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Contents

Opening of the session

The fifty-sixth session of the WHO Regional Committee for Europe was held at the WHO Regional Office for Europe in Copenhagen, Denmark from 11 to 14 September 2006. Representatives of 50 countries of the Region took part. Also present were observers from one Member State of another WHO region, two Member States of the Economic Commission for Europe and two non-Member States, and representatives of the Food and Agriculture Organization of the United Nations, the United Nations Children's Fund, the Council of Europe, the European Centre for Disease Prevention and Control, the European Commission and the Nordic Council of Ministers, and of nongovernmental organizations.

The first working meeting was opened by Dr Godfried Thiers, Executive President of the fifty-fifth session, on behalf of Mr Eugen Nicolaescu, outgoing President, who was unable to attend.

Election of officers

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

Professor Recep Akdağ (Turkey)	President
Dr Jens Kristian Gøtrik (Denmark)	Executive President
Dr David Harper (United Kingdom)	Deputy Executive President
Ms Zamira Sinoimeri (Albania)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC56/2 Rev.1, EUR/RC56/3 Rev.2)

The Committee adopted the agenda and programme of work.

Address by the Regional Director

(EUR/RC56/4, EUR/RC56/Conf.Doc./1, EUR/RC56/Inf.Doc./1)

The Regional Director welcomed Montenegro as the fifty-third Member State in the WHO European Region and paid tribute to the late Dr Lee Jong-wook, WHO Director-General, and three Regional Office staff killed in an accident in Turkey.

His address highlighted the most visible work of the Regional Office in the past year. Following the structure of the comprehensive printed report, it focused on five areas: cooperation with countries and strengthening of health systems, communicable and noncommunicable diseases, health and the environment, information and management. In addition, partnership remained an essential tool, particularly when the Regional Office worked to resolve crises; those efforts included working with the United Nations Interim Administration Mission in Kosovo to protect the health of a Roma population exposed to lead, with a range of partners to deal with avian influenza outbreaks in Azerbaijan and Turkey, and with the Government of Cyprus to cope with an influx of refugees.

First, the Regional Office had continued to improve and tailor its services to all countries in the Region. In the 28 countries with a WHO office, those offices had been upgraded; programme implementation had reached 98%; and a strategy to strengthen partnerships in the field was being developed with the World Bank, the European Commission (EC), bilateral development agencies, United Nations agencies and nongovernmental organizations (NGOs). In countries without a WHO office, biennial agreements had begun to be made, starting with Andorra, Belgium, Germany and Portugal. The Futures Fora Programme

was tackling topics stressed by successive European Union (EU) presidencies, and the programme within the Stability Pact for South Eastern Europe had entered its second phase.

In addition, the Regional Office had carried out activities to address the specific needs of individual countries. To strengthen health systems, the Regional Office not only had developed mechanisms to support Member States but also was consulting widely with them – on such topics as financing, human resources, technology, service delivery and governance – especially as part of the preparations for a ministerial conference in 2008.

Second, the Regional Office continued to combat both communicable and noncommunicable diseases. Working closely with WHO headquarters, the European Centre for Disease Prevention and Control (ECDC), the EC and other organizations, it had advised country governments and coordinated international support in dealing with the outbreaks of avian influenza in Turkey and then Azerbaijan, and helped countries make plans to handle future outbreaks and a possible influenza pandemic in the Region. With the Joint United Nations Programme on HIV/AIDS (UNAIDS) and its cosponsoring organizations, the Regional Office was working to help countries maintain treatment and step up preventive efforts. The spread of tuberculosis demanded stronger political commitment throughout the Region. The first European Immunization Week, in October 2005, had encouraged parents to have their children vaccinated and had fostered social solidarity against vaccine-preventable disease.

As to noncommunicable diseases, the Region had made progress in banning tobacco advertising and smoking in public places, but 14 countries had yet to ratify the WHO Framework Convention on Tobacco Control (FCTC). After wide-ranging preparations, including extensive consultation with Member States and NGOs, the Regional Office, with the EC, would hold a ministerial conference on obesity in November 2006.

Third, the Regional Office's work on health and the environment focused on implementing the recommendations of the 2004 Fourth Ministerial Conference on the Environment and Health and stimulating action throughout the Region on the topics selected each year by the European Environment and Health Committee (EEHC). Fourth, the Office strove to provide decision-makers with information tailored to meet their needs, particularly through the Health Evidence Network (HEN) and the European Observatory on Health Systems and Policies. Fifth, it had improved the transparency and monitoring of its work, with the support of the Standing Committee of the Regional Committee (SCRC), and made an action plan to improve management of its human resources. A Deputy Regional Director had been appointed.

The Director for Public Health and Risk Assessment, Directorate-General for Health and Consumer Protection, European Commission, speaking at the invitation of the Regional Director, recognized that partnership between the EC and the Regional Office was essential to both. EU health policy was at a key stage; activities included making a new health programme in 2007, responding to communicable diseases, building strategies to tackle key health determinants (such as alcohol, mental health and nutrition), using structural funds to invest in health infrastructure and human resources, cooperating with the wider European neighbourhood and building a strategy that would integrate health throughout all Community policies. It was important to involve not only WHO but also all relevant EU agencies, such as ECDC, the European Food Safety Authority (EFSA) and the European Agency for the Evaluation of Medicinal Products (EMEA).

Regional and global health issues would require the EU and WHO to be even more united. The two organizations had complementary roles, and should seek synergy and avoid duplication. Progress had been made in ensuring a coherent approach to partnership, effective collaboration between ECDC and the Regional Office, and joint work on pandemics, obesity, mental health and the environment and health. New areas of collaboration would be developed through the 2006 budget of the EU public health programme, which would allocate resources to WHO. The EC would be glad to build a yet more effective partnership by participating in the discussion on the future of the Regional Office.

In the subsequent discussion, almost all the speakers congratulated the Regional Director on presenting a high-quality report. Positive comments were made on the report's new format and its emphasis on, among others, the risk to health of alcohol abuse, support for health care practice in the Region, identification of health trends and attention to the determinants of health. The Regional Office and its staff received praise for their work against avian influenza, in cooperation with ECDC, and one speaker echoed the Regional Director's tribute to the Regional Office staff who had lost their lives in the service of the Organization.

A number of speakers praised the Office's support to country offices, one describing WHO's country mission as "courageous". The successful conclusion of bilateral and multilateral agreements, particularly those with EC bodies, on matters of importance was noted, as was increased spending on emergency preparedness and support to country offices. The Organization received thanks for the work with the Global Alliance for Vaccines and Immunization (GAVI), which had led to a reduction in the incidence of hepatitis in adults and children in the Region. The strategies and support provided by the Office for strengthening health systems in specific countries were also welcomed.

One speaker expressed regret at the high dependence of WHO on voluntary contributions and its implications for planning and budgeting. It was suggested that the biennial budgetary process would have benefited from the presentation of a more concrete analysis (like that carried out in the Western Pacific Region) in order to encourage a results-based approach to budgets.

The largest number of speakers spoke of their countries' efforts to reduce noncommunicable disease. One speaker noted that cardiovascular illness, cancer and injuries represented 80% of the mortality burden for countries in transition in eastern Europe. Investing in control of such diseases would greatly improve the quality of life in that area. A large number of speakers stressed the importance of prevention and health; prevention policies were a cost-effective key to achieving health for all. Another speaker said the fight against tobacco should be a priority and that the Organization should continue to lead that struggle. Several speakers referred to making public health gains and improving access to care by addressing social exclusion. Two speakers specifically mentioned the importance of promoting mental health in that context.

Representatives made a number of suggestions for further development of the Regional Office's programme. They emphasized the need for concrete links between the General Programme of Work (GPW), the Medium-term strategic plan (MTSP) and country actions. Priorities for the future included the provision of health personnel for improving access to health care and maintaining the political and financial impetus against major diseases. In that fight, low drug prices were important, as was investment in innovative vaccine development work and joint purchasing arrangements. Rapid protection against outbreaks of pandemic diseases required epidemiological surveillance systems and they should be a priority. The Organization was advised to promote public–private partnerships on the basis that health should be understood as an economic driving force. The Region was also reminded that it should demonstrate global responsibility in health beyond its efforts towards improving the health of Europeans.

The representative of Montenegro said that, as the latest member of the WHO family, his country was dedicated to pursuing WHO principles and the goal of health for all. In addition, the Government would work for stronger collaboration on public health issues to intensify social cohesion between Balkan countries, while the Ministry of Health would focus on integration with the European Union and transatlantic cooperation.

In his reply, the Regional Director noted that from the discussion it was clear that WHO and its Member States shared the same concerns. The matters raised were either on the Regional Committee's agenda or in programmes being developed at the Regional Office. Considerable interest had been expressed in lifestyles issues, including the abuse of alcohol. The afternoon's discussion on noncommunicable diseases would cover all the important related factors, although he recognized that alcohol had perhaps not been given sufficient attention as a significant burden on health systems. Once again, Member States had made many requests but there were not enough resources to satisfy them all, and therefore the Office continued to focus on priority areas.

He agreed with the emphasis on putting citizens at the centre of health policy as referred to by one speaker. He hoped such involvement of citizens in public health would become more common.

He supported the comment by one speaker that the Office should adapt its work to specific countries: to be of use, the Organization's advice had to be a basis for implementation. In view of current health crises, if health systems could not adapt, then recommendations on improving people's health could not be put into effect.

The Deputy Regional Director referred to efforts on the social determinants of health: the Office was looking at translating evidence into more concrete, country-by-country plans. With regard to issues of equity of access to health services, gaps remained and disparities were evident throughout the Region, especially for noncommunicable diseases.

Strengthening its country presence was an important way for WHO to be increasingly responsive to country needs, and investment in country work was constantly being increased. Efforts to support Member States in achieving the Millennium Development Goals (MDGs) were presented in a report on the implementation of the country strategy and that work would continue, with emphasis on strengthening health systems. The Office would continue to produce evidence for policy-makers, especially with the European Observatory on Health Systems and HEN.

The Committee adopted resolution EUR/RC56/R1.

Address by Her Royal Highness Crown Princess Mary of Denmark

The Crown Princess welcomed the opportunity to address the representatives of the Member States in WHO's European Region. In her capacity as Patron of the Regional Office for Europe, her intention was to focus on specific areas of the Office's work and to generate greater awareness within Europe, where poor health, suffering and lack of access to basic medical services were an everyday reality for many people. She welcomed the discussion that was to be held during the session on noncommunicable diseases, which were responsible for a high proportion of the disease burden and deaths in the Region. The increasing problem of childhood obesity was a special concern to her, and she intended to play her part in the work related to the forthcoming Ministerial Conference on Counteracting Obesity and in promoting physical activity.

She was to be particularly involved in two other areas of the Office's work. Immunization, an intervention second only to the introduction of safe drinking-water in effectively reducing diseases and mortality, was still not guaranteed for every child in the Region; the decline in coverage was in some ways a result of the success of immunization itself, so that people were no longer aware of the serious nature of the diseases concerned. Finally, as patron of two mental health organizations in Denmark, the Crown Princess intended to work with the Regional Office on initiatives to support and destigmatize those affected by mental health problems. The Princess wished the Regional Committee success in its work.

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

(EUR/RC56/5)

The European member of the Executive Board designated to attend the meetings of the SCRC as an observer began by recalling the untimely death of the Director-General on the eve of the World Health Assembly, and expressing her admiration of and gratitude to the WHO headquarters Secretariat for ensuring the smooth continuation of the Assembly in such difficult circumstances. The Executive Board had asked the Assistant Director-General to assume the functions of Acting Director-General and had then decided on an accelerated procedure for the election of a new Director-General. Thirteen

candidatures had been received, five of which were from the European Region. The Executive Board would meet from 6 to 8 November 2006, and the candidate it selected would be proposed for appointment by an extraordinary World Health Assembly on 9 November 2006.

The Fifty-ninth World Health Assembly had adopted 27 resolutions; two of those had given rise to much discussion within the Programme, Budget and Administration Committee (PBAC). Resolution WHA59.19 on the draft global strategy on prevention and control of sexually transmitted infections had been long awaited: a written consultation procedure suggested by several members from the European Region had made it possible for the resolution to be adopted at the Health Assembly. The second, WHA59.4, on the Eleventh GPW, had required an extraordinary session of the PBAC; the European Region, the SCRC and the two European members of the Executive Board had played an important role in the formulation of the final draft.

In response to a question related to resolution WHA59.2 on the application of the International Health Regulations, and with specific reference to the need to help Member States build up their capacity to respond to epidemics, the Regional Director noted that the Office was indeed in close contact with the WHO Lyon Office for National Epidemic Preparedness and Response, which, it was hoped, given its location, would be of particular assistance to the countries in the European Region. Because of the threat of avian influenza, countries were being encouraged to implement the International Health Regulations as soon as possible. In general, the Office worked closely with the EC, ECDC, WHO headquarters and other European and international organizations, ensuring the efficient use of resources.

Regarding the resolution on implementation of the recommendations of the Global Task Team on improving AIDS coordination (WHA59.12), the Regional Office coordinated its work closely with that of UNAIDS, the Global Fund to fight AIDS, Malaria and Tuberculosis, and other organizations. It had a team of 50 staff working on HIV/AIDS both in the Office and in the field, and took part in regular international meetings and other joint actions.

Responding to a request for clarification related to resolution WHA59.24 on intellectual property rights and the patents database being established by WHO, the Deputy Regional Director noted that the Organization had been monitoring HIV products and prices since 2003 and had already identified 20 antiretroviral medicines to be included in the database. The methodology had been developed and national patent offices were to be contacted in the search for patents. The intergovernmental working group, which was to draw up a plan of action on intellectual property rights, would be open to the participation of all Member States; its first meeting was to be held from 4 to 8 December 2006 in Geneva.

