 six weeks notice was required prior to an RCM.[129] This rule was invoked in 1957 when a supplementary agenda was received too late and was held over until the following year.[130] Under the current rules the period of time is eight weeks if a regular session and 15 days if a special session (subject to a Member State not approving within two weeks). The RCM records do not show a large number of supplementary agenda items. Two examples are from Australia on Care of the Elderly in 1985[131] and from the Cook Islands in 1995 on Health and Environmental Effects of Nuclear Weapons[132].

In response to current WHO reforms and MS' requests for greater input to setting the RCM agenda RCM66 agreed changes to be implemented from RCM67 in 2016:

- Each RCM will now consider items for inclusion in the following year's agenda;
- The Regional Director and WPR EB members will have informal exchange on the sidelines of each January EB.

The Regional Director will then consult with the Chairman in compliance with the Rules of Procedure. Further changes are being discussed including rolling agendas. WPRO has always tracked future agenda items such as when a five or ten-year strategy needs renewal and resolution so there is already a type of rolling agenda. Current Secretariat discussions include how to make these more transparent and less full to give greater flexibility.

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[128] Personal communications

[129] Rule 11 of the RC Rules of Procedures 1951

[130] Referrred to in WP/RC9/6 when Viet Nam proposed an amendment to Rule 25 on the definition of a quorum: http://iris.wpro.who.int/bitstream/handle/10665.1/8762/WPR_RC009_06_Rules_1958_en.pdf

[131] WPR/RC36/19 Supplementary Agenda Item 1: http://iris.wpro.who.int/bitstream/handle/10665.1/6637/WPR_RC036_19_Elderly_1985_en.pdf

[132] WPR/RC46/1 Rev. 1 Add. 1: http://iris.wpro.who.int/bitstream/handle/10665.1/7716/WPR_RC046_01_PA_Rev01_Add01_1995_en.pdf

As this paper was being developed an internal paper was being prepared for RCM67 on various aspects of MS input to setting the RCM agenda including long-term planning, agenda prioritizing criteria and a possibly virtual agenda sub-committee echoing but not emulating EURO's which meets face-to-face five times a year. Even a virtual sub-committee meeting can be costly and complex and RCM may like to consider the costs, translation complexities and the risk of over-bureaucratizing the agenda setting process. A consideration for RCM may be to first test the new agenda consultation arrangements agreed by RCM66.

2.5   RCM Approaches

The RCM has mature formal processes and scripted meetings to support effective chairing, RCM staying focused, reaching its outcomes and complying with the Rules of Procedures. The meeting processes relied on corporate history until 2013. They are now written. Given the Chair rotates annually this is important. In early RCMs there were disagreements and formal voting was required on some agenda items.[133] From the 1960s there were divergent opinions in some discussions[134] but resolutions were usually agreed by consensus.

Over the decades the styles or interests of different Regional Directors[135], senior Secretariat staff, RCM chairs and Member State representatives is said to have influenced how RCMs were conducted and agendas set. This would reflect usual leadership, behavioural and attitudinal differences while it is anecdotal opinion rather than evidence and perceptions vary.

The mature RCM processes perhaps favour interventions[136] over interactive debate as do the well-researched agenda items that aim to achieve agreement by consensus. A risk of this approach is that more controversial or politically sensitive agenda items may not be raised or debate avoided even where the technical or administrative issue is important. Two technical examples are harm minimization for HIV/AIDS prevention during the 1990s and in the 2000s and perhaps trans-border sensitivities such as smoke haze or communicable diseases in border refugee camps today.[137] The considerably strengthened pre-agenda consultation and briefing processes introduced over the last six years further support consensus.

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[133] Rule 7 was debated in the 1950s on the size of a quorum citing travel difficulties within the region and two votes were taken to gain agreement; Rule 20 clarified the official languages as English and French; Rule 21 became that any delegate could speak in another language but would have to make their own provision for interpreting; it was 1972 before RCM23 resolved that Chinese would become an official language to enable interpretation facilities by the WPR Secretariat; English and French were retained as the working languages of the RCM

[134] For example in RC52 on the desirability of having a 'traditional medicine day'; WPR/RC52/7 http://iris.wpro.who.int/bitstream/handle/10665.1/7594/WPR_RC052_07_Traditional_Medicine_2001_en.pdf

[135] There have been six WPR Regional Directors: Dr Fang (1951-1966), Dr Francisco J Dy (July 1966-June 1979), Dr Hiroshi Nakajima (July 1979-June 1989), Dr Sang Tae Han (1989-1999), Dr Shigeru Omi (February 1999-Jan 2009), Dr Shin Young-soo (Feb 2009-current)

[136] During consultations it was said that interventions have been reducing but it is beyond the scope of this paper to analyze this

[137] Personal communication during consultations

The strengthened consultation processes for RCM technical agenda items since 2009 covered a wide range of RCM technical agenda items including universal health coverage (UHC), sustainable development goals (SDGs), environment and health, urban health and mental health. They also included cross-fertilization of thinking and themes with senior technical leaders presenting cross-cutting or other strategically relevant issues. An example is UHC being presented at the environment and health consultation in 2016 and in previous years at urban health and mental health consultations.

The MS briefing processes for each RCM agenda item were considerably strengthened from 2010. In 1999-2009 MS briefings were prepared by the Secretariat and sent to WRs about two weeks before RCMs. How the briefings were implemented is said to have been dependent on the WRs particular technical knowledge and different country contexts. Some WRs personally briefed ministers, others briefed ministry officials and others forwarded the written briefing papers to either ministers or ministries.[138] In the past briefing papers sent to WRs were not necessarily the same as those given to the Regional Director. Now they are. There are also now revised templates that are sent to WRs two months before the RCM.

While the RCM processes appear to be robust and mutual respect apparent in the various records of proceedings, the culture of the RCM does not appear to reflect the diversity of cultures across the region. This would be an interesting further study to directly elicit MS views of RCM cultural mores and their impact on RCM effectiveness.

A consideration for RCM is perhaps to assess the efficacy and impact of the revised RCM agenda consultation and briefing processes with a view to continuous quality improvement. It could be useful to know to what degree either or both contribute to MS discussions and reflections within their own contexts to arrive at RCMs fully briefed and able to agree to the resolutions with little controversy.

A further consideration is how best might RCM develop a process that enabled it to discuss sensitive issues early to ensure ongoing effectiveness in an increasingly complex world. Also for consideration might be how best to engage the highest-level decision-makers and on what issues. A consideration could be for high-level decision-makers to develop big picture thinking for the future, say each five years for the following decade within which strategically focused agendas could be set. A consideration for RCMs of the future is also the importance of relationships for efficient and effective responses to complex issues including those which emerge rapidly.

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[138] ibid

2.6   RCM Minutes[139]

There are Rules of Procedures for RCM minutes. They are largely unchanged since 1951 except for one difference. In 1951 the Rules required corrections to the minutes to be notified in writing within 20 days after their receipt. In 2016 the time line is set by the Regional Director according to the circumstances. The Rules in 1951 or now say that minutes will be distributed to the members *'…as soon as possible after the close of the meeting…'*.[140]

Until 2010 records of each day's RCM sessions were prepared overnight, copied, delivered to each delegate's hotel room by approximately 0500 and corrected or signed off by RCM each morning. The minutes were not always exactly verbatim but were fulsome and comments were attributed to the relevant speaker. Where there was a written intervention this was represented in full. An assumption could be made that because the minutes were fulsome and were checked daily when delegates' memories were fresh they are accurate. A view is that this was not necessarily so as delegates sometimes adjusted wording where they saw possible sensitivities or inaccuracies in what had been said.[141]

The overnight approach required a large number of people of all levels to work long hours each day and night into the early morning, including translators, word processors (and typists in earlier eras), photocopiers (and Gestetner machines and other devices in earlier eras). People from that era describe the experience variously but with a common theme that it was stressful, took a toll on the physical and mental wellbeing of Secretariat staff at all levels and did not add sufficient value to warrant either this or the financial expense while the intense team work required was said to be satisfying for some. Changes were made from 2009 and summary reports were introduced in 2010 and a daily journal summarizing each day's discussions with the draft summary record of meeting circulated after the RCM. The intent of the resolutions became more consistently clear and can now be more usually read as stand alone statements. The changes increased efficiency and clarity.

2.7   Priorities and Planning

RCM technical agendas items should ideally be based on priorities identified through planning. Article 28 (part g) of the WHO Constitution requires the EB *'…to submit to the Health Assembly for consideration and approval a general programme of work covering a specific period…'*. The first (global) General Programme of Work (GPW1) was in 1952 and was originally for four years. It and the next two GPWs were each

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[139] The Institutional Repository of Information (IRIS) commenced in 1998 to digitally store all WHO documents; WPRO's digitalization is up-to-date from RCM1 in 1951
[140] Rule 8 of 1951 and Rule 19 of 2012
[141] Personal communication during consultations

extended by one year to five.[142] In parallel until 1976 the Western Pacific RCM developed its own *General Programme of Work for the Western Pacific Region*. [143]

In 2016 one of the WHO reforms under discussion is forward looking agenda setting for RCM. RCM1 discussed this forward looking approach in 1951. RCM2 wanted a five-year regional progamme plan prepared for recommendation to the Director-General as the framework for WPRO programme preparation and the RCM agenda. RCM2 instructed the Regional Director to prepare this in consultation with *'…as many (countries in the region) as practicable…'* for discussion and consideration by RCM3.[144] RCM2 also called on Member States to make use of WHO WPRO technical support to develop short and long-term national health programmes.[145]

RCM3 reiterated the necessity of long term planning, noted the difficulty of this without data and information from countries, called for their cooperation, instructed the Regional Director to consult further and said RCM4 would consider the issue again the following year.[146] RCM4 again called for member states' cooperation and asked the Regional Director to continue consultation and *'…to prepare, when sufficient data have been accumulated, a long-term programme for discussion and consideration…'* by the RCM *'…in a future session'*. RCM6 recommended that Member States, particularly developing countries, *'…give priority to both short- and long-term planning in environmental sanitation in their annual programmes and budgets in public health…'.[147]*

In 1968 there was a significant shift at global level[148] when WHA and EB proposed long term regional planning and projections to the end of the 20th century with new biennial planning and programme budgets. Regional plans were to be based on Member States national plans - which had been an aim of RCM2 in 1951. Long-term financial indicators were proposed, a different approach to budgeting and programme development and evaluation was emphasised. The five-year GPW4[149] was extended to a sixth year, 1967-1972, to enable wider consultation with countries for a bottom up planning process, to be coordinated by the regions and forwarded to the EB. At RCM66, some fifty years later, the Regional Director affirmed that the *'…bottom-up approach employed in the 2016-2017 budget*

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[142] 1952-1956, 1957-1961, 1962-1966
[143] *Final report of the twenty-sixth session for the Regional Committee of the Western Pacific Region.* WPR/RC26/17: http://iris.wpro.who.int/handle/10665.1/9113
[144] WPR/RC2. R7: http://iris.wpro.who.int/bitstream/handle/10665.1/8248/WPR_RC002_Res07_1951_en.pdf
[145] WPR/RC2.R9 following WHA/4/R/83: http://iris.wpro.who.int/bitstream/handle/10665.1/8251/WPR_RC002_Res09_1951_en.pdf
[146] WPR/RC3.R3: http://iris.wpro.who.int/bitstream/handle/10665.1/8353/WPR_RC003_Res03_1952_en.pdf
[147] WP/RC6.R9 and WP/RC6.R8 in the *Final report of Sixth Session of the Regional Committee of the Western Pacific* WP/RC621 Rev. 1: http://iris.wpro.who.int/bitstream/handle/10665.1/8425/WPR_RC006_21_FinRep_Rev1_1955_en
[148] WHA21.49: (http://apps.who.int/iris/bitstream/10665/167457/1/49006.pdf) and 22.53 (http://apps.who.int/iris/bitstream/10665/141811/1/WPR_RC021_PB4_1970_en.pdf) ; EB43.R19 (http://apps.who.int/iris/bitstream/10665/89855/1/EB43R19_eng.pdf)
[149] EB45/23 stipulated that GPWs were to be 5 years: http://apps.who.int/iris/bitstream/10665/144824/1/EB45_23_eng.pdf

planning process…' was the appropriate approach to identify Member States needs and priorities.

RCM10 in 1969 noted its satisfaction with progress in long term health planning. RCM12 discussed how best to set the priorities requested by WHA14[150] [151] and its views were conveyed to WHA15 along with those of the EB.

RCM20 had an agenda item on regional long term planning in response to a WHA resolution[152] on 'Long-term Planning in the Field of Health, Biennial Programming and improvement of the Evaluation Process' [153] and noted its satisfaction that future GPWs would be five years not four. The RCM20 resolution on planning is long and detailed and contains technical and planning direction and guidelines to Member States.[154]

RCM21 adopted its *Fourth General Programme of Work for the Western Pacific* RCM21 adopted its *Fourth General Programme of Work for the Western Pacific Region (1973-1977)* and recommended its incorporation into WHO's overall GPW5. When completed however, RCM felt that GPW5 did not sufficiently reflect regional needs. For GPW6 RCM26 forwarded its priorities to WHA and decided to review whether it was necessary for WPR to have its own separate General Programme of Work when GPW6 was completed.[155] RCM27 in 1976 resolved that WPR developing its own WPR GPW would *'… serve no useful purpose…'* as GPW6 provided sufficient guidance. Instead it established a RCM Sub-Committee on the WPR General Programme of Work *'…to review analyze and make recommendations on the development and implementation of…'* the Global Programme of Work as it affected the Western Pacific Region.[156]

In 1980 a review of GPW6 revealed challenges however.[157] In particular the way it was structured was found to be *'… a serious obstacle to integrated programming…'* and the implementation responsibilities of each level of WHO were unclear. How the GPW's criteria had been applied was found to be inadequate other than the criteria of responding to the priorities of developing countries. The RCM's comments and views on this review were conveyed to the EB to take into consideration when preparing GPW7.

