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INTRODUCTION

Opening of the session

The fiftieth session of the WHO Regional Committee for Europe was held at the Regional Office for Europe in Copenhagen from 11 to 14 September 2000. Representatives of 49 countries of the Region took part. Also present were observers from one non-Member State and two member states of the United Nations Economic Commission for Europe, and representatives of the Food and Agriculture Organization of the United Nations (FAO), the United Nations Children's Fund (UNICEF), the Council of Europe, the European Commission and nongovernmental organizations.

The inaugural ceremony was held at the Regional Office on Monday, 11 September. Addresses were delivered by Ms Sonja Mikkelsen, the Danish Minister of Health, and Mr Peter Martinussen, the Mayor of Health of the City of Copenhagen.

Dr Danielle Hansen-Koenig, outgoing Executive President, then opened the session, replacing Mrs Rosy Bindi, outgoing President, who was unable to attend.

Election of officers

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

Dr Josep Goicoechea (Andorra)	President
Dr Jeremy Metters (United Kingdom)	Executive President
Professor Ayşe Akin (Turkey)	Deputy Executive President
Dr Marine Gudushauri (Georgia)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC50/1 Rev.1 and /Conf.Doc./1 Rev.1)

The Committee adopted the agenda and a programme of work.

REVIEW OF THE WORK OF WHO

Address by the Director-General

In her statement to the Regional Committee (Annex 4), the Director-General began by explaining why she saw the year 2000 as a turning point for improvements in the health of all peoples. She then outlined the imminent achievements in health relevant to the European Region, pointed to the greater global emphasis being placed on the area of food safety, and noted the effective work on environment and health being carried out in the Region. WHO was doing substantial work on the development of health systems, and the *World health report 2000*, containing an assessment of their performance, had had considerable impact. Other major challenges being faced were related to mental health, tobacco control and WHO's role in emergencies.

To meet those challenges, WHO was changing in order to better serve the Member States. The clearest reflection of that change was to be found in the proposed programme budget for 2002–2003, which was a key instrument for advancing the process of reform. In conclusion, she emphasized that health was becoming big news, which could only be good news for the poorest people in the world, who should benefit from the consequent rise in resources devoted to health.

Many speakers thanked the Director-General for her presentation and congratulated her on her achievements over the previous two years. It was felt that the Director-General's and Regional Director's statements made it easier to place the decisions taken in their right context. Particular appreciation was expressed for her success in placing health high on the political agenda, and for initiating the one-WHO concept that was more cost-effective and took account of the initiatives of the Member States.

Responding to comments from the floor, she first expressed her satisfaction on hearing that smoking among those aged 14–17 years had fallen in one Member State. Among so many negative trends, particularly concerning young people, that was very encouraging news.

On the question of how to deal with the continuing situation of zero nominal growth of the global budget, she explained that rationality was frustrated by the many factors that had to be taken into account in such discussions. Nevertheless, she would not give up trying to find a way out of the situation, and neither should the Member States. In response to the disappointment expressed by some representatives that the European Region was not receiving the maximum reallocation of the regular budget, she explained that she had worked hard on trying to implement fairly a mechanism that had been agreed before she took office. Indeed, the formula in place did not guarantee that the European Region would receive a certain proportion of the reallocated funds; any projection based on the situation in 1998, when the model had been approved, did not necessarily remain valid for the future. Nevertheless, the European Region had received a 2% increase in its allocation, in the light of a maximum of 3%, and the situation would be kept under review. The main problem was in determining the index to be used in the model.

She agreed that the publication of *World health report 2000*, with its ranking and benchmarking approach, was courageous. Nevertheless, it had been done in the knowledge that it would have the desired effect – that of stimulating new levels of debate. The report had followed the example of the United Nations Development Programme's *World development report* with its human development index: not only had the specialized media taken up the issue, but social development had hit the headlines of the popular press and broadcast media. Now, prime ministers and finance ministers were discussing health, perhaps for the first time. Some countries did not want to be evaluated, but transparency was becoming more and more the way to work, and it would continue. There had been comparisons before, of course, according to certain indicators, but the approach adopted in the present case was to use a composite index. She regretted that the report had not been ready for the World Health Assembly in May 2000, and also that some Member States had received their copies very late. Owing to the rapidity with which conditions changed, she envisaged the report being revised annually.

Concerning the 10-year evaluation of the Convention on the Rights of the Child, she confirmed that WHO would be working closely with UNICEF from a standpoint that combined children's health and rights.

Report of the Regional Director
(EUR/RC50/2, /Conf.Doc./2, /Inf.Doc./1 and /Inf.Doc./3)

In his presentation to the Committee (Annex 5), the Regional Director outlined several innovations that had been introduced at the current session, identified what he saw as the seven major challenges to health in the European Region and described the major reform of the Office's policies, structure and approach to country work that had been undertaken since he took office in February 2000.

In the ensuing discussion, many delegates congratulated the Regional Director on his predecessor's written report, as set out in document EUR/RC50/2, and on his verbal presentation. Together, they provided an impressive and accurate review of the Region's health problems and of the efforts made by WHO and the Member States to deal with them. Some speakers felt that certain changes in the form of reporting might make the information more digestible, particularly by highlighting the main themes and by showing trends.

There was strong endorsement of the new approach to country work, which had already led to a sense of fresh energy at country level. It was vitally important for the Regional Office to provide leadership in

health, and to support the Member States in implementing their own health policies in line with the framework set out in HEALTH21. Several speakers stressed the need for countries to learn from each other in order to speed up the process of reform. To that end, the Office could support the countries by identifying suitable partners and raising funds, and also by improving the health indicators.

Responding to questions on the Office's cooperation with other organizations, the Regional Director hoped that negotiations with the European Union (EU) would soon bear fruit. WHO was trying to develop in-depth cooperation with the European Commission (EC), and he was sure that in time those efforts would be successful. Likewise, the fact that WHO and the Council of Europe shared common values was a recipe for successful future cooperation.

Turning to the role of centres located outside the Regional Office, he confessed to having been rather sceptical on first taking office, and he had asked for the situation to be reviewed. That review had indeed revealed some shortcomings. One centre was being closed down. Nevertheless, he had been convinced of the value of centres, although there needed to be clear agreement as to the role of a centre vis-à-vis that of the Office in Copenhagen. The suggestion for a centre on mental health concerned an area that certainly deserved more investment.

He acknowledged that there were differences in the process of reform, but similarities of aims, between headquarters and the Regional Office. The entire Organization was in a process of change, but it was not possible to wait for everybody to agree before changing the structure of the Office. The Regional Office had decided on a functional structure that would reduce fragmentation of its work, and it would indeed be interesting to see whether the rest of the Organization followed that pattern.

Environmental health remained a priority programme, and it was a misperception to believe that WHO was less interested in that field. Nevertheless, the proportion of the regular budget available was limited, and other, perhaps smaller programmes should not be deprived of funds. The balance between the regular budget and voluntary donations in the funding of the environmental health programme should be reviewed.

He agreed that a central data bank for Europe was desirable, and it went without saying that poverty was a serious problem in assuring equitable access to health services. The initiative on combating communicable diseases taken by the countries in the Baltic area should certainly be supported. As to the question of bioethics, that did not yet appear in the Office's structure because it needed further work before a formal unit was established.

The Committee adopted resolution EUR/RC50/R2.

Report of the Standing Committee of the Regional Committee (including review of the Rules of Procedure of the Regional Committee and the SCRC)
(EUR/RC50/3, /3 Add.1, /Conf.Doc./3, /Conf.Doc./4 and /Inf.Doc./2)

The Chairperson of the SCRC noted that a number of the areas of work covered by the SCRC in the past year were also items on the agenda of the current session of the Regional Committee. Members of the Standing Committee would present its views when those items were taken up: his introductory remarks were accordingly confined to those subjects that would not be further discussed at a later stage.

The Standing Committee had met formally on five occasions since the previous session of the Regional Committee, and it had also held a "retreat" with the newly appointed Regional Director in Reykjavik in March, at which a good working rapport had been established. The President of the European Region's Staff Association had addressed the SCRC at its third session, when the Standing Committee (on behalf of the Regional Committee) had paid tribute to the dedication and courage of the staff, especially those serving in hazardous and war-torn areas. It acknowledged that the Organization was wholly dependent on the staff to take forward all of its work.

Having discussed the question of bioethics on two occasions during the year, the SCRC was of the opinion that further analytical work needed to be done in order to clarify the specific contribution that the Regional Office could make in that area. It also recommended that an inventory should be drawn up of ongoing projects with bioethical components, and that efforts should be made to ensure complementarity with the many other organizations active in that area.

The SCRC emphasized that the process of external evaluation of the Regional Office's programmes should be genuinely independent, and it recommended that evaluators should be appointed (and criteria defined) on a case-by-case basis. It would make more detailed recommendations to the Regional Committee at a later date, as the Regional Director had indicated his intention of taking a fresh look at that process.

Similarly, work was still in progress on the question of criteria for membership of the Executive Board and on reviewing the mechanism of the Regional Search Group (for candidates for the post of Regional Director). The SCRC would present its detailed recommendations on those two subjects to the Regional Committee at its fifty-first session.

The Standing Committee had noted with pleasure at its third session that an expert group meeting had been held in the Netherlands to operationalize the "generic" indicators to be used in the forthcoming exercise to monitor progress towards health for all, and it welcomed the assurance that the monitoring exercise would not entail additional work for the Member States. Lastly, it had appointed Professor Ayşe Akin to represent it on the Committee for a Tobacco-free Europe.

In response to comments made by the Regional Committee at previous sessions, the Standing Committee was proposing a number of amendments to its own Rules of Procedure and those of the Regional Committee. Details of those amendments were contained in Annex 2 to its report. Furthermore, and in the light of its own experience, the SCRC recommended that its members should be part of countries' delegations to the Regional Committee and the World Health Assembly.

At its session the previous day, the SCRC had been briefed on the work of the European Environment and Health Committee (EEHC), and it had recommended that a similar briefing should also be given to the Regional Committee. Dr Alán Pintér, speaking on behalf of the co-Chairpersons of the EEHC, accordingly informed delegates that the EEHC currently comprised representatives of nongovernmental organizations and international agencies, as well as of national governments. Two regular meetings and one extraordinary meeting of the EEHC had been held in the previous year; at the latter, it had initiated a pilot project on a rapid risk assessment procedure to assess and rank hazardous installations in the lower Danube basin, an approach that it hoped to extend to many other countries.

The process of ratifying the Protocol on Water and Health had started in a number of countries, and the first Meeting of Signatories was to be held in Hungary in November 2000. Some activities had already been launched in that area, as well as to give effect to the Charter on Transport, Environment and Health.