Report of the Thirteenth Standing Committee of the Regional Committee

(EUR/RC56/6, /6 Add.1, EUR/RC56/Conf.Doc./2)

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

As requested by the Regional Committee, the SCRC had established a working group on the future of the WHO Regional Office for Europe and had closely followed its progress during the year. The report on that subject (document EUR/RC56/11) accordingly presented the combined views of the Working Group, the SCRC and the Regional Office Secretariat.

The SCRC had been regularly briefed on developments with regard to avian influenza, including the outbreaks among humans in two Member States in the early part of 2006. All European Member States currently had preparedness plans in place, and work was continuing to test those plans through visits to Member States, many of which had been carried out jointly with ECDC.

The SCRC had welcomed the arrangements made by the Secretariat to organize a regional consultation on the draft of the Organization's Eleventh GPW in January 2006. The conclusions of that consultation had served as a basis for interventions by European members of the WHO Executive Board at the Board's 117th session, and of the PBAC at its extraordinary meeting in February 2006. The Eleventh GPW had been adopted by the Fifty-ninth World Health Assembly.

Similarly, the SCRC had at several of its sessions reviewed successive refinements of the guiding principles for strategic allocation of WHO's resources, including the mathematical models and validation mechanism to be used in that connection. Its views (notably on the importance of the so-called "engagement factor") had been clearly voiced at global level by the two European members of the PBAC, and consensus on the new, improved methodology had been reached by the Executive Board at its 118th session in May 2006.

At its third session, the SCRC had been introduced to the proposed new format of the Organization's MTSP 2008–2013, in which the previous biennial budget structure of areas of work was replaced with fewer, more strategic objectives. The SCRC had welcomed the new managerial concept, which should ensure better comparability between budget periods and lighten the burden of the budgeting process in subsequent biennia.

On the other hand, the SCRC had not had the opportunity to discuss the concrete budgetary proposals for the biennium 2008–2009. It believed, however, that a fair and transparent methodology for distribution of the regular budget must be an integral part of any budgetary validation mechanism addressing the share of the Organization's total resources going to the different regions.

Lastly, at the Standing Committee's third session, the Regional Director had recalled that he had been asked (in resolution EUR/RC55/R4) to submit a paper on indicators that could be used for monitoring the implementation of the regional health for all (HFA) policy framework in countries. The European Observatory on Health Systems and Policies had informed him that at least three years' work would be required to develop scientifically substantiated indicators for that purpose. At its fourth session, the SCRC had accordingly been presented with three options for HFA monitoring. It had agreed that Member States should be asked, at the current session of the Regional Committee, to specify exactly what they wanted in that connection. The subject would therefore be taken up under the agenda item on Follow-up to previous sessions.

The Regional Committee adopted resolution EUR/RC56/R6.

Policy and technical items

European Strategy for the Prevention and Control of Noncommunicable Diseases

(EUR/RC56/8, EUR/RC56/Conf.Doc./3)

Introducing the item, the Director, Health Programmes, noted that in the WHO European Region, the main noncommunicable diseases (NCDs) accounted for 86% of all deaths and 77% of the burden of disease. Cardiovascular disease (CVD) and cancer were alone responsible for more than two thirds of all deaths. With mental health, they also accounted for over 50% of the total burden of disability. The projected number of deaths for 2005 was around five million from CVD and two million from cancer. Communicable diseases caused fewer deaths (less than 100 000 a year), but some countries were carrying the double burden of high numbers in both. The biggest killer in the Region was CVD: it caused every second death and was the main contributor to the almost twenty years' difference in life expectancy across Europe. The greatest potential for health gains in eastern Europe and the former Soviet Union lay in reducing the number of deaths from CVD.

NCDs were an increasing burden on health systems, the economy and society. Patients with chronic conditions were heavy users of health services. Economic consequences included absenteeism, decreased productivity and employee turnover at work.

The main causes of NCDs were known. Almost 60% of the disease burden was linked to seven risk factors (high blood pressure, tobacco, alcohol, high blood cholesterol, overweight, low fruit and vegetable intake and physical inactivity). Diabetes was also a major trigger. Those risk factors were common to more than one condition – they tended to cluster, especially in the socially disadvantaged. Hence the importance of an integrated approach.

Effective interventions existed to prevent NCDs. An estimated 80% of heart disease, stroke and type 2 diabetes, and an estimated 40% of cancer, could be avoided if the main risk factors were eliminated. However, health services focused on cure not prevention. Only 3% of total health expenditure in countries that were members of the Organisation for Economic Co-operation and Development (OECD) went towards public health programmes and prevention. Nonetheless, a lot had been accomplished. Several countries had achieved reductions in mortality from NCDs, and analysis showed that around 50% of that could be attributed to prevention of risk factors such as smoking, and between 23%–46% to treatment. There needed to be improvements in the quality, the coverage and the implementation of interventions.

What of the future? There were alarming trends of overweight among schoolchildren visible since the 1960s. Europe was ageing. By 2050 over a quarter of Europeans would be over 65 years old, and over one third of men over 60 had two or more chronic conditions.

Two years earlier, the Regional Committee had asked for a strategy that was comprehensive, action-oriented, focused, suitable for a diverse Europe, and adding value to what already existed. It had been achieved through close work with an expert reference group and extensive consultations with Member States, as well as many other partners. Countries had wanted the Strategy to cover health promotion, disease prevention and health care in one framework. The objectives were to take integrated action on risk factors and their underlying determinants, and to strengthen health systems for improved prevention and control.

A member of the SCRC emphasized that tackling NCDs was a very important issue, and a challenge for the economic health of all countries. The Strategy was far-reaching, adding value, putting forward mechanisms for drawing together different strands and providing a platform to reduce the burden of NCDs. It had inequalities in health at its heart. Investment of resources was needed and shifting resources was difficult, but the Strategy offered a critical opportunity to do that. The Standing Committee recommended that implementation of the Strategy should be reflected in the proposed programme budget and MTSP. He looked forward to the action plan for implementation.

In the subsequent discussion, representatives warmly welcomed the Strategy, to which they would give high visibility at all levels. The representative of one country, speaking on behalf of the European Community and the EU accession and candidate countries, commended the Regional Office on preparing the Strategy. NCDs were an area of utmost importance to public health: integrated interventions at relatively low cost offered enormous potential. There had been many developments in this field in the EU in recent years and more were planned, on for example alcohol and health and mental health, as well as health monitoring. The integrated prevention approach was strongly endorsed. Intersectoral policies and health promotion were cost-effective and sustainable, but they required active stewardship by the health sector. The attention paid to health inequalities and gender imbalance was welcome. The Strategy would become the main overall operational instrument for the coming years to improve equitable health in the Region. What was needed now was determined action and an action plan. Success would be measured not only in reduced human suffering but also in increased economic development.

Some speakers reported that their countries in transition had seen increases in NCDs following falls in their standards of living and breakdown of their health systems; they had seen a rise in alcohol consumption and reduced life expectancy. NCDs were an economic burden and added to the other problems of poorer countries, such as coping with communicable diseases and the lack of effective health systems. It was important to move from providing treatment to improving health status. However, disease management was also important. Some patients needed long continuous support in their daily life. A

public health approach of prevention must be accompanied by the proper development of health systems, and strengthening of primary health care should be at the forefront.

Countries had participated in the consultative process to an unprecedented degree, with the fundamental concepts shared and agreed. It was important that mental health was not neglected, as it was the second highest cause of morbidity. It was pointed out that tobacco, obesity and mental health had extremely expensive consequences, yet it was relatively cheap and easy to control them. Ministries of health now had to invest not only in educating physicians about promotion, prevention and early detection, but also in public campaigns on the need for good nutrition and physical activity. One representative asked for more stress to be laid on the responsibility of individuals to lead a healthy life. The integrated approach was very important at many different levels. It was noted that links should be made with the Commission on Social Determinants of Health.

A speaker on behalf of three Baltic states said that it sounded simple to move from scientific knowledge, known causes and recognized preventive measures to empowering health systems through intersectoral action, but it was not always so, and the proposed strategy would help. The Baltic countries were part of the Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) network and Lithuania wanted to build on its experience there to pioneer implementation of the Strategy. Lithuania also offered to host a high-level meeting on NCDs.

Countries spoke of their successes. One representative described how his country's rate of deaths from NCD had been halved in 30 years. It was important to address equity in health in a multi-faceted way and to involve other sectors, as well as local government. Major changes were needed in, for example, the energy and transport sectors and the food industry, as was a more sustainable approach. Another speaker reported reducing mortality from CVD by 34% between 1990 and 2002. Invasive cervical cancer had fallen by 10%; and other screening programmes were being introduced. Cancer would be on the agenda of Slovenia's presidency of the EU in 2008.

Speakers from nongovernmental organizations supported the Strategy. They expressed particular concern about counterfeit drugs, referred to the development of the second Helsingborg Declaration on stroke management and the forthcoming Heart Health Charter, and warned against the marketing of unhealthy products to children and young people.

The Assistant Director-General, Noncommunicable Diseases and Mental Health, WHO headquarters, said that a common vision of control of NCDs had been established in a detailed and promising manner. Commitment would be necessary in coming years to improve the health status of the population. Reducing inequalities was central to controlling NCDs, and innovative thinking was needed.

In his reply the Director, Health Programmes, thanked representatives for their support. The work had just begun and would now move towards the action plan and implementation.

The Committee adopted resolution EUR/RC56/R2.

Proposed programme budget 2008–2009 and Medium-term strategic plan 2008–2013

(EUR/RC56/10, EUR/RC56/10 Corr.1, EUR/RC56/10 Add.1, EUR/RC56/Conf.Doc./4)

The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters introduced the draft Proposed programme budget 2008–2009 and Medium-term strategic plan 2008–2013 (MTSP) as a single, integrated document. The MTSP responded to needs identified in the Eleventh GPW within the framework of that document's long-term perspective on health and its presentation of the Organization's core functions.

Feedback from Member States had indicated that the 36 areas of work used to structure the current programme budget hampered the work across technical areas that was particularly necessary at country

and regional levels; the two-year timeframe was also ill-adapted to the strategic nature of WHO's work. The MTSP thus identified 16 cross-cutting strategic objectives and covered three programme budgets.

Consistent with efforts to improve the administration of resources within the Organization, the proposed programme budget 2008–2009 quantified the resources necessary to achieve each result – a quantum leap forward. Again responding to the demands of Member States, the programme budget was presented as an integrated document with three sources of financing, including a new category, negotiated core voluntary contributions.

The proposed regular budget increase for the Regional Office was 8.6% over the period 2006–2007; the increase for the total integrated budget was about 38%. The trend of shifting resources to regions and countries would continue and was projected to involve 70% of resources in the biennium 2008–2009.

The Senior Advisor, Programme Management and Implementation, WHO Regional Office for Europe discussed the Office's plans within the new context provided by the 10-year Eleventh GPW and the MTSP. That involved looking at the Office's proposed programme budget for 2008–2009 in terms of content and funds. The Office's secretariat welcomed the horizontal approach provided by the 16 strategic objectives of the MTSP, which would enhance implementation at country level. Adapted to the priorities of the Region, the MTSP would focus on four areas: noncommunicable diseases, health security, health systems and strengthened country presence.

On the question of implementation, the increase in the proposed regional budget to US$ 277 million would require an emphasis on increased staffing in countries. If equal opportunities for managing were to be provided across the Organization's seven locations, the same proportion of the budget should be available at the start of the budgetary period. The current situation in which two cost locations with almost identical total budgets had very different regular budgets could not be considered fair. The validation mechanism had been introduced to improve transparency and fairness; nevertheless, the regular budget distribution continued to follow historical practices.

A member of the SCRC expressed appreciation for the work done to take the GPW a stage further into the MTSP. The Standing Committee welcomed the horizontal approach reflected in the 16 strategic objectives – a change it had long advocated. The Standing Committee had previously been quite critical of the process and content of the GPW, and two questions that needed to be answered were whether the links between the GPW priorities, WHO's core functions and the strategic objectives of the MTSP had been made explicit and whether they would enable WHO to perform efficiently.

The Standing Committee was also concerned whether such a large increase in the Organization's proposed programme budget was realistic. She also noted that the relationship between regular and voluntary contributions was likely to become even more unbalanced, with concomitant implications for governance. In view of the uncertainties surrounding the proposed budget, it would be wise to prepare contingency plans to deal with possible budget cuts.

Despite the relative size of the proposed increase in the budget for the Regional Office, it was a small amount compared to the health problems in the Region and compared to budgets in other WHO regions. The Standing Committee was disappointed that the Region was at the lower end of the agreed distribution range, and that the validation mechanism did not apply to the regular budget.

She invited representatives to consider a number of questions: should the Regional Director be asked to start negotiations with headquarters on regular budget distribution? Should the Regional Committee ask its members on the Executive Board to voice the Region's dissatisfaction with the distribution of the regular budget at future meetings?

In the debate that followed, one representative, speaking on behalf of the European Community, the associated countries of the European Economic Area and the EU accession and candidate countries, said that the strategic objectives of the MTSP represented an improvement on vertical areas of work and

would also make it possible to compare budgets over time. The MTSP would thus foster results-based management and transparency. While the importance given to global health security was welcome, insufficient attention was paid to other areas central to WHO's mandate – a matter of concern. That was true for sexual and reproductive health, which was central to achieving the MDGs, and it should be reflected in the budget. It was also true regarding the prevention and control of noncommunicable diseases, which should also be given higher priority, to reflect the evolving disease burden. In some areas, the strategic objectives and expected results might not be attainable, and the linkages between those objectives should be made clearer to avoid duplication of budget allocations. The document also needed to be clearer on how WHO would prioritize should it not receive the expected resources. The potential for cooperation between WHO and other United Nations agencies and the possibilities for synergies should be underlined. Social protection, for example, which was the subject of one strategic objective, was a key mandate of the International Labour Organization (ILO). The relative increase in the share of voluntary contributions in the overall budget weakened the stewardship role of the governing bodies. A better balance needed to be struck between assessed and voluntary contributions. Given the historical increase in voluntary contributions, a better balance could only be achieved by a concomitant increase in the regular budget.

