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Opening of the session

The fifty-third session of the WHO Regional Committee for Europe was held in the Redoutensäle at the Hofburg Congress Centre in Vienna from 8 to 11 September 2003. Representatives of all 52 countries of the Region took part. Also present were observers from two Member States of the Economic Commission for Europe and one non-Member State, and representatives of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Bank, the Council of Europe, the European Commission and nongovernmental organizations.

The inaugural ceremony took place in the Grosser Redoutensaal on Monday, 8 September. Addresses were delivered by Dr Thomas Klestil, Federal President of Austria, Mrs Maria Rauch-Kallat, Federal Minister of Health and Women of Austria, Professor Dr Reinhart Waneck, State Secretary at the Federal Ministry of Health and Women of Austria, and Dr Marc Danzon, WHO Regional Director for Europe.

The first working meeting was opened by Mr Lars Løkke Rasmussen, outgoing President.

Election of officers

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

Mrs Maria Rauch-Kallat (Austria)	President
Dr Jarkko Eskola (Finland)	Executive President
Dr Božidar Voljč (Slovenia)	Deputy Executive President
Dr Ainura Ibraimova (Kyrgyzstan)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC53/2 Rev.1 and EUR/RC53/3 Rev.1)

The Committee adopted the agenda and programme of work.

Address by the Director-General

In his statement, Dr Lee Jong-wook thanked the Government of Austria for hosting the fifty-third session of the Regional Committee and extended a special welcome to Cyprus, attending its first session as a member of WHO's European Region. He expressed shock at the tragic bombing of the United Nations premises in Baghdad and the deaths and injuries of colleagues.

The 25th anniversary of the Declaration of Alma-Ata on Primary Health Care provided an opportune moment to recall that good health was for all. Inequalities in development had reduced life expectancy to 40 years in some countries but had raised it to about 80 years in others. The Director-General identified HIV/AIDS as the greatest challenge in health and stressed the need for a strategy linking prevention, care and treatment. He was working with local, national and international partners to design programmes to treat nearly 3 million people with antiretroviral agents by the end of 2005; that "3 by 5" programme, which marked the beginning of a solution, would be implemented with the support of many partners, including UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Tuberculosis was exploding in some parts of Europe, with drug resistance a growing problem in some prisons in eastern Europe. Rapid expansion of the directly observed treatment, short-course (DOTS) strategy and management of drug resistance were essential. The success in eradicating poliomyelitis in the Region would greatly contribute to the effort worldwide.

The need for health care started at birth and continued throughout life. Skilled attendants were needed in pregnancy and childbirth. The situation whereby most childhood deaths worldwide resulted from five preventable and treatable conditions – diarrhoea, malaria, malnutrition, measles and pneumonia – could be improved through implementing strategies such as Making Pregnancy Safer and the Integrated Management of Childhood Illnesses. Adolescents faced specific health problems such as teenage pregnancy, injecting drug abuse, violence, alcohol abuse and mental disorders. The health needs of the elderly had been made apparent in the recent heat-wave in Europe. All those aspects showed the need for strong and integrated health systems, coupled with strong surveillance systems, such as that which had allowed for the detection of the epidemic of severe acute respiratory syndrome (SARS).

The Director-General also stressed the contribution of noncommunicable diseases and injuries to the burden of disease. The adoption of the Framework Convention on Tobacco Control by the Fifty-sixth World Health Assembly in May 2003 had been a landmark in the fight against tobacco-related diseases, but the challenges ahead lay in the ratification by 40 countries needed to bring the Convention into force and in its subsequent implementation. To tackle the major problem of unbalanced nutrition, an integrated approach to malnutrition, namely the global strategy on diet, physical activity and health, would be presented to the Health Assembly in May 2004. The Director-General also emphasized a greater role for the health sector in food safety and food security, and the need for more effective responses to the toll of road traffic accidents.

Strengthening WHO's country offices in terms of human resources, budget and authority was essential. Activities at WHO headquarters were being reviewed to identify those that could be performed better in regional and country offices. There would be close partnership with the regions, and the changes should be in place for the financial period 2006–2007.

Work would be done in countries to train, deploy and supervise health workers. Effective health information systems would be built by using increasingly powerful and affordable technologies. The quality of health information could be improved in some countries through projects such as the health metrics network, a WHO partnership with Member States, foundations, the World Bank and UNICEF.

Noting the unprecedented commitment to partnership by global leaders, the Director-General pointed out that all the Millennium Development Goals bore directly on health, and he underlined the dependence of WHO's work on partnerships.

Responding to the Director-General's address, representatives congratulated Dr Lee on his election. They expressed both their full support for WHO, including the priorities that he had outlined, and their confidence in his stewardship. His commitment to strengthening work at country level was particularly welcomed. Several speakers underlined the need to continue of the policies of "one WHO", promote healthier lifestyles, protect the health of vulnerable members of society, and strengthen health systems, including mechanisms for disease surveillance.

It was emphasized that strong partnerships were essential. Half the Member States in the Region would soon belong to the European Union (EU), thereby leading to a coherent and coordinated approach to health policy, such as had been seen in the negotiations for the Framework Convention on Tobacco Control (FCTC). That approach would also be followed for the revision of the International Health Regulations and consideration of health-related aspects of trade.

The paradox of the Region being both a donor and a recipient of funds was noted. Countries in economic transition, with straitened financing and allocation of resources, faced difficulties in reforming their health systems, although a speaker from one such country emphasized the opportunity to improve health care through a legislative approach. Dr J. Eskola, Chairman of the Tenth Standing Committee of the Regional Committee (SCRC), recalled that resolution WHA51.31 had called for evaluation of the model for regular budget allocations to regions and asked for the Region to be considered as needing support.

Speakers pledged to continue collaboration with WHO whose leadership role, most urgently in redressing inequities in health, remained essential. One speaker called for increased coordination between Member States, WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and UNAIDS, especially for optimizing the use of resources in countries in the Commonwealth of Independent States (CIS). Besides the Millennium Development Goals, which should be accorded top priority, infectious diseases needed to be revisited, especially with regard to immunization, and the EU's proposed European Centre for Disease Prevention and Control would work closely with WHO.

The Director-General's plan to attend the celebration of the 25th anniversary of the Declaration of Alma-Ata and to officially visit one country in the CIS was welcomed. One speaker asked Dr Lee to support a proposal that would be made to the United Nations General Assembly for the years 2005–2015 to be designated the International Decade of Freshwater and for the creation of a global freshwater fund.

In response, the Director-General affirmed the principle of one WHO and underlined the vital role of primary health care and of stronger health systems in attaining the health-related Millennium Development Goals. He recognized the dual flows of funding in the Region and the need to achieve budgetary balance; for the sake of greater effectiveness, one goal would be to have a single budget that combined regular and extrabudgetary funding.

Report of the Regional Director

(EUR/RC53/Inf.Doc./1)

In his report to the Regional Committee, the Regional Director first paid homage to WHO staff who had died while carrying out their duties, and then cited four events as illustrations of the previous exceptional year. The successful struggle against SARS, the adoption of the Framework Convention on Tobacco Control, and increased awareness of AIDS in countries of the European Region and greater financial investment in them by the Global Fund to Fight AIDS Tuberculosis and Malaria again showed that transparency and scientific cooperation between countries secured the best results in public health, even though much further work in each area was still needed. Those successes and WHO's role in mobilizing resources and encouraging cooperation had increased expectations of the Organization. The fourth important event, the election of a new Director-General of WHO, Dr Lee Jong-wook (whose proposed approaches were very much in line with those adopted for the Region by the Regional Committee) offered opportunities for Member States to benefit from one WHO that respected the diversity of its regions.

Considering the diversity of all the countries in the Region, the Regional Office was offering them increasingly diversified and specific services, in partnership with a variety of organizations. Such services comprised both responses to growing demands from individual countries and broader approaches to different parts of the Region. The latter included the "Futures Forum" programme, to supply tools for decision-makers in western or south-western countries; public health programmes under the aegis of the Stability Pact for South Eastern Europe, with support from France, Greece, Italy, Slovenia and Sweden; work with the European Commission (EC) to extend the benefits of its public health programme to candidate countries for accession to the EU; and better and more effective cooperation in the CIS, especially with the World Bank. While all the Regional Office's technical and administrative services contributed to implementing its country strategy, the country offices in 28 Member States were responsible for much of the progress made.

In addition, activities had been carried out in areas of public health that were the topics of Regional Committee resolutions and ministerial conferences or were covered by global programmes. Within the larger United Nations response to HIV/AIDS and working closely with the Joint United Nations Programme on HIV/AIDS and other partners, the Regional Office was focusing on helping Member States expand their programmes for prevention, treatment and care. It was also supporting countries in submitting strong applications for resources from the Global Fund and the World Bank.

With support from France and Norway and cooperation from other Member States, the Regional Office had set up a European information system to monitor, assess and strengthen alcohol control policies; countries were urged to provide assistance to enable the Regional Office to play its role fully in that area. Prepared with a large number of partners, the Fourth Ministerial Conference on Environment and Health, planned for June 2004, was expected to produce an action plan on children's environment and health, and close links were being developed with the EC's new strategy on environment and health.

To respond to countries' requests for advice on reforming their health systems, the Regional Office had begun to set up a unique mechanism to provide expertise matched to demand. It was making the health of the elderly a cross-cutting theme of its work. In the area of noncommunicable diseases, the Regional Office would present to the Regional Committee the following year a control strategy taking a wide, integrated approach.

The Regional Office provided a European dimension to global WHO work in two other areas; the first was violence and health (where the Office had coordinated the European launch of the WHO headquarters report on that subject), and the second was poverty and health, where the WHO European Office for Investment for Health and Development was also working to adapt the Millennium Development Goals to the needs of the Region.

Major work was being done to reorient and upgrade the Regional Office's information systems and, with the help of the European Advisory Committee on Health Research, to base all its work on evidence. The new Health Evidence Network (HEN) responded to policy-makers' frequently asked questions with useful evidence-based information. The Office would expand the HEN partnership to make the system a unique, value-added entry point to multiple sources of information. In addition, the Regional Office had continued to strengthen its organization and to ensure harmonious and stimulating staff management; in that connection, the Regional Director concluded by paying tribute to the dedication of all the staff.

Ms Zsuzsanna Jakab, Chairperson of the European Committee on Environment and Health (EEHC), reported on the progress made in preparing for the Fourth Ministerial Conference on Environment and Health, to be held in Budapest, Hungary in 2004. As the Conference Steering Committee, the EEHC had assessed that progress and advised the Regional Director at its two meetings and, at the Second Intergovernmental Preparatory Meeting in Stockholm, Member States had agreed on the Conference's scope, direction and expected outcomes.

The priority issues fell into three main areas. The first comprised assessing the progress made since the First European Conference on Environment and Health in 1989, evaluating the effects of the environment and health process on countries and reporting on the progress made since the third conference in 1999. The second was to create two tools for policy-making: an environment and health information system, and guidance on the use of the precautionary principle. The third focused on issues of increasing importance: housing, energy and sustainable development, and perhaps the health effects of extreme climate-related events that required public health action.

Two major outcomes for the Conference were being developed: a children's environment and health action plan (CEHAPE), to mobilize Region-wide action to create healthier environments for children, and the Conference Declaration describing the commitments of Member States on each priority issue. Synergy was needed between WHO work and that of the EC's new environment and health strategy.

The Conference and its follow-up activities needed the widest participation by stakeholders to succeed. A number of activities were planned to involve nongovernmental organizations (NGOs) and civil-society bodies, as well as children and young people, but more funding was required. Future activities included a communication campaign to provide a high profile for the Conference among policy-makers and all other stakeholders, including young people, and two further intergovernmental preparatory meetings.

In the subsequent discussion, many speakers specifically commended the Regional Office's strategy of matching its services to countries' needs and aiming to expand its presence in countries. The work of the

WHO Office in the Russian Federation was an example of what could be achieved. Several representatives also praised the Regional Director's personal contribution to technical activities, to work with donors and other partnership activities, and to reaching a compromise solution to the problem of the CIS' assessed payments to WHO.

A number of representatives noted that the Regional Office was giving priority to technical issues of paramount importance to them, such as HIV/AIDS, tuberculosis, mental health, tobacco and alcohol, and women's and children's health. Many described successful Regional Office cooperation with them on such tasks as health policy-making, health legislation and health system reform, and suggested that other countries could follow those examples. Several offered suggestions for improving or expanding such activities, and asked about future work. For example, one speaker asked whether the Regional Office would reinstall a regional adviser on alcohol, so that the priority of the issue could be maintained, and another asked how the Regional Office would support the national processes needed to ratify and implement the FCTC. Endorsing WHO's work on diet and physical activity, a representative asked how global and regional processes would be coordinated. In addition, two speakers suggested that the Secretariat should report to the Regional Committee at its fifty-fourth session on the progress made in implementing resolution EUR/RC52/R8 on scaling up the response to tuberculosis in the European Region of WHO. Finally, a representative said that his country had named 2003 the Year of Freshwater, and proposed the creation of a global fund on this topic and the designation of 2005–2015 as the United Nations Decade of Freshwater.

Several speakers stressed the importance of health information. One urged the further development of the environment and health information system; another expressed interest in the progress of the new HEN, and it was suggested, especially in view of the large number of deaths in elderly people during the recent heat-wave, that the Regional Office should seek ways to ensure the faster delivery of higher-quality statistics on mortality.

The environment and health was the technical issue arousing the greatest interest. Many representatives praised the report of the EEHC and the preparation for and proposed content and outcomes of the Budapest Conference. They described their countries' contribution to the process and suggested additional topics for discussion, such as the Protocol on Strategic Environmental Assessment to the Convention on Environmental Impact Assessment in a Transboundary Context and the health effects, particularly for children, of climate change and specifically of conditions in the Aral Sea area and the Chernobyl nuclear accident. One representative announced that his country would host the pre-Conference intergovernmental meeting in 2004.

Many representatives praised the Regional Office as a mobilizer of resources, coordinator of activities and builder of partnerships and urged that it continue in those roles.

Three invited speakers representing partner organizations addressed the Regional Committee. Mr Fernand Sauer, Director for Public Health and Risk Assessment at the EC Directorate-General for Health and Consumer Protection, noted that the Regional Director and the Regional Office had assisted the accession process for the 10 countries joining the EU by preparing reports on their health status and health systems. The annual "summit", involving the Regional Director and staff from the EC, had preceded a meeting, also attended by the WHO Director-General and the EU ministers of health, to help coordinate the response to SARS. The two partners would continue to meet to coordinate and plan their work. Exchanges of staff had begun, and the EU hoped to establish a centre for control of communicable diseases in 2005.

The EC had signed the FCTC and would support its ratification by all EU member states. It would participate in the 2005 WHO conference on mental health and supported the preparations for the Budapest Conference. Finally, the EC had included all five of the projects proposed by the Regional Office among the 50 projects selected in the first round for the new EU public health programme.

Ms Gabriella Battaini-Dragoni, Director-General of Social Cohesion at the Council of Europe (CE), described the Council's activities guided by its European Health Committee, of which the EU and WHO were members. The three bodies' cooperation on health matters had started with the European Network of Health-Promoting Schools (ENHPS), partnerships for patients' rights and the project on health in prisons. Further cooperation had followed the exchange of letters between Ms Battaini-Dragoni, Mr Sauer and the Regional Director in 2001: areas added included the CE's contribution to the new EU directive on blood safety, its work with WHO on the Dubrovnik Pledge, and joint efforts to control tuberculosis in the Russian Federation. Three future cooperative schemes would focus on the CE's support to preparation of the 2005 WHO conference on mental health and work for the health of elderly people and on violence and health. In all areas, it was hoped that the Council of Europe Development Bank would help finance projects.

As three WHO Member States in the European Region also belonged to the Region of the Americas, while two more attended its Regional Committee sessions as observers, Dr Mirta Roses Periago, WHO Regional Director for the Americas, was happy to be the first Regional Director to attend the Regional Committee session of another WHO region. She saw many opportunities for the two regional organizations to share experiences, find synergy and work together.

Each region had taken the lead in different areas: the European Region in health promotion, the Healthy Cities project, ENHPS and health system reform, and the Region of the Americas in the eradication of poliomyelitis, measles and now rubella, and in organizing a Region-wide immunization week each year. Both regions had similar interests in many topics such as ageing, poverty, health systems financing and the quality of care, and even parallel programmes on noncommunicable diseases (CINDI and CARMEN) and complementary observatories (on health systems and human resources).

In December 2003, senior staff from both Regional Offices would meet in Washington, DC to discuss developing their cooperation, and the Regional Office for the Americas would follow European progress on the environment and health very closely.

In reply to statements from the floor, Ms Jakab thanked the representatives for their countries' support for and input to the Budapest Conference. She had noted their comments and suggestions, and the EEHC would consider them at its next meeting.

The Regional Director thanked the Member States for their support of the work of the Regional Office. In answer to the questions posed, he confirmed that the Regional Office was committed to supporting Member States, collectively and individually, in the ratification and implementation of the FCTC. That support would take several forms: case studies on countries advanced in those processes, extension of the tobacco policy information system to cover issues related to the FCTC and, with the CE, the possibility of holding a special session of the Parliamentary Assembly to obtain political support for its ratification.

The Regional Director and Mr Sauer had agreed to work together on the systematic and rapid collection of information, and the Regional Committee would be given a summary of a study on the health effects of heat-waves. Further information on the Regional Office's various programmes on the environment and health would also be distributed.

