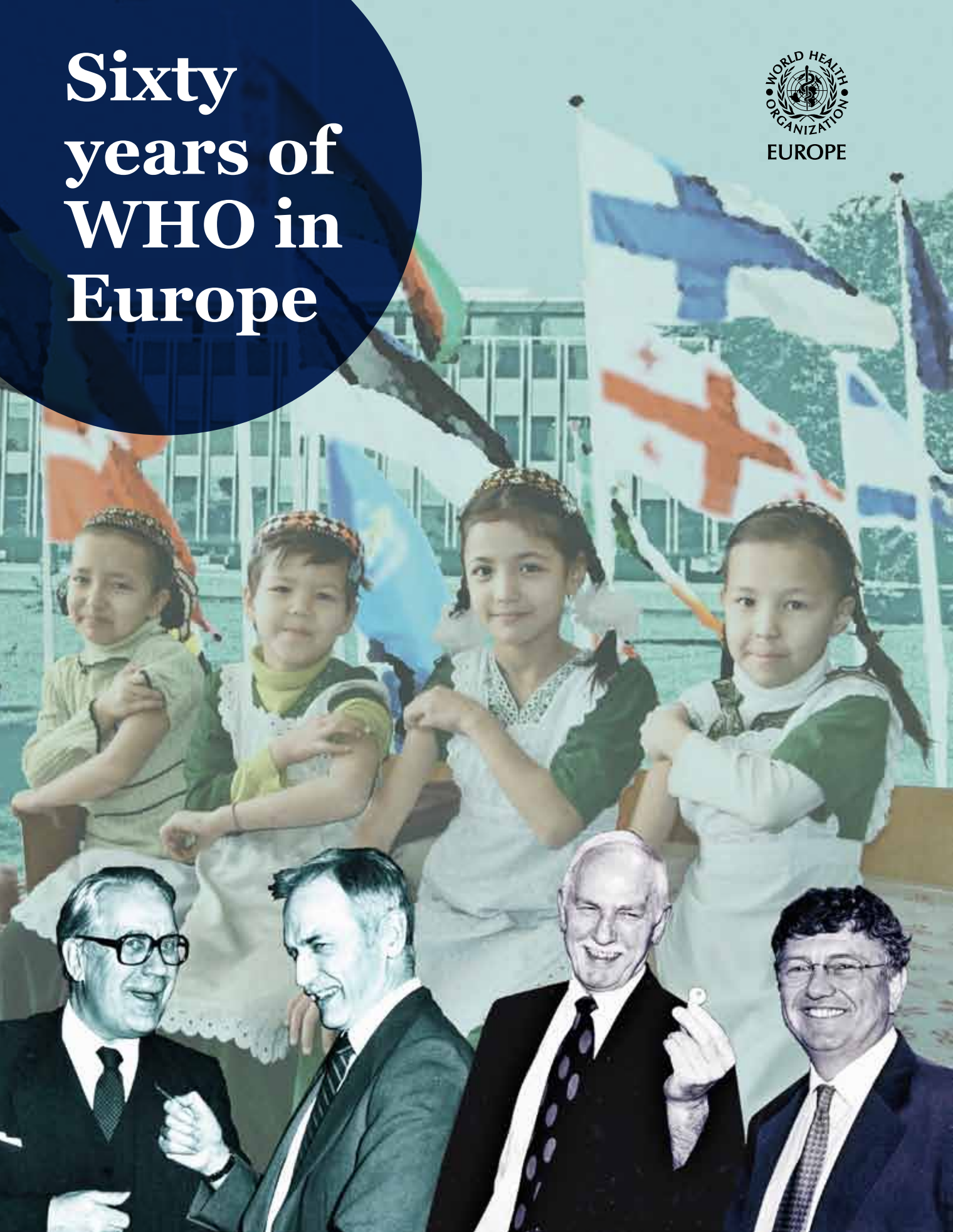
Sixty years of WHO in Europe



WORLD HEALTH ORGANIZATION
EUROPE

This booklet tells the story of the WHO Regional Office for Europe from its beginnings to its state in 2009. A way of keeping alive and handing on the history of this Office and its vital work, it covers five WHO regional directors for Europe and thousands of dedicated staff, not to mention the hundreds of programmes and policies they helped to create and carry out. An earlier book, *Forty years of WHO in Europe*, covered the first 40 years in detail; this booklet focuses more on the last 20 years. *Sixty years of WHO in Europe* is a story of how the Regional Office has spent the past 60 years working to help improve the health of the people in the vast area that it serves.

Cover shows:
Photos of (from right) regional directors Marc Danzon, Jo Asvall, Leo Kaprio and Paul van de Calseyde, and Danish Prime Minister H.C. Hansen.

Sixty Years of WHO in Europe

The World Health Organization was established in 1948 as the specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health. It fulfils this responsibility in part through its publications programmes, seeking to help countries make policies that benefit public health and address their most pressing public health concerns.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region embraces some 880 million people living in an area stretching from the Arctic Ocean in the north and the Mediterranean Sea in the south and from the Atlantic Ocean in the west to the Pacific Ocean in the east. The European programme of WHO supports all countries in the Region in developing and sustaining their own health policies, systems and programmes; preventing and overcoming threats to health; preparing for future health challenges; and advocating and implementing public health activities.

To ensure the widest possible availability of authoritative information and guidance on health matters, WHO secures broad international distribution of its publications and encourages their translation and adaptation. By helping to promote and protect health and prevent and control disease, WHO's books contribute to achieving the Organization's principal objective – the attainment by all people of the highest possible level of health.

WORLD HEALTH ORGANIZATION
EUROPE

Sixty Years of WHO in Europe

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Introduction

As my second and final term as WHO Regional Director for Europe draws to a close, I think it is fitting to leave behind a document – on top of all the formal reports published during my mandate – that tells the story of the WHO Regional Office for Europe from its beginnings to its current state.

A way of keeping alive and handing on the history of this Office and its vital work, Sixty years of WHO in Europe *covers five regional directors and thousands of dedicated staff, not to mention the hundreds of programmes and policies they helped to create and carry out. An earlier book, by an earlier Regional Director, covered the first 40 years in detail; this booklet focuses more on the last 20 years. This is a story of how the Regional Office has spent the past 60 years working to help improve the health of the people in the vast area that it serves.*

Marc Danzon
WHO Regional Director for Europe


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The road to Copenhagen

Original entrance to the Regional Office

WHO was founded over 60 years ago, with a structure setting up six different regions in the world – Africa, the Americas, South-East Asia, Europe, the Eastern Mediterranean, and the Western Pacific – along with headquarters. Originally, the WHO European Region had 21 Member States. Fighting during the Second World War had destroyed the continent's infrastructure, including health care systems and hospitals, while epidemics spread quickly across the Region, owing to huge numbers of refugees and displaced people (estimated at 15 million by the United Nations in March 1945). In April 1947, *Time* magazine reported that tuberculosis (TB) had returned as Europe's most deadly disease and was killing 150 people a week in Berlin alone.

In response, the World Health Assembly called for a "temporary special administrative office to deal with the health rehabilitation of war-devastated countries". The WHO Special Office for Europe faced a massive task when it opened in Geneva on 1 January 1949. Even as it set about its work, there was already discontent about its being based in the Swiss city. Just because WHO's headquarters were in Europe, did the European Region's head office have to be in the same place? Should it move to another city in Europe, perhaps symbolically in one of the most war-damaged countries?

Some within the newly established Organization believed that this made little sense; after all, the Special Office was easily housed with the main WHO headquarters in Geneva's Palais des Nations. On the other hand, others worried that headquarters would squeeze and overshadow the Office if it remained in Geneva, and feared that resources and manpower vital to the reconstruction of Europe would be siphoned off to address global problems. These arguments were put to one side as the Special Office began its vital work across Europe, and revived in 1952 when it became the WHO Regional Office for Europe.

Surely, the argument now ran, with a new name and a new mandate, the Regional Office should move from Geneva. After much discussion of the options available, cities across Europe were asked to put themselves forward as candidates. Each was then assessed according to a number of criteria, including location, communications, office accommodation and staff living conditions, availability of full-time and temporary local staff able to use the Organization's working languages, accessibility of health institutions and medical training centres, a minimum amount of red tape and reasonable living, office and travel costs.

Nice, Florence, Vienna, Frankfurt, The Hague, Geneva, Rennes, Montreux and Copenhagen all offered space to the Regional Office. The mayor of Nice teamed up with Jacques Carlu, the architect of Paris' Palais de Chaillot, to propose a new building for the Regional Office, while Florence offered two eighteenth-century villas, Pellegrino and Villa Loria. Other cities had other advantages. Frankfurt and The Hague were renowned for their medical heritage and had excellent transport links, while Montreux boasted of its excellent communication links, educational establishments, sporting facilities and artistic and cultural amenities.

One Vote

A leafy residential cul-de-sac in Copenhagen might not be the first guess for the location of the WHO Regional Office for Europe. Yet the Organization has been working to alleviate suffering and improve the health in the WHO European Region's Member States at number 8 Scherfigsvej – named after nineteenth-century politician and baker Christian Adolf Scherfig – for over 50 years.

The move to Copenhagen was decided by a close vote of Member States in 1954. Many years of work and lobbying had gone into making sure that the Regional Office had its own base, away from WHO headquarters in Geneva. One man had been behind much of that pressure: Dr Norman Begg, a Scottish doctor who had earned a reputation in the post-war confusion of Warsaw as a man people could count on, a man who, according to a colleague, "gave unstintingly of himself in the service of WHO for more than eight years". Yet Dr Begg, the first WHO Regional Director for Europe, never saw the Office, for which he had fought so hard, open its doors in the Danish capital.

Representatives of the 21 Member States – voting in Geneva as a special session of the WHO Regional Committee for Europe – made the final decision on 21 May 1954. The choice came down to two cities. The result was as close as it could be: Copenhagen beat Nice by 11 votes to 10.

In 1957, Danish Prime Minister H.C. Hansen handed over the keys to the townhouse at Scherfigsvej 8 to WHO Regional Director for Europe Paul van de Calseyde. The Regional Office began its independent existence with the task of facilitating "cooperation between the countries of the Region towards the solution of common health problems", and the promotion of "programmes in the field of professional education and training".

Yet that day in June 1957 was also tinged with sadness. The first Regional Director for Europe, Dr Norman Begg, the man credited with doing the most to make sure that the Regional Office for Europe had its own head office, had died the previous May at the age of 50.

The new Regional Office

Talking in 1979, Ivan Tolstoy, a former Regional Office staff member, described the original building into which the Regional Office moved in 1957 as a "sumptuous villa, with [an] impressive oak-panelled hall and grand stairway … the view from the top-floor windows over the crowns of twin spruces, long since felled, gave out over the full length of a private garden and out towards the broad expanse of sea from Tuborg harbour on the left to Svanemølle harbour and power station to the right."

Its position at the end of a residential cul-de-sac led to some local residents objecting to the arrival of offices in their midst, which posed extra problems for Svenn Eske Kristensen, the local architect chosen to design the new buildings for the office.

"In an area where a substantial number of the other buildings were family houses, it was difficult to incorporate building elements that did not completely dominate the existing environment," said Kristensen. "It was extremely important to me that the structures were kept as low as possible and that the design used natural materials that would work easily by mirroring clouds, trees and sea." When, in 1968, the original villa was razed to make way for these new buildings, the demolition proved more difficult than expected. The villa had an underground bunker that, according to Tolstoy, "resisted all attempts to level it".