Several speakers thanked the Secretariat for the quality, clarity and detail of the presentations and expressed support for the documents. Some speakers asked for clarification of the innovative division of budget funding into three categories. A number of questions were asked in relation to the MTSP and the proposed programme budget 2008–2009: who within the Organization was responsible for deciding where extra money from the regular budget was allocated? At what point during the biennium was the allocation mechanism applied? What about the link to the financing of WHO's human resources, which represented the heart of the Organization? What was the relation between the different types of funding and the expected results? Would the MTSP with its core functions, main areas and cross-cutting strategic objectives help or hinder prioritization?

Representatives noted that the MTSP lacked emphasis on the areas of sexual and reproductive health and the International Health Regulations. Greater importance needed to be attached to health systems; the strategic objectives were achievable only through concerted action to strengthen them. Two strategic objectives (10 and 11) needed to be formulated more clearly in order to avoid overlap.

Several speakers believed that the projected increases of both assessed contributions and voluntary donations in the proposed programme budget were too optimistic, and they recommended that different scenarios should be developed to model the failure of anticipated funds to materialize. The Organization should also seek savings and suppress overlapping activities by developing partnerships and synergies (e.g. with ILO). Generally speaking, it was difficult to assess the appropriateness of the figures in the absence of budget projections for the following biennia of the MTSP. Voluntary contributions should be made on a more long-term basis, to encourage more predictable funding. One speaker emphasized the need to ensure a regular, predictable cash flow to the Regional Office. It was recognized that the strong growth in funding over recent years was evidence of Member States' confidence in the Organization and their realization of the need for action in support of public health.

The current uncertainties in budgetary funding underlined the importance of planning and prioritization. Representatives noted the large number of strategic objectives. Which were the regional priorities? How did they relate to the proposals announced earlier for the future of the Regional Office? Which areas of work were no longer priorities? Organizational coherence was therefore essential: the MTSP should be better articulated around the GPW, to ensure greater consistency between the two entities. All resolutions and mandates should be checked to ensure that they were still needed, and resources should be allocated by mandate and by the capacity to ensure effective delivery. Some speakers reminded the Organization that an essential part of its mandate was to promulgate norms and standards, and that required a critical mass of personnel at WHO headquarters and in the regional offices.

On the question of fair allocations to regions, it was noted that the European Region remained at the lower end of the range of the validation mechanism. The regional budget increase over the 2006–2007

baseline of 0.1% was felt to be small, in view of the proposed increases for the budget as a whole. More intensive efforts should be made by the Secretariat to find a formula that ensured fair allocation of resources. Lastly, the suggestion was made that increased resources should be directed towards the countries in greatest need in the Region.

A representative of the International Council of Nurses read out a prepared statement.

In reply, the Senior Advisor, Programme Management and Implementation thanked representatives for their comments. The common view was that the MTSP and its strategic objectives were useful and that regional specificities could be encompassed within that framework. She recognized that the various strategic objectives and Organization-wide results would have to be looked at together, in order to see which were the most important. Prioritization and "posteriorization" would be applied if the expected resources were not obtained. As an example of the latter, she noted that in some disease areas more high-level policy advice at country level was proposed, to replace large-volume direct country interventions. On the question of core funding, she made it clear that core negotiated voluntary contributions were as suitable as regular budget funds for ensuring secure funding.

The Director, Planning, Resource Coordination and Performance Monitoring said that representatives' comments on the contents of the MTSP would be conveyed to technical managers and would feed through into the process of creating the finished document. She recognized that WHO was not the only actor in public health and that greater emphasis should be given to achieving the strategic objectives through cooperation. She would take note of the comments concerning the reformed United Nations system. On the question of allocations, it should not be forgotten that the proposed increase for the Region was 38%. She accepted that further work was needed on the issue of the balance between the regular budget and voluntary contributions.

Noting that the Region's Member States were also important donor partners, she requested their assistance in improving the system of allocations. In answer to an earlier question, she said that decisions on how to use additional resources were taken by networks of technical officers, based on the relative urgency of public health needs.

The Acting Director-General said that the total budget of US$ 4.2 billion was reasonable to fulfil the Organization's core functions and mandate, and that the current focus was on countries in most need. Did the budget reflect what the Member States wanted WHO to do? He agreed that a better balance should be found between increased normative support and the technical support provided by WHO to countries; work on the International Health Regulations was an example of the Organization's change in emphasis. In the US$ 4.2 billion total for the proposed programme budget, there were clear indications of changing priorities; for example, noncommunicable diseases and health determinants showed the greatest proportional increase. The budget also had a strong health systems component. Work in relation to emergencies had a significant impact on the budget. He again asked Member States if they had the WHO that they wanted. Where should cuts be made? Was the Organization doing the right things, being true to its six core functions?

The level of core voluntary contributions was realistic and in keeping with current trends. However, a good part of the budget should remain in the form of the assessed contributions. He recognized that distributing regular budget allocations on a historical basis was not good. Change was needed, even though that would mean starting from scratch, looking at the totality of the strategic objectives, seeing if they represented core functions for the Organization and allocating resources on the basis of their relative importance.

On the subject of overall United Nations financing, he said that specialized agencies need to become involved; governments needed to take part also. He recognized that there was room for improvement on collaboration across the United Nations system to ensure that there was no overlap. Efforts had already been made in some areas, but not enough was being done with, for example, ILO regarding occupational health.

The strategic objectives should lead to greater opportunities for working across levels of the Organization. Finally, effective resource mobilization was critical. Half the Organization's resources came through the efforts of country and regional offices. It was up to Member States to increase the predictability with which such funds could be raised.

The Regional Director recalled that one representative had said that unfairness was not a problem for the Regional Office; it was a problem for the Member States who were losing out. Not all countries in the European Region were wealthy. Now that a validation mechanism existed, it should be applied to the three levels of the programme budget, and baselines for the regional budgets should therefore be renegotiated to take account of regional realities.

The Committee adopted resolution EUR/RC56/R4.

The future of the WHO Regional Office for Europe
(EUR/RC56/11, EUR/RC56/Conf.Doc./5)

The Regional Director described the process through which the SCRC and the Secretariat had created the document: the SCRC had established a working group and examined and refined its work after each of its four meetings. The Regional Office was proposing and had already embarked on six strategic directions for its work until 2020: all against health inequities, values for health policy; evidence and information for health policy and public health; strengthening health systems; moving from partnership to task sharing; an international response on health security; and the Regional Office's leadership and new regional input in WHO. Those directions had been selected to support the main positive trends and reduce the effects of the main negative trends in the Region, and they were consistent with the Eleventh GPW and the MTSP.

First, the Regional Office would work with its partners to reduce health inequities, starting with the health sector. It would continue promoting the broad vision of health needed in that and other sectors, and produce guidelines, case studies and indicators to monitor progress. Second, it would further promote countries' use of evidence as the basis for public health action. It would support information gathering and dissemination, and research. With its partners, it was already providing health intelligence to Member States through HEN and the European Observatory on Health Systems and Policies.

Third, the Regional Office was working with Member States to improve the performance of their health systems; the preparation for and outcomes of the 2008 conference on health systems would comprise the basis for that strategic direction. In addition, work with partners on citizen empowerment had begun. Fourth, the Regional Office was improving its partnerships by making them more concrete and focused on work in countries. In particular, while the Office's strong links with the EU were based on similar goals and included close collaboration with the Directorate-General for Health and Consumer Protection and ECDC, task sharing was the next step. That would require: an examination of the EU's role in WHO governing bodies and of WHO's links across the EU, including the Directorate-General for External Relations; the Regional Office continuing to act as a bridge to the countries in the Region outside the EU; and the invention of new ways to govern that partnership and distinguish the partners' roles. Further, a strategy was needed to ensure more effective work with NGOs and collaborating centres.

Fifth, the Regional Office needed to promote an international response on health security by helping to make national health systems better prepared for crises, determining, with its partners, the responsibilities for response and ensuring risk communication. Sixth, leadership by the Office comprised working with its partners to translate research into action, issuing guidelines and acting as a bridge between different parts of and sectors in the Region; playing a normative role linked to action in the field; heightening awareness to empower citizens; and playing its part in a new distributed leadership of WHO, in which the Regional Office would play a larger role in global issues while global approaches would recognize the specific character and needs of the European Region. Finally, the geopolitical changes that were under way in the EU and as part of United Nations reform would affect the Office and WHO as a whole.

A member of the SCRC stressed the Standing Committee's participation in development of the document, the importance of WHO's values as a foundation for it and the Regional Office's need for such a "compass" in coping with new health challenges and important geopolitical developments. The document was not an action plan, but it proposed six strategic directions as areas with the largest potential to improve health outcomes. The SCRC commended the paper for the Regional Committee's consideration.

In the discussion, all speakers welcomed the vision of the Regional Office's long-term future. Representatives endorsed the usefulness of the six strategic directions, particularly the move to task sharing, notably with the EC; the importance of values, and especially of equity as a basis for action and improving access to services; and the need to strengthen health systems, including citizen empowerment. Speakers also mentioned the benefits to be gained from the Regional Office's leadership in health security, evidence-based action and practice, the Office's role as a bridge between countries and sectors, a broad view of health and a better balance between WHO headquarters, the regions and country offices. Several speakers noted with satisfaction the accuracy of the document's assessment of the situation in the Region.

Some speakers cited successes in work on the strategic directions that had already been achieved in cooperation with the Regional Office in such areas as country support, strengthening health systems and working for equity. The network of health-promoting hospitals and the South-eastern Europe Health Network were vehicles for effective cooperation.

Representatives also suggested improvements in the document. Those included adding OECD to the list of leading partners, finding ways to improve work with collaborating centres and NGOs, and distinguishing WHO leadership in various aspects of health security.

A representative speaking on behalf of the European Community, the associated countries of the European Economic Area and EU accession and candidate countries welcomed the document as a valuable basis for future discussion and development, commended its reflection of the six issues on the global health agenda and strongly endorsed the idea of streamlining the Regional Office's work with its partners through task sharing. Continuous and systematic work was needed on public health, health promotion and disease prevention within overall work to strengthen health systems and equity. Issues that needed clarification included the links between the document and the implementation of the MTSP. It was suggested that the Regional Office continue to produce regional thematic health reports.

A representative of United Nations Children's Fund (UNICEF) congratulated the Regional Committee, the SCRC and the Regional Office on the initiative, endorsed the strategic directions and noted UNICEF's close cooperation with WHO on achieving the MDGs. Striking inequities in the eastern half of the Region underlined the need for a holistic approach to child and adolescent development. Member States needed support to identify health interventions that would protect children and other vulnerable groups as new funding became available and decentralization continued in the Region.

A representative of the Council of Europe (CE) endorsed the document and noted the convergence of the CE and WHO agendas as grounds for further fruitful cooperation. The CE could contribute to the 2008 conference on health systems. Holding the tripartite meetings of the CE, EC and WHO before the partners had settled their budgets and programmes could increase the usefulness of the meetings.

In reply, the Regional Director thanked the speakers for their support of the document and their identification of its strengths and weaknesses. The emphasis they had placed on strengthening health systems was welcome: WHO's vision of health systems included public health, health promotion and disease prevention, as well as care. Gaps, such as the lack of a policy on work with collaborating centres and NGOs, would be filled as the document evolved. Realizing the ideal of citizen empowerment would take time. The Regional Office's partnerships were efficient, but could be insufficiently innovative, and needed better governance and sharing of tasks. The EC had partnership and status in WHO governing bodies, but the Regional Office worked for all countries in the Region and acted as a bridge between the EU and countries outside it. New divisions of responsibilities in the United Nations made WHO the

Health Cluster lead agency in humanitarian operations. He thanked UNICEF and the CE for their support. The Regional Office was working on a European report on public health through a project led by Italy.

The Executive Director, Office of the Director-General, WHO headquarters noted that the issue of United Nations reform, including WHO's position as a leader in health and its advantage as a specialized agency, would be on the agenda of the next meeting of the WHO Executive Board. Leadership in work at the country level would be examined.

The Committee adopted resolution EUR/RC56/R3.

Enhancing health security

(EUR/RC56/9 Rev.1)

Introducing the item, the Deputy Regional Director looked at the increased risk of health crises occurring from the transmission of animal diseases to human populations, the growing globalization of both travel and trade, and the possible intentional use of biological agents. In any crisis situation, WHO's objective was to reduce avoidable mortality, morbidity and social disruption, and it proposed to do so by adopting a systems approach to enhancing health security in the Region.

Traditionally, "security" had been considered a national issue, linked to defending the national territory against aggressors; it had become a far more complex concept, covering environmental threats, economic issues, education, health and other areas. The definition of health security proposed by the Regional Office would concentrate on the aspects related to health: health emergencies, and events with serious public health consequences or potential cross-border implications. Mention was made of the work under way in the EC and the need for coordination with it and other international bodies to ensure coherence.

The conditions that could be defined as a crisis occurred when local health systems became overwhelmed and were unable to respond to people's needs; or when people could not meet their basic needs. Such situations could be caused by sudden catastrophic events, prolonged societal disruption as in the case of civil war, or disasters that developed slowly. The causes might be different but the events were all challenges to health systems and threatened health security.

The burden of disasters had increased substantially over past decades, at an immense economic cost to countries. Lessons had been learned from recent experiences, including those mentioned in the case studies presented in the document. However, the successful international management of the severe acute respiratory syndrome (SARS) outbreaks did not mean that an influenza pandemic would be dealt with in a similar way. Moreover, as had been found, the political and economic context was of vital importance, and nothing could be achieved without strong government support. Provision needed to be made to cope with any kind of disaster, rather than plans concentrated on specific threats.

