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REPORT OF THE FIFTY-SEVENTH SESSION OF THE REGIONAL COMMITTEE FOR EUROPE

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REGIONAL HEALTH PLANNING
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WORLD HEALTH ORGANIZATION
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Opening of the session

The fifty-seventh session of the WHO Regional Committee for Europe was held at the National Assembly in Belgrade, Serbia from 17 to 20 September 2007. Representatives of all 53 countries in the WHO European Region took part. Also present were observers from one Member State of the Economic Commission for Europe and one non-Member State, and representatives of the United Nations Children's Fund, the United Nations Development Programme, the United Nations Office in Belgrade, the United Nations Population Fund, the World Bank, the Council of Europe, the European Centre for Disease Prevention and Control, the European Commission, the Organisation for Economic Co-operation and Development and of nongovernmental organizations.

The first working meeting was opened by Professor Recep Akdağ, outgoing President.

Election of officers

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

Professor Tomica Milosavljević (Serbia)	President
Dr David Harper (United Kingdom)	Executive President
Ms Annemiek van Bolhuis (Netherlands)	Deputy Executive President
Professor Alexander V. Nersessov (Kazakhstan)	Rapporteur

Adoption of the agenda and programme of work
(EUR/RC57/2 Rev.2 and EUR/RC57/3 Rev.1)

The Committee adopted the agenda and programme of work.

Address by the Director-General

The Director-General began her address by recalling conditions in the European Region in the 1980s and the Region's leadership in providing guidance on emerging health problems in wealthy developed countries. The Regional Office had pioneered work on the environment and health and using multisectoral approaches, led work on the prevention of chronic diseases and promotion of health, and predicted that demographic ageing would become one of the future's biggest problems. Those had become burning issues worldwide in the first decade of the 21st century, as had health financing and the need to strengthen health systems. Multisectoral approaches were now at the heart of the Millennium Development Goals (MDGs), which attacked the root causes of poverty and championed health as the key driver of economic progress.

The health situation in Europe had changed dramatically from that in the 1980s, showing discrepancies between the rich and poor within countries and between western and eastern countries. Problems in the latter included high mortality rates for mothers and babies, some of the world's highest rates of multidrug-resistant tuberculosis (MDR-TB) and the emergence of extensively drug-resistant tuberculosis (XDR-TB). Collective action on those shared threats was required, based on shared responsibility. All regions of the world sought ways to address such problems as shortages of well-trained, skilled health workers. Shared efforts would lead to good health, which was the foundation of prosperity.

Europe's head start in formulating action plans to address those problems placed the Region in a good position to lead international health, and its political leadership had a strong impact on international health policy. The Region's focus on disease prevention, health promotion, multisectoral action and the link between health outcomes and health system performance was increasingly valuable globally. If Europe found ways to, for example, reduce diet-related and foodborne diseases through its action plan on

food and nutrition and define effective strategies and practices to improve health system performance at the 2008 conference, all the world would benefit. One of Europe's great advantages was its skilful use of evidence. A major disadvantage was the possible neglect of the unmet health and health system needs of central and eastern European countries.

The Regional Committee document on the MDGs particularly emphasized maternal and child mortality. In Europe and globally, well-functioning health systems were absolutely necessary to achieve those goals; the insufficient capacity of health systems to reach the poor would be an insurmountable barrier to achieving the health-related MDGs, which were the least likely to be met. An encouraging sign of change was the recently launched International Health Partnership, in which international agencies had agreed to work together in a more coordinated way with clearly defined roles in reaching shared targets. That fitted well with the larger agenda of United Nations reform, in which WHO was fully engaged.

Public health around the world was engaged in the same struggles on three fronts. The first struggle was for attention and resources, which commitment to the MDGs had attracted. European leadership played a critical role in some recent innovations such as UNITAID (an innovative funding mechanism to accelerate access to high-quality drugs and diagnostics for HIV/AIDS, malaria and TB), the International Finance Facility for Immunization, and the use of "advanced market commitments" as an incentive for vaccine development for the developing world. The Director-General thanked European countries and the European Commission (EC) for their contribution to the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. Second, the International Health Regulations (IHR) were of assistance in the struggle against the constantly changing microbial world. In addition, preparations for a possible avian influenza pandemic were useful in stimulating research and strengthening national and international capacities to respond to health threats. For example, implementation of Uganda's preparedness plan had controlled a recent outbreak of Marburg haemorrhagic fever. Third, the WHO Framework Convention on Tobacco Control (FCTC) was a powerful international tool in the struggle to change human behaviour. European leadership had played an influential role in crafting both the IHR and FCTC, with the European Union (EU) providing a role model.

The human species now faced the challenge of adapting to the inevitable consequences of global climate change. The increasing frequency and severity of extreme weather events would have acute immediate and long-term consequences, particularly for health. The challenge for public health was to place health issues at the centre of the climate agenda. Climate change increased the urgency of achieving the MDGs, as countries that had achieved a basic standard of living, supported by adequate health infrastructures, would be best able to adapt to the dramatic changes on the way. The world could benefit from Europe's head start in addressing the impact of environmental conditions on health.

In the discussion that followed, all the speakers thanked the Director-General for her inspiring and encouraging address. Most stressed their countries' support for WHO's work under her leadership. Several speakers called for more resources to be allocated to the European Region. They were needed to meet the Region's increased needs, to support the central Asian countries' efforts to tackle their health problems, and to assist the European struggle against microbial challenges and to change human behaviour. One speaker described the achievements of his country in immunization and child health within its limited resources.

A representative speaking on behalf of the five Nordic countries asked whether the report of the Commission on the Social Determinants of Health could be launched at the 2008 World Health Assembly and whether the Commission's Chairman could speak at the event, in order to maintain the Commission's momentum and ensure that WHO's governing bodies could duly process its proposals.

A representative suggested that the tradeoffs required in tackling European health challenges could be addressed by a multisectoral approach, led by political will. His country would support WHO in approaching other sectors, nongovernmental organizations (NGOs) and business to put health higher on the agenda. Another speaker highlighted the importance of the issues of maternal and child health, and ageing in particular. As the question of how to change human behaviour to protect the environment was

so difficult, perhaps the Regional Committee at its next session could explore ways to do so, including political measures.

The Director of the European Centre for Disease Prevention and Control (ECDC) thanked the Director-General for her role in securing the recent increase in the share of the WHO budget allocated to the European Region. WHO had a special role as both a global and regional partner of ECDC. The EU and ECDC were committed to global, as well as regional, goals and strategies. Examples included the recent European action plan on TB, influenza pandemic preparedness, current work on patient safety and efforts to strengthen the European surveillance system and to build capacity to implement the IHR. Experts trained in the European Programme for Intervention Epidemiology Training (EPIET) regularly took part in outbreak detection and control through the Global Outbreak Alert and Response Network (GOARN) at the global level. WHO headquarters had supported the ECDC study on the burden of disease in the EU, harmonized with WHO methods. WHO and ECDC needed to continue and deepen their cooperation; WHO could rely on ECDC for support in both the global and regional contexts.

In reply, the Director-General recognized the Regional Committee's clear commitment to improving health; WHO would do its utmost to work with countries and mobilize resources to support their efforts. WHO relied on its partners, within and outside the United Nations system. The situation was encouraging; more resources were available but WHO needed to show that it could achieve results on the ground. WHO was very willing to collaborate with centres of excellence such as ECDC. It welcomed ECDC's support in, for example, helping countries build capacity by establishing laboratory networks.

The Director-General fully agreed with the need to maintain the momentum of the Commission on the Social Determinants of Health and was willing to arrange an event for it in connection with the 2008 World Health Assembly, within the constraints of the agenda set by WHO's governing bodies.

Address by the Regional Director

The Regional Director described his address as the first progress report on implementation of work on the future of the WHO Regional Office for Europe 2020. He welcomed the improved cooperation between different levels of WHO, working from the bottom up and the top down and led by the new WHO Director-General, Dr Margaret Chan. For example, headquarters and the regional offices had worked together on the IHR, intellectual property, health workforce policies and strengthening both health systems and WHO's relations with global and European partners, and the whole Organization was taking part in the reform of the United Nations system.

Work in south-eastern Europe focused on peace, human rights and health. WHO, the Council of Europe and several countries had started a programme under the Stability Pact for South East Europe to build peace in the region through shared public health programmes. The numbers of participating countries, donors and common programmes had all increased, and the programme as a whole had started its second phase in 2005. In addition, WHO and other United Nations organizations had helped 530 Roma people in the United Nations Administered Province of Kosovo to move to a safer environment and provided them with support and treatment. Finally, the Regional Office celebrated the release of the Bulgarian nurses and physician from confinement in the Libyan Arab Jamahiriya, towards which it had worked since 2000 with the Bulgarian Government, WHO headquarters and Ms Sylvie Vartan, WHO's Goodwill Ambassador for Maternal and Child Health in the European Region.

The Regional Office was continuing to try to improve its services to the 53 countries in the WHO European Region, which included further developing its country offices. The Regional Director cited some especially important or representative achievements in four areas: communicable and noncommunicable diseases, strengthening health systems and the environment and health. First, the Regional Office had organized the second European Immunization Week, with 25 participating counties; held a meeting with 44 national counterparts on measles and rubella control; agreed to work with the WHO Regional Office for the Eastern Mediterranean for global poliomyelitis eradication; supported

Member States in planning for a possible avian influenza pandemic (including planning an intergovernmental meeting on intellectual property); planned to hold a ministerial forum called "All against Tuberculosis"; and was continuing to work for better access to prevention and treatment for HIV/AIDS. The first 200 cases of chikungunya virus in the Region showed the importance of European participation on the Board of the Special Programme for Research and Training in Tropical Diseases.

Second, the Regional Office was working to implement the European Strategy for the Prevention and Control of Noncommunicable Diseases, providing direct support to surveillance and policy-making in a number of countries. It had held a meeting with 44 countries on improving the prevention of cervical cancer and was working with a number of them on control programmes. In addition, the Regional Office and the EC would soon publish data giving a clearer picture of mental health services in the Region; the Regional Office was also assisting countries, particularly in central Asia, to integrate mental health into primary health care and to train family doctors in diagnosing and treating mental illness.

Third, the Regional Office was supporting 25 countries in work to reduce inequalities in health systems and was helping countries to improve their policies on and management of health systems or to restructure their health ministries. It had issued a European report on health and security and was preparing for a conference on health systems in Estonia in 2008. Strengthening health systems was often included in the Regional Office's biennial collaborative agreements (BCAs) with countries, particularly those recently signed with Andorra, Belgium and Portugal.

Fourth, the work of the European Environment and Health Committee and an intergovernmental review meeting in Vienna, Austria had provided considerable support for the development of national policies on environment and health; case studies of good practice and work with youth groups were also valuable.

In response to a 2006 Regional Committee resolution, the Regional Office had strengthened cooperation with its main partners. Joint activities with the EU included working with ECDC on avian influenza; with the EC to harmonize programmes on health security, equity, the environment and nutrition; and with the EU presidencies of Finland, Germany and Portugal on health in all policies, HIV/AIDS prevention, and the health of migrants, respectively. The Director-General and the Regional Director had met with leaders of the Organisation for Economic Co-operation and Development (OECD) and the EU to harmonize and increase the effectiveness of their joint work.

The Director for Public Health and Risk Assessment in the EC Directorate-General for Health and Consumer Protection, speaking at the invitation of the Regional Director, said that collaboration between the EC and WHO had grown over the years with the intensification of the EC's focus on health-related matters. The EC had launched a health strategy project, with an ambitious intersectoral approach and a ten-year implementation plan. The results of a study carried out by the European Observatory on Health Systems and Policies had served as the basis for an EU proposal to ensure common, clear and enforceable EU rules on cross-border health care issues.

In the EU, mobility of the health workforce was in line with the principle of freedom of movement. While health workers could move to areas that required their professional expertise, that created a risk of further reducing the number of qualified health workers in more remote or poorer parts of the Region. A common European approach was required, so the inclusion of the topic on the agenda of the current session was welcome.

In 2007, the EU had made policies on tobacco and alcohol, as well as on nutrition, overweight and obesity. It was working particularly closely with the Regional Office on food and nutrition. In March 2007 the two partners had co-signed seven joint projects worth over €4.2 million, 60% funded from the EU's public health programme. Those were just a few of the hundreds of joint ventures by WHO and the EC. The EC's total support to WHO amounted to about US$ 100 million annually, making the EU one of the WHO's top five donors.

Also speaking at the invitation of the Regional Director, Ms Sylvie Vartan, WHO's Goodwill Ambassador for Maternal and Child Health in the European Region, said that it had been an honour for her to work with WHO in an area so close to her heart. For many years she had dedicated herself to improving the standard of living of disadvantaged children in her home country, Bulgaria, and through WHO could then extend that help to other areas of the Region. She was grateful to have been able to contribute towards obtaining the release of the Bulgarian health personnel by mobilizing other sectors, such as the media and the entertainment industry. She commended the Regional Office for its work in helping Roma children in the United Nations Administered Province of Kosovo.

In the subsequent discussion, most speakers congratulated the Regional Director on his comprehensive report and the work of the Regional Office.

A representative speaking on behalf of the EU, the candidate countries of Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, and Serbia, as well as Armenia, Georgia, the Republic of Moldova and Ukraine (which aligned themselves with his statement), expressed support for the Regional Office's work in a number of areas and welcomed further discussion of the following topics by the Regional Committee: strengthening health systems (including the 2008 Conference); the elimination of measles and rubella; progress towards the MDGs, especially those related to maternal and child health; the health workforce (including shortages, migration and policy); the reduction of health inequalities; alcohol misuse; gender and reproductive health; and obesity and malnutrition. The Portuguese EU Presidency called for more attention to be paid to improving migrants' health. He looked forward to receiving the report of the Commission on the Social Determinants of Health.

Considering the burden of noncommunicable diseases (NCDs), the 1.3% of the WHO programme budget for 2008–2009 allocated to that area was a matter of concern. The EU would continue to support WHO's work on NCDs, particularly in surveillance and the development of action plans such as that proposed for food and nutrition. In addition, the EU had created a programme to tackle the shortages of health workers in developing countries in 2007–2013, and it was planning an initiative to examine and consider action on issues related to the health workforce in the EU.

Many other speakers echoed those views, particularly the support for WHO's work on health systems (including preparations for the 2008 conference) and NCDs. They also praised WHO's work on health inequalities, HIV/AIDS, mental health integration and its country strategy, and welcomed the increased allocation of funds to the Regional Office in the 2008–2009 programme budget.

Speakers also praised WHO's increased emphasis on partnerships with the EU and other bodies. Some cited the Stability Pact programme as a model that would be useful to other countries and could contribute to peace in south-eastern Europe. Another urged WHO to assess the various technical centres active in the Region.