Today, the site now houses 5 office buildings in which some 400 Regional Office employees work.

The original villa at Scherfigsvej 8 © WHO

Architect's model showing old and new buildings © WHO

15 June 1957

WHO European office moves to Copenhagen

The Danish Prime Minister, H.C. Hansen, handed over the key to the new headquarters of the World Health Organization's Regional Office for Europe. Located in the northern suburbs of the Danish capital at Scherfigsvej 8, the headquarters was initially housed in a townhouse most recently used by the Tuberculosis Research Office. WHO Regional Director for Europe Dr Paul van de Calseyde received the key in front of members of the Danish Government and WHO's Director-General, Dr M.G. Candau.

The result of an agreement signed in 1955, the new headquarters housed the WHO's Regional Office for Europe, a body charged with raising health standards across the continent. WHO said that it planned to replace the current nineteenth-century building with a purpose-built headquarters designed by local architect Svenn Eske Kristensen.

Symbol of change and continuity: each Regional Director gives a symbolic key to the Regional Office to his successor

Dr Norman Begg: the first Regional Director (1949–1956)

"Dr Begg was conscientious, thoughtful, prudent in the best sense of the word, courageous in expressing and defending his opinions, generous in his ideas and in his conduct."

Professor Jacques Parisot, World Health Assembly, 1956

China to Homerton

The fourth child of Scottish missionaries, Norman Begg was born in Kuling (now Lushan), China in 1906. When the Xinhai revolution broke out in 1911, the family left the country and moved to Aberdeen, Scotland. Norman went on to be a brilliant student and rugby player at Aberdeen's grammar school, before studying at the Scottish city's university. He received his medical degree in 1929, and moved to London where in 1932, aged 26, he was awarded his PhD.

He began his career in public health at the North-Eastern Fever Hospital in the British capital, before moving to Southend-on-Sea in 1935. He returned to London in 1937 to work as medical superintendent at the Eastern Fever Hospital in Homerton. During the severe bombing of London during the Second World War, he also worked in the East End, the area of the city perhaps hardest hit by the attacks.

"I remember Dr Norman Begg from the time when he was Medical Superintendent of what was, in 1940, the Eastern Fever Hospital. I was a student and spent 12 months there. Dr Begg was most kind to us all – as well as giving us excellent teaching in fevers – and I have warm memories of that exciting period during the Blitz."
Dr Donald V. Bateman,
physician, United Kingdom, 1986

Post-war world

When the Second World War ended, the United Nations Relief and Rehabilitation Administration invited Dr Begg to Warsaw, Poland. Despite the perils of working in a virtually destroyed city (his daughter said that he had to carry papers showing he could not be arrested), Dr Begg earned a reputation for not only managing to get things done but also getting them done quickly and with a minimum of fuss. These qualities led to him being chosen to be Director of WHO's Special Office for Europe when it opened in 1949 and the first WHO Regional Director for Europe in 1952.

"Begg has more influence in Warsaw than any other person from the western countries."
Dr Martha M. Eliot,
WHO Assistant Director-General, 1947

When he began his work, Dr Begg faced a unique health and health care situation. Europe not only had problems that needed immediate action – such as epidemics – but also needed to rebuild health care systems that, before their large-scale destruction, had been remarkably sophisticated. The best way to begin this effort to reconstruct the Region's health systems so that they were better than before, he believed, was to bring countries together – many of which had recently been enemies – in a spirit of mutual cooperation.

"Country programmes and projects were more important in that early time than intercountry activities. I soon realized how lucidly Dr Begg foresaw the necessity and importance of developing intercountry meetings in some areas."
Dr Alfred Eberwein,
former Regional Office staff member, 1991

This belief was one reason why Dr Begg is said to have been so deeply upset by the withdrawal from WHO of some eastern countries. Early in February 1949, the health ministries of the USSR and the Ukrainian and Byelorussian SSRs[1] announced this withdrawal, saying that: "The swollen administrative machinery involves expenses that are too heavy for Member States to bear [and] the direction taken by the Organization's activities does not correspond to those tasks that were set before it in 1946 at the inaugural conference of the Organization". As there was no mechanism for Member States' withdrawal, they were simply classified as inactive. During 1950, Bulgaria, Romania, Albania, Czechoslovakia, Hungary and Poland also became inactive. These countries resumed active membership in 1957 and 1958.

Dr Norman Begg never saw the return of the eastern countries or the move to Copenhagen. On 23 May 1956, he died in London after a short illness. Yet his legacy lives on in the European Region's continuing belief in the power of cooperation, solidarity and mutual aid.

[1] This book uses the names for countries and other geographical entities, and some health conditions, that were accurate at the time discussed.

Reconstruction: 1949–1956

Dr Begg's service had two distinct periods: the early post-war years in the WHO Special Office for Europe and the first half of the 1950s in the WHO Regional Office for Europe. The change of name reflected a deeper change in the Office and the needs it addressed.

The Special Office years

In the years immediately following the Second World War, Europe was a health care disaster. The hostilities had damaged or destroyed health care systems; the Region was full of millions of displaced people, and once-rare diseases were making startling comebacks. In 1947, TB was on the rise in Europe for the first time in a century: over 600 000 Romanians were infected, cases in Zagreb were up 58% on pre-war levels, and the disease was killing 18 000 Poles a month. The WHO Special Office for Europe was set up to take over when the United Nations Relief and Rehabilitation Administration ceased operations. As its name suggests, it was never meant to be a permanent office, but rather a way to respond to the immediate health care needs of the continent, called the "big five": TB, malaria, venereal diseases, maternal and child health and environmental sanitation. Basic needs were assessed and the material needs of war-damaged countries – for equipment, medicine, transport vehicles and infant foods – were provided for. As the situation became less of an emergency and called more for long-term reconstruction, however, the need to shift the Office's priority towards reorganizing, modernizing and rebuilding countries' health systems became increasingly clear.

One of the most successful initiatives started during this time was the fellowship programme, set up by Yugoslavian health reformer (and first President of the World Health Assembly) Professor Andrija Štampar. Originally focusing on war-devastated Member States, it enabled health professionals from across the Region to study and work in other countries. It was also vital in establishing a sense that cooperation between countries was not just possible but preferable.

From Special to Regional Office

The beginnings of the European post-war boom saw health services and systems across the Region improve and certain countries move from recipients of emergency WHO aid to net contributors to the Organization. This change in the health needs and conditions in many Member States meant that the European Region had a new set of priorities, and WHO needed to begin to adjust its priorities accordingly.

The process of decentralization was well underway throughout the wider WHO and it was becoming clear that a small office on the fourth floor of the Palais des Nations was no longer big enough for a regional organization that was moving beyond simply

"He was loved by all the staff at the Eastern, from porters upwards. He engendered trust in everyone with whom he came into contact, and had the reputation of never failing anyone."

Ms Muriel North, Dr Begg's daughter, 2008

providing immediate aid to war-devastated countries. There was a general feeling that it was time for a change in status and focus. In January 1951, Dr Begg introduced a proposal to the WHO Executive Board, to change the European organization from a temporary special office to a permanent regional one. In September 1951, the Consultative Committee – made up of the 18 active Member States – voted to create the Regional Office for Europe, and became the WHO Regional Committee for Europe, WHO's governing body for the Region. On 1 February 1952, the Regional Office became operational and Dr Norman Begg became the first Regional Director.

A four-year programme: 1952–1956

The establishment of the new Regional Office allowed it to push on with the policy of improving intercountry cooperation throughout the Region. A four-year plan was put together and began in 1952; it was split into three programmes.

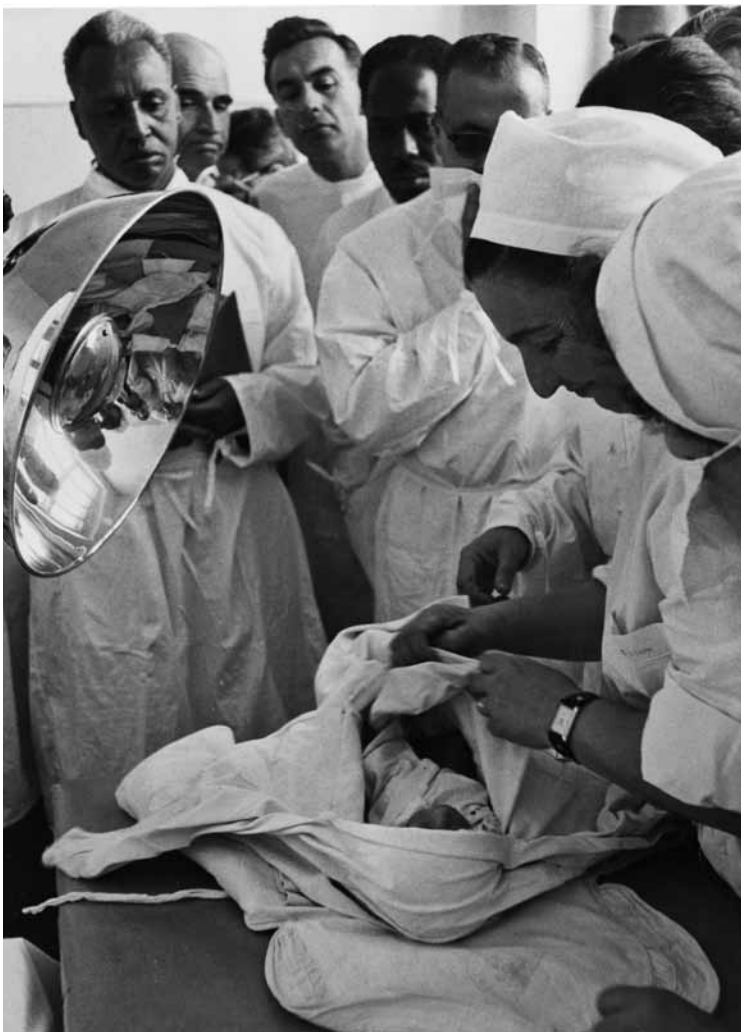
1. The regular programme was broadly based on the exchange of information, professional education and training, the continuing fellowship programme and assistance to training institutions; much of its work was aimed at encouraging a move from country- based to intercountry programmes.
2. Despite European countries' rapid economic development, the technical assistance programme was still needed, and focused on communicable diseases, maternal and child health, occupational health and nursing.
3. Cooperation programmes saw the European Region work closely with other United Nations agencies and nongovernmental organizations (NGOs). This cooperation increased with the establishment of the Regional Office.

Travelling seminars

Another initiative of Professor Andrija Štampar, travelling seminars proved to be one of the most effective methods of spreading knowledge about best practices in public health administration across the Region. Between 1951 and 1966, travelling seminars visited 14 countries and brought together 162 health officials to study other countries' health care methods. The seminars usually visited two countries in quick succession to see how their administrative structures in similar domains differed. For example,

"The early fellowship programme created tremendous goodwill for WHO in Europe and a 'constituency' of thousands of public health, medical, sanitary, engineering and nursing experts, working mainly in national administrations or teaching institutes. The programme made WHO well known in the countries that became Member States of the European Region, and secured for the Regional Office invaluable partners in its development and work."

Dr Leo A. Kaprio, Regional Director Emeritus, 1991



Travelling seminar in the USSR

in 1960 Bulgaria and France hosted two seminars on the administration and organization of health services in rural areas.