[150] WHA14.39: http://apps.who.int/iris/bitstream/10665/89022/3/WHA14.39_eng.pdf
[151] For example priority setting was discussed - at least - at the EB's 19th, 21st, 23rd,and 25th sessions and the WHA's 10th, 11th, 12th, and 13th sessions
[152] WHA22.53: http://apps.who.int/iris/bitstream/10665/91278/1/WHA22.53_eng.pdf
[153] WPR/RC20.R1:
http://iris.wpro.who.int/bitstream/handle/10665.1/9066/WPR_RC020_Res01_1969_en.pdf
[154] ibid
[155] WPR/RC26.R12:
http://iris.wpro.who.int/bitstream/handle/10665.1/9158/WPR_RC026_Res12_1975_en.pdf
[156] WPR/RC27.16:
http://apps.who.int/iris/bitstream/10665/141386/1/WPR_RC027_16_Finrep_1976_en.pdf
[157] DG0/80.5 in WPR/RC31/18 Add. 1:
http://iris.wpro.who.int/bitstream/handle/10665.1/6905/WPR_RC031_SR05_1980_en.pdf

The purpose of GPWs has been described variously over the years contributing perhaps to the many efforts to improve them - a significant challenge without apparent shared agreement on their purpose. WHA4 in 1951 considered that GPW1 (1952-1956) provided *'…a broad general policy that will serve as an appropriate framework for the orderly development of the detailed yearly programmes within this period'*.[158] WHA8 said GPW2 provided guidance *'…for the development of detailed Annual Programmes for the period 1957-1960'*. WHA13 and WHA14 had similar views for GPW3 (over four years, 1962-1965) and GPW4 (over five years, 1967-1971). RCM10 described the GPWs as *'…a broad general policy…'* approach for the development of its regional annual programmes.

In 2006 the then WHO Director-General[159] said that the GPWs were not just to guide the work of WHO but were for the action by all *'…the world health community…'* whether government, non-government or others. In the foreword of GPW12 (2014-2109) the purpose is described differently again as providing *'…a high level strategic vision for the work of WHO…'* with the intent to *'…drive the…work (of WHO)…across and between different levels of the Organization'*.[160]

Adding to the planning complexity are higher-level goals agreed from time to time such as the Millenium Development Goals (MDGs)[161] with GPW11 being developed for a ten-year period to coincide with the MDGs and now the Sustainable Development Goals to 1930. After the 10-year GPW11 Member States requested returning to six-year GPWs and GPW12 is 2014-2019.[162]

None of the changes clarify how RCM set its administrative and technical priorities. A challenge for the current WHO reforms is how to set, and focus on, strategic priorities. As part of this RCM is discussing rolling agendas and other strategies to increase Member States' input to setting RCM agendas.

Setting RCM strategic priorities may, however, continue to be problematic in the absence of a shared strategic vision for the future. A key consideration for RCM is that by reflecting on the past a shared understanding on the desired health future for the region may be possible and also the strategic priorities to achieve that future. In this way RCM could assure that its technical agendas and the work of the Secretariat reflect the strategic priorities. High-level decision-makers set their national health policies within their own socio-economic-political and cultural environments. It would seem appropriate that a consideration for RCM is that this same approach may be appropriate at regional level. An approach might be high-level decision-makers, drawing on their national, regional and global experience, meeting together each five years to first set - and then each five years refresh - the strategic vision, direction and priorities for the future health of the Western Pacific Region.

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[158] A WHA4.2 (A4/R/19): http://apps.who.int/iris/bitstream/10665/86375/1/WHA4.2_eng.pdf
[159] op. cit. see footnote 2 above
[160] http://apps.who.int/iris/bitstream/10665/112792/1/GPW_2014-2019_eng.pdf?ua=1
[161] op. cit. see footnote 2 above
[162] Decisions on changing GPW timelines include WHA2.62; EB4.R.11; EB23,R76; WHA12.27; EB32.R13; WHA17.38 and on in this vein

To support this approach the Secretariat, working with key constituents, could provide informative technical analysis on priority regional health issues including demographic trends and projections. Much valuable oral history and insights about WPR and the RCM have been lost over the years. Regular analysis each five years or each decade could also be invaluable in capturing history efficiently and accurately to enable ongoing reflection to inform future thinking.

Knowing the future vision and direction and the strategic priorities to achieve them would better equip WPRO to ensure it has the future capacity and capability to fulfill the WHO constitution as the lead health agency, including ensuring it has the bold and innovative thinkers needed to shape and lead to the future.

2.8   Programme Budget

GPWs are translated into programme budgets (PB). The PB dictates what plans WPRO can deliver on. RCM has always agreed and monitored the PB annually even when the PB became biennial in 1968. The Programme Budget is a significant RCM agenda item. PBs have always been influenced by geopolitics and the global economy leading to budget uncertainty including because of arrears in voluntary contributions and inflexibility from 'earmarked' budgets.

From 1951-1998 PBs were developed largely from historical budgets with adjustments reflecting that year's fiscal envelope. There was little or no flexibility to respond to emerging issues or health contexts including through extra-budgetary funding. Changes in 1998 and after attempted to redress this.

In 2000 RCM noted the reduced regular budget had a negative impact on collaborative programmes but also noted its appreciation of a new PB format for 2002-2003. The RCM expressed appreciation in particular for *'…the presentation of the budget for the Organization as a whole, the inclusion of expected results and measurable indicators, the clear and transparent explanation of the indicative planning figures for each country, and the opportunity to conduct detailed planning nearer the time of implementation'*.[163]

In 2006 budgeting shifted to a results-based approach but flexibility between programmes remained limited. In 2013 WHA initiated another new approach considering guiding principles, criteria, scope and methodology for country, headquarters, administration and emergency allocation. The percentage allocated to WPR decreased from 14% to 10.6%. As the overall WHO budget increased by 8% there was no impact on RCM agendas for 2016-2017.[164]

Flexibility remained problematic as around 75% of voluntary funds are earmarked for specific programmes while there is an intention to increase flexibility of assessed and voluntary contributions. Monitoring and reporting on the PB is through annual

[163] WPR/RC51.R1: http://apps.who.int/iris/bitstream/10665/138490/1/WPR_RC051_Res01_2000_en.pdf
[164] RC *Final Report of the Regional Committee, Western Pacific Region. 2015:* http://iris.wpro.who.int/bitstream/handle/10665.1/13289/WPR_RC066_12_FinRep_2015_en.pdf

reports to the RCM and globally through the electronic Global Management System (GMS).

The ongoing efforts of RCM to improve efficiency and effectiveness is reflected in the many changes to PBs since 1951 as are the complexities of developing PBs that enable and support WPRO deliver on its plans and RCM resolutions.

2.9 RCM Sub-Committees

Rule 15 of the 1951 and 2012 RC Rules of Procedures enables RCM to establish any sub-committee it thinks necessary for the study of, and for reporting on, any item in the agenda. Since 1951 the RCM must review any sub-committee at least annually. Rule 53 requires an *'…appropriate sub-committee…'* to review any changes to the Rules.

A proposal in the current WHO reforms is that all regions have a programme and budget sub-committee. The WPR RCM had various types of sub-committees from 1951 until 1998 including a programme and budget sub-committee.

RCM sub-committees in 1951 and 1952 reviewed the annual report of the Regional Director and made recommendations to the RCM. In 1953 RCM4 decided to follow the same process because of the length of the agenda. Four MS representatives were appointed, were asked to meet over the weekend and reported back to the RCM on the Monday. RCM5 did not continue this approach.

In 1955 RCM6 established a Programme and Budget Sub-Committee that reviewed the PB. RCM7 resolved that the sub-committee should become a routine activity of the RCM, that there would be rotating membership of six but any MS would be *'…entitled to participate…'*.[165] The range of work of the sub-committee was extensive and its recommendations had far reaching impact on RCM's deliberations including modifying WPRO programmes of work[166] and proposing new emphases and approaches in the region.[167]   RCM21 increased the sub-committee membership to half the members of the RCM defined as 17 members, rotation was retained and any interested RCM member could still participate.[168]   RCM24 in 1973 discussed extensive guidelines for the sub-committee.[169]

In 1976 the Programme and Budget Sub-Committee was not reconstituted and RCM27 established two new sub-committees.

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[165] WPR/RC7.R7:
http://iris.wpro.who.int/bitstream/handle/10665.1/12534/WPR_RC007_Res07_1956_fr.pdf
[166] This happened commonly; an example can be seen at WP/RC12/P&B/WP/1
[167] For example inter-country collaborative activities being emphasized in 1974, see WPR/RC22.R23:
http://apps.who.int/iris/bitstream/10665/139576/1/WPR_RC012_13_SubComPB_1961_en.pdf
[168] WPR/RC21.R1: http://apps.who.int/iris/bitstream/10665/142385/1/WPR_RC021_Res01_1970_en.pdf
[169] WPR/RC24/P&B/1:
http://iris.wpro.who.int/bitstream/handle/10665.1/9371/WPR_RC024_PB1_1973_en.pdf

The first was the Sub-Committee on the General Program of Work with four rotating members, rising to seven and then eight in 1981.[170] RCM31 noted that some Member States were not funding this sub-committee, undermining its roles as *'...a major policy-making organ and forum…'* for technical cooperation.[171] RCM31 set the sub-committee's work program each year and it reported annually the RCM. The report to RCM32 for example was on *'…indicators at country level for the implementation, monitoring and evaluation of national strategies for health for all by the year 2000'.* The sub-committee also presented its preliminary view of activities at country level for the international Drinking-Water Supply and Sanitation Decade. RCM32 requested the Regional Director *'…take into consideration…'* the sub-committees views and asked the sub-committee to continue to analyze the impact of WHO's collaboration with Member States, to review, monitor and evaluate implementation towards health for all by the year 2000, and to review progress on organizational restructuring of WPRO.

The second sub-committee RCM established was for Technical Cooperation among Developing Countries (TCDC). As it did for the Sub-Committee on the General Program of Work, RCM directed TCDC's work annually. RCM30 in 1979 wanted to define *'…the true meaning of the term "technical cooperation" and to establish what, in the activities of WHO, the concept of TCDC embraced'*. It asked the TCDC to discuss this in depth. EB65 echoed the views of the RCM and a report was prepared on behalf of the Director-General and submitted to *'…Regional Directors so that they could bring it to the attention of regional committees'*.

In 1981 the TCDC visited countries for the first time. While RCM32 felt its visits should be longer to be effective the TCDC informed the RCM of problems within countries or agencies including inadequate financing of exchange fellows, communication difficulties between collaborating centres, inadequate knowledge of resources by requesting countries of donor countries and other matters. RCM32 agreed with the TCDC's recommendations to resolve these issues.[172] The RCM directive for the TCDC's 1982 work was *'The role of WHO collaborating centres in promoting technical cooperation among countries, in relation to the special needs of developing countries'*.

In 1985 RCM36 amalgamated the two sub-committees[173] to become the RCM Sub-Committee on Programmes and Technical Cooperation. Its purpose was to annually advise RCM on technical matters as directed by RCM. Examples of RCM directives for this new Sub-Committee include the Expanded Programme of Immunization and the review and analysis of the impact of the WHO's cooperation with Member States in communicable diseases. ⬚

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[170] WPR/RC30.R9:
http://iris.wpro.who.int/bitstream/handle/10665.1/9571/WPR_RC030_Res09_1979_en.pdf
[171] Report of the Regional Director. WPR/RC31/11:
http://apps.who.int/iris/bitstream/10665/141140/1/WPR_RC031_11_RDRep_1980_en.pdf
[172] WPR/RC32/3: http://iris.wpro.who.int/handle/10665.1/6389
[173] WPR/RC36.R13: http://iris.wpro.who.int/handle/10665.1/6721

RCM46 in 1995 asked the Regional Director to undertake a review and analysis of the value and effectiveness of the work of the sub-committee for RCM47 in 1996. RCM47 emphasized the value of the sub-committee including their country visits for information gathering and sharing of experience. It endorsed the recommendation that the sub-committee had a continuing relevant role while the Regional Director stressed its value was dependent on *'…the caliber and experience…'* of its members.[174] Two years later in 1998 RCM49 endorsed the sub-committee's proposals to meet only when required to perform a specific task instead of annually and only do country visits when specifically requested to do so.[175] In 2001 RCM52 also decided not to reconvene the sub-committee and thereafter no mention of it was found.[176] Since 1998 it has not been convened. Table 2 below gives the start and end points of RCM sub-committees.

Table 2   RMC Sub-Committees since 1951

Sub-Committee Name	*Created*	*Discontinued*
Programme and Budget	1955 http://iris.wpro.who.int/handle/10665.1/8542	1976 http://iris.wpro.who.int/handle/10665.1/9387
General Program of Work	1976	1985
Technical Cooperation among Developing Countries (TCDC)	1976/1977 http://iris.wpro.who.int/handle/10665.1/9830 WPR/RC28/19	1985 http://iris.wpro.who.int/handle/10665.1/6721 WP/RC7/16
Programmes and Technical Cooperation	1985 http://iris.wpro.who.int/handle/10665.1/9362	1998 WPR/RC49/R8

2.10   Country reports

Country reports were a regular feature of RCM from the 1960s. By 1973 there were twelve country reports to RCM[177] and also twelve in 1976[178]. In RCM30 in 1979 there were fourteen 'brief' country reports. In 1980 there were no country reports and there do not appear to have been any since. They were perhaps initially replaced by the country visit reports of the TCDC.