In the spirit of partnership, several speakers mentioned successes or assets in their countries that could be of use to others or to WHO's work in the Region. These included a European network and a Nordic declaration against the marketing of harmful food and drinks to children, national conferences on mental health and health in all policies, the implementation of a national health strategy, a ban on indoor smoking, an observatory on women's health, skilled scientific research institutes, and national experience in coping with disasters and other emergencies. Building on the Regional Office's work in various areas, countries had made or planned strategies on NCDs, maternal and child health, the health workforce and patient safety. Speakers described high-priority issues in their countries: the MDGs, the health of women, children and adolescents, gender equality and the fight against counterfeit medicines, the control of inheritable diseases, better care for the ageing and the need for more resources for mental health. One representative stressed the importance of values as the guide for health reforms.

A representative of Bulgaria thanked all those who had supported and contributed to the release of the imprisoned health personnel. They included individual countries, the EU, international governmental and nongovernmental organizations (particularly WHO), and the scientific and health personnel communities. He gave special thanks to some individuals: the EC President, the President of France, the late and current WHO Directors-General, the WHO Regional Director for Europe and WHO Good Will Ambassador Sylvie Vartan. The Bulgarian Government would continue to assist in the treatment of the HIV-infected children; it had recently transferred the foreign debt of the Libyan Arab Jamahiriya to the International Fund Benghazi.

A representative speaking as head of the executive committee of the South-eastern Europe (SEE) Health Network described the history, growth and work of the Stability Pact programme and the Network. He expressed the Network's gratitude to the governments of a number of countries and the partner organizations for their generous technical and financial support. The British Medical Association's Medical Book Competition had recognized the Network by commending a joint publication of the Regional Office and the Council of Europe (CE) Development Bank on health and economic development in south-eastern Europe. The Network's activities were visible on the EU web site. The Network was a sustainable model for collaboration on common health priorities.

The Head of the CE Health Division was proud that the Council could claim a share in the success of the SEE Health Network. Joint action by WHO, the CE and its Development Bank was making health a bridge to peace. Cooperation was smooth because the partners were working for health and human rights for all. The Stability Pact programme and the Network offered a pattern usable in non-health sectors, and the CE was debating a similar initiative for the south Caucasus.

The ECDC Director described the rapid growth and deepening of partnership with the Regional Office in the previous two years. Significant progress was being made in political, strategic and technical cooperation with WHO, both at headquarters and especially at the Regional Office level. WHO and ECDC were represented on each other's governing bodies and took part in each other's technical meetings. WHO seconded staff to ECDC, and ECDC would be willing to reciprocate that arrangement in 2008, and they had jointly developed a methodology for pandemic preparedness. In the integration of disease-specific networks into ECDC, the HIV/AIDS network and database had become a joint project covering all 53 European WHO Member States. It would be good to develop similar work on TB. ECDC had developed an action plan on TB in line with WHO strategies. A good example of the joint response to health threats was a recent mission to investigate chikungunya virus in Italy. Many such activities were taking place under the EU Neighbourhood Policy umbrella. The partnership between WHO and ECDC had great potential for further development.

In reply, the Regional Director emphasized that WHO worked for universal values and those of the United Nations system. The international public sector must insist on the value of ethics. To counter the suffering in the world, all parties had to use their resources as efficiently as possible through partnership. The migration of health personnel was a core ethical issue; it could not be allowed to benefit countries in better situations, while worsening the situation in others. There was an ethical need for WHO and the EU to learn from each other; there was one Europe, comprising 53 countries, and the Regional Office could act as a link between countries and between the EU and other countries.

Address by His Excellency Boris Tadić, President of the Republic of Serbia

The President of Serbia was pleased to have an opportunity to express his appreciation of the work WHO had done since 1948 to ensure health gains for populations through its efforts to shape health policies, strengthen health systems, and combat and prevent disease. The world had witnessed tremendous progress over the past years, affecting all humankind. Technology had become an integral part of daily life. Countries needed to work together to overcome the negative effects of such rapid changes and maximize the positive. Foreseeing future developments, especially with regard to new technologies, was an important task. Establishing links and working in an integrated way were essential. WHO exemplified

the will to resolve global issues together with governments and other agencies and partners. Careful planning was critical to tackling the major challenges ahead.

All parties had a role to play, and Serbia would make a contribution whenever it could. His country closely followed scientific achievements affecting health. Serbia was proud to be able to contribute to scientific knowledge that aided humankind, with WHO assistance and as part of a world-wide network of experts. Serbia was honoured to host the Regional Committee, which had such important topics on its agenda. He fully supported the work of the Regional Committee and wished it success.

Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board

(EUR/RC57/5)

The European member of the Executive Board designated to attend the meetings of the SCRC as an observer reported that three general themes had been features of all the Executive Board sessions during the year: the emphasis placed by the Director-General on all priorities and decisions being strictly evidence-based; the fact that the African Region required particular attention but also had the most problems in making effective use of WHO's assistance; and the need to strengthen health systems, with primary health care as a top priority.

A welcome note to the discussions on the budget and the Medium-term Strategic Plan (MTSP) had been their focus not only on the sums involved but especially on the principles of how those sums should be spent, with agreement that investment should be made where resources existed for its use; where health systems were developed to an appropriate level; and where there was a strong system of accounting and reporting, with time schedules respected. The Director-General had agreed that a redistribution might be envisaged where those conditions did not exist. It had been acknowledged that, although the MTSP was effective for implementation of the General Programme of Work, its development was still ongoing. All proposed resolutions must be in line with the MTSP and set out the financial implications of their implementation, an approach that he recommended for application in the European Region.

Issues of particular interest to the Board had included NCDs, on which the strategy prepared by the European Region was considered a particularly useful example; limiting the availability of unhealthy food to children; and the rational use of medicines. In many of those areas, as well as on the question of the availability of new influenza vaccines, and on public health, innovation and intellectual property rights, there had been conflicts of interest between developing and middle-income countries, on the one hand, and a number of industrial countries, on the other. A positive trend in that regard was that developed countries were increasingly tending to support decisions that were in the interests of public health. Divergences had also appeared on the principle of geographic rotation as the prime criterion for the position of the Director-General, with the opinion expressed that individual qualities should bear more weight. After discussions, it was becoming probable that a compromise could be found, with geographic rotation retained as one of several criteria.

One representative, speaking on behalf of the Nordic countries, raised the issue of the harmful use of alcohol and the global strategy to be discussed at the forthcoming Board meeting in January 2008. The European Region already had a framework on alcohol policy and should continue to play a leading role in the development of a global initiative, since fighting alcohol-related harm was a vital part of combating noncommunicable diseases. The Executive Board member concurred with that view.

In response to a request for more detailed information on the links between the 13 strategic objectives of the MTSP and the 6 strategic directions in the Regional Office's work towards 2020, the Deputy Regional Director explained that the Office had established internal working groups to consider how regional commitments would fit with and contribute to the global strategic objectives and expected results, while being based on countries' priorities as expressed in their BCAs with the Regional Office. Fifteen such agreements covering the period 2008–2009 had already been signed and would be posted on the Office's

website, as would further information as it became available. A recent document from WHO headquarters, giving the interim findings from monitoring implementation of the 2006–2007 Programme Budget, showed that the European Region was making good progress.

In connection with resolution WHA60.28 on pandemic influenza preparedness, further information was also requested on the preparations for the second session of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property.

Report of the Fourteenth Standing Committee of the Regional Committee

(EUR/RC57/4, EUR/RC57/4 Add.1, EUR/RC57/Conf.Doc./1)

The Chairman of the Fourteenth Standing Committee of the Regional Committee (SCRC) noted that individual members of the SCRC would present its views on the key themes to be discussed at the current session when they introduced the corresponding agenda item. He would only highlight some important issues that the SCRC had dealt with during the year.

To allow for better analysis and input into the documents being prepared for the current session, the Fourteenth SCRC had met six times during the year, instead of the customary five. He believed that the initiative had had major benefits for the relationship between the SCRC and the Regional Office, and he encouraged future Standing Committees to continue that practice.

Following on from the discussion about the future of the Regional Office at the previous session of the Regional Committee, the SCRC had tasked a small group of members with looking at how best it could fulfil its remit and work strategically, identifying priorities for action by the Regional Director and the Secretariat. In its report, the working group had defined a number of areas for immediate action, notably increasing the visibility of the SCRC by producing an information note and a briefing pack for new members. That information note would be placed on the Regional Office's website, while the full report would be available to Member States on request.

Suggestions for longer-term consideration (on which consensus had not been reached) included possibly amending the Rules of Procedure of the Regional Committee and the Standing Committee, which had last been updated in 2001. In addition, the working group had posed three questions that would need to be answered in the future:

- Should the SCRC have a remit to act as a conduit for Member States' concerns?
- Should the SCRC be more proactive in linking into European Union (EU) business and reporting on EU developments at the Regional Committee meetings?
- Should the SCRC take a more active position on the East/West divide?

The SCRC had considered the location of future sessions of the Regional Committee and believed that it was prudent to have a neutral venue (i.e. the Regional Office in Copenhagen) for sessions at which the nomination of the Regional Director was under consideration. It was therefore proposed that the 2009 session take place in Copenhagen, while the 2008 session should be held in Georgia and the 2010 one in the Russian Federation.

As Chairman of the SCRC, he had written to the Director-General at the end of 2006 urging her to review the regular budget allocation to the European Region, to ensure greater financial equity in line with the validation mechanism endorsed by the Executive Board in 2006. He had been pleased to see that, in the programme budget approved by the Sixtieth World Health Assembly in May 2007, the allocation for the Region, at US$ 63 million, was securely within the range set by that mechanism.

The SCRC had encouraged the Regional Director to hold high-level discussions with the Council of Europe on the issue of collaboration on blood transfusion and organ transplantation; those discussions were ongoing.

The Standing Committee was overseeing preparations for the Ministerial Conference on Health Systems in 2008. A drafting group had been established to prepare a charter that would build on the values and principles set out in the Ljubljana Charter on Reforming Health Care (1996). Twenty-six Member States had expressed the wish to join the drafting group; he urged all Member States to actively engage in the process of developing the charter.

Lastly, the Standing Committee had reached agreement by consensus on the candidates that it would recommend to the Regional Committee for nomination or election to various WHO bodies.

In conclusion, he invited all Member States to suggest any technical or policy items that they would like to have included in the work plan of the Standing Committee and taken up by the Regional Committee at a future session.

In the ensuing discussion, representatives commended the Standing Committee on the work done during the year, especially with regard to shaping the agenda of the current session and the choice of subjects for technical briefings. The SCRC had been proactive in placing emphasis on discussing strategic priorities such as the health workforce, and food and nutrition (where the Standing Committee's comments had been taken into account by the Secretariat when drawing up the final draft of the Second European Action Plan for Food and Nutrition Policy).

Thanks to the SCRC's guidance, representatives of countries in the European Region had been able to play an effective part in discussions at the 120th session of the Executive Board and the Sixtieth World Health Assembly, which had resulted in an increase in the regular budget allocation for the Region in 2008–2009.

With regard to the role and way of working of the SCRC, representatives endorsed the retrospective analysis of the SCRC's performance. However, in order to further strengthen its function as a link between the Regional Office and the Regional Committee, the SCRC should focus more on strategic issues and set clearer priorities in its work. It was urged to continue to bear in mind the questions posed by the working group.

One representative noted that 2008 would be the fifteenth anniversary of the establishment of the SCRC. That might be a good occasion to review the role that the Standing Committee had played during that period, in order to identify where it could make even better use of its potential in the years to come.

The Committee adopted resolution EUR/RC57/R5.

Policy and technical topics

Health workforce policies in the WHO European Region

(EUR/RC57/9, EUR/RC57/Conf.Doc./3)

The member of the SCRC presenting the item noted that there was an urgent need for action by Member States because the health workforce situation was worsening. One of the issues the SCRC had raised was the need for data to allow proper analysis and a clear understanding of the situation. Another was migration of health personnel to urban areas, or to countries with higher salaries or with health systems that were better organized and funded, or to sectors other than health where salaries were higher. In addition, there was a tendency for countries with a shortage of health workers to recruit them from other countries. Demographics were also a key factor. The population in many countries was getting older, while the number of people of working age was diminishing. The ageing of the population placed a greater demand on health services; health workers were also growing older, with little influx of young people; and life expectancy was increasing. In some countries, those trends would require a more than 100% increase in health workers. Such challenges could only be overcome through action by governments and the international community.

The Coordinator, European Observatory on Health Systems and Policies, had been requested to facilitate a panel discussion and debate. He stated that the goal seemed to be deceptively simple: "to get the right workers with the right skills in the right place doing the right things and the things right" (*The world health report 2006*). The issue, however, was complex and required a health system-wide approach. It was important to comprehend the relationship between the health workforce and other parts of the health system. Driving forces in the environment impacting the health workforce could be grouped under the headings of health needs (demographics, disease burden and epidemics), health systems (financing technology, consumer preferences) and context (labour and education, public sector reforms and globalization). He argued that the migration of the health workforce was a symptom of imbalances in the numbers of health workers (shortages or oversupply), an inappropriate skill mix, and an unsupportive working environment (lack of incentives, low wages, lack of career development and training). Rectifying those conditions would reduce the problem of migration. There were examples in the Region of policy options that could be taken at various levels to manage migration, such as bilateral or multilateral agreements, staff exchanges and twinning, and educational support. They demanded a broad strategic framework that covered performance, education and training, regulation and planning, and information and evidence.

Several speakers raised the ethical dimension of the issue. The freedom of workers to move to other countries where there was higher pay, more career opportunities or better safety at the workplace should not be restricted. That was a basic human right. However, some representatives expressed concern at the loss of investment in health workers' education, amounting to an exploitation of national resources. It also resulted in a lack of qualified personnel for the citizens of their own country and had a negative impact on the sustainability and quality of health services. There was a need to move from rehearsing the philosophical arguments for ethics to a practical code. The Commonwealth Code of Practice for the International Recruitment of Health Workers had had a positive effect in that regard.

Representatives shared examples of initiatives taken in their countries. One stated that his country had passed legislation during the year that would lead to significant pay rises for health workers. That measure had been taken to counteract the lack of motivation among health workers and the difficulty in recruiting qualified personnel. Modern technology had also been installed, to improve working conditions and lighten the workload. Those initiatives were possible owing to improvements in the socioeconomic situation. Another country was looking at ways to utilize the potentially valuable reservoir of employed health workers soon eligible for retirement. It had taken steps to adopt national policies aimed at reducing migration through better human resource planning and providing a favourable working environment for doctors and nurses. A third representative noted the research activities in his country, especially aimed at helping to understand health workforce migration. That type of research should be replicated at international levels.