New workforce capacities and technologies were required, and emergency preparedness had to be integrated with other public health functions; it had been shown that public health agencies that managed to do so performed better in times of crisis. To that end, national health systems had to be strengthened and the International Health Regulations (2005) implemented, particularly in countries with insufficiently well-functioning surveillance systems, as that was where new diseases might arise. Information and communication strategies were essential to ensure that the right advice was given to the public at the right time; social disruption was often a result of poor communication.

WHO was the lead United Nations agency for the Health Cluster and would offer leadership on health-related issues within humanitarian operations, working together with other international organizations and networks. Agreement was needed between the stakeholders at every level to ensure clarity on the functions of each and the complementary use of resources.

The document was the beginning of the European Region's contribution to The world health report 2007, which would deal with health as a security issue in a much broader way, and the participants were asked to comment on the directions that had been suggested.

A member of the SCRC noted that the document under discussion represented an attempt to ensure a proactive approach to health security. It built upon experiences from the Region and proposed a framework for system-based action that would include not only governments but also the United Nations and other international agencies, the private sector and civil society.

In the ensuing discussion, countries welcomed the work that was being done on an integrated approach to enhancing health security. Some speakers also thanked the Regional Office for the support they had already received in health emergencies.

A representative speaking on behalf of the European Community and the EU accession and candidate countries said health security was a high priority for all countries. The EU had strengthened its work in that field, mainly covering preparedness for bioterrorism and pandemic influenza, including the creation of a system for rapid alert and information exchange for disasters, and the setting up of a health security committee. The work of the ECDC would further strengthen collaboration. The EU was cooperating more closely with the United Nations and its specialized agencies, and as part of international initiatives such as the Global Health Security Initiative and the European Neighbourhood Policy. A distinction should be made between disease outbreaks and other health emergencies or crises, as the responses needed were different. The new International Health Regulations would strengthen the role of WHO in public health emergencies. WHO had a specific role to play in promoting a coordinated health care response to disasters with a public health dimension, in continuous close cooperation with the EU. One of the most urgent tasks was to support and assess national work on pandemic preparedness planning.

Other speakers noted that WHO and the countries themselves had to learn how to deal with health emergencies, and advice would be needed on strengthening infrastructure and intersectoral measures for preparedness and risk reduction. Coping with a disaster, as many countries had had to do in recent years, was an emotional and overwhelming experience. Representatives from several countries which had been hard hit by crises such as earthquakes, heat-waves, fires and floods said that they learned they had to develop preventive measures and cross-sectoral coordination, and programmes for risk management. What was needed was an early warning, early action system integrated into general preparedness planning. WHO should continue to support Member States in developing national preparedness plans.

One representative described the targeted and technical programmes his country had set up for crisis prevention and management, including a data bank for emergency services, a network of observatories and civil defence, and regular environmental monitoring and laboratory controls as part of preparedness measures. Their experts would be happy to contribute to WHO's work on health security. Other countries also offered their assistance. One speaker recommended that outside experts should be used in institutional preparation, and emergency health networks should be improved, in liaison with the ECDC.

There was some discussion on the definition of health security: it was important that it should not be too restrictive, and that the definition should be a common one with other partners such as the EU.

One representative emphasized the principles of responsibility and closeness: those responsible for a service in normal conditions should also be responsible for it in a crisis, and a crisis should be handled as close to the event as possible. That approach meant that national services, although they also had to be prepared, should not take over more than necessary. That theme of building local capacity was further developed by another speaker, who underlined the importance of upgrading the availability of regular health systems, rather than creating specific structures. Another important factor was communication, and having clear lines of command and roles, a point that was also important for international bodies.

The Deputy Regional Director, in response, thanked the Committee for their support: more work was needed and would now continue. Health security enhancement was closely linked to investment in health

systems: systems that did not work in normal conditions would not work well in a crisis. Various questions that had been raised would be useful to the ongoing work, which was being done in collaboration with other initiatives such as the Working Group of the United Nations Inter-agency Standing Committee, the United Nations Office for the Coordination of Humanitarian Affairs, the United Nations Economic Commission for Europe, the United Nations' International Strategy for Disaster Reduction and the World Meteorological Organization. WHO was also working closely with NGOs, and there had been an intensive consultation in Geneva to revise operational guidelines for WHO's response to health crises and disasters.

The Regional Committee decided to call on the Regional Director to continue work on enhancing health security in the European Region through integrated and overall health systems preparedness and response, taking into account the views of the Regional Committee.

Address by the Acting Director-General

The Acting Director-General said that the current Regional Committee was the fourth he had attended during the year. It was a pleasure to see at a practical level the relevance of the core functions of the Organization and the commitment of those collaborating to fulfil them. The Organization was hearing stronger calls to show leadership, both generally and specifically. It had an important role to play in gathering information and influencing the research agenda. He outlined work in progress to clarify and develop WHO's role in health research. Developing norms and standards was another crucial function that must be maintained. In addition, the Organization should provide policy options, particularly in support of making health systems efficient. Another core function was technical support to build national capacity. The sixth core function was monitoring and surveillance, ensuring the provision of accurate, objective data.

He was encouraged to see the emphasis placed during the Committee on the prevention and control of noncommunicable diseases. The European strategy would be important, particularly with regard to obesity, and would be interesting for the rest of the world. The discussion on health security was also very timely and would feed into The world health report 2007, while the review of evidence for health financing would influence progress in a vital but difficult field. Those topics were further evidence of the importance of collaboration on key strategic areas for health in the Region. That was the future role of the Regional Office: to ensure the complementarity of actions and to translate global frameworks into the regional context. There should be cooperation between regional offices, between Member States and the Secretariat, and between the Secretariat and the growing number of partners in public health.

Returning to noncommunicable diseases, he observed that with the "Gaining health" strategy, countries in the European Region were taking the lead in work on that important health systems issue, making progress on health equity and the social determinants of health. The challenge was to move from having knowledge about such determinants to implementing practical solutions to tackle them. That included dealing with underlying issues like women's education and environmental factors; it called for policy decisions and was relatively inexpensive, requiring the right modalities to influence government decision-makers. He was looking forward to the report of the Commission on Social Determinants of Health that was due in 2008.

Tobacco use was the leading risk factor for disease burden in 31 Member States in the Region. Although 136 countries had become parties to the Framework Convention on Tobacco Control, 14 countries in the European Region had not yet ratified or acceded to the Convention. WHO remained eager to work with all countries and to be at the centre of tobacco control work.

Another key area was achieving the MDGs for maternal and child health. WHO was playing an active role in the Partnership for Maternal, Newborn and Child Health. However, more needed to be done. Immunization remained a crucial tool, yet some three million unvaccinated children died each year from

preventable diseases. The Region needed to do more in that area, in order to reach out to the population with the global public good of immunization. He appreciated the work of the Global Alliance for Vaccines and Immunization (GAVI); all 11 GAVI-eligible countries in the European Region had successfully introduced hepatitis vaccination, drawing on total funding of US$ 12.4 million.

Global improvements had been made in child health, and the under-five mortality rate had fallen over the previous 20 years; however, that was not the case for maternal mortality. A resolution on improvement of the MDGs would be submitted to the United Nations General Assembly in the autumn of 2006.

Globally, WHO's governing bodies had approved a series of strategies and measures for tackling sexually transmitted diseases, particularly among young people, where the European Strategy for Child and Adolescent Health was an important framework for relevant actions. A related problem was the HIV/AIDS epidemic in eastern Europe and central Asia, especially among injecting drug users. Eastern Europe currently had the fastest rate of new HIV infections. The recent 16th International AIDS Conference in Toronto had emphasized the need for an approach that kept a balance between HIV prevention, testing, treatment, care and support. In that connection, he praised the efforts of Dr Lee Jong-wook. Nobody had believed him when he had put treatment back on the agenda with the "3 by 5" initiative. Now, however, there were positive results: in Africa, for instance, a 10-fold increase of coverage had been achieved, with 1 million people on treatment. At the Conference, the Organization had presented the "3 Ms", setting out the three key areas for action: money, medicines and a motivated health workforce. HIV/AIDS work had opened the Organization's eyes to the fact that getting people into health centres was the role of governments. WHO therefore had to focus on raising awareness. The work on HIV/AIDS and recognition of the threat from emerging infectious diseases had catalysed action in areas not previously viewed as priorities.

Implementation of the International Health Regulations was not just a question of disease control; stronger systems for response and communication, and a global approach to health challenges, were needed. The avian influenza threat was still present, with over 50 countries reporting outbreaks in birds and 10, including two in the Region, reporting human cases. Information dissemination and communication remained key activities. Almost all countries had preparedness plans and those now needed to be tested to see if they could become operational. Drug manufacturing capacities had improved considerably, with new licences being granted to produce drugs in several developing countries. Work was being done on pandemic vaccine development and further expansion of manufacturing capacity. Clinical trials were now producing encouraging results.

The European Region had the highest rates of multidrug-resistant tuberculosis (MDR-TB), and much had been learnt from the Region's efforts to tackle that problem. It was a severe public health threat, especially in populations with high rates of HIV and few health care resources. He urged representatives to participate actively in the following year's ministerial forum on the TB and MDR-TB epidemic in eastern Europe.

Health systems had to be strengthened; without that, it would be impossible to scale up health services or achieve the MDGs. The need was to improve the organization, management and delivery of health services; to strengthen the evidence base for policy-making and implementation; to ensure fair, adequate and sustainable funding; and to secure enough well-trained human resources.

The Region contained some of the key governments and partners involved in development assistance for health. On behalf of the world health community, he thanked those countries for their political and financial commitment to that vital work. However, it needed to be increased and made more effective. Governments were now looking for ways to turn the commitments of the previous year's G8 summit (hosted by the Russian Federation) into action, including doubling the funding to Africa. European partners had announced timetables for achieving that increase. Development assistance was important, but a clear perspective was needed and the majority of resources would necessarily continue to come from domestic sources.

WHO was doing three things to ensure that countries accessed the additional support they needed to improve health outcomes: working with partners on country ownership of national plans, budgets and technical frameworks; empowering countries to coordinate and manage development assistance; and paying attention to health systems constraints that hindered progress.

Partners providing development assistance could also do more to disburse long-term predictable finance against substantive rather than political criteria. That was essential for sustainability. Interested parties should start talking, at least in order to align their priorities. He noted that the EU was particularly active in that area. Technical support also needed to better reflect countries' needs, not those of partners and their timetables. He raised the importance of support for European partners in the poliomyelitis eradication process. In that connection, he also emphasized the importance of surveillance.

In conclusion, WHO's goal was to become more responsive to countries' needs and to work effectively as a partner of the United Nations system. The Organization was engaging in the current debate on how that system could better coordinate its work in countries.

Responding to the Acting Director-General's address, one speaker noted that tackling public health problems increasingly required intersectoral cooperation. The recent G8 summit had raised public health issues to the highest levels of decision-making. He asked how WHO would make use of the machinery created for gaining access to decision-makers.

In reply, the Acting Director-General said that the G8 summit had been very successful, producing 56 recommendations on key subjects, including strengthening the health workforce. WHO would be happy to participate in the next summit if Member States so wished.

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

(EUR/RC56/12)

Implementation of the European strategy on tobacco control

The Deputy Director, Division of Health Programmes reported on progress and trends in the Region since the adoption of the strategy in 2002. Smoking prevalence had been curbed, but not in all countries or on the same scale. Lung cancer deaths in men had fallen, but tobacco remained the leading contributor to the burden of disease in most countries. In addition, the growing concentration of smoking in lower social and economic groups was widening the health gap between the most and least advantaged.

The Region had made significant progress in tobacco control; measures included banning advertising and smoking in public places, increasing tobacco taxes and the size of health warnings, the ratification of the Framework Convention on Tobacco Control (FCTC) by 38 countries and the European Community, and the implementation of two EU directives. Public support for stronger policies and action was increasing. The Regional Office had supported countries in developing legislation, making action plans and conducting surveillance, and it maintained a comprehensive European database on tobacco control. Policy weaknesses remained in many countries, particularly in restricting indirect advertising, introducing smoking cessation into national public health services and combating smuggling. Replying to a question, he confirmed that countries' control efforts should not involve discussion with the tobacco industry, even though it brought revenue to governments.

Speakers welcomed the Region's progress towards effective tobacco control, and the contributions of the Regional Office and WHO headquarters. They stressed the value of the European Strategy and the FCTC to countries' work and the FCTC's role as a vehicle for cooperation. A representative described his country's efforts to ratify the instrument.

A representative of the European Commission, speaking on behalf of the European Community, the associated countries of the European Economic Area and EU accession and candidate countries, congratulated the Regional Office for creating and monitoring the implementation of the European strategy and for its emphasis on partnership. The EU and its Member States were a driving force in tobacco control in Europe: contributing to the development of protocols on illicit trade and cross-border advertising, implementing EU directives on tobacco products and advertising, and taking the lead in introducing pictorial health warnings on package labels and banning direct and indirect advertising at international events. The EU would continue to work with WHO and partners throughout the Region to control tobacco.

The representative of a country that had facilitated European coordination at the most recent Conference of Parties to the FCTC noted that the Conference would deal with templates for the two protocols and urged the remaining European countries to ratify the instrument.

Annual report of the European Environment and Health Committee

The Chairman of the EEHC said that recent meetings of that committee and the Task Force on the Children's Environment and Health Action Plan for Europe (CEHAPE) had focused on scientific aspects and progress in implementation of the four CEHAPE Regional Priority Goals. Attendance had been high; all Member States were welcome to attend.

Workshops had been held to help countries to develop their national plans, and 42 Member States now had active programmes for the protection of children against environmental health hazards. In 2007 an intergovernmental mid-term review in Vienna would take stock of progress made in meeting the commitments entered into at the Fourth Ministerial Conference on Environment and Health (Budapest, June 2004). A set of simple and robust indicators would also be presented, which would help to orient policy-making and initiate a harmonized time series for the Fifth Ministerial Conference in 2009.