In 1955 Dr Begg proposed a second general programme of work for the Region, covering the period 1957–1960. According to his contemporaries, he was excited about continuing this work in the new Copenhagen headquarters and had decided to stand for re-election. After his sudden death, however, the Regional Office needed a new director and, on 1 February 1957, Dr Paul J.-J. van de Calseyde took over.

"I was one of the participants in the first seminar; my colleagues were senior public health administrators from 16 countries. Some later became directors-general of national health services or directors of schools of public health. Professor Andrija Štampar led the group. During their 15 years, the travelling seminars helped to build a new network of European health authorities and experts. With their vital work and support of WHO, these people gradually succeeded the WHO first generation in leading positions in countries, at the World Health Assembly and on the Executive Board."

Dr Leo A. Kaprio, Regional Director Emeritus, 1991

"Dr Begg had a very personal style. Apart from meetings in which he informed the staff, he was a great listener. When talking, however, he gave a clear and precise summary of his thinking, leading up to his opinion or his decision"

Dr Alfred Eberwein, former Regional Office staff member, 1991

Dr Paul van de Calseyde: the second Regional Director (1956–1966)

"Dr van de Calseyde was a good skipper and his ship sailed smoothly, even if he could be quite rough and impetuous. That was part of his nature, his contribution to the leadership of WHO – without it he might have been less efficient."

Mr Ivan Tolstoy, former Regional Office staff member, 2008

On the right-hand wall of the lobby of WHO's European head office in Copenhagen hangs a painting by Belgian abstract artist Félix De Boeck. The subject of the work, which began the tradition of Regional Directors' portraits being displayed in the lobby, is Paul Julien-Joseph van de Calseyde, the second WHO Regional Director for Europe.

Born in Ghent in 1903, Dr van de Calseyde attended his hometown university and qualified as a doctor in 1929, specializing in physiopathology. He almost immediately moved into administrative work, however, and the following year started as a medical inspector at the Postal and Telegraph Ministry. There he built his reputation as an exceptional and ethical administrator. In 1937, he joined the Ministry of Public Health and Family Welfare as chief medical inspector, before becoming head of the Department of Social Medicine.

In 1945, van de Calseyde returned to the Ministry of Public Health as Director-General of Public Health. He completely restructured the Ministry, which had been established in 1936, integrating its disparate parts into a coherent whole and sharing responsibilities between the Ministry and the different levels of government. He also developed a hospital policy for Belgium through the use of a countrywide evaluation, followed by lobbying of the Government, which eventually invested in renovating and equipping the country's hospitals, as well as establishing new ones.

Dr van de Calseyde's reputation as a public health administrator spread outside Belgium, and he was appointed Secretary-General of the Anti-Venereal Disease Commission of the Rhine, a member of the Health Committee of the Western European Union, and from 1948 to 1956, a delegate to the World Health Assembly.

Nominated by the WHO Regional Committee for Europe in September 1956, Dr van de Calseyde took up the post of Regional Director on 1 February 1957. His tenure was marked by:

- the Regional Office's move to Copenhagen;
- the return of the eastern countries to active membership;
- the change in priorities created by the decline in communicable diseases and the rise in noncommunicable diseases; and
- the general philosophical change that saw the European Region move increasingly towards preventive strategies.

"Education and training at that time were our top priority, and the Regional Office provided Member States with this type of assistance through fellowship programmes that offered specialized education to health workers in every country. Ministries of health were extremely interested in making sure that their staff members were able to improve their knowledge and their expertise. So when they went back they could train other people that then could serve their countries in a more efficient way."
Mr Eddie Vesterholm, former Regional Office staff member, 2008

When Dr van de Calseyde retired in 1967, he returned to Belgium to head the Higher Public Health Council. He attended a session of the Council just two days before his death on 3 March 1971.

"He was a nice man, very relaxed, always smoking a big cigar. There was no antitobacco policy at the time and we all smoked at the Office."

Mr Knud Thoby, former Regional Office staff member, 2008

The shock of the new: 1956–1966

New health challenges

By the late 1950s and early 1960s, Europe was undergoing an economic boom. This obviously had a great number of benefits – such as a serious reduction in the number of cases of communicable diseases – but also less positive side-effects, such as increases in:

- rates of noncommunicable conditions (such as accidents and trauma, cardiovascular diseases, cancer, diabetes and rheumatism);
- water, soil, air and noise pollution; and
- nutritional disorders, accidents and drug use.

In addition, increased mental health problems accompanied the increasing urbanization of the Region, as family ties broke down.

The health sector was beginning to understand that health is a multisectoral issue, needing wide-ranging action. The Regional Office faced the difficult problems of becoming far more multifunctional and revising its operational priorities. This meant being more active in promoting health through national and international bodies, as well as through education, agriculture, industry, veterinary medicine, and other economic and cultural activities.

Staff at work in the new office in Copenhagen

Second, it became increasingly important that health services moved from focusing only on cure to placing far more stress on prevention. This idea became a key motivation for the vast majority of the Regional Office's work since the early 1960s.

In addition, the return of the eastern countries to active membership resulted in an overnight rise of 200 million in the population served by the Regional Office. After the 1960 World Health Assembly, Russian joined English and French to become the Regional Office's third official language.

New programmes

The Regional Office introduced new programmes to address the new priorities, including noncommunicable diseases, gerontology, radiation protection (a concern at the height of the so-called Cold War), and epidemiology and health statistics.

In 1960, the Regional Office created a chronic disease and gerontology unit. It worked closely with local public health services, encouraging them to implement early detection programmes, comprising screening, health examinations and special treatment regimes. The unit also sought ways to improve care for elderly people.

In opening an epidemiology and health statistics unit, the Regional Office acknowledged that the changing face of public health required a new, epidemiologically based approach. Good statistical information was needed as the foundation for the planning and implementation of new public health strategies. The Regional Office supported international epidemiological studies, training courses and fellowships on such topics as TB and degenerative heart disease.

New partnerships

Long before anyone talked of knowledge-based economies, the Regional Office was building on existing initiatives to improve education. Meetings, training courses, studies, fellowships, direct consultation and assistance to countries became major tools that helped spread knowledge among health care providers and national authorities across the Region. This emphasis on education and knowledge can be seen in the "demonstration areas" courses run in Soissons, France and Uusimaa, Finland. Consisting of lectures, talks, discussion and visits, these gave practical experience to European and global specialists.

The Regional Office linked with the United Nations Children's Fund (UNICEF) to provide training facilities in maternal and child health services across Europe. School doctors and nurses became a conduit for improving children's health, as personal hygiene, nutrition and road safety became integral parts of school curricula. The United Nations Educational, Scientific and Cultural Organization (UNESCO) and WHO developed programmes on education and mental health for children. With the International Labour Organization (ILO) and UNICEF, WHO also created educational and training activities to improve understanding of the implications of disability.

Other partnerships were established, including one with ILO on improving occupational health. Rapid industrialization, mass manufacturing and the introduction of nuclear energy meant that health professionals had increasingly important roles in improving industrial workers' health and welfare.

The Regional Office also worked closely with the Food and Agricultural Organization of the United Nations (FAO) to control zoonoses, through such means as brucellosis vaccines in Spain and a study of leptospiroses.

New jobs in new hospitals

The role of doctors in modern health care settings was changing. They were increasingly involved in administration, becoming multifunctional health specialists whose work included balancing resources and requirements, setting priorities and placing health problems in the context of larger social and economic concerns.

Economic development and improving health in the Region paradoxically increased the need for nurses in a variety of different fields, with shortages in some countries. In addition to caring for the ill, nurses

became health educators to the wider population and participants in the planning and organization of health services.

Hospitals also changed, as they were forced to shift from treating communicable diseases to caring for the elderly and people suffering from chronic diseases. This meant a gradual shift from inpatient towards outpatient care.

New approaches to communicable diseases and mental health

In this period, rates of certain communicable diseases – such as venereal diseases, typhus and smallpox – fell, but rates of others – such as poliomyelitis – rose. TB was still widespread and trachoma and bacterial conjunctivitis were endemic in the Mediterranean basin. The strengthening of the public health laboratory system was central to the Region's response to these threats. The Regional Office trained staff and helped countries in the production of vaccines. Thanks to help from UNICEF, the problem of vaccine availability in Europe was for the most part solved.

In the early 1960s, decades of mental health policies were overturned, as European approaches to mental health underwent a sea change. New drugs became available that mitigated symptoms and allowed for more community-based options for care. Psychiatric services, like hospitals, shifted their work towards outpatient care, as closed units were shut down and committals and prison-like conditions were reduced.

In 1966, as Dr van de Calseyde's service as Regional Director drew to a close, the Regional Office was in a far stronger position than when he had taken over. Cooperation between countries – a touchstone for him – had improved, and the ideas of a comprehensive approach to health problems and of national health planning as a vital tool in health development had won general acceptance. The next Regional Director would face the challenge of bringing all the strands of the Regional Office's work together into a common health policy.

Europe: Malaria-free Region

In 1962, the Office was able to declare a major victory when the European Region was the first to be declared malaria free. This was due to intense work in the Region in establishing the etiology and epidemiology of malaria, as well as the creation of the protocol for its eradication. The experience of WHO personnel in Greece helped to establish the importance of insecticide spraying and epidemiological surveillance.

During the 1960s and 1970s, malaria in Europe was mostly confined to cases imported from other countries. In the 1990s, however, the disease made a strong comeback, reaching epidemic proportions in countries in central Asia and the Caucasus. Between 1995 and 2008, intensive interventions reduced the number of reported cases from 90 712 to 589. In 2005, all malaria-affected countries in the Region committed themselves to a new effort to eliminate the disease in the Tashkent Declaration: the Move from Malaria Control to Elimination in the European Region.

Dr Leo A. Kaprio: the third Regional Director (1966–1985)

"Leo Kaprio was an observant person and careful in what he did. He wasn't afraid of taking courageous decisions, but remained diplomatic. People respected him because he was a good professional and also because he was straight and never played games."

Dr Jo E. Asvall, Regional Director Emeritus, 2008

Leo A. Kaprio's early life was deeply touched by war. He was born in Finland in 1918, the year in which his homeland suffered a civil war. The Second World War interrupted his medical education; during it, he served as a captain in the Finnish Army medical corps. He finally completed his studies in 1955 with the award of a PhD in the United States. By that time, however, he had already worked in hospitals and universities, supervised health services in 10 Finnish provinces, and been the director of Finland's Uusimaa Health Teaching and Demonstration Centre – used by WHO as an international training centre – as well as an assistant public health officer in Uusimaa province.

Dr Kaprio's first contact with WHO came in 1948, when he represented the Finnish government at a meeting held in Geneva to debate the establishment of the Regional Office. He joined WHO in 1956, working in the regional offices for the Eastern Mediterranean and Europe and as Director of the Division of Public Health Services at WHO headquarters.

Nominated as WHO Regional Director for Europe in 1965, he took up the post in February 1966. He served for 18 years: "outliving in office," as he once said, "an average of two generations of national directors-general and hundreds of ministers and deputy ministers of health".

Dr Kaprio retired in 1985, when he was awarded the title of WHO Regional Director Emeritus. Afterwards, he remained active in the Organization, as well as teaching international health policy in Helsinki, from 1989 until his death in 2000.

"Dr Kaprio was a dominating figure in the Office. Some staff members compared him to a benevolent king. He had a very interesting personality, very good for the job he had. You have to remember it was in the middle of the Cold War, and there was no cooperation between west and east except for health. WHO was a rare exception to the rule and there was practical cooperation."

