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Introduction

Opening of the session

The fifty-second session of the WHO Regional Committee for Europe was held at the Regional Office for Europe in Copenhagen from 16 to 19 September 2002. Representatives of 49 countries of the Region took part. Also present were observers from two Member States of other regions, two Member States of the Economic Commission for Europe and one non-Member State, and representatives of the Food and Agriculture Organization, the Joint United Nations Programme on HIV/AIDS, the United Nations Children's Fund (UNICEF) Regional Office for Central and Eastern Europe, the Commonwealth of Independent States and the Baltics, the World Bank, the Council of Europe, the European Commission and nongovernmental organizations.

The first working session was opened on 16 September 2002 by Professor Ayşe Akin, outgoing Executive President. After a welcome by the WHO Regional Director for Europe, addresses were delivered by Dr Ana María Pastor-Julian, Minister of Health and Consumer Affairs of Spain (the host country for the fifty-first session) and Mr Lars Løkke Rasmussen, Minister of the Interior and Health of Denmark.

Election of officers

In accordance with the provisions of Rule 10 of its Rules of Procedure, the Committee elected the following officers:

Mr Lars Løkke Rasmussen (Denmark)	President
Dr James Kiely (Ireland)	Executive President
Dr Jarkko Eskola (Finland)	Deputy Executive President
Ms Katalin Novák (Hungary)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC52/2 Rev.1 and /Conf.Doc./1 Rev.1)

Notwithstanding a formal request from the delegation of Turkey, supported by the delegation of Azerbaijan, for deletion of item 10 of the proposed agenda (concerning Cyprus's application for reassignment from the Eastern Mediterranean to the European Region of WHO), the Committee adopted the agenda and programme of work as endorsed by the Standing Committee of the Regional Committee. The representative of Turkey requested that her statement be reproduced verbatim in the report of the session of the Committee. The statement is reproduced in Annex 6.

Address by the Director-General

In her statement to the Regional Committee, the Director-General began by recalling the tragic events in the United States during the previous session of the Regional Committee in Madrid. Global interdependence had become clearer since those tragic terrorist attacks, as people became conscious of the potential for threats to health to be used deliberately. European nations had acted to counter those threats and were working to recognize the need to improve surveillance and preparedness. They had also had to respond to new emergencies, such as the recent flooding in central Europe, where WHO had reacted quickly to requests from national authorities.

Health was now accepted as a key element in securing our common future, and that meant delivering efficient health systems that worked and tangible reductions in ill health. WHO was focusing on the issues that mattered, for example by using the Millennium Development Goals, following up the Report of the Commission on Macroeconomics and Health, and giving health increasing prominence in international conferences on finance and trade. Additional resources could be accessed through alliances

and partnerships that targeted common goals, such as the Global Alliance for Vaccines and Immunization, the Healthy Cities initiative and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Partnership was the most important requirement for breaking down the barriers that prevented people from accessing the health system and the commodities they needed. Only if partnerships could be made to work would it be possible to respond properly to environmental health risks. New international agreements such as the Framework Convention on Tobacco Control could help, but on most occasions more informal partnerships needed to be established and sustained.

WHO had been working in partnership with a wide range of actors to broaden access to life-saving medicines. After intense efforts over the previous four years, differential pricing was now commonly used to extend poor people's access to medicines. Safeguards had been strengthened by universal agreement among the member states of the World Trade Organization. No clause in any trade agreement should effectively deny access to life-saving medicines for those who needed them.

Money was vital, but effective action called for a ruthless commitment to making a difference. Some countries in the European Region had shown the way by highlighting mental health. Making a difference also involved building a consensus across sectors. For years, European politicians had known that people's environment could undermine their health, and they had blazed a trail for environmental health. Looking towards the Fourth Ministerial Conference on Environment and Health in Budapest in 2004, steps would be taken to tackle the fact that too many children were made ill by their surroundings. The European Centre for Environment and Health in Rome was helping, together with UNICEF, the United Nations Environment Programme (UNEP) and key nongovernmental organizations (NGOs), to build a global alliance to promote healthier environments for children, making cost-effective interventions using precise indicators.

European countries were reforming their health systems to respond to what people needed. The skills and technologies of health workers often did not match the needs for health care, and negotiations to agree standards for health system staffing, financing and performance were complex. That meant focusing collective efforts on health outcomes, service quality and patient safety. Effective advocates who could access the levers of change could draw on WHO for help, support and guidance.

The world health report 2002 would highlight the most important risks to health in today's world. Some familiar risks were associated with under-development, but others were associated with patterns such as an unhealthy diet and obesity, high blood pressure and blood cholesterol, tobacco and excessive alcohol consumption, and physical inactivity. Throughout the world, unhealthy consumption was replacing healthier patterns of eating and activity. WHO was planning a global strategy on diet and physical activity that would involve the Member States. The report would also address violence as a global public health problem, to break the silence on violence and provide Member States with the tools to address the causes and consequences of violence.

WHO was making public health history with the Framework Convention on Tobacco Control (FCTC), which contained global rules for the promotion, production and sale of a product that killed half of its regular users. Negotiations on the FCTC illustrated the critical role played by the state in advancing the public health agenda and in setting norms and standards. The tobacco industry continued to act and react in its own interests, with flawed science and propaganda, but European countries stood out against them with the uncompromising and firm statement from the Warsaw Conference. The target date for conclusion of negotiations was May 2003, and political commitment was needed in the final crucial stages of WHO's first international treaty.

The Director-General pointed out that the session was the last she would be attending in her current role, and she paid tribute to the staff of the Organization, including those in country offices. The Country Focus Initiative would improve the core competences of country teams, transform administrative systems and promote information sharing, to ensure a better focus on the needs of countries and support for effective health action through standard-setting and technical cooperation.

When the Director-General started her term of office she had committed WHO to making a difference. A corporate strategy had been developed, based on an analysis of the global burden of disease, and clear priorities had been set. Together with its partners WHO was now confronting the risks that contributed to ill health; scaling up action linked to poverty; playing a central role in the pandemic of HIV/AIDS, noncommunicable disease and the tobacco menace; and establishing fair and effective health systems. That agenda was underpinned by the determination to do everything possible to put health at the centre of political attention.

Responding to the Director-General's address, one speaker recalled his surprise and that of his colleagues on hearing that Dr Brundtland would not be a candidate for Director-General of WHO for the period 2003–2008. It was felt that the Organization needed strong leadership for another term. He thanked her for placing health more firmly on the international agenda and felt sure that her initiatives in various fields would continue to prosper far beyond her term of office.

Another representative described the flooding that had recently devastated parts of his country, resulting in 14 deaths and over €2 billion worth of damage. Some 30 000 rescue workers and other volunteers and 50 000 children aged 3–5 years had been vaccinated, and as a result no cases of intestinal infection or hepatitis A had been recorded. He expressed his profound thanks to all the countries and organizations, both within and outside the European Region, that had helped in managing the situation.

The Director-General said that the office of her Special Representative in Moscow was a good example of how all parts of the Organization could work together. The Russian Federation was a huge country, yet through that office it was possible to mobilize funding and address issues both with headquarters and the Regional Office. The history of the European Region and the needs of its Member States were very special, and the nature of WHO's country presence in the Region should be carefully considered, especially in the light of the situation after 1990. WHO needed to be close to the national authorities, who in turn needed access to the global network of information and somebody who could raise awareness in each country. It was a two-way process. The European Region had many wealthy countries and had contributed greatly to the global pool of knowledge, which could be made use of in all regions.

The President and the Regional Director joined in thanking the Director-General for her diligence in attending the sessions of the Regional Committee and sharing her enlightening views. This would be her last session in that office, but there were still 10 months remaining and much work still to be completed. Finally, the Regional Director took the opportunity to thank her on behalf of the staff of the Region who, he felt sure, had developed a heightened sense of pride in their work during her term of office.

Address by the Regional Director

(EUR/RC52/4, /Conf.Doc./3, /Conf.Doc./11, /Conf.Doc./13, /Inf.Doc./3 and /Inf.Doc./4)

In his address to the Regional Committee, the Regional Director described how the work of the Regional Office in 2000/2001 had both contributed to global initiatives and responded to the special characteristics of the European Region. Salient events in the previous year had focused on bioterrorism, tobacco, the eradication of poliomyelitis, the control of HIV/AIDS, the ethics of health care systems, and the environment and health. In work for health and development, the Regional Director stressed the need to recognize the assets of the eastern countries of the Region. The Regional Office would continue to advocate that the debt relief of these countries be applied to reform of their health systems and that WHO set a good example by renegotiating repayment of some countries' arrears in contributions to the Organization.

In continuing and developing its programmes and working methods, the Regional Office had followed the guidance of the Regional Committee and the Standing Committee of the Regional Committee (SCRC), with partnership as a motif. Within the country strategy, a better knowledge of countries' needs had enabled the Regional Office to strengthen its presence in 28 countries through biennial collaborative agreements (BCAs). In addition, the Regional Office had moved to meet the particular needs of groups of countries: working through the Council of Europe (CE) Stability Pact in south-eastern Europe, supporting

the countries in rapid transition (most of which were candidates for accession to the European Union – EU) and holding “futures fora” to open dialogue with others. The Regional Office had sought more concrete cooperation with the CE, the European Commission (EC) and the World Bank, and to extend its partnerships with United Nations agencies and NGOs.

Programmes had made progress in such areas as health system reform, pharmaceuticals policy, nursing and midwifery, food and nutrition, child and adolescent health, and transport. Lack of resources had slowed the implementation of programmes on ageing, noncommunicable diseases (on which it was hoped to produce a European strategy for submission to the Regional Committee in 2004) and alcohol, and threatened the future of humanitarian assistance programmes. To provide countries with advice based on evidence, the Regional Office was working to establishing a database of information useful to health decision-makers. Notable information products included high-quality publications from the European Observatory of Health Care Systems, the new Web site and *The European health report 2002*. The Regional Office had also amassed evidence on its internal management and administration, including a report on its outposted centres, to guide reforms in that area.

The Regional Director concluded by describing some future “milestones” for the Regional Office. Those included disseminating global reports on violence and health and on health risks at regional level, supporting the global FCTC and health promotion in schools, preparing a conference on mental health policies in 2005 and starting a new phase of the policy for Health for All.

Dr Donato Greco, Vice-Chairman of the European Regional Commission for the Certification of Poliomyelitis Eradication, presented a certificate to the Regional Director confirming that the European Region of WHO was polio-free. He urged the continuation of work to preserve that achievement, and he thanked Rotary International, UNICEF and the Centers for Disease Control and Prevention (CDC) for their support.

In the subsequent discussion, representatives commended the Regional Office on its work for and with countries, particularly the new strategy for country support. The development of integrated BCAs ensured that such support was more consolidated and effective and targeted at each country’s particular needs. The Regional Director was requested to provide the Regional Committee at its next session with an in-depth assessment of the strategy, describing how it worked in practice. Representatives wanted to know how the implementation of activities in countries was integrated with Regional Office programming, and what would be the financial impact on the budget of appointing international staff to country offices.

Many speakers congratulated the Regional Office on the eradication of poliomyelitis from the European Region. That success was the result of successful collaboration between the Regional Office, Member States, international organizations and NGOs. Several representatives stressed the need for continued vigilance by Member States, for interregional cooperation to prevent the importation of wild poliovirus, for continued attention to surveillance and mass vaccination programmes, and for safe containment of poliovirus stocks to prevent their use in bioterrorism.

Representatives endorsed the Regional Office’s work to develop and extend its partnerships, particularly with the CE and EC. Evidence of collaborative activities within the Stability Pact was welcomed. WHO was urged to expand its partnerships but to maintain its leading role in public health development. It was suggested that the Regional Office should cooperate with the Commonwealth of Independent States (CIS) Council on Health Affairs and the group working on tuberculosis.

The role of information was acknowledged to be of central importance, and several speakers endorsed the idea of having a “one-stop shop” for information and evidence, with the Regional Office playing a key role. Representatives also welcomed *The European health report 2002*. However, WHO was urged to cooperate with its partners to ensure that data were collected only once even though they would be used by several organizations, such as WHO, the EU and the Organisation for Economic Co-operation and Development (OECD).

The report on outposted centres elicited a number of questions about the value of such centres and how they were related to the office in Copenhagen, to WHO collaborating centres and to the governments of host countries. The Regional Director was asked to provide a clear overview of the centres and their respective mandates and to describe what action he would take on the report's recommendations.

Various representatives praised the work of the Regional Office in different technical areas, such as the control of communicable diseases, environmental health and tobacco control. The exchange of information and the secondment of staff to other influential agencies were endorsed as means of reaching WHO's objectives in communicable disease surveillance. Many representatives expressed satisfaction with the Warsaw Declaration, the outcome of the WHO European Ministerial Conference for a Tobacco-free Europe. In bringing countries together to discuss a sensitive subject, the Regional Office was playing a pivotal role in negotiations on the Framework Convention. In addition, one speaker highlighted the role of WHO in promoting bioethics in the Region and suggested that the Regional Office should draw on the CE's experience in that field.

The futures fora enabled a dialogue to be held on future health challenges. Representatives considered that strategic agendas and responses were necessary, but the Regional Office should take account of populations' desire to see agencies react rapidly to health threats. It was suggested that the work of the fora should be evaluated in terms of opening up the discussion to more participation and securing maximum value for their output.

Several representatives urged the Regional Office to give greater emphasis to noncommunicable diseases and welcomed the prospect of a European strategy on that topic. Others asked what progress had been made, since the Ministerial Conference on Young People and Alcohol in 2001, on implementing the European Alcohol Action Plan and creating a European alcohol information system. In addition, obesity and lack of physical activity were becoming major causes for concern, and it was suggested that those and other noncommunicable diseases be addressed through a health promotion approach.

In reply the Director, Division of Technical Support 2 reported that progress made since 2001 included establishing the European alcohol information system with support from France and Norway, updating and expanding the database on alcohol policies, and starting a survey on the effectiveness of such policies. A regional task force had been established on diet, obesity and physical activity, and the nutrition and food security programme addressed that topic. The European contribution to World Health Day 2002 had focused on the need for greater physical activity, which was a multisectoral issue, not a matter of individual choice.

The Acting Director, Division of Technical Support 1 noted that a high-level expert group had intensified the work on tuberculosis, and that keeping the Region polio-free required the maintenance of surveillance and further close collaboration with the WHO Regional Office for the Eastern Mediterranean. To prevent the use of poliovirus stocks for bioterrorism, the Regional Director would work with expert groups, WHO headquarters and Member States to contain them securely. As part of the partnership with the EC, the Regional Office would second an expert to work on surveillance and other issues.

The Acting Director, Division of Country Support described how the country strategy was put into effect. Measures included drawing up and carrying out BCAs; creating stronger links between country offices, WHO technical programmes and the offices of other United Nations agencies; strengthening the role of country staff; the planned addition of international staff in five country offices; and evaluation of the work done. Country work had three dimensions: health service systems, policies and technical assistance. The Regional Office was increasing support to countries in rapid transition and favoured widening the participation in futures fora. Links with all partners were being strengthened.

The Regional Director thanked the Regional Committee for its guidance. The outposted centres were an asset when they had sufficient staff and budgets, and clearly identified tasks specifically linked to the functions of the office in Copenhagen. The report on the centres should perhaps be discussed further with the Standing Committee of the Regional Committee (SCRC). Centres were at different levels of development; newer ones would be developed according to the recommendations of the report. The

Regional Director would examine the evaluation of the centres and clarify the situation at the fifty-third session of the Regional Committee.

The Regional Office's work as a health intelligence centre or clearing-house was intended to utilize the complementary competences of all partners. That also required improving the technical soundness of the Regional Office's products.

The Regional Director thanked representatives for their support of the Regional Office's work within the Stability Pact and said that the Regional Office would undertake an evaluation of the country strategy. In conclusion, he expressed his appreciation of the Staff Association for its support to the Organization and its constructive approach to working with management.

The Regional Committee adopted resolutions EUR/RC52/R1, EUR/RC52/R2 and EUR/RC52/R3.

Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board (EUR/RC52/6)

Professor Vilius Grabauskas, a European member of the Executive Board, presented an overview of the main items discussed at the 109th and 110th sessions of the Board and at the Fifty-fifth World Health Assembly. In accordance with current practice, he had been invited by the SCRC to attend its meetings as an observer and to report to the Regional Committee.

Professor Thomas Zeltner, Chairman of the Ad Hoc Open-ended Intergovernmental Working Group on the Review of the Methods of Work of the Executive Board, briefed the Committee on the background and mandate of the Working Group. In essence, those were to look at the working methods of the Board and make concrete proposals to it, including possible amendments to the Rules of Procedure. The Group had written to Member States asking for their proposals. They could be classified in three categories: those on which there was a large consensus; those on which there was clearly no consensus; and those that merited further discussion. A compilation of all proposals had been sent back to the Member States with a request for comments, with an extended deadline for reply of 2 October 2002. The Group would then analyse the replies with a view to providing the Executive Board with a package of proposals at its 111th session in January 2003.

Several speakers drew the Committee's attention to the need to broaden the focus in the European Region with regard to the quality of care (resolution WHA55.18). That was not simply a matter of pharmaceutical safety, as covered by the meeting planned for November 2002, and the Regional Office should take a wider view and include all aspects of quality. The representative of the CE said that the European Health Committee was about to set up a working group concerned with the management of safety and quality in health care that would look at patients' complaint procedures and the prevention of adverse events.

Other speakers emphasized the importance of keeping in touch with Health Assembly and Executive Board resolutions concerning poverty and other socioeconomic determinants of health, which were particularly relevant to the countries in transition. It would also be useful to have an analysis of the implementation of resolutions at country level.