The panel, which consisted of members of the WHO Secretariat and other experts, responded to comments and questions. They noted a need to review the roles and responsibilities of health workers and investigate the diversity across the Region. Nurses, for example, could take on a number of activities traditionally performed by doctors in some countries. They also emphasized the importance of effective and efficient planning, so that the health sector had the appropriate balance of health workers. There was also some evidence that bilateral agreements were a useful way to overcome the shortages of health personnel in one country, by importing them from a country with an oversupply; however, more information was needed to be able to draw any firm conclusions. Decentralization also represented an instrument that could be used in specific national or subregional settings to correct imbalances in the health workforce; however, it was not a practice that could be transferred in isolation. The challenge was to get the proper combination of interventions that took account of diversity but within a common strategic framework. Another difficult balance to achieve was that between the public and private sectors; some control or centralization was necessary. The Bologna process represented an important initiative, applying agreed global standards to higher education. A rigorous accreditation system had already been adopted. That process was part of a movement in the Region to improve the quality and competitiveness of university education so that, among other things, young people would be less inclined to move to another country in search of a better education.

The Acting Director, Country Health Systems pointed out that action on the health workforce, a major element in health systems, was not new for WHO: it was reflected in a series of World Health Assembly resolutions, *The world health report 2006*, two recent reports on the European situation and on migration, and recent work from the European Observatory on Health Systems. Health workforce policies would have to be shaped to respond to many challenges.

In the subsequent discussion, a speaker on behalf of the European Union welcomed the report and noted the need to develop comprehensive strategies to improve the situation, including an ethical recruitment code. In 2006, the EU had adopted a consensus statement on the crisis on human resources for health, and the subject should be high on the agenda at the WHO Ministerial Conference on Health Systems to be held in 2008. Action had to begin at national level, but full cooperation across countries was vital, and also with bodies such as the Global Health Workforce Alliance. Other speakers noted that the Global Health Workforce Alliance was convening a global forum in Uganda in March 2008. It was important to build on work already done: one example was the Council of Europe's 2005 report on cross-border mobility of health professionals.

One speaker pointed out that human resources for health presented a set of interrelated problems that could not be solved by a "magic bullet". In her view, the key was to increase political commitment, forget political cost and tackle the challenges.

The complexity of the issue was deepened by the lack of and inconsistencies in data. Proper comparisons were difficult when, for example, even definitions of health workers varied from country to country. Comparable high-quality data and information were needed to facilitate sound decision-making on the health workforce, including migrant health workers. One speaker described a comprehensive study being undertaken in his country on the demand and supply for specialized health care professionals in the period 2006–2030, using decentralized data collected by its regions. The objective was to establish clear forecasts as an integral part of the health care system. One particular concern mentioned was the mismatch in demand and supply in a country with an economically important tourist season.

It was pointed out that mobility between and within countries might be of benefit for health systems, but that had to be balanced against the risk of "drainage" of human resources from poor to rich countries. Not enough was known about what actions were effective in achieving mutual benefits. One country had a policy of abstaining from active recruitment of personnel from developing countries; instead, they were placing greater emphasis on domestic measures to increase the capacity of health personnel, raising educational standards, improving training and working conditions, increasing full-time workers and reducing sickness absence. Several representatives recognized that migration of the workforce was related to the socioeconomic situation of the home country. Many professions, not only in the health sector, were experiencing a "brain drain", although people did not take the decision to move abroad lightly if they had good wages, prospects for career development, opportunities for continuous professional development and job security. Within countries, there was increasing migration from rural areas to cities because of lower pay and fewer career opportunities, so incentives had to be found.

Some representatives stated that the lack of respect for health professions was also a problem. Work in the health sector was perceived as having low status, partly owing to a shift in values where that area of work was no longer considered a calling. Efforts needed to be made to improve the image. It was important to inspire more young people to take up a career in health. A nurse had many choices in a modern health system, and should be paid the same as others with similar educational qualifications. One speaker described improvements in recruitment, in addressing the geographical distribution of health personnel, and in reducing part-time workers.

The global shortage of trained health workers represented a major weakness in countering health security threats. Education systems were often not able to provide the educated health personnel needed. Several speakers reported an increased focus on standardizing medical training and other health sector education and skill development. Harmonizing the structure of education in health care at regional level and increasing management at country level were crucial to maintaining the attractiveness of the career. One

country had recently implemented continuous professional education that would lead to EU accreditation. It had put in place a system of credits that would allow mobility to other countries in the Region. Currently, its greatest challenges were the lack of qualified health workers in rural areas and the imbalance between general practitioners and specialists.

Countries had made efforts not only to improve the quality of professional training but also to align the health workforce with the health needs of the population and health system needs. Reorganization of the health sector along with reforms in health financing were part of an integrated approach to improving the situation of the health workforce. In some countries, numbers of medical and paramedical students had been increased to adapt to the rapidly changing health environment. In others, undergraduate medical education and training for nursing and related sectors were still in their infancy. It was pointed out that delivering quality education meant that students had to have a good command of English.

In some countries training young people would not be enough to satisfy population health needs, and policies on the assimilation of migrant health workers would be essential. A system to recognize qualifications was needed, using common criteria on training, which favoured freedom of movement but maintained quality. It was important to channel efforts to improve training for the health workforce, using a lifelong learning approach to enhance specialized skills. For foreign workers, a non-discriminatory and culture-sensitive approach was needed, and language barriers should be tackled. The rights of those who migrated should be respected. In some sectors such as long-term health care, there was a problem with illegal migrants and that had to be recognized and tackled. It was essential, while developing policy, to build strong partnerships with health organizations, trade unions and health workers.

The head of the Health Division at the Organisation for Economic Co-operation and Development (OECD) noted that migration of highly skilled personnel was taking place at a time of increasing demand for expertise due to new technologies, combined with competition between countries to attract and retain health professionals. He presented recent OECD findings on employment of foreign-born doctors and nurses. Immigration of doctors and nurses reflected the immigration of professionals in general, so any attempt to keep the workforce in their own countries would require active discrimination against health professionals. Available data showed an increase in foreign recruitment and a broadening to a wider number of countries. Further investigation would be most welcome, although that would involve countries in committing resources to yield information adjusted to international standards. OECD Health Data, supported by the EC, already included information on the health workforce, and new data collections were to be launched monitoring migrant health workers and long-term care personnel. A high-level policy conference on health workforce and migration, organized jointly by OECD and WHO, would take place in Geneva on 18–19 March 2008.

A speaker from the Global Health Workforce Alliance noted that it aimed to accelerate country action in the planning and management of the health workforce and to tackle transnational problems. Membership was open to all interested partner institutions, and the secretariat was hosted by WHO headquarters. The Alliance had a number of technical groups: one had produced an action framework on human resources for health. The others focused on areas such as education and policy; migration initiatives; workforce advocacy; financing the workforce, and universal access.

The Regional Director said that the issue of the health workforce was of great importance to people's health and he was glad that WHO and Member States were embarked on addressing it.

Statements were received from the following nongovernmental organizations: the International Council of Nurses, the Association of Schools of Public Health in the European Region, and the International Organization for Migration.

The Committee adopted resolution EUR/RC57/R1.

Second European Action Plan for Food and Nutrition Policy

(EUR/RC57/10, EUR/RC57/Conf.Doc./4)

Introducing the item, a member of the SCRC described the proposed Second European Action Plan for Food and Nutrition Policy as the product of consultation. Consultation with Member States in 2005 had shown the need to renew and adapt the first action plan to provide a coherent set of intersectoral actions and ensure international commitment. For over 18 months, the Regional Office had consulted nutrition and food safety counterparts in Member States, the EC and other stakeholders (including NGOs, intergovernmental organizations (IGOs) and nutrition and food safety experts) on the outline and drafts of the Second European Action Plan. There were two important challenges: the first was to develop effective policy options that involved all government sectors and actors in society at large, as well as international policy-making bodies. The Action Plan could provide a framework for the establishment of partnerships among different sectors and actors, such as economic actors including the food industry. The EC was an essential partner that had welcomed the Action Plan. The second challenge was to reach critical mass for the implementation of actions. Many initiatives were taking place in countries; a collaborative network could be established in the Region, and perhaps facilitate similar work elsewhere in the world. The SCRC had concluded that the Second European Action Plan offered clear guidance on priority actions, the responsible actors, mechanisms for implementation and the role of WHO.

The Regional Adviser, Nutrition and Food Security described the rationale, background and main features of the Action Plan. Diets inadequate in quantity and quality and uneven in distribution led to the double burden of obesity and malnutrition. Health problems related to nutrition and food safety included widespread overweight in women, both obesity and malnutrition in children, conditions related to deficiencies in micronutrients such as iron and iodine, and health risks related to microbiological, chemical and radioactive contamination of food and to farm production methods or food processing technologies. Diets were too high in energy and fat content and too low in fruits and vegetables. Food safety had improved dramatically in the EU, but major challenges remained in south-eastern Europe and the Commonwealth of Independent States, and new threats were continually emerging. In the modern, increasingly globalized food system, diet was mainly driven by food availability, quality, safety and price, although it was influenced by individual characteristics such as education and income. Policies in a number of areas – agricultural, trade and fiscal, social, urban planning, consumer protection and educational – could influence dietary choices. The proposed Action Plan indicated integrated action to tackle those factors.

The Second European Action Plan better reflected the need to take urgent action to counteract obesity and other new challenges. It took account of successful policy approaches in Member States that could benefit the whole Region, and it reflected recent global and regional policy developments such as the global strategies on diet, food safety and young child feeding and the European strategies on NCDs, alcohol, and child and adolescent health, the Children's Environment and Health Action Plan for Europe and the European Charter on Counteracting Obesity.

The Action Plan established Region-wide goals on nutrition, food safety and food security; listed priority actions for countries to take on food supply and consumer behaviour; recognized the need for Region-wide action, while taking account of countries' specific needs and resources; identified actors and potential partnerships, and discussed priority-setting. It aimed to tackle four main health challenges – diet-related NCDs, obesity in children and adolescents, micronutrient deficiencies and foodborne diseases – through work in six action areas: supporting a healthy start in life; ensuring a safe, healthy and sustainable food supply; providing comprehensive information and education to consumers; carrying out integrated actions to address related determinants; strengthening nutrition and food safety in the health sector; and monitoring and evaluation. A list of priority actions was given for each of those areas. The Action Plan assigned primary responsibility to governments, particularly health ministries, but also advocated the involvement of civil society, professional networks and economic actors, particularly food manufacturers and retailers. WHO 's role was to promote political commitment, provide support, help build capacities, analyse policies, assess trends in nutrition and food safety, generate evidence and report on implementation.

The Deputy Regional Director of the UNICEF Regional Office in Central and Eastern Europe and the Commonwealth of Independent States warmly endorsed the Action Plan, congratulated the Regional Office for taking the lead in its development and pledged that UNICEF would work with health and other ministries, WHO country and regional offices and the United Nations and other partners in its implementation. In eastern Europe and central Asia, the uneven distribution of economic benefits was reflected in high rates of malnutrition, a double burden of stunting and overweight, and high levels of micronutrient deficiencies. Inadequate infant and young child feeding practices caused unnecessary nutrition problems; the Action Plan's first action area spelled out the steps needed there, and she called on all countries that had not yet done so to adopt and implement the International Code of Marketing of Breast-milk Substitutes and to make maternity units, communities and workplaces baby-friendly.

While UNICEF and its partners had achieved much to combat micronutrient deficiencies, much remained to be done. UNICEF would work to accommodate the objectives of the Nutrition-Friendly Schools Initiative. Measures were needed to address disparities, including those in the Action Plan's sixth action area, monitoring and evaluation. The gaps in health problems and response capacity between the EU and eastern countries remained wide; she called on EU countries to increase their collaboration with the others to reduce those gaps more quickly. United Nations agencies could play an important role in facilitating such collaboration and exchange of experience. UNICEF and the Regional Office had joined forces to implement the first action plan; the Second European Action Plan for Food and Nutrition Policy provided the partners with a blueprint for furthering and expanding their partnership to better reach and serve the populations of the vast European Region of WHO.

Representatives welcomed the proposed Action Plan as a timely contribution to the international work on food and nutrition. They particularly appreciated the consultative process used in drafting the Plan, which they considered a fundamental reference document for the use of Member States, in that it proposed actions that could be adapted to national circumstances.

Many countries already had their own strategies or programmes related to food and nutrition, several of which had been introduced in the wake of the Ministerial Conference on Counteracting Obesity; they had been developed on the basis of multisectoral collaboration involving many ministries and other agencies. The European Commission's White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity-related Health Issues, too, was a first example of the EC linking so many areas of activities.

The need was emphasized for implementation of the Plan through integrated action on health promotion and risk factors, involving all the key actors: family, school children, civil society, the food industry and other private sector stakeholders, in support of governments and local or regional authorities. Special attention should be paid to economic, social, gender, cultural and geographical situations.

Obesity and overweight were a central concern and it was hoped that implementation of the Action Plan would ensure that both individuals and society accepted their responsibility. There were many contributory factors: representatives drew attention to the need for healthy dietary habits and an active lifestyle to counteract not only obesity but also chronic and noncommunicable diseases. Consistency should be ensured with the European Strategy on NCDs.

A representative speaking on behalf of the EU, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, and Serbia, as well as Armenia, Georgia, the Republic of Moldova, Switzerland and Ukraine, which aligned themselves with the declaration, proposed that an additional target should be included in the Plan, to increase the percentage of women who began to breast-feed their children, as that would bring even more health gains than achieving a prolonged period of breast-feeding.

He also proposed that the request to the Codex Alimentarius Commission in the Action Plan should be that it continue to give full consideration, within the framework of its operational mandate, to evidence-

based action it might take to improve the health standards of foods, consistent with the aims and objectives of the Global Strategy on Diet, Physical Activity and Health.

One representative proposed four amendments to the draft resolution, in order to strengthen the horizontal approach and to make a clear connection between the Second European Action Plan for Food and Nutrition Policy and the overall strategy on NCDs adopted by the Regional Committee at its fifty-sixth session. Particular mention was also made of work related to children, ranging from the prevention of malnutrition, which should include more monitoring of child growth, to action plans and programmes for schools, in order to improve the quality of children's diets.

There was some discussion, in connection with specific action 4 in area 3 of the Plan, on the labelling of food products, with a number of speakers encouraged by existing industry efforts guided by EU legislation, and another noting that changes to that legislation had meant that a successful national campaign to reduce salt intake could not be continued.

Some speakers considered that, in encouraging industry to play its role in achieving better health for the population, a self-regulatory approach should be adopted, with guidelines and targets set by government. Given the importance and reach of advertising and marketing, the media and consumer organizations should also be encouraged to play a role.