The fact that many cases of measles reported in the Region of the Americas were imported from Europe perhaps indicated that the Region should have a target on measles eradication. The SCRC would consider the request for a report on progress against tuberculosis to be submitted to the Regional Committee at its session the following year.

Report of the Tenth Standing Committee of the Regional Committee

(EUR/RC53/4, /4 Add.1, /Conf.Doc./1 and /Conf.Doc./9)

The Chairman of the Standing Committee noted that the Tenth SCRC had met five times during the year and that its reports were available on the Regional Office's web site, so that Member States could react to items discussed between sessions of the Regional Committee. In addition to reviewing the action taken by the Secretariat to follow up resolutions adopted by the Regional Committee, the SCRC had been involved in selecting and preparing technical subjects for discussion at the current session. Individual members of the SCRC would present its views on those subjects under the corresponding agenda item.

Among other topics, the SCRC had also discussed the Organization's budget for 2004–2005. While noting that the implementation of resolution WHA51.31 had resulted in an increase to the European Region's regular budget of some US\$ 4.5 million between 1998–1999 and 2004–2005, the SCRC had called for the measures taken thus far to be properly evaluated and for the resolution to continue to be implemented in full.

During the year, the Chairman of the SCRC and the Regional Director had met one of the members of the team that had made the external evaluation of the Regional Office's health care reform programmes, and they had extensively discussed the team's report and the methods used in the evaluation. That discussion had dispelled any misunderstandings that might have arisen. The SCRC had subsequently reviewed in detail the Secretariat's comments on the external evaluators' recommendations. It had noted with satisfaction the highly professional work done by the evaluators and felt that many of their recommendations had far-reaching implications for the European Region of WHO.

The Tenth SCRC had established a subgroup to evaluate the current arrangements for membership of the Executive Board, with terms of reference as set out by the Regional Committee at its previous session. In addition, and as called for by the Regional Committee at its forty-ninth session, the subgroup had explored the possibilities of introducing a new arrangement whereby agreement on candidates for membership of the Board would be guided by objective criteria relative to geographical distribution and other elements, in line with the principles of solidarity and transparency adopted in the HEALTH21 policy framework. Third, the SCRC had asked its subgroup to review and make proposals on the practice whereby elective posts in some committees of the World Health Assembly were traditionally reserved for countries that were "semi-permanent" members of the Board.

Following several meetings during the year and consultations with selected Member States, the subgroup had reported back to the Tenth SCRC at its third session in April 2003. The subgroup's guiding principle had been that over time all countries should have an equitable chance of participating in the work of the Executive Board. To that end, it had suggested that the periodicity of membership for the "semi-permanent" members should be lengthened to three years out of six, and it had put forward five objective criteria to be applied when selecting countries for membership of the Board. It had also recommended that European Member States should be grouped on a geographical basis for that purpose, and it had proposed guidelines for the selection of individual candidates. It had emphasized the importance of ratifying the amendments to Articles 24 and 25 of the WHO Constitution, which would increase the number of European seats on the Board from seven to eight. The subgroup had also considered that the practice of "semi-permanency" should not be applied to nominations for elective posts in committees of the Health Assembly. Lastly, it had proposed that the new arrangements, if accepted by the Regional Committee, should be evaluated by the SCRC in 2010.

The Tenth SCRC had wholeheartedly endorsed all the subgroup's recommendations and agreed by consensus that they should be presented to the Regional Committee as a package. Having dealt with the issue since 1997, and having had two subgroups and two ad hoc meetings devoted to the question, the Tenth SCRC had also felt that, if the proposals were not acceptable to the Regional Committee, there would be no further benefit in having the matter referred back to it again.

In the ensuing discussion, a number of speakers endorsed the Standing Committee's recommendation that the implementation of resolution WHA51.31 should be evaluated, and they called for a review of the way in which the Organization's extrabudgetary resources were distributed among the regions.

One representative pointed out that the information in the SCRC's report on the Global Fund to Fight AIDS, Tuberculosis and Malaria was outdated: it had been decided that medium-income countries were eligible for support, and indeed 12 European countries had already received funding from that source. The Regional Office was urged to play a leading role in strengthening coordination of the activities being undertaken with those funds.

The Secretariat was asked to provide more detailed information on the work done and planned to give effect to the recommendations arising from the external evaluation of the Regional Office's health care reform programmes. It was also suggested that a working group might be set up to review countries' progress in implementing their health care reforms, with particular attention paid to those who were receiving assistance from WHO in that area.

The Standing Committee was commended on the excellent work it had done with regard to arrangements for membership of the Executive Board. Its recommendations, while recognized as being a compromise, were judged to be acceptable to all countries. A clear preference was expressed for countries to be selected by consensus within the geographical groupings. For the sake of clarity, it was suggested that the objective criteria for selection of Member States and for the selection of candidates, and the details of the geographical grouping of countries, should be incorporated in the draft resolution before the Regional Committee. Lastly, all Member States that had not yet done so were urged to ratify the amendments to Articles 24 and 25 of the WHO Constitution. The SCRC was requested to initiate a collection of information from those Member States who had not yet ratified the amendments.

The Committee adopted resolutions EUR/RC53/R1 and EUR/RC53/R6.

Policy and technical items

Mental health in WHO's European Region

(EUR/RC53/7 and /Conf.Doc./2)

The Director of Technical Services, Reducing Disease Burden, introducing the item, said that various initiatives taken over the past five years had heightened policy-makers' awareness of the burden caused by mental illness. Despite mental health consequently having a higher position on the political agenda, across the Region there remained wide differences, from provision of services to prevalence, mortality and policy development. Progress had been made but was tempered by the increasing burden of mental illness. Regional trends and statistics highlighted the problem. More needed to be done to overcome the stigmatization surrounding schizophrenia. Many people with mental ill health faced neglect as a consequence of the closure of institutions or changes in policy, and many homeless people were mentally ill, with no political or professional entity carrying overall responsibility for their welfare. In central and eastern Europe, too many patients were still being treated in large institutions. Community-based mental health care was needed, with hospitals offering important back-up.

Reform processes were under way. The regional Mental Health programme had responded to requests from Member States by providing expertise for assessments, advice and help in monitoring the implementation of national strategies. Many Member States had either completed or initiated reforms leading to community-based care, and several had reformed mental health legislation in the previous two years.

The Mental Health programme had identified four main areas for attention: premature mortality and morbidity; destigmatization; country assessment; and child and adolescent mental health. The task forces that had been established on those four topics had been well supported by Member States, the WHO

European Network on Mental Health and the WHO European Network on Suicide Prevention and Research. Collaboration with WHO headquarters had been very fruitful.

Given the importance of mental health as a public health issue, the time had come to convene a European ministerial conference on the subject, with the aim of analysing the current situation, agreeing on the guiding principles for mental health policies and ensuring political commitment to action. It was therefore proposed that a WHO ministerial conference should be held in Helsinki in January 2005, on the theme of "Mental health in Europe. Facing the challenges, building solutions". Its aim would be to bring together health politicians, policy-makers and other crucial stakeholders, such as service providers and users, in order to review European policies, explore settings for mental health promotion, identify barriers to the prevention and treatment of mental ill health, suggest evidence-based solutions that could be turned into policies, and draw up an action plan. Preparatory events included meetings on human rights and stigmatization related to mental health, and further meetings were planned on suicide prevention, societal stress, and the mental health of children and adolescents. A steering committee had been created that included representatives of Member States hosting pre-conference events, the EC, the CE and Mental Health Europe. The active involvement and participation of Member States would be sought through case studies, surveys and consultations.

Dr Viktor Jaksons, a member of the SCRC, said that the Standing Committee had affirmed that mental health formed an essential part of public health and had noted that most disability-adjusted life years were lost to depressive disorders, stress and other mental ill health. Factors that triggered mental health problems included changes in socioeconomic status, armed conflicts, increasing poverty and the growing gap between the rich and the poor, even in the developed world. The Committee had welcomed the preparations for the ministerial conference and the effectiveness of the networks on mental health, as well as partnerships with the EC, NGOs and other bodies. Links were needed with programmes such as those on alcohol abuse. Both societal and individual aspects, in particular for children and adolescents, should be considered. Experience had shown that community-based approaches should be introduced in a well balanced way with due consideration of human rights and after sensitization of society. The SCRC stressed that the outcome should be an increased awareness among policy-makers, sound policies on mental health and help to Member States to formulate their own policies based on common principles and values.

In the extensive debate that followed, the report, with its good analysis of trends, achievements, obstacles, and diversity within the Region, was widely welcomed. Some speakers reviewed the mental health situation in their countries and the reforms that had been implemented, such as de-hospitalization, expansion of community-based care with development of training modules for primary care professionals, and mental health promotion, with educational programmes including life-skills development, media training and expansion of medical curricula to cover mental health better. One speaker, referring to partnerships outside WHO, suggested that the projects of the Stability Pact, especially that on mental health in south-eastern European countries, should have been mentioned. Further, the main priority areas of the Mental Health programme should be expanded to cover topics such as substance abuse.

Several speakers, calling for mental health to be incorporated into all public health programmes, underlined the point that key factors for mental ill health included social and economic inequalities, stress, unemployment and workplace issues, gender, social exclusion and marginalization, stigmatization and discrimination, substance abuse, and housing and personal safety. Some participants noted the increasing contribution of mental ill health with cardiovascular diseases to disability, and the fact that reducing societal stress could reduce violence and the impact of disasters. Some countries had low detection rates of depression and chronic disorders, reducing opportunities for treatment. The need for mental health programmes for refugees and others suffering from post-traumatic reactions was emphasized.

Participants recognized that the time had come to close the gap between knowledge and practice and to emphasize treatment and prevention. Innovative programmes, such as psychiatric autopsies, were perhaps easier to implement in smaller countries, and successful examples were quoted; in one case, good results

were being achieved with a suicide prevention programme that was supported by the private sector, and the role that non-experts such as police and clergy could play was affirmed. It was suggested that the social role and responsibility of employers and business enterprises should be covered by policies on mental health. Psychiatric rehabilitation was already an element of some national programmes. A common policy for detection, diagnosis and treatment of mental illness in children and adolescents should be agreed. Training in primary psychiatric care should be improved, and standards for mental health care should be developed. References to financial issues included a recommendation that mental health services should be not only equitable but also well budgeted. One speaker urged Member States to engage more in efforts to harmonize strategies for and approaches to mental health, and another described the creation of a European network on domestic violence.

Some speakers called for the programme of the ministerial conference in Helsinki to include depression and all its direct and indirect consequences, stress in the workplace and at school, alcohol abuse and the prevention of suicide. Any resulting action plan should be strong and comprehensive, with a firm base in human rights.

Under the agenda item, statements were delivered by representatives of the World Federation for Mental Health and Mental Health Europe. Written statements were submitted by a representative of the International Bureau for Epilepsy and the European Forum of National Nursing and Midwifery Associations and WHO.

The Committee adopted resolution EUR/RC53/R4.

The Regional Office's Country Strategy

(EUR/RC53/10 and /Conf.Doc./5)

The Director, Division of Country Support, gave a progress report on how the Regional Office's country strategy was being implemented to ensure that the services provided to countries more closely matched their specific needs. That had involved a change of approach, to increase responsiveness to countries and thus improve the delivery of services. The aim was to support Member States in developing their own health policies, health systems and public health programmes, preventing and overcoming threats to health, anticipating future challenges and advocating public health. It was important to treat countries differently in all their diversity and their wide range of socioeconomic status. In some cases that would involve mechanisms such as biannual collaborative agreements (BCAs), the series of Futures Forum meetings, and integrating WHO's vertical programmes within health systems work and in strengthened international partnerships for health. WHO did not provide equal assistance for every Member State but focused on where it could make a difference.

The Futures Forum brought together high-level decision-makers from the European Member States with no BCAs (in essence, the western European Member States) twice a year to share experience and visions on key health policy questions. Their conclusions were then published and made available. In the previous two years, requests for assistance from western Europe had doubled, and examples were given of work on health promotion with Finland, on violence with Germany and the United Kingdom, on a national health action plan in Portugal, on new public health legislation in France, and assistance with an environmental health threat in Andorra.

One major initiative by the Regional Office in partnership with the CE was the Stability Pact Initiative for Social Cohesion in South Eastern Europe, whereby eight countries were working together on health projects to improve stability and economic development. A video was shown to illustrate the value those countries attached to that unique Initiative, which was underpinned by the Dubrovnik Pledge. They were making progress in priority areas such as mental health. Three invited speakers then recounted their experience of the Initiative.

Mr Tomo Lučić, Minister of Health of Bosnia and Herzegovina, the lead country for the mental health project within the Initiative, noted that the Regional Office's new approach was to help countries help

themselves in partnership with other organizations, and it was showing positive results. The mental health project, whose main donor was the government of Greece, involved external experts at local and regional levels. It was the ideal vehicle to promote regional cooperation and partnership. There were no short cuts: such work needed time, determination and strong political support. Bosnia and Herzegovina offered to host the second forum of health ministers under the Initiative.

Professor Athanassios Constantopoulos from Greece emphasized that, as a donor, his country worked in close partnership and direct involvement with the eight countries, drawing on its own experience of psychiatric services reform. The Greek donation was channelled directly to the countries, and with good will and hard work the initial administrative difficulties had been largely overcome. The challenges now were to ensure continuity and sustainability, to overcome bureaucratic obstacles and to intensify ownership by the countries. The effects of that project would be felt further than the field of mental health, and it could serve as a model for the whole Initiative. He explicitly emphasized that WHO's role had ensured the success of the project.

Mr Karl-Friedrich Bopp of the Council of Europe said that, when they signed the Dubrovnik Pledge, ministers of health had confirmed their belief that health care, social well-being and human development were key to rebuilding society, and they had committed themselves to ensuring the fundamental human rights of societies and vulnerable populations. Two years on it was clear that social cohesion had indeed been strengthened, and that the partnership of WHO with the CE had effectively contributed both technical expertise and values. Once structures were in place, financial support had followed, from the Council of Europe Development Bank, France, Greece, Italy, Slovenia, Sweden and Switzerland. The Public Health in South Eastern Europe Network was an example of cooperation that other regions could follow.

The Director, Division of Country Support, went on to outline further work in countries, including some projects with EU candidate countries such as a survey of their health needs and of WHO's role in helping them, health promoting schools in Latvia and work on HIV/AIDS in Bulgaria. One area of emergency work was with The former Yugoslav Republic of Macedonia as it coped with refugees. It was important not only to respond to needs but also to build systems sustainably, not just provide temporary aid. With WHO's support, a total of US\$ 250 million had been mobilized by 12 Member States from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. Health systems and health policy were increasingly in focus, as was evident from the Division's work with Turkey, for example, on its "Health transformation programme" or with Portugal on its national health action plan.

A group of invited experts then described the health reform process in Kyrgyzstan and how the Regional Office had worked with different partners to put that process back on track when it had been under threat in early 2003. Dr Rifat Atun, from Imperial College in the United Kingdom, outlined his detailed evaluation, on behalf of the United Kingdom's Department for International Development (DfID), of the Kyrgyz health reform programme. That programme was being led by a young cadre of enthusiastic Kyrgyz nationals trained by WHO, with support from the United Kingdom (DfID). It was an excellent example of joined-up working that used evidence and analysis for policy-making, combined with strong local ownership. WHO had provided leadership and objectivity. Mr Dominic Haazen from the World Bank added that the Kyrgyz health reforms were being used by the World Bank as a model of sustainability for other countries. He said that some lessons could also be learned, such as the importance of maximizing transparency and communication from the outset, and the need to coordinate joint action at the highest level in the country. Mr Jerzy Skuratowicz, from the United Nations Development Programme in Kyrgyzstan, then described how early in 2003 the new reform programme had suffered setbacks, but the crisis had been successfully resolved with the crucial support of the Regional Office as well as the United Nations Resident Coordinator. WHO's role was also central in other ongoing initiatives within the framework of the Millennium Development Goals. Dr Ainura Ibraimova, from the Ministry of Health of Kyrgyzstan, stressed the value attached to support received from agencies such as WHO, the World Bank, UNICEF and the United Nations Environment Programme (UNEP) as well as the United Kingdom (DfID). The crisis over health care reforms had come about because the population had wanted to see

immediate results. Training, improvement of primary care, and introducing transparent funding systems took time, however, and those aspects of reform were not always understood by the legislative authorities.

The Director, Division of Country Support made it clear that all divisions in the Regional Office contributed to achieving excellence in country work. The WHO-wide Country Focus Initiative aimed to define strategic agendas for work with countries, improving the capacity and functioning of country offices and teams, and enhancing technical support. The Regional Office's country strategy was fully in line with that. Collecting information on countries, working in partnership and improved resource management were all aimed at strengthening and unifying WHO's country presence. The Organization's improved country presence was making a new impact. The leaders of the country offices underwent competitive selection and extensive retraining, and the regular budget for country programmes, at almost US\$ 12 million, had almost tripled since 1994–1995. Other improvements under way included ensuring faster response rates and developing longer-term strategies for supporting each Member State, which would have a four- or six-year time frame. The strategic agenda in the Russian Federation served as an example of that. Country work was planned in steps, and the process came under continuous scrutiny to ensure it responded to countries' needs and challenges.