Two delegations drew the Committee's attention to the fact that the majority of Member States had not participated in the discussions on the methods of work of the Executive Board. A broad involvement in those important discussions was urged. They were of a strategic nature and would potentially affect all countries. Procedures could well be improved, but it would be wise not to interfere with the current constitutional balance between the Health Assembly and the Board.

Report of the Ninth Standing Committee of the Regional Committee

(EUR/RC52/3, /3 Add.1 and /Conf.Doc./2)

The Chairman of the Standing Committee noted that individual members of the SCRC would present that body's views on the technical subjects it had considered during the year when the Regional Committee came to consider the corresponding item on its agenda.

Recommendations on criteria for membership of the Executive Board

The Chairman of the SCRC recalled that, following informal consultations with European Member States or their Permanent Missions during the 109th session of the Executive Board, an ad hoc session of the SCRC devoted to the subject of the European Region's representation on the Board had been held in Geneva on 13 and 14 June 2002, which all Member States in the Region had been invited to attend. The SCRC, meeting in private immediately afterwards, had endorsed the observations and recommendations made on that occasion.

There were three aspects to the subject of criteria for membership of the Executive Board: the criteria themselves, the question of geographical grouping of countries, and the informal voluntary arrangement concerning those countries that were permanent members of the United Nations Security Council.

Since it was the prerogative of countries to select their representatives on the Board, the SCRC agreed that the suggested criteria, as set out in Annex 3 to document EUR/RC52/3, should be used as guidelines rather than applied in a prescriptive manner, although they had not been formally adopted by the Regional Committee. Subregional groupings were theoretically attractive but difficult to implement in practice, and the SCRC accordingly proposed that the issue should be kept on the table for further consultation.

With regard to "semi-permanent" membership of the Board, the SCRC recommended that the interim arrangement agreed by the Regional Committee at its forty-ninth session should be continued until its expiry in 2006, and that the Regional Committee should consider in 2003 moving by agreement to an extended periodicity of three out of six years for the countries concerned (i.e. the United Kingdom from 2007, the Russian Federation from 2008 and France from 2009). The SCRC also recommended that, before the fifty-third session in 2003, an evaluation should be made of the current arrangements, and it had endorsed the terms of reference for such an evaluation at its meeting on 15 September 2002.

The Regional Committee endorsed the compromise solution reached at the ad hoc session of the SCRC in June, on the understanding that it had no formal status and merely represented a further transitional measure towards equitable representation, as provided for in the Constitution of WHO. To that end, it was agreed that the Regional Committee, supported by the SCRC, should continue to work on objective criteria, including geographical distribution, and explore further the concept of grouping. Furthermore, the Regional Committee agreed to entrust to the SCRC the task of taking forward an evaluation of the current arrangements, using the terms of reference as endorsed by the SCRC, and reporting back to the Regional Committee at its fifty-third session.

Annual report of the European Environment and Health Committee

(EUR/RC52/Conf.Doc./12 and /Inf.Doc./2)

The representative of Hungary reported that the European Environment and Health Committee (EEHC) had concentrated on preparing the agenda for the Fourth Ministerial Conference on Environment and Health, to be held in Budapest in June 2004. A questionnaire had been sent to Member States and NGOs, to elicit their views on the overall theme of the Conference and the priority issues they wished to see addressed, and a high-level intergovernmental meeting had been held in Lucca, Italy, in April 2002. As a result of those initiatives, the EEHC considered that the theme of the Conference should be "The future for our children", within the broader context of sustainable development. That was in line with the initiative launched by the Director-General of WHO at the World Summit in Johannesburg.

In addition, the EEHC had identified a number of environment and health policy challenges to be taken up at the Conference, and proposed that the agenda might accordingly be grouped into three main areas: the progress made since the first European conference (Frankfurt, December 1989); strengthening the policy-making base; and issues of emerging or increasing concern. The Conference was also expected to outline the way forward by adopting a declaration and an action plan on children's health and the environment.

All speakers commended the EEHC on the work it had done during the year and approved of the proposed theme of the Conference. In addition, they welcomed the adoption by countries in July 2002 of the Transport, Health and Environment Pan-European Programme (THE-PEP), although it was felt that the health sector was perhaps under-represented on its steering committee. The proposal to include tourism and health on the agenda of the Conference was also welcomed, but views were divided as to whether it would be better to establish a WHO collaborating centre in that field or have national centres coordinated by WHO.

Referring to the adoption of an action plan by the World Summit on Sustainable Development that included targets for the provision of safe drinking-water, several representatives called for more widespread ratification of the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes.

The Committee adopted resolution EUR/RC52/R6.

Report on the external evaluation of the Regional Office's work on health care reform (EUR/RC52/Inf.Doc./1 and /BD/2)

Dr Dana Farcasanu, a member of the team of external evaluators, recalled that the terms of reference of the external evaluation had been "to assess the extent to which the Regional Office had influenced governments to incorporate, in their health care reform programmes, the principles enshrined in the Ljubljana Charter". The team had broken down the process of health care reform into four stages: (a) development of a shared vision; (b) analysis of the situation, based on scientific evidence; (c) implementation of reform measures; and (d) evaluation. It had obtained information from documents produced by WHO and other bodies, responses to a questionnaire sent to all European Member States, and discussions with WHO staff and more than 100 experts interviewed in the course of visits to eight countries.

Dr June Crown, another member of the evaluation team, noted that the team's findings from all sources were consistent: WHO was universally trusted and respected by Member States, professionals and donor agencies, and it was seen as a source of impartial and authoritative advice. However, while it had achieved successes in influencing governments at each of the four stages of health care reform, there were still challenges to be taken up in those areas, too. For instance, while the values of the Ljubljana Charter underpinned most reforms and the importance of strengthening primary care was recognized by most decision-makers and professionals, broad-based political support and a shared vision with donor agencies still needed to be developed. WHO's technical documents and publications were highly regarded and its conferences, seminars and training events were valued, but steps should be taken to heighten awareness of WHO's services, translate more of its material (especially into Russian) and improve communications and dissemination. WHO's direct or vertical programmes were judged to be a success, but they needed to be integrated into the general health services of countries, in order to maximize their effectiveness and sustainability. While there were some examples of "process evaluations", more technical support needed to be given to health impact analysis. In conclusion, the evaluation team had made a number of recommendations aimed at ensuring that the Regional Office achieved its full potential in providing support at country level.

The Chairman of the SCRC reported that the Standing Committee had discussed the terms of reference of the evaluation at its session in December 2001; he and the Regional Director had then met the team in Dublin in February, and a member of the team had given the SCRC a progress report at its April 2002

session. The numerous contacts had been necessary because the evaluation had proved to be conceptually and operationally difficult. Given the complexity of the subject and the variety of opinions expressed by its members, the SCRC had taken note of the report and recommended that the Regional Committee should refer the matter back to it for further work.

In the ensuing discussion, representatives expressed their appreciation of the report and drew attention in particular to two of the evaluation team's recommendations: to ensure that the funding of BCAs was commensurate with the countries' and the Region's needs, and to review the arrangements for WHO's country presence, including the liaison offices. However, it was not clear what was the status of the report and what follow-up measures would be taken.

In response, Dr José-Manuel Freire, another member of the team, explained that it had quickly become clear to the evaluators that they would have to look at the factors influencing the Regional Office's capacity to have an impact in countries. He reiterated that the SCRC had endorsed the team's interpretation of its terms of reference.

The Regional Committee agreed by consensus to refer the evaluation report back to the SCRC and looked forward to receiving its comments at the following session.

Report of the SCRC subgroup on bioethics

Dr S.M. Furgal, a member of the SCRC's subgroup on bioethics, informed the Committee that the subgroup had held its second meeting in March 2002. Having defined the scope of bioethics as covering an interdisciplinary field concerned with ethical issues in the life sciences, health and health care, the subgroup had identified two principles on which its subsequent recommendations would be based: first, that the Regional Office should not revisit subjects that were already well covered by other international organizations (such as the Council of Europe), and second, that any issues tackled should be directly relevant to the work of WHO in the European Region. In practice, one major area of work might therefore be to develop tools for using ethical principles as criteria for evaluating health system reforms. A consultation with experts could be organized in 2003 to take forward this work.

The Committee adopted resolution EUR/RC52/R11.

Partnerships for health (EUR/RC52/7)

A round-table discussion was held on partnerships for health, moderated by Dr Antonio Duran, Consultant, Division of Country Support, who put questions to representatives of the European Commission (EC), the Council of Europe (CE), the World Bank, the WHO Regional Office for Europe and the UNICEF Regional Office for Central and Eastern Europe, the Commonwealth of Independent States and the Baltics.

The representative of the EC said that partnership with WHO, as well as with EU member countries and NGOs, was needed to carry out the EC's new mandate for public health. Cooperation with WHO addressed strands of the planned public health programme (such as health information, communicable diseases, tobacco, nutrition and obesity) and health elements in the policies of other sectors. There was excellent tripartite cooperation between the EC, CE and WHO on health-promoting schools and blood safety. Means of ensuring that partnership between WHO and the EC had concrete results included the commitment shown by the Exchange of Letters and high-level meetings, constant communication with the WHO Office at the European Union, annual meetings of technical staff and exchanges of staff for capacity-building. In addition, member countries had requested cooperation with the Regional Office on the public health programme and would evaluate the results. The accession of additional countries to the EU, probably starting in 2004, would broaden the field for partnership. Future areas for cooperative work included extending EC competence to cover health care and possibly establishing a European centre on

communicable diseases. It was important that the commitment to partnership permeated the EC; such partnership was essential to enable the EC to live up to the public's expectations for its public health programme.

The representative of the CE noted that the Council and WHO could contribute different assets to their partnership. While the CE was relatively poor in funding, it was rich in values. A good example of complementary cooperation with WHO was the Social Cohesion Initiative in Stability Pact countries; as a result, the Member States in south-eastern Europe, meeting with donor countries, had adopted the Dubrovnik Pledge to meet the health needs of vulnerable populations. Partnership enabled the CE and WHO to turn their principles on poverty and health into action in countries. The aim was to apply ethical issues in human rights on the ground, making values work in practice. While values could be enshrined in texts, such as the European Convention for the Protection of Human Rights and Fundamental Freedoms and the Convention on Human Rights and Biomedicine, partnerships were essential to create mechanisms to implement them, particularly when addressing access to health care. Partnership had evolved to higher levels; the tripartite Exchange of Letters in 2001 between the CE, EC and WHO and Regional Committee resolution EUR/RC51/R9 gave much hope for the future.

The representative of the World Bank described the positive effects and productivity of partnerships with WHO in, for example, public health seminars in the Russian Federation and work to reduce poverty in Albania. Differences in counterparts – WHO worked with health ministers and the Bank with finance ministers – could impede cooperation, and the independence of the Bank's programmes in countries hindered the adoption of broad strategies. The two organizations could also differ in viewpoints, as in the Bank's Poverty Reduction Initiative and the WHO report on macro-economics and health, but those differences could lead to fruitful complementary approaches. Governments could facilitate cooperation and prevent duplication of effort by acting on their responsibility to ensure cooperation between ministries and coordinating the activities of donors. WHO should improve the data it supplied to the World Bank for decisions on programme planning and implementation, so that they clearly showed which problems the Bank could usefully address. A great hindrance to effective action was the erosion of public-sector funds for public health; that trend needed to be reversed.

The WHO Regional Director for Europe viewed partnerships as both a strategic and an ethical necessity; all organizations had the obligation to use their resources as wisely as possible, and wasting resources in uncoordinated activities in countries was bad for all parties. Partnership was the only realistic approach. In its efforts to extend and develop partnerships in recent years, the Regional Office had learned how the different natures of partners led them to take different views of, for example, Member States. Nevertheless successes, such as the work with the CE that had led to the inclusion of health on the agenda of the Stability Pact, proved the value of strong partnerships. Cooperation should assist the implementation of the Regional Office's new country strategy, but Member States would be the best judges of success. Partnership had had immediate benefits for the Regional Office in work with countries, however; it stimulated WHO staff to rise to countries' and partners' demands for work of the best quality. The exchanges of staff with the EC had considerable potential, and the Regional Director hoped that work with all partners would be increasingly fruitful.

The representative of UNICEF noted that, while cooperation with WHO had been established for decades, a relationship with WHO's European Region had begun in the 1990s. The UNICEF Regional Office served 27 eastern countries of WHO's European Region. Areas of successful collaboration with WHO and other partners included the historic eradication of poliomyelitis from the Region, the strengthening of immunization through the multisectoral Global Alliance for Vaccines and Immunization, work for young people at risk carried out through an interagency working group, and UNICEF's contribution to the WHO Action Plan on Food and Nutrition in the European Region. Further cooperation was needed. The United Nations Special Session on Children's outcome document, *A world fit for children*, asked Member States, for example, to eliminate iodine deficiency disorders by 2005 and vitamin A deficiency by 2010. Achieving those goals would require more concerted action with such partners as WHO and the World Bank, countries and health ministries. UNICEF and its partners should help countries make action plans on nutrition, and WHO's country presence offered the opportunity for

collaborative early planning of programmes with UNICEF country offices, to ensure the effective use of resources.

In the ensuing discussion, speakers praised the Regional Office for its work to improve partnerships and for the quality of the document under review. They described the benefits of partnerships for countries and cited additional successes in, for example, south-eastern European countries, Armenia and the Russian Federation. Two representatives endorsed the view that governments should coordinate donor activities.

All speakers suggested ways to improve the Regional Office's partnerships and their effectiveness, such as: increasing participation by some western European countries, devoting a meeting of the Futures Forum to partnerships, taking additional steps to prevent duplication (by, for example, making clear divisions of tasks and concrete plans of work with partners), and considering wider use of the model for multilateral cooperation provided by the WHO High-level Working Group on Tuberculosis in the Russian Federation.

Responding to questions from the floor, the representative of the EC said that the synergy of partnership was particularly important in the areas of tobacco and communicable disease control. The organizational model for EC partnerships ensured commitment at the top of the participating organizations, more frequent meetings of officials and the participation of partners in EC internal meetings. The representative of UNICEF described the Fund's model of partnership as multilateral, involving governments, civil society organizations (CSOs), and children and young people.

The representative of the World Bank found the Russian Federation to provide an excellent model of leadership in the coordination of activities; governments in other countries would find it useful to arrange coordination meetings.

The Director, Civil Society Initiative (CSI), External Relations and Governing Bodies Cluster at WHO headquarters described how WHO was seeking the best means of cooperating with CSOs, as part of the opening of the whole United Nations system to their participation in policy-making and work in the field. CSI had consulted CSOs and would present a paper on that topic to the Executive Board. The new policy would have three components: an accreditation system to enable CSOs to participate in governing bodies, guidelines for WHO work with CSOs at all levels of activity, and improved communications.

At the end of the discussion, oral and written statements were delivered by representatives of the following organizations: the Association of Schools of Public Health in the European Region, the European Forum of National Nursing and Midwifery Associations and WHO, the EuroPharm Forum, the International Confederation of Midwives, the International Council of Nurses, the International Federation of Pharmaceutical Manufacturers Associations, the International Pharmaceutical Federation, the World Confederation for Physical Therapy and the World Health Professions Alliance.

Policy and technical items

Poverty and health

(EUR/RC52/8, /Conf.Doc./4 Rev.1 and /BD/1)

The Director, Division of Technical Support 2 introduced the item, describing the development of the Regional Office's work on social and economic determinants and health. There was growing interest in defining the links between poverty, health and development, now key issues on the global agenda of sustainable development.

One milestone had been the report commissioned by WHO's Director-General on macro-economics and health. It clearly identified the role of poverty as an inhibitor to development and the potential gains in economic terms yielded by investing in people's health. Poverty was experienced not only in poor

countries but also among the populations of more wealthy Member States. In addition, it was a factor in preventing access to health care.

The Head, WHO's European Office for Investment for Health and Development described in more detail the process, methodology and outcomes of action taken to follow up resolution EUR/RC51/R6, through the presentation of 12 case studies of experiences gained in Member States. The intensive process of compiling the studies had been completed within six months. They looked at examples from Member States where the health sector had taken action to tackle poverty and its impact upon health. Thanks were expressed to all the countries that had participated and the staff involved in production of the report.

There were three clusters of findings:

- there were many things the health sector could do to alleviate the impact of poverty on health;
- there were examples of the health sector exacerbating the impact of poverty on health; and
- there was an urgent need to develop knowledge and skills and to mobilize resources, to increase the capacity of the health sector to tackle the impact of poverty on health.

Examples within each of those clusters were illustrated. They included an experimental vaccination programme in a Roma population where, through specific interventions, vaccination rates exceeded those of the resident population; outreach programmes using mobile health services; and the integration of health services with other sectors such as housing and employment. Those activities were ethical in nature and highly cost-effective. In one example, however, the specific structures of health services increased the impact of poverty on health. Stigmatizing and hospitalizing people with certain sexually transmitted infections caused loss of earnings and damage to family life. Those services had since been reoriented with great success.

The case studies showed that some Member States, in light of the findings, were reassessing the financing and structuring of essential services, to eliminate the practice of making “under-the-table” payments, stigmatization and inflexible administration, and to take account of the impact that poverty might have on availability and accessibility.

The case studies also confirmed that poverty was a pan-European challenge. A recent European Commission report indicated that 60 million people in the EU were defined as being at risk of, or were living in, poverty.

Bringing together the lessons learned from the process, five areas of challenge were apparent:

- to ensure the affordability of essential health services;
- to overcome cultural and geographical barriers to accessing health services;
- to address the diseases of poverty;
- to acknowledge that poverty and its impact on health were not confined to marginalized groups; and
- to promote the role of the health sector in working with partners to address the root causes of poverty.