Relating to specific action 6 in area 2 of the Plan, one speaker considered that taxes on "unhealthy" products would not produce any benefits; indeed, they would unfairly penalize people in low-income groups.

One speaker underlined the importance of including physical exercise in the Plan and draft resolution; exercise and nutrition were both key factors in the quality of life, particularly in the case of an ageing population, where exercise could help to extend the independence and maintain the health of elderly people, as well as to reduce their need for care.

A number of comments were made related to food safety: one country was looking at the safety of fish products and of artificial sweeteners that replaced sugar in drinks. Another speaker mentioned the continual introduction by the industry of new additives and colorants into food products and the countries' need for information related to their possible effects. It would be useful to have a reference library with that information. It was also suggested that the issue of genetically modified products and their safety might be included in the Action Plan under area 5.

It was agreed that it was necessary to monitor implementation of the Action Plan; information should be shared between countries, with examples of best practices and tools being particularly useful. Networks, notably those that resulted from the Action Plan, had a very important role to play in that respect. Countries were encouraged to work with the International Food Safety Authorities Network (INFOSAN), set up to improve collaboration among food safety authorities at national and international levels and to link their work more closely to the International Health Regulations (2005); global information was needed to support countries requiring help in strengthening their food safety authorities.

Statements were received from the International Council for Control of Iodine Deficiency Disorders and from Consumers International.

In reply, the Regional Adviser for Nutrition and Food Security welcomed the representatives' helpful comments and suggestions. He suggested that voluntary efforts should be seen in the context of the work of Codex Alimentarius. Experience needed to be expanded in a number of action areas; for example, although most countries already made use of economic instruments such as those related to agriculture, they did not apply them to health goals. In addition, more action was needed on inequalities, especially for vulnerable target groups such as the elderly. He welcomed the emphasis placed on physical activity; perhaps a special document or plan on that subject should be developed.

The Committee adopted resolution EUR/RC57/R4.

The Millennium Development Goals in the WHO European Region: Health systems and the health of mothers and children – lessons learned

(EUR/RC57/8, EUR/RC57/Conf.Doc./2)

A member of the Standing Committee noted that the MDGs had been adopted seven years earlier by the United Nations General Assembly. They represented an historic effort to tackle poverty worldwide and provided a mechanism for monitoring development. In the European Region, progress towards the MDGs was positive in terms of regional averages, but national and subnational figures revealed a much more inequitable picture. WHO was promoting a strategy to attain the MDGs which emphasized cross-sectoral action and improved health systems and that helped to provide direction.

The Deputy Regional Director summarized WHO's approach to the MDGs, which involved close country support and emphasized working in partnership, strengthening health systems and making focused technical interventions. Efforts should be concentrated on where there were gaps, which were all too clearly apparent in the infant mortality rates given in the latest global update report. Mortality in children under five years in the country with the highest rate was 40 times higher than in the country with the lowest rate. Maternal mortality in the central Asian republics was at least double the regional average. There were imbalances within countries (including western European countries), as well as between them; poor women with low levels of education, or from ethnic minorities or in rural areas, were most vulnerable. The situation was complicated by changing baselines in some countries, as they modified the way in which they counted and collected data. The population's health was far too important to be left to doctors alone, it should involve the whole of society. Insufficient health system capacity was a considerable barrier to achieving the MDGs. Resources and technologies were available, yet progress was not being made as fast as it should.

WHO had been working in various countries, using an integrated and unified health system approach that focused on effective interventions on service delivery, resources, financing and stewardship. By 2015, the prognosis was that most EU members should achieve most of the MDGs. Most south-eastern European countries would meet most goals, with some exceptions. Middle-income countries in the Commonwealth of Independent States (CIS) would struggle to achieve the health MDGs, while low-income CIS countries were unlikely to meet between four and six of them. It was up to WHO, and more particularly the Member States themselves, to prove that prognosis wrong. The Ministerial Conference on Health Systems in 2008 would explore the virtuous circle of health systems, health and wealth.

In the subsequent discussion, representatives expressed support for the strategy promoted by the Regional Office. A representative speaking on behalf of the EU, the candidate countries of Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, and Serbia, as well as Armenia, Azerbaijan, Georgia, the Republic of Moldova, Switzerland and Ukraine (which aligned themselves with his statement), expressed concern at the fact that some MDGs were far from being reached in part of the European Region and endorsed the approach of giving priority to increasing the capacity of health systems. WHO had a leading role to play in that approach. The conclusions of the Brussels European Council in June 2006 on common values and principles in European health systems emphasized the need to adopt an ethical approach to health systems development.

More attention should be paid to areas such as migration. Migrants were often poor and at risk of disease, with less access to medical services. Some countries had large numbers of post-conflict refugees, who were particularly vulnerable. Reaching the MDGs would require investment in disease prevention, health promotion and access to treatment and rehabilitation. Services should be culture-sensitive. The MDGs provided a way to break the chain of poverty and ill health and to promote gender equality.

A coordinated approach to the MDGs was needed by the competent United Nations bodies at international level, as well as by the various stakeholders at national level. It was suggested that the MDGs should be a standing item on the agenda of the Executive Board.

Country representatives reported on their progress towards the MDGs, notably with regard to improving TB detection and treatment, ensuring access to clean water, reducing neonatal deaths through investment in technology and capacity-building, screening for genetic defects and securing access to health care for children and adolescents as part of WHO's European Strategy for Child and Adolescent Health and Development. Improving maternal and child health was a key priority for many countries, and better access to services included bringing them out of specialist areas and into primary care. A normal birth was a non-pathological process, where women should participate in decision-making with skilled birth attendants. Addressing the reproductive health needs of young people was a special challenge, especially in urban areas and immigrant communities. It was only by improving health systems in terms of all the health-related MDGs that those goals could be attained.

Reliable and comparable data were central to measuring progress, and countries that had brought their indicators and data collection into line with WHO standards faced the challenge of losing their baselines, in addition to the fact that the new figures appeared to indicate a worsening situation.

Speakers identified a range of partnership initiatives, including networks of professionals working together to reduce teenage pregnancy, and the recently launched International Health Partnership. There was still a need for the safety net of emergency obstetric care, and to consult partners, including professional organizations, as the capacity of health systems was scaled up. It was important to harness the synergies: health could be seen as indicative of broader development trends. It was pointed out that there was a need to provide for future generations on the planet, and globalization had not resolved the problems: Member States were urged to intensify their efforts. Health ministries needed support from WHO in a moral coalition that would heighten political commitment across various sectors of government, including especially finance ministries, and with WHO.

The Health Sector Manager from the World Bank's Human Development Unit for Europe and Central Asia underlined the World Bank's commitment to the MDGs. Their policy dialogues and research indicated four key points: one was that, while it was helpful to know the average costs of reaching the MDGs, the marginal or extra costs were important, too, because they would increase as countries approached the MDGs; those marginal costs would need to be put into perspective against the expected reduction in the overall disease burden. Second, progress could only be achieved through working across sectors and tackling health determinants. Third, there were clear disparities within populations, and the average could not tell the whole story. Lastly, the quality of data had to be improved to ensure sound data for decision-making.

The Deputy Regional Director of the UNICEF Regional Office for Central and Eastern Europe/Commonwealth of Independent States noted that it was important to remember that investing in health systems served to improve productivity and economic growth and could contribute to addressing the demographic crisis. In some countries of the Region, total expenditure on health was as low as €15 per capita per year, which could not sustain basic health care. Unless poverty and inequality were addressed, and financial allocations for health increased, sustainable improvements to health could not be achieved. Data from 13 recent multiple indicator cluster surveys and 3 demographic and health surveys demonstrated the need to accelerate efforts to achieve the MDGs. There was clear evidence backing up the interventions that worked, particularly prevention programmes, which had to reach the most vulnerable people.

The Committee adopted resolution EUR/RC57/R2.

Follow-up to issues discussed at previous sessions of the Regional Committee

(EUR/RC57/6)

Follow-up to the Ministerial Conference on Counteracting Obesity

The Director, Division of Health Programmes, explained the background to the Conference that had been held in November 2006 and developments that had taken place since. Rates of obesity and overweight had tripled in the European Region over the previous 20 years and, if no action were taken, the epidemic could lead to 20% of the population being obese, 10% of those being children. The Conference had attracted extensive participation in terms of both the number of countries and the range of sectors represented, as well as representation of European and international organizations. The immediate outcome had been the European Charter on Counteracting Obesity.

The most important message from the Conference was that the obesity epidemic was reversible. Greater responsibility for working towards that end needed to be taken by governments and society, as well as individuals. There should be a particular focus on children and disadvantaged groups, and closer coordination between countries, for no single state could face the epidemic alone. Much was being done and, indeed, had already been achieved within the Framework for Action in terms of promoting an environment conducive to physical activity, facilitating access to a healthy diet for both adults and children, and reducing marketing pressure on children, through legislation and partnerships between the public and private sectors.

Since the Conference, many countries had translated the Charter and put it to use with new and revised policy documents, and multisectoral processes. Industry was ready to participate in partnerships with the public sector; alliances and a policy dialogue had been established; and a number of policy tools had been developed. Several international bodies had taken inspiration from or made specific reference to the Charter in their own reports and activities. What was still needed was increased funding. In all, the Conference had been well received and the Charter was widely referred to, but continued action was needed; there was no room for complacency.

Representatives welcomed the introduction of the Charter as a milestone in the work to combat obesity and its risk factors, and noted various documents, action plans and other initiatives related to it that had been or would soon be introduced in their countries. One speaker emphasized the need to win political commitment, which could then bring more funding.

Another speaker mentioned positive developments that had been reported in his country in recent years, with indications that there were now fewer obese children and that body mass index in adults was rising less dramatically than in the past, possibly as a result of local and regional programmes to counteract obesity.

A statement was made by a representative of the International Union of Nutritional Sciences.

Implementation of work on strengthening health systems

The Acting Director, Division of Country Health Systems, gave an overview of activities related to health systems in the Region in the two years since the adoption of resolution EUR/RC55/R8. It had been demonstrated at that time that, despite general improvements in health indicators in all countries, there were still great geographic and social inequities; the challenge was to make health systems as effective as possible in their particular context.

Activities in which the Regional Office had supported Member States could be grouped under the four functions of the health system functional framework: stewardship, resource generation, service delivery and financing. With regard to the stewardship function, the Office had had high-level policy dialogues in several countries on subjects such as public-private partnerships and hospital reforms. Switzerland had

carried out a health system performance review, in close collaboration with OECD and the Regional Office. The Office had also contributed to the work done under the EU presidencies of Finland, Germany and Portugal, and the upcoming presidency of Slovenia.

On resource generation, and more specifically the subject of pharmaceuticals, the Regional Office had contributed to the work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. Again, policy dialogues had been held on human resources in the Baltic states, Slovakia and Turkey. The Office had also been very active on blood safety and organ transplants.

So far as the organization of health services was concerned, tools for quality assurance, performance assessment and health promotion had been developed for use at primary health care level or in hospitals. In the fourth area, high-level discussions on health systems financing had been started in many countries, while several were engaged in drawing up national health accounts. Flagship courses on health financing had been organized in Kyrgyzstan and Hungary, in collaboration with the World Bank Institute. The Office had pursued and intensified its work on improving health expenditure estimates, in collaboration with the World Bank, OECD and Eurostat.

A further major component of the Regional Office's health systems work related to information, data collection and analysis. In addition to the Health for All database, a new database had been created on hospital morbidity, while the Health Evidence Network and the European Observatory on Health Systems and Policies had contributed to numerous publications on health system-related issues.

The Ministerial Conference on Health Systems: "Health Systems, Health and Wealth" was being prepared through four pre-conference events, on performance measurement, health workforce, the performance of health services and public health governance. The Conference was to be held in Tallinn, Estonia in June 2008.

The Minister of Social Affairs of Estonia described her country's interest in hosting the event, as every country needed to ensure that its health system was the best possible in its context. The health system was intertwined with the economy, and health and wealth must thus be addressed together. When it had needed advice, Estonia had benefited from the help of experts from other countries; it was now able to share its experiences, but also wished to learn from others about coping with demographic and health workforce problems on a limited budget. The Minister looked forward to discussing how the health systems of Member States in the European Region could face the future, and warmly invited all those present to the Conference in Tallinn in 2008. A short film was shown on Tallinn and the country's preparations for the Conference.

A number of speakers welcomed the report and the increasing quality of the Regional Office's work on health systems, as well as the change compared to previous decades in the appreciation of the relationship between health and wealth. It was suggested that emphasis should be placed on the crucial role of public health and implementation of its essential functions in the structure and functioning of health systems. There was some discussion on the term "stewardship" in English and its equivalents in the other official working languages of the European Region. A suggestion was made that a glossary should be drafted giving clear definitions and translations of the principal terms used in the health systems domain. All the speakers thanked the Minister of Social Affairs of Estonia for her kind invitation.

Action taken towards implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases

The Director, Division of Health Programmes, noted that the decision to make a report on implementation of the European Strategy on noncommunicable diseases (NCDs) only a year after its endorsement by the Regional Committee resulted from the high level of interest shown by Member States. Encouragingly, the Strategy was being implemented in many countries, with bodies established and policies introduced or reviewed; requests had been received from 20 countries for help with policy development.

The Strategy had two inseparable objectives, of integrating action on the risk factors and determinants that linked NCDs, and of strengthening health systems for better NCD prevention and control. Over the year, alliances and partnerships had grown, with the involvement of international bodies, as well as public health and professional organizations in the Region. A network of NCD counterparts had been set up; it would take advantage of the experience accumulated under the Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme, focusing on integrated action, health systems and reducing inequalities; it was also developing an action plan for implementation of the Strategy.

Information exchange was being promoted, a regional policy review had been initiated and tools that could be used by Member States were being developed. A policy observatory was being set up, and examples and best practices would be shared in the forthcoming European NCD report. In monitoring, risk factors were particularly important; in contrast to the measurements of mortality and morbidity that looked at the result of past situations or the present, they could produce information on the likely future situation. There was a need to improve national competences to conduct risk factor surveys, and a European overview of their prevalence was still not available.

The challenges therefore were to integrate action in countries and in WHO, while achieving a balanced focus between risk factors and diseases, and between communicable and noncommunicable diseases. There was a need for increased capacity, both in countries and in WHO, and for political commitment. Existing WHO European strategies and frameworks, such as those on tobacco and alcohol, also needed to be integrated.

Representatives welcomed the update, and the horizontal approach adopted in the Strategy that had made it possible to integrate various vertical programmes. It could be taken as an example for other regions. The introduction of structural measures such as regulations, codes of conduct, subsidies in favour of health and taxes should be considered. It was also suggested that the establishment of a council of experts might usefully contribute to the monitoring process.