In conclusion, some challenges remained, such as the need for closer contact with counterparts and more effective links with stakeholders at all levels. More and better qualified staff were also needed, along with more standardization between country offices and improved liaison with WHO headquarters and the global Country Focus Initiative. The Country Help Desk was ready to assist Member States with their enquiries.

Dr Kiely, a member of the SCRC, said the Standing Committee agreed with the new approach of the country strategy and acknowledged the success achieved so far in its implementation. Much more needed to be done on that pivotal and vital part of the Regional Office's work, but work so far on implementation of the strategy represented a radical shift of emphasis, and the changes in structure and function were supported.

In the subsequent debate, representatives expressed their approval of the increase in quality and volume of service provided by the Regional Office to Member States, allowing them to share and benefit from others' experiences as well as from technical expertise. They welcomed the way in which the different wishes, priorities and policies of decision-makers in the countries were listened to. BCAs had allowed the support given to countries by the Regional Office to become even more tangible, and the idea of developing strategic agendas for the Regional Office's work with countries covering four or six years was welcomed. Country offices played a special role: for example, the Special Representative of the Director-General in the WHO Office for the Russian Federation now formed the principal link for partnerships in the Russian public health sector.

For the Stability Pact countries, the high level cooperation on health issues at subregional level was a flexible and responsible way of making use of resources and know-how to promote teamwork and awareness. The Regional Office's support for countries tackling health reforms was particularly appreciated. It was pointed out by one representative, however, that senior policy-makers had to tackle complex questions in "the big picture" of their health systems, and that the Regional Office and its leaders in country offices must therefore be able to offer help at a high level. The financial resources for health lay overwhelmingly within countries, and the responsibility for the success of the Regional Office's country strategy therefore lay with governments. The Regional Office should also concentrate its international resources on work that was essentially international, such as HIV/AIDS and the environment and health. A balance also needed to be struck between those activities and normative work. One delegation proposed further strengthening the Division of Country Support by creating a unit for evaluation and quality assurance, to improve performance at country level.

The work of the Futures Forum should continue, and one country representative urged the Regional Office to put poverty at the top of the agenda, thus ensuring a "pro-poor policy dimension" for all programmes, particularly in the poorest countries. It was suggested that the next progress report should

contain an annex with succinct reports from individual country offices, and that at an appropriate time the work of the Regional Office should be evaluated.

It was pointed out that, while the Regional Office must remain relevant to and serve the needs of all Member States, the countries most in need of the Regional Office's technical assistance should have the highest priority.

Dr Arletty Pinel from the Global Fund to Fight AIDS, Tuberculosis and Malaria said that the Fund had given US\$ 1.5 billion over two years to support 150 programmes in 93 countries, including 12 countries from the eastern part of the Region. The Fund relied on its partners such as WHO to complement that support to countries, because funding on its own was not enough. The Regional Office was a key partner with whom the Fund had already collaborated on projects, but the Fund was keen to receive more proposals involving specific technical support for HIV/AIDS prevention and care, tuberculosis and malaria. That way the Fund could contribute to the "3 by 5" strategy, the possibility of treating 3 million people living with HIV and AIDS by 2005, particularly targeting those populations most at risk such as vulnerable young people and injecting drug users. However, that needed political will and commitment at a high level, sound technical approaches and a strong collective response. There were other contextual issues affecting HIV and tuberculosis that should also be addressed, such as depression, communicable disease surveillance and social cohesion initiatives. Closer collaboration between the Region, the Global Fund and donors would ensure that countries could benefit from truly comprehensive support.

Later in the session, the WHO Regional Director for the Americas reported on the decentralized structure of her Region. Twenty years before, offices had been set up in 28 countries, as had a facility for Caribbean Program Coordination, while a field office for the United States/Mexico border had been in existence for 60 years. In addition, there was a framework for cooperation with bodies such as the Caribbean Community (CARICOM) and the Southern Common Market (MERCOSUR). Each country in the Region of the Americas had a specific budget, a feature made possible by the fact that the Pan-American Health Organization received funding from two sources: direct contributions from all its member countries, and funds from WHO's regular budget. Very high proportions of both regular and extrabudgetary funds were managed by country programmes or offices, which also played a major role in mobilizing partners, coordinating donors and ensuring interagency support. Each part of the Organization had similar approaches to country work and attached equal importance to it.

The Committee adopted resolution EUR/RC53/R2.

Update of the regional Health for All (HFA) policy framework (EUR/RC53/8 and /Conf.Doc./3 Rev.1)

Recalling that resolution EUR/RC48/R5 required the submission of an updated HFA policy framework to the Regional Committee in 2005, the Regional Director described the update's proposed content, process and timetable. The Regional Office was basing its work on four recommendations from the SCRC: to update rather than replace the existing policy, using HEALTH21¹ as a point of departure; to focus more on evidence and proposals for concrete action; to place the ethics of health systems at the core of the update; and to reassess and reconfirm the basic values of HFA.

The Regional Office had accordingly decided to organize the work in four closely linked pillars. To begin the process, the European Observatory on Health Care Systems would summarize the lessons learned from HFA and the HEALTH21 policy framework by conducting two studies: reviewing the use of HFA in forming national and subnational health policy, and in establishing national health targets and objectives. The latter would lead to development of guidelines on proven methods for that task.

¹ HEALTH21: *the health for all policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).

To build the second pillar, a “think tank” was assessing the continued relevance of the existing values underpinning HFA. The group had recommended: linking the values in the update to existing international treaties and declarations in order to prevent duplication or contradiction; retaining the central values of equity, solidarity and participation, while clarifying their definitions in the changed and varying circumstances in the Region; and espousing the ethical governance of health system management and decision-making.

The third pillar comprised ensuring that Member States could use new tools for decision-making, such as HEN, the conclusions and recommendations of global and regional governing bodies, and reports on risk factors, poverty, violence and mental health. The fourth pillar, concrete guidance on implementation of the renewed HFA policies, based on case studies, would be built when the other three were well into development.

The timetable for the process comprised work on the pillars in 2003/2004, discussion with the Regional Committee in 2004, finishing the work in 2004/2005 and submission of the results to the Regional Committee at its fifty-fifth session. Consultation with Member States would take place throughout the process.

Dr Božidar Voljč, a member of the SCRC, identified the great political and economic changes in the Region, and the subsequent dramatic changes in countries’ health systems, as the motivation for the Regional Committee’s call for an HFA update. The components of HFA were described: three basic values, four main strategies and 21 targets or benchmarks for measuring progress. The SCRC believed that the 2005 update would maintain HFA as the driving force for health in the Region.

The speakers from the floor endorsed the content, process and timetable for the HFA update; some particularly approved of various aspects, such as the core values and the emphases on ethics, implementation and a sound practical knowledge base as the basis for action. One representative asked for clarification of the process whereby the think tank had been selected to work on HFA values. Another stressed the importance of respecting the values of international treaties and declarations on human rights. Some described how and under what conditions HFA-based policies had been made in their countries and volunteered to share their experience or to take part in the studies comprising the pillars. Others suggested that the process should cover additional issues such as bioethics and terrorism as a threat to health and ethics.

Several representatives stressed the need for broad and transparent consultation and for partnerships at all levels throughout the update process, and for maximum participation by all stakeholders (including the media) in policy implementation. Nearly all endorsed WHO’s role in building a good knowledge base, and one speaker commended the potential usefulness of HEN in that task. Suggested activities in that area included cooperating with national and international partners, improving the collection and dissemination of health statistics, extending the pillar studies to cover all countries in the Region, and taking account of the initiative to monitor dangerous and new diseases proposed by the President of the Russian Federation. One speaker asked how the countries participating in the study on the impact of HFA in policy development had been selected.

The representatives of the International Council of Nurses made a statement and asked when a report on implementation of the Munich Declaration (Nurses and midwives: A force for health) would be available, and about the status and obstacles to the WHO project on family health nursing.

Replying to comments, the Director, Division of Information, Evidence and Communication thanked speakers for their support for HEN; the Regional Office was making an important contribution to developing an evidence base on public health. Work was under way on the HFA database to reduce overlap with other organizations handling health statistics and to increase Member States’ participation. Work on the first pillar of the HFA update would include an overview of projects in Member States to implement policies at the national and subnational levels.

The Director, Division of Country Support reported that the family nursing project was on track in a number of countries; a training package was being pilot tested. The Regional Office had presented an interim report on implementation of the Munich Declaration at a recent meeting of the European Forum of National Nursing and Midwifery Associations and WHO. It showed that some countries faced special obstacles; the Regional Office was following up with those countries and would present a report to the Regional Committee at its fifty-fourth session.

The Regional Director found that the discussion showed the importance of the HFA update as a tool for health policy. Acting on the need for transparency created a management problem, as definitions of the concept varied. Consultation with Member States was essential to the process, and the guidance of the SCRC would be sought on how to ensure maximum transparency. In the meantime, the names of the members of the think tank on values and of the nine countries participating in the study on the impact of HFA on policy development would be made available to the Regional Committee.

Under the agenda item, a statement was also delivered by the representative of the World Federation of Acupuncture and Moxibustion Societies.

The Committee adopted resolution EUR/RC53/R3.

Strategic orientations of the Regional Office's work with geographically dispersed organizational entities, including WHO country offices

(EUR/RC53/9 and /Conf.Doc./4)

The Regional Director presented the item, remarking that the complicated issue of geographically dispersed offices (known as GDOs) had been under consideration by the Regional Office for many years. The quality of the work they produced was not in question, but problems arose over their role, status, sustainability and relationship with the Office in Copenhagen, the host country and the rest of the Region. There had been much discussion and opposing views.

The Senior Adviser, Programme Management and Implementation, introduced her overview of the issue by agreeing that the issue was complex and multidimensional, encompassing many managerial issues. She gave a brief history of the setting up of the GDOs, established initially in Rome and Bilthoven to carry out vital technical work following the success of the First Ministerial Conference on Environment and Health (Frankfurt, 1989) which had endorsed the European Charter on Environment and Health. It was not clear whether the administrative, financial, managerial and other implications of the GDOs had been systematically investigated at the time. The issue had resurfaced in 2000, when two GDOs had closed and three more were near finalization at a time when the new Regional Director wanted to make changes in the way the Regional Office functioned so as to focus more on providing services to Member States. A report had been commissioned from Professor Silano from Italy and discussed by the SCRC in December 2001. The Regional Committee at its fifty-second session had requested the Secretariat to prepare a report that would clarify the strategic role of GDOs for discussion at the present session.

Much work had been done in the past year, including a survey, 50 in-depth interviews and brainstorming, as well as analysis, appraisal and comparisons with other Regions. The findings were that the GDOs had developed in an unsystematic manner, that the governing bodies had not been involved, and that host agreements and management arrangements varied, but that the GDOs provided technical capacity where resources were otherwise scarce. The GDOs were the subject of a kaleidoscope of opinions: it was apparent that there was no consensus.

It was felt that WHO needed the technical expertise of GDOs to serve countries, but that no new centre should be set up without the full agreement of the governing bodies. In the event of an exceptional opportunity arising in the next few years, a new centre would have to meet certain strict and clear criteria and would be subject to a process of appraisal of its strategic and operational dimensions, a kind of administrative benchmarking. Steps continued to be taken to improve the management of GDOs, focusing

on clearer technical delineation, conformity with Organization's new ways of working, the relationship with the host country and the visibility of the GDOs.

The activities of all GDOs were planned, run and monitored in the same way as the rest of the Regional Office. It was possible that their terms of reference could be expanded to accommodate a special relationship with the host country. The impetus was on serving Member States. It was noteworthy that during the SARS crisis, the Rome office of the European Centre for Environment and Health had had the capacity to respond to substantial public concern.

WHO collaborating centres were quite different, as they were national institutions working in defined areas; they were not controlled by, and did not form part of, WHO. A total of 474 collaborating centres were in the European Region, with 87 in the United Kingdom, 47 in France, 42 each in the Russian Federation and in Italy, and 38 in Germany. Fourteen Member States had none. Work was being done to standardize the designation of centres, and the Regional Office would welcome Member States' views on the ways in which they were used.

Change would not happen overnight. Improved management and cohesion, along with the introduction of novel ways to revitalize WHO's presence in Member States, would take time and would involve liaison with WHO headquarters. Most importantly however, it would involve ongoing liaison with Member States.

Dr Danielle Hansen-Koenig, SCRC member, confirmed that the SCRC did not have an overarching policy on WHO's presence in countries: its views were not unanimous. It considered that the information collected did not provide an adequate basis on which to shape a strategic response. The brainstorming had to continue, and the SCRC encouraged experiment with new models, possibly using pilot projects. The SCRC recommended that the Regional Committee should decide to adopt a strategy in the following year, 2004.

Professor Silano, in a telephone contribution that was broadcast to representatives, tended to agree with that recommendation. He felt that the role of the GDOs had always been to provide scientific evaluation and technical advice, requiring special staff at the forefront of science: that had enabled great progress to be made on the environment and health, including the production of guidelines on air quality, water, waste, etc. Such expertise was still needed. Those special characteristics should be taken into account, as the GDOs were not at all the same as country offices or collaborating centres.

To decide that the Regional Office would not set up GDOs in future would be to penalize it. Such bodies were after all part of the strategy of the European Union, which was currently poised to set up a new centre for the control of communicable diseases. Setting up a GDO required effort and goodwill from the donor country as well as a heavy financial commitment, and it would necessarily be working in a core area for public health where expertise was needed. The issue should be regarded in a positive way, since the quality of the work of the GDOs was not questioned and they also brought considerable financial resources to WHO, generously provided by the Member States, benefits that surely far outweighed any administrative and management costs incurred.

In the subsequent debate, representatives agreed that WHO was at a crossroads. It was important that the Regional Office did not become simply a coordinator of centres all over Europe, and efforts had to be made to analyse the subject again and in full so that an informed decision could be made. It was generally agreed, however, that this could not be done until the fifty-fourth session of the Regional Committee in 2004. The Regional Director was requested to submit to the Regional Committee, at its fifty-fourth session in 2004, a report with concrete proposals.

One point made by many representatives was that it would be helpful to have full budget figures and financial statements available, so that the exact costs and benefits of the GDOs were clearer. It was felt that there was still a lack of understanding and clarity about the GDOs, their various definitions and roles, and their relationship with the Regional Office and Member States. Their work was not easily identified:

one representative suggested that it should be the subject of an annual report on the Regional Office's web site, another that it should be made clear which GDO was accountable to whom. One speaker suggested that they should be called technical centres or centres of programme support, since they allowed WHO's work to be expanded. Representatives were not enthusiastic about the idea that, in countries which had neither a GDO nor a country office, a collaborating centre could serve as a holistic WHO coordination point. Some felt that the technical centres were also unable to take on such coordination roles, and that the Regional Office itself should forge strategic alliances with other appropriate agencies and national and international organizations.

The criteria for establishing collaborating centres were also not clear. It would be useful to bring together all heads of collaborating centres, as had been done in the Russian Federation. It was felt that the current position, whereby only the Director-General could endorse a collaborating centre, was a laborious process which involved long delays. One representative suggested that collaborating centres should be the subject of discussion at a future session of the Regional Committee.

The Regional Director agreed that the terms of reference for any GDO had to be clear and that the GDOs should be working only in priority areas. If their purpose was only to create knowledge, then the work could be done by a collaborating centre or research institution, especially bearing in mind the fact that the Regional Office's main strategy now was to serve Member States. He underlined the Office's commitment to transparency and said that the report which would be submitted to the Regional Committee in 2004 would include financial details: the GDOs did indeed have budget implications. He looked forward to presenting a sharp and comprehensive report to the Regional Committee at its next session.

The health of children and adolescents in WHO's European Region

(EUR/RC53/11 and /Conf.Doc./6)

Introducing the item, the Director, Division of Technical Support, Reducing Disease Burden, listed the reasons for focusing on the health of children and adolescents: the wide variations in young people's health found in every Member State in the Region, the progress towards social justice that could be made by reducing health inequalities, the lifelong benefits of investing in the early stages of life and the very great scope for improving young people's health. In fact, the attainment by the 20% most disadvantaged children of the level of health of the 20% most fortunate would transform the health of children and adolescents.

Trends indicated growing threats to the health of children and adolescents. Examples from the past, in which advances in health had led to social and economic benefit, encouraged future action to tackle the threats posed by environmental and lifestyle factors, and socioeconomic inequalities.

Much was known about those threats. For example, children under the age of 5 years comprised 10% of the world's population but bore over 40% of the global burden of disease due to environmental factors. In the area of sexual and reproductive health, the Region showed very wide variations in rates of maternal and infant mortality and teenage pregnancy. People under 30 years of age accounted for 84% of new cases of HIV infection. Young people were experimenting with alcohol and drugs at earlier ages. The Health Behaviour in School-aged Children (HBSC) study showed a clear correlation between socioeconomic status and diet. Mental health disorders and suicide were increasing, and many young people suffered from violence and accidents. Finally, both relative and absolute poverty, perhaps the most important determinant of ill health, as recognized by the Regional Committee at previous sessions, was found throughout the European Region.

In action to protect and promote the health of children and adolescents, all eight Millennium Development Goals were relevant. In addition, the World Health Assembly had approved a global strategy for improving the health and development of children and adolescents with seven priorities: maternal and newborn health, nutrition, communicable diseases, injuries and violence, the physical environment, adolescent health, and psychosocial development and mental health. European work on the

strategy would highlight the last of those, as well as working for the health of mothers by discouraging alcohol and tobacco use and encouraging vaccination against rubella.