That led to the conclusion that next steps should be to expand the scope of the studies, in order to build up a “European action studies data bank”, to systematize and distil the knowledge base to identify models of best practice, and to increase capacity through human resource development.

Additional comments on the report were provided by Dr Božidar Voljč, a member of the SCRC and of the study group. The report clearly indicated that the topic was multisectoral and multidisciplinary in relation to, for example, the fight against tuberculosis (TB), the consideration of bioethics, and health care reform. It transcended the health development of European populations alone and touched upon matters of solidarity, cultural differences and how the meaning of health was understood. The Standing Committee

hoped the work would continue and suggested that the Regional Office might organize a conference on poverty and health, with the aim of extending involvement to actors outside the health sector.

Many speakers endorsed the findings of the report, agreeing that the topic was of considerable importance, not only to countries in transition who were experiencing poverty as a result of social and economic change, but also to more affluent countries. Poverty and health inequalities were seen in terms of a decline in the health status of populations, as a threat to solidarity and security in the Region, as grounds for stigmatization and as a cycle of deprivation that was hard to break into.

The intersectoral nature of poverty and health was referred to by many representatives, who identified the role of the health sector as being but one in partnership with housing, social welfare, environment, education and finance. The emergence and re-emergence of infectious diseases and the burden of noncommunicable diseases were thought by many to have their roots in poverty. A number of the most vulnerable groups were identified, such as the unemployed, and the consensus view was that poverty knew no borders. One delegate pointed out that poverty also affected the middle class. WHO should provide Member States with data and evidence of good practice, and support countries since they could not act alone.

Attention was drawn to the fact that other agencies were engaged in poverty eradication programmes in the Region. A cautious approach was advocated when setting targets, especially where there was little evidence on the best methods to address the issue. The case studies were a good starting point, and several speakers described their countries' national strategies for poverty eradication, including some where "poverty-proofing" of all new policies was being carried out.

In conclusion, the Regional Director acknowledged that the discussion had provided the Regional Office with clear instructions for the next steps to be taken. They included broadening the scope of case study collection and analysis, gathering examples of good and poor practices, and developing a strategy on poverty and health. Thanks to the work that had been done and the discussion held, a vision and a direction for the WHO European Office for Investment for Health and Development was now in place.

The Committee adopted resolution EUR/RC52/R7.

Tuberculosis, HIV/AIDS and malaria

(EUR/RC52/9, /9 Add.1, /Conf.Doc./5 Rev.1, /Conf.Doc./6 Rev.1 and /Conf.Doc./7 Rev.1)

Introducing the item, the Director, Division of Technical Support 2 stated that over the past several years there had been growing international recognition of the extent of the impact on public health of diseases such as TB, malaria and HIV/AIDS. WHO had played a significant role in raising awareness at all levels of the need to intensify the response to those threats. Through various channels, Member States had undertaken substantial commitments to fight these diseases, and recently donors had agreed to strengthen their support by creating the Global Fund to Fight AIDS, Tuberculosis and Malaria. It was therefore timely for the Regional Committee to address the matter in more detail.

The Head, Communicable Diseases outlined the current situation in the Region regarding the three diseases. Over the past decade, the Region had seen a more than 30% rise in TB case notification, mainly in the countries of the former USSR and Romania. In other countries the situation was largely stable, but there was no room for complacency. In addition multidrug-resistant TB was spreading in the Region. To control the resurgence of the disease, the Regional Office was collaborating with international partners to expand the successful DOTS (directly observed treatment, short course) strategy, which required a flexible approach taking into account the priorities of each country involved. DOTS represented the best way of achieving WHO's global targets for combating TB, yet there remained serious challenges: multidrug resistance; TB control in prisons; health sector reform; the threat of TB/HIV co-infection; and the hitherto limited scope of DOTS implementation. The DOTS Expansion Plan to Stop TB in the WHO European Region was therefore submitted to the Committee for endorsement.

A deterioration in the malaria situation in the Region had begun in the early 1990s as a result of political and economic instability, massive population movements and large-scale irrigation projects. In 1998, the global Roll Back Malaria programme had been set up, and between 1996 and 2001 the reported number of autochthonous cases in the Region had fallen from over 90 000 to some 21 000. Nevertheless, ten countries were still affected, and the problem was thought to be much larger than official statistics indicated. To control the situation, a regional Roll Back Malaria strategy had been developed, whose ultimate goal was interruption of transmission by 2010. It was thus crucial that WHO's strategic role in coordination activities and partnerships be strengthened.

The epidemiological situation of HIV/AIDS in the Region was a direct consequence of social, economic and political inequities, and of poverty both within and among countries. Of the 1.6 million people with HIV/AIDS at the end of 2001, almost two thirds lived in Belarus, the Russian Federation and Ukraine. Eastern Europe and central Asia were the areas with the fastest growing incidence of HIV infection, and in some of those countries access to treatment was very low. Throughout the Region, the increasing prevalence of injecting drug use had fuelled the current epidemic, with some 75% of new HIV cases in eastern Europe being among injecting drug users. Unsafe sex was the most important challenge for effective control, and heterosexual transmission was increasing, especially among vulnerable groups such as partners of injecting drug users and women forced into sex work by poverty or trafficking. Transmission through the use of blood and blood products, organ transplantation or occupational exposure had been very rare of late. There were evidence-based strategies within the health care sector for reducing the risk of infection and prolonging or improving the quality of life, but the most significant obstacle was the lack of political and professional consensus on the appropriate response to HIV infection.

The scaling up of prevention, treatment and care for all three diseases was an investment in preventing the devastating impacts of epidemics. Some of the recommended interventions were cheap and simple, others less so, but they were all evidence-based and the result of tireless research and extensive operational experience. Member States needed to actively promote those interventions and to make every effort to mobilize the necessary resources.

The Executive Director, UNAIDS said that the fact that the item was being discussed was a clear indication that Member States were taking the HIV/AIDS epidemic seriously, and that the engagement of the Regional Office was commensurate with the extent of the problem. The level of engagement shown by countries was not always so high, but there were several excellent examples of national programmes involving prisons, drug users and sexual transmission, antiretroviral treatment and political commitment. The challenges faced included those of political leadership, scale of operation, access to treatment and combating discrimination, with the concomitant need for resources. There was a need within UNAIDS itself to become more efficient, by concentrating on each partner's strengths and pulling together to defeat the common enemy.

Dr Danielle Hansen-Koenig, on behalf of the SCRC, said that the setting up of the Global Fund had been seen as a good opportunity for the Regional Committee to debate such a major subject. The SCRC had stressed the importance of extending the DOTS strategy, and of supporting countries in preventing HIV infection and providing better treatment for those infected. In terms of malaria control, it had also seen the importance of cooperation among countries from different WHO regions with common borders.

Speakers from the floor described the situation in their own countries in respect of the three diseases under discussion. Some sounded an optimistic note, while others painted a more depressing picture. All were nevertheless mindful of the need for constant vigilance. Several representatives thanked the Regional Director for the documentation provided and congratulated him on the strong commitment of the Regional Office to combating those diseases. Some were appreciative of the help that their countries had received from the Global Fund, while others expressed the hope that they might also receive financial support from the Fund. It was generally agreed that the building of systems for sharing information and knowledge, managed through WHO, was highly desirable.

Several speakers described the good experience of implementing DOTS in their countries, and there was an expressed willingness to make that experience available to others through WHO and the Interagency Coordinating Committee. Others, however, considered that proven national strategies should not be simply thrown aside – DOTS should be used only as appropriate and not in all cases. Several representatives stressed the strong link between TB and poor and marginalized groups in society.

As to HIV/AIDS, appreciation was expressed of the efforts of the UNAIDS secretariat and co-sponsors. Various speakers mentioned that, unlike TB, there was no cure for HIV/AIDS and prevention was thus of the utmost importance. There was a need for an open and tolerant attitude to the disease in order to combat stigmatization, as well as improved surveillance and the promotion of condom use. The provision of preventive and treatment services for drug abusers was mentioned as an effective means of controlling the disease. On the subject of malaria, representatives stressed the need for an interregional approach and for increased intercountry cooperation.

The Committee adopted resolutions EUR/RC52/R8 on tuberculosis, EUR/RC52/R9 on HIV/AIDS and EUR/RC52/R10 on malaria.

Proposed programme budget for 2004–2005

(EUR/RC52/12, /12 Add.1 and /Conf.Doc./9)

The Senior Adviser, Programme Management and Implementation introduced the consolidated budget for the entire Organization for 2004–2005. One of the problems with the first consolidated global budget for 2002–2003 had been the poor consultation with countries and regional offices. That was why European Member States had been consulted shortly after the fifty-first session of the Regional Committee in 2001, to obtain a first impression of their priorities. There had followed a meeting at WHO headquarters in March 2002, where the technical content of each area of work had been discussed with the participation of regional offices. The result of early consultation with Member States prior to global discussions was a high degree of congruence between the global priorities and the priorities of the European Member States as expressed in the replies to that early consultation.

The structure of the document was very similar to that of the programme budget for 2002–2003, but with the addition of a section on strategic approaches under each area of work. The number of areas of work remained at 35, with only minor adjustments, allowing a much better comparison with previous biennia. The most important novelty was the introduction of a new area of work on WHO's presence in countries. The aim was to improve WHO's performance at country level through coherent Organization-wide approaches to working in and with countries, and stronger alliances and partnerships with development agencies at country level. That objective was directly in line with the Regional Office's country strategy, "Matching services to new needs", adopted by the Regional Committee in 2000. Two global priorities (maternal health and health systems) had been expanded and an internal managerial priority for WHO (investing in change) had been replaced by a new priority, health and environment.

The Organization was presenting a zero-based global budget, with a total regular budget of US \$855 million. The estimated 23% increase in the overall budget was attributable to funds expected from other sources. There had been a shift in funds under the regular budget from the global level mainly to country level, and it was envisaged that the European Region would qualify for a large proportion of those funds. The European Region was to receive 9.6% of global funds allocated to regional and country level, or 6.4% of the total global budget. So far as Europe was concerned, the regular budget showed a nominal increase of US \$1 561 000 as a result of the provisions of resolution WHA51.31, and those funds had been allocated to the country programme.

The breakdown of the total regional regular budget by major components remained largely unchanged, although the total allocation to the intercountry programme had increased by US \$400 000 at the expense of the Regional Director's Development Fund. Country funds, totalling over US \$13 million, comprised (a) funds for activities in countries negotiated through the BCA process, and (b) support to WHO's presence in countries. While the global budget document presented only total figures by area of work,

split by country and region, the regional document provided a further breakdown to show the proportion of funds allocated to salaries and intercountry work. It also provided a comparison with the programme for 2002–2003 and a more detailed breakdown of other sources of income.

As to the alignment of the two documents, although the actual figures were not always the same, that did not relate to any discrepancy. Such variances related primarily to differences in presentation and also to the Director-General's decision earlier in the year to make a global transfer of 10% from country activities to the newly established area of work on WHO's presence in countries. The result of that shift for the European Region was a reduction in funds available for BCAs from US \$7.5 million to US \$6.8 million. Balancing that was the increase in funds for a strengthened country presence, which was indeed one of the aims of the Regional Office.

A new aspect of the global budget document was the presentation of other sources of income by the level at which they were expected to be spent: country, regional and global (headquarters). The fact that most of those funds would be spent in the countries required that WHO had an appropriate infrastructure at country level. The Regional Office had estimated its need for funds from other sources at just under US \$115 million, 62.6% of which was earmarked for country work. Whereas emergency preparedness and response has previously been the single largest consumer of extrabudgetary funds, it was no longer envisaged to be so.

Professor Jerzy Szczerbań, speaking on behalf of the SCRC, said that the discussions of the SCRC on the programme budget were reflected in document EUR/RC52/3. The Regional Office was continuously concerned to identify resources, although that concern was unfortunately not reflected at global level. He commended the Office on the valuable consultation exercise carried out with the Member States and the clear and informative presentation of the budget documentation. The SCRC welcomed the 10% shift from country activities to WHO's presence in countries.

In the ensuing debate, there was wide appreciation of the work carried out by the Secretariat in preparing and presenting the budget documentation in such a clear manner. It was considered that the global budget document and related regional perspective were a positive continuation of the previous budget formulation in a useful and improved format. Specifically, objectives and indicators by area of work were seen as very useful tools, and the strategic orientation showed considerable improvement in terms of expected results and indicators. There was a call for more detailed budget information on such items as administration and common services. The increase in the regional regular budget was welcomed, but it was regretted that the interregional transfer of funds in accordance with resolution WHA51.31 was slower than expected. The decision to review the effects of that resolution in May 2004 was welcomed, and it was hoped that it would provide the background for further transfer of funds to the European Region. The fact that the Director-General would not finalize her introduction to the global programme budget until comments had been received from the regional committees was highly appreciated.

There was a generally positive response to the priority areas shown in the budget, especially the inclusion of health and environment as a new priority. There was also satisfaction that the four regional priorities recently identified were well covered by the global priorities. Nevertheless, there was some debate on the proposed resources when some priority areas (such as mental health, substance abuse, women's health, injury prevention and blood safety) appeared to have suffered a reduction in regular budget funds, and some speakers were concerned about a lack of balance in the budget amounts. In discussing priorities, there was a request to include ageing as a priority and to establish a full programme on ageing.

Concern was expressed about the continued application of zero nominal growth. A proposal was put forward that a zero real growth policy be adopted instead, since effective and efficient operations could not continue under the current policy. The increase in country funds and expanded country-level activities outlined in the budget were seen as a continued positive trend, and the increase for WHO's presence in countries was also welcomed. Representatives were generally pleased about the increase in funds from other sources, although one speaker urged equitable, integrated distribution among the regions by headquarters. Concern was expressed that the increased proportion of funds from other sources in relation

to the regular budget might turn WHO into an executing agency at the whim of the donors. There was also concern as to the realism of budgeting for such a large increase in funds from other sources and what mechanisms would be put in place should such funds not materialize.

The Executive Director, General Management at WHO headquarters, replying to interventions, said that it was indeed important to present budget data that everyone understood, and the breakdown by global, regional and country levels gave a better overview. He agreed that zero nominal growth was a serious problem: three biennia with no real growth was a real threat to the operation of the budget. He stressed that there had been no reduction in the total funds for mental health and for prevention of violence, since the regular budget deficit had been compensated for by allocation of extrabudgetary funds. The estimates of other sources were considered rather reliable, with some 50% of the increase in donations being for immunization.

On the concern expressed as to the neutrality of donors, he said that the current process allowed flexibility, and more precision might cause problems. Fortunately, not all resources had been earmarked ahead of time. The Information Technology Fund would cost US \$50 million, to be found equally from the regular budget and other sources. The pharmaceutical industry's donations would include contributions in kind. The sizable increase in WHO country presence would be expensive, but it was the only way to monitor and control the necessary infrastructure. That could be seen from the way in which other United Nations agencies worked in countries. It would not necessarily duplicate the existing United Nations infrastructures in countries, and if those were used they would also have to be paid for.

The Regional Director said that the lack of a programme on ageing was purely a question of a lack of regular budget resources; if extrabudgetary funding became available for the purpose, the possibility could be explored. The policy on centres would be reviewed, but it was clear that without centres the Office would not be able to accomplish the current level of work.

The Committee adopted resolution EUR/RC52/R4.

European Strategy for Tobacco Control (Fourth Action Plan for a Tobacco-free Europe) (EUR/RC52/11, /Conf.Doc./8 and Warsaw Declaration for a Tobacco-free Europe)

The Director, Division of Technical Support 2 summarized the challenges posed to public health by smoking. Nearly 30% of the regional adult population were regular smokers, and in eastern Europe 47% of men smoked. There were about 1.2 million deaths per year from tobacco-related disease, 14% of all deaths. A recent worrying trend was the increasing prevalence of smoking among young people, particularly among girls. Tobacco control measures varied significantly between countries, and many programmes were inadequately funded and monitored. The tobacco industry was continuing and intensifying its tactics of undermining public health policies. WHO had responded with a forceful programme of activities leading to the Warsaw Declaration for a Tobacco-free Europe, in which Member States had committed themselves to developing and approving the European Strategy for Tobacco Control, and to playing an active role in the FCTC.

The Regional Adviser for Tobacco Control reported that the WHO European Ministerial Conference for a Tobacco-free Europe, held in Warsaw in February 2002, had been attended by 46 Member States, the EC, the World Bank and 12 other international organizations. The political will of Member States to tackle tobacco was expressed in the Warsaw Declaration, which reconfirmed the fact that tobacco was one of the greatest public health challenges in the Region and highlighted the political will of Member States to coordinate efforts for effective action nationally and in the Region as a whole. Three European action plans on tobacco spanned the period from 1987 to 2001. The lessons learned from assessment of the implementation of those plans had been taken into consideration while developing the European Strategy for Tobacco Control. The SCRC had endorsed its underlying concepts and structure, and it had been reviewed by national counterparts at the end of May 2002. The new strategy was driven by Member States' needs, and they had been fully involved in drawing it up.

The strategy, which drew on international evidence, both global and regional, set out a strategic framework for action in the Region, recognizing that it would be carried out through national legislation, policies and action plans. Instead of setting universal targets and a time frame for all countries, it provided a range of evidence-based mechanisms to enable countries to adopt tailor-made policies. The second cornerstone of the document was international cooperation for effective tobacco control in the Region. Finally, the strategy set out a timetable for international cooperation until 2006, when the next report on tobacco would be presented to the Regional Committee.

The conviction was that Europe would speak with a strong voice in Geneva during the last round of intergovernmental negotiations in October 2002 and during adoption of the FCTC by the World Health Assembly in May 2003. The world was close to completing the negotiations for the first-ever global public health treaty. That could play a truly historic role for international health, possibly serving as a model for other areas of public health.