The purpose of country reports was to assist RCM understand MS issues and progress and for MS to learn from each other. T The breadth and depth of their content varied as did the perception of their value. Most lacked data and rigorous analysis. Some governments did not wish to present all aspects of their systems where there were perceived weaknesses. Not all members found all content equally

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[174] WPR/RC47/18: http://iris.wpro.who.int/handle/10665.1/7055

[175] WPR/RC49.R8: http://iris.wpro.who.int/handle/10665.1/7345

[176] WPR/RC36/5: http://iris.wpro.who.int/handle/10665.1/6633

[177] Australia, French Polynesia, Hong Kong, Japan, Khmer Republic, Laos, Macau, Malaysia, New Zealand, Republic of Korea, Republic of Viet Nam, Portuguese, Timor

[178] Australia, Fiji, French Polynesia, Hong Kong, Japan, Macao, Malaysia, New Zealand, Papua New Guinea, Phillipines, Republic of Korea, Socialist Republic of Viet Nam

useful. The feeling of some people at the time was they did not add sufficient value to RCM deliberations yet took up valuable MS time to prepare them and RCM time to consider them.

Given the maturity of RCM and the strategic philosophy to place and keep countries at the centre, countries presenting in RCM side events on their key successes and also, importantly, their key challenges is being progressed. The aim is a facilitated and interactive format with other countries provide advice and insights from their experience and potentially lively, interesting and constructive debate becoming a norm.

2.11   WHA and EB Resolutions

Regionally relevant WHA and EB resolutions and decisions have been a fixed item on the RCM agenda since 1951[179] to ensure coordination and alignment. In 1976 WHA29 gave EB responsibility to more actively manage the Organization.[180] RCM27 considered this would mean an increase in the involvement of all Member States especially given some RCM members are also members of EB. The Regional Director reported to RCM47 that WPR was among the most responsive to EB requests. He cited the shift of 5% of the allocation for 1996-1997 to programmes identified by the EB saying that WPR had exceeded that target.

The WHA and EB Resolutions are generally either an agreed global approach (for example the WHO Framework Convention of Tobacco Control in 2003) leading to regional strategies[181] or framed as requests or suggestions. From time to time RCM commented favorably on coordination and alignment with WHA and EB. An example is RCM32 when it expressed satisfaction with the efforts being made by WHA, the EB and the regions to *'…correlate…'* their work.[182] On rare occasions the RCM records contain a critique of WHA such as RCM47 when a delegate said the WHA agenda was not responsive to country needs. The specific issue was no WHA agenda item marking the International Decade of the World's Indigenous People.

2.12   Technical Discussions

There have been non-agenda technical discussions at RCM from 1952 of various formats. They began following a suggestion by EB8 that regions consider the merits of such discussions, focused on technical areas of interest regionally. RCM7 in 1956 stressed that technical discussions should be of regional interest and also appropriate to the place of meeting.[183] Initially the Regional Director proposed one

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[179] See Table 2
[180] EB58.R11: http://apps.who.int/iris/bitstream/10665/90971/1/EB58R11_eng.pdf
[181] This was the first WHO treaty adopted under article 19 of the WHO constitution and led to WPR initiatives recently refreshed as WPR/RC65.R2, the *Regional Action Plan for the Tobacco Free Initiative in Western Pacific (2015-2019):*
http://apps.who.int/iris/bitstream/10665/170625/1/WPR_RC065_Res02_2014_en.pdf and
http://www.wpro.who.int/tobacco/en/
[182] WPR/RC32.R10:
http://iris.wpro.who.int/bitstream/handle/10665.1/6401/WPR_RC032_Res10_1982_en.pdf
[183] WP/RC11/TD4:
http://iris.wpro.who.int/bitstream/handle/10665.1/8785/WPR_RC011_TD4_1960_en.pdf

topic to RCM for the following year. In 1957 the topic was leprosy control and included a field visit. In 1958 the topic was *'Methods and Approaches in the Improvement of Vital and Health Statistics Services in Rural Areas'*.

By RCM11 the Regional Director was proposing several topics to the RCM for it to choose one.[184] The technical discussions were not to exceed three half-day periods and included an opening and closing plenary session and small group discussions. Participants included representatives from Member States, United Nations Specialized Agencies and non-governmental organizations in official relations with WHO.

Examples of later topics include *'Environmental pollution problems and approaches to their control'* in 1972. In RCM24 in 1973 the topic was *'The Role of the Hospital in the Community and the Financing of Hospital-Based Medical Care'*. In 1974 the topic was *'Control of Vector Mosquitos of Dengue Haemorrhagic Fever'*. *'Health education and rural water supply and sanitation'* was the topic in 1981 and *'New policies for health education and information in support of health for all by the year 2000'* in 1982. It was not always clear whether the technical discussions if there was a strategic link between them and RCM agenda items.

RCM24 discussed whether to continue technical discussions as part of the RCM meetings. RCM25 agreed to them continuing. [185] The topic was to be particularly relevant to the Region and ample time allowed for discussion and for conclusions to be reached.

On occasion technical topics have been a backdrop to a future agenda item to increase knowledge and understanding as part of the RCM agenda item preparation process. This is said to be true today[186] and dates from RCM3 in 1952 where the technical topic was *'Education and Training of Medical and Public Health Personnel'*. There were three subsequent RCM agenda items on education and training (1952 and 1953) building up to seven in the next decade (1961-1970) and reducing to two and then one in each subsequent decade. This is a pattern reflected over the years – an RCM focus, sometimes intense and over several years, and then tapering off as other issues become priorities.

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[184] WP/RC11/TD4 The topics were (i) the role of health services in the improvement of community water supplies as environmental sanitation had never been discussed at a technical discussion and WHA12.48 had emphasized its importance; (ii) dental health as the 1961 RC was to be in NZ where there dental health service was 'well advanced' and there had been a 2nd regional seminar on dental health approximately two years previously which had stimulated interest; (iii) the role of immunization in communicable diseases because CDs would remain a problem and immunization needed to be brought to the foreground
[185] WPR/RC25.R12:
http://apps.who.int/iris/bitstream/10665/142499/1/WPR_RC025_Res12_1974_en.pdf
[186] Personal communication during consultations as well as documented evidence e.g. the 1952 example used

In 1995 RCM46 referred to *'…its commitment to continuing to review its own methods of work in the light of changing circumstances and the health needs in the Region'.* As part of this, RCM said it was willing to explore alternative methods to the Technical Discussions for conveying information to Member States during an RCM. The 1995 WHA decided that a limited number of technical briefs and informal forums for dialogue would replace technical discussions[187] and this was introduced for using subject experts for RCM47 and RCM48.

RCM48 determined the Technical Briefs were valuable and would continue. RCM48 also requested the Regional Director to explore changing their format to reduce them by half a day. RCM48 also decided the topic for the RCM49 would be traditional medicine and it would be preceded by a presentation by an expert in the field.[188]

RCM50 included a Ministerial Round Table. RCM50 felt this approach was useful to member States and to WPRO and contributed to the Regional Director's aim of RCM meetings being more participatory. It decided to continue Ministerial Round Tables as part of future RCM and discontinue technical briefings.[189] The Ministerial Round Tables continued until RCM57 in 2006.[190] There were also two keynote speakers additional to the Director General during this period.[191]

Expert technical panels with an expert moderator were introduced in the current era and are said to be stimulating and useful.[192] The topics for the technical panel can be suggested by Member States or the Secretariat. [193] If the former then WHO works with the MS nominating the item to prepare the detail. There are also lunchtime technical discussions. Representatives at RCM63 expressed interest in health financing reform and universal health coverage. Many offered to share their national experiences and expertise in both fields and at RCM66 the panel discussion was Universal Health Coverage (which incorporates health financing). At RCM66 there were concurrent lunchtime technical discussions. MS requested these revert to one only each lunchtime to allow all to participate. This was agreed.

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[187] WPR/RC46/21: http://apps.who.int/iris/bitstream/10665/142197/1/WPR_RC046_21_TD_1995_en.pdf
[188] WPR/RC48.R6:
http://iris.wpro.who.int/bitstream/handle/10665.1/7220/WPR_RC048_Res06_1997_en.pdf
[189] WPR/RC50.R9
[190] The subjects covered by the Ministerial Round Tables were Health and Poverty (WPR/RC51/1); Diet, Physical Activity and Health (52nd RC); Future Directions for Public Health in the Region (53rd RC); International Co-operation in the Face of Public Health Emergencies (54th RC); Responding to Health Aspects of Disasters (55th RC); Translation of Research into Policy and Health Care Practice (56th RC)
[191] Mr Tadao Chino, President, Asian Development Bank in 51st RC; Professor Willia Hsiaio in 55th RC
[192] Personal communications during consultations
[193] Panel discussion topics include non-communicable diseases at RCM62; food and nutrition security at RCM63; Universal Health Coverage at RCM66

2.13   Regional Committee Delegates

Historically there has always been a mix of delegates, now called representatives, at RCM.[194] There were no Ministers at the RCM1 in 1951. Britain's chief delegate was the deputy Chief Medical Officer (CMO) of the Colonial Office. Australia's chief delegate was the CMO from Australia House and the Australian Director-General of health was a delegate. From Korea was an advisor to the Minister of Health and from Viet Nam a former Minister. New Zealand's chief delegate was the Director of Public Hygiene.

Traditionally more Pacific ministers and heads of their ministries have attended than from other MS. In 1970 RCM21 discussed a possible conference of health ministers to enable policy makers to discuss issues perhaps prior to a WHA and see whether this might assist greater effectiveness in coordination.[195] The proposition was not agreed.

Table 3 below shows trends in representatives to RCM by each decade from 1955 - and each five years for 2005-2015, as far as can be ascertained given titles were not always recorded. The data shows no Ministers attending each five years from 1955, five in 1985, a 65% increase in Ministers attending in 2010 compared with 2005 and a return to 1995 levels in 2015 when RCM was held in Guam. The only apparent variables in the last 15 years are venue and visa access and in 2010, the relatively recent election of the current Regional Director.[196] Table 4 explores Ministerial and non-MS attendance further.

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[194] Originally called 'delegates'
[195] WPR/RC21/15; the suggestion was from Malaysia and did not come to fruition
[196] Dr Shin Young-Soo

Table 3 RCM attendees each 10-years 1955-2005 and each five-years 2005-2015

Category	*2015 RCM66 Guam*	*RCM61 2010 Putrajaya*	*RCM56 2005 Noumea*	*RCM46 1995 Manila*	*RCM 36 1985 Manila*	*RCM 26 1975 Manila*	*RCM16 1965 Seoul*	*RCM 6 1955 Singapore*
Total people at RC	170	203	131	150	106	77	47	39
MS Representatives	124	143	112	102	64	40	43	28
Ministers attending+	11	21	13	10	5	Nil	Nil	Nil
% Ministers from Pacific	57%	43%	54%	80%	60%	Nil	Nil	Nil
Heads of MOH+	11	16	12	11	5	5~	4	2
% Heads MOH from Pacific+	82%	63%	58%	63%	80%	60%	50%	Nil
UN Offices, Specialized Agencies & Related Organizations	Nil	3"	2	3	3	2	2	3
Other Intergovernmental Agencies	2	2"	1	2	2	1	2	2
NGOs with official WHO relationship	13	12"	6	37	33	30	20	9
*Other Observers^*	7*	Nil	2'	Nil	Nil	3	Nil	Nil

+ Figures are based on some assumptions of titles used in the RCM Lists of Representatives
* Six of the observing organizations were from Guam with 23 people observing out of a total of 25 people representing 7 organizations; the low number of non- Guam observers may be related to the relative difficulty in travelling to Guam and visa requirements
~Figures include the director-general of PNG when PNG was an Associate Member and its attendance was reported separately
" Non-MS attendees in RCM61 were all recorded in one group; these figures are extracted according to the taxonomy in table above
' The observers were called 'special guests' and were a consultant from Canada and a professor from the University of Noumea
^Observer figures refer to the number of organizations, not the number of people

Given the importance of strategically effective collaboration to the future of international health cooperation a closer look at the data on non-MS attendees 2005-2015 and for each ten years previously to 1988 is presented in Table 4 below. The data is presented as a ratio of the number of non-MS organizations attending in each category against the total number of non-MS representatives. The first-term election year for the last three Regional Directors is also included and the year of the new Regional Directors' first RCM to see if this influenced either non-MS attendees or Ministerial attendance.

The data shows an increase in Ministerial attendance in the first-term election year of Regional Directors and in the year following for their first RCM as the Director. This is most prominent in the last two first-term elections in 2008 and 1998. The percentage of Ministers from the Pacific remains fairly steady independent of the spikes. The percentage is approximately 50% as is attendance of heads of health departments from 1995 with approximately 50-80% of these from the Pacific.

The data also shows that the overall number of non-MS attendees may be influenced by where the RCM is held, possibly related to ease of travel and visas. There were fewer non-MS attendees in Guam and Patrajaya for example at RCM66 and RCM61 respectively than there were at RCM60 in Hong Kong and at most of the RCMs held in Manila. UN representation is fairly steady other than where travel is more challenging and with a noticeable spike in the current Regional Director first-term election years of 2008 and 2009; similarly for other intergovernmental agencies.

NGO attendance has varied. On the data analyzed NGO attendance was higher in 1989 and 1998 than in ensuing years, spiked in the 2008 and 2009 election years in terms of number of representatives attending, was building steadily from 2012 but had a large drop off in RCM66 in Guam. Observers from host countries are actively encouraged and this is reflected in recent data. There was a dip in non-MS representatives to RCM62 in 2011, for reasons unknown, which picked up from 2012 to drop again at RCM66 in Guam.

A consideration for RCM is to ensure non-MS organizations are strategically targeted given the new imperatives triggered by more sophisticated understanding of public health and the SDGs, to strategically engage with a range of constituents, some of which may be new.