The action to take was clear: increasing the practical application of knowledge; ensuring action to improve health by all socioeconomic sectors, stimulated and coordinated by health ministries; and basing that action on the numerous evidence-based tools and proven programmes, many originated by WHO, that were already available. The Regional Office proposed a three-step process: the discussion at the present session; discussion of a summary of the planned chapter on the health of children and adolescents in the next European health report, and of the results of the Fourth Ministerial Conference on the Environment and Health, at the fifty-fourth session in 2004; and the possible adoption of a European strategy on the issue at the fifty-fifth session in 2005. Other events, such as the publication of the HBSC survey results and the 2005 conference on mental health, would feed into the work on the strategy.

Giving the views of the SCRC, one of its members, Professor Jenny Kourea-Kremastinou, welcomed the initiative. The interest in children's and young people's health raised by recent and forthcoming international conferences and reports, such as the Budapest Conference and the HBSC study, would create a good opportunity to consolidate the various initiatives under way. The content and aims of the document presented to the Regional Committee reflected the SCRC's deep concern about the subject. It rightly stressed the opportunities for better health for children and young people, as well as the threats faced between birth and the age of 18 years, and it called for action, based on readily available tools and programmes, through country strategies based on the seven priorities in the global strategy. The SCRC hoped that the document would stimulate discussion and lead to further developments.

Two invited speakers, representing partner organizations of WHO, addressed the Regional Committee. Dr Shahnaz Kianian-Firouzgar, Deputy Regional Director, UNICEF Regional Office for Central and Eastern Europe, Commonwealth of Independent States and the Baltic States, endorsed the call for a strategy for the Region. UNICEF strongly supported the principles underlying the Regional Office's initiative: children's right to health, as spelled out in the United Nations Convention on the Rights of the Child; a seven-point approach focusing on a multisectoral response; equity; securing adequate resources for services; and the importance of each country making its own strategy. Much of UNICEF's work in central and eastern Europe, the CIS and the Baltic states was carried out in cooperation with WHO and focused on such areas as reducing infant mortality, especially through immunization; tackling deficiency disorders; and preventing and managing HIV/AIDS in children and young people, in close cooperation with the United Nations Interagency Group on Young People's Health Development and Protection.

Dr Régine Meyer, Manager of Health Eastern Europe and Health Promotion, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), a WHO collaborating centre, welcomed the initiative to create a strategy for the health of children and adolescents, a subject of high priority in Germany and GTZ. Her organization was committed to helping WHO assist countries in improving people's health. GTZ's approach was based on children's and adolescents' right to health and on their active participation in planning and carrying out its activities. Integrated multisectoral approaches were needed to strengthen children's and young people's ability to develop health-promoting behaviour. Often in cooperation with WHO, GTZ carried out projects in countries on topics ranging from safe motherhood and the integrated management of childhood illnesses, school health, the prevention and management of risk behaviour, and cross-cutting topics such as gender equality, to work with adults to improve the environment in which young people lived.

All speakers from the floor welcomed the Regional Office initiative and stressed the importance of the topic, with several describing their own work in that area, often carried out with support from WHO. In particular, representatives of the five Nordic countries, supported by four subsequent speakers, fully supported the development of a well focused and clear strategy on children's and adolescents' health, with a strong emphasis on the health behaviour of adolescents and based on a non-discriminatory approach seeking equal access to health for children, according to legal standards in the United Nations Convention on the Rights of the Child. Improving children's and adolescents' health would be an important step towards achieving the Millennium Development Goals.

Those representatives and others suggested that the strategy should more strongly emphasize combating risk behaviour in adolescents, including obesity, smoking, alcohol and drug abuse, teenage pregnancies and sexually transmitted infections, notably HIV. Particularly useful tools in two of those areas would be the FCTC and the 2001 Declaration on Young People and Alcohol. Further research was needed into the determinants of and effective interventions against risky health behaviour; it would be appropriate for WHO to take the lead in that work.

Other representatives stressed the need for international cooperation, including cooperation with WHO headquarters, to implement a Region-wide strategy on children's and adolescents' health, and for cooperation within countries on such tasks as reducing infant and child mortality. Representatives mentioned the importance of involving young people as partners and agents of change.

Several speakers called for the strategy to specify the action that should be taken in areas such as sex education, to stress the importance of prevention through health education and to help countries create long- and short-term programmes, based on primary health care. Health maps would be a useful decision-making tool for Member States.

Additional topics suggested for the strategy included the prevention of road traffic accidents, low birth weight, the effects on children's behaviour of violence portrayed in the media, and mental and physical rehabilitation. Finally, the Minister of Health of Armenia suggested that WHO and other organizations should support an initiative to hold, in Armenia for CIS countries, a conference on children's and adolescents' health in the CIS, to encourage the exchange and pooling of information.

In reply, the Director, Division of Technical Support, Reducing Disease Burden, thanked the Member States for their constructive and clear guidance. The suggestions made had been carefully noted and would be further discussed with representatives at future sessions of the Regional Committee and in other settings as the work continued.

The Team Coordinator, Technical Support, Department of Child and Adolescent Health and Development, WHO headquarters, believed that the new global strategy was just the first step in the process of improvement. The next two were to make region-specific and then related national strategies. The European Region was to be congratulated for being the first to take such a step, and headquarters would assist the process. Finally, as emphasized by the Director-General, WHO's role was to set directions, mobilize resources and monitor action, but it should also work cross-sectorally with all possible partners.

Written statements were submitted by the following NGOs: the International Council for the Control of Iodine Deficiency Disorders, the International Lactation Consultant Association, the International League against Epilepsy, the Thalassaemia International Federation and the World Association of Girl Guides and Girl Scouts.

The Committee adopted resolution EUR/RC53/R7.

Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board (EUR/RC53/6)

Sir Liam Donaldson, a European member of the Executive Board, reviewed the main items discussed at the 112th session of the Board and the Fifty-sixth World Health Assembly. In accordance with common practice, he had been invited by the SCRC to attend its meetings as an observer and to report to the Regional Committee.

He emphasized the need to learn the lessons from the SARS outbreak, which posed a continuing threat, and he presented a checklist of questions for countries to answer in order to determine whether more

precautionary work was necessary. With regard to poliomyelitis, European Member States that had good contacts with the three countries where there were remaining pockets of the disease should encourage them to take the necessary steps to reach the goal of eradication. The adoption of the FCTC was a landmark. The European Region, with 15% of the world's population, carried a third of the global burden of tobacco-related disease and should throw its weight behind implementation of the Convention. Referring to evidence and experience showing that smoke-free policies for public places were effective and did not damage profits in the leisure industry, he proposed that the Region should take urgent action against passive smoking and take the lead in banning smoking from all public places.

The Board had adopted a resolution revising its Rules of Procedure, following the work of the Ad Hoc Open-ended Intergovernmental Working Group to Review the Working Methods of the Executive Board, chaired by Professor Thomas Zeltner. At its 112th session, Board members had agreed that the Health Assembly should improve its methods of discussion and have less recourse to working groups, which placed a burden on small delegations.

He suggested that, at its future sessions, the Regional Committee should consider the item on "Matters arising" earlier in its proceedings, in order to help to shape its work and to decide on follow-up on issues.

The Senior Adviser, Programme Management and Implementation, updated the Committee on budgetary matters. Full implementation of the regular budget for the financial period 2002–2003 was likely, but unfavourable exchange rates had been unhelpful. The forecasts for income from "Other sources" had proved to be accurate, although expenditure and donations received by the end of the year would determine the amount carried over to the next biennium.

The appropriation resolution for the financial period 2004–2005 (WHA56.32) implied severe pressure on the regular budget of the Regional Office. Although there had been an increase of US\$ 1.5 million, which would be injected into country operations, the approved budget was US\$ 2 million less than proposed, meaning that not all the activities planned for a proposed budget of US\$ 56.2 million could be done. The overall country allocation had been increased to US\$ 13.2 million, but the intercountry allocation remained fixed at US\$ 41 million – a freeze that, given the implementation of the new salary scale for staff, meant that the current pattern of staff funded from the regular budget could not be sustained. A number of contingency measures would have to be taken. At the same time, the Region awaited details of the decentralization of funding and human resources from headquarters, as the Director-General had pledged. She confirmed previous estimates that the Regional Office's unmet needs, mostly for investment in country operations, amounted to US\$ 115 million; with the approved programme budget estimating income from Other sources for 2004–2005 at US\$ 1824 million, the Regional Office's needs constituted only about 6% of that total. A fair and equitable distribution of WHO's extrabudgetary resources was essential.

World Health Assembly resolution WHA51.31 had introduced a model for regional allocations of the regular budget based on the UNDP human development index, with population statistics incorporated, and called for a thorough evaluation to be presented to the Fifty-seventh World Health Assembly. The Regional Office maintained that that evaluation should adequately consider what model should guide the distribution of WHO funds to its regions and how such a model should be implemented. Currently, transfers of funds met the criteria of the resolution, but the maximum reduction for any region of 3% per annum was not being fully implemented. She stressed that the evaluation of the model was, as stipulated by the resolution, "for the purpose of continuing response to health needs". The Regional Office wanted to know whether the model was the best possible one for distributing funds with that goal in mind and wished to see objective appraisals of other models that included all resources, not just the regular budget. The Regional Director had expressed his views in a letter to the Director-General elect in June 2003, asking for specific data, but that information had not been provided. The Regional Office considered that such information was vital to enable the governing bodies to take informed decisions.

The Regional Director welcomed Sir Liam's report as a link between the governing bodies and the Committee that was necessary for the work of one WHO. The proposed action on passive smoking could

be an outcome of the current session of the Committee and he would authorize the development of a proposal. Other decisions of the governing bodies, such as that on WHO's work towards the Millennium Development Goals, could similarly be taken up with a European specificity.

He said that European members of the Board needed to be aware of the problem with the regular budget. The economic reality of the Region was not recognized, especially given the tremendous changes since 1990. The Region's current share of the overall budget was inadequate and raised concerns about sustainability of programmes, and he urged the Board members to work to improve the recognition of its needs, including that for the distribution of voluntary donations.

Speakers agreed that the funds available should be shared in a fair and transparent way, although one representative commented on the different needs of each of the 52 Members and the fact that, given the uncertainty of extrabudgetary sources, some programmes could rely only on the regular budget. The slight net increase in budget allocation was welcome.

Strengthening work at country level was important, and the Nordic countries called for priorities such as health promotion and healthy lifestyles, including concerted follow-up to the European action plan on alcohol, to be accommodated. A review of work done by the European Commission in order to avoid duplication of efforts was suggested.

One speaker criticized the format and content of document EUR/RC53/6 and proposed that future such documents should include information on work executed or planned by the Regional Office, difficulties encountered, past experiences and points for discussion. Only resolutions relevant to the Region should be included in the document.

Under the agenda item, a statement was delivered by a representative of the World Confederation for Physical Therapy.

Elections and nominations

(EUR/RC53/5, /5 Corr.1 and /5 Corr.2)

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

Executive Board

The Committee decided following a secret ballot that Luxembourg and Romania would put forward their candidatures to the Health Assembly in May 2004 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee by secret ballot elected Austria, Denmark and Uzbekistan for membership of the SCRC for a three-year term of office from September 2003 to September 2006.

Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

In accordance with the provisions of paragraph 2.2.2 of the Memorandum of Understanding on the Special Programme, the Committee by consensus selected Georgia for membership of the Joint Coordinating Board for a three-year period from 1 January 2004.

Regional Search Group

The Committee by consensus selected:

Members:

Dr Ainura Ibraimova	Kyrgyzstan
Mrs Barbara Bitner	Poland
Professor José Martin-Moreno	Spain

Alternates:

Mr David Gunnarsson	Iceland
Dr Sergej Mikhajlovich Furgal	Russian Federation
Professor Sabahattin Aydin	Turkey

It consequently adopted resolution EUR/RC53/R5.

Future sessions of the Regional Committee in 2004 and 2005

(EUR/RC53/Conf.Doc./8 Rev.1)

The representatives of Romania, Estonia and Georgia all offered to host the fifty-fifth session of the Regional Committee in their respective countries.

The Committee adopted resolution EUR/RC53/R8.

Resolutions

EUR/RC53/R1

Membership of the Executive Board

The Regional Committee,

Mindful of the principle that all Member States in the European Region of WHO should have an equitable opportunity, over time, of participating in the work of the Executive Board;

Having considered the report of the subgroup established by the Standing Committee of the Regional Committee to evaluate current arrangements in the European Region of WHO with regard to membership of the Executive Board, as contained in Annex 2 to the Standing Committee's report (document EUR/RC53/4);

Noting that the Standing Committee has fully endorsed the whole set of recommendations made by the subgroup;

1. URGES those Member States that have not yet done so to ratify the amendments to Articles 24 and 25 of the WHO Constitution, which *inter alia* would give the European Region an eighth seat on the Board;
2. RECOMMENDS that, as from 2004, the criteria regarding the Member State and regarding the candidate and the geographic groupings, as proposed by the Standing Committee's subgroup in Annex 2 of document EUR/RC53/4 and annexed to this resolution, should be applied when selecting Member States in the European Region of WHO to submit candidatures for membership of the Board;
3. FURTHER RECOMMENDS that, as from 2006, the periodicity of Board membership for those Member States in the European Region of WHO that are permanent members of the United Nations Security Council should be extended to three out of six years;
4. CALLS ON Member States to take account of the guidelines contained in paragraph 15 of Annex 2 to the Standing Committee's report when designating persons to serve on the Board;
5. REQUESTS the Standing Committee to assess the experience gained in implementing the above recommendations and to report its findings to the Regional Committee at its sixtieth session in 2010.

Annex

Criteria for membership of the Executive Board

Objective criteria for selection of Member States

1. The Member State entitled to designate a person to serve on the Board should appoint a person technically qualified in the field of health, as spelled out in Article 24 of the WHO Constitution;
2. Previous representation on the Board:
 - Country never represented on the Board (although a member of WHO before 1991)
 - Country represented on the Board more than 20 years ago;

3. No country should be a member of the Board and the SCRC at the same time;
4. Having already been a member of the SCRC is an asset;
5. Having ratified amendments to Articles 24 and 25 of the WHO Constitution should be taken into consideration.

Criteria regarding the candidate

The following guidelines are proposed to Member States for the selection of candidates:

- (a) current position in the health administration in his/her country (or the position held in the near past) close to the political decision-making level;
- (b) experience of working with international organizations, WHO or other United Nations organizations;
- (c) ability to collaborate, coordinate and communicate within the country and between the countries;
- (d) experience of coordinating high-level political and/or technical programmes, nationally (interregional, interministerial) or internationally (bilateral or intercountry);
- (e) availability and commitment;
- (f) gender (female candidates encouraged).

Geographic groupings

- I. Member countries of the European Union (EU) and the European Free Trade Association (EFTA) and southern European countries: 32 countries (5 seats)

EU: 26 countries

EFTA + southern European countries:

Iceland, Norway, Switzerland, Andorra, Monaco, San Marino

Divided into two subgroups:

“North”

Belgium, Czech Republic, Denmark, Estonia, Finland, Germany, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Slovakia, Sweden, United Kingdom

“South”

Andorra, Austria, Croatia, Cyprus, France, Greece, Hungary, Italy, Malta, Monaco, Portugal, San Marino, Slovenia, Spain, Switzerland

- II. Commonwealth of Independent States (CIS) + “South-East”: 20 countries (2 seats)

Divided into two subgroups:

CIS

Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan

“South-East”

Albania, Bosnia and Herzegovina, Bulgaria, Israel, Romania, Serbia and Montenegro, The former Yugoslav Republic of Macedonia, Turkey

EUR/RC53/R2**Progress in implementing the WHO Regional Office for Europe's Country Strategy
"Matching services to new needs"**

The Regional Committee,

Recalling its previous resolutions on cooperation with countries, in particular resolution EUR/RC50/R5, and the principles outlined in the WHO Country Focus Initiative;

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

Having reviewed the WHO Regional Office for Europe's report on progress achieved in implementation of its Country Strategy, "Matching services to new needs", as contained in document EUR/RC53/10;

1. AGREES that:
 - a) progress is being made by the Regional Office in its efforts to improve the quality of services and tailor them to the health needs of Member States;
 - b) the Country Strategy approved at the fiftieth session should be further pursued by the Regional Office through the specific services provided to individual countries or groups of countries;
 - c) Member States should support the Regional Office in further developing and implementing the European Country Strategy;
2. REQUESTS the Regional Director:
 - (a) to continue initiatives that facilitate implementation of the European Country Strategy as described in document EUR/RC53/10; and
 - (b) to report back to the Regional Committee at its fifty-fourth session on the impact of implementation of the Country Strategy on working with countries in the European Region, based on short specific reports from the country offices concerned.