Many representatives expressed their satisfaction with the documents and the draft resolution. The process of developing and agreeing on the strategy, including subregional and regional coordination meetings, was generally acknowledged to have been a highly successful mechanism. It had ensured that transparency, consensus and unanimous agreement had been achieved. It had also allowed experience to be exchanged and deeper understanding gained of the various ways in which tobacco control policies were built up in the Region. Those involved taking account of prevailing cultural norms and values when taking decisions and action to tackle that sensitive subject.

It was acknowledged that the Fourth Action Plan was closely linked to the FCTC. Adoption of the latter, together with the Action Plan, would facilitate strong policy-making and strategy implementation. Member States were eager to ensure that the Regional Committee's resolution, the Action Plan and the FCTC were all worded in the strongest of terms. That would enable policy-making and action planning to be equally strong, supported by WHO's unequivocal position concerning tobacco use and its damage to health and wellbeing.

Tobacco control was seen as a national and cross-national issue. Solidarity between states was a fundamental factor in achieving successful outcomes. The issues of tobacco smuggling, duty-free sales, cross-border advertising, Internet purchasing and sponsorship were of particular concern.

Many countries described the actions they were already taking to combat the tobacco epidemic. It was observed that countries implementing advertising bans had not experienced serious problems and in addition had measured a decline in smoking prevalence in certain groups. Some countries were planning or were about to introduce comprehensive control programmes, many of them bold political decisions as they were designed to have an impact on traditional patterns of behaviour. Countries would look to WHO for support and guidance.

Some concerns were expressed about the timetable of forthcoming meetings, which included a regional consultation in Copenhagen in September 2002, the intergovernmental negotiations in Geneva in October 2002, and the projected adoption of the FCTC by the Health Assembly in May 2003. Norway offered to facilitate an extra regional consultation meeting, if necessary, in January 2003. In reply, the Regional Adviser explained that there was some flexibility in the timetable, but that the outcome would not be affected.

The Committee adopted resolution EUR/RC52/R12.

The role of the private sector in the health system (EUR/RC52/10)

Introducing the item, the Director, Division of Information, Evidence and Communication noted that, in view of Member States' increasing interest in the role of the private sector in health system reform and

with the guidance of the SCRC, a paper had been prepared that used evidence to describe the lessons learned by countries throughout the European Region.

The Regional Adviser, European Observatory on Health Care Systems described current developments in the use of the private sector and privatization in the reform of European health systems, defined contentious terms in the debate, outlined and drew conclusions from the existing evidence and proposed three ways in which WHO could help Member States.

Countries' aims in increasing the role of the private sector and privatization were to contain costs while increasing the quality, efficiency and responsiveness of health services. A wide variety of models were being applied, but evidence on their effectiveness was patchy. In its absence, ideology tended to dominate the debate; furthermore, the meaning of the terms used was unclear. A common definition of the private sector in health care – "private ownership of health care assets" – was proposed and distinguished from entrepreneurialism, market competition and the decentralization of management.

While the nature of health care systems varied widely between different parts of the Region, all countries employed a mixture of public and private funding, with the former predominating in all but a few of the newly independent states (NIS). Private funding took the forms of private health insurance and out-of-pocket payments. Private-sector provision of care was strongest in pharmaceuticals and dental care but its role in hospital, primary and social care had started to grow in the 1990s. It was important to distinguish between for-profit and non-profit actors and assets.

No single model could be proposed to meet the needs of all countries. The main lesson learned from the evidence available was the need for governments to exercise strong stewardship: taking the lead in explicitly stating societal objectives for health systems, establishing the roles of the public and private sectors in pursuing them, regulating and managing systems and assessing performance to guide future decision-making. When government stewardship was weak, privatization failed to meet societal objectives.

WHO could assist Member States by: strongly advocating the goals of solidarity, equity and efficiency in health systems and providing evidence on which to base decisions about the appropriate mix of public and private service provision and funding; continuing to strengthen its capacity to assess health systems and disseminating the results in ways that would assist policy-making (including making an in-depth study on the role of the private sector); and supporting countries in building capacity for effective stewardship of health systems.

Dr Jarkko Eskola, a member of the SCRC, explained that it had asked the Secretariat to provide the objective evidence on privatization mechanisms that Member States needed. The request had originated with eastern countries of the Region, but western countries also faced pressure on their health systems and needed to decide which privatization mechanisms to use. It was hoped that the resulting paper could stimulate discussion and lead to further developments.

Nearly all the speakers in the discussion praised the quality and usefulness of the paper under review, and most endorsed one or all of the proposals for action by the Regional Office. Several commented on conditions or particular problems in their countries that made the initiative particularly timely and useful. The importance of making values (such as solidarity, equity and quality in services) the foundation for policy was emphasized, as was the need for stewardship by national governments. It was important to clarify the terms used in the health reform debate and to exercise caution in using terms whose meaning had not yet been established. WHO could help governments build capacity for stewardship by developing evaluation methods that were free of ideological bias, and by providing a framework to help ensure the quality and relevance of private-sector service provision.

The usefulness of the evidence produced by the European Observatory on Health Care Systems was commended. Several representatives suggested that WHO should make studies on such topics as non-profit organizations involved in private-sector service provision, the experience of the NIS with the involvement of the private sector in the health system, and the role of the private sector in the quality of

and access to care, long-term and home care, dental and stomatological care and mental health care. A number of speakers urged the Regional Office to cooperate with the Organisation for Economic Co-operation and Development (OECD) and the World Bank, both to take advantage of the useful work they had done on the role of the private sector and to ascertain what added value WHO could bring.

The representative of the World Bank offered the Bank's continued collaboration with WHO on that important issue and agreed that the Regional Office should examine the work of OECD in Europe, particularly that on supplementary insurance. There was some concern at the de facto privatization of health care systems in some NIS, the danger of taking such moves too far and the harmfulness of attempting to use privatization to downsize excessive health service infrastructure. In addition, trade-offs between values were an essential part of policy-making, but efficiency should not be assigned equal value with solidarity and equity.

The Regional Adviser, European Observatory on Health Care Systems agreed on the need to find common definitions of difficult concepts and to work in partnerships, and welcomed the general support expressed by speakers for the three proposed areas of WHO assistance to Member States.

Elections and nominations

(EUR/RC52/5, /5 Corr.1, /5 Add.1, /5 Add.2 and /5 Add.3)

The Committee met in private to consider the nomination of members of the Executive Board and to elect members of the SCRC, the EEHC and the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction.

Executive Board

The Committee decided, following a secret ballot, that the Czech Republic, France and Iceland would put forward their candidatures to the Health Assembly in May 2003 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee by secret ballot elected Armenia, Belgium and Croatia for membership of the SCRC for a three-year term of office from September 2002 to September 2005.

European Environment and Health Committee

The Committee by consensus selected Hungary, Turkey, the United Kingdom and Uzbekistan for membership of the EEHC for a two-year term of office from September 2002 to September 2004.

Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction

The Committee by secret ballot elected Slovenia for membership of the Policy and Coordination Committee for a three-year term of office from 1 January 2003.

Date and place of regular sessions of the Regional Committee

(EUR/RC52/Conf.Doc./10)

The Committee adopted resolution EUR/RC52/R5, confirming that its fifty-third session would be held in Vienna, Austria from 8 to 11 September 2003 and deciding that its fifty-fourth session would be held at the Regional Office for Europe in Copenhagen from 6 to 9 September 2004.

The representative of Austria looked forward to welcoming participants at the Hofburg Congress Centre and informed the Committee that preparations for the fifty-third session were already well under way, in cooperation with the Secretariat.

Cyprus's application for reassignment from the Eastern Mediterranean to the European Region of WHO

(EUR/RC52/Inf.Doc./5)

The Executive President explained that World Health Assembly resolution WHA49.6 required that the regional committees concerned presented their views on any Member State's request for reassignment. Accordingly, the views of the Regional Committee for Europe would be conveyed through the Director-General to the World Health Assembly for its consideration. If there were no uniformity of view, the section of the report of the session containing the different views expressed would be conveyed.

The representative of Denmark, speaking on behalf of the 15 EU member countries, supported the request of Cyprus for a number of reasons. The request concerned the transfer (not the admission) of a Member State, and Cyprus had links with Europe and significant changes were under way in the EU. That support was based on the understanding that no financial disadvantage to the European Region would result, and that a positive response to the reassignment would emerge from the WHO Regional Committee for the Eastern Mediterranean (although no formal expression of views had yet taken place). The representatives of Estonia, Lithuania and Malta also supported the request.

The representative of Turkey objected to the request on several grounds: that no uniformity of view could be established within the Regional Committee, that no political authority was competent to speak for the whole population of Cyprus, and that acceding to the request would interfere with the negotiations under way between the two communities in Cyprus and could create difficulties in implementing the technical activities of WHO in the European Region. She requested that discussion of the issue be postponed until those negotiations were complete and that her statement be reproduced verbatim in the report of the session of the Committee. The statement is reproduced in Annex 6.

The representatives of Kyrgyzstan and Tajikistan endorsed the request for postponement, and the latter requested that the Regional Office prepare a paper for discussion by the Regional Committee, spelling out the financial and legal considerations of including Cyprus in the Region. The representative of Turkey endorsed the request and asked that the views of the Regional Committee not be transmitted until after the Committee's discussion of the paper.

The representative of Switzerland suggested that the Member States in the European Region consider such a paper at their meeting before the next World Health Assembly. The representative of Turkey endorsed the idea of a discussion before the World Health Assembly. The Regional Director expressed his willingness to carry out the instructions of the Regional Committee.

Speaking on behalf of the EU countries, the representative of Denmark requested a postponement of discussion of the item, to allow for consultations. The Regional Committee agreed to resume discussion of the item on the following day.

When the discussion resumed, the representative of Denmark – speaking on behalf of the 15 EU member countries and the candidate countries of Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia – proposed that the views expressed by representatives during the fifty-second session of the Regional Committee on the reassignment of Cyprus to the European Region should be promptly conveyed to the WHO Director-General for the forthcoming World Health Assembly in May 2003, as required by World Health Assembly resolution WHA49.6, and to the WHO Regional Committee for the Eastern Mediterranean for information. No need was seen for reconsideration at any special meeting of the Regional Committee prior to the Fifty-sixth World Health Assembly. The question would be discussed and decided in the Assembly by all WHO Member States, including all Member States in the European Region. In a spirit of good will, a request could be accepted

from this Regional Committee to the Regional Director to prepare – prior to the Fifty-sixth World Health Assembly – a report for European Member States on the financial aspects of the reassignment. The representatives of European Member States could take such a report into account when preparing for the discussion and decision by the Fifty-sixth World Health Assembly. The representatives of Iceland, San Marino and Switzerland endorsed the proposal.

The representative of Turkey asked the Regional Director to confirm his statement that the funds allocated for Cyprus, which she believed to be about US \$375 000, had been or would be transferred to the budget of the European Regional Office. Her inquiries of WHO headquarters and the Regional Office for the Eastern Mediterranean on the issue indicated that no transfer had yet been made and that this could be difficult to decide. She requested that her question and the Regional Director's response be recorded verbatim (see Annex 6). The Regional Director replied that he had made no public statement on that topic; it would be covered in the paper to be prepared.

The Regional Committee agreed that the views of its members on the reassignment of Cyprus would be conveyed to the Director-General and the Regional Committee for the Eastern Mediterranean, and that a paper would be prepared on the financial aspects for Member States in the European Region before the Fifty-sixth World Health Assembly.

Resolutions

EUR/RC52/R1

Report of the Regional Director on the work of WHO in the European Region 2000–2001

The Regional Committee,

Having examined and reviewed the Regional Director's report on the work of WHO in the European Region in 2000–2001 (document EUR/RC52/4) and the related information document on implementation of the 2000–2001 programme budget (document EUR/RC52/Inf.Doc./3);

1. THANKS the Regional Director for the report;
2. EXPRESSES its appreciation of the work done by the Regional Office in the biennium 2000–2001;
3. REQUESTS the Regional Director to take into account and reflect the suggestions made during the discussion at the fifty-second session when developing the Organization's programmes and carrying out the work of the Regional Office.

EUR/RC52/R2

Certification of the European Region of WHO as a territory free from indigenous wild poliovirus

The Regional Committee,

Welcoming with great satisfaction the report of the European Regional Commission for the Certification of Poliomyelitis Eradication, which certified the Region as polio-free on 21 June 2002, and the regional plan of action to sustain "polio-free" status until global certification;

1. ACKNOWLEDGES the global efforts made to eradicate poliomyelitis since the adoption by the World Health Assembly of resolution WHA41.28 in May 1988;
2. STATES that the goal of elimination of poliomyelitis from all countries of the Region proclaimed in resolutions EUR/RC39/R5; EUR/RC47/R4 and EUR/RC50/R1 has been achieved;
3. CONGRATULATES all Member States, all partner organizations concerned, the WHO Secretariat and all other organizations and individuals that contributed to this historical achievement;
4. RECOGNIZING that thorough virological surveillance is the key to ensuring that wild poliovirus is not lying undetected in pockets from which it could re-emerge;
5. REQUESTS Member States to continue their efforts to sustain "polio-free" status until global certification, particularly with regard to sustaining a high level of routine immunization coverage, implementing supplementary immunization activities where necessary, maintaining surveillance of acute flaccid paralysis and polioviruses and making progress in the process for laboratory containment of wild poliovirus;
6. REQUESTS the Regional Director to support Member States in continuing to implement the above-mentioned activities at country level, in order to sustain a "polio-free" status within the European Region, and to:

- (a) promote the development of interregional projects on the control of poliomyelitis, malaria and other particularly dangerous infectious diseases;
- (b) initiate new fund-raising strategies;
- (c) strengthen the Regional Office's activities in the field of information and cooperation with the mass media;

7. ENCOURAGES the partners of the Polio Eradication Initiative to continue to give strong support to and cooperate with the Regional Office for Europe in keeping the European Region "polio-free" and to help mobilize the necessary resources for global activities until the global certification of poliomyelitis eradication.

EUR/RC52/R3

Recommendations of the FAO/WHO Pan-European Conference on Food Safety and Quality, 25–28 February 2002

The Regional Committee,

Concerned that food-related ill health represents a serious threat to public health in the European Region;

Recalling its resolution EUR/RC50/R8, by which it endorsed the Food and Nutrition Policy and Action Plan for the European Region, and requested the Regional Director to cooperate with and support Member States and other organizations in comprehensive efforts to promote public health through appropriate food and nutrition policies;

Further recalling World Health Assembly resolution WHA53.15, which urged Member States to integrate food safety as one of their essential public health functions and requested the Director-General to give greater emphasis to food safety, in collaboration and coordination with other international organizations, notably the Food and Agriculture Organization of the United Nations (FAO);

Having considered the report of the FAO/WHO Pan-European Conference on Food Safety and Quality, held in Budapest from 25 to 28 February 2002;

Aware that the 23rd FAO Regional Conference for Europe, held in Nicosia from 29 to 31 May 2002, endorsed the conclusions of the FAO/WHO Pan-European Conference and requested that its recommendations be forwarded to member countries, the European Union, and other international organizations for follow-up;

Recognizing that development of a food safety strategy within the framework of the Food and Nutrition Policy and Action Plan for the European Region is in line with many of the recommendations from the FAO/WHO Pan-European Conference, and that these recommendations will strengthen and complement current efforts to integrate the food safety strategy in the Food and Nutrition Policy and Action Plan;

1. URGES Member States:

- (a) to endorse the recommendations of the FAO/WHO Pan-European Conference on Food Safety and Quality related to public health in the context of development of the Food and Nutrition Policy and Action Plan in Europe;

- (b) to ensure appropriate support to follow up the recommendations of the FAO/WHO Pan-European Conference related to public health within the framework of development of a food safety strategy for implementation of the Food and Nutrition Policy and Action Plan in Europe;
2. REQUESTS the Regional Director to facilitate cooperation among Member States, WHO, FAO, the European Commission and other organizations in order to promote public health by improving food safety and nutritional quality through the development of enhanced food safety and nutrition policies and action plans in the European Region.

EUR/RC52/R4

Proposed programme budget for 2004–2005

The Regional Committee,

Having reviewed the proposed programme budget for the biennium 2004–2005 (documents EUR/RC52/12 and EUR/RC52/12 Add.1) and taken note of the comments made in this respect by the Standing Committee of the Regional Committee (SCRC) and the Regional Committee;

Welcoming the continuing efforts made throughout the Organization to present a more focused policy and a single global strategic framework, in line with the concept of “one WHO”, and noting the improved comparability between successive biennial programme budgets;

Further welcoming the improved transparency in the distribution of funds from other sources to the three levels of the Organization;

Noting that the budget proposals are in accordance with resolution EUR/RC47/R9, which requested the Regional Director to prepare the regional perspective of the programme budget in accordance with the principles used for presentation of the global programme budget, while at the same time reflecting the exclusively regional priorities;

Noting further that the present budget proposals are still to be regarded as drafts, in view of the fact that Article 34 of the Constitution of WHO stipulates that the Director-General shall submit the final budget proposal of the Organization to the Executive Board;

1. REQUESTS the Regional Director to convey to the Director-General the views, comments and suggestions expressed by the Regional Committee on the proposed programme budget document, to be taken into consideration when finalizing and implementing the programme budget;
2. FURTHER REQUESTS the Regional Director to distribute any additional allocation for the biennium 2004–2005 based on the Human Development Index model endorsed at its forty-ninth session (resolution EUR/RC49/R5), taking particular account of the situation of countries facing natural disasters;
3. ENDORSES the strategic directions contained in the document “The European Region’s perspective” (EUR/RC52/12 Add.1) and WELCOMES the proposed budget for 2004–2005 contained in document EUR/RC52/12, which is to be financed with regular funds and funds from other sources, to the extent that the latter become available, and which provides an excellent basis for further discussions in the Executive Board and the World Health Assembly.