In response to a query on the current status of the CINDI network, the Director, Division of Health Programmes, explained that, as had been the case with a number of other networks, it had been outsourced and the secretariat was being moved to Kaunas, Lithuania, where it had in fact originated more than 20 years previously. Funding was to be made available to facilitate the transition.

A statement was made by a representative of the International Federation of Medical Students' Associations.

Update on health security

The Regional Adviser, Disaster Preparedness and Response, gave the Regional Committee a progress report on work done by the Regional Office on health security in the previous year. Public health threats to regional health security included the broad area of communicable diseases (HIV/AIDS, TB, an influenza pandemic, etc.), the persistent threat of accidental or deliberate release of biological, chemical or radionuclear agents, natural and human-made disasters, conflicts and complex emergencies, and global phenomena such as climate change. WHO's objectives in a crisis (defined as a situation where local systems were overwhelmed and unable to respond to demand, and where people were unable to meet their basic needs) were to reduce avoidable mortality and morbidity by taking a health systems approach to multi-hazard crisis preparedness.

Between 1990 and 2006 the Region had been affected by 1 483 disasters and health crises (excluding complex emergencies and conflicts) – causing 98 119 deaths and affecting more than 42 million people., Floods had been the type of health crisis causing the most economic damage (more than US$ 66 million) in the Region, while extreme weather events and earthquakes had been responsible for substantial extra mortality (more than 52 000 and nearly 22 000, respectively). The Regional Office had accordingly assisted countries to develop multi-hazard health systems preparedness plans including heat health

warning systems and action plans (as part of the EU-funded EuroHEAT project) and provided technical guidelines for heat-related health problems. It had also promoted flood prevention and early warning systems, and it was to launch a Safe hospitals campaign in 2008, promulgating building codes and heightening public awareness to manage and construct health facilities in such a way that they remained functional in a health crisis when they were needed most.

In response to earthquakes that had affected central Asia, the Regional Office had conducted joint damage assessments with authorities in Kyrgyzstan and Tajikistan, mobilized resources and provided essential medicines and supplies in the form of health kits. To counter the continuing threat of avian influenza and a potential human influenza pandemic, the Regional Office was conducting joint assessment missions with ECDC to review countries' pandemic preparedness plans and was providing technical support to build up surveillance and laboratory capacities.

Efforts to rebuild and consolidate disrupted health systems in post-conflict environments had focused on two areas: an EU-funded joint project with UNICEF to strengthen health systems and primary care services in the North Caucasus; and the development and implementation of a lead crisis action plan in the United Nations Administered Province of Kosovo, involving voluntary relocation of members of vulnerable groups to safer environments and the implementation of a multifaceted intervention package, which successfully resulted in minimizing the health consequences of heavy metal contamination. In all those efforts, WHO's comparative advantage was its close collaboration with ministries of health in advocating health systems' preparedness for multiple hazards, building local partnerships, facilitating the provision of sustainable support and adapting interventions to the national context.

The Regional Office's own institutional readiness had been built up during the year, with revised internal emergency management procedures, further consolidating the regional surge capacity to mobilize technical experts, and public health pre-deployment training for emergency specialists. Health security capacity assessments were ongoing in priority countries, and workshops had been organized on crisis preparedness for hospitals. In the coming year, attention would continue to be focused on health systems' preparedness.

Representatives acknowledged the leading role played by the Regional Office in helping Member States to ensure that their health systems were prepared to deal with the comprehensive aspects of health security. One essential component that should be further emphasized and strengthened in the future was the organization and performance of drills or simulation exercises. Countries experienced in running such exercises were encouraged to invite representatives of ministries of health from other countries, as well as senior WHO staff, to participate in them. Preparation was the best protection, and WHO was commended on organizing training events for specialists, who could then provide assistance to other countries. The Secretariat indicated that cooperation with the WHO Lyon Office for National Epidemic Preparedness and Response was to be scaled up to European level.

Annual report of the European Environment and Health Committee

In view of the fact that his term of office was coming to an end, the outgoing Chairman of the European Environment and Health Committee (EEHC) presented a "balance sheet" of the EEHC's work since its first meeting in Paris in January 2005. The members of the EEHC (representatives of Member States, international organizations and civil society) all shared the conviction that improving the quality of the environment was an essential condition for protecting and promoting the health of the populations of Europe. Risk factors could be modified, and people were increasingly unwilling to accept that their health should be threatened by exposure to environmental hazards. Those two facts justified continued efforts towards prevention.

Preventive activities were also essential because people's ability to generate new environmental risk factors had never been greater. A common feature of such risk factors was that they were extensive yet almost invisible; however, in terms of epidemiology, even a slight increase in a health risk could have a sizeable health impact if the exposed population was large. Recent research had identified new groups of

people at risk: not only children and the elderly, but also people with the most common health conditions in Europe, such as high blood pressure, obesity, heart disease, diabetes and asthma. A better understanding was being gained of the interaction between various forms of pollution and a number of social factors, but nonetheless the disease burden attributable to environmental hazards was likely to grow in the years to come.

Those observations had been shared at the Intergovernmental Mid-term Review (IMR) meeting held in Vienna in June 2007, with extensive participation by representatives of Member States and NGOs and by young people. A monitoring tool, the European Environment and Health Information System (ENHIS), had been launched on that occasion; it provided validated data from all European Member States covering the 26 indicators specified in the Children's Environment and Health Action Plan for Europe (CEHAPE). The meeting had underlined the need to link the environmental sector more closely with that of health care; environmental health officers needed to bear in mind the fact that their primary goal was to prevent diseases, while doctors should appreciate that environmental quality was part of disease prognosis.

The IMR had also reiterated the point that, rather than diagnosing environmental health problems, efforts should now be focused on creating the conditions for effective, evidence-based preventive action. That would entail developing research into risk management. Ultimately, the aim should be to develop a certification system for public policies on environmental health, and no organization was better placed than WHO to take that initiative and ensure that health remained at the core of such a system.

In the ensuing discussion, representatives welcomed the fact that the environment and health sectors had been brought together and pointed out that well-functioning primary health care should take account of environmental health aspects. They confirmed that the IMR meeting had enabled a useful exchange of experience. The links between the environment and children's health were becoming more evident, and many countries had drawn up national action plans on that issue, although further work would need to be done on the physical and mental health effects of children's exposure to chemicals.

A representative of the European Commission confirmed that a number of activities were being carried out jointly by EC and WHO in order to fulfil the commitments made in the CEHAPE and in the declaration adopted at the Fourth Ministerial Conference on Environment and Health (Budapest, June 2004). Those activities were being implemented under a three-year project with EU members and accession countries, in the framework of the EU's programme of Community action in the field of public health (2003–2008).

Elections and nominations

(EUR/RC57/7 and EUR/RC57/7 Corr.1)

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

Executive Board

The Regional Committee decided by consensus that Hungary and the Russian Federation would put forward their candidatures to the Health Assembly in May 2008 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Regional Committee by consensus selected Slovakia, Switzerland and The former Yugoslav Republic of Macedonia for membership of the SCRC for a three-year term of office from September 2007 to September 2010.

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

In accordance with the provisions of paragraph 2.2.2 of the Memorandum of Understanding on the Special Programme for Research and Training in Tropical Diseases, the Committee by consensus selected Bulgaria for membership of the Joint Coordinating Board of the Special Programme for a three-year period from 1 January 2008.

European Environment and Health Committee

In accordance with paragraph 1 of the Rules of Procedure of the European Environment and Health Committee (Reconstituted, 2004), the Regional Committee by consensus selected Cyprus, Estonia, Kyrgyzstan, Norway and the Republic of Moldova for membership of the EEHC until the Fifth Ministerial Conference on Environment and Health or for three years ending September 2010, whichever came first.

Date and place of regular sessions of the Regional Committee in 2008, 2009, 2010 and 2011

(EUR/RC57/Conf.Doc./5)

Endorsing the proposal made by the SCRC earlier in the session, the Committee adopted resolution EUR/RC57/R3, by which it decided that its fifty-eighth session would be held in Tbilisi, Georgia, from 15 to 18 September 2008; its fifty-ninth session would be held at the Regional Office in Copenhagen, Denmark, from 14 to 17 September 2009; its sixtieth session would be held in Moscow, Russian Federation from 13 to 16 September 2010; and its sixty-first session would be held in Copenhagen from 19 to 22 September 2011.

The Executive President acknowledged the kind offer made by Kazakhstan to host a future session of the Regional Committee.

Other matters

Technical briefings

During the session, a technical briefing was organized by the Ministry of Health of Serbia on the achievements and limitations of health reform in that country. In addition, technical briefings were organized by the Secretariat on the International Health Regulations (2005), the citizen's voice in public health, and the regional situation with regard to water-related diseases and the Protocol on Water and Health.

Proposal from Greece on the establishment of a geographically dispersed office in Athens

(EUR/RC57/11)

The representative of Greece introduced the proposal. For decades, Greece had had a long-standing commitment to the work of WHO, and the aim of the proposed Centre was to strengthen technical work on NCDs and increase implementation of the European NCD strategy across the Region.

Representatives welcomed the proposal to establish a geographically dispersed office in Athens and the opportunity to strengthen capacity. It was agreed that the Regional Director would start discussions on the area of work as well as the technical, financial and managerial details, keeping the SCRC continuously informed, and that he would report back on progress at the fifty-eighth session of the Regional

Committee, in accordance with the provisions of resolution EUR/RC54/R6. The Secretariat had noted the discussions in the SCRC and the Regional Committee.

Public health, innovation and intellectual property
(EUR/RC57/Inf.Doc./1)

The Vice-Chair for the European Region of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property Rights (IGWG) welcomed the opportunity to address the Regional Committee. There was a perception that the initiative was of less importance to the European Region than to other parts of the world, but by including the item on its agenda, the Committee had sent a clear signal that that was not the case. The initiative should be driven by public health considerations, and intersectorality was the key to success.

By resolution WHA59.24 the World Health Assembly had decided to establish an intergovernmental working group open to all interested Member States to draw up a global strategy and plan of action with the aim of "securing an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries …". The final global strategy and plan of action would be presented to the Sixty-first World Health Assembly in May 2008.

Several meetings and consultations had taken place since then, including a consultation meeting with Member States of the Region in August 2007, where useful suggestions had been made with regard to setting clearer priorities, establishing a manageable set of indicators and identifying gaps in research and development. Participants in that meeting had also pointed out that some actions needed to be targeted specifically at developing and transitional countries, while others would apply to all countries. They had also emphasized that that work needed to be linked to other initiatives, such as the Project on Priority Medicines for Europe and the World. He thanked Member States for their interest and support and invited them to continue to engage in the debate by participating in the various meetings leading up to the second session of the IGWG on 5–10 November 2007.

A representative speaking on behalf of the EU, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, and Serbia, as well as Armenia, Georgia, the Republic of Moldova and Ukraine, which aligned themselves with the declaration, thanked the IGWG and the Secretariat for their work, which would provide a sound basis for negotiation at the meeting in November. She especially commended the mapping exercise which would be helpful in building a common level of understanding between all actors. EU member countries and the Commission were playing a constructive role in the IGWG, as acknowledged by the Director-General in her address to the Committee. The EU aligned itself with WHO's principles of improving the availability, affordability and access to medicines for those in need and affirmed the aim of supporting needs-driven research and development relevant to diseases that disproportionately affected developing countries. While recognizing that progress had been made since earlier drafts of the global strategy and plan of action, she believed that further structural changes were required, especially with regard to the number of actions and process indicators. More explicit references should also be made to the quality and safety of medicines, to the MDGs and to earlier political commitments on health policies at international level.

Other representatives also offered suggestions on how the draft documents could be improved; they emphasized, however, that it was Member States themselves who should ensure that the process was truly intersectoral, by engaging other ministries and partners, and that the strategy led to real action. It was important to attribute roles and responsibilities to specific actors. They reiterated their commitment to the process and hoped that the European Region would be well represented at the IGWG's November session.

In his response, the Regional Adviser, Health Technologies and Pharmaceuticals, reassured the Committee that the work would continue to be aligned with WHO's four "access pillars": rational use of drugs, affordable prices, sustainable financing, and strengthening health system and medicine supply. He

also assured the Committee that WHO would continue to collaborate with the World Intellectual Property Organization, the World Trade Organization, OECD and other international partners.

A representative of the European Commission thanked the IGWG and WHO Secretariat and hoped that the reports and documents would be made available on the HQ web site. The WHO Secretariat confirmed that that would be done.

Statements were made by the International Federation of Medical Students' Associations and the International Federation of Pharmaceutical Manufacturers and Associations.

Some representatives took the opportunity to ask for clarification on the intergovernmental meeting on virus sharing. The Director, Division of Health Programmes, described the process that had taken place leading to the adoption of resolution WHA60.28. The aim of that resolution was to ensure sharing of clinical specimens and viruses for assessment of the pandemic risk and development of pandemic vaccines. An intergovernmental meeting would be convened in November 2007, to which all Member States were invited. In preparation for that meeting, the Regional Office would be interacting with Member States to highlight some of the main issues, and its staff would attend a joint meeting with EC and ECDC in September 2007, the outcomes of which would be formally communicated to Member States.