Dr Jo E. Asvall, Regional Director Emeritus, 2008

Planning for the future: 1966–1985

Health planning

"Modern medical science," wrote Dr Kaprio in 1969, should be "applied effectively and economically for the benefit of the whole population. … There is a growing need for long-term planning as well as better managerial leadership of the 'medical service', which is, in economic terms, one of the major employers in modern industrialized society." The WHO Regional Office for Europe had begun to react to this idea three years earlier, when the Regional Committee began to develop the idea of national health planning. The Regional Office started by reorganizing its programme and budget to allow for a more systematic approach. This entailed making long-term plans across the Region, in collaboration with national health services, WHO headquarters, and other governmental organizations and NGOs.

Long-term programmes

The Regional Office used comprehensive long-term programmes to replace the usually short-term and uncoordinated activities across the Region with a wide range of projects contributing to a central goal. (They were also an excellent way of testing health planning principles.)

The three programmes – on cardiovascular diseases (CVD), mental health and environment – began at about the same time and lasted for roughly a decade. They set the course for future activities in these areas. In practice, this meant a general move to expand from treatment strategies towards preventive action.

Her Majesty Queen Margrethe II of Denmark and His Royal Highness Prince Henrik at the inauguration of new buildings, 1972

Long-term programme on CVD (1968–1980)

In 1968, in "most European countries, cardiovascular diseases were considered an 'individual' fate, to be dealt with by the patient and the physician. The idea of considering coronary heart disease as a mass phenomenon was alien to the vast majority of European cardiologists". The long-term programme on CVD aimed to change this and worked to develop policies and test methods to control coronary heart disease. (Rheumatic heart disease, stroke and arterial hypertension were tackled from WHO headquarters.) The programme also improved knowledge about the epidemiology and natural history of CVD.

The programme helped to change the whole approach to CVD in the Region by advocating the use of intensive coronary care, bypass surgery and active rehabilitation in outpatient units. It also "benefited all the ongoing important projects in the field, within and outside WHO. In return, the work of thousands of trainees, participants and experts in the programme was an important influence on the future work of the Regional Office."

The programme also had an unexpected side-effect. It established contact between politically concerned cardiologists who later organized a group, the International Physicians for Prevention of Nuclear War, whose work earned it the Nobel Peace Prize in 1985.

Long-term programme on mental health (1970–1978)

The Office first called for a mental health programme in the wake of the political and social upheavals of 1968, when it began to focus on the mental health of young people. In 1970, a more general programme was put in place concentrating on eight problem areas:

1. the stigma of mental disorders;
2. traditional systems of care, based in hospitals;
3. large, isolated mental hospitals;
4. outdated legislation;
5. few ambulatory alternatives to hospital;
6. a shortage of nonmedical staff;
7. a lack of adequate data; and
8. a lack of coordination with other community services.

The long-term programme proposed a new model of care: comprehensive preventive, treatment and rehabilitation services delivered in the community by multidisciplinary teams of health professionals. This approach is dominant today.

To build understanding, the Office began collecting statistics and training personnel. The programme acted as an umbrella under which the Regional Office could bring together disparate initiatives, while increasing collaboration with other agencies and organizations.

"A WHO programme has been simply defined as consisting of 'two major elements: (a) the recognition and adequate description of a problem and (b) the sum of actions proposed to solve it, partly or wholly'. The three long-term programmes met this definition and shared a striking comprehensiveness of both structure and approach."

Dr Leo Kaprio, Regional Director Emeritus, 1991

It concentrated on four broad areas:

1. organization and planning of services and personnel;
2. education and training;
3. information on and classification of mental health problems; and
4. problems of specific social groups, such as young people and abusers of alcohol and illicit drugs.

In 1978, the Region's long-term programme became part of the global WHO strategy.

Long-term programme on environmental health (1971–1980)

In 1970, the Regional Committee approved a long-term programme for pollution control. As it evolved, the Regional Office aimed to aid Member States through a systematic and coordinated long-term programme that sought ways to prevent environmental hazards to health and/or to render them harmless through legislative, administrative and technical methods. The programme covered water supply and sanitation, treatment and disposal of solid waste, chemical safety, food safety, radiation protection, the public health aspects of housing and occupational health.

"The long-term programme," wrote Dr Kaprio in 1991, "broke new ground by urging a multisectoral, preventive approach and international cooperation on environmental health." While resource and political difficulties hindered implementation (particularly in the eastern countries in the Region), the programme helped build and train a Region-wide network of environmental health experts. They proved valuable allies in WHO's future work on environmental health.

New global policy: Health for All

In May 1977, the World Health Assembly adopted the founding document of what would become the global policy for health for all. The resolution said that WHO and governments should seek "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".

The next stage came at the International Conference on Primary Health Care in Alma-Ata, USSR in 1978, where the participants adopted a Declaration that carefully defined primary health care and recognized it as key to attaining health for all. As one of the policy's original aims was to help poorer, less developed countries, many well-off, developed countries unfortunately believed that the policy had no relevance for them.

Regional strategy and targets

Dr Kaprio was keenly aware that, for the Health for All policy to succeed, developed countries had to participate. He believed that, if these Member States' involvement meant only donating money, their less developed counterparts would rightly consider the policy a two-tier system and reject it out of hand. The Regional Office therefore worked to show developed European Member States that the policy was relevant to them as a way to improve the health of their populations.

After all, every Member State had its share of health problems. These included vulnerable groups in need of more primary care and social assistance, and large differences in access to health care within and between countries, often due to unevenly distributed services. There was also far too much emphasis on treatment and cure and not enough on disease prevention and health promotion.

The Regional Committee session in 1969 was an important stage in the development of the Health for All policy. The Regional Office presented the results

Europe: smallpox-free Region

After more than a decade of work, the European Region was officially declared smallpox free in 1977. The eradication of smallpox remains perhaps one of the greatest achievements in public health.

of a six-year study on family health that provided important background for the development of the European strategy and targets for health for all. In 1970, the Regional Committee voted to introduce a "comprehensive, coherent and consistent long-term strategy for the Region as a whole", which included objectives and programmes on the national and regional levels for:

1. the promotion of healthy lifestyles;
2. the reduction in preventable conditions; and
3. the provision of adequate and accessible health care for all.

An important part of this strategy was its compatibility with the global WHO strategy, but European Member States had already attained most of the global targets by 1981. The Region needed to set its own targets. Thus, between 1982 and 1983 the Regional Health Development Advisory Council consulted relevant partners and developed a set of policy proposals based on desired outcomes, such as improvements in health and reductions in health hazards, rather than resources and problems. It looked into health planning and management, and ways of promoting health and improving the equity and quality of health systems.

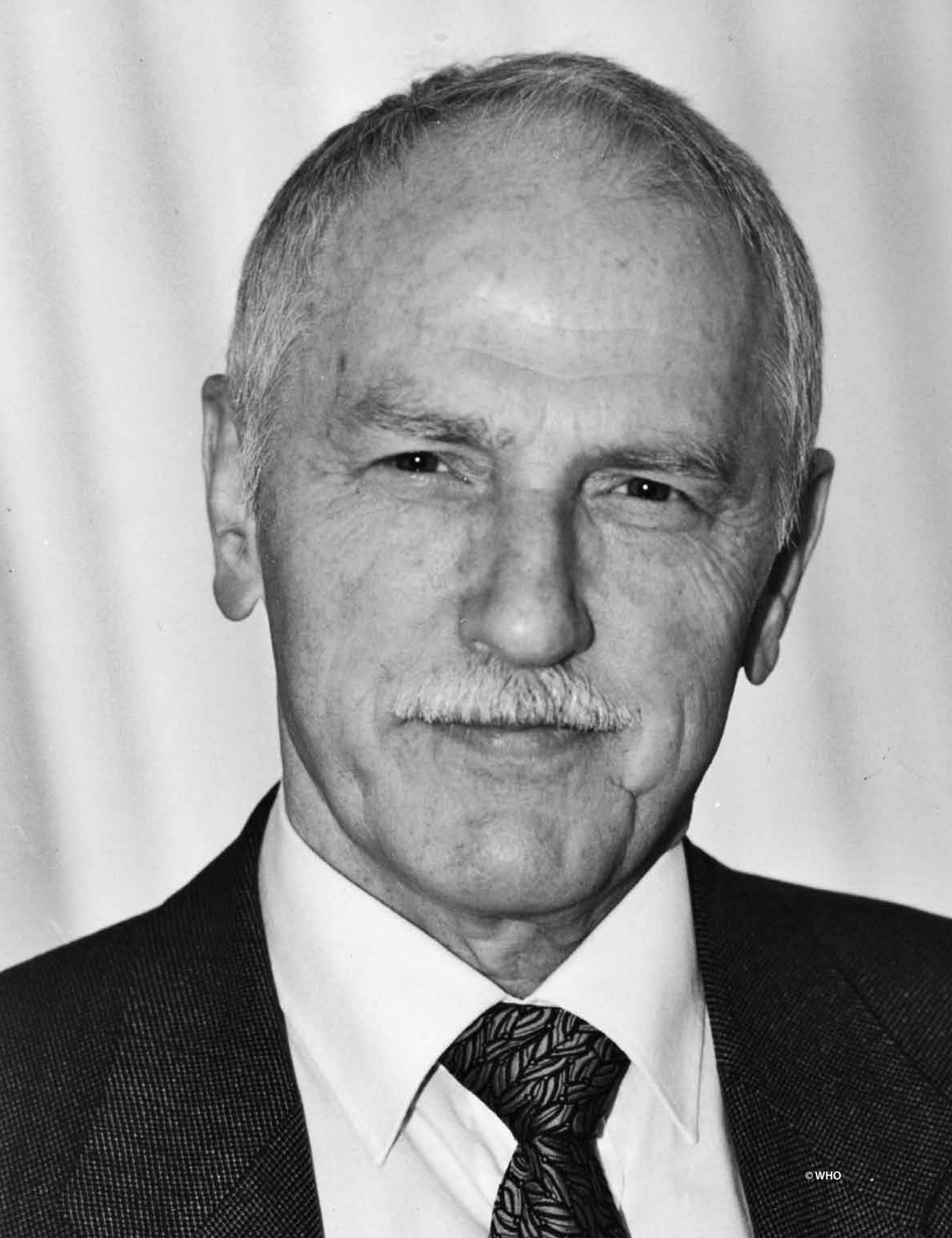
The Council's first draft of the European strategy for health for all proposed 82 targets for attainment by 2000. By the time the Regional Committee adopted the European Region's first Health for All policy document in 1984, this number had been cut to 38, plus 65 linked indicators. This document was intended to be the foundation for all future WHO activities in the Region.

The policy gave a clear ethical framework for policy development, a shift away from hospital-oriented health systems and towards systems based on improved primary care. It was based on and driven by basic values including: equity, solidarity and participation. Equity meant that everyone should have a fair opportunity of attaining his or her health potential, based on fair distribution across societies. Solidarity meant that societies should work for the health of all their members. Participation meant that stakeholders must take part in any decision-making intended to improve health and/or health systems.

The strategy was also based on ideas of health policy that included the prevention of disease, promotion of healthy lifestyles and management of health determinants. This, of course, meant expanding public health policy beyond the health sector to other sectors in society, such as education, environment, agriculture and industry.

In addition, it acknowledged that health policy was also economic policy. Improving the health of a population helps to promote a society's development and economic growth.