EUR/RC52/R5**Date and place of regular sessions of the Regional Committee in 2003 and 2004**

The Regional Committee,

Having reviewed the decision taken at its fifty-first session, as expressed in resolution EUR/RC51/R2;

1. CONFIRMS that the fifty-third session shall take place in Vienna, Austria, from 8 to 11 September 2003;
2. FURTHER DECIDES that the fifty-fourth session shall be held at the Regional Office for Europe in Copenhagen from 6 to 9 September 2004.

EUR/RC52/R6**Fourth Ministerial Conference on Environment and Health**

The Regional Committee,

Recalling resolution EUR/RC51/R7, which calls on Member States to actively engage in strengthening the health dimension of sustainable development and asks for the recommendations and conclusions of the World Summit on Sustainable Development to be duly considered when the agenda for the Fourth Ministerial Conference on Environment and Health (Budapest, June 2004) is developed;

Recalling the United Nations Millennium Declaration, adopted by the General Assembly at its Fifty-fifth session in 2000, which notes that “We must spare no effort to free all of humanity, and above all our children and grandchildren, from the threat of living on a planet irredeemably spoilt by human activities...” (paragraph 21);

Acknowledging the Declaration of the Second High-level Meeting on Transport, Environment and Health, adopted in Geneva on 5 July 2002, which established a pan-European programme that integrates existing regional initiatives in the area of transport, the environment and health, as part of implementation of the London Charter on Transport, Environment and Health and in follow-up of resolution EUR/RC49/R4 calling for such international initiatives;

Having considered the theme and priority issues for the Budapest Conference proposed by the European Environment and Health Committee (as outlined in document EUR/RC52/Inf.Doc./2), as well as the expected policy outcome of a children’s health and environment action plan for Europe;

1. THANKS the European Environment and Health Committee for its work in promoting, facilitating and monitoring the actions set out in the Declaration of the Third Ministerial Conference on Environment and Health (the London Declaration), including preparation of the agenda for the Budapest Conference;
2. ENDORSES the theme of “The Future for Our Children” for the Budapest Conference and further development of the proposed priority issues, as well as of a children’s health and environment action plan for Europe;
3. URGES Member States:
 - (a) to mobilize their political, technical and financial resources for further development of the agenda for the Budapest Conference and in support of the actions to be decided on at that Conference;

- (b) to further mobilize their political, technical and financial resources to ensure increased implementation of the actions that were decided on at the London Conference, including the new instrument, "THE PEP," and which will be reported on at the Budapest Conference;
4. REQUESTS the Regional Director:
- (a) to continue to provide leadership to the environment and health process in the European Region and to ensure the necessary Regional Office support for the Budapest Conference, the next milestone in this process;
- (b) to give increased support to Member States in ratifying the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes;
- (c) to intensify support for the successful implementation of national environmental health action plans in countries undergoing economic transition and those with low incomes.

EUR/RC52/R7

Poverty and Health – Evidence and action in WHO's European Region

The Regional Committee,

Having considered the contents and recommendations of document EUR/RC52/8 (*Poverty and health – Evidence and action in WHO's European Region*);

Recognizing the overwhelming evidence of the close relations between poverty, both absolute and relative, and ill health;

Being aware of the responsibility of the health system to improve the health of the poor and to contribute to the reduction of poverty, as part of comprehensive multisectoral efforts;

Recognizing that health is an integral part of social development;

1. THANKS the Regional Director for the action taken to implement the provisions of its resolution EUR/RC51/R6 and for including the subject of poverty and health on the agenda of the present session;
2. EMPHASIZES that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being;
3. ACKNOWLEDGES that the issue of poverty and health is a central concern both of WHO and of its Member States, which are all affected, although to different degrees;
4. URGES Member States:
 - (a) to accelerate the formulation and further development of actions to combat the harmful effects of poverty on health;
 - (b) to develop a minimum guaranteed package of free medical services for the poor, and to ask donor countries to consider supporting these efforts;
5. REQUESTS the Regional Director:
 - (a) to impress upon the international community the need for political commitment in order to place health at the centre of sustainable development, and consider the socioeconomic and political implications of failure to address poverty and ill health;

- (b) to review the criteria used for defining absolute and relative poverty, considering the specificity of each country;
- (c) to continue the process of developing, analysing and disseminating knowledge on the relationship between poverty and health, and in particular the systematic collection, validation and dissemination of case studies on the practical role of the health system in addressing issues of poverty and health;
- (d) to establish a data bank at the WHO Regional Office for Europe on the effective actions taken by the health systems of Member States in the European Region to promote the health and wellbeing of the poor and the most vulnerable groups;
- (e) to assist Member States by providing evidence-based information on best practices to improve policy-making in addressing issues of poverty and health;
- (f) to utilize the resources available within the Regional Office, including the recently established European Office for Investment for Health and Development in Venice, to develop activities related to poverty and health and provide technical assistance to Member States;
- (g) to work closely with other relevant agencies active in the field, with the aims of producing regular comprehensive reports on the poverty and health situation in the European Region and monitoring progress.

EUR/RC52/R8

Scaling up the response to tuberculosis in the European Region of WHO

The Regional Committee,

Recalling World Health Assembly resolution WHA53.1, which recognized that the global burden of tuberculosis (TB) is a major impediment to socioeconomic development and a significant cause of premature death and human suffering and called for the acceleration of TB control by implementing and expanding the strategy of directly observed treatment, short course (DOTS);

Recalling the Amsterdam Declaration in 2000 and the Washington Commitment to Stop TB in 2001, which endorsed the need for rapid acceleration of DOTS expansion to reach the targets for 2005 set by the World Health Assembly (70% detection of infectious cases and 85% treatment success) and the goals for 2010 set out in the Global Plan to Stop TB (50% reduction in mortality and prevalence);

Recognizing that TB is out of control in many countries of central and eastern Europe and newly independent states (NIS), and that rates of multidrug resistant (MDR) TB found there are either the highest in the world among the countries surveyed or unknown in the majority of NIS;

Recognizing that the overall strategy for TB control in the European Region of WHO is to increase detection of infectious cases and treatment success by expansion of the DOTS strategy and thereby to contain the spread of the TB epidemic;

1. ENDORSES the DOTS Expansion Plan to Stop TB in the WHO European Region 2002–2006 contained in document EUR/RC52/9 Add.1, as approved at the twelfth meeting of the Interagency Coordinating Committee focusing on TB in January 2002, in order to strengthen the commitment of all Member States and partners to DOTS expansion in the Region;

2. URGES Member States:

-
- (a) to ensure that TB is one of the highest priorities on the health and development agenda in the European Region of WHO, and especially in the countries of central and eastern Europe and the NIS;
 - (b) to strengthen their political commitment to implementation and expansion of the DOTS strategy, taking due account of the specific features of the tuberculosis situation and control services at country level, and in circumstances where its effectiveness has been demonstrated, in order to reach the targets set by the World Health Assembly for TB control by the end of 2005 and to prevent the onset of new MDR TB cases;
 - (c) to promote implementation of the DOTS Plus strategy for the management of MDR TB in countries with high MDR TB rates;
 - (d) to rapidly implement adequate preventive measures and scale up the implementation of the DOTS strategy in penitentiary facilities in eastern Europe and the NIS, as well as the integration of TB control in prisons with TB control in the civilian sector, in order to stop the current epidemics of TB and MDR TB in prisons;
 - (e) to ensure the availability of and access to high-quality drugs for all forms of TB in all Member States, in particular in the framework of the DOTS and DOTS Plus strategies, taking into consideration the fact that treatment of all detected TB cases is the best means of preventing the spread of TB;
 - (f) to increase efforts to secure full collaboration between TB and HIV prevention and control programmes because of the rapidly growing HIV epidemic in the NIS, which is fuelling the dual TB/HIV epidemic;
 - (g) to ensure that TB prevention and control become an integral part of primary health care and give them high priority in the context of health system development, while maintaining the fundamentals of TB control following decentralization and integration;
 - (h) to sustain and strengthen regional and country-level partnerships for controlling TB at country and regional levels, drawing the attention of the international community and donors to the TB and MDR TB epidemics in the Region;
 - (i) to support the Global Partnership to Stop TB;
 - (j) to develop strategies to enhance involvement and collaboration of different actors in the private sector as appropriate;
 - (k) to call on the Global Fund for AIDS, Tuberculosis and Malaria to take account, when allocating resources for tuberculosis control, of low-income countries in the European Region;
3. CALLS UPON international, intergovernmental and nongovernmental organizations and donors to take joint action with Member States and with the Regional Office to maximize the Region-wide efforts for controlling the TB and MDR TB epidemics in the Region and also to help low-income countries attract donor resources and develop proposals for the Global Fund;
4. REQUESTS the Regional Director:
- (a) to consider TB control as one of the highest priorities on the health agenda for Europe;
 - (b) to ensure support to Member States in order to assess, implement, monitor and evaluate TB control activities aimed at attaining the targets set by the World Health Assembly;

- (c) as part of strengthening country work within the framework of the Country Focus Initiative, to provide technical support to Member States in need, so that they can develop plans for accessing the Global Fund for AIDS, Tuberculosis and Malaria;
- (d) to increase and facilitate intercountry cooperation on TB control in the Region;
- (e) to support countries' efforts to raise more voluntary donations for TB control, and to promote fund raising to secure additional extrabudgetary resources in support of the Regional Office's activities on TB;
- (f) to promote partnerships with the donor community at regional and country levels with the aim of scaling up the response to tuberculosis in the European Region;
- (g) to report periodically to the Regional Committee, as part of his report, on the progress made in implementation of the DOTS Expansion Plan to Stop TB in the WHO European Region 2002–2006.

EUR/RC52/R9

Scaling up the response to HIV/AIDS in the European Region of WHO

The Regional Committee,

Recalling the Declaration of Commitment on HIV/AIDS adopted by the special session of the General Assembly of the United Nations in June 2001;

Recalling World Health Assembly resolutions WHA54.10 and WHA55.12, which called for scaling up of the response to HIV/AIDS;

Noting with satisfaction the report on tuberculosis, HIV/AIDS and malaria as contained in document EUR/RC52/9, as well as the efforts made by the Regional Director and the Regional Office to scale up activities in response to STI/HIV/AIDS in the European Region;

Taking account of the recommendations of the meeting of European regional directors of the co-sponsoring organizations of the Joint United Nations Programme on HIV/AIDS (UNAIDS), held in Moscow on 25 and 26 April 2002;

Recognizing that the HIV/AIDS epidemic is a major public health crisis of unprecedented proportions in the European Region, which threatens development, social cohesion and political stability and places a significant and unacceptable burden on many countries;

Recognizing that the overall strategy for the European Region is to contain the epidemic and to reduce vulnerability to HIV infection by focusing action on expanding targeted interventions for vulnerable groups, particularly injecting drug users, on enhanced prevention and treatment of sexually transmitted infections (STI), and on developing comprehensive interventions to promote and protect the health of young people, while simultaneously developing the capacity to respond to a more generalized epidemic;

1. URGES Member States:

- (a) to ensure that HIV/AIDS is one of the highest priorities on the health and development agenda, and to develop multisectoral strategies and mechanisms for involving all sectors of society in the response to HIV/AIDS;

- (b) to rapidly and significantly scale up the implementation of prevention and control programmes in all countries through development of comprehensive, multisectoral national strategic plans and programmes and allocation of adequate resources for the response to HIV/AIDS, including the development of plans and projects for accessing the Global Fund for AIDS, Tuberculosis and Malaria in countries in need;
- (c) to promote ethical legislative and normative activities that conform to the highest standards of civil and human rights and protect the privacy and dignity of individuals;
- (d) to develop comprehensive programmes for adolescents' and young people's health, promoting the use of condoms and the knowledge and skills required to develop healthy and safe lifestyles;
- (e) to promote, enable and strengthen widespread introduction and expansion of evidence-based targeted interventions for vulnerable/high-risk groups, such as prevention, treatment and harm reduction programmes (e.g. expanded needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, substitution drug therapy, STI diagnosis and treatment) in all affected communities, including prisons, in line with national policies;
- (f) to develop a supportive social and legal environment for groups at risk, especially sex workers, and for people living with HIV/AIDS and to fight social and legal exclusion, including travel restrictions;
- (g) to make every effort to ensure effective prevention of mother-to-child transmission of HIV/AIDS;
- (h) to make every effort to continue preventing the transmission of HIV/AIDS through blood transfusion, organ and tissue transplantations, by further ensuring the safety of blood, blood products, tissues and organs supplies, to promote and to strengthen the quality, adequacy and safety of transfusion practice;
- (i) to strengthen implementation of the prevention and control of STIs, with increased access and affordability of appropriate and humanized prevention and care services, reaching out in particular to marginalized groups and ensuring their access to such services;
- (j) to strengthen and extend HIV population-based systems including sentinel and behavioural surveillance of HIV/AIDS and STI;
- (k) to provide universal and affordable access to prevention, treatment and care services for all people at risk including antiretroviral (ARV) treatment for people living with HIV/AIDS, emphasizing the need to ensure its safe and effective use;
- (l) to call on the Global Fund for AIDS, Tuberculosis and Malaria to take account, when allocating resources for HIV/AIDS control, of low-income countries in the European Region;

2. REQUESTS the Regional Director:

- (a) taking due account of the role of UNAIDS, to regard the prevention and treatment of STI/HIV/AIDS as one of the highest priorities on the health agenda of the Regional Office and to ensure that the Regional Office has the necessary resources to provide appropriate expertise and assistance to Member States;
- (b) to continue cooperating actively with the UNAIDS Secretariat, co-sponsors and other interested parties, in order to provide appropriate technical support to Member States for improved

prevention of HIV transmission and a public health approach to safe and effective use of drugs for prophylactic and therapeutic purposes;

(c) to continue collaborating with Member States on promoting the inclusion of integrated approaches to STI/HIV/AIDS prevention and treatment in their health systems;

(d) to assist Member States in drawing up and implementing national projects on blood safety, with the aim of attracting donor resources;

(e) as part of strengthening country work within the framework of the Country Focus Initiative, to provide technical support to Member States in need, so that they can develop plans for accessing the Global Fund for AIDS, Tuberculosis and Malaria;

(f) to report annually to the Regional Committee on the progress made in responding to the HIV/AIDS epidemic in the European Region.

EUR/RC52/R10

Scaling up the response to malaria in the European Region of WHO

The Regional Committee,

Recalling World Health Assembly resolution WHA52.11, which identified Roll Back Malaria as a priority project for WHO;

Reaffirming the fact that the impact of malaria is hampering human development, and appreciating the innovative concepts and operational mechanisms included in the Director-General's January 1999 report on Roll Back Malaria;

Recognizing the large epidemics of malaria occurring in some European countries and the recent resurgence and possible spread of *Plasmodium falciparum* malaria transmission in some countries of the European Region of WHO;

Welcoming the Roll Back Malaria strategy as developed and promoted by the WHO Regional Office for Europe to reduce the regional burden of malaria;

1. URGES Member States:

(a) to ensure that concern and action to control malaria are high on the health and development agenda throughout affected countries in the European Region of WHO;

(b) to match their political commitments to the actual magnitude of the malaria problem in each country;

(c) to ensure implementation of national malaria programmes in accordance with the regional Roll Back Malaria strategy and complementary with international standards for environmental protection, placing emphasis on the needs of populations at risk, on evidence-based actions, and on more efficient use of existing tools, as well as on a firm move towards an integrated approach to malaria prevention and control within the context of health sector development;

(d) to establish, sustain and intensify actions in partnership at country level through the mobilization of external resources, including the development of plans and projects for accessing the Global Fund for AIDS, Tuberculosis and Malaria in countries in need;

- (e) to monitor progress and evaluate the outcomes of Roll Back Malaria interventions in accordance with criteria recommended by WHO;
 - (f) to improve capacities for early diagnosis and prompt treatment;
 - (g) to develop strategies to enhance the involvement and collaboration of different actors in the private sector;
 - (h) to call on the Global Fund for AIDS, Tuberculosis and Malaria to take account, when allocating resources for malaria control, of low-income countries in the European Region;
2. REQUESTS the Regional Director:
- (a) to ensure that the control and prevention of malaria remain a high priority on the European health agenda, as well as to promote appropriate strategies and provide technical guidance for Roll Back Malaria efforts;
 - (b) to support the identification of additional resources for the WHO Regional Office for Europe, in order to support Member States in achieving the regional Roll Back Malaria targets;
 - (c) to promote partnership with the donor community at regional and country level, in order to facilitate implementation of the required actions;
 - (d) as part of strengthening country work within the framework of the Country Focus Initiative, to provide technical support to Member States in need, so that they can develop plans for accessing the Global Fund for AIDS, Tuberculosis and Malaria;
 - (e) to strengthen surveillance and vector control;
 - (f) to increase and facilitate intercountry cooperation on malaria control in the Region;
 - (g) to report periodically to the Regional Committee on the progress achieved, with particular emphasis on the contribution that the partnership makes to reducing the burden of malaria and preventing its resurgence or reintroduction.

EUR/RC52/R11

Report of the Ninth Standing Committee of the Regional Committee

The Regional Committee,

Having considered the report of the Ninth Standing Committee of the Regional Committee (documents EUR/RC52/3 and EUR/RC52/3 Add.1) and the proposed actions and recommendations contained therein;

1. THANKS the Chairperson and members of the Standing Committee for their work on behalf of the Regional Committee;
2. INVITES the Standing Committee to pursue its work on the basis of the discussions held and resolutions adopted by the Regional Committee at its fifty-second session;
3. REQUESTS the Regional Director to take action, as appropriate, on the conclusions and proposals contained in the report of the Standing Committee, taking fully into account the changes agreed by the Regional Committee at its fifty-second session, as recorded in the report of the session.