Resolutions

EUR/RC57/R1

Health workforce policies in the European Region

The Regional Committee,

Recalling World Health Assembly resolutions WHA57.19 and WHA58.17 on the international migration of health personnel: a challenge for health systems in developing countries that urged Member States and requested WHO to develop strategies to mitigate the adverse effects of the migration of health personnel in order to minimize its negative impacts on health systems; and resolutions WHA59.23 on the rapid scaling up of health workforce production that urged Member States and requested WHO to facilitate the activities to scale up the production of a competent health workforce in countries; and WHA59.27 on the strengthening of nursing and midwifery that urged and requested Member States and WHO to establish comprehensive programmes for the development of a highly skilled and motivated nursing and midwifery workforce;

Recalling also its resolutions EUR/RC50/R5 and EUR/RC55/R8 on cooperation with countries and strengthening European health systems as a continuation of the WHO Regional Office for Europe's Country Strategy "Matching services to new needs" that urged Member States to ensure that appropriate attention is paid to the quality and skills of human resources;

Acknowledging that educated and well-trained health workers save lives, that the functioning of health systems depends on the availability, efforts and skill mix of the workforce and relies on their knowledge, skills and motivation;

Recognizing the crucial importance of human resources in strengthening health systems, managing and delivering health services, and ensuring the quality of their performance;

Recognizing that the health workforce should be appropriate to people's health needs and that social, demographic, epidemiological and economic circumstances remain a challenge for the attainment of health for all;

Recognizing the diversities that exist in the composition, distribution and dynamics of the health workforce within and between countries in the Region; and the influence of ageing of both the population and the health workforce, and of technological innovations and environmental changes on health workers;

Noting with concern the geographical and skill-mix imbalances in the health workforce and the increased migration of health workers in the Region;

Having considered document EUR/RC57/9 on Health workforce policies in the WHO European Region;

1. ENDORSES the recommendations contained in the report;

2. URGES Member States:

   (a) to improve and expand the information and knowledge base on the health workforce at country level, where appropriate in order to strengthen information systems, encourage research and build capacities in policy analysis, planning and implementation related to human resources for health;

   (b) to develop, embed and mainstream policies concerning human resources for health as a component of health systems development, and to take responsibility for the development of human resources plans and strategies relevant to the needs of the country including a balanced distribution of the workforce within countries, ensuring their implementation;

(c) to assess the trends in and impact of health workforce migration in order to identify and act on effective migration-related policy options, including establishing agreements with other countries to address the movement of health workers, based on the principles of transparency, ethics, fairness and mutual benefits;

(d) to orient, where appropriate, workforce planning towards achievement of health for all, in primary health care as a first step;

3. REQUESTS the Regional Director:

(a) to cooperate with and support Member States in their efforts to improve their health workforce;

(b) to continue to build and support capacities in health workforce policy development, planning and management at national level and in the WHO European Region as a whole, and to facilitate and promote the harmonization of health workforce data and the use of standard indicators and tools to improve quality and comparability;

(c) to develop a core set of health workforce indicators to be used for monitoring and evaluation of the current situation and trends at national and WHO European regional levels, and to facilitate the exchange of knowledge, information, experience and evidence in effective health workforce development and management among Member States and partners;

(d) to develop recommendations to set up systems for stimulating and motivating the health workforce to work in remote and rural areas, as well as mechanisms for professional development;

(e) to give high priority to monitoring health worker migration and policy interventions at national and international levels through the continuing analysis of country reports and the publication of annual regional syntheses of those reports;

(f) to facilitate the development of an ethical guide/framework for international recruitment of health workers into and within the European Region;

(g) to ensure that the health workforce remains a priority of the WHO Regional Office for Europe, in the context of strengthening health systems, and to mobilize resources to support countries in the area of health workforce development, in line with the WHO Medium-term strategic plan;

(h) to continue building and strengthening networks and partnerships that contribute to establishing sustainable human resources for health in the Region, and to advocate with national stakeholders, development partners, international agencies, donors and all relevant programmes within WHO that more effective investment should be made in health workforce development and better resource coordination;

(i) to put health workforce policies on the agenda of the WHO European Ministerial Conference on Health Systems in 2008;

(j) to report back to the Regional Committee at its fifty-ninth session in 2009 on the progress made.

EUR/RC57/R2

The Millennium Development Goals in the WHO European Region: Health systems and health of mothers and children – lessons learned

The Regional Committee,

Recalling that the World Health Organization contributed to the elaboration of the Millennium Development Goals (MDGs) and has made a firm commitment to their achievement, and more specifically that *The world health report 2003* highlighted the principles guiding WHO's work in relation to MDGs, and that WHO's commitment to the United Nations Millennium Declaration was reaffirmed at the Fifty-eighth World Health Assembly in 2005 by the adoption of resolution WHA58.30;

Recalling that the WHO Regional Office for Europe has promoted a specific strategy on MDGs in the WHO European Region,[1] and that achieving many of the MDGs will require sustained multisectoral action addressing all the determinants of health and the involvement of all partners nationally and internationally;

Welcoming the discussions on the MDGs at the current session of the Regional Committee, during which representatives of the 53 European Member States of WHO have assessed the progress made towards achievement of the goals in their countries and have taken stock of the challenges ahead, while sharing evidence and proposing strategies to promote multisectoral action;

Recognizing that strengthening health systems has been considered by the WHO European Member States to be an integral part of the Regional Office's interventions at country level[2] and welcoming the special attention paid to strengthening health systems as a particular approach to implementing programmes that address the health of mothers and children in the WHO European Region;

Recognizing that insufficient capacity in health systems in many countries is a considerable barrier to achieving the health-related MDGs in the WHO European Region, and the need for a better alignment between the health systems agenda in WHO and its various health strategies and programmes for improved effectiveness, efficiency and coherence of WHO's support to countries;

Recognizing that the health of mothers and children concerns particularly the reduction of child mortality (MDG4) and improvement of maternal health (MDG5), and requires political commitment at all levels as well as the awareness and participation of men in their roles as husbands, fathers and guardians;

Having considered the initiative to mobilize international efforts to tackle the challenges identified in the High-Level Forum on the Health MDGs that is being taken forward jointly by WHO and the World Bank, with support from other agencies and global bodies such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria;

1. COMMENDS the Regional Office on its efforts in promoting achievement of the MDGs in the Region in partnership with other organizations;

2. REAFFIRMS the European strategy on the MDGs as political guidance and strategic direction for Region-wide action in this area;

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[1] Document EUR/RC57/8.

[2] See *Next phase of the WHO Regional Office for Europe's Country Strategy: Strengthening health systems*. Copenhagen, WHO Regional Office for Europe, 2005 (document EUR/RC55/9 Rev.1).

3. URGES Member States to:

(a) substantially scale up activities for achieving the MDGs in accordance with each country's systems and policies, national and subnational needs, circumstances, context and resources;

(b) link their efforts to achieve the MDGs, in terms of national goals and priority actions, to the strengthening of health systems in particular by networking vertical programmes and schemes and strengthening national reporting systems;

(c) monitor progress in implementing priority actions for all social groups, with particular attention to the poor and disadvantaged, taking account of gender, ethnic and social differences, and addressing gender inequalities and social inequities in health;

4. REQUESTS the Regional Director to continue to ensure that the MDGs are well integrated in the work of the Regional Office and pursued according to the measures outlined in the European strategy by:

(a) promoting political commitment in Member States;

(b) advocating and promoting actions at international level in collaboration with all relevant stakeholders, including the European Commission, the World Bank, the Council of Europe, United Nations organizations and nongovernmental organizations;

(c) providing Member States with technical support and assistance in capacity-building;

(d) stimulating the generation, translation and dissemination of knowledge and experience, as well as of novel policy approaches, among countries;

(e) strengthening the information system in the Regional Office to monitor the situation of the MDGs and associated health trends;

5. REQUESTS the Regional Director to report to the Regional Committee every two years on the progress made towards the MDGs.

EUR/RC57/R3

Date and place of regular sessions of the Regional Committee in 2008–2011

The Regional Committee,

Recalling its resolution EUR/RC56/R5 adopted at its fifty-sixth session;

1. DECIDES that the fifty-eighth session shall be held in Tbilisi, Georgia from 15 to 18 September 2008;

2. DECIDES that the fifty-ninth session shall be held in Copenhagen from 14 to 17 September 2009;

3. DECIDES that the sixtieth session shall be held in Moscow, Russian Federation from 13 to 16 September 2010;

4. FURTHER DECIDES that the sixty-first session shall be held in Copenhagen from 19 to 22 September 2011.

EUR/RC57/R4

Follow-up to the WHO European Ministerial Conference on Counteracting Obesity and Second European Action Plan for Food and Nutrition Policy

The Regional Committee,

Recalling World Health Assembly resolutions WHA53.15 that established the guiding principles for the improvement of food safety; WHA55.25 that described the need to improve infant and young child feeding; and WHA57.17 that highlighted the need to reduce the burden of disease linked to diet and physical activity;

Recalling its resolution EUR/RC50/R8, by which it recognized the First European Action Plan for Food and Nutrition Policy as a set of basic principles for Member States to follow, and its resolutions EUR/RC55/R6 on child and adolescent health and EUR/RC56/R2 on noncommunicable diseases that underlined the need to take integrated action and to provide clear guidance on the management of risk factors throughout the life course;

Recognizing that the WHO European Region is challenged by a double burden of nutrition-related diseases, characterized by a growing epidemic of obesity, particularly alarming in children and adolescents, and by the extensive presence of chronic malnutrition due to micronutrient deficiencies in vulnerable populations and of acute malnutrition in areas of food insecurity;

Recognizing that foodborne diseases represent a considerable concern for and threat to the health of European populations and that it is important to address the quality and safety of food in combination;

Recognizing that the burden of disease related to nutrition and food safety can be substantially reduced by carrying out preventive actions from early life onwards, directed at a safe, healthy and sustainable food supply, at information and education to consumers, at the related health determinants and at nutrition and food safety in the health sector;

Having considered the European Charter on Counteracting Obesity and documents EUR/RC57/6, which illustrates developments since the WHO Ministerial Conference on Counteracting Obesity, and EUR/RC57/10, which sets out a Second European Action Plan for Food and Nutrition Policy (2007–2012);

Noting that the European Charter on Counteracting Obesity calls for an action plan in view of strategic and policy development in Member States;

1. COMMENDS the Regional Office for Europe for organizing the WHO European Ministerial Conference on Counteracting Obesity in Istanbul on 15–17 November 2006, in successful partnership with the European Commission;

2. THANKS the Government of Turkey for hosting the Conference and providing excellent arrangements for it;

3. ENDORSES the European Charter on Counteracting Obesity adopted at the Ministerial Conference as political guidance and strategic direction for Region-wide action in this area;

4. ACKNOWLEDGES the positive trends that have been initiated by the First Action Plan for Food and Nutrition Policy for the WHO European Region (2000–2005);

5. ADOPTS the Second European Action Plan for Food and Nutrition Policy (2007–2012);

6. URGES Member States to:

(a) design, implement and put into effect a comprehensive, integrated and intersectoral strategy for the promotion of breastfeeding;

(b) develop, implement and reinforce comprehensive, integrated and intersectoral food and nutrition policies in connection to the wider European strategy to effectively prevent and control noncommunicable diseases;

(c) implement the commitments outlined in the European Charter on Counteracting Obesity and the related resolutions adopted by WHO's governing bodies at global and regional levels, in accordance with each country's government structures and policies, national and subnational needs, circumstances and resources;

(d) define national goals and priority actions in line with those set out in the Second European Action Plan for Food and Nutrition Policy, taking account of gender, ethnic, social and cultural differences, addressing inequalities in health; and targeting all stages of the life cycle, with particular attention to early life;

(e) monitor the progress made in the priority actions;

7. REQUESTS the Regional Director to take the necessary steps to ensure that food and nutrition policy development as well as physical activity, is well integrated in the work of the Regional Office, notably on the prevention and control of noncommunicable diseases, and implemented according to the measures outlined in the Second European Action Plan for Food and Nutrition Policy by:

(a) raising awareness and promoting political commitment in the Member States;

(b) advocating and promoting actions at international level in collaboration with the European Commission, the Council of Europe, United Nations bodies and nongovernmental organizations and in open dialogue with all relevant stakeholders;

(c) providing technical support to food and nutrition policy analysis and development in the Member States, building capacity and developing relevant policy tools;

(d) stimulating the generation, translation and dissemination of knowledge and experience among countries;

(e) stimulating the development of novel policy approaches;

(f) making use of existing databases and, if needed, developing a European information system to monitor the public health nutrition situation and assess associated health trends, in connection with the comprehensive mechanism for monitoring noncommunicable disease morbidity;

8. REQUESTS the Regional Director to report to the Regional Committee on the progress made in implementing the Second European Action Plan for Food and Nutrition Policy, aligned with the triennial reports envisaged by the European Charter on Counteracting Obesity.

EUR/RC57/R5

Report of the Fourteenth Standing Committee of the Regional Committee

The Regional Committee,

Having reviewed the report of the Fourteenth Standing Committee of the Regional Committee (documents EUR/RC57/4 and EUR/RC57/4 Add.1);

1. THANKS the Chairperson and the members of the Standing Committee for their work on behalf of the Regional Committee;

2. INVITES the Standing Committee to pursue its work on the basis of the discussions held and resolutions adopted by the Regional Committee at its fifty-seventh session;

3. REQUESTS the Regional Director to take action, as appropriate, on the conclusions and proposals contained in the report of the Standing Committee, taking fully into account the proposals and suggestions made by the Regional Committee at its fifty-seventh session, as recorded in the report of the session.

Annex 1

Agenda

1. Opening of the session

Election of the President, the Executive President, the Deputy Executive President and the Rapporteur

Adoption of the provisional agenda and programme

2. Address by the Director-General

3. Address by the Regional Director on the work of the Regional Office

4. Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board

5. Report of the Fourteenth Standing Committee of the Regional Committee (SCRC)

6. Policy and technical topics

(a) Health workforce policies in the WHO European Region

(b) Second European Action Plan for Food and Nutrition Policy

(c) The Millennium Development Goals in the WHO European Region: Health systems and the health of mothers and children – lessons learned

7. Follow-up to previous sessions of the WHO Regional Committee for Europe

– Follow-up to the Ministerial Conference on Counteracting Obesity

– Implementation of work on strengthening health systems

– Action taken towards implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases

– Update on health security

– Annual report of the European Environment and Health Committee

8. Private meeting: Elections and nominations

(a) Nomination of two members of the Executive Board

(b) Election of three members of the Standing Committee of the Regional Committee

(c) Election of a member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

(d) Election of five members of the European Environment and Health Committee

9. Date and place of regular sessions of the Regional Committee in 2008, 2009, 2010 and 2011

10. Other matters

(a) Proposal from Greece on the establishment of a geographically dispersed office in Athens

(b) Public health, innovation and intellectual property

11. Approval of the report and closure of the session

Technical briefings

Organized by the Ministry of Health of Serbia:

– Achievements and limitations of the health reform in Serbia

Organized by the Secretariat:

– International Health Regulations

– The citizen's voice in public health

– Regional situation with regard to water-related diseases and the Protocol on Water and Health

Annex 2

List of documents

Working documents

EUR/RC57/1 Rev.1	List of documents
EUR/RC57/2 Rev.2	Provisional agenda
EUR/RC57/3 Rev.1	Provisional programme
EUR/RC57/4	Report of the Fourteenth Standing Committee of the Regional Committee
EUR/RC57/4 Add.1	Fourteenth Standing Committee of the Regional Committee Report of the sixth session
EUR/RC57/5	Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC57/6	Follow-up to previous sessions of the WHO Regional Committee for Europe
EUR/RC57/7 + /Corr.1	Membership of WHO bodies and committees
EUR/RC57/8	The Millennium Development Goals in the WHO European Region: Health systems and health of mothers and children – lessons learned
EUR/RC57/9	Health workforce policies in the European Region
EUR/RC57/10	Proposed Second WHO European Action Plan for Food and Nutrition Policy 2007–2012
EUR/RC57/11	Proposal for establishment of the European Centre for the Prevention and Control of Noncommunicable Diseases in Athens, Greece

Information documents

EUR/RC57/Inf.Doc./1	Public health, innovation and intellectual property

Annex 3

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Annex 4

Address by the WHO Regional Director for Europe

Introduction

Mr President, ministers, distinguished participants in the fifty-seventh session of the WHO Regional Committee for Europe, ladies and gentlemen,

This is my eighth report as Regional Director, and I have decided to do something a little new, a little different from the way I presented my previous seven reports. Although I generally leave the Secretariat until the end of my report, I would like today, exceptionally, to mention it first. A number of important events have affected the life of the Organization over the past year, and I think it useful to talk about them first of all. They have had, and will continue to have, significant repercussions on the services that WHO provides to Member States.