Table 4 RCM Ministerial and non-MS attendees 2005-2015 and in first-term election years and 1st-term RCM election year and 1st RCM year 1998-99 and 1988-89

Category	RCM66 2015 Guam	RCM65 2014 Manila	RCM64 2013 Manila	RCM63 2012 Hanoi	RCM62 2011 Manila	RCM61 2010 Patrajaya	RCM60> 2009 Hong Kong	RCM59" 2008 Manila^	RCM57 2006 Auckland	RCM50> 1999 Macau	RCM49" 1998^ Manila	RCM40> 1989 Manila	RCM" 1988
Ministers attending+	11	15	13	11	13	21	20	16	19	15	13	6	10
% from the Pacific	57%	66%	46%	55%	62%	43%	55%	56%	58%	53%	77%	66%	60%
UN Offices, Specialized Agencies & Related Organization:people	Nil	3:4	3:4	3:3	1:3	3:4	7:9	6:6	3:3	Nil	1:1	3:3	2:2
Other Intergovernmental Agencies:people	2:2	2:2	1:1	Nil	2:2	2:2	Nil	5:5	5:7	2:2	2:2	3:3	2:2
NGOs with official WHO relationships:people	13:19	22:71	20:42	24:40	15:29	12:18	21:81*	21:35	15:37	20:30	35:50	32:34	20:21
Other Observers organizations:people	7:25	4:23+	6:15+	7:40+	4:38+	Nil	8:8	5:20	23:25+	1:1	1:1	3:3	2:2

+ Figures are based on some assumptions of titles used in the RCM Lists of Representatives

"First-term election for Regional Director; there have been six regional directors since 1951 (Dr. I. C Fang 1951-June 1966; Dr Francisco J. Dy of the Philippines Junly 1966-June 1976; Dr Hiroshi Nakajina of Japan July 1979-January 1989; Dr Hang Sae Tae of Korea Feb 1989-Jan1999; Dr Sigeru Omi of Japan Feb 1999-Jan 2009; Dr Shin Young-Soo of Korea Feb 2009-current

> First RCM of new Regional Director

* Includes 28 people from the International Council of Nurses; its International Congress was held that year in South Africa – it is unknown why there was this one-off surge in attendance

+ Sixteen of the observers at RCM65 were from the Philippines DOH, ten at RCM64, and 22 at RCM62 – all were RCMs held in Manila; at RCM63 in Hanoi 30 observers of the 40 were from the Government of Viet Nam; this is a pattern repeated when RCMs are hosted by a MS

^Korea and Japan had unusually large numbers of official representatives at RCM59 in 2008 and RCM49 in 1998, first term election years for Regional Directors; at RCM59 Korea had 35 official representatives to witness the election of Korea's Dr, Shin Young-Soo and Japan 12 to witness their Dr. Sigeru Omi's last RMC as Regional Director; at RCM49 there were 34 official representatives from Japan to witness the election of Japan's Dr Omi as Regional Director and from Korea 14 to witness its Dr Hang Sae Tae last RCM as Regional Director

It is unknown why Ministers and directors-general from all countries do not always attend. Accurate exploration and analysis would require consultations beyond the scope of this paper and this could be a future consideration. Some hypotheses can be postulated.

The first is that perhaps the Secretariat is doing its job so well that some countries feel well briefed and can comfortably send representatives for their Ministers. The change to the consultation process for RCM technical agenda items this decade will have contributed to this and could have at least three impacts. The first is that increased understanding and engagement translates into more of the most senior decision makers attending RCM. The second is the opposite – the consultation process is translating into high-level decision makers feeling they do not need to attend RCM as the agenda items and likely outcomes are understood and agreed. A third scenario is that the consultation process builds networks and relationships and there is interest in furthering these through attending RCM.

All RCM MS are also members of the WHA and perhaps some ministers and directors-general choose to attend WHA preferring to send their deputies and other technical experts to the RCM. On a rotating basis some WPR MS are also members of the EB and may not feel they need to also attend RCM. Senior health leaders have many demands on their time including requests to attend international meetings and choices need to be made about priorities. Regional Directors appear to have always engaged at the highest levels across the Region between RCMs. Perhaps some ministers felt this sufficient and they did not need to attend RCM.

Perhaps the processes for developing an agenda item and resolution meant that controversy was unlikely and some ministers and directors-general were happy to entrust their country's views and contributions at RCM to their delegates. Perhaps for some countries there was no latitude for a delegate's own view only that formally agreed within country and it mattered not that ministers or directors-general were not there. Where a new item was raised at RCM for example it was not usually extensively explored at that RCM. It may have become a future agenda or dealt with in some other way to allow analysis and consultation.

It could be that the formal format of RCM does not suit all cultures given the diversity and complexity of the region. It may be that processes could better reflect the region's cultural diversity and add richness to RCM proceedings.

There have been various strategies to make RCM stimulating and interesting beyond the formal agenda. These include technical discussions from 1950s, the Ministerial Round Tables and key-note speakers in the 1990's and the moderated expert panels and side technical discussions now. These last are said to engage strong interest of RCM attendees. A consideration could be to further examine the topics chosen for their strategic relevance to high-level national decision-making. The suggestion that it may be useful for countries to present at RCM side events has been made earlier.

Technology is already changing how RCM is conducted and may influence who attends in the future. Given that from 2014 the RCM proceedings have been streamed live, and interactive virtual attendance is technologically possible, virtual engagement of some may become a norm over the next decade or two either through them being live-streamed in or they using instant technology to give instructions to their on-site representatives. Either scenario could result in greater debate rather than representatives coming to RCM with instructions on a country's position.

RCM2 identified the importance of having consistent delegates for RCM to be maximally effective. Overall, there is no particular pattern of continuity of delegates since 1951 reflecting realities as politics and positions and public health issues change within countries.

A gender analysis of representatives has not been possible without extensive further research as initials only were sometimes used for delegates in the early years with or without the gender-neutral title 'doctor'. A representative at RCM47 in 1976, the International Women's Year[197], stated *'…there was not one woman sitting at the meeting table…'*[198]. RCM47 consequently resolved to increase the participation of women on expert advisory bodies and requested the Regional Director to '…continue efforts *to reach the 30% target for representation of women in the professional category…'* including through increasing the number of women on the Fellowship program.[199] Thought could be given to capturing gender data on RCM attendees to enable trend analysis.

A consideration for RCM is whether the uneven attendance of Ministers and directors-general of health at RCM matters. If RCM considered developing a regional strategic vision with high-level decision-makers as discussed earlier, and given that RCM is being live streamed and virtual attendance is a future possibility, it may not. If it does matter then a consideration is in what way and what might be strategies for further engagement. The personal inputs and face-to-face communications are powerful factors for encouraging formal and informal debate, understanding and relationships despite technological possibilities of virtual meetings. A key consideration for RCM remains high-level decision makers setting the vision and direction for the region's health gains to enable setting of strategic priorities.

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[197] WHA29.43: http://apps.who.int/iris/bitstream/10665/93070/1/WHA29.43_eng.pdf
[198] WPR/RC27/16: http://iris.wpro.who.int/handle/10665.1/9250 and http://www.who.int/iris/handle/10665/207428
[199] WPR/RC47/SR18 and WPR/RC47.R11 recalling WHA38.12, WHA49.9, EB91.R 16, EB93.R 17 and EB97.R 12

2.14   Regional Director Annual Reports

The annual reports of the Regional Director to each RCM are a rich source of information on trends, progress and issues in the Region over the years. They provide context to the RCM agenda items and resolutions and show interesting points of history such as when (then Western) Samoa was first considering introducing primary health care in 1976. There is no legal requirement for them but they have been custom and practice since 1951. A consideration for RCM is the annual reports as a collective being worthy of a separate historical analysis of greater depth. A few of the annual reports have been selected at random to illustrate their richness, historical importance and continuing importance to contextualizing RCM agendas and deliberations.

The first Regional Director's annual report was presented to RCM2 in September 1951 in Manila. It was eighteen pages long and covered administrative matters (such as relocation of WPRO from Hong Kong to Manila, a host agreement with the government of the Philippines, the EB-approved organizational structure), comment on a range of technical issues and the specific support WPRO had provided to Member States.

The technical issues presented in the report included eradication of epidemic and endemic diseases (malaria, tuberculosis, diphtheria and yaws) including a malaria and insect control program in Cambodia and a joint BOG vaccine project with UNICEF and the United States Public Health Service; health systems strengthening including proving public health administrators, promotion of maternal and child health and welfare; promotion of improvement in nutrition and promotion of improved standards of teaching and training in the health, medical and related professions including through Fellowships. The Regional Director emphasized that the educational aspects of all projects had been stressed from the beginning.

The 10th Annual Report of the Regional Director (1 July 1959 – 30 June 1960) was 160 pages long, provided a four page summary overview and the remainder was detail on administrative matters and technical programmes. The Regional Director[200] noted the assistance given to strengthen central health administrations *'…in the belief that …no logical and rapid development of health services will be possible without technically strong central administrations'*. He talked of expanded support for rural health services; some increased acceptance of an integrated approach to public health; implementation of long range plans in maternal and child health, encouraging strengthening of nursing; increased awareness of Member States on strengthening environmental sanitation and an anthropological study which demonstrated the relationship of nutrition to whole of life.

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[200] Dr. Francisco J Dy, WPRO's 2nd Regional Director

The Regional Director also highlighted challenges including the difficulty of appointing suitable counterpart staff, frequent changes of national staff and the importance of maintaining continuity, project implementation challenges where rural health services were weak, delayed or there was inadequate government contribution to local costs and the prescient view of the risk that WHO's focus was spread too widely and expansion was too rapid.[201]

In 1976 the Regional Director reported to RCM27 that there were preliminary talks with (then Western) Samoa on establishing a primary health care system, that governments were being encouraged to expand their programmes of immunization with its health workforce properly oriented and sufficient vaccine supplies. He noted the reduced number of requests for health workforce development and suggested this indicated that some countries were now able to develop their own workforce. He also reported that the Regional Teacher Training Centre in Sydney commenced its first Master's degree in health personnel education in 1975. He reported as a *'…milestone…'* the establishment of the Regional Advisory Committee on Medical Research in 1976. He also said that four *'…country health information profiles…'* had been cleared by the governments concerned compiled from various government, WHO and United Nations sources.

RCM46 proposed a new approach to the annual report of the Regional Director, agreeing there would in future be a health situation report focused on priority activities and their results. RCM47 in 1996 resolved there would be short annual reports in even-numbered years covering significant issues and developments. In odd-numbered years there were to be comprehensive reports. RCM47 said this new approach was *'…more focused…'.*[202] The Regional Director reported on communicable disease control and the work done in rapid response to disease outbreaks; health reform and New Horizons in Health; progress in eradicating polio; the future of small island countries linked to environmental issues; exchanging information on traditional medicine and control of tobacco use. He also suggested adding a seventh priority to WPRO's work, the management and control of new, emerging and re-emerging diseases. RCM47 agreed to this after reviewing the programme budget.

RCM47 requested the Regional Director to include *'…an in-depth review of a certain issue…'.*[203] RCM48 decided this should be called *Fifty Years in the Western Pacific 1948-1988.* It was published as a separate book as part two of the Regional Director's report to RCM49.[204]

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[201] The Regional Director's 10th annual report also warned RCM there was *'…a danger which should be avoided at all costs and that is that activities may be spread too widely and expansion may be too rapid'* http://iris.wpro.who.int/handle/10665.1/8746
[202] Final report of the forty-seventh session of the Regional Committee for the Western Pacific Meeting: http://iris.wpro.who.int/handle/10665.1/7055
[203] PR/RC47.R3: http://iris.wpro.who.int/bitstream/handle/10665.1/7106/WPR_RC047_Res03_1996_en.pdf
[204] ibid WPR/RC49/3: http://iris.wpro.who.int/handle/10665.1/10212

While commending the Regional Director on the clarity of the new reporting format RCM47 also wanted analysis of health statistics, including the use of graphs or tables as relevant, and analysis of the outcomes of WHO's collaborative activities. In addition RCM47 wanted successes and failures included and the reasons for them, with a view to learning from the past. RCM felt the Regional Director reports had not been clear about successes, failures and impediments to progress.

RCM also noted that a new approach to the PB included narrative on evaluation and achievements and constraints and budget trends and that this greater analysis could be included in future Regional Director reports. RCM47 agreed future annual reports would include an in-depth study, the subject to be proposed by the Regional Director each year. Human Resources for Health was the subject chosen for 1997.[205] The Regional Director committed to make every effort to improve the reports on an incremental basis and would attempt to reconcile the RCM requests with WHA and HQ requirements.

In 1980 the Regional Director described in his annual report *'…newly emerging trends…'* which were *'…the very foundation on which programmes of cooperation rested…'*. They were:

- The managerial process for national health development;
- Adoption of a multidisciplinary approach to the development and delivery of primary health care;
- Community involvement in health activities and activities not necessarily directly concerned with health but leading to the promotion of health;
- The training of health workers so as to re-orientate them to the specific delivery of disease control activities within primary health care; and
- Intersectoral coordination between national agencies and other agencies whose activities had an impact on health.

The 1995-1996 annual report is illustrative of that decade. It was long, 105 pages of script, and reported on both broad issues and on detail using a programmatically-based framework. Like all the annual reports it reported on historically important issues. These included:

- The 1994 *Yanuca Island Declaration on Health in the Pacific in the Twenty First Century* which had adopted *Health Islands* as its unifying theme;
- The increasing importance of multisectoral collaborayion for health development; and
- The link between the RCM-endorsed 1994 *New horizons in health* and the WHO *Renewing the health-for-all strategy*.

As with previous decades, it also reported considerable details such as two meetings with the Economic and Social Committee of Asia and the Pacific.

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[205] WPR/RC47.R3: http://iris.wpro.who.int/handle/10665.1/7106

From 2009 there was significant effort to re-shape the Regional Director's annual report framework, approach and presentation. This included a shift away from presenting details such as the number of training courses or meetings to focus instead on important themes and highlights in an integrated approach rather than along WHO technical programme structure. Detail is now to be found in background papers. There is now consistency of style and approach and powerful use of imagery and stories focused on keeping countries at the centre.