EUR/RC53/R3**Update of the regional Health for All (HFA) policy framework**

The Regional Committee,

Recalling its resolution EUR/RC48/R5 agreeing that the next update of the regional HFA policy framework should be submitted to it in 2005;

Having reviewed the proposed methodology for updating the regional HFA policy framework, as contained in document EUR/RC53/8;

1. AGREES that:

- a) the update should strike a balance between ensuring the continuity of HEALTH21, as it is only five years since its adoption, and incorporating changes that take into account the new knowledge in public health and recent developments in European health systems;
- b) the core of the update should emphasize knowledge-based public health policies and strategies, and the ethics of health systems, as recommended by the Standing Committee of the Regional Committee subgroup on bioethics in its report to the fifty-second session of the Regional Committee in 2002 (document EUR/RC52/3, Annex 2) and by the Standing Committee of the Regional Committee in its report to the fifty-third session (document EUR/RC53/4, page 3, paragraph 13);
- c) the update should be based on four pillars: (i) implementation of HEALTH21 and lessons learnt; (ii) review and update of values; (iii) from ethics to policy and action: tools for decision-making; and (iv) guidelines for Member States;
- d) the updating process should be carried out in consultation with Member States and with experts from outside the Organization, for example a “think-tank” on values, and from within the Organization, in particular the European Observatory on Health Care Systems and the WHO Barcelona Office;

2. REQUESTS the Regional Director:

- a) to continue the updating process as described in document EUR/RC53/8;
- b) to consult with Member States;
- c) to report on progress made to the Regional Committee at its fifty-fourth session; and
- d) to submit a final update for adoption by the Regional Committee at its fifty-fifth session in 2005.

EUR/RC53/R4

Mental health in WHO's European Region

The Regional Committee,

Welcoming the fact that, since the adoption of resolution EUR/RC51/R5 on the Athens Declaration on Mental Health and Man-Made Disasters, Stigma and Community Care at its fifty-first session, mental health has been increasingly addressed by Member States and is more and more being accepted as a priority in promoting better health and reducing the burden of disease;

Concerned at the increasing evidence, most recently in *The world health report 2002*, that the disease burden from mental disorders in Europe is nonetheless not diminishing;

Having reviewed document EUR/RC53/7;

1. REQUESTS the Regional Director, when organizing and implementing activities concerning the update of the Health for All policy, to give high priority to mental health issues in the European Region of WHO;
2. REQUESTS the Regional Director to arrange a Ministerial Conference on Mental Health in Europe in Helsinki, Finland in January 2005;

3. DECIDES:

- a) that the theme of the Conference will be “Facing the challenges – building solutions”;
- b) that the scope and purpose of the Conference will be:
 - to review the status of mental ill health in Europe and of policies for tackling this problem, taking account of regional and local diversities and the needs stemming from them;
 - to explore the settings and age groups in which mental health and inclusion should be promoted and mental ill health addressed, such as schools, workplaces and health services;
 - to identify the barriers to the promotion of mental health and the prevention and treatment of mental ill health in communities and individuals, especially those who have little or no access to health care, work or education;
 - to suggest evidence-based solutions that could be shaped into common and sustainable policies, setting a priority agenda for European Member States; and
 - to develop an action plan that provides policy recommendations to Member States and WHO;
- c) that the participants in the Conference should be ministers of health, mental health counterparts, representatives of users’ and family organizations and professionals from all European Member States;
- d) that the outcome of the Conference will be the Helsinki Mental Health Action Plan for Europe, setting out common and sustainable policy recommendations in the context of a priority agenda within a specific time frame and calling for initiatives to be supported by the WHO Regional Office for Europe over the years to come.

EUR/RC53/R5**Appointment of a Regional Search Group**

The Regional Committee,

Pursuant to Rule 47 of its Rules of Procedure;

1. APPOINTS a Regional Search Group composed of the following members and alternates:

Members:

Dr Ainura Ibraimova (Kyrgyzstan)
 Mrs Barbara Bitner (Poland)
 Professor José Martin-Moreno (Spain)

Alternates:

Mr David Gunnarsson (Iceland)
 Dr Sergej Mikhajlovich Furgal (Russian Federation)
 Professor Sabahattin Aydin (Turkey)

2. REQUESTS the Regional Search Group to carry out its work according to the Rules of Procedure of the Regional Committee and other criteria laid down in document EUR/RC53/Inf.Doc./2, and to report on its work to the Regional Committee at its fifty-fourth session.

EUR/RC53/R6**Report of the Tenth Standing Committee of the Regional Committee**

The Regional Committee,

Having reviewed the report of the Tenth Standing Committee of the Regional Committee (documents EUR/RC53/4 and EUR/RC53/4 Add.1);

Noting the decisions taken through resolution EUR/RC53/R1 on membership of the Executive Board;

1. ADOPTS the report, together with the conclusions and proposals contained therein;
2. REQUESTS the Regional Director to take action, as appropriate, on those conclusions and proposals.

EUR/RC53/R7**The health of children and adolescents in WHO's European Region**

The Regional Committee,

Recalling the World Health Assembly's resolution WHA56.21 on the strategy for child and adolescent health;

Recognizing the right of children and adolescents to the highest attainable standard of health and access to health care, as set forth in internationally agreed human rights instruments;

Recognizing that the future health and prosperity of the Region will be determined to a large extent by the investments made in the children and adolescents of today;

Acknowledging that healthy children are more likely to become healthy adults and that in turn healthy adults are assets in the creation of a more socially and economically productive society, and will make fewer demands upon the health system;

Conscious of the fact that health is determined by the physical, economic, social, family and educational environment, as well as by the quality of health care provision, and that children and adolescents need a supportive environment in which to grow and develop into healthy young adults;

Mindful of the many threats to the health of children and adolescents, from which no society, rich or poor, is immune;

Welcoming the comprehensive efforts already made by the specialized agencies of the United Nations system to improve the health of children and adolescents;

Having reviewed document EUR/RC53/11;

1. URGES Member States to give high priority to making improvements in children's and adolescents' health and development, including physical activity and mental health, through advocacy at the highest level, scaling up programmes, increasing the allocation of national resources, creating partnerships and ensuring sustained political commitment;
2. REQUESTS the Regional Director:

- a) to continue the process of preparing a comprehensive European strategy on the health of children and adolescents, in collaboration with Member States, and to present it to the Regional Committee at its fifty-fifth session;
- b) to ensure that the outcomes of the Fourth Ministerial Conference on Environment and Health (Budapest, 23–25 June 2004) and the special section on the health of children and adolescents in The European health report 2005 are taken fully into account during that process.

EUR/RC53/R8

Date and place of regular sessions of the Regional Committee in 2004 and 2005

The Regional Committee,

Having reviewed the decision taken at its fifty-second session, as expressed by resolution EUR/RC52/R5;

1. CONFIRMS that the fifty-fourth session shall be held at the Regional Office for Europe in Copenhagen from 6 to 9 September 2004;
2. DECIDES that the fifty-fifth session shall be held from 12 to 15 September 2005;
3. GRATEFULLY ACKNOWLEDGES the proposals made by Estonia, Georgia and Romania to host the fifty-fifth session of the Regional Committee;
4. REQUESTS the Regional Director to discuss with these Member States with a view to enabling the Regional Committee to take a final decision on the location of the fifty-fifth session at its fifty-fourth session;
5. DECIDES that, in the event that no Member State is in a position to commit itself to hosting the fifty-fifth session by 30 November 2003, such session will be held at the Regional Office for Europe in Copenhagen.

*Annex 1***Agenda**

- 1. Opening of the session**
 - (a) Election of the President, the Executive President, the Deputy Executive President and the Rapporteur
 - (b) Adoption of the agenda and programme of work
- 2. Address by the Director-General**
- 3. Address by the Regional Director, including:**
 - Annual report of the European Environment and Health Committee
- 4. Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board**
- 5. Report of the Tenth Standing Committee of the Regional Committee, including:**
 - report of the evaluation of current arrangements for membership of the Executive Board
 - follow-up to the external evaluation of the Regional Office's health care reform programmes
- 6. Policy and technical items**
 - (a) Mental health in WHO's European Region
 - (b) The health of children and adolescents in WHO's European Region
 - (c) Update of the regional Health for All (HFA) policy framework
 - (d) The Regional Office's Country Strategy
 - (e) Strategic orientations of the Regional Office's work with geographically dispersed organizational entities, including WHO country offices
- 7. Elections and 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
 - (d) Appointment of a Regional Search Group
- 8. Future sessions of the Regional Committee in 2004 and 2005**
- 9. Other matters**
- 10. Approval of the report and closure of the fifty-third session**

<p style="text-align: center;">Technical briefing on "Challenges for the Austrian health system" organized by the Ministry of Health and Women, Austria.</p>

*Annex 2***List of documents****Working documents**

EUR/RC53/1 Rev.1	List of documents
EUR/RC53/2 Rev.1	Provisional agenda
EUR/RC53/3 Rev.1	Provisional programme
EUR/RC53/4	Report of the Tenth Standing Committee of the Regional Committee
EUR/RC53/4 Add.1	Report of the fifth session of the Tenth Standing Committee of the Regional Committee
EUR/RC53/5	Membership of WHO bodies and committees
EUR/RC53/5 Corr.1	Membership of WHO bodies and committees
EUR/RC53/5 Corr.2	Membership of WHO bodies and committees
EUR/RC53/6	Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC53/7	Mental health in WHO's European Region
EUR/RC53/8	Update of the regional Health for All (HFA) policy framework
EUR/RC53/9	Strategic orientations of the Regional Office's work with geographically dispersed organizational entities, including WHO country offices
EUR/RC53/10	Progress report on implementation of the WHO Regional Office for Europe's Country Strategy since 2000
EUR/RC53/11	The health of children and adolescents in WHO's European Region

Conference documents

EUR/RC53/Conf.Doc./1	Report of the Tenth Standing Committee of the Regional Committee
EUR/RC53/Conf.Doc./2	Mental health in WHO's European Region
EUR/RC53/Conf.Doc./3 Rev.1	Update of the regional Health for All (HFA) policy framework
EUR/RC53/Conf.Doc./4	Strategic orientations of the Regional Office's work with geographically dispersed organizational entities, including WHO country offices
EUR/RC53/Conf.Doc./5	Progress in implementing the WHO Regional Office for Europe's Country Strategy "Matching services to new needs"
EUR/RC53/Conf.Doc./6	The health of children and adolescents in WHO's European Region
EUR/RC53/Conf.Doc./7	Appointment of a Regional Search Group
EUR/RC53/Conf.Doc./8 Rev.1	Date and place of regular sessions of the Regional Committee in 2004 and 2005
EUR/RC53/Conf.Doc./9	Membership of the Executive Board

Information documents

EUR/RC53/Inf.Doc./1	Annual report of the European Environment and Health Committee (EEHC)
EUR/RC53/Inf.Doc./2	Appointment of a Regional Search Group

*Annex 3***List of representatives and other participants****I. Member States****Albania**

Representative Dr Eduart Hashorva
Deputy Minister of Health

Andorra

Representatives Mrs Montserrat Camps Gallart
Secretary of State for Health, Ministry of Health and Welfare

Dr Margarida Coll Armangué
Head, Epidemiological Surveillance Unit, Ministry of Health and Welfare

Armenia

Representative Dr Norayr Davidyan
Minister of Health

Adviser Dr Haik Grigorian
Head, International Relations Department, Ministry of Health

Austria

Representatives Maria Rauch-Kallat
Federal Minister for Health and Women

Professor Dr Reinhart Waneck
State Secretary for Health, Federal Ministry for Health and Women

Alternates Dr Clemens Auer
Head, Office of the Federal Minister, Federal Ministry for Health and Women

Dr Hubert Hrabcik
Director-General of Public Health, Federal Ministry for Health and Women

Advisers Volker Hammer
Head, Office of the State Secretary, Federal Ministry for Health and Women

Dr Franz Pietsch
Deputy Director-General of Public Health, Federal Ministry for Health and Women

Professor Dr Robert Schlögel
Deputy Director-General of Public Health, Federal Ministry for Health and Women

Dr Verena Gregorich-Schega
Head, International Health Relations, Federal Ministry for Health and Women

Dr Hubert Hartl
Head, Preventative Care and Health Promotion, Federal Ministry for Health and Women

Dr Thomas M. Buchsbaum
Director, Division for Health Policy, Federal Ministry for Foreign Affairs

Dr Elke Atzler
Deputy Head of Mission, Permanent Mission of Austria to the United Nations Office and other international organizations at Geneva

Edda Strohmayr
Deputy Head, International Health Relations, Federal Ministry for Health and Women

Professor Dr Heinz Katschnig
Chair, University Clinic for Psychiatry, Faculty of Medicine, University of Vienna

Professor Dr Michael Kunze
Chair, Institute of Social Medicine, Faculty of Medicine, University of Vienna

Secretaries

Mag. Christoph Hörhan
Office of the Federal Minister, Federal Ministry for Health and Women

Mag. Florian Pressl
Office of the Federal Minister, Federal Ministry for Health and Women

Mag. Daniela Reczek
Office of the Federal Minister, Federal Ministry for Health and Women

MMag. Christina Cerne
Office of the State Secretary, Federal Ministry for Health and Women

Martin Glier
Office of the State Secretary, Federal Ministry for Health and Women

Mag. Gero Stuller
Office of the State Secretary, Federal Ministry for Health and Women

Mag. Raphael Bayer
International Health Relations, Federal Ministry for Health and Women

Mag. (FH) Michael Oberdünhofen
International Health Relations, Federal Ministry for Health and Women

Mag. Rupert Weinmann
Division for Health Policy, Federal Ministry for Foreign Affairs

Ursula Dlouhy
International Health Relations, Federal Ministry for Health and Women

Outi Isotalo
International Health Relations, Federal Ministry for Health and Women

Anita Schinko
International Health Relations, Federal Ministry for Health and Women

Roland Dietrich
Federal Ministry for Health and Women

Azerbaijan

Representatives Professor Ali Binat-ogly Insanov
Minister of Health

Dr Alexander Umnyashkin
Head, International Relations Department, Ministry of Health

Belarus

Representative Dr Liudmila Andreevna Postoyalko
Minister of Health

Belgium

Representatives Dr Godfried Thiers
Director, Louis Pasteur Public Health Research Institute

Mr Alfred Berwaerts
Director-General, International Relations, Federal Public Service for Public Health, Food Safety and the Environment

Alternate Mrs Machteld Wauters
Department of Health, Ministry of the Flemish Community

Advisers Mrs Leen Meulenbergs
Expert, Federal Public Service for Public Health, Food Safety and the Environment

Mr Jean-Cédric Janssens de Bisthoven
First Secretary, Embassy of Belgium in Vienna

Mr Mathias Bogaert
Third Secretary, Embassy of Belgium in Vienna

Bosnia and Herzegovina

Representatives

Dr Safet Halilović
Minister of Civil Affairs, Federation of Bosnia and Herzegovina

Mrs Amira Kapetanović
Ambassador, Permanent Representative of Bosnia and Herzegovina to the
United Nations Office and other international organizations at Vienna

Alternates

Dr Marin Kvaternik
Minister of Health and Social Welfare, Republika Srpska

Mr Tomo Lučić
Minister of Health, Federation of Bosnia and Herzegovina

Advisers

Professor Žarko Pavić
Coordinator of WHO programmes, Ministry of Health and Social Welfare,
Republika Srpska

Dr Bakir Nakaš
Member, Advisory Board of Bosnia and Herzegovina for HIV/AIDS

Ms Nada Janković
Counsellor to the Minister, Permanent Mission of Bosnia and Herzegovina to
the United Nations Office and other international organizations at Vienna

Mrs Aida Durić
Ministry of Civil Affairs of Bosnia and Herzegovina

Secretary

Mrs Stela Vasić
Embassy of Bosnia and Herzegovina in Vienna

Bulgaria

Representatives

Dr Petko Salchev
Deputy Minister of Health

Ms Romyana Toshkova
Senior Expert, Ministry of Health

Alternate

Ms Iskra Angelova
Expert, Ministry of Foreign Affairs

Croatia

<i>Representative</i>	Professor Marija Strnad Pesikan Institute of Public Health
<i>Alternates</i>	Dr Andro Vlahušić Minister of Health Mr Dražen Vukov Colić Ambassador of the Republic of Croatia to Austria
<i>Adviser</i>	Ms Karmen Klemente Head, Minister's Office, Ministry of Health

Cyprus

<i>Representatives</i>	Mrs Constantia Akkelidou Minister of Health Dr Charitini Komodiki Chief Health Officer, Ministry of Health
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Czech Republic

<i>Representative</i>	Dr Marie Součková Minister of Health
<i>Alternates</i>	Mr Pavel Vacek Ambassador, Permanent Representative of the Czech Republic to the United Nations Office and other international organizations at Vienna Dr Milan Špaček Vice-Minister, Health Care and International Relations, Ministry of Health Dr Anna Olšanská Director, Department of International Relations and European Integration, Ministry of Health Mr Jaroslav Štěpánek Counsellor, Permanent Mission of the Czech Republic to the United Nations Office and other international organizations at Vienna
<i>Adviser</i>	Professor Bohumil Fišer Head, Physiology Institute, Masaryk University

Denmark

<i>Representatives</i>	Mr Lars Løkke Rasmussen Minister of the Interior and Health
	Dr Jens Kristian Gøtrik Director-General and Chief Medical Officer, National Board of Health
<i>Alternate</i>	Mr Mogens Jørgensen Head of Division, Ministry of the Interior and Health
<i>Advisers</i>	Ms Marianne Kristensen Senior Adviser, National Board of Health
	Ms Karen Worm Head of Section, Ministry of the Interior and Health
	Mr Kåre Geil Personal Secretary to the Minister of the Interior and Health