Dr Pintér therefore called on the Regional Committee to support the process of preparing for the Fourth Ministerial Conference, which was scheduled to take place in Budapest in 2004. It could do so by acknowledging the importance of the EEHC's work, playing an active part in identifying environmental health problems, promoting international cooperation and addressing donor countries and agencies. In addition, the Regional Committee was requested to extend the terms of office of the members of the EEHC until September 2002, so that the new members elected at that time could serve through to the Budapest Conference.

Lastly, the Chairperson of the SCRC informed the Committee of the criteria which it had agreed to apply in its consideration of candidates for membership of various bodies. For the Executive Board, those were (a) equitable geographical distribution (which would entail increased representation from the newly independent states – NIS); (b) the need to respect the interim arrangement adopted by the Regional Committee at its previous session; (c) the candidates' skills, knowledge and experience of WHO; and (d) the desirability of giving preference to candidates from countries not represented before. Criteria (a), (c)

and (d) had also been retained for the Standing Committee, with the additional criterion of the undesirability of a country being represented simultaneously on that body and on the Board. For the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases, the sole criterion was the candidate's knowledge and personal experience of the technical subject concerned. The SCRC Chairperson emphasized that, in the case of the Executive Board and particularly the SCRC, those criteria were only applicable for the current year, pending submittal to the fifty-first session of its recommendations concerning membership of the former body.

In the ensuing discussion, delegates commended the SCRC on the work it had done during the year. A number of speakers proposed experimenting with structural changes, in order to delimit more clearly the respective fields of competence of the Regional Committee and its Standing Committee, mirroring the developments that were taking place in the World Health Assembly and the Executive Board. It was also suggested that the SCRC should consider the strategic and political aspects of global programmes that were of regional significance, such as the Roll Back Malaria initiative and tobacco control. It might be useful to set up working groups under the Standing Committee, on which more Member States could be represented. Another way of strengthening interaction with Member States would be to make available the detailed reports of each of the SCRC's sessions, as well as reports of its subcommittees and progress reports submitted to it.

The Regional Committee welcomed the information it had been given on the work of the EEHC. The response to the environmental damage of the lower Danube basin clearly showed the value of WHO's work, and it was hoped that the Regional Office would continue to support action on the environment and health.

On the issue of bioethics, the Regional Committee endorsed the views of the SCRC on that important subject, called for further work to be done and looked forward to considering the question at a session in the near future. Equally, the Regional Committee wished to be presented with annual reports from the EEHC, in view of the importance of environmental health matters.

Delegates were reassured to learn that no additional work would be entailed in evaluating their progress towards the HEALTH21 targets, and that the guidelines and list of indicators for use in the exercise had been sent to national counterparts after the meeting in the Netherlands.

Lastly, representatives endorsed the rationale underlying the proposed amendments to the Rules of Procedure. The Regional Committee accordingly adopted resolution EUR/RC50/R1.

Having considered the presentations by SCRC members of its views on subsequent major agenda items, the Committee also adopted resolution EUR/RC50/R7.

Collaboration with other United Nations agencies and with integrational, intergovernmental and nongovernmental organizations in Europe
(EUR/RC50/6 and /Inf.Doc./4)

The Regional Adviser, International Partnerships, indicated that in the coming year the Regional Office intended to review systematically partnerships for health with other organizations. The aim would be to provide a more focused strategy for the development and maintenance of partnerships and for ensuring a dialogue between organizations concerning both policy development and implementation. So far as nongovernmental organizations (NGOs) were concerned, the aim would be to create opportunities for a more regular and informal dialogue.

Some guiding principles for development of the strategy were already clear: high-level joint political commitment to partnership was a necessary, but not sufficient, condition; common goals and strategies must be sought by negotiation and renegotiation; differences between partners must be recognized and respected; in each case, the level and content of collaboration needed to be made explicit; and there must be some mechanism for the management of joint activities.

Collaborative work during the previous year with the EC included malaria control activities in Tajikistan and the European Network of Health Promoting Schools. With the Council of Europe, joint work had been done on promoting peace and stability, democracy and free elections, building civil society and fostering human rights in south-east Europe, in the context of the Stability Pact for the Balkans. In addition, two Council staff members were to be based in Moscow, to strengthen its action in tackling tuberculosis in Russian prisons. Activities with the United Nations system included environmental health work with the United Nations Development Programme (UNDP) in the Caspian Sea area of Kazakhstan and Turkmenistan, and cooperation with UNICEF on all aspects of the Expanded Programme on Immunization. The World Bank had been working with WHO in areas such as the Roll Back Malaria global partnership and health sector reforms. In the field of humanitarian affairs, close operational collaboration had continued with the Office of the United Nations High Commissioner for Refugees and the World Food Programme.

So far as the Regional Office's collaborative networks were concerned, the annual meeting of the European Forum of Medical Associations and WHO (EFMA) had taken place in Warsaw in March 2000, hosted by the Polish Chamber of Physicians and Dentists. There had been collaboration within the network of pharmaceutical associations and WHO (the EuroPharm Forum) on the development of best pharmacy practice in the areas of asthma care, diabetes care, hypertension management, HIV/AIDS, and tobacco control. Efforts had been made within the European Forum of National Nursing and Midwifery Associations and WHO to twin nursing and midwifery associations in the newly independent states (NIS) and countries of central and eastern Europe (CCEE) with associations in western Europe. Work was continuing within the European Observatory on Health Care Systems to support and promote evidence-based health policy-making in Europe.

The Regional Committee endorsed the importance of the further strategic development of partnerships between the Regional Office and other agencies and organizations interested in health in Europe, and noted with approval the proposals and activities described in document EUR/RC50/6. A proposal was made that Member States should designate focal points for partnership development, to disseminate information and collaborate with each other as well as with the Partnerships function at the Regional Office.

The representative of the EC referred to the high priority given to health by the new Commission. For the first time, a commissioner had been appointed with explicit responsibility for health, and an expanded directorate-general covering health and consumer protection had been set up. A white paper on food safety had been published in January 2000. Then in May 2000 the Commission had put forward a new health strategy, including a new public health programme and an array of legislative and incentive measures in three areas: improving health information and knowledge; responding rapidly to major health threats; and tackling health determinants. Other important components of the public health framework included blood safety and the safety and quality of organs and substances of human origin. In addition, considerable attention was being paid to the health issues related to the enlargement of the Community. Cooperation with WHO was accordingly of the greatest importance, and a new exchange of letters between the Community and WHO was being finalized. That would cover both procedures and formal arrangements governing relations and the way in which priorities and activities would be pursued. Meanwhile, extensive cooperation continued at the technical level, in areas such as health monitoring, the surveillance of communicable diseases, HIV/AIDS, support for countries in crisis, and technical guidelines in areas such as air and water quality, and safety and health protection against physical, chemical and biological agents.

The representative of the Council of Europe noted that the Committee of Ministers had set new priorities and laid down a new strategy for the Council. The place of health was now clear. The focus would be on linking health to social cohesion and human rights, a link also articulated by WHO. Accordingly, the European Health Committee would increasingly incorporate the social dimension in its work on ethical and human rights issues as they related to health matters. The Committee's new programme had three elements: equity in access to care and health promotion; health care quality standards; and citizen participation and individual responsibility. The Committee was proposing to amend Article 11 of the

Social Charter, in the light of several issues relating to health and involving social relations and the role of the individual in modern society. WHO's participation in that process would be welcomed. Other important issues of concern to the Committee where WHO input would be welcomed included the impact of health information technology and the role of the media in health matters. A joint declaration between WHO and the Council on the importance of health and human rights in maintaining social cohesion in Europe would also be welcomed. The Council also hoped for regular meetings on health issues at secretariat level between itself, WHO and the EC.

Statements were delivered by representatives of the following NGOs: the International Association of Medical Laboratory Technologists, the International Council of Nurses, the International Council of Women, the World Federation of Neurology, the World Organization of Family Doctors, EFMA, the European Forum of National Nursing and Midwifery Associations and WHO, and the EuroPharm Forum. In addition, written statements were submitted by the International Association of Cancer Registries, the Medical Women's International Association, Soroptimist International, the World Confederation for Physical Therapy, and the World Federation of Occupational Therapists.

Eradication of poliomyelitis
(EUR/RC50/9 and /Conf.Doc./8)

The responsible Medical Officer reported on the progress made towards the goal of poliomyelitis eradication since the adoption in 1997 of resolution EUR/RC47/R4 and the regional plan of action for 1998–2000. No new case of poliomyelitis had been detected in the Region since November 1998. That meant the European Region was very close to being certified as a region free from the disease. The global picture was less impressive, however, with several countries reporting high rates of poliomyelitis.

There was a wide range of achievements in relation to implementation of the Action Plan, many of which had been done in association with international partners. They included a high and sustained level of immunization coverage across the Region, and the mass vaccination initiative (Operation MECACAR Plus), together with the mopping up exercise. The latter initiative, coordinated jointly by the regional offices for Europe and the Eastern Mediterranean, had ensured the protection of very large numbers of children in high-risk and border territories.

Improvements were also reported in the quality of surveillance for acute flaccid paralysis (AFP) and wild poliovirus, particularly in recently endemic countries. Laboratory-based surveillance for wild poliovirus was also singled out as an area where progress had been made. The regional poliomyelitis laboratory network (Labnet) was proving to be a useful mechanism for the maintenance of quality standards. Only three of the 38 national laboratories in the network remained unaccredited by the end of 1999.

Nevertheless, despite those obvious successes, the Regional Committee's attention was drawn to the need for ongoing vigilance in each Member State, to ensure that current achievements were sustained and that the risk of importation of wild poliovirus from the remaining endemic countries was minimized. Countries whose surveillance systems were still operating at less than optimal levels would need to redouble their efforts. Certification of the Region as free of poliomyelitis would be achieved only if all countries in the Region united their efforts to maintain high immunization coverage and high-quality surveillance and took all appropriate actions to ensure laboratory containment of wild poliovirus.

Sir Joseph Smith, Chair of the Regional Certification Commission, reported that the formal process of certifying the European Region as poliomyelitis-free was proceeding well. National certification committees had been established and were operational in 49 Member States. He made special reference to the information required from each country, especially in relation to AFP surveillance. However, responsibility for the eradication of poliomyelitis rested with each individual country and its national certification committee. Good surveillance was the key to ensuring that wild virus was not lying undetected in pockets from which it could re-emerge. Containment involved the identification by each country of every laboratory in which wild virus was known to be present; that might include laboratories

to which samples had been taken for research purposes when poliomyelitis had still been endemic. That was an intensive process, and one that required political will.

In conclusion, he hoped that in 2002 or 2003 the Commission could declare with confidence that the Region had interrupted all transmission of wild poliovirus and that were it to reappear it would be identified and stopped.