In March 2015 there were internal discussion on the merits of moving to a biennial report. The conclusion was that annual reports were important, allowing countries' stories to be captured each year, achievements and challenges to be highlighted and communicated externally and internally, that they assisted accountability and provide opportunity for cross-cutting team work across WPR.

Examples of the new approach from the 2014-2015 Regional Director's annual report highlight the significant and sustained effort needed by many, sometimes for years, to achieve sustainable public health gains, and the importance of new thinking to address ongoing and emerging issues to reflect the deeper understanding of public health and contextual changes, including socio-politically, scientifically and technologically. Examples included in the Regional Director's report are:

- Progress on tobacco reduction initiatives;
- The elimination of measles in three countries bringing the total to seven countries and areas;[206]
- The reduction of hepatitis B prevalence to less than 1% in five year olds in American Samoa;
- The new Early Essential Newborn Care approach;
- The first ever regional forum for regional collaborating centres;[207]
- The inclusion of violence for the first time in the agenda of RCM66 and that it causes more deaths each year than AIDS, malaria and tuberculosis combined; and
- A priority new issue of strengthening emergency response preparedness following the Ebola crisis in Africa and the outbreak of the Middle East respiratory syndrome coronavirus in the Republic of Korea.

The Regional Director also reported to RCM on the importance of *'…working across sectors, across borders and across societies'.[208]*

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[206] Brunei Darussalam, Cambodia and Japan
[207] Cambodia, the Lao People's Democratic Republic, Malaysia, Mongolia and Solomon Islands
[208] RC66 Record of Meeting on the Regional directors annual report

2.15   Multisectoral Collaboration

Collaboration with state and nongovernmental organizations has been a feature of WPR's work since 1951. There was less collaboration with the private sector although RCM27 conveyed its appreciation to the Japan Shipbuilding Industry for its second donation to WHO. Early cooperation with the United Nations Children's Fund (UNICEF) in 1951 continued through the decades. In 1960 the Regional Director informed the RCM of a range of cooperation activities. These included with UNICEF, the Rockefeller and Asia Foundations, the Food and Agriculture Organisation[209]; close working with a special UN committee in the Mekong Delta[210]; collaboration with UNESCO and others. The Regional Director described the most ambitious of the joint undertakings was a rural development project in Laos with the UN, ILO, FAO and UNESCO.[211] The Regional Director reported increasingly close cooperation with SPC[212] and also, illustrating both collaboration and the level of detail in annual reports of that period, the WPRO nursing advisor's attendance at the International Council of Nurses Conference held in Melbourne that year.

In 1988 WHA41 resolved to eradicate polio across the world and launched a global initiative led by the World Health Organization, Rotary International, the US Centers for Disease Control and Prevention and the United Nations Children's Fund (UNICEF).[213] [214] In 1998 the Regional Director's report showed separate collaborative projects with UNFPA[215], UNICEF and UNDP[216], UNICEF and a ministerial-led meeting with ESCAP[217], the World Bank, ADB[218] and SPC[219]. The numerous WPR collaborations now are no longer reflected specifically in RCM records.

RCM27 noted the extent to which WHO was becoming dependent on extra budgetary resources to implement some WHA resolutions.[220] RCM47 expressed its thanks to extra-budgetary partners that had enabled immunization activities. The Regional Director at RCM63 noted that voluntary funding for WHO *'…was closely and rigidly attributed…'* reducing flexibility to move funds to underfunded strategic objectives. The risk was, and is, potentially skewed programmatic work driven by donor funding. The Regional Director hoped that increased accountability and transparency through the WHO reforms would increase funding flexibility.

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[209] Bilharziasis project in the Phillipines and a survey in Laos

[210] United Nations Committee on Co-ordination of Investigations in the Lower Mekong Basin

[211] The International Labor Organization, the Food and Agricultural Organization of the United Nations and the United Nations Educational, Scientific and Cultural organization

[212] Formally the South Pacific Commission now called the Pacific Community

[213] WHA41.28: http://www.who.int/iris/handle/10665/195671 HA 41.28 Global eradication of poliomyelitis by the year 2000 [pdf 25kb]

[214] Continued through the GPEI's Polio Eradication and Endgame Strategic Plan 2013-2018 (PEESP)

[215] United Nations Fund for Population Activities

[216] United Nations Development Program

[217] The United Nations Economic and Social Commission for Asia and the Pacific

[218] Asia Development Bank

[219] WHO and SPC signed a Memorandum of Understanding in 1996

[220] Twenty-sixth annual report of the Regional Director to the Regional Committee for the Western Pacific covering the period, 1 July 1975-30 June 1976: http://iris.wpro.who.int/handle/10665.1/9199

In 2016 WHO hosts or participates in a multitude of multi-agency groups for a range of activities. An for example is as a member of the Board of the Asia Pacific Observatory on Health Systems and Policies which was first hosted by WPRO and now SEARO.

RCM66, noting the Regional Director's emphasis on the importance of collaboration, said that WHO *'…should engage fully, appropriately and pragmatically…with foundations, academia, nongovernmental organizations and private industry, bearing in mind the massive proportion of health dollars spent in the private sector, in food industries and on medicine…'.*

Considerations for RCM include the extent that extra-budgetary funding influences programmatic work of WHO and its alignment with WPR strategic priorities; increasing future budget flexibility, and the minimization, management or mitigation of conflict of interest. To assist the expanded approach to collaboration RCM66 considered the draft *Framework for Engagement with non-State Actors,* a resolution of the 2016 WHA. [221] [222]

2.16 Current reforms

There have also been criticisms of *'…entrenched structural and managerial problems…'* in WHO and capacity gaps.[223] In 2012 a view was '…*WHO has been going through a reform process for the past decade without first understanding why the reform is needed...'.*

WPR strongly embarked on new strategic and anticipatory technical and organizational reforms from 2009 with an overarching focus of keeping countries at the centre. Reviews in 2012 and 2014 showed strong progress and successes and the reforms continue with clear actions to achieve further progress. WHO globally has four reform targets: programmatic, governance, managerial and emergency response. The WPR and global reform processes are strategically linked including through the Regional Director jointly chairing the global T*askforce on the Roles and Functions of the Three Levels of WHO* and MS representation on the global reform governance committee[224]. It is not the first time that WHO has embarked on reforms. RCM47 for example noted global discussions on the purpose of WHO and also felt organization reform was needed if WHO were to retain its lead position in world health, a prescient view.[225]

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[221] Including for the SDGs
[222] WPR/RC66/10
[223] ibid
[224] China and Australia are the RCM representatives; the committee first met in March 2015
[225] For example see EB136/PSF/4 Provisional Summary Record of the Fourth Meeting (p. 8):
http://apps.who.int/gb/ebwha/pdf_files/EB136-PSR/B136_PSR4-en.pdf

RCM66 in 2015 was briefed on currently proposed reform measures. These include:

- A six-year, forward-looking agenda for the Executive Board and the World Health Assembly;
- Further restrictions on late proposals;
- A code of practice for participation in governing body meetings;
- Changes to the process for selection of Regional Directors;
- An accountability compact between the Director-General and Regional Directors;
- Formal constitution of the Global Policy Group; and
- Improvements to regional committee processes including standing committees for all regions and budget documentation.

RCM66 noted that the global reforms were proceeding slowly.

PART 3   TECHNICAL RESOLUTIONS

3.1   Global Trends

WHA set six public health priorities in 1948, mainly vertically focused. In 2016 the priorities in GPW12 encompass broader approaches such as rural-urban differences and under-five mortality reflecting the increasing tension over the decades between vertical and systems approaches. The broader approaches give a larger canvas on which to paint but also require significant strategic focus at global and regional level to ensure impact. Overarching priorities also influenced the RCM agenda such as *Health for All*, the *Millenium Development Goals 2000-2015* and the current *Sustainable Development Goals (SDGs) 2015-2030* which aim to *'…transform our world…'*[226] and which have been linked to relevant RCM agenda items from RCM66. Table 5 below presents this information in tabular form for easy comparison.

Arguably some of the MDGs were less systems focused than the SDGs. MDG4 for example was reduce child mortality, MDG5 was improve maternal health and MDG6 was combat HIV/AIDS, malaria and other diseases which could be likened to WHO programmatic approaches of the time. A criticism of the MDGs is that progress was limited, uneven across countries and improvements may have happened without the MDGs. Others assert they were a bold and galvanizing idea that was needed to reinvigorate waning international donors. Evidence for this is that between 2000-2005 aid flows doubled to US$120b, health spending doubled, primary education spending tripled and there was greater donor coordination towards common goals.[227]

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[226] https://sustainabledevelopment.un.org/post2015/transformingourworld

[227] ww.huffingtonpost.com/michael-hobbes/the-millennium-development-goals-were-bullshit_b_8114410.html; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3877943/

To achieve the three SDG end-goals of end poverty, combat climate change and fight injustice and inequality by 2030[228] will require vigorously strategic inter-sectoral work. It will be challenging for WHO as the world's lead technical agency on health to find the balance between the sometimes necessary vertical focus to achieve impact such as its DOTS[229] strategy for tuberculosis treatment versus the integrated intersectoral and systems-focus needed to achieve the SDGs, while not working so broadly that impact is dissipated.

Some examples illustrate. Still to be fully conceptualized is how WHO will vigorously and strategically ensure maximum synergy and measureable cross-cutting impact through its work on clean water and sanitation (SDG6) with sustainable cities and communities (SDG11), industry, innovation and infrastructure (SDG9), climate action (SDG13), life on land (SDG15) and below water (SDG 14) and partnerships for end goals (SDG17). An added challenge is that not withstanding GPWs and the higher-level goals agreed from time to time such as MDGs and SDGs the RCM must also respond to Member States' priority needs in the region and within countries that may not always mirror SDG priorities.

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[228] www.globalgoals.org
[229] *Directly Observed Treatment Short-Course* (DOTS) for tuberculosis treatment

Table 5 Trends in Global Priorities influencing RCM technical agendas

1948 WHA priorities	*Millenium Development Goals 2000-2015*	*Twelfth WHO Global Programme of Work 2014-2019*	*Sustainable Development Goals 2015-2030*	*SDG End-Goals for 2030*
1. Malaria, maternal and child, tuberculosis, venereal disease, nutrition and environmental sanitation 2. Public health administration 3. Parasitic diseases 4. Viral diseases 5. Mental health 6. Other	1. Eradicate extreme hunger and poverty 2. Achieve universal primary education 3. Promote gender equality and empower women 4. Reduce child mortality 5. Improve Maternal Health 6. Combat HIV/AIDS, malaria and other diseases 7. Ensure environmental sustainability 8. Develop a Global Partnership for Development	1. Reduce under-five mortality 2. Reduce maternal mortality 3. Reduce the number of people dying from AIDS, tuberculosis and malaria 4. Prevent death, illness and disability arising from emergency 5. Reduce rural-urban differences in under-five mortality	1. No poverty 2. Zero hunger 3. Good health and wellbeing 4. Quality education 5. Gender equality 6. Clean water and sanitation 7. Affordable and clean energy 8. Decent work and economic growth 9. Industry, innovation and infrastructure 10. Reduced inequalities 11. Sustainable cities and communities 12. Responsible consumption and production 13. Climate action 14. Life below water 15. Life on land 16. Peace, justice and strong institutions 17. Partnerships for end goals	1. End poverty 2. Combat climate change 3. Fight injustice and inequality

3.2   RCM Resolutions Overview

The importance of RCM technical resolutions is that most represent the key RCM technical focus and decisions over the decades that guided WPRO's technical work. Many of the resolutions require a degree of analysis to understand their context and what they were responding to, particularly from the earlier years when they were less consistently written as stand-alone statements. Table 6 below presents an overview of RCM technical resolutions since 1951 within the newly developed taxonomy.[230]

Table 6 RCM Technical Resolutions 1951-2015

Taxonomy Category	Number of Technical Resolutions
Communicable Diseases	106
Disability	3
Emergencies and Disasters	4
Food and Nutrition	21
Health Information	3
Health Promotion	6
Health Research	21
Health Risk Factors	23
Health Service Delivery	14
Health Systems	8
Human Resources for Health	36
Maternal and Child Health	21
Medicines	14
National Health Plans	26
Non-Communicable Diseases	20
Occupational and Environmental Health	38
Populations	12
Total	**376**

Key change in the characteristics of RCM technical discussions from the 1950s and now are that the deeper understanding and knowledge of public health issues is reflected in more complex conceptual thinking. This has led to new and innovative approaches. Progress reports are now clustered and do not require RCM resolutions. A major strategic development is that all RCM resolutions since 2013 are specifcally related to strategies, actions and plans rather than urging commitment on a technical issue with few or no specifics as was the case on occasion previously. Table 7 below illustrates.