Estonia

<i>Representatives</i>	Mr Marko Pomerants Minister of Social Affairs
	Mrs Katrin Saluvere Deputy Secretary-General for Health Policy, Ministry of Social Affairs
<i>Alternate</i>	Mr Ain Aaviksoo Head, Public Health Department, Ministry of Social Affairs

Finland

<i>Representatives</i>	Dr Kimmo A.E. Leppo Director-General, Department of Health, Ministry of Social Affairs and Health
	Ms Liisa Ollila Ministerial Adviser and Head of Section, International Affairs Unit, Ministry of Social Affairs and Health
<i>Alternates</i>	Dr Merja Saarinen Ministerial Counsellor, Health/Medical Affairs, Ministry of Social Affairs and Health
	Mr Sakari Lankinen Ministerial Counsellor, Health/Medical Affairs, Ministry of Social Affairs and Health
<i>Advisers</i>	Ms Kristiina Haikio Counsellor, Permanent Mission of Finland to the United Nations Office and

other international organizations at Geneva
Dr Jarrko Eskola
Consultant, Ministry of Social Affairs and Health

Dr Juha Teperi
Director of Division, National Research and Development Centre for Welfare and Health

France

Representatives Mr Patrick Villemur
Ambassador, Permanent Representative of France to the United Nations Office and other international organizations at Vienna

Dr Jean-Baptiste Brunet
Director, International Relations, Ministry of Health, the Family and the Disabled

Alternate Mrs Catherine Feuillet
Adviser, Ministry of Foreign Affairs

Advisers Mrs Isabelle Virem
Adviser to the Directorate-General, Ministry of Health, the Family and the Disabled

Mr Alain Guepratte
Foreign affairs adviser, Permanent Mission of France to the United Nations Office and other international organizations at Vienna

Georgia

Representative Dr Amiran Gamkrelidze
Minister of Labour, Health and Social Affairs

Germany

Representatives Susanne Weber-Mosdorf
Director, European and International Health and Social Policy, Federal Ministry of Health and Social Security

Udo Scholten
Head of Division, International Health and Social Policy, Federal Ministry of Health and Social Security

Alternates Thomas Hofmann
Head of Section E2I, Multilateral Cooperation in the Field of Health, Federal Ministry of Health and Social Security

Dr Ingo von Voss
Counsellor, Permanent Mission of the Federal Republic of Germany to the
United Nations Office and other international organizations at Geneva

Dr Christian Luetkens
Head, Division of Prevention, Health Promotion and Epidemiology, Hessian
Ministry of Social Affairs

Helene Reemann
Head of Section, Federal Centre for Health Education

Dr Assia Brandrup-Lukanow
Head of Department, German Agency for Technical Cooperation (GTZ)

Dr Christoph Beier
Head, Planning and Development, German Agency for Technical Cooperation
(GTZ)

Dr Regine Meyer
Manager, Eastern Europe, CIS and Latin America, German Agency for
Technical Cooperation (GTZ)

Greece

Representatives

Mr Ektor Nasiokas
Deputy Minister of Health and Welfare

Professor Jenny Kourea-Kremastinou
Dean, National School of Public Health

Advisers

Dr Meropi Violaki-Paraskeva
Honorary Director-General of Health

Dr Athanassios Constantopoulos
Director, Mental Health Centre, Regional General Hospital of Athens

Dr Alexander Botsis
Adviser to the Minister, Ministry of Health and Welfare

Secretary

Mrs Dionysia Dapada
International Relations Division, Ministry of Health and Welfare

Hungary

Representatives

Ms Zsuzsanna Jakab
Permanent Secretary of State, Ministry of Health, Social and Family Affairs

Dr Tivador Tulassay
Rector, Semmelweis University

Alternate Ms Katalin Novák
Head, Department for International Cooperation and Coordination of
European Integration, Ministry of Health, Social and Family Affairs

Adviser Dr János Annus
Senior Adviser, Ministry of Health, Social and Family Affairs

Iceland

Representatives Mr David Á. Gunnarsson
Permanent Secretary, Ministry of Health and Social Security

Mr Ingimar Einarsson
Head of Department, Ministry of Health and Social Security

Alternate Mr Sigurdur Gudmundsson
Medical Director of Health, Directorate of Health

Advisers Mrs Vilborg Ingolfsdottir
Chief Nurse, Head of Division, Directorate of Health

Mr Helgi Mar Arthursson
Information Officer, Ministry of Health and Social Security

Ms Asthildur Knutsdottir
Adviser, Permanent Mission of Iceland to the United Nations Office and other
international organizations at Geneva

Ireland

Representatives Dr James Kiely
Chief Medical Officer, Department of Health and Children

Mr Colm Keenan
Principal Officer, International Unit, Department of Health and Children

Israel

Representatives Mr Yair Amikam
Deputy Director-General for Information and International Relations,
Ministry of Health

Dr Yitzhak Sever
Director, Department of International Relations, Ministry of Health

Italy*Representatives*

Dr Francesco Cicogna
Senior Medical Officer, Directorate for International Relations and
Community Policies, Ministry of Health

Mrs Natalia Quintavalle
First Counsellor, Permanent Mission of Italy to the United Nations Office and
other international organizations at Geneva

Alternate

Professor Giancarlo Majori
Director, Laboratory of Parasitology, National Institute of Health

Kazakhstan*Representative*

Dr Saule Dikanbayeva
Deputy Minister of Health

Alternates

Mrs Aigul Kuspan
Counsellor, Embassy of Kazakhstan in Vienna

Mr Yermukhambet Konuspayev
Attaché, Embassy of Kazakhstan in Vienna

Kyrgyzstan*Representative*

Professor Mitalip Mamytovich Mamytov
Minister of Health

Alternates

Dr Ainura Ibraimova
Deputy Minister of Health

Dr Boris Ivanovich Dimitrov
Head, Department of External Relations, Ministry of Health

Latvia*Representatives*

Ms Ingrida Circene
Minister of Health

Mr Viktors Jaksons
Former Minister of Welfare

Lithuania*Representatives*

Dr Juozas Olekas
Minister of Health

Ms Romalda Baranauskiene
Under-Secretary, Ministry of Health

Alternate

Mr Viktoras Meižis
Head, Division of Foreign Affairs and European Integration, Ministry of Health

Luxembourg

Representatives

Mr A. Berns
Ambassador, Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office and other international organizations in Geneva

Dr Danielle Hansen-Koenig
Director of Health

Alternate

Mrs Aline Schleder-Leuck
Principal Executive Adviser, Ministry of Health

Malta

Representatives

Dr Louis Deguara
Minister of Health

Dr Noel Buttigieg-Scicluna
Ambassador, Permanent Representative of Malta to the United Nations and other international organizations at Vienna

Alternates

Dr Ray Busuttil
Director-General for Health, Ministry of Health

Dr Karen Vincenti
Principal Medical Officer, Office of the Director-General for Health, Ministry of Health

Dr John Paul Grech
Counsellor, Permanent Mission of Malta to the United Nations Office and other international organizations at Vienna

Advisers

Dr Anthony Vella
Permanent Secretary, Ministry of Health

Mr Saviour Gambin
Personal Assistant to the Minister of Health

Monaco

Representatives Dr Anne Nègre
Director, Health and Social Work, Department of the Interior, Ministry of State

Mrs Carole Lanteri
First Secretary, Permanent Mission of the Principality of Monaco to the United Nations Office and other international organizations at Geneva

Netherlands

Representatives Mr Hans de Goeij
Director-General, Ministry of Health, Welfare and Sport

Mrs Annemiek van Bolhuis
Director, International Affairs Division, Ministry of Health, Welfare and Sport

Alternates Ms Monique A.C.M. Middelhoff
First Secretary, Permanent Mission of the Kingdom of the Netherlands to the United Nations Office and other international organizations at Geneva

Mr Lejo van der Heiden
Coordinator, Global Unit, International Affairs, Ministry of Health, Welfare and Sport

Norway

Representatives Ms Anne Kari Lande Hasle
Secretary-General, Ministry of Health

Mr Sveinung Røren
Deputy Director-General, Ministry of Health

Alternates Dr Tharald Hetland
Senior Adviser, Ministry of Health

Ms Eldrid Røine
Adviser, Ministry of Health

Advisers Ms Hilde Marie Rognlie
Senior Adviser, Ministry of Health

Mr Dag Rekve
Senior Adviser, Ministry of Social Affairs

Ms Mari Trommald
Director, Directorate for Health and Social Affairs

Mr Jens Guslund
Director, Directorate for Health and Social Affairs

Ms Turid Kongsvik
Counsellor, Permanent Mission of Norway to the United Nations Office and
other international organizations at Geneva

Poland

Representatives

Dr Wiktor Masłowski
Under-Secretary of State, Ministry of Health

Professor Jerzy Szczerbań
Chairman, Scientific Advisory Council to the Minister of Health

Alternate

Ms Barbara Bitner
Director, Department of European Integration and International Relations,
Ministry of Health

Portugal

Representatives

Professor José Pereira Miguel
Director-General and High Commissioner of Health, Ministry of Health

Dr Aldino Salgado
Board member, Institute for Financial Management in the Health Sector,
Ministry of Health

Alternate

Mr Paulo Barcia
Health Attaché, Permanent Mission of Portugal to the United Nations Office
and other international organizations at Geneva

Republic of Moldova

Representatives

Dr Andrei Gherman
Minister of Health

Mrs Natalia Gherman
Ambassador, Permanent Representative of the Republic of Moldova to the
Organization for Security and Co-operation in Europe (OSCE) at Vienna

Alternate

Dr Silviu Domente
Head, Foreign Relations Division, Ministry of Health

Romania

Representatives

Dr Vasile Cepoi
Secretary of State, Ministry of Health

Dr Radu Constantiniu
Director-General, European Integration and International Relations, Ministry
of Health

Russian Federation

Representative

Dr Sergei Furgal
Director, Department of International Cooperation, Ministry of Health

Advisers

Dr Anatoly V. Pavlov
Deputy Director, Department of International Cooperation, Ministry of Health

Mr Vladimir Zimyanin
Chief Adviser, Department for International Organizations, Ministry of
Foreign Affairs

Dr Yuri Mshensky
Counsellor, Permanent Mission of the Russian Federation to the United
Nations Office and other international organizations at Vienna

Mr Dmitri Tokin
Second Secretary, Permanent Mission of the Russian Federation to the United
Nations Office and other international organizations at Vienna

Mr Konstantin Voronin
Counsellor, Embassy of the Russian Federation in Vienna

San Marino

Representative

Mrs Federica Bigi
Ambassador, Permanent Representative of the Republic of San Marino to the
United Nations Office and other international organizations at Geneva

Serbia and Montenegro

Representatives

Professor Miodrag Pavličić
Minister of Health of the Republic of Montenegro

Mr Branislav Milinković
Ambassador, Permanent Representative of Serbia and Montenegro to the
OSCE at Vienna

Alternates

Dr Snežana Simić
Deputy Minister of Health of the Republic of Serbia

Ms Slobodanka Krivokapić
Deputy Minister of Health of the Republic of Montenegro

Mr Jovica Čekić
Counsellor, Permanent Mission of Serbia and Montenegro to the OSCE at
Vienna

Slovakia

Representatives

Dr Rudolf Zajac
Minister of Health

Dr Svätopluk Hlavačka
Ministry of Health

Alternates

Dr Andrej Mayer
Ministry of Health

Dr Kvetoslava Prúhová
Ministry of Health

Advisers

Dr Alexandra Novotná
Ministry of Health

Mrs Zuzana Červená
Magister, Ministry of Health

Slovenia

Representatives

Professor Dušan Keber
Minister of Health

Dr Ernest Petrič
Ambassador of the Republic of Slovenia in Austria

Alternates

Dr Jožica Maučec Zakotnik
State Secretary, Health Promotion, Ministry of Health

Dr Andrej Marušič
Director, Institute of Public Health

Advisers

Dr Vesna-Kerstin Petrič
Adviser to the Minister of Health

Mr Goran Križ
First Secretary, Embassy of the Republic of Slovenia in Austria

Ms Barbara Kremžar
Attaché, Embassy of the Republic of Slovenia in Austria

Spain

<i>Representatives</i>	Professor José M. Martín Moreno Director-General of Public Health, Ministry of Health and Consumer Affairs
	Dr Paloma Alonso Cuesta Deputy Director-General, International Relations, Ministry of Health and Consumer Affairs
<i>Alternate</i>	Mr Julio Fernandez Torrejon Embassy of Spain in Vienna
<i>Advisers</i>	Mrs Ana Clavería Fontan Technical Adviser to the Minister of Health and Consumer Affairs
	Dr Patricia Crespo Gonzalez Ministry of Health and Consumer Affairs

Sweden

<i>Representative</i>	Mrs Kerstin Wigzell Director-General, National Board of Health and Welfare
<i>Alternates</i>	Ms Cecilia Halle Desk Officer, Ministry of Health and Social Affairs
	Ms Birgitta Schmidt Administrative Director, National Board of Health and Welfare
	Mr Bo Pettersson Deputy Director-General, National Institute of Public Health
	Mr Bengt Rönngren Desk Officer, Ministry of Health and Social Affairs
	Ms Margareta Carlberg Programme Manager, National Board of Health and Welfare
<i>Adviser</i>	Mr Thomas Rostock Senior Adviser, Federation of County Councils

Switzerland

<i>Representatives</i>	Professor Thomas Zeltner Director, Federal Office of Public Health
	Alice Scherrer-Baumann President, Health Directorate, Conference of Directors of Public Health
<i>Alternates</i>	Dr Gaudenz Silberschmidt Head, International Relations, Federal Office of Public Health

Franz Wyss
Central Secretary, Conference of Directors of Public Health

Adviser Dr Stephanie Zobrist
Acting Head, International Relations, Federal Office of Public Health

Tajikistan

Representative Professor Nusratullo Faizullaev
Minister of Health

The former Yugoslav Republic of Macedonia

Representatives Dr Rexhep Selmani
Minister of Health

Mrs Snezana Cicevalieva
Head, Sector for European Integration and International Cooperation, Ministry of Health

Alternates Mr Aleksander Tavciovski
Permanent Representative of The former Yugoslav Republic of Macedonia to the OSCE at Vienna

Mr Zoran Todorov
Second Secretary, Permanent Mission of The former Yugoslav Republic of Macedonia to the OSCE at Vienna

Turkey

Representatives Dr Recep Akdağ
Minister of Health

Professor Necdet Ünüvar
Under-Secretary, Ministry of Health

Alternates Professor Sabahattin Aydın
Deputy Under-Secretary, Ministry of Health

Mr Kamuran Özden
Head, Department of External Relations, Ministry of Health

Mr Namik Güner Erpul
Counsellor, Permanent Mission of the Republic of Turkey to the United Nations Office and other international organizations at Vienna

Ms Sevim Tezel Aydın
Deputy Head, Department of External Relations, Ministry of Health

Dr Oguz Karamustafalioglu
Head, Clinic of Mental Health and Diseases, Istanbul Sisi Etfal Hospital

Mr Tanju Bilgiç
Second Secretary, Embassy of the Republic of Turkey in Denmark

Secretary Mr Mehmet Saribuva
Secretary to the Minister of Health

Turkmenistan

Representative Dr Byashim Sopyev
Deputy Minister of Health

Ukraine

Representatives Dr Michajlo Pasichnyk
Deputy Minister of Health

Mr Wolodymyr Ohrysko
Ambassador of Ukraine to Austria

Alternates Mr Igor Schepotin
Head, Health Affairs, Cabinet of the Council of Ministers

Mrs Zhanna Tsenilova
Head, International Relations, Ministry of Health

Mr Dmytro Aleshko
Adviser to the Minister of Health

United Kingdom of Great Britain and Northern Ireland

Representative Sir Liam Donaldson
Chief Medical Officer, Department of Health

Alternates Mr Nick Boyd
Head, International Affairs, International Branch, Department of Health

Mr Anthony Kingham
Head, International Public Health Team, International Branch, Department of Health

Advisers Dr Andrew K. Fraser
Deputy Chief Medical Officer, Scottish Executive Department of Health

Dr Sarah Watkins
Senior Medical Officer, Health Professional Group, Welsh Assembly Government

Dr Jason Lane
Regional Health Adviser, Department for International Development

Secretaries

Ms Lorna Demming
International Business Manager, International Branch, Department of Health

Mr Noel Bartels
Assistant Private Secretary to the Chief Medical Officer, Department of Health

Uzbekistan

Representative

Professor Feruz Nazirov
Minister of Health

Advisers

Dr Abdunumon Siddikov
Head, Foreign Economic Relations, Ministry of Health

Dr Shavkat A. Razakov
Director, Isaev Research Institute of Medical Parasitology

Mr Vladimir Kononov
Ministry of Health

Professor Vladimir Zelman

II. Observers from Member States of the Economic Commission for Europe

Canada

Mrs Carla Gilders
Counsellor, Health and Social Affairs, Canadian Mission to the European Union

Mr Garry Aslanyan
Senior Health Adviser, Central and Eastern Europe Branch, Canadian International Development Agency (CIDA)

United States of America

Mr David E. Hohman
Health Attaché, Permanent Mission of the United States of America to the United Nations Office and other international organizations at Geneva

III. Observers from Non-Member States

Holy See

Mgr Jean-Marie Mpendawatu
Pontifical Council for Pastoral Assistance to Health Care Workers

IV. Representatives of the United Nations and related organizations

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Mr Arkadiusz Majszyk

United Nations Children's Fund (UNICEF) Regional Office for CEE, CIS and the Baltics