Professor Frantisek Kölbel, on behalf of the SCRC, paid tribute to the many players who were contributing to a striking victory for preventive medicine. It was important to continue with the current vaccination strategy, ensuring high levels of immunization coverage with special attention to the needs of countries bordering endemic areas. Equally, it was essential to achieve high levels of surveillance in patients with AFP. He reiterated that the European Region would only be certified as poliomyelitis-free when all 51 countries could report interruption of transmission and satisfied all the surveillance criteria. That would require ongoing cooperation across WHO's regions and with other external partners.

In the ensuing discussion, all speakers commended the staff of the programme concerned on their extraordinary dedication and effort. One speaker suggested that the Region's success story should also be attributed to the efforts of a much wider group which included the public, politicians and health professionals. It was cited by several delegates as an excellent example of cooperation between different partners, WHO's regional offices and headquarters. The suggestion was put forward that the approach used could be applied in other areas of communicable disease such as malaria, viral hepatitis B and measles. Speakers from countries bordering endemic areas emphasized the importance of MECACAR Plus in allowing them together to find common solutions to problems related to poliomyelitis eradication and made a special plea for its continuation.

Several representatives described the efforts that were ongoing in their countries to satisfy the criteria for being certified as poliomyelitis-free, especially in relation to establishing effective and comprehensive surveillance systems, and not least to managing the issue of containment. One speaker felt that the indicators in his country were not sufficiently robust and had requested help from WHO and other agencies to assist with achieving certification. Concern was expressed by at least one country from the western part of the Region regarding the availability of data in countries where the disease had not been endemic for a long time.

The history of the poliomyelitis eradication campaign was seen as a good example of what WHO could achieve if it was focused and concentrated on a few priority areas. However, one speaker raised the issue of the necessary follow-up work after eradication of poliomyelitis throughout the world. He referred to the experience of smallpox: more than ten years after it had been eradicated, the future of the strains of the disease was still under discussion, since the stakes involved were both strategic and health-related. With poliomyelitis, that problem should be anticipated and considered at present.

One representative drew attention to the fact that the data on immunization coverage, as given in the Regional Committee documentation, did not reflect the most up-to-date position in his country. Immunization coverage was now 90%, rather than the 80% reported.

The problem of short-stay illegal immigrants from endemic areas was raised by another speaker who queried, from an ethical standpoint and in the interests of the greater good, whether immunization should be offered in the absence of information about vaccination status.

The representative of Rotary International pledged the ongoing support of his organization to the Regional Office in pursuit of eradicating poliomyelitis from the Region.

In reply, the Medical Officer emphasized that the immunization strategy was of prime importance to ensure that future generations were not placed at risk of reoccurrence of the disease. He thanked the governments of several countries for their support to the global and regional programmes on poliomyelitis eradication, referring in particular to the important work of the regional centres. He confirmed that the

more developed countries of the Region would be able to use alternative information for certification, such as validated information on enteroviruses.

In conclusion, he acknowledged that there was a need to build on the success of Operation MECACAR Plus. The forthcoming meeting in Cairo would provide an opportunity to do that.

The Committee adopted resolution EUR/RC50/R3.

Evaluation of the EUROHEALTH programme
(EUR/RC50/4 and /BD/1)

Dr Danguole Jankauskiene, one of the external evaluators, outlined the background, terms of reference and methodology of the evaluation of the EUROHEALTH programme. It had included an extensive analysis of documentation and background papers, and interviews with WHO staff in countries as well as in the technical programmes of the Regional Office. The evaluation had also entailed making an in-depth analysis of a selected number of countries participating in the programme. Seven countries had been visited by the team, and more than 300 people had been interviewed.

The overall conclusion was that the EUROHEALTH programme had been successful. The resources allocated, though slender, had been used effectively. That positive outcome was, according to the evaluators, due in no small measure to the dedication of staff in the Country Health Department, including those in the liaison offices. Nevertheless, the evaluators believed there were many issues that had detracted from the outright success of the programme and which needed to be addressed in future, if countries were to gain maximum benefit from WHO's investment.

Two areas singled out for special attention were health policy development and health care reform. Successes in health policy development were reported in those countries where a special policy adviser had been assigned by WHO and where a firm political commitment had been made by the Member State itself. The targets set for health care reform had not been reached due to two contributing factors: the difficult political and economic circumstances in countries, and inadequate support from the Regional Office. As a result, other international agencies had filled the gap, often inappropriately, offering uncoordinated and conflicting advice.

WHO programmes that had been more successful included those on the health of women and children, nursing, infectious diseases, and drug policy (although the evaluators were concerned that many countries were not yet self-reliant in vaccine provision). The programmes on noncommunicable diseases and health promotion, on the other hand, were highlighted as being underdeveloped and in need of further investment.

The biggest problem in country work related to the interface between country and intercountry activities in the Regional Office. The current structural arrangements militated against integrated working and resulted in fragmentation and uncoordinated efforts.

The role played by the liaison offices and liaison officers in the EUROHEALTH programme was deemed to be very successful. However, there was a need to further develop the capacity of liaison officers and to invest in their training and development. The interface and working arrangements in countries between staff from headquarters and the Regional Office, as observed by the evaluators, was positive.

Less positive was their reaction to the work of the Office with other international donor organizations. There was a great need to establish better working relationships at all levels of WHO with bodies such as the World Bank and the EC, in particular. Only when that happened could there be more effective coordination of activities at country level and maximum support to countries.

In conclusion, the evaluators proposed that the Regional Office should extend its work to all 51 countries of the European Region. Countries should become much more involved in deciding and setting their own

priorities. The role of liaison officers should be expanded and developed. It was further suggested that countries in the process of accession to membership of the EU might no longer have a need for a liaison officer once they had joined. The establishment of subregional offices was not supported.

Dr Nikolaj N. Fetisov, speaking on behalf of the SCRC, paid tribute to the evaluation team for their considerable work. The SCRC had discussed the findings from the exercise at one of its sessions and had accepted the report.

In the following discussion, representatives thanked the external evaluators, commended them on their work and felt that the report was timely. The EUROHEALTH programme was hailed by several speakers as a real success story for WHO. Many delegates recounted how, in their own countries, morbidity and mortality figures had fallen and access to health care for their populations had improved as a result of the programme. The two priority areas of health policy development and health care reform were supported, although one speaker emphasized the importance of considering issues wider than the health sector which impacted negatively on health.

It was agreed that liaison officers played a very important role and that there was merit in developing their capacity further. Different arrangements for liaison officers were in operation in the Region, and their role would still be vitally important after a country joined the EU. One speaker suggested that the EUROHEALTH model should be transferred to other WHO regions and the lessons learned shared widely. Many countries were not yet in a position to manage the coordination of a large group of international donors, each with its own perspective and agenda, and they valued the role of WHO in that connection.

There was general recognition of the need for WHO to move forward and embrace the 51 countries in the European Region. To that end, several speakers endorsed the recommendations in the report.

In reply Dr Jussi Huttunen, the other external evaluator, thanked the Committee on both his and his colleague's behalf for the opportunity to undertake the evaluation, which they believed had been a unique experience. They were of the view that there was sufficient evidence on which to base their recommendations and to reach the conclusion that the EUROHEALTH programme was a success.

THE FUTURE WORK OF WHO

The Regional Office's future strategy for work with countries
(EUR/RC50/10 and /Conf.Doc./9)

The Coordinator, Division of Partnerships for Country Health Development, described the new country strategy as a turning point for the Regional Office and evidence of a marked shift in emphasis, the aim of which was to better address the needs of the Member States. The strategy was informed by ten years' experience and know-how gained through the EUROHEALTH programme, as well as by the results of the recent evaluation. It embraced the principle of one WHO and reflected the importance placed in the global agenda on working in and with countries.

The strategy attempted to take account of the huge diversity in the Region yet acknowledged that there were areas common to all 51 countries. To that end, it recognized the need to work with all of them, albeit in different ways. Informal groupings of countries to address common concerns and challenges, as well as to facilitate the cross-fertilization of ideas and to share experiences, would be a major feature of the new strategy. The intention was to create a structure that would be functional and foster an integrated and coordinated approach by the various elements of the Regional Office, so that fragmentation was at least minimized and at best avoided.

The strategy also acknowledged the need to strengthen international partnerships, and in particular to build strong alliances with those organizations that were increasingly interested in the health agenda, such

as the EU and the World Bank. That in turn should ensure that scarce resources were used more effectively and the negative effects of uncoordinated efforts in countries were reduced to a minimum.

WHO was held in high regard for its competence, and it was intended to build on that strength by addressing the broader issues of health and its determinants. That would be done not only by developing the evidence base but also by establishing fora in which knowledge could be exchanged and deepened.

Advanced knowledge and the associated technical tools were not enough in themselves, however. There was also a need to ensure that the Organization was capable of implementing its strategies and policies in ways that were sustainable. That point was well taken in the strategy, which also made reference to the need for political sensitivity and maturity in the pursuit of common health objectives.

The strategy outlined the services that WHO would make available on health policy and health systems development, in particular for countries in transition and those preparing themselves for accession to membership of the EU. It also set out how WHO would assist countries in addressing their public health priorities, and the different methodologies it would employ. It tackled the issue of building the evidence base, as well as good information systems that were also country-oriented. It acknowledged the importance of developing the role of liaison officers and outlined ways of doing that.

In conclusion, he stressed that it was essential to see the country strategy as a joint undertaking between the Regional Office and the Member States. WHO believed that its work with and through countries was of paramount importance. Each side had an important role to play, each could learn from the other. The staff at the Regional Office were fully committed to the strategy, and he expressed the hope that it would be endorsed by the Regional Committee.

Dr James Kiely advised the Committee that, while the SCRC had not seen the latest version of the strategy, it welcomed the reorientation towards all the 51 countries in the Region. The SCRC had been concerned that the full rationale for the changes proposed should be made explicit. The outcome of the EUROHEALTH evaluation had been perceived to be of particular importance in developing the new strategy. The SCRC had also emphasized that the strategy and the new structure of the Office should ensure strategic consistency, organizational coherence and operational effectiveness.

Because of the long-term importance of the strategy, the SCRC believed that regular monitoring was important. The Regional Director would report on progress to the Regional Committee in 2002, but the SCRC also agreed to pay particular attention to the matter at its sessions throughout the year.

During the ensuing discussion, speakers welcomed the new strategic direction and believed it to be a clear statement that would underpin the future work of the Regional Office. The attempt to address the needs of all 51 Member States, taking individual characteristics into account, was seen as a positive move forward. So, too, was the obvious determination of the Office to operate in a more systematic way in the future, ensuring that advice to countries was consistent and robust.

Many speakers made reference to the benefits that had accrued to their countries through the work of the EUROHEALTH programme, but at the same time they acknowledged that it was important to “widen the net” and take in all the countries of the Region. Concern was expressed, however, about how the many developments outlined in the presentation would be financed.

The focus on building the evidence base and investing in information systems was broadly welcomed, as was the concept of “futures fora”. Climate change was suggested as an additional topic for consideration in such a group, but one representative felt it would be helpful to have a clearer view of the exact function and modus operandi of the fora.