The adoption of a common European health policy was Dr Kaprio's final accomplishment as WHO Regional Director for Europe. He stood down in 1985 and was replaced Dr Jo E. Asvall, who, as Director, Programme Management in the Regional Office, had been vital to the establishment of the Health for All policy. The policy having been adopted, the new Regional Director faced the challenge of putting it into practice.



Dr Jo E. Asvall: the fourth Regional Director (1985–2000)

"I was always impressed by Dr Asvall's deep conviction that WHO's actions could make a difference in the health of people in all countries. He always abided by this principle."

Dr Paul A. Lamarche, former Regional Office staff member, 2008

Born in 1931 in Norway, Jo E. Asvall qualified as a doctor in 1956. He wrote his first application letter to WHO two years later and was among 10 students chosen for malaria eradication courses in Latin America in 1959. Dr Asvall worked in Ecuador, Jamaica and Mexico, before moving to West Africa where he headed up WHO's malaria team for Benin, Cameroon and Togo.

Returning to Norway in 1963, he took up a hospital post and became increasingly involved in clinical management and hospital administration. This experience stood him in good stead when he became director of the hospital department at the Norwegian Ministry of Social Affairs in 1973. He was key to formulating a new Norwegian national health policy, which was implemented in 1975. A year later he was a delegate to the World Health Assembly; then he joined the WHO Regional Office for Europe, where he served as Officer for Country Health Planning until his appointment as Director, Programme Management in 1979.

Dr Kaprio considered Dr Asvall to be the driving force behind the Health for All policy in the WHO European Region. When it was time to nominate Dr Kaprio's successor in 1984, Dr Asvall was seen as the natural choice. His mandate was spent attempting to make sure that Health for All – or the "Bible of health policy", as he put it – became the driving force of the Regional Office's work.

Dr Asvall left his post as Regional Director in January 2000, becoming Regional Director Emeritus. He lives in Copenhagen and Geneva, and is considered a leading public health expert, as well as a good skier.

"We were in the middle of the Cold War, and what was scientifically valid for some was politically unacceptable to others, and I well remember some loud debates about certain targets, but Dr Asvall's management style was transparent. He listened to others and accepted critical remarks and comments if they were formulated in a constructive and polite way."

Dr Paul A. Lamarche, former Regional Office staff member, 2008

Health for All: 1985–2000

Implementing Health for All in Europe

At its heart, Health for All was about changing attitudes towards health. This meant altering policy, empowering the sector's participants – from service users to carers to administrators – and mobilizing international networks of health professionals, politicians and the mass media to promote the health of all people. "Active health promotion" was seen as the best way to implement the policy in the European Region: WHO's role should be to increase Member States' – and so their citizens' – understanding of how ill health could be prevented and suggest strategies for improving health across the Region.

For the WHO Regional Office for Europe, part of this policy of active health promotion was to support the country health services that wanted to implement Health for All. From 1985 to 1990, this saw the Office aiding Member States in creating health policies and programmes that supported the ideas of Health for All. Consultation and research across the Region revealed that Member States shared a certain number of problems with implementation:

- insufficient attention by national authorities to the link between social and economic behaviour and health;
- worsening economic indicators during the 1970s and subsequent austerity measures in health systems, despite rapidly rising costs; and
- widespread dissatisfaction with available care among users with serious investments too often producing minimal results.

The challenge facing the Regional Office in the early years of Dr Asvall's tenure was to balance competing demands with the necessity of implementing Health for All.

Collaboration

The first step was actually taken before Dr Asvall became Regional Director. As Director, Programme Management, he had organized a series of meetings dubbed "leadership through advocacy" between 1982 and 1986 to explain and promote the strategy and explain how it could be implemented. Four meetings were held – in Turkey (Antalya), Norway (Oslo),

"Health for All opened new operational opportunities beyond health systems, became an integral part of a variety of sectors of society. The idea was that health services had to be delivered to everyone and not just the most advantaged. This was a brand-new idea and revolutionary idea for that time. It catalysed the whole of WHO's resources, and the European office was no exception."

Dr Paul A. Lamarche, former Regional Office staff member, 2008

Greece (Corfu) and Ireland (Shannon) – bringing together health leaders from across the Region. The meetings, based on the travelling seminars of the 1950s and 1960s, were also attended by non-medical figures such as political scientists and management experts. They proved extremely useful in creating new networks of health professionals across the Region, with knowledge of Health for All and a desire to implement it.

The second step was to support strategies and action programmes in Member States. The Regional Office and Member States began intensive consultation and negotiations with the idea of creating tailored health policy documents. By the end of 1987, 10 countries had such documents, including Bulgaria, the German Democratic Republic, Hungary, the Netherlands, Ireland and Yugoslavia. This number increased by seven by the end of 1989. In the wake of the political changes in the early 1990s, countries in the eastern half of the Region needed to reconstruct their health services. Most were happy to collaborate with the Regional Office in reformulating their national policies in terms of Health for All.

Chernobyl

The accident at the Chernobyl nuclear power station on 26 April 1986 was a health emergency of unprecedented scale. In the immediate aftermath, the Regional Office organized a team of staff and other experts that collected and analysed data for distribution to Member States. In early May, the Office announced appropriate countermeasures and four days later released a report aimed at quelling panic and allowing for measured debate based on facts. The Office's long-term work on environmental health, including the effects of ionizing radiation, proved a valuable foundation.

The Chernobyl disaster was the one of the first events in the European Region with genuine transnational health effects. The Office's experience during the disaster proved valuable in responding to other events.

International Conference on Health Promotion

WHO headquarters recognized the Regional Office for Europe's success in implementing Health for All in 1986, by asking it to organize the first International Conference on Health Promotion. Held in Ottawa, Canada, the Conference resulted in the Ottawa Charter for Health Promotion, which defined health promotion as a process of enabling people to increase their control over their health and thus improve it. It also concretized Health for All in five main areas: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services.

As the Regional Office's work in promoting Health for All became increasingly complex, it reoriented its activities around five distinct but intertwined pillars:

1. Health for All, for work related to equity in health and the health of an increasingly elderly population;

Europe against tobacco

In 1988, the European Conference on Tobacco Policy was held in Madrid, Spain. Participants from 27 European Member States and 4 countries outside the Region met to discuss how Europe could lead the way in regulating tobacco and its harmful effects on health. The resulting Charter against Tobacco declared that people had a moral right to be protected from the diseases caused by tobacco, as well as the pollution caused by second-hand smoke.

The Conference was a vital step forward in European tobacco policy and influenced subsequent national tobacco policies. The European Region has been leading in tobacco control ever since. In 2002, Member States adopted the European strategy for tobacco control, which reviews progress annually. In addition, the process went global and culminated in the adoption of the WHO Framework Convention on Tobacco Control (FCTC), WHO's first globally binding public health treaty.

2. healthy lifestyles, aimed at preventing tobacco use, improving nutrition and preventing and treating HIV/AIDS;
3. healthy environments, acknowledging the link between the environment and health;
4. appropriate care, dealing with maternal and child health, sexuality and family planning, the quality of care and technology;
5. research and health development support, including research, health management and medical education.

Soon after the Ottawa Conference, the Regional Office introduced additional initiatives designed as vehicles to carry health promotion and the Health for All message to specific settings: the Healthy Cities project and the European Network of Health Promoting Schools. In addition, health promotion was central to the countrywide integrated noncommunicable disease intervention (CINDI) programme, which had started earlier in the 1980s.

EUROHEALTH

The political changes in the eastern half of the Region not only nearly doubled the Region's number of Member States (from 31 to 50) but also changed how the Regional Office worked. In the new situation, a huge gap in health between the eastern and western halves of the Region was revealed.

In 1990, the Regional Office reallocated funds for countries in the eastern half of the Region and set up EUROHEALTH, a programme aimed at meeting these countries' immediate and medium-term needs. This programme adapted the Region-wide Health for All programme to have a greater country focus. It initially dealt with 26 Member States, of which 21 received

More Member States: flags at a Regional Committee session

WHO assistance in four areas: health services, disease prevention and quality of care, healthy lifestyles, and environment and health. In addition, the Regional Office began to establish liaison offices in countries to ensure contact and information exchange with governments and to coordinate the activities of WHO and other agencies. There were liaison offices in 13 countries by mid-1993, and more were set up later. They were the forerunners of today's country offices.

The first external assessment of EUROHEALTH, in 1994, reported that the programme had been generally successful in raising health levels, although a number of problem areas remained, including health care reform, health promotion and noncommunicable disease prevention. These were said to be due to a lack of will at the national level and a lack of support from the Regional Office. This report led to the updating of the programme to include six new priorities: health policy, health care reform, women and children's health, infectious diseases, noncommunicable diseases and health promotion, and environmental health. The rethink also led EUROHEALTH implementation to become more country oriented, with the Regional Office taking more care to tailor its assistance to the needs and budgets of Member States.

The real success of the EUROHEALTH programme – and thus its basis, Health for All – can be seen in the way that it became a natural part of many Member States' health budgets, priorities and systems.

WHO in the former Yugoslavia, 1999

The Regional Office and the former Yugoslavia

The armed conflict in the 1990s, following the dissolution of Yugoslavia, required the WHO Regional Office for Europe to respond to an enormous humanitarian crisis. The Office responded by making new policies to tackle the immediate problems caused by the fighting – such as access to health care and refugee health – while putting in place longer-term programmes to help the new Member States reconstruct their health systems.

WHO's first head of operations in these countries was Sir Donald Acheson, of the United Kingdom, who ran a network of offices in Bosnia and Herzegovina, Croatia and the Federal Republic of Yugoslavia (Serbia and Montenegro), as well as a special field office in The Former Yugoslav Republic of Macedonia. From these offices, Regional Office staff fanned out across the subregion to assess immediate emergencies and the possible medium- and long-term health needs of local populations, and coordinate and take part in the responses. This work formed the basis for the current emergency preparedness and response programme.

Four lessons

The Regional Office learned four vital lessons from this experience; it:

1. must always ensure that it has proper information and statistics as the basis for action;
2. is responsible for the coordination of assistance in war-torn regions and helps by providing a forum in which different groups can work together;
3. must support the rehabilitation and restoration of local public health facilities; and
4. must identify and fill the gaps in the health response left by other agencies.

Health21

In 1998, the WHO Regional Office for Europe revised the Health for All policy framework. The result was Health21, an acknowledgement and reflection of the enormous changes that the Region had witnessed since 1991. Twenty-one targets were set to measure progress in improving, promoting and protecting health and reducing risks. Health21 saw health as a precondition for well-being and quality of life, a benchmark for measuring progress towards the reduction of poverty, promotion of social cohesion and elimination of discrimination. Importantly, the Health21 framework included the link between health and sustainable economic growth.

As a new millennium began, Dr Asvall moved on from the WHO Regional Office for Europe, declared by the Regional Committee to be Regional Director Emeritus. He left an organization radically altered from the one he inherited. The Region had nearly two dozen new Member States, and the Regional Office had changed the way it worked with countries. Plenty more work, however, remained to be done.


© WHO

Dr Marc Danzon: the fifth Regional Director (2000–2010)

"The importance of the role played by well-functioning health systems in improving and maintaining the health of populations is one of those facts so obvious that it can sometimes take a long time to become obvious to all. Since 2005, strengthening health systems has become an even more central priority for the Office."