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[230] See Annex 2 for all RCM technical resolutions since 1951

Table 7 RCM Resolutions Related to Regional Action Plans 1970-2015
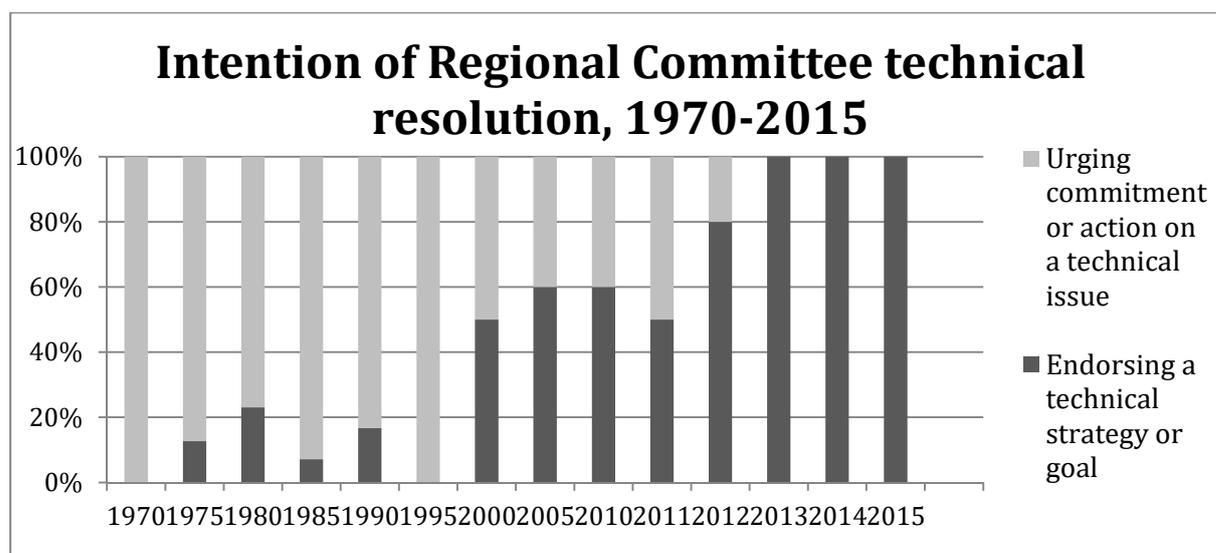
The new technical focus on the newborn, for example, is reflected in the *Action Plan for Healthy Newborn Infants in The Western Pacific Region (2014-2020)*, ageing in the *Regional framework for action on ageing and health in the Western Pacific (2014–2019)*, UHC in *Universal Health Coverage: Moving Towards Better Health*, tobacco in the *Tobacco Free Initiative: Regional Action Plan (2015-2019)*, neglected tropical diseases in the *Regional Action Plan for Neglected Tropical Diseases in the Western Pacific (2012-2016*), disaster management in the *Western Pacific Regional Framework for disaster risk management* and similarly for other current technical issues. Resolutions now also include a reporting-back requirement to RCM, are time bound and are based on documented strategies, action plans or frameworks.

RCM resolutions are referenced by the particular RCM number, the agenda item to which it refers and where it is in the sequence of resolutions for that RCM. Because there is little consistency in the titles of RCM technical resolutions searching for and categorizing the digitalized data-base can be a lengthy process. In preparing this paper WPRO's organizational structure was tested as a way of categorizing the technical resolutions. This approach was discarded as the structure has changed regularly and may again. To understand, interrogate and analyze the pattern of technical resolutions a technical taxonomy was therefore developed with senior WPRO technical staff. WPRO may like to consider the merits of having a formally agreed taxonomy, taking its digitalized data base to the next step to make searches faster and its rich literature, guidelines and other documents more immediately accessible.

The number of RCM agenda items and resolutions has varied from four each in RCM1 in 1951 to a high of 31 in 1980. The percentage of technical resolutions to administrative resolutions steadily increased from 22% in 1951-1960 to 58% in the five years 2001-2015. [231] The figures are not strictly comparative as the structure of the agendas and whether each agenda item required a resolution changed over the years. From 1951 to 1997 every RCM agenda item had a resolution, including each regionally relevant WHA or EB resolution. From RCM24 in 1973 regionally relevant WHA and EB resolutions were clustered as one agenda item with one ensuing RCM resolution.[232] From RCM51 in 2000 WHA and EB resolutions were listed as a 'coordination' agenda item and were adopted or noted or discussed without, usually, any RCM resolution.

From 1998 there were RCM resolutions only on selected agenda items. An example was in 2000 when RCM discussed hepatitis and a resolution was not required.[233] RCM58 in 2007 introduced 'follow up reports' - called 'progress reports' from 2008 – which were clustered as one agenda item and there was no resolution. This continues to today.

Some RCM resolutions appear to be one-off but may signal the start of a five-year or longer strategic plan or framework particularly from the 2000s. Significant technical work and progress may have resulted but further RCM resolutions were not required. In 2006, for example, a one-off RCM57 resolution was for the Regional Strategy on Human Resources for Health 2006-2015. A different type of one-off resolution was in RCM2 on countries establishing an international health section in their health directorates. Other one-off resolutions that did not trigger new or continuing work by the Secretariat or MS included a RCM10 resolution on the International Health and Medical Research Year[234] and a RCM46 resolution in 1995 acknowledging the International Decade of the World's Indigenous People.

Not all the Secretariat's technical work required a RCM resolution. For the first three decades for example there was no RCM resolution on venereal disease but PBs show there was technical support to countries from the very early years and RCM26 adopted a cluster of WHA resolutions that included sexually transmitted diseases under one RCM resolution.[235] The numbers and types of technical advisors[236] gives further insight into WPRO's work outside the RCM resolutions as do successive Regional Director reports and PBs. Since 2009 the agendas and resolution requirements have been significantly streamlined reducing further the number of resolutions. Progress reports, for example, are now clustered and do not generally require a resolution.

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[231] See Annex 2 for agenda items and resolutions disaggregated for each year
[232] WPR/RC24.R2: http://www2.wpro.who.int/rcm/en/archives/rc24/wpr_rc24_r02.htm
[233] WPR/RC50/9: http://iris.wpro.who.int/handle/10665.1/12122
[234] WPR/RC10.R10: http://www2.wpro.who.int/rcm/en/archives/rc10/wpr_rc10_r10.htm
[235] WPR/RC26.R3 which included the adoption of WHA28.58 on sexually transmitted diseases: http://iris.wpro.who.int/handle/10665.1/9812
[236] For example, in 1953/1954 the Regional Advisers were for tuberculosis, venereal disease, nursing, health education of the public, maternal and child health, environmental sanitation, education and training

In summary, since 1998 the number of technical issues RCM discussed was greater than the number of technical resolutions made.

Table 8 RCM Agenda Items, Total Resolutions and Technical Resolutions

	1951-1960	*1961-1970*	*1971-1980*	*1981-1990*	*1991-2000*	*2001-2010*	*2010-2015**	*Total 1951-2015*
Total Number of Agenda Items	198	124	239	201	167	154	60	**1143**
Total Number of Resolutions	198	124	239	201	146	90	40	**1038**
Total Number of Technical Resolutions	43	38	81	77	66	48	23	**376**
% Technical to Administrative Resolutions	**22%**	**31%**	**34%**	**38%**	**45%**	**53%**	**58%**	**36%**

* Five years only

3.4   Technical shifts

The technical focus of RCM shifted across the decades, remaining responsive to regional and country health needs. Priorities in the 1950s included workforce development to address the collapse of heath systems from the devastation caused by World War Two, communicable diseases (CDs) and non-communicable diseases (NCDs)[237]. In 1953 RCM4 gave the Regional Director authority to establish regional priorities for projects of regional significance, subject to funding. Within this authority, RCM4 directed the Regional Director to assist in strengthening national health administrations, continue to assist education and training, relate both to region-wide disease control where possible and ensure *'…maximum aid…'* for the control of smallpox, tuberculosis, malaria, yaws, venereal disease and nutritional diseases'.[238]

In the decade 1951-1960 RCM made resolutions on insecticide resistance, water and sanitation, nutritional diseases and mental health and RCM's health system focus was mainly workforce development and national health plans. In 2001-2015 RCM resolutions reflected the increasingly complex issues and conceptual thinking to achieve health gains and included now the double burden of nutrition[239], violence, urban health, tobacco, antimicrobial resistance, universal health coverage (UHCO

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[237] The terms 'non-communicable diseases' did not come into common useage until the 1970s and 1980s
[238] WP/RC4.R12:
http://iris.wpro.who.int/handle/10665.1/8446 and
http://www.who.int/iris/handle/10665/246708
[239] By 2010-2015 nutrition was not just nutritional diseases but nutrition within the context of the double burden of disease as in Lewis, Milton James and Macpherson, Kerrie L. *Health Transitions and the Double Disease Burden in Asia and the Pacific* 1980

and ageing. Table 9 below presents examples (only) of changes in RCM technical focus 1951-1960, 1991-2000 and 2011-2015.

Table 9 <u>Examples</u> of shifts in RCM technical focus by RCM resolution or progress reports 1951-1960, 1991-2000, 2010-2015*

Taxonomy Category	1951-1960*	1991-2000	2011-2015*
Communicable Diseases	*leprosy, smallpox, malaria, vector-borne*	*CSR, tuberculosis, STIs and HIV/AIDS, cholera and diarrheal diseases, leprosy, malaria, poliomyelitis,*	*CSR, viral hepatitis, tuberculosis, neglected tropical diseases*
Disability	*-*	*-*	*blindness prevention*
Emergencies and disasters	*emergencies and disasters (responding to national disaster in Taiwan)*	*-*	*regional framework*
Food and Nutrition	*nutritional diseases (micronutrients)*	*nutrition in WPR, breast milk substitutes marketing, infant & young child nutrition*	*double burden of nutrition, food safety*
Health Information	*-*	*-*	*-*
Health Promotion	*-*	*-*	*urban health, violence*
Health Research	*International Health and Medical Research Year (acknowledgement of)*	*development of health research*	*-*
Health Risk Factors	*-*	*tobacco*	*tobacco*
Health Service Delivery	*-*	*quality assurance*	*-*
Health Systems	*-*	*-*	*universal health coverage*
Human Resources for Health	*training, fellowships*	*training, fellowships*	*regional strategy (includes fellowships)*
Maternal and Child Health	*immunization*		*immunization, new born infants*
Medicines	*-*	*-*	*AMR, essential medicines, traditional medicines*
National Health Plans	*planning & programmes, public health cooperation*	*planning & programmes*	*-*
Non-Communicable Diseases	*mental health*	*NCD plans and strategies*	*risk factors (e.g. tobacco), mental health, health promotion, NCD plans and strategies*
Occupational and Environmental Health	*chemical safety, sanitation & water safety*	*environmental health*	*-*
Populations	*refugees*	*ageing, indigenous people, women's health*	*regional strategy on ageing*

* Examples are based on RCM resolutions in each period

A striking pattern in RCM resolutions is the intense focus on a particular issue or issues for discrete periods and the different influencing factors for this. In the first decade 1951-1960 there were 11 RCM resolutions on malaria. The key influencing factor was that WHA1 in 1948 determined that malaria was the first of its six global health priorities.[240] There were twelve resolutions on training in 1961-1970 and ten in 1971-1980 reflecting that it was a key strategy in that era for strengthening health systems.

In 1971-1980 the major focus was occupational and environmental health with seventeen resolutions encompassing chemical safety, air pollution and water and sanitation. Health research and health risks, specifically alcohol and other drug dependence, were also a focus in the same decade (seven resolutions each). The Regional Director noted in his 1973 annual report that the then family health programme was a high priority because of the many requests from countries for support. The RCM was focused as well on the planning and organizing of health services including management, health system research and analysis and health workforce planning and development.

By 1975 the health system focus included increasing the effectiveness and efficiency of health and medical services and the planning and organizing of health services at various levels. Successive RCMs also considered and made resolutions on matters such as health planning courses, consultant services, management and health practice research and systems analysis.

In 1980 the Regional Director reported on the *'…newly emerging trends…'* which were *'…the very foundation on which programmes of cooperation rested…'*[241] included management and national health development, primary health care (PHC) and a multidisciplinary approach, community involvement in health promotion outside the health sector, re-orientation of health workers to disease control within PHC and intersectoral coordination.

In the decade 1981-1990 the RCM focus included essential medicines for the first time (six resolutions). There were also seven resolutions on national health plans (specifically national planning processes and programmes) and health research was a continuing priority (seven resolutions). HIV/AIDS appeared for the first time in the same decade (four resolutions) followed by eleven resolutions in the following decade 1991-2000 along with the intense focus on polio and a continuing focus on national planning processes and programmes (eight resolutions).

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[240] WHA1 priorities were to control the spread of malaria, tuberculosis and sexually transmitted infections, and to improve maternal and child health, nutrition and environmental hygiene
[241] *Report of the Regional Director to the Regional Committee for the Western Pacific thirty-first session*: http://iris.wpro.who.int/handle/10665.1/6873

In 1991-2000 there were ten resolutions on polio driven by the global strategy to eradicate polio. In 2001-2010 there were six resolutions each on tuberculosis and communicable disease surveillance, and a ground-breaking patient-centred care resolution, said to have been key technical interests of the Regional Director at the time.[242]

The RCM focus on communicable disease surveillance and response began in the 1970s. Severe Acute Respiratory Syndrome (SARS) triggered new urgency in 2003 as did the 2015 outbreak of Middle East respiratory syndrome coronavirus in the Republic of Korea. By 2015 the RCM's focus included implementing the *International Health Regulations (2005)* and progress was being reviewed in the *Asia Pacific Strategy for Emerging Diseases* launched in 2005.[243]

Emergency and disaster preparedness and response was an early focus of RCM in the 1950s with little focus in the following decades. There is now a strong focus reflected by the *Western Pacific Regional Framework for Action for Disaster Risk Management for Health* issued in 2015. This responds to country needs following devastating cyclones (Viet Nam in 1997 and Vanuatu in 2015), earthquakes and tsunamis (Samoa in 2009 and Japan in 20011), typhoons (Philippines in 2015) and floods and droughts (China in the 1990s).

RCMs also made various resolutions over the decades on health service delivery including for primary health care[244] [245] [246] and quality assurance[247]. Important regional strategies included *New Horizons for Health, Healthy Cities* and *Healthy Islands*.[248]

In the five years 2011-2015 there was technical continuity across a range of key regional health issues such as immunization, food safety and mental health. There were also significant new areas and approaches included violence, neglected tropical diseases, universal health coverage based on health system attributes and action domains, ageing, urban health and intensified approaches to the double burden of nutrition. In 2015 the Regional Director's annual report noted that violence was a newly identified regional health need as it caused more deaths each year than AIDS, malaria and tuberculosis combined.[249] The Regional Director also noted WHO reforms and he stressed the importance of *'…working across sectors, across borders and across societies…'* foreshadowing the imperative of how WHO needs to work including strong and strategic engagement with socio-political economic forces for public health gains.

