



Report of the sixty-first session
of the WHO Regional Committee
for Europe



World Health
Organization

REGIONAL OFFICE FOR **Europe**



Report of the sixty-first session
of the WHO Regional Committee
for Europe

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Abbreviations

AMR	antimicrobial resistance
ART	antiretroviral treatment
BCA	biennial collaborative agreement
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EPHOs	essential public health operations
EU	European Union
FCTC	WHO Framework Convention on Tobacco Control
GDO	geographically dispersed office
GDP	gross domestic product
IHR	International Health Regulations
MDGs	Millennium Development Goals
M/XDR-TB	multidrug- and extensively drug-resistant tuberculosis
NCDs	noncommunicable diseases
NGOs	nongovernmental organizations
OECD	Organisation for Economic Co-operation and Development
RCC	European Regional Certification Commission for Poliomyelitis Eradication
SCRC	Standing Committee of the WHO Regional Committee for Europe
SEEHN	South-eastern Europe Health Network
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund



Opening of the session

(EUR/RC61/2 Rev.1, EUR/RC61/3 Rev.1)

The sixty-first session of the WHO Regional Committee for Europe was held at the Gulistan Palace, Baku, Azerbaijan from 12 to 15 September 2011. Representatives of 50 countries in the Region took part. Also present were an observer from a Member State of the Economic Commission for Europe and representatives of the Food and Agriculture Organization of the United Nations, the United Nations Children's Fund (UNICEF), the United Nations Office on Drugs and Crime, the World Bank, the World Food Programme, the Council of Europe, the European Union (EU), and of nongovernmental organizations (NGOs) (see Annex 3).

The first working meeting was opened by Dr Vladimir Lazarevik, outgoing Executive President.

Election of officers

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

Professor Ogtay Shiraliyev (Azerbaijan)	President
Dr Josep Casals Alís (Andorra)	Executive President
Dr Lars-Erik Holm (Sweden)	Deputy Executive President
Ms Carole Lanteri (Monaco)	Rapporteur

Adoption of the agenda and programme of work

The Committee adopted the agenda (Annex 1) and programme of work.

Following consultations, the Committee subsequently agreed to defer until its sixty-second session consideration of agenda item 6(h), strategic coherence of the work of the WHO Regional Office for Europe (including the sub-items on the Regional Office's country strategy and policy on the Regional Office's geographically dispersed offices and the European Observatory on Health Systems and Policies) and agenda item 9, partnerships.

Address by the President of Azerbaijan



His Excellency Mr Ilham Aliyev, President of Azerbaijan, extended a cordial welcome to his country. Health care was a very important issue for his government: the health budget had been increased by a factor of eight in the previous five years. The technical basis of health care had been strengthened: more than 400 new health care facilities had been renovated or built in the past few years, including specialist institutions in areas such as cancer control, perinatal care and surgery, and centres for diagnosis and treatment had been set up in 14 cities. The latest health technology was being purchased as necessary, and Azerbaijan was drawing on the experience of other countries by sending its young doctors abroad for further training. All health care services in government facilities were available to the population free of charge.

It was recognized that environmental conditions had a considerable impact on people's health: his country had declared the year 2010 to be a "Year of the Environment", 10 million trees had been planted, and efforts were being focused on managing water resources. Thanks to assistance from international organizations, projects were under way to improve water supply and sanitation, and Azerbaijan expected that its drinking-water would comply with WHO standards by the end of 2013.

Improving the health of young people was also of paramount importance. To that end, 30 Olympic-size sports facilities had been constructed, and the government's State Programme on Youth 2012–2015 included a component on controlling drug abuse among young people.

The economic reforms under way in Azerbaijan had enabled it to tackle social issues. The country's gross domestic product (GDP) had tripled in the previous seven years, there had been no cuts in social benefits, and pensions had been increased by 40%: as a result, poverty currently affected only 9% of the population (down from 49%). As people's financial assets grew, they were attaching more importance to health and their health status was improving significantly. Social and economic reforms had borne fruit, but some problems still remained and programmes were continuing to be implemented to tackle them (125 000 families were still receiving government welfare support).

Azerbaijan shared close ties with partner countries through bodies such as the EU's Eastern Partnership. One aim of such initiatives was to introduce European standards to the country's health care system. He was convinced that the current session of the WHO Regional Committee would enable his country to make further progress towards that end.

The President of the session read out a statement of welcome on behalf of Mrs Mehriban Aliyeva, First Lady of Azerbaijan and President of the Heydar Aliyev Foundation.