EUR/RC52/R12**European Strategy for Tobacco Control**

The Regional Committee,

Recalling World Health Assembly resolutions WHA52.18 and WHA53.16, which established an intergovernmental negotiating body open to all Member States to draft and negotiate the proposed Framework Convention on Tobacco Control and possible related protocols and called on the Intergovernmental Negotiating Body to commence its negotiations, and resolution WHA54.18 which called for transparency in tobacco control;

Recalling its resolution EUR/RC47/R8, by which it recognized the Third Action Plan for a Tobacco-free Europe as a set of basic principles for European Member States to follow;

Acknowledging that the tobacco epidemic is one of the greatest public health challenges facing WHO's European Region, which therefore needs a joint response;

Having considered the Warsaw Declaration for a Tobacco-free Europe and document EUR/RC52/11 which proposes a European strategy for tobacco control based on an assessment of implementation of the Third Action Plan for a Tobacco-free Europe and the recommendations of the WHO European Ministerial Conference for a Tobacco-free Europe (Warsaw, 18–19 February 2002);

Noting that the Warsaw Declaration for a Tobacco-free Europe underlines the Member States' high-level political commitment to coordinating and strengthening their action against the tobacco epidemic;

Taking into consideration the constitutional framework of Member States;

1. COMMENDS the Regional Office for Europe on the work it has done in recent years to promote the Action Plan and on organizing the WHO European Ministerial Conference;
2. THANKS the government of Poland for hosting the WHO European Ministerial Conference, the governments of Malta, Slovenia and the Netherlands for hosting the pre-conference and follow-up meetings of national counterparts, and the government of Switzerland for providing financial resources and hosting and coordinating the work of the drafting committee for the Warsaw Declaration;
3. ENDORSES the Warsaw Declaration for a Tobacco-free Europe as political guidelines for coordinated tobacco control policies in WHO's European Region;
4. ADOPTS the European Strategy for Tobacco Control as a strategic framework of action for European Member States to follow through their national policies and international cooperation;
5. THANKS the Committee for a Tobacco-free Europe for the work it has done during the period of its mandate and ASKS the Regional Director to transfer the functions of the Committee to the existing network of national counterparts representing Member States, with appropriate involvement of key international partners in the field;
6. URGES Member States to:
 - (a) strengthen their tobacco control policies and capacity in line with the European Strategy for Tobacco Control;
 - (b) contribute to the establishment of a WHO European monitoring system for tobacco control, as a key international component of the European Strategy for Tobacco Control;

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- (c) intensify intergovernmental consultations for a coordinated European approach in the process of negotiations for the Framework Convention on Tobacco Control, and actively contribute to the adoption of a strong, public health-driven Framework Convention by the World Health Assembly in May 2003;
 - (d) speed up the process of adoption and ratification of the Framework Convention on Tobacco Control;
7. REQUESTS the Regional Director to:
- (a) give high priority to providing guidance and support to Member States in their activities in strengthening their policies and building capacity in the field of tobacco control;
 - (b) mobilize resources and facilitate implementation of the international components of the European Strategy for Tobacco Control, particularly for a WHO European monitoring system for tobacco control;
 - (c) adopt, in consultation with the Standing Committee of the Regional Committee, terms of reference for the network of national counterparts to act as an international advisory body on the European Strategy for Tobacco Control;
 - (d) examine the possibilities for and facilitate the creation of a European coalition for tobacco control that will involve Member States and international and nongovernmental organizations interested in sharing their expertise and resources for accelerating coordinated tobacco control action in the European Region;
 - (e) submit a report on implementation of the European Strategy for Tobacco Control to the Regional Committee at its fifty-sixth session.

*Annex 1***AGENDA**

- 1. Opening of the session**
 - (a) Election of the President, the Executive President, the Deputy Executive President and the Rapporteur
 - (b) Adoption of the agenda and programme of work
- 2. Address by the Director-General**
- 3. Report of the Regional Director**
- 4. Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board**
- 5. Report of the Standing Committee of the Regional Committee, including:**
 - (a) recommendations on criteria for membership of the Executive Board
 - (b) annual report of the European Environment and Health Committee
 - (c) report on the external evaluation of the Regional Office's work on health care reform
 - (d) report of the SCRC subgroup on bioethics
- 6. Partnerships for health**
- 7. Policy and technical items**
 - (a) Poverty and health
 - (b) Tuberculosis, HIV/AIDS and Malaria
 - (c) Proposed programme budget for 2004–2005
 - (d) European Strategy for Tobacco Control (Fourth Action Plan for a Tobacco-free Europe)
 - (e) The role of the private sector in the health system
- 8. Elections and nominations**
 - (a) Nomination of three members of the Executive Board
 - (b) Election of three members of the Standing Committee of the Regional Committee
 - (c) Election of four members of the European Environment and Health Committee
 - (d) Election of a member of the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction
- 9. Date and place of future sessions of the Regional Committee**
- 10. Cyprus's application for reassignment from the Eastern Mediterranean to the European Region of WHO**
- 11. Other matters**
- 12. Approval of the report and closure of the fifty-second session**

Technical briefing on health impact assessment (organized by the Secretariat during the session)
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*Annex 2***LIST OF DOCUMENTS****Working documents**

EUR/RC52/1 Rev.2	List of working papers and background documents
EUR/RC52/2 Rev.1	Provisional agenda
EUR/RC52/3	Report of the Ninth Standing Committee of the Regional Committee
EUR/RC52/3 Add.1	Report of the sixth session of the Standing Committee of the Regional Committee
EUR/RC52/4	Report of the Regional Director on the work of WHO in the European Region – 2000–2001
EUR/RC52/5	Membership of the Executive Board and various other committees
EUR/RC52/5 Corr.1	Membership of the Executive Board and various other committees
EUR/RC52/5 Add.1	Membership of the Executive Board and various other committees
EUR/RC52/5 Add.2	Membership of the Executive Board and various other committees
EUR/RC52/5 Add.3	Membership of the Executive Board and various other committees
EUR/RC52/6	Matters arising out of resolutions and decisions of the Executive Board and the World Health Assembly
EUR/RC52/7	Partnerships for health
EUR/RC52/8	Poverty and health – Evidence and action in WHO's European Region
EUR/RC52/9	Tuberculosis, HIV/AIDS and malaria
EUR/RC52/9 Add.1	DOTS expansion plan to stop TB in the WHO European Region 2002–2006
EUR/RC52/10	The role of the private sector and privatization in European health systems
EUR/RC52/11	European Strategy for Tobacco Control
EUR/RC52/12	WHO's proposed programme budget for 2004–2005
EUR/RC52/12 Add.1	Proposed programme budget 2004–2005: the WHO European Region's perspective

Conference documents

EUR/RC52/Conf.Doc./1 Rev.1	Provisional programme
EUR/RC52/Conf.Doc./2	Report of the Ninth Standing Committee of the Regional Committee
EUR/RC52/Conf.Doc./3	Report of the Regional Director on the work of WHO in the European Region 2000–2001
EUR/RC52/Conf.Doc./4 Rev.1	Poverty and health – Evidence and action in WHO's European Region
EUR/RC52/Conf.Doc./5 Rev.1	Scaling up the response to tuberculosis in the European Region of WHO
EUR/RC52/Conf.Doc./6 Rev.1	Scaling up the response to HIV/AIDS in the European Region of WHO
EUR/RC52/Conf.Doc./7 Rev.1	Scaling up the response to malaria in the European Region of WHO

EUR/RC52/Conf.Doc./8	European Strategy for Tobacco Control
EUR/RC52/Conf.Doc./9	Proposed programme budget for 2004–2005
EUR/RC52/Conf.Doc./10	Date and place of regular sessions of the Regional Committee in 2003 and 2004
EUR/RC52/Conf.Doc./11	Certification of the European Region of WHO as a territory free from indigenous wild poliovirus
EUR/RC52/Conf.Doc./12	Fourth Ministerial Conference on Environment and Health
EUR/RC52/Conf.Doc./13	Recommendations of the FAO/WHO PAN-European Conference on Food Safety and Quality, 25–28 February 2002

Information documents

EUR/RC52/Inf.Doc./1	External evaluation of the WHO Regional Office's Health Care Reform programmes. Summary and recommendations of the external evaluators
EUR/RC52/Inf.Doc./2	Annual report of the European Environment and Health Committee (EEHC)
EUR/RC52/Inf.Doc./3	Regional Director's report – implementation of the programme budget 2000–2001
EUR/RC52/Inf.Doc./4	A review of the Regional Office's Centres ("geographically dispersed offices")
EUR/RC52/Inf.Doc./5	Reassignment of Cyprus from the eastern Mediterranean to the European Region of WHO

Background documents

EUR/RC52/BD/1	Poverty and health – Evidence and action in WHO's European Region
EUR/RC52/BD/2	Full report on the external evaluation of the WHO Regional Office's Health Care Reform programmes
EUR/RC52/BD/3	Technical briefing – Health impact assessment
EUR/01/5020906/6	Warsaw Declaration for a Tobacco-free Europe

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Mr Antonis Lanaras
Dr Vladimir Kozyreff

VII. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL RELATIONS WITH WHO

International College of Surgeons

Dr Yaw-Tang Shih
Dr Peter Chang Wushou

International Confederation of Midwives

Ms Lillian Bondo

International Council for Standardization in Haematology and International Society of Haematology

Dr Benedicte Laursen

International Council of Nurses

Ms Ea Trane
Ms Kirsten Stallknecht
Ms Annie Marrot

International Federation of Pharmaceutical Manufacturers Association

Ms Sissel Brinchmann

International Pharmaceutical Federation

Dr Peter Kielgast
Ms Ida Gustafsen

Medical Women's International Association

Dr Vibeke Jørgensen
Dr Annemette Mygh

World Association of Girl Guides and Girl Scouts

Ms Estrid Staehr Hansen

World Confederation for Physical Therapy

Ms Inger Brondsted
Ms Elisabeth Berents

World Hypertension League

Dr Svend Strandgaard

VIII. OBSERVERS

Association of Schools of Public Health in the European Region

Professor Roza Adany

European Forum of National Nursing and Midwifery Associations and WHO

Ms Merete Thorsen

European Forum of National Pharmaceutical Associations and the World Health Organization Regional Office for Europe (EuroPharm Forum)

Ms Ida Gustafsen

Regions for Health Network

Dr Jaroslav Volf

World Health Professions Alliance

Dr Peter Kielgast

*Annex 4***ADDRESS BY THE DIRECTOR-GENERAL OF WHO**

Chair,
Ministers,
Distinguished delegates,
Ladies and gentlemen,

It is a pleasure to join you at this meeting and to greet all delegations present. I join you from Jakarta and Kyoto just as you are reaching the end of your work: I look forward to hearing your conclusions.

Chair and distinguished delegates,

The twenty-first of June this year was a great day for the Region. Declaring the European Region polio-free was the result of a major effort.

But those of us who were there will never forget last year's session of this Regional Committee in Madrid. The images of burning towers in the United States numbed us all. Perhaps we were starting to think about how that tragic event might shape so much of what has happened in subsequent months.

Global interdependence has become even clearer. We have become aware of the potential for threats to health to be used – deliberately. To cause alarm, provoke suffering and undermine our security. European nations have acted, in solidarity, to counter these threats.

WHO Member States have worked with the Secretariat to examine the possible public health consequences of incidents due to biological, chemical and radio-nuclear material. We have all recognized the importance of sharing information, better surveillance and preparedness. We have acted – together.

We need to maintain the effort.

Within the Region we have had to respond to new emergencies while, at the same time, recovering from past crises. The recent flooding in central Europe is one example where the resources of countries have been tested to the extreme. WHO has reacted quickly in response to requests from the national authorities.

Chair,

I am in the midst of a month of continuous travel. September started just after I had worked with Southern Africa's health ministers in Harare, as they focused on mitigating the region's humanitarian crisis, and reducing its long-term impact. Then I joined the Heads of State gathered in Johannesburg to focus on the critical sequel to the Rio Summit: making hard-fought commitments to a common future for people and planet. I travelled to Lesotho for a close-up review of responses to untold suffering. I then moved on to WHO's Committees for its most populous Regions – the South-East Asia Region in Jakarta and, yesterday, the Western Pacific Region in Kyoto.

The themes are consistent.

Ten years on from Rio, the world accepts that health is a key element in securing our common future.

We have to deliver. That means efficient health systems that work, as well as tangible reductions in ill health. So we have to focus on the issues that matter the most, and find better ways of working to achieve our results.

How are we focusing on the issues that matter?

Two years ago, world leaders agreed on the Millennium Development Goals. Many of these Goals are concerned with health. MDGs help us all to coordinate our actions: international agencies – including WHO – are analysing the cost of achieving them and defining indicators of progress.

Last year I received the Report of the Commission on Macroeconomics and Health. The Commissioners showed the benefits of investing in health. They advocated investing in cost-effective interventions, in systems and people who are committed to results, and in measurements of progress. This means reforming health systems so that they emphasize the pursuit of health equity: experiences in this Region demonstrate that reforms can be achieved but only if they take account of local and national realities.

That is why health has been so prominent in recent international conferences – particularly in Financing for Development in Monterrey, Mexico, the start of the new Trade Round in Doha and the Sustainable Development Summit in Johannesburg.

Investment in health means accessing additional resources through alliances and partnerships that are built around common goals – like the Healthy Cities Initiative, the Global Alliance for Vaccines and Immunisation and the Global Fund to Fight AIDS, TB and Malaria.

How are we working better?

The most important requirement is that we find ways to make our partnerships work – and work really well. Only then can we break down the barriers which prevent people accessing the health systems and commodities they need. Only then can we respond properly to environmental health risks. New international agreements can help. Three years ago, we began to negotiate the Framework Convention on Tobacco Control. I hope that the Health Assembly next year adopts a strong Convention: when it comes into force we must implement it with all speed.

But on most occasions we will need to establish and sustain more informal partnerships. The challenge is for governments, civil society and private entities to respond, within this spirit. There are many good examples within this Region. WHO helps ensure that the outstanding achievements of a few are the new paradigms that inspire action from us all.

Let us dwell for a minute on the Global Fund to Fight AIDS, TB and Malaria. It is a bold response to the extraordinary impact of these illnesses. Several countries have made substantial resources available to the Fund for investing in effective programmes. You discussed it earlier this week. So, too, did the health ministers in Kyoto, as well as in Jakarta.

All want the Fund to be a success. They have asked WHO to help. We are working with countries as they try to access funds, and – if they are successful – as they spend them. We want to see effective mechanisms for handling funds and to encourage further contributions so that the Fund has enough resources to respond to country needs.

We have all worked hard for reductions in the price of essential health commodities, including medicines. After intense efforts over the last four years, differential pricing is now commonly used to widen poor people's access to medicines. Prices of some anti-retrovirals dropped by 80–90% and TB medicine prices were reduced by a third. Nevirapine is available free of charge for preventing mother-to-child transmission of HIV, as is multi-drug therapy for leprosy.

Several new partnerships have been established to develop new medicines for neglected diseases. And at Doha, safeguards in the TRIPS agreement were strengthened with respect to essential medicines.

Governments, NGOs, researchers, companies, the media, and the UN should all take credit for these achievements. They have broken the mould. They have put access to medicines on the global agenda, insisting that people's health must take precedence over trade.

There is more work to be done. I take the view that no clause in any trade agreement should work in a way that denies – to those who need them – access to life-saving medicines for common diseases. This applies wherever they live and whatever their ability to pay.

Money is vital. But effective action calls for a ruthless commitment to making a difference. To changing people's lives. Countries within the European Region have shown the way. Finland, Greece, and then Belgium highlighted mental illness, generating interest in the issues, bringing in new players and defining a vibrant and vivid agenda for us all. The world has taken notice: together we have put mental health on the map.

Making a difference means building consensus – not just within the health sector, but across other sectors, so that the efforts of all bring benefits to many. For years Europe's politicians have known that without careful attention, people's environment can undermine their health. Soon after the Rio Summit ten years ago they showed the value of investing in healthy environments. Within the last decade they have acted, bringing together different ministries, with both NGO and private partners, to work together for healthy environments.

Since my time in government within Norway I have seen how Europe's environment and health ministers have blazed a trail for environmental health. The familiar European lexicon of political agreements, codes of conduct, joint planning, common programmes and measurable indicators has led to real results. It has inspired much of the emphasis on healthy environments at the Johannesburg Summit. Children's environmental health issues now bring together the peoples of Europe and their countries, both East and West.

As we look towards the meeting of Health and Environment Ministers in Budapest in 2004 we can see how Europe has influenced the world. WHO's European team has shown the way too – focusing on evidence for action and cost-effective interventions, fostering alliances that involve the European Commission, OECD, NGOs, academic networks and governments, and helping these varied actors to make things happen.

Let's face it. Too many children are made ill by their surroundings – where they live, work and play. In 2000, nearly 5 million child deaths resulted from unhealthy environments. Most commonly the children developed acute respiratory infections and diarrhoea.

We know how unsafe environments make children sick. Human waste finds its way into water, into food. Water is further contaminated with pathogens and chemicals. Air is polluted with smoke from indoor cooking or tobacco use. Other toxins get into air and soil. Disease-carrying insects bite children. Too many children are injured at home or on the road.

You have shown us how alliances can work in practice. The Rome Centre has been on hand to help. Two weeks ago, in Johannesburg, the WHO team worked with UNICEF and UNEP, together with key NGOs, to expand on your example. We started to build a global alliance to promote healthier environments for children.