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[242] Personal communication during consultation
[243] The acronym is APSED
[244] For example WPR/RC26/5, WPR/RC32.R6 and WPR/RC61/5
[245] WPR/RC36.R19
[246] WPR/RC61/5
[247] WPR/RC43.R7 and WPR/RC45.R11
[248] For example WPR/RC49.R6 addresses progress on the last two
[249] WPR Director General's Annual Report of 2015 as recorded in RC66 Record of Meeting

Table 10 below gives the aggregated number of RCM technical resolutions within each taxonomy category. A disaggregated list of all RCM technical resolutions since 1951 is at Annex 1 categorized by each RCM and by the taxonomy.

Table 10 RCM technical resolutions each decade

Taxonomy Category	1951-1960	1961-1970	1971-1980	1981-1990	1991-2000	2001-2010	2011-2016	Total
Communicable Diseases	19	11	14	14	27	17	4	106
Disability	-	1	1	-	-	-	1	3
Emergencies and Disasters	2	-	-	1	-	-	1	4
Food and Nutrition	3	-	6	4	4	2	2	21
Health Information	-	-	-	2	-	1	-	3
Health Promotion	-	1	1	-	-	1	3	6
Health Research	2	-	7	7	5			21
Health Risk Factors	-	-	9	4	4	5	1	23
Health Service Delivery	1	-	5	4	2	2	-	14
Health Systems	-	-	-	2	-	5	1	8
Human Resources for Health	2	12	10	7	4	1	-	36
Maternal and Child Health	2	1	3	6	1	5	3	21
Medicines	-	-	-	8	-	3	3	14
National Health Plans	3	2	5	7	8	1	-	26
Non-Communicable Diseases	1	3	3	5	2	3	3	20
Occupational and Environmental Health	7	3	17	4	5	2	-	38
Populations	1	4	-	2	4	-	1	12

3.5   Priorities and Influences

In her 2015 report to the WHA the Director-General spoke of dramatic changes in the world over the previous fifteen years alone. [250] These changes included mega disasters; increasing climate change concerns and its impact on human health; the challenges of global interdependency; population increases with changing demographics and NCD trends; information availability, not always valid or reliable, which was challenging scientific evidence; emerging and re-emerging pathogens; antimicrobial resistance; and the world's ill-preparedness to respond effectively to health crises such as Ebola. It is within the kaleidoscope of ongoing and emerging issues and shifting scientific, social, political, economic, technological change and cultural contexts that RCM technical agenda items were, and are, set.

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[250] Dr. Margaret Chan

Often WP RCM was at the forefront of global thinking in its technical agendas and resolutions such as with malaria in the 1950s, *New horizons for health* in the 1970s, people-centred care in the 2000s and currently UHC, AMR, neglected tropical diseases, emergency response, the double burden of nutrition, the emerging thinking on responding to the Sustainable Development Goals (SDGs) – and other matters. Violence and ageing[251] are among the few examples of considerable lag time between global thinking and WPR response while they also demonstrate current vision and leadership in their being addressed.[252]

Regional health needs

All RCM technical agenda resolutions since 1951 appear to reflect a significant regional health need at the time. That does not answer the question why some health issues attract more of the attention of health leaders and political systems and why at a particular time? A view of some is that morbidity and mortality and cost-effective interventions may not necessarily be the key influencing factors. A question posed to support this view was why did HIV/AIDS receive one third of all international donor health funding[253] in the early 2000s when it represented 5% of mortality and issues such as diarrheal diseases that had far greater impact did not attract such interest? [254]

New significant health issues

New significant health issues also influenced the RCM agenda. The first RCM resolution on HIV/ AIDS was in 1985[255] and there were sixteen resolutions in the next twenty years. In the 1970s RCM made its first resolution on food safety (as distinct from water and sanitation resolutions) because of wide-spread food borne diseases on international flights.[256] This also provides an example that RCM resolutions can influence EB and WHA agendas. The EB53 response to the RCM resolution was to update the 'Guide to Hygiene and Sanitation in Aviation' with wide distribution intended. The EB also noted that work was *'…under way for the establishment of international microbiological standards for food…'.*[257] The agenda item did not re-appear at RCM while there was significant ongoing technical work including development of monitoring systems.

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[251] RCM64 endorsed the first *Regional framework for action on ageing in the Western Pacific* in 2014
[252] WHA49 declared violence a leading worldwide public health problem (WHA49.25, WHA50.19) and the 2003 World Report was on Violence and Health (WHA56.24)
[253] For low and middle income countries
[254] Shiffman, J. A social explanation for the rise and fall of global health issues. Bulletin of the World Health Organization 2009;87;608-613. doi: 10.2471/BLT.08.060749
[255] WPR/RC36.R2
[256] WPR/RC23.R12 and WPR/RC24.R6
[257] EB53.27 in response to WPR/RC24.R6

Table 11 .... *Significant new health issues influence RCM resolutions*
Example: RCM Resolutions on HIV/AIDS

Taxonomy Category	1951-1960	1961-1970	1971-1980	1981-1990	1991-2000	2001-2010	2011-2015	Total
Communicable Diseases								
HIV/AIDS	-	2	-	2	10	1	-	**15**

Public health and politics

WHO is a technical agency and part of the UN. This suggests that both public health and politics may be influencing factors on setting RCM agendas. Pragmatism suggests that the importance of a health issue as measured in objective or evidence-based public health terms may be tempered by the strength and persuasiveness of key actors; the prevailing political, cultural, social and economic contexts; the interest, capacity and capability of institutions and countries to lead and implement change; and the human emotions aroused. All of these factors had a part to play in the response to HIV/AIDS for example. These elements provide a backdrop to looking further at the influencing factors on RCM technical agendas since 1951.

Member States' perceptions

Member States' perceptions of their own needs as distinct from what WPRO thought were their needs have been an influencing factor from the beginning. An early example is when the Regional Director presented the WPRO advisor roles - technical analysis, advice and support – to RCM2 in 1951. Member States did not see that these roles matched their priorities and instead wanted materials, equipment and funds. RCM2 made a resolution to the Executive Board and WHA5 for WHO to change its role to reflect these needs.[258] The RCMs of Africa and SEAR made similar resolutions. WHA asked the then Technical Assistance Board (TAB) to give greater discretion to providing supplies and equipment. The TAB decision was that the rules on providing supplies and equipment should be *"…generously interpreted…".*[259] An unintended consequence of this decision was avoidable waste. WHO estimated in 1988 that up to one third of equipment purchased was unused due to inappropriate purchases and inadequate maintenance.[260]

Geopolitics

Geopolitics influenced RCM agenda such as the post-war health needs of Viet Nam, Laos and Cambodia in the 1970s. The sudden emerging of SARS in 2003 as a new and significant health issue of unknown impact galvanized political as well as public health responses and there was some palpable public panic. A consequence was the RCM focus on the capacity and capability of WHO and MS for effective surveillance and response.

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[258] WP/RC2.R16: http://iris.wpro.who.int/handle/10665.1/8258
[259] WP/RC3.4: http://iris.wpro.who.int/handle/10665.1/8267

[260] *Four decades of achievement: Highlights of the work of WHO.* Geneva, WHO, 1988:10: http://www.who.int/iris/handle/10665/40590

Politics and Science

Just as with cholera in the 1800s, politics and scientific disagreement influenced RCM discussions and resolutions in ways that are not always apparent from RCM documents. An example is harm minimization as a strategy for HIV/AIDS prevention in the 1980s and again in the 2000s where a resolution on harm minimization was not put.[261] Another example is the first RCM resolution on health and climate change in 2008[262] despite Samoa and Tuvalu raising concerns about the future of small island countries in a potentially detrimental global environment in 1996. In 2016 an end goal of the Sustainable Development Goals (SDGs) is combatting climate change.

WHA Resolutions

WHA resolutions are an influencing factor for some RCM resolutions. WHA1 in 1948 determined that malaria was the first of its six global health priorities[263] and RCM made ten resolutions on malaria in 1951-1960. There were only eleven resolutions on malaria in the following 56 years. RCM made four resolutions on poliomyelitis in the first 40 years and ten in the ten years 1991-2000. The influencing factor was the landmark resolution of WHA41 in 1988 for the worldwide eradication of polio[264] that led to regional eradication of polio in 2000[265]. Health of the elderly was reviewed by RC47[266] in 1996 and 1998 because of the upcoming *International Year of Older Persons* but it took another 15 years before the first *WPR Regional Framework for Action on Ageing and Health (2014-2019)* was developed.[267] This is an unusual lag time for WPR, now rectified.

Table 12   WHA resolutions influence RCM resolutions
Example: RCM Resolutions on Malaria, Poliomyelitis and Ageing

Taxonomy Category	1951-1960	1961-1970	1971-1980	1981-1990	1991-2000	2001-2010	2011-2015	Total
Communicable Diseases								
Malaria	11	2	6	1	1	1		**22**
Polio		2		2	10	1		**15**
Populations								
Ageing				1	2		1	**4**

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[261] Personal communication during consultation
[262] WPR/R59.R7: http://www2.wpro.who.int/rcm/en/archives/rc59/rc_resolutions/WPR_RC59_R7.htm
[263] op. cit.
[264] WHA41.28: http://apps.who.int/iris/bitstream/10665/164531/1/WHA41_R28_eng.pdf
[265] http://www.wpro.who.int/mediacentre/factsheets/fs_20120227_polio/en/
[266] WPR/RC47.13: http://iris.wpro.who.int/handle/10665.1/7043
[267] WPR/RC64.R3:
http://www.wpro.who.int/about/regional_committee/64/resolutions/WPR_RC64_R3_Ageing_and_health.pdf?ua=1

In 1956 RCM7 considered there were eight regionally relevant WHA resolutions. They were leprosy control, sessions of Regional Committees outside Regional Headquarters, future organizational studies, regionalization, mental health programmes, rights and obligations of Associate Members, the world situation and relations with UNICEF. In 1976 RCM27 considered twenty-eight WHA resolutions were regionally relevant.[268] Examples are GPW6; an organizational study on the planning for, and impact on, extra budgetary resources on WHO's programmes and policies; psychosocial factors in health to human health and the environment; disability prevention and rehabilitation; development of anti-malaria programmes; primary health care and rural development; the need for laboratory animals and the EB methods of work. The minutes also reflect the impact of some WHA decisions. The Regional Director reported he had reduced staff to comply with WHA29.48 to re-orientate technical cooperation to governments and curtail all *'…non-essential expenditure on establishment and administration…'*. [269]

In 1996 there were seventeen regionally relevant WHA or EB Resolutions and RCM discussed three specifically. They were the *International Decade of the World's Indigenous People* and RCM requested the Regional Director report on progress in implementing the regional component of this in the Western Pacific and emphasized the need for frequent reporting in the region on impediments to improvement of maternal mortality rates and infant and young child nutrition.

By RCM65 there was a more strategic approach where WHA and EB resolutions were integrated with corresponding RCM agenda items. They were the framework of reengagement with non-state actors; implementation of IHR (2005); report of the external auditor; health intervention and technology assessment in support of universal health coverage; follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage; and antimicrobial resistance.

RCM65 also discussed separately the two remaining regionally relevant WHA resolutions and one of the seven above. They were strategic budget space allocation; the framework of engagement with non-State actors and a multilingualism action plan. RCM66 discussed separately three WHA resolutions and two WHA decisions and four others were incorporated into relevant agenda item discussions.

There was and is no centralized tracking or monitoring system of the WHA and EB Resolutions. The responsibility was and is decentralized to WPRO divisions perhaps limiting the ability to monitor progress and prioritize workload.

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[268] WPR/RC27.R4: http://iris.wpro.who.int/handle/10665.1/9501
[269] W WPR/RC27/16: http://iris.wpro.who.int/handle/10665.1/9250

United Nations declarations

United Nations declarations and resolutions can also influence RCM resolutions. RCM made 22 RC resolutions on sanitation and water safety between 1951 and 2000.[270] While the initial influence was WHA1 in 1948 deciding that environmental hygiene was the sixth global health priority[271] a further influence was the United *Nations International Drinking-Water Supply and Sanitation Decade* (1981-1990) followed by the 2008 *UN International Year of Sanitation* where sanitation was described as a neglected crisis of *'…epic scale…'*. [272] By then RCM was considering all WHA resolutions in one cluster and so there is no specific RCM resolution on this.

Table 13   United Nations resolutions may influence RCM agendas
Example: RCM Resolutions on Sanitation and Water Safety

Taxonomy Category	1951-1960	1961-1970	1971-1980	1981-1990	1991-2000	2001-2010	2011-2015	Total
Occupational and Environmental Health								
Sanitation & Water Safety	4		5	4				**13**

Regional Director leadership

The leadership of Regional Directors is an influencing factor. The twenty four resolutions on training between 1951-1970 for example can be linked to the first Regional Director's first annual report to RCM2 where he said that a regional priority was *'…improved standards of teaching and training in the health, medical and related professions…'* for health system strengthening.[273] Similarly, prior to 1971 there were no resolutions on tuberculosis, four in the next thirty years and six in the decade 2001-2010 said to link to the particular technical leadership of the Regional Director at the time.[274]

Table 14   Regional Directors' technical leadership influences RCM agendas
Examples: RCM Resolutions on Tuberculosis and Training

Taxonomy Category	1951-1960	1961-1970	1971-1980	1981-1990	1991-2000	2001-2010	2011-2015	Total
Communicable Diseases								
Tuberculosis			1	1	2	6	1	**11**
Human Resources for Health								
Training	1	10	5	1	3			**20**

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[270] And one additional resolution 'catalogued' under Food Safety because it related to food and water safety on international flights

[271] WHA Priorities op cit

[272] https://esa.un.org/iys/docs/iys_flagship_web_small.pdf showing that on 20th December 2006, the UN General assembly declared 2008 as the International Year of Sanitation; the proposal was brought into the General Assembly by 48 Countries at the recommendation of the UN Secretary General's Advisory Board on Water and Sanitation

[273] WPR/RC2/10: http://iris.wpro.who.int/handle/10665.1/8228

[274] Personal communication during consultations

Organizational arrangements

Organizational arrangements can influence the RCM agenda. RCM26[275] and RCM27 in 1975 and 1976 noted the appointment of a WPRO regional adviser on biomedical research. It also noted the first meeting of the Regional Advisory Committee on Medical Research (RACMR), the proposal to designate the Institute for Medical Research in Kuala Lumpur as a WHO regional centre for research and training in tropical diseases and the development of close cooperation with the multidisciplinary programme of operational research in the Republic of Korea.