He gave the dates of forthcoming meetings, thanked host and donor countries and noted that, given the commitment of Member States, necessary resources should be allocated within WHO to ensure that the progress in environment and health would be sustained.

In subsequent discussion, representatives noted the proactive and innovative approach that was being taken in the environment and health process. The involvement of different stakeholders ensured that the process was effective and sustainable over the long term. That deserved closer study by the governing bodies and could be applied in other fields.

A representative speaking on behalf of the Nordic countries was pleased that the EEHC had encouraged youth involvement. It was vital to achieve good living conditions and a sound environment for young people and children, and the EEHC was an important tool in that work. There were good examples of cooperation between Member States concerning the national implementation of CEHAPE. To that end, the Nordic Council of Ministers had been an important facilitator of cooperation between the Nordic countries. The EEHC had the resources, the know-how and the networks to help countries meet their environmental health challenges.

It was further pointed out that the state of the environment in a country determined the state of health of its population. A representative described the many federal and regional laws and statutes that had been introduced, resulting in decreased air pollution and improved water quality, for example. It was important to continue work to improve environmental conditions and to prevent and respond to disasters that could have health consequences.

The Regional Director commended the EEHC on achieving the difficult task of bringing science closer to action based on decisions taken at a ministerial conference. Implementation was what mattered. At the mid-term review of the CEHAPE process in 2007 and the ministerial conference in 2009, Regional Office

staff, scientists and representatives of Member States would meet to build on the achievements resulting from the Budapest Conference.

Indicators of implementation of the Health for All policy framework

The Coordinator, European Observatory on Health Systems and Policies, considered issues related to the methodology for developing indicators to be used in monitoring implementation of the Health for All policy framework update. Since the update was non-prescriptive and did not contain targets or benchmarks, comparisons could not easily be made. There was also a lack of common definitions. Work was being done in various fora to reach common understanding on some points, but no indicators were as yet seen in the same way across all Member States.

Health systems formed the setting for implementation of the Health for All policy framework, but its implications went beyond the health sector, meaning that the place of health concerns in other sectors' policies had to be assessed, and that was not a straightforward task. Moreover, there was as yet no consensus between the Member States on the common indicators to be used in monitoring health system objectives. In monitoring ethical governance, attention needed to be paid, beyond quantitative indicators, to the way that values were implemented, and the role of ministries and governments.

Extensive collaboration with other agencies already took place and some common specifications were in use. Data already existed, too, in the WHO European health for all database, as well as in databases and through other initiatives of the OECD, the Statistical Office of the European Communities (EUROSTAT), the EC's Directorate-General for Health and Consumer Affairs and other international organizations. That work was all helping to produce indicators.

Three options needed to be considered. The first consisted of a comprehensive approach that would allow for comparisons and benchmarking, with the development of new indicators. It would require a high level of resources. The second was selective monitoring, which would build on existing indicators; it would limit the scope of monitoring, but would include case studies of ethical governance. Member States would have to put significant effort into data collection and it would still require substantial resources. The third option was that of selective country monitoring. It would be based on a limited set of available proxy indicators and make use of evidence currently collated, complemented by individual case studies on governance that could then be shared between the Member States. The resource requirements would be lower than for the other two options, but not insignificant.

In the ensuing discussion, it was noted that selective country monitoring would not only provide much of the information needed but would also form a baseline for rapidly assessing future progress. The results would also highlight the real problems, and the methodological support provided by the Regional Office would thus be better targeted and more effective. The Regional Committee therefore preferred the third option as being the most feasible and one that would build on the work already under way with other agencies; it requested the SCRC to look into implementation of that option.

Report on implementation of the DOTS strategy for tuberculosis control and progress achieved in malaria control

The Director, Division of Health Programmes noted that the tuberculosis (TB) emergency in the Region demanded greater commitment from all countries, not just the 18 worst affected. Coverage with the DOTS strategy had increased from 17% of the Region's population in 2001 to 47% in 2004, but needed further expansion. The main challenges were multidrug-resistant TB (MDR-TB), HIV-related TB and health systems that were weak and undergoing reform. Milestones in TB control included: the 2002 Regional Committee resolution on scaling up the response, the 2006 Stop TB Strategy, the Global Plan to Stop TB 2006–2015, the related plan being prepared for the WHO European Region that would cover the period 2007–2015, and the ministerial forum to be held by the Regional Office in 2007. Regional Office resources for the task included a budget of US$ 12 million for 2006–2007 and 56 staff (49 in the field).

The Regional Office had supported countries in obtaining large grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria; it was helping 11 Member States to prepare new proposals to the Fund.

The Region had made so much progress in malaria control, although the disease remained a problem in eight countries, that it was ready to move towards elimination, as shown by the 2005 Tashkent Declaration, already signed by nine malaria-affected countries. The Regional Office was devoting US$ 2 million for 2006–2007 and three staff (one in the field) to that goal, and had supported four Member States in securing grants from the Global Fund. Elimination could be achieved by 2015 and would remove a health threat to 30 million people; to do its part, however, the Regional Office would need US$ 2 million per year.

All the speakers thanked the Regional Office for supporting their efforts against TB and malaria; some also noted the value of the Global Fund's support as well. Representatives described their countries' progress against both diseases and offered to share their experience, including that with DOTS expansion. One speaker urged that care be taken, in efforts to prevent TB, HIV and malaria, to protect the health of people with parasitic diseases.

Representatives stressed the importance of the problem of MDR-TB. One speaker endorsed the Regional Office's approach to fighting TB by strengthening health systems and training health personnel, pledged his country's continued support and looked forward to its participation in the 2007 ministerial forum. Another suggested that the next follow-up report to the Regional Committee include extensive drug-resistant TB and asked about the future of the Health in Prisons Project, a valuable means of combating TB, HIV and other sexually transmitted infections and protecting the health of a vulnerable population.

Several speakers welcomed the Tashkent Declaration and its goal of eliminating malaria by 2015.

A representative of the Global Fund to Fight AIDS, Tuberculosis and Malaria welcomed countries' successful use of its grants in, for example, treating MDR-TB. Grants to fight malaria could help accelerate the implementation of the Tashkent Declaration. WHO's technical support was crucial to successful work in grant-receiving countries. The Global Fund would continue to support the Region's struggle against TB, malaria and HIV/AIDS by financing locally and nationally designed programmes, and to celebrate its successes.

The Director, Division of Health Programmes replied that the mutual support provided by countries, the Regional Office and the Global Fund was essential to success. The Regional Office continued to give priority to the Health in Prisons Project.

Report on progress achieved in occupational health

The Director, Special Programme on Health and Environment summarized the progress made in occupational health since the Regional Committee at its fifty-fourth and fifty-fifth sessions had asked for the work in that area to be strengthened.

Within the attributable burden of disease in the Region, occupational risks were among the first ten risk factors and accounted for 2.5 % of disability-adjusted life years (DALY), often affecting young and productive members of society. Every year, 27 000 workers died in accidents at work and 200 000 died from work-related diseases. For every person who died, there were at least 100 other people affected by occupational disease.

Ministry of health involvement in the occupational health field was sometimes marginal, yet in a stewardship role the health sector could make a significant contribution. Globalization was a challenge, with increasing numbers of migrants from poor to rich countries working in sub-standard conditions in sectors such as construction and agriculture and in the health sector itself. Other problems included new hazardous technologies, the ageing workforce, and child labour.

The work of the occupational health programme had been strengthened in the Office with a part-time manager whose focus was on supporting countries in their implementation of international commitments, in some cases through biennial collaborative agreements. He also contributed to updating and promoting the Global strategy on occupational health for all, through the network of WHO collaborating centres. Human and financial constraints had prevented further scaling up.

The Global plan of action on workers' health 2008–2017 was being developed by WHO headquarters for submission to the World Health Assembly in 2007, and a high-level meeting was to be held on the plan in Geneva in October 2006. The Regional Office would adapt the global strategy and plan to serve the European Region and link activities more closely with other partners, such as ILO and the EC in the context of the Community strategy for safety and health at work. The European network of collaborating centres would be asked to continue to provide human resources and technical expertise.

In discussion, country representatives welcomed the Office's activities in occupational health and considered that it would benefit from more resources. In times of constraint, different ways of working were needed, and the well-structured network of collaborating centres could efficiently provide knowledge and technical assistance. Occupational health policy had been developed on a multisectoral basis, and the centres played a leading role in their countries' occupational health services. At an informal meeting of European ministers of health, social affairs and labour held in Helsinki in July 2006, the two-way connection between health and work had been emphasized: each impacted on the other. Many policies beyond the mandate of the health sector influenced health at work. Occupational health activities should be broadened to cover the identification and prevention of work-related diseases, and also health promotion at work. The representative of one Member State suggested that consideration might be given to a regional strategy.

Elections and nominations

(EUR/RC56/7 and /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 and the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases.

Executive Board

The Committee decided by consensus that the Republic of Moldova and the United Kingdom of Great Britain and Northern Ireland would put forward their candidatures to the Health Assembly in May 2007 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee elected Georgia, Norway and Kyrgyzstan to membership of the SCRC for a three-year term of office from September 2006 to September 2009.

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

In accordance with the provisions of paragraph 2.2.2 of the Memorandum of Understanding on the Special Programme, the Committee decided by consensus that Uzbekistan would be a member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases for a three-year period from 1 January 2007.

Date and place of regular sessions of the Regional Committee in 2007, 2008, 2009 and 2010

(EUR/RC56/Conf.Doc./6)

The delegations of the Russian Federation and Georgia offered to host the fifty-ninth session of the Regional Committee in their respective countries. Those kind offers would be further considered by the Standing Committee of the Regional Committee during the year ahead.

The Committee adopted resolution EUR/RC56/R5, confirming that its fifty-seventh session would be held in Belgrade, Serbia from 17 to 20 September 2007, and deciding that its fifty-eighth session would be held in Copenhagen from 15 to 18 September 2008; that the fifty-ninth session would be held from 14 to 17 September 2009; and that the sixtieth session would be held in Copenhagen from 13 to 16 September 2010.

Other matters

During the session, technical briefings were held on influenza, HIV/AIDS prevention, approaching health financing policy in the WHO European Region, and preparations for the WHO European Ministerial Conference on Counteracting Obesity.

Resolutions

EUR/RC56/R1

Report of the Regional Director on the work of WHO in the European Region 2004–2005

The Regional Committee,

Having reviewed the Regional Director's report on the work of WHO in the European Region in 2004–2005 (document EUR/RC56/4) and the related information document on implementation of the 2004–2005 programme budget (document EUR/RC56/Inf.Doc./1);

1. THANKS the Regional Director for the report;

2. EXPRESSES its appreciation of the work done by the Regional Office in the biennium 2004–2005;

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

EUR/RC56/R2

Prevention and control of noncommunicable diseases in the WHO European Region

The Regional Committee,

Recalling World Health Assembly resolution WHA53.17 on the global strategy for the prevention and control of noncommunicable diseases, together with resolutions WHA57.17 on the global strategy on diet, physical activity and health and WHA55.25 on the global strategy on infant and young child nutrition, and recent resolutions on public health problems caused by harmful use of alcohol (WHA58.26), cancer prevention and control (WHA58.22), disability, including prevention, management and rehabilitation (WHA58.23) and health promotion in a globalized world (EB117.R9);

Acknowledging Member States' existing commitments and the ongoing work under the European Strategy for Tobacco Control (EUR/RC52/R12), the Framework for Alcohol Policy in the WHO European Region (EUR/RC55/R1), the European Food and Nutrition Action Plan (EUR/RC50/R8), the Children's Environment and Health Action Plan for Europe (EUR/RC54/R3), the Mental Health Action Plan for Europe (EUR/RC55/R2) and the European Strategy on Child and Adolescent Health and Development (EUR/RC55/R6);

Recalling its resolution EUR/RC54/R4, by which it requested the Regional Director to prepare a comprehensive action-oriented European strategy on noncommunicable diseases;

Recognizing that 86% of all deaths and 77% of disease burden in the European Region are caused by noncommunicable diseases, which represent the most important current and future public health problem in all Member States in the Region;

Acknowledging the progress and gains already made, but still concerned about the health consequences and the distribution in society of noncommunicable diseases that result in immense loss of quality of life, particularly in socioeconomically disadvantaged groups and poor countries;

Recognizing the substantive negative impact of noncommunicable diseases on economic and social development in any society and the widening of health inequalities;

Recognizing that the noncommunicable disease burden can be significantly reduced through large-scale health promotion and disease prevention interventions, in combination with systematic and continuous work to tackle wider health determinants and risk factors, and effective control of chronic conditions;

Recognizing the need for governments to take the lead in upgrading efforts to overcome the avoidable disease burden caused by noncommunicable diseases and, given the multifaceted underlying causes of those diseases, to invest in comprehensive and multisectoral efforts at appropriate levels in societies;

Reaffirming core values and principles as expressed in the updated Health for All policy framework adopted by the WHO Regional Committee for Europe at its fifty-fifth session in 2005;

Having considered document EUR/RC56/8 and its proposals for a European strategy on noncommunicable diseases with the goals of avoiding premature death and significantly reducing disease burden from noncommunicable diseases through integrated action, improving the quality of life and making healthy life expectancy more equitable within and between Member States;

1. ADOPTS the European Strategy for the Prevention and Control of Noncommunicable Diseases as a strategic framework for action by Member States in the European Region to implement their country policies and engage in international cooperation;

2. URGES Member States:

(a) to develop or strengthen, as applicable, national public health strategies for tackling noncommunicable diseases that provide for integrated action on risk factors and their underlying determinants through a multisectoral approach, where appropriate;

(b) to strengthen health systems towards improved prevention and control of noncommunicable diseases so that health services are fit for their purpose, respond to the present disease burden and increase opportunities for health promotion and disease control;

(c) to regard prevention throughout the life-course as an effective investment with a major impact on a society's economic and social development, and to reallocate resources accordingly;

(d) to ensure universal access to health promotion, disease prevention and health services as a fundamental means to achieve equity in health; and

(e) to set up accountable multisectoral mechanisms at appropriate government levels for the implementation and regular monitoring of the public health strategies mentioned above, involving major stakeholders and making systematic use of health impact assessments;

3. REQUESTS the Regional Director:

(a) to actively support the implementation of the Strategy in the Region and to set up mechanisms for taking action on determinants through a multisectoral approach;

(b) to support Member States in implementing the Strategy by strengthening bilateral and multilateral cooperation, through:

- the development of an alliance for advocacy and action on noncommunicable diseases with major partners;
- the establishment of a network of national counterparts as an international resource and advisory mechanism for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases;
- the facilitation of exchanges of information on evidence and best practice, focusing on policy development and implementation of the Strategy;
- the strengthening of intervention and implementation research; and
- the establishment of a monitoring mechanism to measure progress in policy development, implementation and its related impact on health development, and to collect regularly and report common indicators of noncommunicable disease morbidity in the Region;

(c) to report back to the Regional Committee at its fifty-eighth session in 2008 on the implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases.