Dr Marc Danzon

Born in 1947 in Toulouse, France, Marc Danzon was not sure if he was going be a doctor or journalist until the last minute. Aged 18, however, he enrolled in medicine at Université Paul Sabatier in his hometown, staying for 7 years, studying and becoming involved in politics (the events of May 1968 and a stint on the student council). In 1974, two years after graduating, he joined the Comité français d'éducation pour la santé (French Health Education Committee – FHEC), a public body charged with defining and implementing policies and programmes for health promotion and education. At the same time he began his postgraduate studies, eventually finishing with a "certificate of special studies" in preventive medicine, public health and hygiene, a diploma in advanced specialized studies in health economics and, finally, in 1984, a specialization in psychiatry.

The following year, Dr Jo E. Asvall, then WHO Regional Director for Europe, offered Dr Danzon the job of head of public information. The chance to combine his longstanding love of journalism and his medical qualifications proved irresistible and Dr Danzon moved to Copenhagen. He stayed until 1989, when he returned to FHEC. Inspired by the huge upheavals in the wake of the political changes in the eastern half of the Region, he returned to the Regional Office in 1992 as director of the newly created Department for Country Health Development. Thus, he became responsible for the implementation of the EUROHEALTH programme. He later became head of a newly created department of public health.

In 1997, Dr Danzon again returned to his native country, this time to head up the Fédération nationale de la mutualité française (National Federation of Mutual Insurance Companies), a body representing non-profit-making health insurance companies. In parallel, he prepared to campaign for election as WHO Regional Director for Europe. He called for a streamlined Regional Office that would better serve Member States. With this vision, he was nominated as Regional Director by the WHO Regional Committee for Europe in September 1999.

On taking up his post in February 2000, Dr Danzon started work to make the Regional Office a better partner to countries, tailoring its services to their needs. This came to be known as the country strategy and, following his re-election in 2004, it concentrated the Regional Office's mission on strengthening health systems in ways adapted to countries' particular needs.

As Dr Danzon leaves the post of Regional Director, he hands over a strong and focused Regional Office that concentrates on Member States' needs, and is engaged with WHO headquarters and key international organizations.

"The programme put together for the Stability Pact is particularly important to me. In fact, it will always remain one of the acts in my career of which I feel genuinely proud."

Dr Marc Danzon

Putting countries first: 2000–2010

Country strategy

In September 2000, Member States adopted a document that profoundly changed the WHO Regional Office for Europe and its work. The Regional Office's Country Strategy: "Matching Services to New Needs" was a first step in establishing a new approach that became the basis of new relationships with Member States (which now number 53).

The Country Strategy gave the Regional Office a new mission: "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". Its aim was to make the Regional Office a service provider that addressed each country's particular needs, by:

- taking account of each country's characteristics and circumstances;
- strengthening international partnerships for health;
- making the WHO Regional Office for Europe's work part of WHO's global country strategy; and
- making the best use of the Regional Office's long experience.

The first step in this process was allowing country offices, now located in 29 countries in the Region, to function better and more independently. This meant upgrading the skills of their staff. The process helped strengthen country offices in technical expertise and in relation to the governments of the countries in which they are based. It significantly improved country offices' relevance and efficiency.

The other essential step to implementing the Country Strategy was the upgrading of biennial collaborative agreements (BCAs), which the Regional Office signed with countries' governments. Each spells out the issues of top priority to the country and the work that it will do with the Regional Office to address them. BCAs were essential in strengthening the Regional Office's reputation for transparency, accountability and sustainability. The Regional Office initially signed BCAs mainly with eastern European countries, but has recently negotiated them with some western European countries, too. In 2008, 3 of the 33 BCAs were made with countries in the western part of the Region.

BCAs have allowed country offices to work more openly and with greater clarity of mission, and have improved efficiency. Since 2000, they have evolved to reflect Member States' priorities more visibly. They have also helped to improve the Regional Office's relationship with Member States, allowing it to be widely seen as a credible adviser in the field of public health across the Region.

Health and the Stability Pact

In June 1999, armed conflict in Kosovo[2] was drawing to a close and the Stability Pact for South East Europe was established in Cologne, Germany, with the support of the European Union (EU), the United States of America and the Group of Eight (G8). Forty countries agreed to help the countries of south-eastern Europe "in their efforts to foster peace, democracy, respect for human rights and economic prosperity, in order to achieve stability in the whole region". The Stability Pact was officially launched at a summit meeting in Sarajevo, Bosnia and Herzegovina in July 1999.

In early 2001, Mrs Gabriella Battaini-Dragoni, Director, Directorate of Social Affairs and Health, Council of Europe, approached Dr Danzon during a meeting in Strasbourg, France. "Her energy and determination immediately impressed me," remembers Dr Danzon. "She then told me that she thought it was a scandal that health was not included in the Stability Pact's programme."

As a result, the WHO Regional Office for Europe agreed to look into access to health services for the vulnerable and organize a high-level meeting to create a transnational health network in the subregion. The Regional Office reported on its proposals in March 2001, including a detailed assessment of the political context and problems of the south-eastern European

[2] In accordance with Security Council resolution 1244 (1999).

countries involved in the Stability Pact. It recommended the pilot-testing of a new country strategy in the subregion to facilitate and stimulate dialogue and debate between countries. In May 2001, a joint action plan featuring 11 principles of cooperation was agreed, to support the strengthening of health services. Each country would take on a health care project and develop it for the benefit of the other participating countries. After nearly a decade of fighting between some of the Stability Pact countries, this idea was a strong symbol and method for progress in the subregion.

Thus, health ministers from Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, The former Yugoslav Republic of Macedonia and Yugoslavia gathered in Croatia to sign the Dubrovnik Pledge: Meeting the Needs of Vulnerable Populations in South East Europe in September 2001. Dr Goran Cerkez, of Bosnia and Herzegovina's health ministry, described the agreement as "a very positive step in the process of reintegration in the region. For the first time, seven ministers of health agreed to work together and develop a project of common interest".

The Dubrovnik Pledge was based on three health objectives:

- restructuring health services in a cost-effective way to ensure universal access to high-quality health care;
- restructuring and strengthening public health functions and infrastructure; and
- developing professional capacities for health.

Seven public health strategies targeting the most vulnerable in the region were put in place with one country leading the response to each:

- infectious diseases, strengthening surveillance and control (Albania);
- strengthening social cohesion through the development of community-based mental health services (Bosnia and Herzegovina);
- establishment of a social and health information network (Bulgaria);
- capacity building to ensure equal access to high-quality health care (Croatia);
- blood safety (Romania);
- emergency health care (The former Yugoslav Republic of Macedonia); and
- food and nutrition (Yugoslavia).

Three health projects – on mental health, communicable diseases, and food and nutrition – had

"The process was extremely interesting and centred on the idea of giving each country the leadership of a health project, which it would then develop for all. In a way it reminded me of the way the European Union began just after the Second World War, an organization aimed at ensuring peace through joint economic and industrial interests – except that in our case, we were sharing health projects. The Dubrovnik meeting was really an exceptional moment."

Dr Marc Danzon

been funded and were under way by January 2002; this number rose to six by mid-2005, and projects that had not yet received funding were reorganized. The Dubrovnik Pledge also called for the establishment of a permanent organization to coordinate and implement the commitments made in the Pledge, and evaluate results. Accordingly, the South-eastern Europe Health Network was launched in May 2002, made up of representatives of eight south-eastern European countries, five neighbouring donor countries and four international organizations.

In November 2005, the health ministers of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Romania, Serbia and Montenegro and The former Yugoslav Republic of Macedonia signed the Skopje Pledge, the second political agreement on cross-border health development in the region. It confirmed that more investment in public health – combined with greater political and organizational efforts – could achieve real improvements in health, and help to reduce poverty and stimulate economic growth. The signatories – along with the Council of Europe, the Council of Europe Development Bank, the WHO Regional Office for Europe and the Stability Pact Secretariat – also committed themselves to reducing the health gap between south-eastern Europe and the EU.

Opening of a new mental health centre in Bosnia and Herzegovina, 2005 © WHO

Improvements in the region's political, social and economic situation meant that the Stability Pact was replaced in February 2008 by the Regional Cooperation Council. Driven less by international organizations and more by the region's countries, it is proof that a country-oriented strategy, far from leading to donor dependence, efficiently helps countries act both independently and as part of an interdependent system.

In 2009, the south-eastern European countries took over the process. The initiative's secretariat will be established in Skopje, while three regional health development centres will be created, dealing with organ transplants (Croatia), blood safety (Romania) and health systems and public health services (the former Yugoslav Republic of Macedonia). The process continues, but this result is perhaps the best that the WHO Regional Office for Europe could have envisaged.

Mental health care reform in south-eastern Europe

The project to enhance social cohesion by strengthening community mental health services in south-eastern Europe began in June 2002. Over seven years later, the countries involved have adopted mental health legislation, and begun the transition to community-based care through the creation of pilot community mental health centres.

Today, 10 such centres across the subregion provide services to over 1 million patients, and training for mental and primary health care professionals. Their work also includes raising public awareness and advocacy. The participating countries now appear ready to roll out the pilot scheme more generally.

Health security and humanitarian action

The traditional reaction to health emergencies has been to use vertical technical support to respond to the specific challenges of each crisis. Unfortunately, this has always had serious shortcomings, including high costs and overlapping activities. The Regional Office is equipped to provide immediate support to Member States in crises, but also follows a policy that tackles acute health emergencies and ensures health security upstream through the continual strengthening of health systems.

Threats and emergencies require health systems to have complex strategies for prevention and preparedness; these demand good governance and good management that make information available for operational and strategic decision-making. For example, fewer people die as a result of an earthquake when hospitals are well equipped and ready; a disease outbreak is more quickly and effectively managed when preparedness plans are already in place and health systems have procedures to limit spread.

Of course, different countries' health systems are organized and managed in different ways. The debate

"Before the mid-1980s WHO was neither expected nor indeed equipped to intervene in 'health emergencies' – those acute man-made or natural catastrophes, such as wars, floods, earthquakes and epidemics, that strain countries Region-wide. Since then, however, it has become a key role for the Organization. This became especially apparent during the series of conflicts that followed the break-up of Yugoslavia in the early 1990s. Practically, this marked a crucial step in the development of activities since grouped under the title 'humanitarian assistance'. This has seen the Office gain a new programme and team, new skills and new experiences; politically, it has become increasingly important for the Office to be present during health emergencies to reassure, raise awareness and, in some cases, help with the collection of funds."

Dr Marc Danzon

is not about what a health system should look like, but what each country can do to make sure that its system can tackle the various types of acute health crises, both known and as yet unknown.

Health emergencies: a casebook

Avian influenza in Turkey

In early January 2006, Turkey alerted the Regional Office to the possibility of an outbreak of avian influenza in the far east of the country. Three children had been hospitalized and had tested positive for influenza A(H5N1), after having been in contact with poultry in an area where the virus had been reported in chickens.

The Turkish Government requested the help of the Regional Office, which immediately sent a team led by a world-renowned expert, Dr Guénaël Rodier, to investigate. Dr Danzon arrived a few days later and was briefed on the situation by the team and Government officials. One of the Regional Office's most important jobs in Turkey was to keep the mass media informed and reassure the Turkish people that there was no need to panic. It hoped that this would stop any calls for unnecessary measures, such as travel bans. The epidemic was successfully contained, thanks to the excellent work of the Turkish Government and the WHO team, in close cooperation with the European Centre for Disease Prevention and Control (ECDC), UNICEF, FAO and the World Organisation for Animal Health (OIE).