Since our last session, the World Health Assembly has appointed a new Director-General, Dr Margaret Chan. She took up her post in January of this year. Her vision and her first accomplishments have visibly altered the roles of the regions and of headquarters within the Organization.

The Member States and the regional offices have long said that they would like to see better integration between the different levels of WHO and a new balance in the various roles and responsibilities. Over this year, with impetus from the new Director-General, a very clear movement has appeared, a movement from the bottom up, as well as from the top down. The regional offices and headquarters have been working together on a number of important issues, including the International Health Regulations, intellectual property, the migration of health personnel, strengthening health systems and relations with WHO's main partners, including the Organisation for Economic Co-operation and Development (OECD), the European Union and the European Commission. And the whole Organization, under the aegis of the Director-General, has also been working on one very important subject this year: the reform of the United Nations system.

Dr Chan will tell you more about these subjects tomorrow morning when she gives her address. However, I can say now that the collaboration and cooperation we have seen this year have strengthened WHO's relations, both within and outside the Organization. They have been a real stimulus to the Regional Office for Europe, which had been hoping for something like this for many years.

These global issues, and their regional dimension, will be dealt with at length throughout this session of the Regional Committee. The main discussions this year will concern the health workforce and strengthening health systems, particularly to help mothers and children, in the context of the Millennium Development Goals. Another global issue that has very strong European dimensions is food and nutrition policy, and we will be hearing about the results of the Ministerial Conference on Counteracting Obesity, held in Istanbul last November.

In my report, I have mentioned most of the aspects raised in last year's paper on the future of the Regional Office for Europe. So it is, to a certain extent, a first update on the implementation of that programme, which covers the period to 2020.

The Balkans: peace, human rights and health

This is the first time that we have held a session of the Regional Committee in Belgrade, right at the heart of south-eastern Europe, which, until recently, was the centre of bloody confrontations, and so I would like, as I have done at previous sessions, to mention the programme known as the Stability Pact for South Eastern Europe.

The programme was launched six years ago in Dubrovnik and has seen many more developments over this past year. It was set up as a joint initiative of the Council of Europe and the WHO Regional Office for Europe; since 2001, it has brought together the governments of countries that had just emerged from a ten-year period of conflict: Albania, Bosnia and Herzegovina, Croatia, Serbia and The former Yugoslav Republic of Macedonia, together with their neighbours, Bulgaria and Romania. The Republic of Moldova and, more recently, Montenegro have also joined the programme.

The original idea was simple. Some people even said it was too simple. The hypothesis was that public health programmes common to the different countries could help them to work together and lead to reconciliation. A simple idea indeed, and one that reflects the values of the United Nations and puts WHO's expertise in the area of health and its independence at the service of the countries involved.

The process began and it found a number of donors immediately: initially four – three countries and the Council of Europe Development Bank. Today there are nine: the Bank, and eight countries as well. Public health topics of common interest to all the countries were chosen: mental health, prevention of communicable diseases, and nutrition; then came public health services, maternal and newborn health, information systems and tobacco control. As I told you last year, the initiative was extended in 2005 in Skopje, with a second four-year phase.

This past year has seen the programme broadened and extended, notably with a study on the effectiveness of the public health services in the nine member countries. We consider this to be an exemplary initiative that has brought science and politics together, and has so benefited the people's health.

I would also like to mention another situation that occurred quite close to where we are today and that I also spoke about last year. It was in Kosovo, where WHO and the other United Nations organizations, under the political aegis of the United Nations Mission in Kosovo (UNMIK), provided assistance to 530 people, including 250 children, of Roma origin. Under a large public health programme, they were helped to move to a healthier and more hygienic environment. They were also provided with psychosocial support and health education programmes, their blood lead levels were monitored and appropriate treatment was given.

A year and a half later, the results are surprising. They are soon to be published in a scientific journal. They demonstrate not only the need for and effectiveness of preventive measures and medical interventions, but also the limits of those measures.

And, to conclude this section on human rights and humanitarian action, I would like, of course, to mention the recent release of the Bulgarian nurses and doctor.

Without going into the political background, I can say that the Regional Office for Europe is delighted with the final outcome of the affair, with which it has been involved since 2000. We were in regular contact with the Bulgarian Government, and worked closely with WHO headquarters to ensure that both scientific truth and human rights were respected.

I would like most particularly to thank our goodwill ambassador, Sylvie Vartan, who worked without respite to get everybody she could involved to ensure a positive outcome to the affair. This is a good, if somewhat exceptional, example of intersectoral work that managed to mobilize the world of entertainment, the arts and the media. It was something that the health sector could not have achieved by itself.

Ms Vartan, thank you so much for what you have done to help us; I know that you will continue to give your support to our teams working for better health for the children of our Region.

Action and countries

A lot has been done over the past year in collaboration with and in the countries of the Region. The objective is still to improve the services WHO provides to the 53 countries of the Region and adapt them to the countries' specific requirements.

Today, I would like to give just a few especially important or representative examples of what has been achieved this year. The report that will be presented at the next session of the Regional Committee will give more details of this work. Our prime concern is to meet the expectations and needs of each of the countries in our European Region, particularly through implementation of the agreements we sign together every two years.

First of all, I will talk about immunization and communicable diseases. Despite everything that has been done, vaccine-preventable diseases still kill 32 000 children under the age of five in our Region each year. And 600 000 newborns are not given the routine immunizations during their first year of life. Moreover, many parents and health professionals are no longer aware of the danger these preventable diseases represent; indeed, they are sometimes more worried about the vaccine than the disease itself. Something has to be done now to meet this challenge. The introduction of new vaccines is another issue, of particular importance in reducing the health gaps between the east and the west of the Region.

I will give you a few examples to show what the Regional Office has been doing about immunization. First of all, European Immunization Week has been organized for the second time. It attracted more participation this year, with 25 countries actively involved, and much more visibility in the media. There was also a meeting held in April with 46 national counterparts for measles and rubella control; the goal is still to eliminate these two diseases by 2010. An immunization campaign on the same subject was organized in Azerbaijan, targeting 2.5 million people, with the support of 6 countries. Its objectives were: epidemic surveillance, the identification of high-risk groups, and strengthened immunization policies and programmes on the two diseases.

Although it is no longer found in the European Region, poliomyelitis is still a matter of great concern, as there are four countries in the world that have not yet managed to get rid of it. The Director-General has made its elimination a priority for the Organization, and a way of demonstrating that public health really works. She has called on the regions that are free of the virus to help the other regions that are not. As a response to this, during the World Health Assembly, the regional offices for Europe and the Eastern Mediterranean signed an agreement on strong collaboration between their two regions.

I would like briefly to respond to a question I was asked about the European Region's involvement in the Board of the Special Programme for Research and Training in Tropical Diseases. The members of this global Board are elected by the regions. And at our private session on Wednesday, we will be filling a seat left vacant by Greece. The answer to the question is in the news right now. This summer, for the first time, the European Region was affected by chikungunya, a disease more usually found in Africa, south-east Asia and the Philippines. Two hundred cases were reported in north-eastern Italy, on the Adriatic coast. This epidemic is one more illustration of how pathologies, particularly communicable ones, are becoming globalized.

Avian influenza is another illustration of this globalization. The Regional Office has continued to support Member States in their preparations for fighting a possible pandemic. Because of the resources it has, notably in the field of vaccine production, the European Region is playing a global role in these preparations. Since the World Health Assembly adopted a resolution on the subject in 2007, WHO has made progress in promoting the rapid sharing of the virus, on the basis of transparency, with the aim of

assessing the pandemic risk and developing vaccines. Establishing an international stockpile is one part of this process.

In the coming months, the Regional Office will be approaching Member States about preparations for an intergovernmental meeting on intellectual property in November. This will be discussed in greater detail during this session of the Regional Committee.

To conclude this section, I would like to mention the Ministerial Forum "All against tuberculosis" to be held in Berlin next month. The objective of the Forum is to decide on the action to be taken to halt the spread of the disease. In a letter I sent to ministers of health in 2005, I drew their attention to the rapid spread of tuberculosis in the Region.

I would also like, as I do each year, to draw your attention to the development of the AIDS epidemic in the Region and its rapid growth, despite all the efforts that have been put into prevention and treatment. There are 2.5 million people living with HIV/AIDS in the Region, and 850 000 who are on extended treatment. Our commitment in this area for the year 2010 is to achieve equitable, effective, danger-free and economically affordable access to prevention and treatment. The main problem is still to work out how health systems can cope with the disease and its costs.

I would like now to turn to the area of noncommunicable diseases. These diseases are responsible for nearly nine-tenths of all deaths in the Region and more than three-quarters of the disease burden in DALYs. Cardiovascular diseases alone are responsible for half of all deaths. They also contribute significantly to the 20-year difference in life expectancy between countries in the Region.

This year, the Regional Office has been working with a group of eight countries on the further development and implementation of the European Strategy adopted by the Regional Committee last year. There has been good collaboration with WHO headquarters, the European Commission, the European Heart Network and the European Society of Cardiology. To illustrate the direct support given to Member States, I would mention the cancer surveillance programme in Albania, the strategy review related to cardiovascular diseases in Estonia, and the noncommunicable disease policy update in the Russian Federation.

Another area of action for the Regional Office has been reproductive health. More than 30 000 women die each year in Europe from cervical cancer, although it is a largely preventable disease. With the aim of bringing down this high figure, representatives of 44 countries in the Region met in May to look at ways of improving prevention management, notably through the use of the new vaccine. There have also been some interesting developments in multinational collaboration on a national cervical cancer control programme in Armenia that is being supported by Lithuania, Iceland, Norway and Finland, as well, of course, as by experts from WHO. Many countries in the Region have put reproductive health on their agenda in different ways: policy reports in Azerbaijan and Kyrgyzstan, vocational training in Turkey and Turkmenistan, and sex education on the programmes of the 27 countries that took part in the Cologne meeting in November 2006. Finally, 26 countries in the European Region are involved in the SAFE network that promotes the sexual health and rights of young people.

In conclusion of this section, I would like to give you, as I do each year, a quick report on what has been happening in the mental health programme. Since the Regional Committee last year, we have worked together with the European Commission on the continued implementation of the action plan adopted in Helsinki, particularly in the area of data collection. We will be publishing the data in the coming months, and this will give us a far clearer picture of the state of mental health services in the Region. The assistance we give to Member States in this area relates primarily to the integration of mental health into primary health care, and training for family doctors in the diagnosis and treatment of mental illness. The central Asian countries are especially interested in these initiatives.

I would like now to look at the subject of health systems as one of the essential determinants of health. In application of the Regional Committee's 2002 resolution on poverty and health, the Venice centre has built up its activities to be able to increase the help it offers Member States in the Region.

A total of 25 countries representing the different parts of the Region are working on specific activities in this field. For instance:

- Germany is working on improving the health of migrant populations by integrating social services and health services;
- Montenegro is aiming to improve the health of Roma refugees by encouraging better use of the health services; and
- Sweden has a health protection and promotion programme for the unemployed.

The Regional Office has worked with many Member States in the area of health systems governance and stewardship. There are, for instance, the health systems assessments conducted in Armenia, Georgia, Kazakhstan, the Russian Federation and Uzbekistan.

Other examples include:

- the studies published in the Czech Republic and Hungary on inequalities in health care systems;
- the health policies and health system management strategies developed in Bosnia and Herzegovina, Portugal, Switzerland and Tajikistan;
- the collaboration between the Regional Office and Azerbaijan, the Republic of Moldova, Romania and Turkey in restructuring their health ministries and building up their stewardship function.

Finally, and still in the area of strengthening health systems, a European report on security and health has been published as the European contribution to World Health Day 2007.

Our work on health systems is being galvanized by the preparations for the Ministerial Conference on Health Systems, to be held in Estonia in June 2008. Various consultations and preparatory meetings have been held in 2006 and 2007, mobilizing a large number of Member States in the Region. Preparations for the Conference are proceeding in a very satisfactory way. You will be given the details during our different sessions here. Given this context, it is not surprising that strengthening health systems are one of the subjects that comes up most frequently in the biennial collaborative agreements between the Office and the Member States, particularly those signed recently with western European countries, such as Belgium, Portugal and Andorra.

To conclude this presentation on the Regional Office's activities in the countries, I would like to talk about environment and health, a particularly lively area this year. There has been support for the development of national policies from the work of the European Environment and Health Committee and the Vienna meeting in June 2007 that looked at the progress made on implementing the Budapest Declaration. We should also note the case studies of good practice in environment and health policies, and the work with youth groups in Austria, Ireland, Norway and Sweden.

In conclusion of this section, I would to say how pleased I am to see how activities are developing at country level. This is happening as the country offices are being built up and field staff are improving their skills. This presence in the field will need to be increased in the coming years, as it really contributes to the effectiveness of the Regional Office's action and helps it adapt its services to the individual needs of the Member States.

There are, of course, many programmes and units within the Regional Office whose task is to support the operational units and programmes. I am thinking of, among others, administration and finance, and information technology. I would simply like to say how useful they are, and how indispensable in ensuring that the activities I have just described can actually take place.

Working with our partners

At its last session, the Regional Committee adopted a paper on the future of the Regional Office for Europe, with a resolution asking the Regional Director to strengthen the joint activities shared with its main partners.

Here is what we have done this year on specific issues: we have worked with the Council of Europe on the health of migrants, and with the World Bank on the Millennium Development Goals. And our collaboration with the European Union and European Commission has increased to a level where, as recommended in the document adopted last year, there is now a true sharing of responsibilities. We have, for instance, worked with the European Centre for Disease Control and Prevention (ECDC) to finalize the plans preparing for avian influenza, and with many sections within the Commission to harmonize our programmes and ensure that they are complementary, notably in the fields of health security, equity, environment and nutrition.

The European Union presidencies have been particularly auspicious periods for building up collaboration. With Finland and the Health in All Policies programme, which has now become a point of reference in public health; and with Germany on HIV/AIDS prevention; and currently with Portugal on health and migration. The Director-General will be attending a meeting on that topic in Lisbon at the end of the month.

In terms of policy, both Dr Chan and I have met with the OECD and the main European Union leaders to harmonize our work and make it more effective. Dr Andrzej Rys is here today to attest to the work we have done together, and I would like to thank him publicly for including us, as he did at a recent meeting in Portugal, in the preparatory work for the Commission's new health strategy.