Dr Shahnaz Kianian-Firouzgar

United Nations Development Programme

Mr Jerzy Skuratowicz

World Bank

Mr Dominic Haazen

V. Representatives of other intergovernmental organizations

Council of Europe

Ms Gabriella Battaini-Dragoni

Mr Karl-Friedrich Bopp

European Commission

Mr Fernand Sauer

Mr Bernard Merkel

Mr Antonis Lanaras

VI. Representatives of nongovernmental organizations in official relations with WHO

International Bureau for Epilepsy

Mrs Hanneke M. de Boer

International Catholic Committee of Nurses and Medico-social Assistants

Ms Christa Nowakiewitsch

International College of Surgeons

Dr Wushou Peter Chang

International Council for the Control of Iodine Deficiency Disorders

Professor Aldo Pinchera

International Council of Nurses

Ms Pat Hughes

International Council of Women

Mrs Gertrude Harrer

International Federation of Pharmaceutical Manufacturers' Associations

Ms Helena R. Brus
Dr Lukas Pfister

International Lactation Consultant Organization

Ms Johanna Thomann

International League against Epilepsy

Dr Giuliano Avanzini

International Society of Doctors for the Environment

Dr Hanns Moshhammer

International Union of Nutritional Sciences

Dr Ibrahim Elmadfa

Medical Women's International Association

Dr Corrine Bretscher-Dutoit

Mental Health Europe

Dr Karl Dantendorfer
Mr Rudolf Wagner

Thalassaemia International Federation

Mr Panos Englezos
Dr Androulla Eleftheriou

World Association of Girl Guides and Girl Scouts

Ms Sandra Dybowski

World Association for Psychosocial Rehabilitation

Dr Johannes Wancasa

World Confederation for Physical Therapy

Ms Anne Lexow
Mrs Silvia Mériaux-Kratochvila

World Federation for Mental Health

Professor John R.M. Copeland

World Federation of Acupuncture-Moxibustion Societies

Mr Sergio Bangrazi
Professor Filomena Petti

World Federation of Hydrotherapy and Climatotherapy

Dr Nikolai A. Storozhenko
Professor U. Solimene
Dr Elisabetta Minelli
Dr Simona Busato

World Organization of the Scout Movement

Mr Alexander Söllei

World Self-Medication Industry

Dr Gerhard Stummerer
Dr Ariane Titz

VII. Observers*European Forum of Medical Associations and WHO*

Dr René Salzberg

European Forum of National Nursing and Midwifery Associations and WHO

Ms Sylvia Denton

Global Fund to Fight AIDS, Tuberculosis and Malaria

Dr Valery Chernyavskiy
Dr Arletty Pinel
Dr Urban Weber

Imperial College, London

Dr Rifat Atun

International Programme on Chemical Safety

Dr Gunnar Bergtsson

Order of Malta

Mr Herbert Sticklberger

Regions for Health Network

Dr Jaroslav Volf
Dr Ricard Tresserras

Standing Committee of Nurses of the EU

Mr Paul De Raeve

Urbani International

Dr Peter W.S. Chang

*Annex 4***Address by the Director-General of WHO**

Madam Chair, Honourable Ministers, Distinguished Representatives, Colleagues,

I am honoured to be with you here in Vienna, and to join your discussions on our work in the 52 countries of the European Region. Let me thank our hosts, the Government of Austria, and say a word of welcome to the delegation of Cyprus to their new region.

We live in a time of great challenges. I feel a great responsibility being in charge of WHO, an important part of the UN system, and am grateful for your support and expressions of good wishes for success.

The United Nations system is going through a testing time. We were profoundly shocked by the bombing of the UN premises in Baghdad and by the deaths and injuries of so many of our colleagues. Despite these terrible losses, we continue our missions with great determination.

On this 25th Anniversary of the Alma-Ata Declaration on Primary Health Care, it is good to remind ourselves that health is for all. Everyone equally needs health, and, when society fails massively through negligence to meet that need, it is in very serious trouble. I am looking forward to going to Almaty at the end of next month to mark the anniversary.

“Unequal development in different countries in the promotion of health and control of disease ... is a common danger,” our Constitution says. In some countries, conditions associated with poverty are bringing life expectancy down to 40 years, while in others, wealth and health technology are enabling it to rise towards 80. Inequalities of this magnitude are not just a danger but an injustice which itself undermines human well-being.

The greatest challenge facing us now is the catastrophe of HIV/AIDS. More than 42 million people in the world are HIV-positive. More than one and a half million of them are in this Region, in some parts of which the epidemic is growing rapidly. Each of those infected urgently needs treatment. This has to come through an integrated global HIV/AIDS strategy linking prevention, care and treatment.

I am working with local, national and international partners to design the necessary programmes to treat three million people with antiretrovirals by the end of 2005. “Three by five” will not solve the problem but it will mark the beginning of a solution, and be proof that it is possible. A comprehensive strategy for making this happen will be announced on the first of December, World AIDS Day, three months from now; and our work with countries will be initiated immediately.

We are working with many partners, including UNAIDS and the Global Fund, to mobilize the resources to put these plans into action. We are encouraged by the latest WTO developments concerning better access to medicines. Overall success will require the commitment of civil society, United Nations agencies, the private sector and Member States. Above all, it will require the commitment of each one of us here today.

TB is exploding in parts of Europe, especially drug resistant strains in prisons in eastern Europe. Rapid expansion of DOTS and more aggressive management of drug resistance is essential.

Europe’s achievement in eradicating polio last year has made a tremendous contribution to the effort worldwide. The financial support pledged by four countries in this Region, through the G8, will greatly help us to press home our hard-won advantage on this front to complete eradication during this year and next.

The need for health care starts at birth. Protection during pregnancy, childbearing and motherhood forms the core of the health system. Half a million women die every year from giving birth. Skilled attendants are needed in pregnancy and childbirth, with access to emergency obstetric care when complications arise.

Despite the struggle of parents for their children's survival, ten million children in low- and middle-income countries die every year before reaching the age of five. Seven million of those deaths are from five preventable and treatable conditions: pneumonia, diarrhoea, malaria, measles and malnutrition. We can reduce this toll substantially by working with countries to build up strategies such as Making Pregnancy Safer and Integrated Management of Childhood Illnesses. Reducing child mortality worldwide by two-thirds by 2015 is probably achievable. But it will not happen without major rethinking and commitment.

A vitally important part of this entails making the health system work as an integrated whole. Many of the problems that beset adolescence in particular, such as teenage pregnancy, injecting drug use, and violence, are inseparable from maternal and child health. Low birth weight babies are one outcome, rapid transmission of HIV is another. A high prevalence of violence, alcohol abuse and mental disorders, is also associated with this age group.

At the other end of life, the health needs of the elderly have been made dramatically apparent during the heat-wave this summer in Europe.

All of this shows the need for integrated health systems at the heart of any viable society – not just as an investment but as recognition of the value of human life and health in their own right.

In addition, good health care calls for good surveillance systems in WHO and our Member States. These showed their effectiveness in the eradication of smallpox and, earlier this year, in stopping the SARS epidemic. They are a key to success now, both for the eradication of polio and for the control of new and re-emerging infections. We also need to finalize the important work on the Revision of the International Health Regulations.

Meanwhile, noncommunicable diseases and injuries account for a growing share – now about 60% – of the burden of disease worldwide. In May, the World Health Assembly adopted the Framework Convention on Tobacco Control. This was a global achievement in the fight against tobacco-related diseases. The Convention has now been signed by fifty countries, and ratified by one, Norway. I urge you all to follow suit without delay. It will give the world the means to protect people from tobacco harm by banning advertising, preventing smuggling, raising tobacco taxes and enforcing more visible warning notices on packages.

We must do everything we can to speed the process to the ratification by forty countries that will bring the Convention into force.

The unbalanced nutrition now affecting all societies, rich and poor, poses a major challenge for health. Our objective is integrated approaches that work against malnutrition – from deficiencies and excesses. WHO's Global Strategy on Diet, Physical Activity and Health will be presented to the World Health Assembly next May.

This year's Health Assembly reviewed the work of the Codex Alimentarius and concluded that the health sector should play a more prominent role in setting safety standards for food. The Health Assembly also stressed that developing countries should be given more support to participate fully in the process of international food standard-setting. In many cases, this is a matter not just of food safety but of food security – of ensuring intake of the minimum calories essential for survival and health.

Every year, more than a million people die in traffic accidents around the world making it a leading cause of death in all regions. What is needed is to raise awareness and strengthen our response. World Health Day 2004 will be dedicated to road safety.

All that we are doing has to do with reinforcing national health systems. Our work everywhere is important, but the real centre of it has to be countries. We have to give our country offices more people, more realistic budgets, and more authority. At the same time, we also have to ensure sound management and financial practices, as well as transparent budgeting.

At headquarters, all the Assistant Directors-General are looking at the global issues under their responsibility, to see which of their activities could be better carried out in regional and country offices.

Overall, I want to see these changes completed for the 2006–2007 budget. Strengthening country offices is a major objective for me because, having worked for 20 years in WHO, I can see very clearly that strengthening our work in countries is by far the most effective way to help achieve the goals of our Member States. We will work in close partnership with the Regions towards this goal.

Health systems depend most of all on skilled and dedicated personnel, and here we face a major challenge: the brain drain. It is, above all, good staff that will enable us to reach “3 by 5”, and achieve the Millennium Development Goals, and everyone is short of human resources. We will be working closely with countries on innovative methods to train, deploy and supervise health workers, with particular emphasis on the community and primary health care level. That is where we can make the swiftest progress in getting results.

In most countries, the systems for providing reliable health information are also inadequate. This is one area in which the trend is on our side: the means for building effective information systems are becoming more powerful and more affordable all the time. I believe this problem can be effectively addressed with the health metrics network being formed by WHO’s information partnership with Member States, foundations, the World Bank and UNICEF.

Over the years, WHO has built strong and effective working relations with Member States, foundations, nongovernmental organizations, the private sector and fellow multilateral organizations. Our work depends on partnerships; some long-standing and some more recent. By combining our strengths we can do so much more.

There is a commitment to partnership by global leaders on a scale we have not seen before. At the United Nations Millennium Summit in September 2000, the global community committed itself to eight goals. Three of them were directly about health: to reduce child mortality, improve maternal health, and control major infectious diseases. The five others are about poverty, education, gender equality, the environment and global partnership. All these, as we have seen, have a direct bearing on health.

I look forward to listening to our debate.

Better health for all is our common goal. Let’s work together to achieve this.

Thank you.

*Annex 5***Report of the WHO Regional Director for Europe**

Madam President, Ladies and gentlemen, Participants in the fifty-third session of the WHO Regional Committee for Europe,

First of all, I should like to pay homage, on behalf of all of us, to the victims of the bomb attack in Baghdad, and especially to our friend and colleague Mrs Nadia Younes and to Mr Ahmed Shukry. I extend this tribute to Mr Bacquerot, who was with us last year, and to Dr Urbani, our Italian colleague, killed by the disease he was engaged in fighting. His words, "Get closer to the victims", could serve as our watchword.

Introduction

There is no doubt that the past year, between the fifty-second and the fifty-third sessions of the Regional Committee, will leave its deep and lasting mark on public health. It will also be remembered as a historic year for WHO. I have singled out four events to illustrate this exceptional year.

First, the SARS epidemic. The initial phase of this health crisis, at least, has been won thanks to intense mobilization of efforts and international cooperation. Of course, we will need to remain vigilant long into the future, but it has been proven that the best results in terms of public health are secured through transparency and scientific cooperation between all countries in the world.

The same conclusions can be drawn from another success achieved this year: the adoption by the World Health Assembly of the Framework Convention on Tobacco Control, the first international treaty on public health. I should like to thank the Member States in the European Region and express my admiration of the determination and courage they have shown in this difficult undertaking. But here, too, there is still a long way to go before the Convention is ratified and, what is more important, applied throughout the world. Only one country, Norway, has so far ratified it, and I want to make a strong appeal at this Regional Committee to other European countries to do the same as soon as possible. The European Region will continue to act as the driving force in this process, playing the role that has been unanimously attributed to it. In this way, it will contribute to international efforts aimed at ensuring that the Convention comes into force in December 2004. We must not let up now, and there can be no question of putting off taking action until the end of the ratification process. You can count on continued support from your Regional Office here. Through this long-term commitment and intense mobilization, the global community will continue to demonstrate its ability to cooperate in the defence of public health, by refusing to consider the 5 million people who die each year from smoking as unavoidable fatalities.

These two events, among others, have made WHO more visible and more credible. We have Dr Brundtland to thank for this. The expectations placed on our Organization are now greater than ever before. The lessons we have learned this year will help us to fulfil them more effectively. This is true not only of the global level but also for the Regional Office. We are now becoming better at analysing the needs of our Member States. We are continuing to match our services to their needs more effectively and more quickly, both in health crises and with our long-term programmes. Better communication, both internally and with the countries of the Region, has helped a great deal here.

The conclusions we can draw from the way in which the SARS epidemic has been handled and how the Framework Convention on Tobacco Control has been adopted also apply to the third issue that has been a feature of the European Region in the past year. There is no doubt that people have now become fully aware of the seriousness of the epidemic of AIDS and tuberculosis in many countries in the Region. This heightened awareness, transmitted by UNAIDS' partner organizations, has found practical expression through the allocation of considerable resources from the Global Fund to Fight AIDS, Tuberculosis, and

Malaria. The Regional Office has contributed to this mobilization. I am pleased to see that senior representatives of the Global Fund are attending this session of our Regional Committee. Here, too, there is an immense amount of ground still to cover, especially because the health systems of the countries concerned are in the throes of transition in a very difficult economic context. The solidarity being shown by the European Region is essential to help these countries strengthen their health systems, so that the funds targeted on AIDS, tuberculosis and malaria are used in the best possible conditions. It would be disastrous for all countries if the situation, instead of improving, were to deteriorate further.

Lastly, I should like to mention a fourth event which, while perhaps more internal to WHO, is nonetheless very important for the future. You have elected a new Director-General, Dr Lee Jong-Wook, who will join us tomorrow. It is clear that the approaches proposed by the new Director-General are very much in line with the ones you have adopted for the European Region, especially regarding the high priority given to country support. My recent visit to Geneva, during which I met many members of the new management team, convinced me that our objectives and projects are well matched. Cooperation has started from a sound foundation, which ensures that our Member States will benefit from one single organization which respects the diversity of its regional dimension.

Cooperation with countries in the Region

In this report on the work of the European Office in the past year, I will mention not only activities carried out by the Regional Office for the Region itself but also the Region's involvement in global initiatives.

This report will consist of three parts: the first devoted to our work with countries; the second on technical programmes; and the third on some areas of major work in progress and future activities.

I should like to begin by emphasizing the close cooperation we have with the Standing Committee, both in preparing for the Regional Committee itself and in carrying out the resolutions it has adopted. I thank the members of the Standing Committee and especially its chairman, Professor Jarkko Eskola, for their advice and support. This was particularly valuable to me in following up the evaluation presented to the Regional Committee last year.

One of our joint decisions about how to organize this session of the Regional Committee was to integrate the issue of partnerships into each major agenda item, depending on the topic under discussion, rather than devoting a separate item to this aspect, as was done in the past. I therefore have the honour and the pleasure to introduce the three invited speakers and partners for this item: Mrs Gabriella Battaini-Dragnoni, Director-General of Social Cohesion at the Council of Europe, Mr Fernand Sauer, Public Health Director at the European Commission, and Mrs Mirta Roses, the new WHO Regional Director for the Americas. I would also like to welcome the representatives of our other partners attending this session, some of whom will be invited to speak under other agenda items. In line with the Committee's Rules of Procedure, they will take the floor either during the presentation of the item or after the comments and questions by Member States.

In 2000, the Regional Committee adopted the strategy to be followed by the Office in working with countries in the Region. The document setting out this strategy, entitled *Matching services to new needs*, has since served as a framework for most of the Regional Office's work. A detailed report on this subject will be presented to you tomorrow morning. Here, I will confine myself to giving a few examples illustrating the fundamental principle underlying this strategy: considering all the countries of the Region in their diversity.

Consider all countries in the Region in their diversity

In addition to horizontal programmes, such as those on mental health, smoking, nutrition or the environment, in which all the countries are involved, we offer our Member States increasingly diversified

and specific services. To illustrate this, I will now give a few examples covering the various parts of the Region.

In countries where WHO has no country office, broadly speaking those in the west and south-west of the Region, we have launched the "Futures Forum" programme, as set out in the country strategy document. After a slow start, this programme is now better structured. One over-arching theme has been chosen: Tools for public health decision-makers. At each of the Forum's two annual sessions, one particular aspect of this theme is taken up: evidence for public health, the health impact of political decisions, communication on health crises, etc.

Apart from this programme, which is aimed at all countries in this group, the Office is responding to increasing demands for individualized interventions. For us, this is a good indicator of the interest shown by the most developed countries in the Regional Office's activities. This category includes the Office's work alongside the Finnish government on developing its health promotion policy, and its active involvement in the design of new health policies in Portugal and France. We have also responded to requests for help in crises related to SARS, of course, but also to an industrial waste problem at the request of Andorra, and an oil spill at the request of Spain. Another form of support that we think will develop in the future relates to the role we have been asked to play by the Austrian government in the context of the health assistance that country is developing in Iraq. We have placed the technical resources of the Organization at Austria's disposal, by fostering cooperation between the country and the two Regional Offices concerned. Our Austrian colleagues will cover this point in more detail during their presentation at lunch time on Wednesday. They will invite the countries in the Region to join this movement to support countries in major difficulties. These few examples are a sign of increasing demand for the Regional Office's services from this group of countries. Of course, these requests are an honour for us, and we will meet them as specifically as possible. However, they must not obscure the problem of the scarcity of the Regional Office's financial and human resources. We need your expertise and your experts to carry out these missions, and together we must find innovative ways of achieving this mix for the benefit of all countries.