EUR/RC56/R3

The future of the WHO Regional Office for Europe

The Regional Committee,

Recalling resolution EUR/RC55/R5 and the principles as outlined in the report of the Twelfth Standing Committee of the Regional Committee (SCRC) (documents EUR/RC55/4 and /4 Add.1) on the setting up of a working group on the future of the WHO Regional Office for Europe;

Having studied and discussed document EUR/RC56/11 on the future of the Regional Office;

Reaffirming the objective and functions of WHO as set out in the Organization's Constitution;

Noting that the document is consistent with other policies, such as the Millennium Development Goals, WHO's General Programme of Work and the Regional Office's Country Strategy;

1. ENDORSES the overall approach of this document, and the directions that the Regional Office should be taking to be positioned at the right place on the international public health scene in 2020, in strong partnership with other organizations concerned by and active in the health field;

2. REQUESTS the Regional Director to ensure effective and efficient implementation, enabling input of Member States, of the strategic directions as outlined in the document and to report on progress achieved to the Regional Committee at its fifty-ninth session in 2009, taking into account the directions set by the Medium-term strategic plan 2008–2013.

EUR/RC56/R4

Proposed programme budget for 2008–2009 and Medium-term strategic plan for 2008–2013

The Regional Committee,

Having reviewed the proposed programme budget for the biennium 2008–2009 within the framework of the Medium-term strategic plan (document EUR/RC56/10) and the regional perspective thereon (EUR/RC56/10 Add.1), and having taken note of the comments made in this respect by the Standing Committee of the Regional Committee and the Regional Committee;

Welcoming the continuing efforts made throughout the Organization to present a more focused budget now aligned to a longer-term strategic vision covering three biennia, as articulated in the Medium-term strategic plan;

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

Noting further that the present budget proposal is to be regarded as a draft, in view of the fact that Article 34 of the Constitution of WHO stipulates that the Director-General shall submit the budget proposal of the Organization to the Executive Board prior to final approval by the World Health Assembly;

1. REQUESTS the Regional Director to convey to the Director-General the views, comments and suggestions expressed by the Regional Committee on the proposed programme budget document, for these to be taken into consideration during its finalization;

2. NOTES the global proposed programme budget 2008–2009 contained in document EUR/RC56/10, which is to be financed by regular funds and funds from other sources, to the extent that the latter become available;

3. ENDORSES the strategic directions contained in the document "Proposed programme budget 2008–2009: The European Region's perspective" (EUR/RC56/10 Add.1).

EUR/RC56/R5

Date and place of regular sessions of the Regional Committee in 2007–2010

The Regional Committee,

1. THANKS the Government of Serbia for its commitment to host the fifty-seventh session of the Regional Committee.

2. CONFIRMS that the fifty-seventh session shall be held in Belgrade, Serbia from 17 to 20 September 2007;

3. DECIDES that the fifty-eighth session shall be held in Copenhagen from 15 to 18 September 2008;

4. FURTHER DECIDES that the fifty-ninth session shall be held from 14 to 17 September 2009, exact location to be decided, and that the sixtieth session shall be held in Copenhagen from 13 to 16 September 2010.

EUR/RC56/R6

Report of the Thirteenth Standing Committee of the Regional Committee

The Regional Committee,

Having reviewed the report of the Thirteenth Standing Committee of the Regional Committee (documents EUR/RC56/6 and EUR/RC56/6 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-sixth 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-sixth session, as recorded in the report of the session.

Decision

EUR/RC56(1)

Enhancing health security in the European Region

The Regional Committee decided to call on the Regional Director to continue work on enhancing health security in the European Region through integrated and overall health systems preparedness and response, taking into account the views of the Regional Committee.

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 Acting Director-General

3. Address by Her Royal Highness Crown Princess Mary of Denmark

4. Address by the Regional Director, including report on the work of the Regional Office

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

6. Report of the Thirteenth Standing Committee of the Regional Committee (SCRC)

7. Policy and technical topics

(a) European Strategy for the Prevention and Control of Noncommunicable Diseases

(b) Proposed programme budget 2008–2009 and Medium-term strategic plan 2008–2013

(c) The future of the WHO Regional Office for Europe

(d) Enhancing health security

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

– Implementation of the European strategy on tobacco control

– Annual report of the European Environment and Health Committee

– Indicators of implementation of the Health for All policy framework

– Report on implementation of the DOTS strategy for tuberculosis control and progress achieved in malaria control

– Report on progress achieved in occupational health

9. 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

10. Date and place of regular sessions of the Regional Committee in 2007, 2008, 2009 and 2010

11. Other matters

12. Approval of the report and closure of the session

Technical briefings

Update on influenza

Approaching health financing policy in the WHO European Region

Update on preparations for the WHO European Ministerial Conference on Counteracting Obesity

HIV/AIDS prevention

Annex 2

List of documents

Working documents

EUR/RC56/1 Rev.3	List of documents
EUR/RC56/2 Rev.1	Provisional agenda
EUR/RC56/3 Rev.2	Provisional programme
EUR/RC56/4	The work of WHO in the European Region, 2004–2005. Biennial report of the Regional Director
EUR/RC56/5	Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC56/6	Report of the Thirteenth Standing Committee of the Regional Committee
EUR/RC56/6 Add.1	Report of the fifth session of the Thirteenth Standing Committee of the Regional Committee
EUR/RC56/7 + /Corr.1	Membership of WHO bodies and committees
EUR/RC56/8	Gaining health: the European Strategy for the Prevention and Control of Noncommunicable Diseases
EUR/RC56/9 Rev.1	Enhancing health security: the challenges in the WHO European Region and the health sector response
EUR/RC56/10 + /Corr.1	Draft Medium-term strategic plan 2008–2013 and draft Proposed programme budget 2008–2009
EUR/RC56/10 Add.1	Draft Medium-term strategic plan 2008–2013 and draft Proposed programme budget 2008–2009: The WHO European Region's perspective
EUR/RC56/11	The future of the WHO Regional Office for Europe
EUR/RC56/12	Follow-up to previous sessions of the WHO Regional Committee for Europe

Information document

EUR/RC56/Inf.Doc./1	Regional Director's report – Implementation of the programme budget 2004–2005

Background document

EUR/RC56/BD/1	Approaching health financing policy in the WHO European Region

Annex 3

List of representatives and other participants

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Mrs Zamira Sinoimeri
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V. Representatives of the United Nations and related organizations

Food and Agriculture Organization of the United Nations (FAO)

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International Coordinator, Avian Influenza, Animal Health Service

Joint United Nations Programme on AIDS

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FDI World Dental Federation

Ms Marianne Koch Uhre

International Agency for the Prevention of Blindness

Mr Christian Garms

International Catholic Committee of Nurses and Medico-social Assistants

Ms Christa Nowakiewitsch

International Council for Control of Iodine Deficiency Disorders

Professor Peter Laurberg

International Council of Nurses

Mrs Judith Oulton

International Diabetes Federation

Dr Michael Hall

International Federation of Health Records Organizations

Ms Darley Petersen

International Federation of Medical Students' Associations

Mr Jacob Hejmdal Gren
Ms Anne-Karina Larsen
Ms Louise Hammer Pettersen

International Federation of Pharmaceutical Manufacturers and Associations

Mr Boris Azaïs
Ms Peli Giachni
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International Planned Parenthood Federation

Ms Vicky Claeys

International Stroke Society

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International Union Against Cancer

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Dr Vibeke Jorgensen

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Ms Anne Lexow

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Annex 4

Address by the WHO Regional Director for Europe

Introduction

Your Royal Highness, Mr President, Distinguished participants in the fifty-sixth session of the WHO Regional Committee for Europe, Representatives of other organizations and of WHO headquarters, Ladies and Gentlemen,

My speech this morning will mainly focus on the events that have taken place since our meeting in Bucharest last September. It will both illustrate and supplement my report on the work of the Regional Office in 2004–2005, which has already been sent to you.

This year was deeply marked by the sudden and unexpected death of Dr Lee. His death shocked the international community, people in the health sector, WHO's Member States and, of course, the Organization itself. Memories of his character and his contribution will long remain rooted in our Organization. The current period is, for all of us, one of both continuity and change.

Our Region has also mourned the death this year of three staff members in a car accident in Turkey. I should like to pay tribute to their memory here by citing them by name: Missimiliano Di Renzi, Anders Truels Nielsen and Orhan Sen.

I would also like to extend a welcome to Montenegro, the fifty-third Member State in the WHO European Region.

In my address in Bucharest, I drew the Committee's attention to the dramatic situation of a population in Kosovo who were exposed to lead emissions and living in unacceptable and inhuman sanitary conditions. In close coordination with the United Nations Mission in Kosovo, the Regional Office for Europe has deployed its technical skills and mobilization capacity, in order to put an end to this disastrous health situation.

Today 600 people, including 250 children, are living in a more favourable environment and receiving appropriate medical follow-up and treatment. I should like to thank the Serbian Minister of Health for his determined and courageous support.

Among the important events that have occurred during the year, I would emphasize our close cooperation with WHO headquarters and other organizations in dealing with human cases of avian influenza, especially in Turkey and Azerbaijan. In these two countries, the combination of technical competence, international cooperation and the political will to be transparent resulted in a rapid and effective response that yielded positive and practical results.

Another example of the Regional Office's capacity to react is given by the mission we sent to Cyprus, as early as July of this year, to help the Government deal with the situation created by the influx of displaced persons and refugees as a result of the conflict in the Middle East. This mission has since been transformed into a temporary office located in Nicosia.

Within the Regional Office itself, we have moved towards more transparency and increased monitoring of programme implementation, the use of funds, internal management procedures and the information we provide to our governing bodies. The Standing Committee of the Regional Committee, and in particular its chairman, Dr Gøtrik, has given us continuous, solid and effective support in this undertaking.

Our drive towards greater transparency is reflected in my report on the work of the Regional Office in 2004–2005.

Cooperation with countries in the Region and strengthening of health systems

Since the adoption of the country cooperation strategy in 2000, constant efforts have been made to improve and make more specific the services that the Regional Office provides to the 53 Member States in the Region. Since 2005, this strategy has placed emphasis on the strengthening of health systems.

In the 28 countries where there is a WHO office, progress has been made in upgrading competences, responsibilities and resources. The proportion of Regional Office staff working in the field is now 40%, an increase of 5% over the previous biennium. The priorities for joint work are set out in a biennial agreement that is negotiated with the country concerned and regularly evaluated.

In 2004–2005, the programme implementation rate amounted to 98%. The areas most commonly covered in the agreements are communicable diseases, health systems, mental health, and maternal and child health. With regard to the latter area, I would point to the stimulus given in many countries by the adoption last year of the strategy on child and adolescent health.

It is at field level, too, that cooperation with other organizations is most practical and specific. We are currently working out a strategy for strengthening partnerships by fostering consistency in the international cooperation aimed at supporting countries' priority programmes. Our main partners in the field are the World Bank, the European Commission and many bilateral development agencies, as well as bodies in the United Nations system and nongovernmental organizations.

We are beginning to extend the concept of biennial agreements to other countries in the western part of the Region that do not have a WHO country office, such as Andorra, Belgium, Germany and Portugal.

Successive presidencies of the European Union have pointed up the need for national action on such important public health topics as the environment and health, patient safety, equity and "health in all policies". Some of these topics have also been taken up at the two annual meetings of the Regional Office's Futures Fora Programme.

In another part of the Region, the Stability Pact programme (launched in 2001 to help south-east European countries re-establish links by sharing public health programmes) has this year entered phase 2 with the common themes "Investing in health" and "Public health systems".

One area where cooperation with countries is particularly important nowadays is that of strengthening health systems. This has increasingly become a priority for the future of health, and hence for the Regional Office, too. At last year's Regional Committee session in Bucharest, we presented a programme setting out the mechanisms that the Office would use to support Member States in this area.

Since then, the Regional Office has worked on service integration, health system financing, primary health care reform and improving the quality of care in Georgia, Kyrygzstan, the Russian Federation, Turkey and Uzbekistan.

In addition to emergency response interventions, the Regional Office has been investing efforts in preparing health systems to handle disasters.

It has supported specific programmes, such as the design and implementation of health policy in Portugal; a review of the Swiss health system, in close cooperation with OECD; the organization of training programmes in public health for health personnel in Greece; the preparation of clinical guidelines in the

United Kingdom, in collaboration with the National Institute for Clinical Excellence (NICE); and the new programme for disease prevention and health promotion in France.

To cite another example that demonstrates the diversity of our collaborative work, I would mention Kyrgyzstan, where we have helped to set up a centre for monitoring health system reform. This unique initiative could serve as a model for other countries, even outside this eastern part of the Region.