There was a welcome emphasis, in the strategy, on helping countries in transition with health policy development and providing technical assistance on health care reform issues. However, it was important that countries were helped to find their own solutions, to ensure long-term sustainability. Several speakers

were concerned that focusing on health care reforms could be a narrow approach, often dealing only with structures and finance while ignoring the important issue of health outcomes. Poverty and the effects of alcohol abuse, for example, were of much greater importance, and WHO should recognize that fact. The Organization, it was suggested, had a much more important role to play in that area, because of its comparative advantage in the Region and its credibility with multinational companies and other international organizations, as well as its intersectoral experience.

There was unanimous support for strengthening partnerships with the EC and the World Bank, but more information was requested on how that would be achieved.

One representative proposed that the principles of the new strategy should be broadened: the Regional Office's activities should take account of people's health status, the operation of health systems, and countries' political, economic and social features. In addition, the Regional Office should play a more prominent methodological and coordinating role in strengthening international partnerships for health.

Responding to interventions by Member States, the Coordinator, Division of Partnerships for Country Health Development thanked speakers for their encouragement and in particular for their comments and advice, which would shape further development of the country strategy. While the paper set out the overall framework and gave the strategic directions, there would be flexibility in its application and in the resulting practical actions in countries. Liaison Offices existed in 26 countries, but other mechanisms would be explored to ensure more systematic cooperation with the other 25 Member States.

Many speakers had noted the need for improved partnerships and in doing so had focused on the uniqueness of WHO's mandate. That welcome point of view would enable WHO better to play its specific role in collaboration with other agencies. Equally, the advice given by some delegates, to focus not only on public heath systems but also on health care and the quality of services, was welcomed and would be taken into account when the mix of new expertise and skills to implement the country strategy was put together.

Summing up the debate, the Regional Director reiterated that the strategy was for all the 51 Member States, although it was recognized that 26 countries were still in need of more intensified support. Three cardinal areas of the strategy were of importance to all Member States: (i) assistance at the time of a health crisis; (ii) participation in the futures fora; and (iii) the need for information and knowledge to support public health decisions.

Finally the Regional Director used the implementation of the country strategy to explain the overall logic that had governed the reform process at the Regional Office, and in particular the reasons for the new organizational structure based on functions. In his opinion, that structure was the best way of ensuring competent action in the field, by which he meant that all 51 Member States were given relevant and useful services by the Office. The exact nature of those services would be based on the reviews to be carried out in the coming months.

The Committee adopted resolution EUR/RC50/R5.

Policy framework and regional component of the proposed programme budget 2002–2003
(EUR/RC50/7, /7 Add.1 and /Conf.Doc./6)

The Senior Policy Adviser, Regional Director's Resource Group, presented the proposed programme budget 2002–2003. While it built on lessons learned in previous budget cycles, it also incorporated innovations with regard to both content, structure and the preparatory process. Working as one WHO was one of the cornerstones of the new policy framework for the whole Organization, and the proposed programme budget under discussion was a very clear demonstration of putting the concept of one WHO into practice.

WHO's corporate strategy, with its four main strategic directions, clearly reflected the Organization's mandate and orientation throughout all of its levels (country presence, regional offices and headquarters). Through a series of consultations, eleven priority areas had been defined and adopted by the Executive Board for 2002–2003. The eleven priority areas collectively reflected very major international health concerns, and it was proposed to shift significant resources towards them.

The proposed programme budget was set out in a new structure: all activities were grouped into 35 areas of work, whose descriptions had been drawn up through a consultative process between headquarters and the regional offices. For each area of work, there was a statement of the issues and challenges, the overall goal, the WHO objective and the expected results. That structure portrayed a hierarchical relationship of cause and effect between the various strategic planning elements in each area of work: the overall goal was the highest level to which WHO's work would contribute, the WHO objective represented the change to which the WHO Secretariat as a whole was committed, while the expected result denoted the level for which WHO assumed direct responsibility. With that structure, there was a clear commitment to results-based management, and in each of the 35 areas of work clearly defined expected results had been elaborated, with corresponding indicators against which performance could be measured. The new hierarchy clearly distinguished the responsibilities of the WHO Secretariat from those of the Member States and established a more explicit relationship between the different levels of achievement.

So far as Europe was concerned, the regular budget showed a nominal increase of 2.1%, corresponding to US $1.1 million. The additional funds allocated under the provisions of resolution WHA51.31 would go to country cooperation, as specified in resolution EUR/RC49/R5.

Comparison with the 2000–2001 programme budget showed a significant shift from intercountry to country programme support. Further efficiencies were being sought by streamlining administrative procedures, and there were decreases in provisions for common services and duty travel.

The eleven global priorities were well respected, and 10% of the regular budget allocation, totalling US $4 million, had been shifted to seven of the global priority areas. In addition, the Regional Office had included in its priority shifts funding for the ongoing process of certifying poliomyelitis eradication. With regard to other sources of funds, the Regional Office had conservatively projected an increase of 2.8%, pending further confirmation of forthcoming extrabudgetary funding. In recent biennia, a large proportion of the Office's total extrabudgetary funding had been received for emergency and humanitarian action and was thus difficult to predict.

The current review of the budget document was the first in a series of steps leading up to final approval at the Fifty-fourth World Health Assembly in May 2001, when any adjustments regarding currency fluctuations and inflation would also be decided.

Mr Davið Gunnarsson reported that the SCRC had warmly welcomed the new approach, which entailed drawing up one single strategic outcome-oriented budget for the whole Organization. With the new budget presentation, the role of the Regional Committee had also changed, since it would now be commenting on the totality of the budget while also having to safeguard interests specific to the Region. In that respect, the SCRC had noted that certain issues of importance to the European Region were not sufficiently highlighted in the global document.

In the following debate, there appeared to be a consensus view that the new budget formulation was an improvement: in particular, it was felt that it would more readily lend itself to meaningful monitoring of progress, as well as to end-of-biennium evaluation of achievements against defined indicators. The Organization was encouraged to continue to refine its methodologies and tools for monitoring and evaluation.

The attempts to simplify and shorten the budget were welcomed, as was the consultative process that had been followed during elaboration of the budget. It was hoped that the more intensive collaboration on preparation of the budget between WHO headquarters and the regions would also result in closer

coordination during its implementation. It was also pointed out that the document under consideration was more than a strategic budget, it was a political tool linking the corporate strategy more clearly to the WHO activities planned for the biennium.

Overall, the 35 areas of work were considered to respond to the global health challenges, and the eleven global priorities were well accepted. The effort to redirect scarce resources was commended, and it was acknowledged that this was never an easy task. Some delegations referred to the continuing need to make efficiency savings, especially with regard to overhead costs. The reduction in the regular budget allocated to environmental health, both at global level and especially at regional level, was thought to be inappropriate, given the enormous challenges in that area and its strong link to the corporate strategy.

The question of the relative balance between global and region-specific priorities was addressed by many speakers. It was understood that global priorities were important for consolidated action, but it was felt that a reasonable level of flexibility should be allowed, to ensure that problems specific to any one region could be adequately addressed. In that respect the global document was seen as not attaching enough importance to such regional issues as environmental health, the aging population, traffic accidents, noncommunicable disease, child and adolescent health, and human genetics. It was also felt that the global budget should make reference to the agreed values of HEALTH21, as that was an endorsed policy framework clearly stipulating the overall principles underlying WHO's work.

Several speakers, and in particular the SCRC member, noted with disappointment that full redistribution of the funds expected in accordance with resolution WHA51.31 was progressing slower than expected, and the additional allocation to the European Region for 2002–2003 was accordingly lower than originally anticipated.

The level of detail in the budget document was found to be insufficient by some Member States, who wished to be able to see clearly the dollar investment in individual programmes at the Regional Office. That was made more difficult by the fact that the new organizational chart for the Office was based on functions, rather than the more traditional structure based on areas of public health. Further details were also requested regarding the staffing component of the proposed programme budget, and overviews of expenditure in the completed biennium, if presented in a similar structure, would facilitate meaningful comparisons.

A plea was made that full advantage should be taken of work done by other organizations, in order to avoid duplication. That applied in particular to the EC and the Council of Europe, the latter having a long and illustrious record of well accepted work in the area of blood safety.

The Executive Director, General Management, WHO headquarters responded to the question of the level of detail by pointing out that the presentation of too much detail would divert the budget from its strategic orientation. However, a series of more detailed information documents would be produced to supplement the budget when it was presented to the Executive Board in January 2001 and in preparation for its final approval in May 2001. Such specific information documents would address issues of staffing, inflation and exchange rates and should be read in conjunction with the financial report giving details of expenditure during the completed biennium.

Referring to the methodology used to establish the overall level of extrabudgetary resources, she noted that by its nature the amount was not predetermined but only a best estimate. However, the predictions had proved to be relatively accurate in the past. In that connection, it should be understood that extrabudgetary resources received at headquarters, and hence accounted for there, were very often and to a large extent spent in countries.

The Regional Director concluded the debate by emphasizing the importance he attached to the views expressed by the Regional Committee. He felt certain they would constitute an important input to the Secretariat as a whole and to the Director-General when the budget was refined and further elaborated in the months to come.

The Committee adopted resolution EUR/RC50/R4.

A Food and Nutrition Action Plan for the European Region
(EUR/RC50/8, /Conf.Doc./7 and /BD/2)

The Regional Adviser for Nutrition presented a short video film illustrating the burden of ill health and disease related to unsafe food and poor nutrition. Those problems could not be tackled successfully without comprehensive action by many sectors, and three main strategies were therefore recommended: a food safety strategy based on the entire food chain; a nutrition strategy based on the life cycle and focusing on periods when people were most vulnerable; and a strategy for sustainable food production and distribution based on improved food security. To ensure that those three strategies complemented each other, and to avoid contradiction and overlap, collaboration would be needed with all sectors involved. In small countries a national coordination mechanism could be sufficient, but in large countries regional and city coordination mechanisms might also be needed.

Partnerships at both international and national levels were essential, and thus bodies and organizations such as the EU, the Council of Europe, United Nations agencies, development banks and nongovernmental organizations should have a forum in which they could discuss and develop their future policies in collaboration with Member States. The Action Plan thus included a proposal to establish a European task force to facilitate such discussions.

As to implementation of the Action Plan, guidance for those countries that wished to develop or strengthen their own national food and nutrition policies and action plans was available in the form of a three-day workshop for policy-makers, organized in collaboration with FAO and UNICEF. Some 17 countries had already participated in those workshops. In addition, specific tools had been developed, and an analysis of existing national policies had been compiled from country reports submitted at a consultation held in Malta in November 1999 and from questionnaires completed by national counterparts. Those data would provide baseline information against which to evaluate the impact of the Action Plan.