"This experience was important in that it showed how the WHO Regional Office for Europe can help a cooperative national government control a potentially desperate situation, and how we can usefully play the role of adviser to national authorities without overstepping our mandate."
Dr Luigi Migliorini,
Head, WHO Country Office, Turkey, 2006

Cold wave in Tajikistan

During the winter of 2007–2008, Tajikistan suffered abnormally cold weather, with temperatures of –15 °C during the day dropping to –25 °C at night.

Press conference in Turkey

As Tajikistan is one of the poorest countries in the European Region, this led to the near collapse of the health system at a time when it was needed more than ever, owing not only to the cold but also to results such as power blackouts, problems with the water supply, increased numbers of burns from heaters and a rise in infectious disease cases.

The Regional Office took the lead in calling for generous support to help shore up the health services during the cold weather and to continue rehabilitation in the long term to avoid a similar situation arising. This led to donations of US$ 1.4 million from the international community to address urgent health needs.

Lead poisoning in Kosovo[3]

In 1999, the United Nations High Commissioner for Refugees set up camps for internally displaced people (IDP) near Mitrovica in Kosovo. Originally put in place as a temporary solution, they were still being used by IDP with Roma, Ashkali and Egyptian ethnicity in late 2004. Unfortunately, the camps were located near lead-tailing dams from mines closed by the United Nations Interim Administration Mission in Kosovo (UNMIK) in 2000, and were heavily contaminated. This had dramatic health consequences for the IDP, including children, living in the camps. A WHO risk assessment revealed that 100 of the 160 children qualified as medical emergencies owing to severe acute and chronic lead poisoning. The only solution was to move the people away from the site as soon as possible, before more damage occurred.

At the 2005 session of the Regional Committee, the Regional Office called for urgent action and financial help from Member States to aid UNMIK in the relocation process. International organizations, the Government of Serbia and other countries offered support, so the vast majority of the IDP were moved from the contaminated area to a former French

[3] In accordance with Security Council resolution 1244 (1999).

Hospital ward in Tajikistan

military camp by March 2006, and later to their place of origin in South Mitrocia.

The Regional Office's excellent relations with the Serbian health minister, Professor Tomica Milosavljević, greatly facilitated this work. Another outcome of this successful initiative was that, with the Ministry of Health of Serbia, a long-term programme to support the Roma population in the European Region was devised.

Mass immunization in Ukraine

After strong urging by UNICEF and the Regional Office, the Ukrainian Government organized a mass immunization campaign against measles and rubella for spring 2008. The WHO pre-qualified vaccine to be used was chosen after an open, thorough and transparent bidding process and the contract awarded to an Indian company. Then the trouble began.

"I know Tajikistan well, after many years of working closely with it, and we decided to respond immediately to the request from our local office to visit the country for four reasons: firstly, to help spread the word about the country's need for funds; secondly, to put that appeal into the context of a long-term programme of health system improvements; thirdly, to review WHO collaboration with Tajikistan and discuss the genuine need for health reforms that the cold snap had revealed; and, fourthly, to see with our own eyes the effects of the cold on the population. What we saw on arrival was shocking – children with terrible burns suffering in hospital beds, their parents unable to comfort them; health centres and hospitals where patients were sharing beds because only certain areas were heated; medical consultations in rooms lit only by candles."

Dr Marc Danzon

Just before the campaign to vaccinate everyone aged 15–29 years began in earnest, a 17-year-old boy died 15 hours after having received the vaccine. His death was almost immediately attributed to the vaccine, and politicians and the media began to sensationalize the situation. Under enormous pressure, the Ministry of Health of Ukraine decided to suspend the campaign, even though there was no evidence to suggest that the vaccine was actually at fault.

The Regional Director met WHO Director-General Dr Margaret Chan and the Ukrainian Minister of Health a week after the crisis began. They agreed that the WHO Regional Office for Europe should send Dr Danzon to Ukraine to help the Government reassure the Ukrainian press and people. Dr Danzon and Ms Maria Calivis, UNICEF Regional Director for Central and Eastern Europe, went to the country a week later.

After consultations with the Ukrainian Government, the pair held a press conference to say that the vaccine was not responsible for the young man's death, and called for the continuation of the vaccination campaign.

Sadly, the campaign was never restarted, and the delay meant that the goal of eliminating measles and rubella from the Region by 2010 will not be attained.

"It is a terrible shame that our targets will not be met by 2010, and the episode in Ukraine reminds us that WHO's work is as much political as medical – one cannot be forgotten to the detriment of the other. The best results always come when the technical/political dialogue takes place in a clear and respectful way, with a real will to arrive at the best result in terms of health on both sides."
Dr Marc Danzon

"Marc Danzon's leadership during his tenure as Regional Director has led to a much stronger and coherent engagement of Europe in public health, notably through a strong focus on bridging east and west. His advocacy and personal commitment around the Tallinn Conference clearly showed that, in Europe and throughout the world, an effective response to disease cannot be mounted without, at the same time, supporting health systems: that is, strengthening laboratories, training health workers and enabling countries to establish the surveillance and monitoring systems that are essential to respond to public health threats."

Professor Michel Kazatchkine,
Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria

Health systems and public health programmes

A good health system should never be a luxury for affluent countries alone, but a fundamental part of all countries' prosperity. WHO defines the six building blocks to a good health system:

- health services that deliver effective, safe, high-quality health care to those who need it with a minimum waste of resources;
- a health workforce that is responsive, fair and efficient to both workers and patients;
- a health information system that guarantees the production, analysis, dissemination and use of reliable, timely and high-quality data and information;
- equitable access to essential medical products, vaccines and technology of assured quality, efficacy and cost–effectiveness;
- good health financing both within the system and for those using it; and
- good leadership and governance that ensures, among other objectives, effective oversight, appropriate regulations and incentives, and accountability.

By adding country-oriented policies to these six building blocks, the Regional Office has tried to ensure that assistance is tailored to each Member State's health system.

The greatest proof of progress came with the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth", held in June 2008 in Tallinn, Estonia. Attended by the WHO Director-General, Dr Margaret Chan; the EU Health Commissioner, Ms Androulla Vassiliou; the Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Professor Michel Kazatchkine; and health ministers from across the Region, the Conference provided a platform for debating sensitive and often politically charged issues, such as equitable access to health care, transparent health financing and accountability for public health spending. Member States and active stakeholders also benefitted from the long series of consultations held across the Region in preparation for the Conference, at which information and experiences were collected and shared.

The Conference resulted in the adoption by all 53 European Member States of the Tallinn Charter: Health Systems for Health and Wealth.

It shows Member States' strong commitment to improving their populations' health by strengthening their health systems. This will be achieved through increased transparency and accountability from countries, allowing for improved assessment of policies' achievements and failures.

Signing of the Tallinn Charter by the Regional Director and Ms Maret Maripuu, Minister of Social Affairs, Estonia

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"While the Conference was a success, what really counts is, as always, what happens afterwards: whether Tallinn can contribute to making positive changes in Member States. It will be encouraging to see it used as part of a long-term process that creates tools for modernization, improves efficiency and increases capacity in health systems. And, of course, any process involving Member States means that the Regional Office has responsibilities, too, such as providing technical expertise; relevant, high-quality information; and a forum for the exchange of information between Member States."

Dr Nata Menabde,
Deputy Regional Director, WHO Regional Office for Europe, 2009

Milestones: WHO European conferences

The WHO Regional Office for Europe organizes ministerial conferences at Member States' request. A country can suggest a subject and the other Member States vote on whether to address it through a conference. Such conferences usually lead to Member States' committing themselves to joint action on the topic addressed. The major meetings and conferences organized over the past 10 years, in addition to the 2008 Ministerial Conference on Health Systems, reveal some of the preoccupations of Member States during this time.

- The WHO European Ministerial Conference on Young People and Alcohol (Stockholm, Sweden, February 2001) called for Member States to create policies that were part of broader societal responses to how young people deal with drinking.
- The WHO European Ministerial Conference for a Tobacco-free Europe (Warsaw, Poland, February 2002) strengthened coordinated action against tobacco in Europe.
- The Fourth Ministerial Conference on Environment and Health (Budapest, Hungary, June 2004) adopted the Children's Environment and Health Action Plan for Europe to help countries create healthier environments for children.
- The WHO European Ministerial Conference on Mental Health: Facing the Challenges, Building Solutions (Helsinki, Finland, January 2005) made a declaration and action plan that have driven policy on mental health in the WHO European Region.
- The WHO European Ministerial Conference on Counteracting Obesity (Istanbul, Turkey, November 2006) adopted a charter spelling out effective solutions to the obesity epidemic in the Region.
- The WHO European Ministerial Forum: "All Against Tuberculosis" (Berlin, Germany, October 2007) adopted a declaration committing countries to urgent action to stop the spread of TB, including its man-made multidrug- and extensively drug-resistant strains, and particularly in the high-priority countries in the Region.

Polio-free Europe

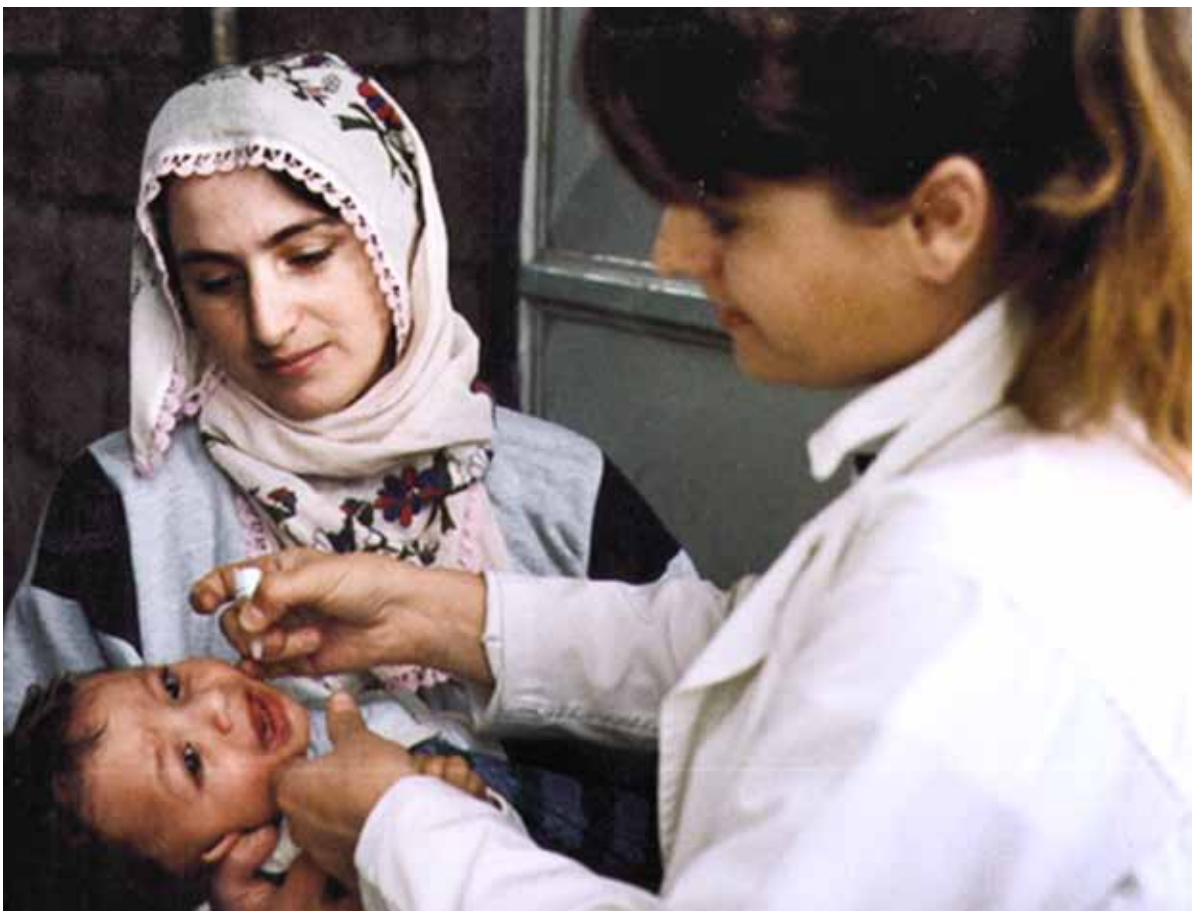
"During my tenure I had the immense honour of declaring the European Region polio free. As someone who remembers how much this illness affected the world around me as a young man and just how much I was afraid of it, it was an emotional moment in Copenhagen when, on 21 June 2002, in front of representatives of all 53 Member States, I was able to announce that Europe was polio free."
Dr Marc Danzon

In 1988, WHO teamed up with Rotary International, the Centers for Disease Control and Prevention in the United States and UNICEF to attempt to free the world of poliomyelitis. The partners pursued this goal in the WHO European and Eastern Mediterranean regions through a series of targeted national immunization campaigns, called Operation MECACAR (named after the geographical areas targeted in the eastern Mediterranean, Caucasus and central Asian republics), in 18 countries and regions where poliomyelitis was endemic.