For the countries of south-eastern Europe, I have already described at previous sessions the Office's involvement with our partners from the Council of Europe in the Stability Pact programme for the Balkan countries. Trying to forge specific links between health and the peace process in this war-torn area is a risky and uncertain task. After only three years it is much too early to say whether this challenge has been successfully met, but four public health programmes are being developed in the countries concerned, with the support of Greece, Italy, France and, more recently, Slovenia and Sweden. The programme on mental health, which is essential to break the cycle of violence, is the most advanced. Those on communicable diseases, public health training, and nutrition and food security are progressing well, and funding for them has been identified. For this group of countries, too, we are meeting specific requests, such as determining the etiology of a disease that affected certain population groups in The former Yugoslav Republic of Macedonia.

For countries that are candidates for accession to the European Union, and especially those in central Europe, our support has been long-standing and was strengthened by the EUROHEALTH programme in the 1990s. In the past year, we have emphasized the various forms of assistance that we can give these countries at such a special period in their history, inevitably one that will have repercussions on their health systems and so also on the health of their populations. We have worked with our colleagues in the European Commission to extend the benefits of the Commission's new public health programme to the accession countries. More specifically, staff from the Regional Office have participated in meetings with representatives of these countries, and we have organized ourselves to clearly understand their needs and expectations. With them, we have decided to focus on practical implementation of health system reforms, looking in particular at funding options, health service management, continuing education of professionals and monitoring the development of health systems. Like for the previous groups of countries, we have responded to specific requests, such as those made by Bulgaria in the context of its new public health law.

Lastly, **for the countries in the Commonwealth of Independent States**, our support is also becoming increasingly specific. The very close relations we have maintained with each of them for more than 10 years have given us a clearer understanding of their needs and enabled us to meet them in increasingly appropriate ways. The process of negotiating priorities has improved and now takes more account of the results already achieved, those that are likely to be achieved and the work of other organizations and the international community. One very tangible result in recent years has been the cooperation we now have in these countries, especially with the World Bank. This cooperation enables us to be more effective and better coordinated. A good example in the past year is given by Kyrgyzstan, where the international community, with the support of the President of the Republic and the government, has been able to take forward the health system reform launched several years ago, a process in which the Regional Office is playing a role that is regarded as very important.

These are just a few illustrations of our increasingly specific activities in the various parts of the Region, but I would also like to emphasize that while cooperation at national level is our main approach, it is not the only one. I am pleased to note that we have forged closer links this year with the members of the Healthy Cities and Regions for Health networks.

To conclude this first section of my report, I would note that all the Regional Office's technical and administrative services have helped to give effect to the Office's new country strategy. Much of the progress we have made has also been thanks to our country offices and to the increasingly high quality of the staff in those offices, located in 28 Member States. Stringent recruitment procedures and upgrading of their responsibilities are all well advanced and will continue in future. A major programme of on-the-job training is being developed to strengthen the administrative and technical competence of these offices. The appointment of international staff is another step in the same direction.

Public health programmes

Our country work can only be effective if the Regional Office maintains its scientific competence in public health and contributes, at its level, to the development of this discipline. Here, too, it will be difficult to give you an exhaustive list of activities, and I will therefore limit myself to a few examples: areas in which the Regional Committee has adopted resolutions; areas that will be more prominent in the years to come, especially the topics of forthcoming ministerial conferences; and lastly, areas covered by global programmes.

HIV and AIDS

As I said in my introduction, two features of the past year have been a heightened awareness of the seriousness of the situation in some countries of the Region, and the financial investments in these countries made by the Global Fund. The Regional Office has contributed, especially within UNAIDS, to mobilizing efforts to ensure that the situation in the European Region is better known and acknowledged

In its resolution EUR/RC52/R9, the Regional Committee requested the Regional Director to report on the Region's response to this epidemic. In the past year, the number of people in the European Region infected with HIV has risen from 450 000 to 520 000. In the same period, 15 000 people have developed AIDS, and more than 4000 have died from the disease. Within the larger United Nations response to the epidemic, and in close collaboration with UNAIDS and other partners, the Regional Office has focused on helping Member States to expand and scale up national programmes for the prevention, treatment and care of HIV/AIDS, guided by the principles of the resolution.

As part of the global effort to provide antiretroviral treatment to 3 million people by 2005, WHO has developed model clinical protocols for HIV/AIDS treatment and care in partnership with Ukraine and the CIS Council, thereby making it possible to scale up antiretroviral therapy. These technical documents will be used as model for developing national policies in the Caucasus and in the central Asian republics before the end of 2003. Intensive work in other technical areas – such as targeted interventions and harm

reduction, surveillance, blood safety, diagnosis and treatment of sexually transmitted infections, voluntary testing and counselling, and the prevention of mother-to-child transmission – was also possible due to the expanded technical capacity of the Regional Office and of country offices, thanks to the generous support from Germany, France, the United Kingdom and the United States.

In the next five years, 12 countries will receive more than US\$ 120 million from the Global Fund and more than US\$ 200 million from the World Bank. Despite its limited resources, the Regional Office is helping all the countries concerned to submit applications that are likely to be successful. The Office considers that ensuring proper use of these funds is part of its mission and one of its responsibilities towards both countries and donors. As called for in the resolution, I will present a new report to you next year, which I hope will be more favourable, thanks to your support. As you know, the Global Fund is also designed to tackle tuberculosis and malaria.

The tuberculosis situation in some countries of the Region is extremely serious, as reported to you at the Regional Committee session last year. However, all the parties involved are now cooperating more closely in an increasing number of countries. One example of the progress we are making here is in the Russian Federation, where the programme at the WHO office has, among many other activities, trained 3000 professionals and specialists in tuberculosis surveillance.

Still on the subject of communicable diseases, you will recall that poliomyelitis was eradicated from the European Region last year. We have now taken up the objective of eradicating measles, in line with this year's World Health Assembly resolution. Some countries, such as Turkey, have launched mass campaigns of immunization against this disease, which kills 7000 children in the Region every year.

Alcohol

In resolution EUR/RC49/R8, the Regional Director is asked to report on implementation of the alcohol action plan that was adopted in 1999. The action plan and the Stockholm Declaration, the outcome of a ministerial conference in 2001, form the basis of the regional strategy to respond to the disaster caused by alcohol abuse, which accounts for 9% of the global burden of disease in the Region. Thanks to contributions from Norway and France, and with the cooperation of the Member States, we have set up a European information system to monitor, assess and strengthen alcohol control policies. The second phase of this project will soon incorporate more extensive information on lifestyles, risk factors, good practices and legislation, especially laws designed to protect young people. We now need to move forward, both at global level and regionally, drawing on all the positive and negative lessons from our fight against smoking. I appeal to all countries in the Region to strengthen their policies in this area, based on the conclusions of the Stockholm conference. I would also ask them to provide assistance to the Regional Office, so that our financial and technical resources match the ambitions of the Member States in this field, which is unfortunately far from being the case at present.

Environment and health

Environment and health is always a priority topic for our cooperation with you. The Budapest conference next June will certainly be a strong link in the chain of ministerial conferences on the environment. A great deal of attention is being paid to preparing for this conference, and a large number of partners are involved. Mrs Jakab, Chairperson of the European Committee on Environment and Health, will take the floor at the end of my address to report to you on the work done by that Committee to prepare for the conference. There is no doubt that, thanks to the highly effective and sustained work it has been doing, the conference will produce important results in the form of an action plan on children's environment and health, the central topic of the conference, and a more general declaration on the environment. A progress report will also be presented at the conference on the implementation of recommendations made by the previous conferences. An indicator-based monitoring system will be proposed, so that each country can evaluate its own situation and compare it with that of other countries. The studies and documents produced for World Health Day 2003, as well as the round-table discussions at the World Health

Assembly on “Children’s health and the environment”, are of course valuable contributions that will be extensively used for the Budapest conference. Close links are also being developed with the European Commission’s new strategy on environment and health. Lastly, I would point out that the next World Health Day in 2004 will have as its theme “Traffic accidents”, which was one of the main topics at the London conference in 1999. This convergence does not happen by chance – it demonstrates the extent of the concerns about health and the environment, both in Europe and throughout the world.

Health systems

As I have already said, many countries are asking the Regional Office for advice on reforming their health systems. We have begun to set up a unique mechanism for providing expertise matched to demand. This mechanism will be developed to enable a relevant and useful response to be made, on the basis of the most recent experience. In the past year, we have re-established links with national associations of nurses and midwives, to stimulate attainment of the objectives proposed by the Munich conference in 2000.

The elderly

Recent events in some countries have highlighted the precarious situation of the elderly and the vital necessity of adapting health systems to the needs of this increasing population group. The Regional Office’s programme in this area is under-resourced. However, we have decided, at the request of Standing Committee, to make this a cross-cutting theme in our work and to integrate it as much as possible in all our activities. This interim solution will, I hope, result in the establishment, in the near future, of a separate programme on this public health topic that is essential now and will become even more so in the future.

Noncommunicable diseases

Under the heading of positive news, I should also like to mention our efforts in the area of noncommunicable diseases, where a new post has just been created. In actual fact, the Office’s work in this area is more extensive and diversified than it might appear. Apart from the specific programme on countrywide integrated noncommunicable disease interventions (CINDI), we are also working on health promotion, especially in schools, through the health promoting schools network. We are also engaged in tackling health determinants and risk factors such as alcohol, tobacco and dietary imbalances. These numerous and diversified activities mean that we will be able to incorporate a wide and integrated approach in the strategy to control noncommunicable diseases that we will present to the Regional Committee at its next session. The adoption this year of the Framework Convention on Tobacco Control will probably be one of the most important steps ever taken to prevent noncommunicable diseases. We have already entered into commitments with WHO headquarters to step up our cooperation in this field, aware that the European Region is not only particularly affected but also highly experienced in this area.

Violence and health

This is a new topic, which has been launched at global level. I should like to mention it here, first of all because of its importance as a risk factor for health, secondly because of the extensive and coherent approach proposed in the report issued by WHO headquarters last spring, but above all as an example of good linkages between a global programme and the Region. As many of you know, we have worked closely with our colleagues from headquarters on launching the report in many countries of the Region, adapting it to the specific conditions in Europe. Launches have already taken place in Belgium for the European Union countries, in Croatia for the countries of south-eastern Europe, in Germany and in the Russian Federation, and similar events will shortly be held in the Netherlands, France and the United Kingdom.

The millenium development goals, poverty and its repercussions on health

In his very first statements, the new Director-General reaffirmed WHO's priority commitment to helping countries attain the millenium developments goals. In the past year, we have analysed the regional situation with regard to the eight goals, to see what the Region's position could be with regard to this major global programme. That analysis, being carried out by our Venice Centre with the support of a scientific committee, will be finalized next spring and then of course presented to you. The work also includes an analysis of the regional situation in the areas covered by the report on macro-economics and health that was submitted to the World Health Assembly in 2002.

It is already clear from this work that some of the millennium development goals, especially those related to AIDS and tuberculosis, are perfectly valid for the European Region. The focus on maternal and infant mortality, on the other hand, is too restrictive for the Region, and targets on excess mortality among young adults and on healthy life expectancy among the elderly should be added.

The fight against poverty occupies an important position both in the global report on macro-economics and health and in the millenium development goals. The Region is of course contributing to global efforts to mitigate and its health repercussions. This issue has already been taken up at the two previous sessions of the Regional Committee, and new case studies have since been added to those presented last year and now available in a publication. This update is accessible from our web site. Here, too, the work under way in Venice shows the need to take account of the specific features of the European Region, which has not been spared by poverty – far from it – since it affects all countries to differing degrees. As I emphasized at the Regional Committee session last year, some countries of the Region are in a very difficult but probably only transitory situation, since they can build up their reforms on the solid foundations that already exist. Assimilating them to developing countries, as is all too often done, is a serious mistake. The other countries in the Region have an obligation and an interest in giving them rapid and effective support, to help them weather this difficult turning point.

Over and above that, the European Region also owes it to itself to assist those countries outside the Region, who are often suffering more than it is from the scourge of poverty.

I have intentionally not mentioned two major fields of our work, mental health and the health of children and adolescents, because specific meetings during this session will be devoted to them.

Update on some major work in progress and future activities

To conclude this report, I should like to bring you up to date on some major areas of work in progress that I have already mentioned on several occasions at previous Regional Committee sessions.

Adjusting information systems

Information is more than ever a priority for the Regional Office. It is one of WHO's basic missions and a vital service that the countries expect of us. Our ambition is still to provide each country in the Region with analysis and information that are useful to, and usable by, decision-makers. During the year we have also made progress towards the objective of ensuring that all the Regional Office's work is evidence-based. I should like to thank the members of the European Advisory Committee on Health Research and its Chairperson, Professor Banta, for their contribution in this area. We have distributed to you a very interesting document stemming from their work.

During the Regional Committee session this year, we are launching the Health Evidence Network or "HEN", a system of operational, evidence-based information designed to answer public health practitioners' questions and meet their needs. HEN takes the Advisory Committee's concept and definition of evidence and puts them into practice. Two services are now available: the first gives easy access to the databases and web sites of selected and, to a certain extent, accredited organizations; the

second gives summary responses, based on current evidence, to frequently asked public health questions. We hope you will try out this system, which has been set up in the Congress Centre, and that you will let us have your comments, suggestions and criticisms. The system belongs to you; it has been designed in cooperation with numerous national and international partners, in particular the European Commission. This partnership will be expanded as quickly as possible, so that the system becomes a unique, value-added entry point to multiple sources of information, as recommended by a participant in last year's session of the Regional Committee.

In the area of information, the past year has been one of intense activity, especially for European Observatory on Health Systems, which is working more and more specifically with and for the countries of the Region, notably those that are candidates for accession to the European Union. The Observatory has also taken forward the work on the private sector presented to you last year, incorporating this subject into the various studies it has been making.

We also hope you have received and appreciate the Office's recent publications, and that they are useful to you. Do not hesitate to tell us if this is not the case, and please do give us your comments and advice, which will help us to improve our work.

Adjusting the management of the Regional Office

During the past year, we have continued and intensified the process of adapting the organization of the Regional Office, its working methods, its administration and its staff management practices. Since he took up his post, the new Director of Administration and Finance, André Laperrière, has given fresh impetus to projects designed, on the one hand, to strengthen administrative support to programme implementation in the Office and, on the other, to ensure harmonious and stimulating management of human resources. With the appointment of Mr Laperrière and the confirmation of Gudjón Magnússon as director of one of our technical divisions and of Nata Menabde as director of country support, our management team is now up to full strength. It also includes Roberto Bertolini, Anca Dumitrescu, Anne-Marie Worning and Yves Charpak, and therefore consists of four men and three women. This highly motivated group shares the conviction that the Regional Office must continuously strive both to maintain its technical competence and to adapt its operational capacity on an ongoing basis.

The changes in the work that you expect the Regional Office to do mean that particular attention must be paid to continuous training of the staff and the development of new skills in areas as varied as public health, communication, administration, consulting, evaluation, geopolitics and many others. The executive management team in the Office are aware of the need for such changes, and they see the area of skills development as one of their priority responsibilities for the years ahead, so that the Regional Office is always capable of responding better to the needs and requests of the Member States.

In this connection, I should like to pay a sincere and sustained tribute to all the staff at the Regional Office – in the countries, in the centres, and in Copenhagen. Throughout the year, I have clearly seen how competent and devoted they all are. They are deeply committed to their work and to the missions entrusted to their Organization, and they prove it every day. I know that you share this view, because I have heard you say so.

During this session of the Regional Committee, in addition to the subjects I have already mentioned – the country strategy, mental health, and the health of children and adolescents – you will be discussing two essential components of the Regional Office's policy for the years ahead: the revision of the policy for health for all, where the final text will be submitted to the Regional Committee in 2005, and the question of coordinating the work of the Regional Office in every country of the Region. Your comments and suggestions on these two issues will be essential in helping us define our policy and approaches for the years ahead.

Conclusion

Before concluding, I should like to remind you that it is of great importance to the Region that every country takes the necessary steps to ratify the amendments to the WHO Constitution, and in particular I should like to draw your attention to the amendments to Articles 24 and 25, which will allow us to have eight instead of seven seats on the Organization's Executive Board.

I should also like, on behalf of all of us, to extend a welcome to Cyprus, our 52nd Member State. We will do our best to ensure that this transfer is to everyone's benefit. At this point, I would ask our new Member State to accept the Secretariat's apologies for the fact that Cyprus has not yet been included in some of our lists and maps of the Region. This inevitable delay will be rectified as soon as possible.

At this session, the Regional Committee will be taking up some major technical and political issues. We, the staff at the Regional Office, expect much of it because we all regard the Regional Committee as the body that judges our work and sets the directions for us to follow. We also hope that you will find this session interesting and of value for your own work. We have planned it with that aim in mind.