Dr Anca Dumitrescu said that the SCRC considered that the Action Plan reflected well the concerns of Member States on the issue of food and nutrition. The SCRC had felt that WHO should act as an advocate of public health by providing independent advice and performing a normative function, especially in those Member States that were not members of the EU. It had also wished to see greater emphasis placed on what it saw as the most important issues: the burden of nutrition-related diseases and disorders, and the rationale for a policy and plan of action. It was essential that the document gained the interest and support of ministers of health, since they were in the best position to promote the necessary partnerships with all sectors responsible for aspects of the food chain.

In the ensuing discussion, the many speakers who took the floor welcomed the draft Action Plan and congratulated the Regional Director on bringing food and nutrition policy to the forefront once again. The whole subject was a most complex one, and the Action Plan was a welcome attempt at an integrated approach that could have a large impact. The Regional Office was therefore urged to move forward as quickly as possible. The Action Plan would apply to all countries of the Region, regardless of the stage of their development. It was desirable that countries drew up national food and nutrition policies as soon as possible, in which the various social, cultural and economic factors could be taken into consideration.

Delegates placed great emphasis on coordination among the various bodies working in the health field in Europe and requested the Regional Director to elaborate in more detail on WHO's complementary role in that area. They supported the setting up a task force to provide the necessary mechanism. Several speakers pointed out the great difference between food security and nutrition: the former was a technical issue, while the latter was an area in which change could only be brought about by a long-term programme of education.

One representative suggested that the mention of the dietary guide for the countrywide integrated noncommunicable disease intervention (CINDI) programme should be clarified, in order to avoid suggesting that reference was being made to the European dietary guidelines. Another requested that during the period of the Action Plan, the Office should also stimulate research on the production of bio-engineered foodstuffs.

The representative of the EC said that the new Commission was considering a comprehensive policy on nutrition and drawing up an action plan, and working closely with the Regional Office was therefore highly desirable in such a difficult area. He was rather sceptical, however, about the creation of a task force, which appeared to have little to do with the actual implementation of the Plan. The representative of FAO fully supported efforts to continue collaboration in seeking solutions to the problems of hunger and malnutrition. The development of the Action Plan would be a valuable follow-up to the 1992 International Conference on Nutrition. The representative of UNICEF also expressed her organization's willingness to continue working closely with WHO, especially on issues affecting women and children such as breastfeeding and iodine deficiency disorders.

The representatives of the European Heart Network and the International Council for Control of Iodine Deficiency Disorders provided statements supporting the work of the Regional Office in the field of nutrition and welcoming the initiative to develop an Action Plan.

The Regional Director thanked all Member States for their support of the Action Plan and noted that, with the exception of the representative of the European Commission, there was unanimity about establishing a task force. He welcomed the strong mandate they had given him to work towards setting up such a body with willing partners.

The Committee adopted resolution EUR/RC50/R8.

An informal meeting was held outside the session to discuss the issue of a new global strategy for infant and young child nutrition. A note reflecting the views expressed by those participants attending was prepared for use as background information for the open-ended Working Group to be convened in conjunction with the one hundred and seventh session of the Executive Board.

ELECTIONS AND NOMINATIONS

The Committee met in private to consider the nomination of members of the Executive Board and to elect members of the SCRC and the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases.

Nomination of members of the Executive Board
(EUR/RC50/5 Rev.1 and /5 Rev.1 Corr.1)

The Committee agreed that Kazakhstan and the United Kingdom would put forward their candidatures to the World Health Assembly in May 2001 for subsequent election to the Executive Board.

Election of members of the Standing Committee of the Regional Committee
(EUR/RC50/5 Rev.1 and /5 Rev.1 Corr.1)

The Committee elected Finland, Luxembourg and Tajikistan for membership of the SCRC for a three-year term of office from September 2000 to September 2003.

Election of a member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
(EUR/RC50/5 Rev.1 and /5 Rev.1 Corr.1)

In accordance with the Memorandum of Understanding on the Special Programme for Research and Training in Tropical Diseases, the Committee selected Portugal for membership of the Joint Coordinating Board for a three-year period from 1 January 2001.

OTHER MATTERS

Tribute to United Nations staff

The Committee observed two minutes' silence in honour of the three staff members of the Office of the United Nations High Commissioner for Refugees murdered in West Timor (Indonesia).

Place of the fifty-first session and date and place of the fifty-second session
(EUR/RC50/Conf.Doc./5)

The Committee adopted resolution EUR/RC50/R6, confirming that its fifty-first session would be held in Madrid, Spain from 10 to 13 September 2001 and deciding that its fifty-second session would be held at the Regional Office for Europe in Copenhagen from 16 to 19 September 2002.

The delegation of Austria extended an invitation to the Regional Committee to hold a future session in its country.

RESOLUTIONS

EUR/RC50/R1

AMENDMENTS TO THE RULES OF PROCEDURE OF THE REGIONAL COMMITTEE AND THE STANDING COMMITTEE OF THE REGIONAL COMMITTEE

The Regional Committee,

Having considered the recommendations of the Standing Committee of the Regional Committee (contained in Annex 2 to document EUR/RC50/3) regarding amendments to the Rules of Procedure of the Regional Committee and the Standing Committee of the Regional Committee;

1. ADOPTS the changes contained in EUR/RC50/3 Annex 2, to be effective forthwith;

2. ENCOURAGES Member States to include members of the Standing Committee on their delegations to Regional Committees and World Health Assemblies.

European HEALTH21 target 0.

EUR/RC50/R2

REPORT OF THE REGIONAL DIRECTOR ON THE WORK OF WHO IN THE EUROPEAN REGION 1998–1999

The Regional Committee,

Having examined and reviewed the Regional Director's report on the work of WHO in the European Region in 1998–1999 (document EUR/RC50/2) and the related information document on implementation of the 1998–1999 programme budget (document EUR/RC50/Inf.Doc./1);

1. THANKS the former Regional Director for the report and the new Regional Director for his presentation;

2. EXPRESSES its appreciation of the work done by the Regional Office in the biennium 1998–1999;

3. REQUESTS the Regional Director to take into account and reflect the suggestions made during the discussion at the fiftieth session when developing the Organization's future programmes and carrying out the work of the Regional Office.

European HEALTH21 targets 0–21.

EUR/RC50/R3

POLIOMYELITIS ERADICATION

The Regional Committee,

Recalling its resolution EUR/RC47/R4, by which it endorsed the plan of action for eradication of poliomyelitis from the European Region, and World Health Assembly resolution WHA52.22, which called for poliomyelitis eradication activities to be stepped up and the quality of surveillance to be enhanced;

Noting with satisfaction the report to the Regional Committee on the current status of the poliomyelitis eradication programme in the Region and the activities envisioned towards certification of the European Region as polio-free by 2003 (document EUR/RC50/9);

Welcoming the substantial progress made in recently endemic countries of the Region towards the eradication of poliomyelitis, thanks to well coordinated interregional and intercountry efforts known as "Operation MECACAR Plus", and welcoming the substantial support that has been provided by international partners, nongovernmental organizations and individual Member States;

Aware that the goal of certifying the European Region as a territory free from poliomyelitis by the year 2003 will be attained only if all countries of the Region maintain high immunization coverage and high-quality surveillance and ensure the laboratory containment of wild poliovirus;

1. ENDORSES the plan of action for the poliomyelitis eradication programme in the European Region for 2000–2001;

2. URGES all Member States:

(a) to reaffirm their commitment to the poliomyelitis eradication programme and to make available the staff and resources necessary to achieve certification of the eradication of poliomyelitis;

(b) to implement their part of the plan of action, focusing on maintaining high immunization coverage and high-quality surveillance up to the time when global certification is achieved, and including preparedness for potential importation of wild poliovirus;

(c) to begin the process leading to the laboratory containment of wild polioviruses in maximum containment laboratories, in the framework of the WHO global action plan for laboratory containment of wild polioviruses;

(d) to mobilize the human and financial resources needed for the final stage of global and regional eradication of poliomyelitis and to assist the Regional Director in raising additional voluntary funds from governmental and nongovernmental organizations and agencies;

3. FURTHER ENCOURAGES recently endemic Member States to maintain high-quality mass vaccination activities, where appropriate, and to accelerate improvement in the quality of surveillance;

4. REQUESTS the Regional Director:

(a) to urge all partners to provide the support needed to achieve the regional goal, as part of the global programme for poliomyelitis eradication;

(b) to develop additional joint transboundary activities and to continue coordination of interregional efforts of the European and Eastern Mediterranean Regional Offices for polio eradication;

(c) to collaborate with Member States on establishing a mechanism for overseeing the process of laboratory containment of wild polioviruses in maximum containment laboratories;

(d) to report to the Regional Committee in 2002 on the status of certification of the European Region as free from poliomyelitis.

European HEALTH21 target 7.

EUR/RC50/R4

PROPOSED PROGRAMME BUDGET FOR 2002–2003

The Regional Committee,

Having reviewed the proposed programme budget for the biennium 2002–2003 (documents EUR/RC50/7 and EUR/RC50/7 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 efforts taken throughout the Organization to present a more focused policy and strategy framework in line with the concept of "One WHO";

Noting that the budget proposals are in accordance with resolution EUR/RC47/R9, which requested the Regional Director to prepare the regional 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 2002–2003 based on the Human Development Index model endorsed at its forty-ninth session (resolution EUR/RC49/R5);

3. ENDORSES the strategic directions contained in the Regional Director's document "The European Region Perspective" (EUR/RC50/7) and WELCOMES the proposed budget for 2002–2003 contained in document EUR/RC50/7 Add.1, 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.

European HEALTH21 target 0.

EUR/RC50/R5

THE WHO REGIONAL OFFICE FOR EUROPE'S COUNTRY STRATEGY "MATCHING SERVICES TO NEW NEEDS"

The Regional Committee,

Having considered the WHO Regional Office for Europe's country strategy (document EUR/RC50/10);

Recalling previous resolutions of the Regional Committee on cooperation with countries, and in particular those in central and eastern Europe through the EUROHEALTH programme (EUR/RC40/R7, EUR/RC41/R2 and EUR/RC43/R10), including its evaluation and updating (EUR/RC44/R10, EUR/RC45/R6);

Mindful of the need for continuing review and strategic planning in relation to the European Region's country cooperation, as called for in resolution EUR/RC49/R5;

Noting with satisfaction the ongoing reform of the Regional Office and the increased emphasis placed on country cooperation;

1. ENDORSES the framework for the new European country strategy, as outlined by the Regional Director;

2. URGES Member States to collaborate in the further development and implementation of the new strategy;

3. REQUESTS the Regional Director:

(a) to continue to seek ways of optimizing country cooperation strategies in order to improve the quality of health care services to users;

(b) to take initiatives to mobilize the human and financial resources required for effective implementation of the new strategy;

(c) to report back to the Regional Committee at its fifty-second session on the progress made in working with countries in the European Region.