The time is ripe for governments and NGOs, scientists and politicians, private entities and campaigners to work together to this end. To put children first. To tackle environmental health risks with cost-effective interventions. To agree strategies and use precise indicators. By working together we will make a difference to public health, and our children's future.

But much more remains to be done.

You have exposed Europe's AIDS crisis. Now the demands for prevention programmes are on the increase. Resources are needed, but they are not easily mobilized. And the many thousands of people living with AIDS need effective care – including anti-retrovirals. They wonder why they cannot yet access the cheap medicines. We have to continue searching for the right response, even though the challenges seem enormous.

European nations are reforming their health systems. You have worked hard to do this in a way that responds to what people need. Yet the technologies and skills of health workers often do not match the needs for health care. The reform seems to be never ending, much to the frustration of health professionals. This is inevitable. The negotiations to agree standards for health system staffing, financing and performance among the different interested parties are extraordinarily complex.

I see that our WHO support to your reforms has recently been evaluated. I know, from my own experience, that the process is not simple. But the stakes are high: we need to secure public support for our health systems, and be credible. This means focusing our collective efforts on health outcomes, service quality and patient safety.

Life would be so easy if health systems could be reformed as a direct result of something said by the WHO's Director-General, and disseminated by our staff. But that is not how it works. Action for health involves interplay among professionals, backed by evidence from research, and interactions which involve professional associations, politicians, the media and campaigners, at least.

Whether we like it or not, the achievement of health equity calls for effective – and of course, principled – action by those who can access the levers of change. Effective advocates find ways to pull these levers, working both inside and outside institutions. They can draw on WHO for help – using our standards as a point of reference, using our technical materials to exercise influence. Sometimes we will go out in front, acting as pathfinder. More often, though, we are both the supporters club and the training staff. We offer guidance and encouragement, and, I would hope, are there when we are needed.

WHO should be in a position to help countries obtain information about their people's health, options for preventing or tackling illness, and tools for assessing the performance of health systems. We learn from your experiences and share examples of best practice. Working with partners like the World Bank, OECD and the European Commission, we seek to help you compare your experiences with others – through health observatories based here in the Region and standardized instruments like the World Health Survey.

Chair,

What are the most important risks to health in today's world? This year's World Health Report, to be issued in October, provides some of the answers. They include some familiar risks associated with underdevelopment such as unsafe water, poor sanitation and hygiene, unsafe sex (particularly related to HIV/AIDS), iron and other nutrient deficiency, and indoor smoke from solid fuels.

Other enemies of health are more associated with unhealthy consumption patterns such as unhealthy diets and obesity, high blood pressure and blood cholesterol, tobacco use, excessive alcohol consumption, and physical inactivity. These risks, and the diseases they cause, are dominant in all lower-middle and high-income countries.

Throughout the world, unhealthy consumption patterns are replacing healthier ways of eating. Sedentary life has replaced regular activity. These changes are now starting to affect the health of all – young and old, rich and poor.

We know that some cardiovascular conditions, types of diabetes and cancers can be prevented through changing diets and increasing exercise. WHO is responding to a World Health Assembly Resolution of last May with a global strategy on diet, physical activity and health. Member States will discuss this at six regional consultations in the next year. I know that countries in your Region will set the right tone for this work.

We have shown the value of focusing on key issues together. Why else have we fought so hard to regulate a product that kills half of its regular users? For decades we have known how to prevent each of the four million annual deaths caused by tobacco consumption. It's not difficult: tax increases, advertising bans and regulations to keep indoor air clean.

In 1998 I was convinced that we must act.

So we examined Article 19 of WHO's Constitution. Member States can use this to negotiate global standards. That is why we chose to use the Organization's treaty-making power to prevent tobacco-related diseases. By setting in motion the Framework Convention on Tobacco Control negotiations, we were making history.

The FCTC negotiations have reminded us about the critical role of the State in public health, particularly in setting norms and standards, and ensuring that others adhere to them.

Such efforts do encounter opposition. In all Regions we find tobacco companies continuing to act solely in their own interests – safeguarding market share and profits, luring ever-younger women and men into the smoking habit. How? With flawed science and false propaganda, often disguised as corporate citizenship. You have stood out against them: your declaration at the Warsaw meeting is uncompromising and firm.

The first draft of the FCTC is now ready for the next round of negotiations in October. It spells out possible agreements on tobacco advertising, promotion, sponsorship, illicit trade in tobacco products, taxes, and international cooperation. If countries want it badly enough, FCTC can become real. But this means political determination in the final, crucial stages to determine the strength of WHO's first international treaty.

My target date for finishing is the World Health Assembly in May 2003. The FCTC will then come into force. It will bring benefits to countries and to their people. It will help safeguard important public health policies, in a way that is tailored to national needs. I know that you are better prepared than ever before. I know you are committed to make the FCTC a treaty in the service of public health.

Chair, distinguished delegates,

On Monday Marc Danzon referred to the public health consequences of violence. Just think: in 2000, 1.6 million people died as a result of violence. Half were suicides, one third were homicides, and one fifth were affected by war. Millions more are scarred for life by violence that they have suffered: for many, the scars are locked away. And many of those affected are women.

We need to break the silence and confront violence – now. That is why I am going to Brussels early next month to launch the first World Report on Violence and Health. That is why I look to countries to show how to confront this blot on our civilization. Can Europe respond to the challenge? I hope so.

As many of you know, these will be the last regional committees I shall be attending as Director-General. It has been a special period in my life as a public servant.

For me, WHO is a vibrant network of many parts and a very long reach. It touches the lives of billions of people in many different ways. It links – in a particular way – with each of its Member States. WHO's skeleton is its regional structure: the Regions are the bare bones on which our country action depends. The Regions give WHO a unique strength.

The diversity of countries' needs is reflected within the Regions, and this feeds through to our WHO-wide programmes of work. In this way, regional perspectives influence the position that the Director-General takes on all global issues.

At the same time, the Geneva office and the collaborating centres respond directly to the needs of countries. I would like to be sure that they are there to help as and when required. They should be helpful, useful and – as Marc said at the beginning of the week – ready to sort out right from wrong. I am most encouraged by the way in which experience shared among countries has resulted in regional solidarity and solutions.

I want to express my appreciation to the staff of our country offices. But I also want to pay a special tribute to our dedicated staff in the regional offices. The demands on them are legion, and – generally – they respond well.

Our performance within countries should be stronger. The regional directors and I are now looking at ways to improve our country operations. That is why we have launched the Country Focus Initiative.

WHO is present in 147 countries around the world. Within your Region we are working hard to build up our presence within countries. The Country Focus Initiative is particularly important. It will help us focus on countries' needs, supporting effective health action through both standard setting and technical cooperation.

We will build on strategies for cooperation and memoranda of understanding between individual countries and WHO. The whole Organization will respond to the strategic agenda for health in each country. We will build up the competencies of our country teams so that they are able to lead this response. We will do our best to transform WHO's administrative systems so that WHO country offices operate more effectively – whether they are using regular or extrabudgetary funding. And we will encourage WHO country teams to work better with UN system agencies, the World Bank and other development partners.

Chair,

The new budget, which you discussed yesterday, includes expected results and indicators that integrate activities at all levels of WHO. It relates to all sources of funds. In response to requests from many Member States, the budget proposals also show, for the first time, how much of our extrabudgetary resources we estimate will be spent in countries and at the regional level.

I have made proposals for investing in stronger WHO presence within countries. This will supplement work already under way in the European Region. It is vital if we are to reach the goals of the Country Focus Initiative. It is needed if we are to administer effectively what we expect to be a growing role for country offices in handling extrabudgetary resources and dealing with donors.

Friends and colleagues,

When I started my term in 1998, I committed WHO to making a difference.

Our analysis of the global burden of disease encouraged us to set clear priorities, and we have done so.

We now have a focused approach to worldwide improvements in health that reflects our corporate strategy. We build on our regional perspectives and solidarity. We work with partners at all times.

Together,

- We are confronting the risks that contribute to ill health worldwide.
- We are scaling up action to address the health conditions that drive and are driven by poverty.
- We are making sure that the health sector plays a central role in curbing the pandemic of HIV/AIDS, as well as noncommunicable diseases and the tobacco menace.
- We are helping to establish health systems that are effective, fair and responsive to people's needs.
- And, to underpin all these efforts, we are doing everything we can to put health at the very core and centre of political attention.

It is a challenging agenda; and one which we can only tackle if we continue this focused effort – together.

Thank you very much

*Annex 5***ADDRESS BY THE WHO REGIONAL DIRECTOR FOR EUROPE****Introduction**

Mr President, Distinguished representatives of Member States in the European Region, Participants in the fifty-second session of the WHO Regional Committee for Europe, Colleagues at headquarters and in the Regional Office, Ladies and Gentlemen,

Since my last address to the Regional Committee in Madrid on 10 September 2001, many things and ideas have changed in the world, in the Region, in our countries and, I would even say, for every one of us. In my address this morning, I would like to describe the work done by the Regional Office this year in that context of global change, but I would also place emphasis on continuity.

I will not, of course, be able to give you all the details, most of which you will find in the written report on the work of WHO in the European Region in 2000–2001. I will therefore limit myself to the most significant activities and trends, as well as to the events in 2002 that are not covered in the written report.

I will then answer any questions you may wish to ask.

The salient events of the year

There is one constant feature running through the events that have marked this year for WHO's Regional Office for Europe: the European Region's strong involvement in global programmes, combined with an equally strong affirmation of its specific characteristics.

This is true, for instance, of the response to **bioterrorism**. The Region has contributed to many global activities. It has itself organized some of them, especially in the areas of water safety (as early as November 2001) and epidemiological surveillance and early warning systems (in Lyon in February 2002). In December 2001, during a second "Futures Forum" organized specifically on the subject of bioterrorism, subjects rarely tackled elsewhere were examined and discussed with experts in fields that are sometimes far removed from that of public health. This meeting concluded that as a whole the health system needs to respond to bioterrorism. Emphasis was placed on good information practices in times of crisis, and on the social and mental support to be given to the population.

In the area of **tobacco**, the year has also been a very active one. The Declaration adopted by the Warsaw Ministerial Conference in February is clear and unambiguous about the response to this major public health hazard which (as recent studies show) increasingly affects young people, women and socioeconomically disadvantaged groups. The European Region will thus contribute in a responsible and determined way to adoption of the global Framework Convention in 2003.

Another major event marked this year: the **certification of the eradication of poliomyelitis** from the European Region. This great public health success is the fruit of the efforts and determination shown by all the public and private partners involved. But total success will only be achieved when this disease (that has wreaked such havoc among the world's children) will be finally eradicated from our planet in 2004, we hope.

In the control of **AIDS**, the past year has been striking for the general acknowledgement of the severity of the situation in some countries in the east of the Region. These countries' economic difficulties prevent them from tackling the epidemic, which has been made considerably worse by drug trafficking and use. The European offices of the eight United Nations bodies sponsoring UNAIDS have decided to join forces

to tackle this problem. We met in Moscow in March 2002 to coordinate our efforts and help the countries concerned to mobilize the necessary international funding. The declaration adopted on that occasion sets out a specific plan of action and places emphasis on the rights of young people to information, education and access to health services.

Still on the subject of this year's events, I should like to refer to a topic that is less spectacular than the ones I have just mentioned, but which is certainly essential for the future of public health. This is the area of **ethics**. In Europe and throughout the world, there has been much talk this year of bioethics, especially seen from the point of view of genetics. For its part the Regional Office for Europe, based on a recommendation by a working group set up by the Standing Committee, has decided to broaden the subject to include the ethics of health systems, and to make it one of its major topics for the future. That is why it was chosen as the central theme of the third Futures Forum, held in Stockholm in June.

Lastly, to conclude this section on the salient events of the year, I should like to touch on a subject that has been much talked about globally, especially in connection with publication of the Sachs report on macro-economics and health, namely **health and development**. The main conclusion in that report is fully applicable to the countries in the European Region: "investing in health is the best investment for development". Having said that, the report does not devote enough space to the specific features of countries in the European Region. It would be a dangerous mistake to regard the countries of central Europe and the former Soviet Union as developing countries. Their economic situation calls for considerable amounts of aid to be made available urgently, to meet the health needs of their populations and reform their health systems. But what distinguishes them from developing countries is their experience in public health, the quality and training of their health professionals and the presence of a health infrastructure that certainly must be reformed but which does exist at all levels in these countries. These differences were clearly expressed at the conference which brought them together in Washington in July. I should like to recall here the proposal to devote part of these countries' debt relief to rapid and determined reform of their health systems, following a precise plan and clearly formulated objectives. The Regional Office for Europe would like to play its role here, giving advice to governments and ensuring good practice in the use of the funds freed up. I hope that WHO will set a good example by renegotiating, with some of these countries, payment of their debt to the Organization. They have made an official request to this end and have asked me to be their spokesman, which I have been and will continue to be. Original methods of giving support need to be devised and tested: this might include arrangements whereby one country hosts fellowship holders from another, as has been done by the School of Public and Community Health in Jerusalem with physicians from central Asia.

Europe has had and will no doubt continue to have numerous opportunities to exert its influence in the field of global public health, while giving voice to its own particular characteristics. The environment and health is one of these opportunities. Some topics tackled in Johannesburg will be taken up again at the European conference in Budapest in June 2004, especially the subject of the environment and children's health. In conjunction with the European Environment Agency, we have recently published a book that reviews the scientific evidence in this field. Another recent event highlights, in all too tangible a way, unfortunately, the links between the environment and health. The populations who have been suffering from the floods in numerous countries in the Region have seen this for themselves. We hope that the assistance and advice we have given has been useful to the countries concerned. We have available for you a document that has just been finalized on the repercussions of flooding on public health. Lastly, so far as the environment is concerned, and with the recent Johannesburg conference in mind, I would ask all Member States to ratify the Protocol on the availability and quality of water and to make it an effective instrument for health protection and promotion.

Among the events of the past year, I have not mentioned an important meeting, even if it was not a technical one, which took place in Geneva in July under the auspices of the Standing Committee, on membership of the Executive Board. The presentation of the Standing Committee's report this afternoon will touch on this subject and the solutions proposed to make progress in this area and, I hope, prevent it becoming a perennial problem.

Continuation and development of programmes and working methods

Since the last session of the Regional Committee, the Office has developed its activities and programmes, taking full account of the guidelines given by the Committee – especially the country strategy it adopted in 2000 – and the advice of the Standing Committee. In order to illustrate this work, I have selected some representative fields of activity.

During the year, we have refined **our country approach**, by gaining a better understanding of their needs and responding to them in a more specific way. We are strengthening and upgrading our presence in the 28 countries with which we have biennial cooperation agreements. We have stepped up the training of our field personnel this year, and we are preparing to staff some of our country offices with international personnel in the near future. The cooperation agreements for the current period were negotiated with these countries on the basis of a genuine concerted effort to identify, with each of them, where WHO's technical and financial investment could best be placed. For our part, this negotiation process has enabled us to understand better the priorities and working methods of our Member States. We know that the discussions which have taken place in the countries have proved to be stimulating and motivating for them, too. Health system reform is a subject which the Regional Office is most often called on to support. Our unit is currently developing its capacity to respond in this complex field, with the help of a committee whose members include experts and decision-makers. Pharmaceuticals is one of the sensitive points of health policy, and an area where WHO can most usefully play an advocacy role, to ensure that all people finally have the right of access to essential drugs. Other essential elements of health policy entail defining the role of health professionals and ensuring that they are properly trained. In this context, the Munich Conference on the role of nurses has raised great hopes and attracted considerable interest. Our programme has been maintained and, despite a lack of resources, we are continuing along the lines set out in the Munich Declaration.

The Office's services and programmes have moved forward to meet the specific needs of groups of countries. I have already mentioned communicable diseases and the problems of poverty faced by the countries in the most eastern part of the Region. For those in south-east Europe, I stressed last year the productive cooperation between the Council of Europe and the Regional Office, which led to the inclusion of health in the Stability Pact's programmes. I am pleased to inform you this year that projects on mental health, communicable disease surveillance, nutrition and food safety have all attracted funding and are ready to be put into effect. So far as mental health is concerned, the Athens Declaration you adopted has already played a stimulating role. This topic will also be important for the Greek presidency of the European Union. On behalf of the seven – soon eight – countries involved in the Stability Pact and our partner, the Council of Europe, I should like to thank the contributors, notably Greece, Italy and France. I am committed to ensuring that these projects are carried out with exemplary monitoring.

I am also committed to giving intensive support to those countries in rapid transition, most of which are candidates for accession to membership of the European Union, by seizing the numerous opportunities now on offer thanks to our cooperation with the European Commission and the interest shown in this issue by the countries holding the Presidency of the Union. We have tried, and will continue to try, to respond better to their expectations and requirements, especially in the field of health information and "observation".

For those countries that have no cooperation agreement with us, the "Futures Fora" offer an organized framework for tackling the sensitive public health issues they are or will be facing. This year, under the heading of the ethics of health systems, the Forum tackled subjects such as patient consent, rationing of care and assisted suicide.

Others, such as the mobility of health personnel and the credibility of government information, will be taken up at forthcoming sessions. I place great hope in the continuation of these forums, the stimulus they give, and networking them and disseminating their results throughout the Region, as well as the contribution they can make to the new Health for All policy. To conclude this description of our country work, I should like to share one concern with you, about the future of humanitarian aid programmes.

They are part of the essential services that the Regional Office provides to the countries concerned. Unfortunately, as I pointed out last year, it is increasingly difficult to find sufficient resources once the acute phase is passed. This naturally leads us to focus on a few high-priority technical fields. But my fear now is that our resources in this area are being cut back so much that we will be forced to terminate these humanitarian aid programmes too early, despite the fact that our presence is so important in the rehabilitation phase, when the media have moved on. So I am appealing for a reasonable amount of funds to continue to support our humanitarian aid programmes.