And I would say to him again in all friendship what I said in Lisbon: it is quite legitimate for each organization to have its own strategy, but it is good if the Member States can see that the proposals made by the various bodies they contribute to do in fact work towards the same ends. And that is what we are trying to achieve together.

Here again, this collaboration with international organizations is increasing, I hope, to the greater benefit of all the Member States in the Region. And I emphasize "all the Member States". Thus, the Regional Office for Europe is acting as a bridge, a way of transferring knowledge between the countries that are members of the European Union and those that are not, or not yet, members.

This Regional Committee

I have already mentioned various of the sessions that will take place during this Regional Committee. I would like to add that there will be technical briefings on such important subjects as water, the International Health Regulations and citizen's participation in public health decision-making – a new and promising topic.

For the third year now, we will have a session tomorrow afternoon devoted to the follow-up to previous sessions of the Regional Committee. The issues to be discussed include environment and health, obesity, the noncommunicable diseases strategy, strengthening health systems and health security.

Conclusion

In conclusion, I hope that all the participants at this session of the Regional Committee will find something of interest to them for their work in their own country, and feel at ease as members of WHO's governing bodies. Your comments and suggestions are welcome, as always, and we will take them into account in our work between Regional Committee sessions.

I would like to thank most warmly the members of the Standing Committee, particularly the chairperson, Dr David Harper, for the support and encouragement they have given the Regional Office again this year, and particularly in the preparations for this session of the Regional Committee.

Finally, I would like to give special recognition to all the staff of the Regional Office. I do this each year, and each year I am more convinced than before of the luck that I have to be leading such an exceptional, devoted and competent team, that is proud to serve the noble cause of WHO.

Thank you for your attention, and I wish you an excellent session of the Regional Committee.

Annex 5

Address by the Director-General of WHO

Your Excellency, President Tadic, Mr Chairman, honourable ministers, distinguished delegates, Dr Danzon, our Regional Director, ladies and gentlemen,

First let me thank the government of Serbia for its hospitality in hosting this Regional Committee in this city.

In the late 1980s, public health looked to this Region for guidance on how to address the unique health problems that were emerging, or at least becoming visible, in wealthy, highly developed countries. This was the most uniformly affluent Region, with high standards of living matched by long life expectancies. Health ministers aimed to make good health even better.

This Region looked broadly at the determinants of health, and closely at preventive and health-promoting measures. This Office produced pioneering work on health and the environment and, in so doing, pioneered ways of making multisectoral approaches work. European countries led work on the prevention of chronic diseases and made the importance of lifestyle factors a priority on the health agenda.

This Region promoted healthy diets, healthy cities, healthy schools, healthy workplaces, and the health of immigrant populations. Early on, this Region took a comprehensive look at the special health needs of the elderly, and predicted that demographic aging would become one of the biggest problems in the near future.

These were bold steps at the time. Who would have imagined that these problems, these "luxury items" on the agenda of wealthy nations, would become the burning health issues, worldwide, during this first decade of the twenty-first century?

More and more, health problems all around the world are being shaped by the same powerful forces. More and more, public health is being challenged to address a shared set of very complex problems.

Urbanization is a burning issue, with population density in urban areas growing fastest in the developing world. As the demand for energy and transportation increases, suffocating urban air and the consequences of greenhouse gas emissions are issues of urgent global concern. The effects of climate change are already being felt. Globalization has helped spread lifestyle changes, often to the detriment of health.

Chronic diseases, long considered the companions of affluent societies, have changed places. Low- and middle-income countries now bear the greatest burden from these diseases. Obesity, which has reached epidemic proportions in Europe, is now a global problem. No region is spared. Health needs of the elderly are a burning issue. Each month, one million people worldwide will reach the age of 60. Of these people, 80% live in the developing world.

Health financing has become a burning issue, and an especially hot one. This is partly because of the new demands, on health systems and family finances, created by the rise of chronic diseases. It is partly because of the renewed emphasis, embodied in the Millennium Development Goals, on equity and poverty reduction. The logic is simple. If we want health to work as a poverty-reduction strategy, we cannot let the costs of health care drive impoverished households even deeper into poverty. In just the past few years, the need to strengthen health systems has become a burning issue, taking centre stage in the development debate. I will have more to say about this later.

As for multisectoral approaches, pioneered when European ministers of health and the environment joined hands, this approach is now at the heart of the Millennium Development Goals. These goals attack

the causes of poverty at their roots, and acknowledge that these causes interact in intricate ways. Most importantly for us, they champion the role of health as a key driver of economic progress, and thus elevate the role of health. Health is no longer a mere consumer of resources. It is a producer of economic gains. Despite the complex problems we face, this elevated role of health gives us great cause for optimism.

Health in Europe has also been influenced by powerful geopolitical forces. Health problems associated with an advanced level of development are still present, but the overall situation in Europe is dramatically different from what it was in the late 1980s. Not so long ago, the international community tended to think of gaps in health outcomes as divided, more or less neatly, along north-south lines. Here in Europe, you have discrepancies between east and west, and discrepancies nearly everywhere between the rural poor, the urban poor, and the residents of wealthy urban suburbs.

As one document before this Committee notes, Europe has areas and subgroups where mortality rates for mothers and babies are just as serious as those seen in sub-Saharan Africa or southern Asia. Countries in the eastern part of this Region have some of the world's highest rates of multi-drug resistant tuberculosis. These countries are also seeing an even more alarming trend: the emergence of extensively-drug resistant tuberculosis, or XDR-TB. This form is virtually impossible to treat, with mortality rates approaching 98%.

Our vulnerability to these threats is shared. Our response – whether in self-defence or out of respect for our common humanity – must be one of collective action, based on shared responsibility.

Infectious diseases spread. XDR-TB spreads. Air and water pollution spread. The global reach of marketing and distribution spreads lifestyle changes, and these speed the rise of chronic diseases.

The labour market is globalized. You have before you an item on health workforce policies. All regions are seeking ways to address this universal shortage of appropriately trained, motivated and skilled health workers. We are all working to solve similar problems.

And here is one of the rewards of all our shared efforts. Good health contributes to stability, and is a foundation for prosperity. A stable and prosperous region serves the interests of every country.

In retrospect, it is good for international health that leadership here in Europe has had a head-start in understanding these issues and formulating plans of action for addressing them. With its head-start, Europe is in a good position to lead international health on many of today's most pressing global issues.

Without question, political leadership in Europe is having a strong impact on health policy internationally. This is especially true because of the traditional focus of this Region: on preventive approaches, on health-promoting behaviours, on multisectoral action, and on the link between health outcomes and the performance of health systems. This experience will hold us in good stead, globally. This is good currency to have in our pockets, and I believe its value can only increase.

Needless to say, solutions to many of the problems you are working on in Europe, including issues before this Committee, have global significance. If you find a way to reduce reliance on hospital-based care, all the world will benefit. This applies, most especially, to home-based care for the elderly, and primary health care for mothers, infants, and young children.

If you can find a way to improve urban design to counter the health consequences of sedentary lifestyles, all the world will benefit. If your plan of action for food and nutrition policies reduces the incidence of diet-related and foodborne diseases, all the world will benefit.

Let me assure you: I know how difficult this issue is, how hard it is for health to have the most convincing voice when so many other sectors are involved. In this regard, this Region has another great advantage on its side: its skilful use of the strategic and persuasive power of evidence.

Next year, this Office will convene a ministerial conference on strengthening health systems. If this conference can define effective strategies and good practices for improving the performance of health systems, all the world will benefit.

Having said all of this, there is one important downside. I am referring to the perception, sometimes seen at the international level, that Europe is perfectly capable of managing all its health problems on its own. When development assistance is allocated, some countries in eastern and central Europe may be overlooked. The international community has a duty to pay attention to unmet health needs anywhere in the world they occur.

As so clearly stated in documentation before this Committee, traditional health systems in some parts of this Region have simply collapsed. They have not yet been replaced by alternative systems capable of addressing vast unmet health needs, in a comprehensive and fair way.

The report before this Committee on the Millennium Development Goals gives particular emphasis to maternal and child mortality. It provides an insightful analysis of health systems and their inadequacies. This is absolutely in line with thinking at the global level, when we assess overall progress towards the attainment of the goals.

Globally, the achievement of the goals for maternal and child health represents the greatest challenge. To meet these goals, the importance of a well-functioning health system is absolute. Deaths from complications of pregnancy and childbirth have remained stubbornly high, despite more than two decades of efforts. The number of these deaths will not go down appreciably until more women have access to skilled attendants at birth and to emergency obstetric care.

Last year, coverage with routine childhood immunization reached record highs, thanks to the commitment of health ministers and support from the GAVI Alliance. But child mortality will not go down significantly until more newborns, infants and young children have clinical care for premature birth, asphyxia, pneumonia and diarrhoeal disease.

Again, the need for a well-functioning health system is absolute.

The document before this Committee makes a particularly striking statement. It says: “Experience at the regional level has shown that insufficient capacity in the area of health systems is an insurmountable barrier to achieving the health-related MDGs.” Yes. Insurmountable, unless things change quickly, dramatically, and in the right direction.

The performance of a health system – however you want to define this system – is measured by its impact on health outcomes. Let me remind you: our ability to attain the health-related Millennium Development Goals will not be measured by national averages. It will be measured by how well we are able to reach the poor, with comprehensive care, on an adequate scale.

This is where we fail. The poor tend to live in hard-to-reach places, in Europe and everywhere else in the world. They live in remote rural areas or urban slums or have no homes. The insufficient capacity of health systems to reach these people is, indeed, the barrier.

The health-related Millennium Development Goals, focused on maternal and child health, HIV/AIDS, tuberculosis and malaria, are the least likely to be met. These are precisely the goals that make the most immediate life-and-death difference for millions of people. These are the goals that have powerful tools – first-rate vaccines, drugs, and other proven interventions – to support their attainment.

How can we fail? Is the barrier really insurmountable? I see some encouraging signs that things are, indeed, changing quickly, dramatically, and in the right direction.

Earlier this month, I attended the launch of the International Health Partnership in London, together with prime ministers Gordon Brown of the United Kingdom and Jens Stoltenberg of Norway, and heads of the other major agencies and foundations working to improve health. This partnership was launched in response to slow progress in meeting the health-related Goals. It addresses head-on the two major barriers to success: inadequate systems for delivering interventions, and ineffective aid.

This is the test of true commitment. When progress stalls, step back, assess the reasons, shift gears and accelerate action. This has happened. On this occasion, international agencies expressed their commitment to work together in a more coordinated way, with clearly defined roles for reaching shared targets. This fits well with the larger agenda of United Nations reform, where WHO is fully engaged.

In my eight months in office, I have been impressed by the commonality of health problems in all regions, and the common aspirations of health leaders. Public health around the world is engaged in basically the same struggles on three fronts. First, we struggle against the constantly changing microbial world. Second, we struggle to change human behaviours. And third, we struggle for attention and resources.

At the international level, commitment to the Millennium Development Goals has given health unprecedented attention and resources. Commitment to these goals has unleashed the best of human ingenuity.

It is appropriate for me to mention some recent innovations, especially as European leadership has played a critical role in their creation. I am referring to UNITAID, a drug purchasing facility which draws funds from a tax on airline tickets. I am referring to the International Finance Facility for Immunization, which will fund the immunization, by 2015, of 500 million children. I am also referring to the use of Advanced Market Commitments as an incentive to develop new vaccines for the developing world.

We all know that the issues surrounding the development and pricing of new products for the developing world are enormously complex. I want to take this opportunity to thank European countries and the European Commission for their contribution to the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property.

In our struggle against the constantly changing microbial world, we have support from the greatly strengthened International Health Regulations, which came into force this past June. The revised Regulations move away from the previous focus on passive barriers at national borders, to a strategy of pro-active risk management. This strategy aims to detect an event early and stop it at source, before it has an opportunity to become an international threat. This strategy greatly strengthens our collective security, and raises the preventive power of these Regulations to new heights.

We must never again allow a disease such as HIV/AIDS to slip through our surveillance and control networks. We have lived under the looming threat of an influenza pandemic for four years. I am often asked if the effort invested in pandemic preparedness is a waste of resources. Has public health cried "wolf" too often and too loudly? Not at all. Pandemics are recurring events. We do not know whether the H5N1 virus will cause the next pandemic. But we do know this: the world will experience another influenza pandemic, sooner or later.

Recent concern has stimulated enormous research, and we know much more about influenza viruses and pandemics than we did four years ago. Most importantly, preparedness for a pandemic has strengthened national and international capacities in fundamental ways.

Last month's outbreak of Marburg haemorrhagic fever, in Uganda, was stopped dead in its tracks, before it had a chance to become a national or international threat. As the minister of health informed me, the outbreak was promptly controlled by activating the preparedness plan for pandemic influenza. All the procedures were in place, and worked flawlessly.

In the struggle to change human behaviours, we have another powerful international instrument. The Framework Convention on Tobacco Control has become one of the most widely embraced treaties in the history of the United Nations. This is preventive medicine, on a global scale, at its best.

European leadership played an influential role in crafting both of these instruments, with the European Union providing a role model. First, it made a strong, coordinated and unified contribution to the preparatory processes. Second, it made a strong commitment to implementation, by adapting global policy to the specific situations of the European Union and its member states.

International instruments, such as these, derive from our shared vulnerability to threats that are increasingly global in nature. They embody our collective responsibility, and express our solidarity in matters of health. These are the qualities, I do believe, that will become increasingly important as this century – with all its complex health challenges – continues to advance.

As my final point, I must refer to climate change. The world's best scientists tell us: human activities have committed this planet to climate change. The effects are already being felt. Even if greenhouse gas emissions were to stop today, the changes we are already seeing would progress throughout this century. The emphasis is now on the ability of our human species to adapt to changes that have become inevitable.

Climate change will affect, in profoundly adverse ways, some of the most fundamental determinants of health: food, air, water. The warming of the planet will be gradual, but the increasing frequency and severity of extreme weather events – intense storms, heat waves, droughts, and floods – will be abrupt and the consequences will be acutely felt, and most especially so for health. We have all heard about the devastation caused by the worst rains in large parts of Africa seen in 35 years. The consequences for health are both immediate and long-term, and they are enormous.

Just as we fought so long to secure a high profile for health on the development agenda, we must now fight to place health issues at the centre of the climate agenda. I personally believe that the inevitability of climate change makes it all the more imperative for us to reach the Millennium Development Goals. Countries that have achieved a basic standard of living, supported by adequate health infrastructures, will be best able to adapt. They will be best able to cope with dramatic changes that are already on their way.

Again, we are grateful that European leadership has such a solid head-start in addressing the impact of environmental conditions on health. Again, all the world can benefit from your experience on this issue, which may turn out to be the most challenging of them all.

Thank you.