RCM27 in 1976 acknowledged the Regional Director's interest and efforts to strengthen the role of research in the Region. The research focus was given further stimulus by the WHA resolution on greater involvement of regions in biomedical research that became an RCM resolution in 1979.[276] There were two resolutions on health research in 1951-1960, none in the next decade, nineteen in the thirty years 1971-2000 and none since the RACMR was not re-convened after this period.

Table 15   Organization influences on RCM agenda
Example: RCM Research Resolutions 1951-2015

Taxonomy Category	1951-1960	1961-1970	1971-1980	1981-1990	1991-2000	2001-2010	2011-2015	Total
Health research	2	-	7	7	5	-	-	*21*

Funding

Funding influences WPRO programmatic work and therefore may influence the RCM technical agenda. An example is donor funding for a time-limited technical specialist on avoidable blindness culminating in a RCM64 resolution.[277] When the funding finished avoidable blindness was integrated into existing Secretariat work and may or may not re-appear as a specific item on a future RCM agenda. A risk of this approach is the diminution of the sustained effort over time that is needed to achieve public health outcomes. A counter argument is that a single RCM resolution[278] can raise awareness, interest and trigger ongoing work – assuming resources are available.

Secretariat

Historical documents do not show the degree to which the Secretariat influenced RCM technical agendas. Some eras are said to have been more internally inclusive when developing the agenda. The Secretariat's role is to have the technical expertise, the data, the helicopter view and the technical relationships across the region to analyze, think about and understand regional health needs. Its technical

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[275] W WPR/RC26.R10: http://iris.wpro.who.int/handle/10665.1/9156
[276] R/RC28. R15: http://iris.wpro.who.int/handle/10665.1/9381
[277] WPR/R64.R4 (there was only one other resolution on blindness since 1951 and that was in 1961 on isolation of the trachoma virus and vaccine): http://iris.wpro.who.int/handle/10665.1/8097
[278] There was one previous RCM resolution on blindness in RCM12 in 1961 on the isolation of the trachoma virus and trachoma vaccination

influence should be expert and strategic in supporting the Regional Director develop the provisional agenda, as it is in this era.

Summary

In summary, RCM technical resolutions since 1951 have clearly responded to regional health needs while there are a number of influencing factors. These include, in no particular order:

- regional health needs - ongoing, emerging or urgent;
- RC Rules and Procedures;
- geopolitics;
- global initiatives beyond health (for example United Nations resolutions);
- World Health Assembly resolutions;
- Regional Director and secretariat technical leadership;
- budget availability. [279]

It remains unclear whether these were the absolute priorities of the time given there was no transparent priority setting processes and supporting evidence and epidemiological data is rarely included in the RCM reports. As the technical agenda and resolutions were agreed by successive RCMs, the assumption could be made that they were the priorities of the time. This may be a false assumption given contextual political, economic and health complexities and competing demands. Other than through the global or WPR GPWs there was no articulated high level RCM vision or strategic framework for the region within which RCM technical agenda items were framed and prioritized.

The analysis of RCM resolutions raises issues for reflection and RCM consideration which link with and build on the consideration raised in Part 2 of this paper. In the absence of an articulated, shared vision for the region's health how else could RCM guide and prioritize future RCM technical agendas and thus WPRO's work?

A further consideration for RCM is whether it would benefit from a change to how resolutions are entitled to enable efficient internal tracking and monitoring of progress within a formally agreed technical taxonomy. Such a taxonomy may also have strategic added-value for searches by external actors.

Much valuable oral history and insights about WPR and the RCM have been lost over the years. Regular analysis each five years or each decade could also be invaluable in capturing history efficiently and accurately to enable ongoing reflection to inform future thinking.

An added value of knowing the future vision and direction and the strategic priorities to achieve them would better equip WPRO to ensure it has the future capacity and capability to fulfill the WHO constitution as the world's lead health agency.

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[279] A different study to this paper could examine the relationship between when the data demonstrated a significant health issue, when it appeared on the RCM agenda and the impact of RCM resolutions

Part 4   ISSUES AND CONSIDERATIONS

The context of WHO has been one of constant change since 1948. WPR has often either led global thinking[280] or responded with fresh and strategic approaches with some issues lagging[281]. In this decade there is bold and innovative thinking as well as vigilance for strategic technical continuity, the latter a hallmark since 1851. The difference now is the pace of change, increased knowledge and new public health challenges, a more crowded international stage of actors interested in health and instant access to data and information for many people providing both accurate and inaccurate information.

Social media has exploded shaping how many, including upcoming generations, receive and generate views and information, accurate or inaccurate. Scientific advances on a myriad of matters have influenced and will continue to influence RCM responses to health challenges from Hepatitis B vaccine in the 1980s to the current globally synchronized shift to new approaches to polio vaccination[282].

Old issues have become new and more complex requiring re-conceptualization and new approaches such as for urbanization, the double burden of nutrition, health systems, neglected tropical diseases, emergency responses. There are new challenges to add such as zoo-onitic diseases and AMR. There is also an overcrowded and more uncoordinated global health stage and increased complexities require new types of engagement by WHO with new constituents to ensure policy coherence and strategic focus for impact.[283]

A lesson from history is the importance of visionary and bold leadership where ambition and foresight reverberated through the decades such as for eradication of poliomyelitis. Another example is that after a slow start grounded in geopolitics a grand global vision on smoking was developed. What would have been unthinkable in 1951 was achieved sixty years later, measles eradication in some countries. UHC and its transformational thinking has the promise of supporting transformational approaches by countries to their health systems. There are many other examples.

RCM records show that all technical agenda resolutions since 1951 reflected a regional health need but not whether it was a strategic priority of the time. Influences on agenda items varied and, beyond the given of regional health needs, included new significant health issues, geopolitics[284], regionally-relevant WHA resolutions[285], relevant UN declarations[286], Regional Director leadership[287] and the

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[280] For example people-centred care in the 2000s which was eight years ahead of its time and Neglected Tropical Diseases in the current decade; ageing and violence are two issues which lagged and have now been addressed

[281] For example, UHC and the double burden of nutrition in this decade

[282] The shift is to Inactivated Polio Vaccine and Bivalent Oral Vaccine

[283] www/GlobalHealth_WHO_ReformWorkshop_Feb2712

[284] For example, support to Viet Nam, Cambodia and Laos in the 1970s

[285] For example, malaria in the 1950s in response to it being the first of six WHA priorities; tobacco control through WHA31.6, 33.5, 42.19, 52.18, 54.18 culminating in WHA56.1, the *Framework Convention on Tobacco Control* and AMR adopted by RMC in 2011

Secretariat. An aim of the WHO reforms is that strategic priorities are better set with a transparent process. RCM may like to consider whether the current reform agreements and proposals to increase MS input to RCM provisional agendas enable the setting of strategic priorities or whether additional strategies are needed. Setting strategic priorities may remain problematic in the absence of a shared strategic vision for the future.

Given its history and the current WPR and global WHO reform initiatives RCM would appear to be well positioned for its leadership role in the changing world of the future including the shift to 100% of RCM resolutions having specific regional plans and action. Lessons from history suggest considerations for RCM to assure its continuing leadership role for the future. These considerations include:

1. Encouraging bold and innovative thinking in RCM;
2. Developing a shared understanding and vision for the desired future health of the Region through high-level decision makers, refreshed each five years, within which to set strategic priorities for the RCM agenda and the Secretariat;
3. Defining information needed not only to respond to scientific and technological changes but also to anticipate and lead change;
4. Assessing risks and opportunities of virtual attendance at RCM;
5. Identifying and strategically engaging with new and continuing constituents and other socio-political aspects of public health;
6. Eliciting from MS views of RCM cultural mores and their impact on effectiveness;
7. Assessing of efficacy and impact of the revised RCM agenda consultation and briefing processes including on RCM attendance of high-level decision makers
8. Maintaining effort towards increased budget flexibility;
9. Initiating facilitated country presentations at side events at RCM;
10. Testing the agreed new approaches for MS input to provisional agenda items before embarking on additional processes such as sub-committees, virtual or otherwise;
11. Requesting regular five-year retrospective analyses of RCM agendas and resolutions (desk analysis and oral history);
12. Gathering gender-specific data on RCM attendees;
13. Developing a technical taxonomy for further categorization of all technical resolutions;
14. Commissioning an historical analysis on Regional Director reports since 1951;
15. Strongly encouraging ongoing WPRO reforms to ensure capacity and capability to meet the future and keep countries at the centre.

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[286] For example *The Human Rights to Water and Sanitation* declaration in 2010 and the *Sustainable Development Goals* in 2015

[287] For example *Healthy Islands* from 1995 and continuing; tuberculosis, EPI and people-centred care in the 2000s; and now ageing, AMR, UHC, NCDs, emerging diseases and continuing and renewed vigilance on ongoing issues including Neglected Tropical Diseases and Emergency Responses

ANNEX 1   RCM RESOLUTIONS 1951-2015

See separate document (spreadsheet).

Total Technical Resolutions	Period							
Topic area (Main) / Topic area (sub)	1951-1960	1961-1970	1971-1980	1981-1990	1991-2000	2001-2010	2011-2015	Grand Total
Communicable diseases								
Cholera and diarrheal diseases		4	4	1	1			10
Communicable Disease Surveillance and Response (CSR)			1	2		6	1	10
Leprosy	2			1	2			5
Malaria	11	2	6	1	1	1		22
Neglected Tropica Diseases							1	1
Parasitic diseases			1					1
Polio		2		2	10	1		15
Small pox	5	2						7
STIs and HIV/AIDS				4	11	1		16
TB			1	1	2	6	1	11
Vector-borne	1	1	1	1		2		6
Viral hepatitis				1			1	2
Communicable diseases Total	19	11	14	14	27	17	4	106
Disability								
Blindness prevention		1					1	2
Disability Prevention and Rehab			1					1
Disability Total		1	1				1	3
Emergencies and disasters								
Emergencies and disasters	2			1			1	4
Emergencies and disasters Total	2			1			1	4
Food and Nutrition								
Food Safety			3			2	1	6
Nutrition	3		3	4	4		1	15
Food and Nutrition Total	3		6	4	4	2	2	21
Health Information								
Biomedical Information System				1				1
Communication and health				1				1
MDGs						1		1
Health Information Total				2		1		3
Health Promotion								
Healthy Settings						1		1
Injury prevention		1	1					2
Urban Health							1	1
Violence							2	2
Health Promotion Total		1	1			1	3	6
Health Research								
Health Research	2		7	7	5			21
Health Research Total	2		7	7	5			21
Health Risk Factors								
Alcohol and other drug dependence			7	2		1		10
Tobacco			2	2	4	4	1	13
Health Risk Factors Total			9	4	4	5	1	23
Health Service Delivery								
Blood safety			1	1				2
Community-based and Primary Health Care Delivery	1		1	1				3
Laboratory			2			1		3
Nursing			1	2				3
People-centered care						1		1
Quality Assurance					2			2
Health Service Delivery Total	1		5	4	2	2		14
Health Systems								
Health Financing				1		2		3
Health Systems and Ethics						1		1
Health Systems and PHC				1		2		3
UHC							1	1
Health Systems Total				2		5	1	8
Human Resources for Health								
Fellowships	1	2	4	2	1			10
Human Resources for Health			1	4		1		6
Training	1	10	5	1	3			20
Human Resources for Health Total	2	12	10	7	4	1		36
Maternal and Child Health								
Adolescent Health				1				1
Child health	1	1	1			2		5
Immunization	1		1	4		3	3	12
Maternal and child health				1				1
Reproductive health			1		1			2
Maternal and Child Health Total	2	1	3	6	1	5	3	21
Medicines								
AMR						1	2	3
Essential medicines				6		1		7
Traditional medicine				2		1	1	4
Medicines Total				8		3	3	14
National Health Plans								
Planning process and programmes	1	2	5	7	8			23
Public health cooperation and functions	2					1		3
National Health Plans Total	3	2	5	7	8	1		26
Noncommunicable Diseases								
Cancer			1					1
Cardiovascular disease				2				2
Endemic Goitre		1						1
Mental health	1	1	2	2		1	1	8
NCD Plans and Strategies					2	2	2	6
Oral Health		1		1				2
Noncommunicable Diseases Total	1	3	3	5	2	3	3	20
Occupation and Environmental Health								
Chemical Safety	3	2	5					10
Environmental Health		1	4		5	2		12
Occupational Health			3					3
Sanitation and water safety	4		5	4				13
Occupation and Environmental Health Total	7	3	17	4	5	2		38
Populations								
Ageing				1	2		1	4
Demographics		2						2
Genetics		1						1
Indigenous People					1			1
Refugees	1							1
Women's health				1	1			2
World Population		1						1
Populations Total	1	4		2	4		1	12
Grand Total	43	38	81	77	66	48	23	376
Grand Total All Resolutions	198	124	239	201	146	90	40	1038
% Technical Resolutions	22%	31%	34%	38%	45%	53%	58%	36%