In the area of **partnerships**, which also contribute to the Office's country strategy, we have endeavoured this year to make our cooperation more specific. Thanks to modern communication techniques, coordination meetings have been held at regular intervals with our main partners, the Council of Europe, the European Commission and the World Bank. This coordination is increasingly focused, either on harmonizing our interventions in each country or to ensure that our technical programmes are mutually supportive and that the best possible use is made of our respective resources. We have strengthened our cooperation with UNICEF and its European office this year, and we hope to steadily extend this type of committed and practical partnership to other United Nations agencies and nongovernmental organizations. We are of course continuing our work with the professional associations for general practitioners, nurses and medical educators. However, like with our country support policy, the problem of resources is crucially important for our partnership strategies. We greatly hope that the Organization's new policy on collecting and redistributing voluntary contributions will finally compensate for the historic weakness of the European Region's regular budget, given the economic and health situation faced by many countries.

A third major field of work for the Regional Office is, of course, to develop and **carry out a range of technical programmes**. I have already touched on some of these in the previous section of my address. I will therefore restrict myself here to mentioning just a few others.

Since it was adopted in September 2000, the action plan on **food and nutrition** has given rise to a great many activities aimed at training decision-makers. To date, 28 countries have benefited from this initiative. National action plans based on the regional one are currently being put into effect, with the Office's assistance, in 21 countries. There is now both technical and operational collaboration with the European Commission, the Council of Europe, UNICEF and FAO. The initial difficulties with setting up the "task force", which the resolution you adopted last year referred to, have now been overcome. In this field, I should also like to draw attention to the first conference on food safety and quality, organized by WHO and FAO and held in Budapest in February, attended by representatives of 45 countries of the Region. At the request of that Conference, we are proposing that you should adopt a resolution, the draft version of which was distributed to you this morning.

Many countries have again benefited from the Office's programmes on **childhood, adolescence and reproductive life**, on subjects such as the prevention of child abuse, tackling the main perinatal and childhood diseases, promoting safe pregnancy and gender mainstreaming. **Our networks** have also continued their activities, especially those involving healthy cities and health-promoting schools and hospitals.

With a view to the conference in Budapest in 2004, the past year has also seen a wealth of activities related to **health and the environment**. The impact of transport on health has again been stressed in the pan-European programme adopted at the end of the second meeting on this topic in Geneva in July, organized in partnership with the United Nations Economic Commission for Europe, following World Health Day in April 2002.

To conclude this section, may I again voice a concern that I hope will bear fruit: that our programme on **noncommunicable diseases** will finally be expanded to match the real burden imposed by these diseases. A group of experts who met in Copenhagen in May 2002 have proposed that a European strategy to prevent these diseases should be drawn up in consultation with Member States and submitted to the Regional Committee in 2004.

After the Ministerial Conference in Stockholm on **alcohol and young** people, the Office has fostered the adoption of national strategies and plans, especially in the countries of central and eastern Europe. Thanks to support from Norway and France, an information system on alcohol consumption was set up last December. Additional resources are needed to maintain the programme at the level called for by the Ministerial Conference.

I have not, of course, overlooked **communicable diseases**. We will take them up when we come to consider this item on the agenda.

Having talked about our work in and with countries, our partnerships with other organizations and our technical programmes, I should now like to mention an area of work close to my heart: **evidence and information**. Our work on evidence is moving forward. We now have a technical team and a high-level scientific group to guide our work. The aim is to bring together and analyse the experience acquired over the years in the field of public health, in order to draw useful lessons from it that can guide us in the support we give our Member States. The idea is to base this support as far as possible on the most tangible evidence and good practice; in short, to add "intelligence" to the advice we give our Member States. What we are currently developing is primarily a working method for the Office, but we also hope that it will contribute to progress in public health. In the months to come, an article on this subject will be published by the scientific group that is assisting us in our work. The paper on poverty drawn up for the Regional Committee also takes its inspiration from this method. "Evidence" is part of the more extensive work that we are taking forward in the field of information. Our ambition is still to give decision-makers easier access to validated information that they can use in making their decisions. In this age of communication, the need to distinguish between true and false, useful and useless, is more indispensable than ever. With our national and international partners, we are working towards this end. It is a difficult area, and I personally feel our progress is too slow, but what is at stake is so important that the project we are building up must be solid, lasting and of high quality. Within the Office, this project calls for contributions from all the technical units. It is influencing our working methods and helping to break down barriers. It will increasingly be one of the elements bringing all our activities together, especially to ensure that our own contribution to this "knowledge base" is exemplary, even if necessarily limited.

May I draw your attention to the high quality publications produced by the European Observatory on Health Care Systems. They are exhibited in the Lobby. The Office's new Web site and the European Health Report (which will appear in book form in all the languages in November) are also available to you throughout this session. On the subject of access to information, I should also like to inform you that thanks to a WHO headquarters initiative several ministries and national organizations, as well as our liaison units and offices, can now have access to the main international publications and databases.

To a certain extent, the spirit of "evidence" also guides the current **management and administration** of the Regional Office. We are making efforts to reduce some cumbersome administrative procedures. The spirit of "evidence" regularly leads us to ask ourselves questions about good practice in the administrative field, as we do for our technical programmes. The administration must of course continue to play its role of monitoring and ensuring compliance with WHO's regulations, but it must also contribute to attainment of the objectives and implementation of the activities that you expect of us. The many audits and studies carried out in the past two years have given us a basis on which to develop our reforms. One of these studies that I should like to mention is Professor Silano's, on "outposted" centres. His report was discussed by the Standing Committee and has been distributed to you. I am naturally very interested to hear your comments on this subject. Innovative events during the year include renewal of the agreement on the Rome centre, the opening of centres in Bonn on the urban environment and in Venice on the socioeconomic determinants of health, and expansion of the Brussels centre to take in some health observatory functions.

So now I have covered the main areas of work in which I have involved the Office since I arrived. Nothing revolutionary, but ongoing and organized efforts to match the countries' needs and the missions of the Office. In total, these amount to nine major fields. I have kept to the end that of **human resources management**. Even though I can be critical, I must say that I am always impressed by the quality of work

and commitment of the staff in the Office. I have seen proof of that this year by systematically visiting all the units in-house, as well as the centres and liaison offices outside Copenhagen. But above all, I have heard it from our partners and during my visits to countries. And if you ask me for the evidence on which I base my opinions, I can respond that I have found it in the many professional audits that have been carried out in the past two years. Again, however, these compliments must always be tempered by criticism. In the year ahead, I should like to support and develop the training of our human resources. A new unit responsible for this area has been set up. The programme planned will tackle the technical, cultural and political aspects of training. I also hope the participatory process that has now been put in place will be fully scaled up this year. The new forms and objectives of our training will make it easier for staff to adapt their skills to the tasks they have to carry out. They will also facilitate the movement of staff within the Organization and what is known as “rotation”. So far as staff movements are concerned, I would say that I interpret their comings and goings in a positive way. Even though it is sad when people who have spent many years within the Organization leave, it is pleasing and reassuring to see what high-level posts they are offered in the countries or other international organizations. I am thinking here, of course, of Mrs Zsuzsanna Jakab, who left us on 1 September to become Permanent Secretary at the Ministry of Health in Hungary, whose delegation she is heading today. Among those who have joined us, I am pleased to welcome Professor Gudjón Magnússon, Dean of the Nordic School of Public Health, who is responsible for a major part of our technical programmes. Lastly, I should like to pay tribute to the work of the Staff Association, which does not hesitate to criticize us but always in a constructive way and in the interests of the Organization.

Future milestones

Among the events planned for the coming months, I should like to draw attention to **two global reports** that will be issued in October. The first, on violence and health, will deal with preventing violence against women, child abuse and neglect, young people and violence, suicide and the health consequences of conflicts and human trafficking. The second is the World Health Report 2002, which will cover health risks. Here, too, the Office will transmit these global initiatives at regional level.

The months ahead will also be crucial for the **Framework Convention on Tobacco Control**. The European Region has made its preparations at preliminary meetings held in Bulgaria, Russia and Estonia. The Office is organizing a consultation in Copenhagen next week for the 51 countries in the Region, in order to prepare for the last round of negotiation in Geneva in October before the Convention is concluded at the World Health Assembly in May 2003.

In the area of **health promotion**, I should like to point to the meeting in Amsterdam from 25 to 27 September, on the partnership between the education and health sectors for school health promotion.

I have already mentioned the importance we attach to **countries in rapid transition**, most of whom are candidates for membership of the European Union. This subject will be on the agenda of the annual coordination meeting between WHO and the European Commission, to be held for the first time in Copenhagen on 3 and 4 October. As I have said, we hope to take advantage this year of the Danish and Greek presidencies to strengthen our support to these countries.

Mental health is not forgotten after the major events in 2001, which concluded in October with a European conference on stress and depression organized by the Belgian government, the European Union and the Regional Office, and the adoption of a declaration by the European Parliament and a resolution by the World Health Assembly. We will continue to raise awareness of this issue and build on the progress made by Member States in this field, by making preparations for a ministerial conference on mental health policies in Europe. Having discussed this question yesterday with the Standing Committee, I propose that it should be held in Helsinki in January 2005. We have already suggested to Estonia that it might co-sponsor this conference, which could have two “poles” separated by just the few kilometres of the Gulf of Finland.

Lastly, I should like to inform you that, straight after this session of the Regional Committee, we intend to launch preparations for the **new phase of Health for All**. I hope to present a methodological approach to you next year, and that you will be able to adopt a final document at the Regional Committee session in 2005. During the Futures Forum meeting in Stockholm, we tested the issue of the ethics of health systems, and it appears to be a good central theme and backbone for the project. We will very soon set up a mechanism not only to include experts in this work but also to involve you as much as possible. We cannot do without your support in this area and, in this specific instance, I am thinking more of intellectual and creative support than financial assistance.

Conclusion

During this year, and in a world in the throes of change, we have tried to carry out our mission, to ensure that the voice and specific features of our Region are heeded and to respond more effectively to the needs and expectations of our Member States. We are very impatient and, of course, very interested to hear your views on our work. You are both our statutory body and our guides, an idea that we translate in our in-house jargon by the phrase “our bosses and our customers”. We hope that this session of the Regional Committee will be equally interesting for you, and that you will be able to benefit from it in your work when you return to your countries. Owing to Dr Brundtland’s recent announcement, this session in Copenhagen has taken on a slightly special dimension, but the spirit of WHO as “one organization” that she has imparted will persist, while respecting the regional differences that you represent here.

Thank you.

*Annex 6***STATEMENTS OF THE REPRESENTATIVE OF TURKEY****First meeting, Monday 16 September 2002, a.m.****Adoption of the agenda and programme of work (agenda item 1(b))****Mrs Fügen OK (Ambassador of the Republic of Turkey to Denmark)**

Thank you Mr President. Allow me first to congratulate you on the post of the presidency. I wish you success during the coming year. I also wish to congratulate the new Vice-President, the Deputy Executive President and the Rapporteur. In the meantime, I would like to express my delegation's thanks to the outgoing President, the outgoing Executive President, the Deputy Executive President and the Rapporteur.

Now the reason I have taken the floor, Mr President, relates to the draft agenda. The Turkish delegation has an objection to the inclusion of item 10 in the agenda. We believe that the inclusion of this item in the agenda for our meeting is inappropriate, first of all on procedural grounds. The request of a country that wishes to be transferred from one region to the other must be addressed by the membership of both regions, since such a decision entails technical, practical and financial implications for both of the regions concerned. Although the resolution adopted by the Forty-ninth Assembly of the World Health Organization on the transfer of countries from one region to another contains no specifics on the procedure to be followed, common logic dictates that any question of admission of a particular country in a region must be preceded by a formal decision of the region which the country concerned wishes to leave. We understand that the Eastern Mediterranean Region is already aware of the request of the Greek Cypriot administration to leave that group, but there is no formal endorsement of the Region to that end. Therefore the European Region should wait for the outcome of the next meeting of the Eastern Mediterranean Region on this issue, which has no urgency other than a possible political gain to be exploited by the Greek Cypriot administration at a critical stage of the efforts directed to solution of the Cyprus problem, which has been on the agenda of the United Nations for nearly four decades.

Mr President, the World Health Organization is a technical organization which pursues the noble goal of improving the health conditions of all our peoples. Its work is based on close cooperation among its members and a spirit of consensus. The Regional Committee for Europe also traditionally operates on the principle of consensus on all issues. Political exploitation of procedural advantages has always been abhorrent to the nature of the Committee's work. If this conventional principle of consensus is somehow revoked for political reasons, the Committee will not be able to deal unanimously with the eminent technical health problems facing the Region.

In view of these problems, Turkey does not agree with the inclusion of item 10 on the agenda of this Committee before a decision is finally taken by the Eastern Mediterranean Region. Consequently, to ensure the continuation of the smooth and coherent functioning of the Regional Committee for Europe and to prevent this sensitive political issue to occupy its agenda, the delegation of Turkey proposes the exclusion of item 10 relating to the inclusion of the Cypriot administration in the European group and requests that this statement be recorded verbatim in the summary record of this meeting. Thank you very much.

Fourth meeting, Tuesday 17 September 2002, p.m.**Cyprus's application for reassignment from the Eastern Mediterranean to the European Region of WHO (agenda item 10)****Mrs Fügen OK (Ambassador of the Republic of Turkey to Denmark)**

Thank you. Mr President, we have explained our objections to the inclusion of this item on the agenda. Now, we are discussing item 10 relating to the agenda. I listened carefully to the statement of the European Union's representative. It is true, it is only a question of transferring somebody from one region to another. But what are you transferring? You are transferring a member of the Mediterranean Region to the European Region where there is no uniformity of opinion. And you are pre-empting a lot of issues: you are pre-empting the solution of the problem on Cyprus and you are pre-empting the possibility of reaching uniformity in this Committee on this issue. So I think the European Union's statement is openly a declaration of the reality, which is that it is a transference from a committee where there was peaceful, uniform working and operation of activities. But it is being transferred to another committee where there is no uniformity of opinion or views and there is no unanimous – there will not be unanimous – action in this Committee because of this problem. So this is to make clear what the European Union's declaration means for us.

Now, secondly I want to touch the statement made by the Executive President that this is an automatic issue. It is not automatic. There are some people who are very familiar with UN tactics and UN rules of policy and procedure; particularly the European Union and European diplomats know this very well, and I am sure the Regional Director is very experienced in doing this. So it is not automatic. There are many ways of dealing with these issues, it is very politicized, it depends on the goodwill of the person who is at the head of the organization.

Now with these remarks, since we have come to the agenda, I would like to explain why we objected to this issue. The Republic of Cyprus, dating back to the 1960s, was established in the 1960s, ceased to exist as such after its constitution had been unilaterally abrogated in 1963 and when the Turkish Cypriot side was ejected by force from the partnership republic. For the past 36 years, there has been no single political authority in Cyprus which is competent to represent jointly the Turkish Cypriots and the Greek Cypriots and legitimately empowered to act on behalf of the whole island. The jurisdiction of the Greek Cypriot administration only covers the area of the island under Greek Cypriot control in the south of Cyprus. The Turkish Cypriot people are represented by the government of the Turkish Republic of Northern Cyprus, which exercises sole jurisdiction and political authority on its territory. Moreover, Turkey does not recognize the Greek Cypriot administration, which since 1963 represented exclusively the Greek Cypriots and their interests. The request of the Greek Cypriot administration to be transferred from the Eastern Mediterranean Region to the European Region of the World Health Organization should be assessed in this reality. We believe that non-recognition of the said administration by Turkey, besides its adverse political implications, would also create political and technical problems and difficulties in the work to be carried out in the European Region. This would inevitably have a negative impact over the smooth and harmonious functioning in the Region, as well as the spirit of cooperation among the Member States.

On the other hand, at a time when direct talks are being held between the two sides in Cyprus, we believe that it is particularly important that they are conducted in an atmosphere far from third parties' interference. We expect the third parties to refrain from taking any action which could harm the ongoing talks and treat the two sides equally. This will indeed constitute the most substantive contribution to the process.

Mr President, for the above arguments, Turkey opposes the transfer from the Eastern Mediterranean group to the European group of the Greek Cypriot administration at this particular time and requests the postponement of this issue to a later date, when this political problem is resolved between the two

communities and states existing on Cyprus. I request that my statement be recorded verbatim in the records of this meeting. Thank you very much.

Fifth meeting, Wednesday 18 September 2002, a.m.

Cyprus's application for reassignment from the Eastern Mediterranean to the European Region of WHO (agenda item 10)

Mrs Fügen OK (Ambassador of the Republic of Turkey to Denmark)

Thank you Mr President. I am posing a very technical question and I would like this question and the answer from the Secretariat to be recorded verbatim. And my question is, yesterday we all heard the Regional Director saying that the funds that are necessary for the transfer of this member to the European Region, which I understand is about US \$375 000, he said this will be transferred from the EMRO Region to the EURO Region, has been transferred or will be transferred. Now I have enquired from the Geneva Office, from the headquarters, and from members of EMRO that this transfer has not been made, and cannot be made, and EMRO has not decided anything like this in their meetings. And it is very difficult for them therefore to decide such a transfer. Now this is my question and I would like a very clear answer from the Secretariat on this, again to be recorded verbatim for the World Health Assembly. Thank you very much.

Dr Marc DANZON (WHO Regional Director for Europe)

Madam Ambassador, I don't remember having said anything publicly on this issue, and it is here that I make the official declaration, so ... Perhaps you heard it, but as you are requesting a paper of us, that will be included in the paper, of course.