On a more personal note, I would point to the celebration of World Health Day, which this year was on the theme of health personnel. Topics discussed in that connection included the migration of health personnel, the quality of teaching, and the availability and distribution of health workers, as well as the forecasting of future needs.

At the invitation of the Russian Federation, I was able to visit the country and see for myself the devotion of health personnel and medical students. It is essential to support them and to regard the goal of upgrading their status and management as a high-priority task for health systems. Subjects such as the migration of health personnel call for a genuinely international policy, where WHO is of course deeply involved. Work is under way on this subject, which will be one of the priority themes of a future presidency of the European Union.

As part of the preparations for the ministerial conference on health systems, scheduled to be held in 2008, an extensive consultation with Member States has already been launched on subjects such as health system financing, health service organization and integration, governance, human resources, and access to drugs and health technologies.

These same subjects are also themes running through the Office's work in 25 countries of the Region, but there is diversity here, too. For instance, the Regional Office is supporting Armenia, Estonia and Kazakhstan in setting up performance evaluation systems, it is helping the former Yugoslav Republic of Macedonia and Portugal with developing their national health policies and programmes, and it is facilitating Estonia's access to the European Structural Fund.

The area of health system financing has given rise to many activities this year, and a technical briefing on this subject is scheduled for Wednesday afternoon.

Communicable and noncommunicable diseases

The most visible aspect of the Office's work in the area of communicable diseases has of course been on the cases of avian influenza in Turkey and, one month later, in Azerbaijan. Efficient and transparent cooperation was quickly established with the countries concerned, in close collaboration with WHO headquarters. The Regional Office acted simultaneously as an adviser to governments and a coordinator of international support, presaging the forthcoming application of the new International Health Regulations. These human cases in Europe have stimulated the Region's capacity to respond in an appropriate way to this type of health crisis. To some extent, they have also given impetus to the plans prepared by each country in the Region. During the year, with the active support of the Regional Office, the European Centre for Disease Control (ECDC) and the European Commission, all the Member States in the Region have met in Luxembourg, Copenhagen and Uppsala. The European Region is now seen as being relatively well prepared for a possible pandemic. However, preparations must continue, and national plans must be better tested. This will be a priority in the months ahead. A briefing session on this subject is scheduled for tomorrow evening.

The AIDS situation in the Region continues to be worrying: some progress has been made, but there are still grounds for concern. Access to appropriate treatment has clearly been improved. In two years, 120 000 new patients have received appropriate treatment. In our Region, the coverage rate of people requiring such treatment now stands at 70%. However, considerable efforts need to be made if we are to

reach the goal of universal coverage by 2010. On the negative side, one concern is the increase in the number of cases and countries affected by the epidemic. According to UNAIDS and WHO estimates, 2.3 million people are infected with HIV in the European Region, with 250 000 new cases occurring each year. In 2005, more than 30 countries in the Region reported an increase in the number of cases. It is now essential to maintain treatment efforts while stepping up preventive actions. To respond more efficiently to this situation, the Regional Office has increased the number of experts in field posts in the 12 countries most affected. There are currently 40 people in this field team. All these activities are of course closely coordinated with UNAIDS and its cosponsoring organizations. I would also invite you to attend the technical briefing that will be held on this subject.

At Bucharest, I drew the Regional Committee's attention to the very worrying situation caused by the spread of tuberculosis in the Region. Despite the efforts made, there is no evidence of progress yet. To achieve this, there must be a stronger political commitment to action, not just in the 25 countries concerned but throughout the Region. It is surprising, to say the least, that we still have today the same level of cases of tuberculosis as we did in the 1970s, thirty years ago.

As you know, an immunization strategy has been adopted at the European level, and I informed you about the launch of the first European Immunization Week, which was held in October 2005. Evaluation of this pilot effort has clearly shown not only that it gives impetus to parents but also that it heightens people's awareness of the solidarity dimension of the subject. Ten countries participated very actively in this event, which we will of course continue in the years to come.

As you also know, one of the important topics on the agenda of this session of the Regional Committee is the European Strategy for the Prevention and Control of Noncommunicable Diseases, including mental health, which will be discussed this afternoon. The strategy has been drawn up over a two-year period, features of which included in-depth consultation with all Member States and cooperation with other nongovernmental organizations, as well as with numerous experts. I will therefore not dwell on this subject, but let me just mention the area of tobacco, where the Region has made progress in at least two main directions: a comprehensive ban on advertising in 45 countries, and a ban on smoking in public places, where several countries have set an example that will no doubt be followed by others. Fourteen of the 53 countries in the Region have still to ratify the WHO Framework Convention on Tobacco Control. This is already a good result, but I would urge those countries that have not yet done so to take this step.

Lastly, nutrition is another subject that is very important for the Region and the Regional Office. Vigorous preparatory work has been done for the conference to be held in Istanbul in November this year, with the title "Counteracting obesity". As with previous ministerial conferences, it is being jointly organized with the European Commission. Extensive consultation with Member States and nongovernmental organizations is under way. Numerous high-level experts are also cooperating on preparations for this event. The aim of the conference is to make recommendations on the policies that need to be put into effect in order to reduce the prevalence of obesity. The health sector is far from being the only responsible body in this area, and it is essential to mobilize other sectors. A briefing session on this subject is also scheduled to be held on Thursday morning.

Health and the environment

It is now two years since the Environment and Health Conference was held in Budapest. The importance of the work done at that conference, and its outcomes, has meant that the Office has had to focus its efforts on implementing the recommendations made there, as contained in the Conference Declaration and the Children's Environment and Health Action Plan for Europe.

In eight countries (Bulgaria, Cyprus, Estonia, Kyrgyzstan, Lithuania, Malta, Serbia and Slovakia), the Regional Office has joined with the national government to give effect, in the medium term, to all the commitments made in Budapest.

In addition to that approach, the European Environment and Health Committee (EEHC) has selected a number of themes each year, to act as a stimulus for action throughout the Region. Following air pollution, the subjects of violence and accidents, together with chemical products, have been chosen for this year.

One important date for follow-up of the Budapest Conference will be 2007, when a mid-term review will be made and presented at a meeting in Austria.

Later in the session Professor Dab, Chairman of the EEHC, will give you further details of the work done during the year by this very active programme.

While the Budapest Conference has been the top priority for work on the environment, other one-off interventions have also been made, in particular to respond to extreme weather events, such as heat waves and flooding, which are no doubt linked to climate change.

Information production

Since 2000, the Regional Office has constantly striven to provide decision-makers with targeted information that is carefully tailored to meet their needs. This work is done by all the Office's technical programmes, and their communication skills have clearly improved in recent years. The hub of the Office's information arrangements consists of the activities of the Health Evidence Network (HEN) and the European Observatory on Health Systems and Policies. In addition to producing its own publications, the Observatory has this year organized innovative meetings in countries, at their request, bringing together all the actors involved in work on priority themes.

In addition, analysis of the requests for information sent in to the Regional Office has led us to critically review our products and has highlighted the need for more accessible communication that nonetheless retains its technical and scientific quality.

Lastly, I would note that the Regional Office is increasingly visible in scientific journals (more than 100 articles published) as well as in the mass media.

Management and governance

The discussion of the proposed programme budget later in the session will give us the opportunity to come back to the management of the Office and the instruments that have been developed this year to improve transparency and the preparation of the 2008–2009 budget.

Here I would just like to mention a recently launched initiative that will bear fruit in the years to come. This is an action plan designed to improve human resources management, with the aim of promoting a stimulating working environment and ensuring that the Regional Office's competences are always matched to the countries' needs.

This gives me the opportunity, in your presence and, I have no doubt, on your behalf to thank all the staff of the Regional Office for the quality of their work, their devotion to duty and their competence. I see evidence of this every day and I am sure that at country level you do, too.

Lastly, among the innovations this year, I am sure you already know that, acting on a proposal from me, the Director-General has appointed Dr Nata Menabde as Deputy Regional Director.

Conclusion

In this necessarily selective address, I have placed emphasis on the most visible and recent aspects of the work of the Regional Office. My printed report is of course more comprehensive.

I have already mentioned several sessions of this Regional Committee. I should, however, like to draw your attention to the importance of an item that we will consider tomorrow, on the future of the WHO Regional Office for Europe. During the meeting at which this topic is taken up, we will have the opportunity to discuss our partnerships with other organizations, in particular the European Commission; that is why I have not devoted a special section of my speech today to this subject. But, as you will have certainly noticed, I have referred to it several times, because it is an essential direction for the work of the whole Office.

Nonetheless, I would like to recall once again that the mission of the Office is to serve all the 53 Member States of WHO in the European Region.

I hope that this Regional Committee will be not merely a session of one of WHO's governing bodies but also, and more importantly, of value in moving public health forward, both throughout the Region as a whole and in each individual country.

Annex 5

Address by the Acting Director-General of WHO

Mr Chairman,
Honourable Ministers,
Distinguished representatives,
Dear Colleagues,

It is a great pleasure for me to join this, my fourth regional committee session. It has been a pleasure seeing the strong commitment, relevance and engagement in the core functions of WHO. I will return to these six core functions later. We hear a much stronger call today for leadership and coordination both from WHO generally, and in specific areas.

Yesterday I spoke about the need to increase the profile of research. WHO itself does not conduct research, but we play an important role in information gathering and influencing the research agenda. We need to ensure that we continue the critical function of norms and standards. We also need to provide policy options especially those relating to increasing the efficiency of health systems.

The fifth core function, of providing technical support to build sustainable national capacity, is very important if we are to be able to translate the agenda for initiatives like "Making pregnancy safer" into practice in the national context.

The sixth core function concerns monitoring and surveillance. It is essential that WHO is able to deliver data information with quality and integrity.

I missed the Regional Director's report yesterday on progress in the Region. However I have read it and appreciated its clarity and strong focus on countries.

I would like to highlight three specific topics. The first is the prevention and control of noncommunicable diseases. We need a balanced approach. We need to continue to focus on tackling communicable diseases, finishing the work on polio, but we also need to address the underlying causes of noncommunicable and chronic diseases. The European Strategy will be very important here. The specific emphasis here on obesity is also going to be interesting for the rest of the world.

The discussion yesterday about health security will feed into next year's world health report with its theme of health and security – which is also going to be the theme for World Health Day.

The third issue that I would like to highlight is health financing. The progress made and lessons learnt from this Region can also be shared globally.

These topics clearly indicate how we need to work together throughout the Organization, in Geneva, the regional offices and country offices, as well as in the Member States and the Secretariat. Your discussions on the future role of the Regional Office will support this alignment and complementarity, making sure that the global framework is translated into the regional or country context.

Yesterday we discussed the Medium-term strategic plan for 2008 to 2013 and the Proposed Programme Budget for 2008 to 2009. I very much appreciate the discussion and your comments. We will revise the document after the regional committees and then it will be submitted to the Executive Board. I strongly encourage you to attend the session of the Board, if you normally do not. It will be crucial. The revised document will be ready at that time.

The increase in the budget is a direct reflection of increased expectations and demands from Member States. It will target core areas of need, namely: achieving the Millennium Development Goals for

maternal and child health; increasing the focus on noncommunicable diseases; making health development sustainable through greater attention to the determinants of health; implementing the International Health Regulations, and strengthening health systems.

To finance these plans, the Proposed programme budget for 2008–2009 has been costed at US$ 4.2 billion. This is very ambitious and a major challenge to all of us, as we discussed yesterday. Again – as was presented and discussed – the proposed financing of the programme budget is through: an 8.6% increase in assessed contributions from the Member States amounting to US$ 1 billion; the introduction of negotiated core voluntary contributions amounting to US$ 600 million; and the remainder through specific voluntary contributions.

Even with this increase, the share of the assessed contributions will continue to decline (23%). This is unfortunate. We hope however that the introduction of negotiated core voluntary contributions will achieve better alignment and reduce the transaction costs.

The total proposed increase for the European Region is about 36% against the current biennium. This represents an absolute increase of US$ 72 million for a total of US$ 273 million.

There are five main areas of focus coming from the General Programme of Work, the proposed Programme Budget and the Medium Term Strategic Plan.

The first is increasing universal coverage, scaling up basic health services to people with an equitable perspective.

The second is the health security dimension, which is becoming more prominent with the implementation of the International Health Regulations. Today WHO has a different and much stronger role in security and humanitarian issues as the Health Cluster lead. I am shortly going to see Jan Egelund in Geneva to discuss how we can further improve the ways that WHO and OCHA work together.

The third dimension in the future concerns the determinants of health. We will see that increasing further. We look forward to 2008 and the report from the Commission on Social Determinants of Health. I had a meeting with the chairman, Mike Marmot, a month ago, to discuss how to make WHO's work reflect the knowledge of what really makes a difference in health.

The fourth area of focus is on health systems and the fifth on strengthening WHO’s leadership both at the global and regional levels, to support the work of governments in countries.

There has been a very thorough consultation throughout the Organization, reflecting what has been decided in resolutions, what has come from country strategies, and what has come from specific strategies on immunization, tuberculosis, etc. The process has been to gather this together to see what is the direction forward.

Let me then turn to five very specific areas.

First to noncommunicable diseases. Your strategy, “Gaining health”, describes very clearly how to plan to be able to tackle some of the major causes of chronic noncommunicable diseases. The Ministerial Conference in Istanbul on obesity will be very important and provide significant input on what we need to do in terms of chronic noncommunicable diseases. The Global Strategy on Diet, Physical Activity and Health is important; we need to translate it into practice now, seeing what we can do as Member States, what we can do as the Secretariat, which partners we need to engage with if we want to make a difference. The epidemic of obesity is growing very rapidly. There are a number of changes that need to be made in government policies, in private business practices and also by the consumer. WHO has an important role to play here.