European HEALTH21 targets 1, 21.

EUR/RC50/R6

DATE AND PLACE OF REGULAR SESSIONS OF THE REGIONAL COMMITTEE IN 2001 AND 2002

The Regional Committee,

Having reviewed the decision taken at its forty-ninth session, as expressed in resolution EUR/RC49/R7;

1. DECIDES that the fifty-first session shall take place in Madrid, Spain from 10 to 13 September 2001;

2. FURTHER DECIDES that the fifty-second session shall be held at the Regional Office for Europe in Copenhagen from 16 to 19 September 2002.

European HEALTH21 target 0.

EUR/RC50/R7

REPORT OF THE STANDING COMMITTEE OF THE REGIONAL COMMITTEE

The Regional Committee,

Having considered the report of the Standing Committee of the Regional Committee (documents EUR/RC50/3 and EUR/RC50/3 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 fiftieth 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 fiftieth session as recorded in the report of the session.

European HEALTH21 target 0.

EUR/RC50/R8

THE IMPACT OF FOOD AND NUTRITION ON PUBLIC HEALTH

THE CASE FOR A FOOD AND NUTRITION POLICY AND AN ACTION PLAN FOR THE EUROPEAN REGION OF WHO 2000–2005

The Regional Committee,

Concerned by the threat to public health from the lack of safe and healthy food;

Recognizing the roles of other international organizations and sectors with an interest in food;

Recalling Health Assembly resolution WHA46.7, which called for implementation of comprehensive plans of action on nutrition and which endorsed the goals of the fourth United Nations Development Decade and the World Summit for Children;

Further recalling previous Health Assembly resolutions and particularly WHA49.15 on infant and young child nutrition and WHA52.24 on the prevention and control of iodine deficiency, which demonstrate the need for comprehensive food and nutrition policies;

Having considered document EUR/RC50/8, entitled *The impact of food and nutrition on public health – The case for a food and nutrition policy and action plan for the European Region of WHO 2000–2005*;

1. ENDORSES the Action Plan for the European Region of WHO for 2000–2005;

2. RECOMMENDS that Member States take steps to carry out the Action Plan, taking account of differences in their cultural, social, legal and economic environments;

3. REQUESTS European integrational, intergovernmental and nongovernmental organizations to undertake joint action with Member States and the Regional Office to maximize Region-wide efforts to promote public health through food and nutrition policy;

4. REQUESTS the Regional Director:

(a) to ensure appropriate support for the Action Plan from the WHO Regional Office for Europe;

(b) to cooperate with and support Member States and other organizations in comprehensive efforts to promote public health through appropriate food and nutrition policies;

(c) to examine the possibility of setting up, in collaboration with international agencies, the European Commission and the Council of Europe, a Task Force for Food and Nutrition Policies in the European Region of WHO;

(d) to organize a ministerial conference in 2005 to evaluate the implementation of comprehensive food and nutrition policies at regional and country levels;

5. URGES Member States to report on steps taken to promote the health of their population through a food and nutrition policy at the ministerial conference to be held in 2005;

6. REQUESTS the Regional Director to report to the Regional Committee in 2002 on the progress made in implementing the Action Plan.

European HEALTH21 targets 3, 11.

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. **Review of the work of WHO**
   - (a) Address by the Director-General
   - (b) Report of the Regional Director
   - (c) Report of the Standing Committee of the Regional Committee (including review of the Rules of Procedure of the Regional Committee and the SCRC)
   - (d) Collaboration with other United Nations agencies and with integrational, intergovernmental and nongovernmental organizations in Europe
   - (e) Evaluation of the EUROHEALTH programme
   - (f) Eradication of poliomyelitis

3. **The future work of WHO**
   - (a) Policy framework and regional component of the proposed programme budget 2002–2003
   - (b) A Food and Nutrition Action Plan for the European Region
   - (c) The Regional Office's future strategy for work with countries

4. **Procedural matters and elections/nominations**
   - (a) Nomination of two members of the Executive Board
   - (b) Election of three members of the Standing Committee of the Regional Committee
   - (c) Election of a member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

5. **Other matters**
   - (a) Place of the fifty-first session and date and place of the fifty-second session
   - (b) Other business
   - (c) Approval of the report and closure of the fiftieth session

Annex 2

LIST OF WORKING DOCUMENTS

Working documents

EUR/RC50/1 Rev.1	Provisional agenda
EUR/RC50/2	Report of the Regional Director on the work of WHO in the European Region 1998–1999
EUR/RC50/3	Report of the Standing Committee of the Regional Committee
EUR/RC50/3 Add.1	Report of the fifth session of the Standing Committee of the Regional Committee
EUR/RC50/4	External evaluation of the EUROHEALTH programme – Report of the external evaluators
EUR/RC50/5 Rev.1	Membership of the Executive Board and various other committees
EUR/RC50/5 Rev.1 Corr.1	Membership of the Executive Board and various other committees
EUR/RC50/6	Collaboration with agencies and organizations active in health in Europe
EUR/RC50/7	Proposed programme budget 2002–2003 – The European Region perspective
EUR/RC50/7 Add.1	WHO's proposed programme budget for 2002–2003 – "One WHO"
EUR/RC50/8	The impact of food and nutrition on public health – The case for a food and nutrition policy and action plan for the European Region of WHO 2000–2005
EUR/RC50/9	Eradication of poliomyelitis in the European Region and plan of action for certification 2000–2003
EUR/RC50/10	The WHO Regional Office for Europe's country strategy "Matching services to new needs"
EUR/RC50/11 Rev.1	List of documents

Conference documents

EUR/RC50/Conf.Doc./1 Rev.1	Provisional programme
EUR/RC50/Conf.Doc./2	Report of the Regional Director on the work of WHO in the European Region 1998–1999
EUR/RC50/Conf.Doc./3	Report of the Standing Committee of the Regional Committee
EUR/RC50/Conf.Doc./4	Amendments to the Rules of Procedure of the Regional Committee and the Standing Committee of the Regional Committee
EUR/RC50/Conf.Doc./5	Date and place of regular sessions of the Regional Committee in 2001 and 2002
EUR/RC50/Conf.Doc./6	Proposed programme budget for 2002–2003
EUR/RC50/Conf.Doc./7	The impact of food and nutrition on public health – The case for a food and nutrition policy and an action plan for the European Region of WHO 2000–2005
EUR/RC50/Conf.Doc./8	Poliomyelitis eradication
EUR/RC50/Conf.Doc./9	The WHO Regional Office for Europe's country strategy "Matching services to new needs"

Information documents

EUR/RC50/Inf.Doc./1	Regional Director's Report – Information document – Implementation of the 1998–1999 programme budget
EUR/RC50/Inf.Doc./2	Annual report of the European Environment and Health Committee (EEHC) October 1999 – June 2000
EUR/RC50/Inf.Doc./3	Matters arising out of decisions and resolutions of the World Health Assembly and the Executive Board
EUR/RC50/Inf.Doc./4	Disaster preparedness in the European Region – Progress report

Background documents

EUR/RC50/BD/1	EUROHEALTH evaluation: Detailed report (English only)
EUR/RC50/BD/2	Infant and young child nutrition: follow-up – Briefing note for Regional Committees

Annex 3

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Annex 4

ADDRESS BY THE DIRECTOR-GENERAL OF WHO

Mr Chairman,
Ministers,
Dr Danzon,
Excellencies,
Ladies and Gentlemen,

It is a great pleasure for me to be with you here in Copenhagen for our first meeting in the new millennium and one held at a time when there are both great opportunities and great challenges in front of us.

When I came to WHO two years ago, I saw the need for renewal and reform. We have carried it out at Headquarters, and throughout the Organization. But reform cannot simply be imposed – in particular not on a decentralized organization like WHO. I am therefore extremely pleased about how Dr Danzon has entered his position with a real determination to make this Regional Office more streamlined, more effective in its work with countries and more in line with the one WHO philosophy.

I believe that the process of change that EURO is now undertaking will be to the benefit of the Member States of Europe. I am pleased about the efforts to take up and adapt the global priorities of WHO to the needs and conditions of this Region. I am particularly looking forward to the discussions about the future strategy for work with countries.

Mr Chairman,

Most often, turning points in world history are only reported in retrospect. Events that may seem important at the time quickly fade into oblivion. Momentous achievements may be inconspicuous at the start. Only years later can one see a pattern and identify the starting point for fundamental change.

I begin today's address to you by explaining why this year could be seen as a turning point for improvements in health for all the world's people.

I have always believed that it is difficult to make real changes in society unless decision-makers fully appreciate the economic dimensions of the issues affecting their people. This is how thinking about the environment has shifted. It used to be a cause for convinced and marginalized greens: it now commands the attention by all the major players within national and international society.

When we last met, at the World Health Assembly in Geneva in May, there were already several promising signs that the world's decision-makers saw a new and important linkage. They recognized that health is a central factor in economic and social development. Improving health is key in breaking the debilitating cycles of poverty.

One such sign was the Ministers meeting on tuberculosis hosted by the Government of the Netherlands in March, where governments from the countries hardest affected by TB committed to scaling up their fight against the disease, including an expansion in the use of DOTS. This was an excellent opportunity for an exchange of experiences and shared visions between Europe and the rest of the world. Since then, we have seen signs that the world is willing and eager to act.

Europe has also taken an important lead in the global fight against HIV/AIDS. In July, the 13th International AIDS conference in Durban established new norms: that all people living with HIV/AIDS worldwide should have access to adequate care, and that everyone everywhere should be in a position to prevent themselves from HIV infection.

Also in Durban, the European Commission announced renewed support for the fight against HIV/AIDS, malaria and tuberculosis. Later the same month in Okinawa, I joined leaders of the G8 nations as they met with leaders of key G77 countries, including the Prime Minister of Thailand.

Subsequently the G8 heads called for a step change in international health outcomes. They agreed to specific targets to reduce the tolls from malaria, HIV/AIDS, TB and children's diseases by 2010.

Mr Chairman,

While health problems have dominated the headlines, we are also on the brink of several important achievements that are relevant to the European Region.

The certification of polio eradication is on course for 2003. But remember, some of the remaining large pools of wild poliovirus exist just south and east of the European Region, in an area where trade and movement of people is as regular as it is ancient. *We must be prepared* to complete the task.

A concerted effort to improve national drug policies has born fruits, leading to a number of countries developing new drug laws and more effective regulatory agencies. There has been a sharper focus on access to essential medicines for the poor, with trial schemes in drug cost reimbursement. In Europe, this work has also led to better management of medications, more information and improved use of appropriate medicines.

We are working with you on a renewed commitment to fight TB. This is important given the alarming increase in the incidence of multi-drug resistant TB, even in western European countries. We have to work hard together to implement the DOTS strategy and overcome this global threat.