Over 60 million children aged under 5 were given two extra doses of polio vaccine every year between 1995 and 1998. Supplementary vaccination campaigns continued in the highest-risk countries until 2002, when the European Region was declared polio free.

The European model of synchronized national immunization campaigns has since become a model for global eradication. Under a new name, Operation MECACAR: New Millennium, the project focuses on interrupting poliovirus transmission in endemic countries, eliminating measles and strengthening disease surveillance and immunization systems.

Polio vaccination in Turkey



International partnerships

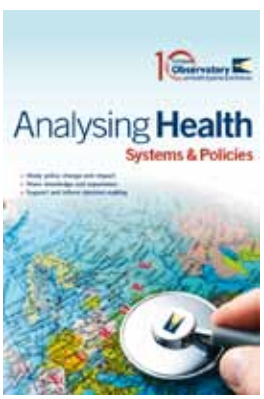
The WHO Regional Office for Europe has devoted time and energy to developing stronger relationships with a range of partners, particularly the EU, but also the World Bank, the Council of Europe and other United Nations organizations, as shown above. The aim is better coordinated and more efficient work in countries.

The Regional Office's relationship with the EU, particularly the European Commission, may have once been described as a "stimulating competition", but it has also grown increasingly close. During the 1990s, the partners strove to increase the coordination and complementarity of their activities. The Regional Office has worked hard to advance the process. For example, partnership with the European Commission has taken many forms, including the close collaboration over the Stability Pact for South East Europe and an increasing role for the Regional Office in health agendas of countries preparing to take over the presidency of the EU.

Within the United Nations family, UNICEF has been the Regional Office's closest partner on such tasks as working to eradicate measles and rubella, but other regular partners include the Joint United

"My strong impression – and I hope that it is one shared by Member States and our partners – is that we have moved on significantly over the past 10 years. This is extremely important to me. When resources for health are scarce – and we are all going to see budget cuts in the current climate – it is our duty to work towards strong and efficient partnerships, so not one cent is wasted."

Dr Marc Danzon



European Observatory on Health Systems and Policies

Set up in 1998, the Observatory is a flagship WHO European project and a unique partnership that aims to bridge the gap between the theory and reality of health systems. The partners include the WHO Regional Office for Europe, leading international organizations (such as the European Commission, World Bank and European Investment Bank), national and regional governments (including those of Belgium, Finland, France, Spain, Sweden and the Veneto Region of Italy) and academic institutions (such as the London School of Economics and the London School of Hygiene and Tropical Medicine).

The Observatory helps governments across the Region construct evidence-based health policies through country monitoring, health system and policy analysis, and the sharing of evidence.

Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA) and the United Nations Development Programme (UNDP). The Regional Office also works with FAO on avian and pandemic (H1N1) 2009 influenza. It has begun to work more closely with the Global Fund to Fight AIDS, Tuberculosis and Malaria: aiding Member States with making project proposals, negotiating with the Fund and acting as guarantor of project implementation.

Inside the Regional Office

Managers decided to strengthen, improve and sustain the structure of the Regional Office to better reflect and support its changes in direction, so that it could offer the best services to Member States. This meant re-envisaging, reorganizing and reworking the organization. Three of these changes are described here.

The reorganization of the Office around the goal of providing services tailored to countries' needs meant that it needed a new structure to reflect the different functions of its programmes. Thus, the Office was reorganized according to four functions – technical, country, communication and administration – and programmes with similar functions were grouped under common umbrellas.

To make the Office a learning organization, more emphasis was placed on staff development and training.

The Way of Working (WOW) initiative started in 2001 to help staff members work more effectively together, to make the exchange of information and knowledge transparent and to enable staff to find joint solutions to common problems. WOW also created methods for identifying, debating and analysing problems and shortcomings, and for communicating them to the Regional Director and other managers. The WOW Steering Committee was disbanded after the organizational development initiative was set up in May 2006. Its legacy continues in the altered way that the Office now operates.

Perhaps as a measure of Member States' confidence in the Regional Office, its resources increased considerably between 1999 and 2009. In this period, the total number of staff rose from 509 to 609, and the budget increased from US$ 124 million to US$ 280 million (or by 225%).

Staff training today

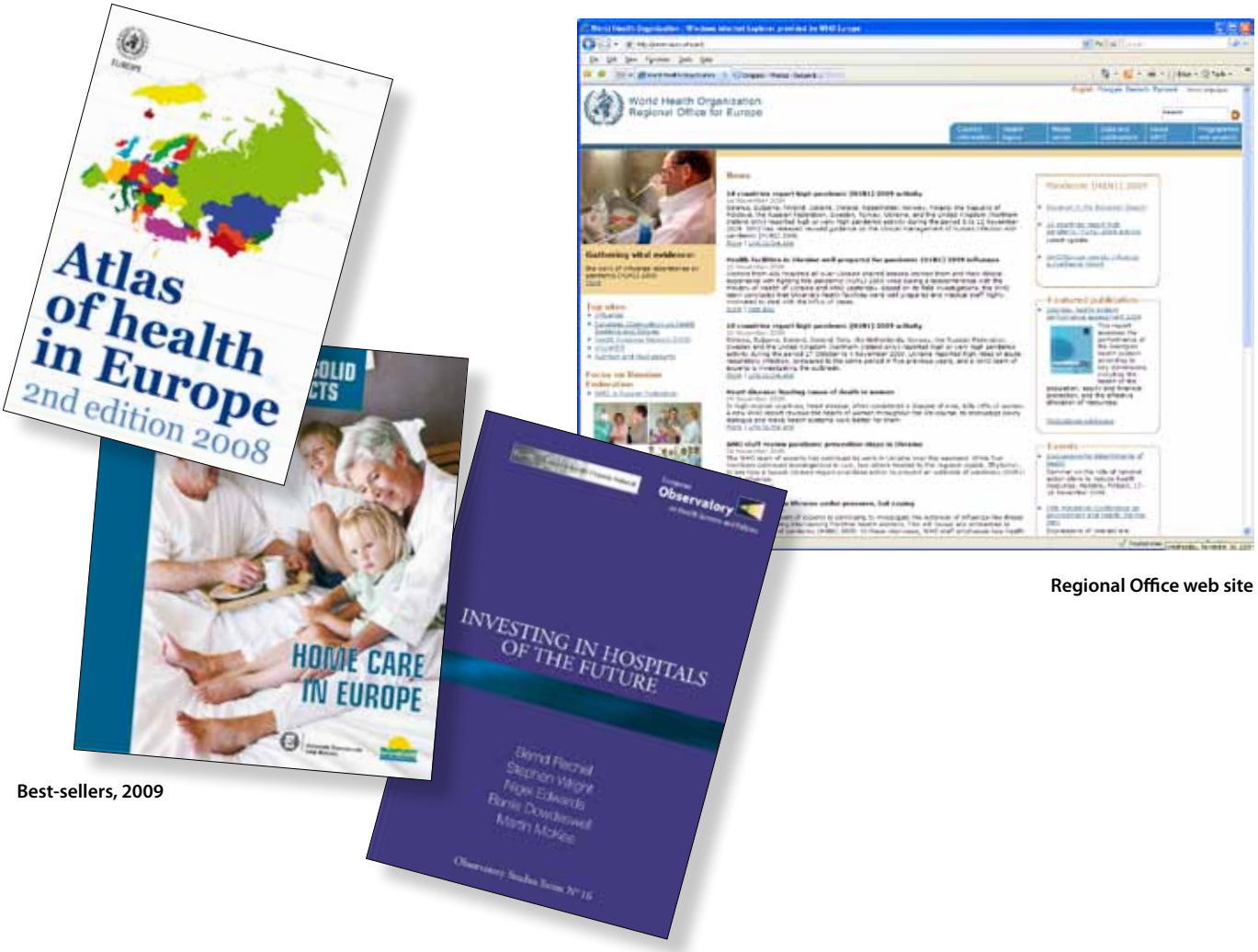
Evidence-based work and information for action

Trustworthy, evidence-based information is a vital part of the Country Strategy, and the Regional Office has made important progress in making sure that it is available to those who need it. For example, the Health for All database, the European Observatory on Health Systems and Policies, and the Health Evidence Network (HEN) all provide excellent data and information to public health officials and professionals of all types.

The Office made a new policy on information to raise its visibility and accessibility. After all, better information and data must not only be produced but also reach the people who need them. Paradoxically, this has meant reducing the number of publications – by more than half between 2002 and 2006 – and increasing the quality of each one published. A survey showed that 90% of their readers are now satisfied or very satisfied with the Office's publications. Several Regional Office books have won prizes in recent years.

In addition, the Regional Office successfully expanded its presence on the Internet. Its web site (http://www.euro.who.int) now attracts around 10 000 visitors a day, a number that tripled during the emergence of pandemic (H1N1) 2009 influenza.

Perhaps the best example of this communication strategy paying off came during the WHO European Ministerial Conference on Health Systems in June 2008. The Conference received excellent coverage in major health and medical media.



Best-sellers, 2009

Regional Office web site

Epilogue

Since February 2000, I have led an Office made up of over 600 people; 400 of them work in Copenhagen, while the others represent the Office in Member States or work in technical centres across the Region.

These people, the Regional Office team, do its real work; in fact, my job has been simply to help give orientation and support. After nearly a decade in this job, I want to thank everyone with whom I have worked and who has helped make the WHO Regional Office for Europe a truly twenty-first-century organization.

There is still plenty of work to be done, but I hand over the reins to my successor, safe in the knowledge that she will take charge of over 600 people who are determined to do all they can to make sure that the WHO European Region never stops getting better.

Marc Danzon
WHO Regional Director for Europe

Information sources

This booklet draws on information from a variety of sources, including the following. Particularly for work in the last 10 years, the Regional Office web site (http://www.euro.who.int) offers much more detailed information on the subjects discussed. Only a few major electronic resources are listed here.

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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World Health Organization
Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel.: +45 39 17 17 17
Fax: +45 39 17 18 18
E-mail: postmaster@euro.who.int
Web site: www.euro.who.int