We need to go beyond the obvious to look into the underlying causes of ill-health. What are the determinants that relate to women's education, the empowerment of women, to the environment? What is happening in terms of air pollution? There are a number of underlying determinants of health that we need to tackle. This does not need to cost much. Policy decisions in other sectors than the health sector can have a large impact on health. It is a matter of finding the right modality for us to influence ministers, for example, so that road-building decisions also reflect public health interests and can save mothers that are dying in childbirth because of lack of access to healthcare services.

I was part of the Swedish Government when there was a Swedish parliamentary commission looking into the broad public health issues and the actions to be taken by the different sectors. How is that now translated into action? Do we then see an impact on health? That is the big challenge. It is easy to say; it is much more difficult to do.

This is something on which WHO needs to work on with you, to gain experience and to find the right modalities. This is an important health systems issue.

Countries of the European Region continue to take the global lead in research and action on health equity and on social determinants of health. The upcoming meeting on these issues in London in November will be important to explore them further.

A specific dimension of this is tobacco and the implementation of the WHO Framework Convention on Tobacco Control. So far, 136 countries and the EC have become Parties to the Convention. However, 14 Member States from this Region have not yet ratified, accepted approved or acceded to the Convention. I urge you to do so as soon as possible. WHO is very keen to work with all countries, both those which are Parties and those that are not.

Tobacco use is a critical risk factor if we want to have an impact on health. It is a very easy one to change. Just stop smoking. Easy to say. Difficult to do.

We have seen some important progress in terms of child health worldwide, including in this Region. More needs to be done. WHO is playing an active role in the Partnership for Maternal, Newborn and Child Health.

Immunization is a crucial part of our work and one of our most successful tools. We have learnt of the engagement in this field by her Royal Highness the Crown Princess of Denmark, and that is very much welcomed. However, even though we have been working on immunization since Almaty, we still have two to three million children who are not immunized, who we are not reaching.

In St. Petersburg when I addressed the G8 leaders, I compared a generic cola bottle with a polio vaccine to make a point about access. One product is able to reach out in every single village. The other does not. So what is wrong? We can save lives for a fraction of the cost of a soft drink. We need to rethink how we reach out to be just as efficient. We need to think in terms of our health systems, our logistical systems, and to learn from those who are more efficient than we are to be able to reach out with the global public good of immunization.

This Region has made enormous progress, yet still much more needs to be done. We appreciate the partnership with the GAVI Alliance. Out of the 11 countries that are eligible for GAVI support, all have now successfully introduced Hepatitis B vaccine. Overall, this represents a financial commitment of some US$ 12 million.

Let me now turn to an area which is of great interest and importance to me, to WHO and also very specifically to this Region – the area of sexual and reproductive health. Much more needs to be done here, especially the underlying problems relating to maternal mortality. We have seen some progress globally in terms of child health. The infant mortality rate and the under-5 mortality rate have gone down during

the last 10, 20 and 30 years. Maternal mortality has not really seen any change. Many countries in this Region have also made good progress but much more needs to be done.

WHO's governing bodies have approved a series of strategies that will be important for us to be able to take this agenda forward. We have the strategy on sexually transmitted infections; we have the strategy on reproductive health; we have the strategy on family health; we also now have the new strategy on HIV/AIDS. All of these now need to be translated into practice on the ground. We must try to focus even more on young people.

The European strategy for child and adolescent health that was adopted last year will be an important framework in the Region. I have tried, during my months in this Office, to make this a personal commitment. One of the first meetings I had was with Thoraya Obaid, the Executive Director of UNFPA. We held a very good review of what each agency is doing. This has been going on for some years and we trying to increase the focus on countries and complementarity on the ground. We sent a joint letter to emphasize that we do have different roads and different mandates. We are now implementing certain decisions by our governing bodies. Working together is crucial for concrete actions in countries.

I recently attended the XVI International AIDS Conference in Toronto. The theme of that Conference was "Time to deliver". One of the key outcomes of that Conference was "Stop talking; do it". Despite some people's concerns about big conferences I would say that this was not a conference, this was not about producing a declaration, this was about working. I am not ashamed that we had 100 people there. We needed to be back on the stage to be able to do our work. We gained a lot also from listening to others, so that we can take the work forward. I am very happy with the new five-year strategy for WHO, making sure that we are an effective partner and cosponsor to the UNAIDS broader UN programme.

During the last years, thanks to Dr Lee Jong-wook, we have put treatment back on the agenda through the 3 by 5 initiative. Nobody believed it was feasible when he announced this initiative but he proved that change was possible. We did not reach the three million on treatment but, at the AIDS Conference in Toronto, we had reached 1.65 million, with the figures for Africa having increased by 10 times from 100 000 to 1 million on treatment in Africa alone. We have not seen anything like this for any disease before – achieved in roughly two years. That was enormous progress. We should recognize what the Director-General did there.

We need now to move forward on HIV/AIDS in a balanced approach, making sure that we work on behavioural aspects, that we work on new opportunities when it comes to prevention and that we continue to work on treatment.

At the Conference I introduced the "3 Ms": the three key areas for action of Money, Medicines and a Motivated workforce.

We have seen an increase in terms of financial resources. Yet more is needed. The total measures for this biennium are expected to be in the region of US$ 8 to 10 billion.

There have also been major improvements in terms of access to drugs. Prices have come down and new products are available. I recently attended a conference with the Secretary-General and some of the CEOs from the largest pharmaceutical companies in the world on the Secretary-General's Accelerating Access Initiative. There has been a major improvement both in terms of drug prices and in terms of new formulas for children, primarily targeting developing countries. Still, much more has to be done in terms of getting prices down on paediatric formulas for second-line treatments. But it is still a very different situation compared to five to six years ago, when the Secretary-General initiated that discussion.

Yet neither of these two will bring more than short-term benefits if the longer-term development issues of an effective health system and the health workforce crisis are not dealt with. Everybody recognizes that this is the main bottleneck. At the Toronto Conference WHO launched the "Treat, train, retain" initiative

to protect and support health workers living with HIV. This joins wider global efforts to sustain and build through the Health Workforce Alliance.

HIV/AIDS work and the epidemic have opened our eyes, both technically and politically to the need to address issues on motivation, incentives, salaries and structure of the health sectors, both private and public. People today are driving taxis instead of delivering health services. We need to understand the structural issues of public sector health reform – something which is not WHO's role, but that of the governments, the role of the ministry of finance.

A motivated health workforce requires more than training. That has been our solution for many years. We need to go beyond training. We have to address the underlying issues. Health workers are being driven away by low salaries and poor working conditions. Some are forced away to other jobs, either nationally or elsewhere in the world. This year's World Health Day and World Health Report had the theme "Working together for health" to highlight this. The Report proposes immediate country-based actions within a 10-year plan.

The work on HIV/AIDS, and the recognition of the threat to human health from emerging infectious diseases has catalysed action in many areas not previously viewed as a priority in public health.

So let me now turn to the implementation of the International Health Regulations, and to avian influenza. Those of you here who were involved in the careful negotiations to revise the International Health Regulations know how highly this instrument is regarded by Member States.

This is not only about controlling avian influenza, of course; it is not only about narrow disease control, it is also about building systems in countries that are robust enough to be able to monitor, and to be able to respond. It is also about transparency, communication across the world and taking more of a global approach to how we can manage key health challenges.

In terms of avian flu and the risks of a human influenza pandemic, there is still a threat. Today, more than 50 countries in central and southern Asia, Europe, Africa and the Middle East have reported outbreaks in birds. Human cases have now been reported in 10 countries, including 2 from this Region. As at 8 September there had been 244 confirmed cases and 143 deaths.

Information and communication are key here, to have a good understanding of how you can protect yourself and what you need to do. For example, it is safe to eat cooked chicken. But it is not safe to handle dead birds in certain ways, and that message needs to get across. I am encouraged to see that we now have preparedness plans in more or less all countries, and I hope that these will be broad enough also to be able to build up wider health systems and surveillance systems. It is important that they are tested so that they can become operational.

Manufacturer capacity in terms of antiviral drugs has improved considerably. New licenses have been granted and production capacity is increasing in some of the developing countries. We also see some progress in terms of a vaccine. The capacity issue is more difficult, but there is movement. We are now focusing on capacity-building in developing countries. Some recent clinical trials are showing promising results.

Let's look briefly at a couple of other areas of importance to our health work.

First I would like to say a few words about tuberculosis. This Region has one of the highest rates of multidrug-resistant TB. We have learnt a lot from how you have been able to tackle this here. It is still a severe threat to human health and to public health, especially in the countries where there is a high rate of HIV/AIDS. The ministerial conference to be held next year will be important and I encourage everybody to participate in this. It is an important issue for all countries, not only developing countries and HIV/AIDS-affected countries, but for all countries in this Region.

In terms of malaria, there are still some key challenges in this Region. At the same time, we have seen some important and impressive progress. I congratulate all the malaria-endemic countries in the Region that have achieved a decrease in malaria relative to 2000.

In polio eradication, only four countries in the world remain polio-endemic: Nigeria, Afghanistan, India, and Pakistan. Our work to reach all those children continues, urgently. Until polio has gone, children everywhere will continue to be at risk. The success of the global polio eradication effort now depends on political will, and strong commitments to close the funding gap. I particularly congratulate the Russian Federation's leadership in making a new commitment of US$ 10 million to support polio eradication. It is essential that other G8 countries now follow suit. For 2006, we urgently need US$ 50 million by October to ensure activities through the rest of the year can proceed. For 2007–2008, we face a US$ 390 million funding gap.

And this brings me to the last of the core areas identified in the proposed Programme Budget: the need to continue strengthening health systems. Without functioning and efficient health systems we will not be able to scale up basic health services nor achieve the MDGs. I think health reform and health systems generally need to be de-mystified. Simply: we need to achieve four things.

First, we need to improve the organization and the management and delivery of health services. That has to do with primary health care, with ensuring that we have hospitals, with getting efficient delivery of health services, including both the private and the public sectors, and with making sure that we achieve public health through that approach. We need to encourage different stakeholders' and providers' involvement in that.

Second, we need clear information and evidence, to be able to take the right sort of decisions. We need to strengthen the evidence base of health systems to support policy-making and implementation. This means good information and surveillance systems and investing in national capacity for research. I think we have seen some progress here. I am very happy that the Health Metrics Network will improve how we can work with countries in terms of getting more quality data and information.

Third we need fair sustainable financing. This means looking at policy options for how to finance health services, exploring different financing alternatives, and reviewing the most effective allocation of resources. There are a lot of experiences in this Region that can also be shared with others.

The fourth component is the people, the staff, the human resources. This is the key area, both where we spend most money, and also where we can make rapid progress if we are prepared to deal with the underlying issues.

I would also like to say a few words about development assistance for health, and the aid effectiveness agenda. Some of you in this room are key partners in terms of development assistance. You provide substantial amounts which are very welcome. We see a very clear increase in investing in health in terms of overseas development assistance. This is vital, but one should see it in perspective. The world today spends US$ 3600 billion on health worldwide, US$ 340 billion in developing countries. About US$ 10 billion of that is development assistance. Sometimes we believe that development assistance will solve everything. It will not. The majority of the resources, if we want to scale up basic health services, are already coming from domestic resources. That will continue to be the future. Development assistance is important, both in terms of showing political will and political support. The G8 in St Petersburg was extremely important – and again, many thanks to the Russian Government for their firm positioning of health issues on that agenda. The G8 outcome document was the most elaborated thus far and a strong commitment to sustain scaling up and to invest in health.

A number of European partners have announced timetables to achieve this increase. 'Scaling up' thus remains an achievable goal. And one that we are firmly committed to achieving.

WHO is not the lead in terms of development assistance or aid effectiveness but it is critical that we work with countries on some of these issues. The first and most important thing is to ensure that there is country ownership: that there are national plans, national budgets, national policy frameworks, that are truly owned and that are technically sound in terms of priorities. We are engaging in many countries to support and to respond to their needs and expectations.

We need to empower those plans and those governments, respecting what has been developed and what are the national priorities. That needs to be at the forefront if we want to be effective. And we must work on the health systems issues which are crucial if we are to be effective in development assistance. The bottlenecks are related to the systems. I think we can do more to work with countries on that.

Partners providing development assistance can also do more. Discussion, however tentative about the next four or five years, will help all those involved to begin to get a better alignment between financial resources and priorities. There has been some good progress in this. The European Union and the European Commission are doing some very interesting work on MDG contracting, to achieve long-term financial support, both in this Region and elsewhere.

The way money is spent must focus on building sustainable national capacity. I therefore believe that we have to look closely and critically at the way that technical assistance is provided and discuss this openly. The Paris Principles on Aid Effectiveness provide us with a guide for what needs to be done. Working together we can make them a reality on the ground, moving from principles to practice.

In concluding: our goal is to make WHO more responsive to the needs of countries. Our goal is a WHO that works effectively as part of the UN system. We are engaging fully in the current debate on how the UN system should better coordinate its work in countries. We are engaging in the system to see how we can be become a more efficient partner, especially in the resident coordinator system. One of my staff members is currently in New York to discuss with UNDP what we can do in practical terms.

We have had a number of discussions with the UN High-level Panel on System-wide Coherence, and we are very much looking forward to the outcome of that report. The financing of the specialized agencies and the nature of the work of the specialized agencies are issues that we have brought to that Panel. We are now putting this together.

The Executive Board agenda in January includes an item called “WHO and UN reforms”. There will be a paper that sets out the broad directions on this, to support discussion with the governing bodies based on the report that was reviewed by the World Health Assembly last year.

Finally, I would like to thank Marc Danzon and his team, and the Member States, for the support you have given to me and the team since the shock of Dr Lee's death in May. I think we have been able to move on and make progress. The Organization had a shock but was not paralysed. This is quite a robust organization. This is very much thanks to your continued efforts during the World Health Assembly, thanks to a strong team, and thanks to the support I have been given during these months from Marc and from other colleagues. Thank you very much.