Even Malaria remains a problem in this Region. But action over the past five years has resulted in a sharp reduction in the number of cases. This has led Europe to set ambitious targets for the coming five-year period: the first is to halve general malaria incidence in the epidemic countries. The second is to eradicate malaria in countries such as Armenia and Turkmenistan. And the third is to maintain malaria-free status in countries where malaria has been eradicated; we would also like to see the fatality rate of falciparum malaria halved. Countries in the Region are due to recommit themselves to Rolling Back Malaria in Baku, Azerbaijan in November 2001.

HIV/AIDS is a global pandemic. Recently, the focus has been on the tragedy unfolding in Africa, as countries there are devastated by HIV infection rates of up to 30%. This should not give any reason for complacency in Europe, although we have been seeing a very positive overall reduction in AIDS cases and deaths over the past few years in several western European countries.

In spite of remarkable successes in the prevention of HIV, the virus continues to spread in the Region. The growing economic disparities observed in recent years between and within countries in the Region, and the limitations of some HIV/AIDS national programmes, have increased the vulnerability of young women and men to HIV infection.

All countries in the Region remain vulnerable to HIV and we will work with you to find ways to replicate successful efforts on a large scale. Only then can we work together to achieve a significant and sustainable impact on the spread of HIV across the Region.

Yet, the discovery and widening availability of new HIV therapies in the high income countries have lead to a public perception that HIV/AIDS has become, after all, manageable. As economically affluent countries are already confronting issues of mounting resistance of HIV to existing drugs, developing countries are struggling with a general lack of access even to basic treatment for opportunistic infections.

Following the World Health Assembly in May, WHO – together with UNAIDS, and other UN agencies – has pursued its mandate and progressed in a dialogue with the pharmaceutical industry. A contact group,

due to hold its first meeting this month, will bring together Member States, UN agencies and representatives of the industry and NGOs. We hope that this meeting will not merely result in a fruitful exchange of information and views but, much more importantly, in a mutual commitment to scale up HIV/AIDS prevention and care programmes in countries that need them most.

Mr Chairman,

Earlier this year, Member States encouraged WHO to scale up activities in the area of food safety, sensing that this issue will grow in importance in the years to come as global trade increases and advances in science present us with new possibilities, choices and dilemmas.

The wisdom of this global move was supported by the weight the G8 nations gave to the issue of food safety during their last meeting in Okinawa in July. They specifically stressed the need for an active role by WHO and FAO in the work to ensure that the food we produce, trade and consume is safe.

As with many other areas of health, the resources and the technology to ensure food safety exist in the industrialized countries, while the vast majority of the 2 million annual deaths from food and waterborne diseases take place in the developing world. Most developing countries possess neither the technology, nor the resources or the infrastructure to ensure that the food it produces and imports is safe. This makes the role of the international agencies particularly important, and WHO will see it as one of our main priorities to make information widely available and to share the advances in knowledge about what is safe and what is not with all countries which need it.

In what we can perhaps call the first generation of bio-technological engineering, a number of improved products came on the market. These have been said to benefit producers, rather than consumers. For these products, the main challenge has been to ensure safety to consumers and to the environment.

Now we are seeing the coming of a new generation of bio-engineered products. These have potential for higher production as well as better nutritional value. However, these discoveries present new and more complicated questions in relation to their safety and benefits. It will be a major challenge to ensure proper scrutiny of all potential issues associated with change to these products.

Together with FAO, WHO will do all it can to provide decision-makers with the information they need to decide on such matters. We will ensure that high quality, independent science is assembled through WHO auspices and disseminated into existing intergovernmental mechanisms, like the Codex Alimentarius Commission.

As we prepare for the Rio +10 meeting in 2002, I am encouraged by the consistent and effective work of European Governments and the WHO Regional Office on environment and health. Highlights include the emphasis on national environment and health action plans, constructive action on transport health assessment, early human health effects of climate change, and children's health and the environment. There are promising new initiatives on public involvement in the understanding of health risks.

Mr Chairman,

Renewed efforts to address the diseases which cause the most suffering should clearly contribute to the development of health systems.

As you all know only too well, the management of any health system is a delicate balancing act: coping with competing demands, matching resources to need, and attempting to ensure that all have access to the care essential for their good health. The balancing act is particularly difficult for those countries whose per capita spending on people's health is less than, say, $100 per person per year. It is even more difficult in settings where the institutions of government are undermined – or even paralysed – by conflict.

We have responded to needs of Member States to find better ways to assess the performance of health systems that reflect the three purposes: improving health outcomes, responding to the people and fairness of financing. As you know, this year, WHO attempted such a first assessment, using the limited data available, in the World Health Report 2000.

Not surprisingly, the Report proved controversial, but the debate has generally been good. Discussion about the concepts and analyses in the World Health Report has given us all new insights. To continue the global dialogue on how to get the most out of health systems, we will work closely with Member States to make better uses of existing data sources and where necessary to collect new information so that the annual assessments of health systems performance are based on the best available evidence.

WHO is aware that there are no quick and easy answers. In response to numerous requests, WHO will be working closely with a number of Member States in an Initiative to Enhance the Performance of Health Systems to apply the new WHO assessment framework at national and also subnational levels; to use this analysis as an aid to national policy formulation; and to work together to facilitate positive change. Within EURO, seven countries are already participating in the Initiative.

Mr Chairman,

In many countries, the coexistence of infectious and noncommunicable diseases seriously challenges health care systems.

For most noncommunicable conditions, there is a lag between exposure to risk and visible outcomes, but policy decisions to deal with are growing burden is required now. Global tobacco control is a key priority area. In addition, we will in the next 12 months be looking at mental health – an area of public health that is neglected in some countries.

Next year, mental health will be the focus of World Health Day on April 7. No country and no community is immune to mental disorders and their impact in psychological, social and economic terms is huge. Yet, societies raise barriers to both care and the integration of people with mental disorders. What makes our task doubly urgent is that there is no reason for inaction – much less exclusion. World Health Day, the World Health Assembly in May 2001 and the World Health Report 2001 – all will focus on mental health. We expect to find promising solutions through drawing on the experience of countries – especially some of those in Europe.

Europe also has an important role to play in tobacco control. WHO is at the front of this vital struggle for global health. We are not interested in tobacco wars. We want tobacco solutions. Next month, Member States will begin negotiating the Framework Convention on Tobacco Control; this will be the first time that the public health community has led treaty negotiations. The process that has been set in motion has already fostered a global debate and pushed governments, as well as tobacco companies, to think about their actions from a public health perspective. The success of the FCTC will depend on our ability to link compelling data to robust decisions.

The negotiations will be preceded by two days of public hearings in Geneva. We will listen to the views of all interested parties, including the tobacco producers and the industry as we prepare to write global rules for tobacco control. This is an occasion for everyone interested to contribute to a global tool for public health.

Mr Chairman,

WHO has established a clear role in emergencies. We are a coordinating and strategic planning agency, which can bring former experience to new emergencies and link short-term relief work with long-term rehabilitation and reconstruction of the health sector. We have proved this both in our work in Turkey last year and in the ongoing work in Kosovo and its neighbours.

There has been a marked improvement of coordination between HQ, EURO and WHO Country Offices in health emergency management. But we must continue to improve coordination and links between emergency project planning and long-term regular WHO activities in European countries affected by emergencies.

WHO presence at country level has been strengthened in many emergency countries using emergency funds. These experiences have also shown that field presence is of paramount importance both for implementation of emergency projects and support of regular WHO collaboration with countries.

Mr Chairman,

Given the major challenges that face us all – governments and technical agencies – how will we respond, and what can you, our Member States, now expect from WHO?

WHO continues to have a unique role. At all times we pursue the best interests of our constituency – the optimum health of all the people within our 191 Member States.

At all times we try to ensure that we are guided by the best available evidence – based on the careful analysis of experience, on the results of relevant research.

The clearest reflection of how WHO is changing to serve Member States better is the Programme Budget 2002–2003 which is a key instrument for advancing the process of change and reform in WHO. Both in its content and in the way it is being prepared, it marks a significant departure from previous biennia.

The budget is a manifestation of the new corporate strategy, which sets out the ways in which WHO's Secretariat intends to address the challenges of rapid evolution in international health. The programme and budget for each area of work has been worked out through an Organization-wide process, jointly between staff from Regional Offices and from headquarters.

Thirty-five areas of work have been identified for the whole Organization and constitute our common building blocks. In the process, we clearly identify the 11 priorities endorsed by the Executive Board and have moved additional resources to those priorities.

The new approach to budgeting and planning has particular significance for our work in countries. We want to facilitate a strategic approach to the development of WHO's country cooperation. Defining clear priorities will help to ensure that there is a better match between country needs and globally agreed strategies. We will be discussing with countries also, how to focus better on country cooperation.

As you know, the Health Assembly adopted a resolution in 1998 dealing with the reallocation of the regular budget between Regions. In the current biennium the first application of the resolution resulted in an increase in the funds of the AFRO and EURO Regions and reductions for the other four Regions.

The second application of the resolution for the 2002–2003 biennium is based on new data. There is a further increase for EURO, although not as large as in 2000–2001. Based on extensive discussions in the Global Cabinet, and within the flexibility in the resolution, I have felt it was necessary to recognize that the four Regions which were the subject of reductions have faced *great difficulty* this biennium because of the need to absorb their relatively high inflations on top of their regional allocation reduction. Their reductions will be two percent, altogether five percent over the two biennia.

I will continue to seek ways in which we can reflect the challenges faced by countries in the European Region which are undergoing economic and social transition.

Mr Chairman,

We are seeing a change in perceptions. Health is big news. Health is accepted as a central and necessary element in reducing poverty and ensuring economic growth and social progress. There is movement

among donors to allocate more money towards interventions that will fight diseases. There is a growing realization that we need international agreements and cooperation to fight threats to health, such as from tobacco. In short – health has been placed at the centre of the development agenda.

The first decade of this century can become the one in which the world's two billion poorest can share in the health revolution.

But there is nothing irreversible in this process. We need to continue our hard work to maintain the momentum. The tiniest sense of complacency may turn health's central role in development from a permanent paradigm shift to little more than this year's fashionable theory.

We are on the brink of seeing real and substantial gains for the health of poorer people, but to do so we need to have realistic perceptions of what we can all achieve and what will be necessary for us to succeed.

First of all, we need to see increases in resources for poor people's health, not only from governments but also from donors and foundations. The contribution should add to and not replace existing financial commitments.

Secondly, the demand for improved results and measurable outcomes will be relentless. Additional funding will dry up unless it can be shown that increased activities have led to improved indicators within a relatively short period of time.

Thirdly, of course, the challenge is more than anything for governments of all countries, particularly – in this Region – for countries in transition. A new focus on health will put increasing demands on countries funding, on absorption capacity, and on governance. To make substantial and lasting improvements to health, people themselves and their governments will always be the main driving force.

Let us work together to grasp this opportunity. Let us make this decade the decade that spread the health revolution to all.

Thank you.

Annex 5

ADDRESS BY THE WHO REGIONAL DIRECTOR FOR EUROPE

Ladies and gentlemen, participants in the fiftieth session of the WHO Regional Committee for Europe, I should like to begin by describing to you some of the innovations that have been made in this session of the Regional Committee, at the request of the Standing Committee:

- a shorter session (three and a half days, instead of four);
- a sharper focus on a limited number of important subjects (poliomyelitis eradication, food and nutrition policy, the Regional Office's country strategy, and the programme budget);
- an initial attempt to shorten and simplify the documents (we will try to do even better next time);
- attempts to make the meetings more lively and interactive, by giving specific examples and having opinions presented by Member States, partners and distinguished speakers from outside the Organization. This applies in particular to the meeting on food and nutrition policy, where we have asked FAO, UNICEF and the European Union to contribute to our discussions. It is also the case for the country strategy which, at the request of the Standing Committee, will be preceded by a presentation of the results of evaluation of the EUROHEALTH programme. The same approach will also be systematically adopted for the major topics, where the Standing Committee's views will be presented just after the item has been introduced by a member of the regional Secretariat.
- Another innovative measure this year is the technical briefing, outside the official programme on the Thursday afternoon, after the adoption of the report, on the very important subject of emergency preparedness. If this initiative is successful, we will repeat it on a different subject each year. I would therefore urge all delegations to take part in this briefing and to make their points of view known.

We would like participants to have a lively, productive and interesting Regional Committee. We hope that Member States' delegations will contribute to this when they make their statements and take the floor. We hope to hear questions and criticisms but, of course, expressions of support, too.

For my first eight months in office, I set myself the goal of observing the Region and getting to know the Office and the Organization again. I have visited many countries, and will continue to do so. I have met the various divisions and units in the Office on several occasions. Today, I should like to present to you the results of my active observation, expressed in the form of the challenges and opportunities that I see for the European Region. That will be the first part of my report. The second part will cover the challenges and opportunities that I see for the Regional Office itself.

With regard to the challenges and opportunities for health in WHO's European Region, it is a fact that the health sector is now facing many complex and difficult challenges, at least in the short term. This is another reason to seize the opportunities that arise, and indeed to create them.

Twenty years ago, we thought we would soon be able to control infectious diseases. Today, they are exploding, new ones are appearing, and others (which we thought had disappeared) are re-emerging. Demography, emigration, poverty, a weakening of health structures, disasters, climate change and poor drug use are the main factors responsible for this. There were 350 000 new cases of tuberculosis in the Region in 1999. Malaria is on the increase in some countries and is threatening others. Syphilis is spreading very fast in the east of the continent. And, of course, AIDS is still with us. Alongside this dramatic picture, however, an extraordinary opportunity is opening up, to eradicate poliomyelitis. This

can be achieved provided, of course, that we continue our vaccination and surveillance efforts until final certification. This subject is on the agenda of the fiftieth session.

Chronic diseases and their risk factors are another challenge. Chronic diseases (cardiovascular diseases and cancers) are placing an increasingly heavy burden on people's health and, consequently, on health systems. It is difficult to control risk factors. In trying to do so, we often come up against very resistant economic interests. Only a collective commitment on the part of health advocates and genuine political will can make a difference to this situation.

The global tobacco convention is an opportunity not to be missed. The European Region, a forerunner in this field, must maintain and strengthen its total commitment to the success of this movement. The ministerial conference on tobacco, to be held in Warsaw in June 2001, is a stage in this process. At the European level, the Alcohol Action Plan and the Stockholm conference in February 2001 can be levers for acting on this risk factor, which has dramatic repercussions on health.

During this fiftieth session, we will also have the opportunity to revisit another essential component of public health, namely food and nutrition policies. I hope the Regional Committee will endorse an action plan that complements the resolution on food safety adopted by the World Health Assembly. This action plan will enable the health sector to take its rightful place in a field where partnerships are essential in the face of diverging interests.

In the area of chronic diseases, we have another major challenge to take up: mental health, with its dramatic manifestations such as suicide, especially among young people, and the marked increase in depression. It is time to tackle this problem in all its dimensions, in a comprehensive and thorough way. Let us therefore take the opportunity of initial mobilization offered to us by the selection of this topic as the theme of World Health Day and of the *World health report* in 2001.

There is also a challenge to the health of certain vulnerable population groups. Firstly, the health of women, mothers and children has significantly improved in recent decades in some parts of the Region, but it remains a major concern in the poorest countries and for disadvantaged social groups, even in the richest countries. The health of adolescents and the elderly makes it essential to set up new services that are more appropriate to their situation and problems, striking a difficult balance between social and medical considerations. The new approach proposed by WHO, of taking account of the whole life cycle from birth to death, is an opportunity to create synergy between interventions which, all too often, are disparate and lack continuity. This approach is an integral part of primary health care.

Health determinants are also a challenge. The environment is probably the area that best illustrates the health impact of external factors. The London Conference and its conclusions give us an excellent opportunity to take up this challenge in all its multisectoral dimensions. But this still leaves the challenge of how the health sector can take account of all the other social, economic and cultural determinants of health. Their importance is now more clearly realized, but only hesitant steps have been taken to integrate these dimensions into health action. The new approach of "health impact assessment", where the Regional Office has already taken several initiatives, is certainly an opportunity for further action. We also hope that the new centre on health determinants in Venice will play a catalytic role in transforming noble intentions into practical action.

We must also confront the challenge of health systems reform. We must make sure that our health systems are:

- accessible to all, and in particular the poorest sections of society;
- of better quality;
- respectful of patients' rights and accessible to citizens; and
- efficient in their use of the human and financial resources allocated to them.

This is certainly the most urgent and widespread challenge facing all those responsible for health in the Region, and probably throughout the world. But while the challenge is enormous, the opportunities are, too.

The main opportunity is the experience that has been gained through success and failure, especially in organizing and financing health systems. But here, too, each must be able to benefit from the experience of others. Collecting information, analysing it impartially and making it more accessible, especially in the form of case studies, is one of the challenges that the Regional Office is now committed to tackling. Some circumstances can also be the opportunity to give fresh impetus to health system reforms. This is true of the process of accession to the European Union and the grouping of certain countries in the Stability Pact. The Regional Office, in partnership with the international community, intends to seize these opportunities to help the countries concerned improve their people's health. Lastly, many countries in the Region, and especially those in the more eastern part, have made primary health care and family health the priority for their health policies. Making the transition from "hygiene" to primary health care is difficult, but it is under way. The challenge for the international community is to support this movement in a coherent way, while respecting the choices made by countries themselves.

One important challenge is that of tackling health crises. They have multiplied in the Region in recent years, taking the form of epidemics, contaminated blood, poisoning, foodborne infections, natural disasters, etc. Health officials are facing the challenge of setting up systems for the surveillance of and rapid response to these crises. The challenge for WHO is to ensure that the Member States have rapid access to a summary of scientific knowledge in the fields concerned.

The technological challenge, too, is an essential one. Will health systems be able to make rational use of high technology, especially to make primary health care accessible to all? I am thinking in particular of the development of telemedicine. Will they be able to make use of the most modern means of communication to improve their information management and communicate more clearly with professionals and the general public, especially during crises? How will they solve the problem of the uncontrolled use of the Web by interests that are hazardous to consumers' health? All these fundamental questions must be raised in the near future, if health is to really benefit from technological progress.

What are the challenges and opportunities for WHO's Regional Office for Europe? Since the last session of the Regional Committee, the units and programmes at the Office have continued their work. I cannot detail here all the activities which are described in the Regional Director's report. Since my arrival in February, I have undertaken a major reform of the Office's orientations, structure and modes of intervention. This work has been carried out in addition to prior commitments. I should therefore like to take this opportunity to thank all the staff, in the presence of representatives of all the Member States, for their participation and their professional approach.

The main challenge facing the Regional Office is to bring about the necessary adaptation of its services to the needs of the Member States in the Region and the health of their populations. This alignment is the sole aim of the reform currently under way. In any case, it must be an ongoing feature, since the situations in countries are evolving rapidly. In its current phase, the reform consists in reviewing the Organization's collaboration with each country, all the technical programmes, and the Regional Office's basic functions.

With regard to collaboration with countries, we are currently reviewing the information we have in our internal databases and from liaison offices in countries where those units exist. We are also analysing the priorities for our cooperation with each country. This work, which at the moment is being done on an internal basis, is a preliminary step before the discussions we will later have with the Member States, to set the objectives and priorities for our cooperation with each of them. We shall have the opportunity to develop this point further during the part of the session devoted to the Office's country strategy.

The review of technical programmes that we are currently carrying out is designed to verify how operational they are and to see how far they meet countries' needs. This review is looking first at the evidence base for the programmes. We feel that this question of evidence is of fundamental importance

for guaranteeing the quality of our interventions. We also feel that it is essential in order to give more credibility to public health.

In each of our technical fields, we are also reviewing the best intervention strategies, the quality of our expert networks and collaborating centres, and the action being taken by our partners. The aim of reviewing the Office's basic functions is to make it more coherent in its partnerships with other organizations, in resource mobilization, in information management, in communications policy and, of course, in the services delivered to countries. For each of these "cross-cutting" functions, we are setting up procedures for ensuring an integrated and harmonized approach. Once we have reviewed and adapted our programmes, we will be able to develop the four strategic orientations chosen for the Office:

- to consider all countries in their diversity;
- to strengthen international partnerships for health;
- to be part of WHO's global country strategy; and
- to incorporate the experience acquired by the Regional Office for Europe.

A new organizational structure has been put in place, to reflect the new orientations and priorities not only of the Regional Office but also of the Organization as a whole. It is built up on the basis of the functions to be carried out by the Office, rather than on the various fields of public health, as was the case in the past. It consists of four divisions:

- one that is responsible for country cooperation and health policy and systems;
- another that covers all the technical programmes;
- a third responsible for information and communication; and
- one responsible for operational support (administration, budget and finance).

The new areas in this structure will be progressively introduced as soon as possible. These are:

- health system organization and financing;
- health determinants;
- health impact assessment;
- the evidence base for public health action; and
- training of Regional Office staff.

Fields to be taken up at a later date include the health of the elderly, accident prevention and expanded disease surveillance.

In conclusion, the reform currently under way will be completed by the end of 2000, and its implementation will be developed as from the start of 2001. It should be seen as a process of adapting to current realities, rather than one of questioning the past. It is a continuation of the health for all policy so effectively advocated by Dr Asvall.

May I briefly mention here the forthcoming conference on HEALTH21, which will take place in Istanbul next month.

I should again like to wish the Regional Committee a productive and interesting session for each of you. From a selfish point of view, I know that if it is good for you, it will necessarily be good for us, too.