Address by the WHO Regional Director for Europe

(EUR/RC61/5, EUR/RC61/8 Rev.2)

In her address (Annex 4), the Regional Director welcomed representatives to the session and expressed deep regret at the lives lost in the tragic events in Norway and other emergencies in the European Region, and the attack on the United Nations office in Nigeria. She then described achievements in the WHO European Region in the previous year, current challenges and opportunities to overcome them in four areas: health threats, noncommunicable diseases (NCDs), health systems and public health, and working together for better health for Europe.

The health threats tackled included emergencies, public health crises and major communicable diseases. Building on recent collaboration with the Government of Italy, the Regional Office was implementing an action plan on migration and health that could lead to a long-term programme. Under the International Health Regulations (IHR), the Regional Office had followed up 3–4 events per week with Member States and coordinated action with partners and within WHO, as well as helping countries develop the required core capacities. It had also, with the help of the Danish Government, coped with two floods of its premises in Copenhagen. With WHO leadership and strong support from global partners including UNICEF, countries had successfully responded to the 2010 poliomyelitis outbreak, and in August 2011 the European Regional Certification Commission for Poliomyelitis Eradication (RCC) had reconfirmed the Region's polio-free status. While large measles outbreaks persisted, 52 Member States had participated in the 2011 European Immunization Week, which helped to scale up the response. With Member States and partners – particularly the EU, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Stop TB Partnership – the Regional Office had both tackled and developed action plans for presentation to the Regional Committee on three alarming problems: multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB), HIV/AIDS and antibiotic resistance. Finally, the Region was on course to eliminate malaria by 2015.

The Regional Office would submit to the Regional Committee an action plan to implement the European Strategy for the Prevention and Control of Noncommunicable Diseases in 2012–2016. Europe's leadership in NCD prevention and health promotion, and global and regional progress against NCDs in the previous year, set the stage for strong implementation of the action plan. The Regional Office's Athens Office, to be launched later in September 2011, would provide additional capacity in that area. In addition, the Regional Office was strongly addressing the social and environmental determinants of NCDs. In 2010–2011, many European countries had ratified the WHO Framework Convention on Tobacco Control (FCTC) and/or made strong smoke-free policies, and the Regional Office had developed the European action plan to reduce the harmful use of alcohol 2012–2020 for submission to the Regional Committee. The European Environment and Health Ministerial Board and Task Force had been established and were holding their first meetings in 2011 to continue the European environment and health process, and the Regional Office was taking the lead in preparing a chapter on the social and health dimensions of sustainable development for inclusion in a European regional report for the 2012 United Nations summit. Owing to the need to close its Rome Office, the Regional Office was consolidating its environment and health programmes in the Copenhagen and Bonn offices, with support from the German Government. The Millennium Development Goals (MDGs) had been made an Office-wide priority; the Regional Office was working with the First Lady of Georgia, the Region's WHO Goodwill Ambassador, and WHO was the leading agency in the United Nations interagency group on tackling inequities in progress towards achievement.

As to health systems and public health, the Tallinn Charter: Health Systems for Health and Wealth and the new European health policy, Health 2020, reinforced each other. Feedback from countries confirmed the Charter's impact on health systems. The Regional Office's work on health systems included the development of a new approach centred on health outcomes and a package of strategies and services, direct work with countries, a project on national health policy frameworks and a study on the economics of prevention. To act on its renewed commitment to public health, the Regional Office had developed a framework for action complementary to Health 2020 for discussion by the Regional Committee, provided countries with a tool for assessing their essential public health operations and encouraged them to assess their health systems' performance. In the area of health financing, the Regional Office had issued important publications, conducted training courses for groups of countries and worked with individual countries, and implemented an action plan based on the 2010 world health report. The Regional Office was working with Member States and partners, particularly the EU, to develop a common health information system for Europe, to support work in all areas of health.

Concluding her address, the Regional Director described the progress made in developing the overarching European health policy initiative, Health 2020, and strengthening the Regional Office so it could better serve Member States. The first year of the participatory process of developing Health 2020 had shown that countries welcomed it as a timely and valuable tool. The Regional Office had strengthened itself by concentrating core functions in the main office in Copenhagen, fully streamlining and integrating the geographically dispersed offices, integrating the work of country offices, improving governance functions and developing strategies on country work and partnerships for presentation to the Regional Committee. It had improved its work with partners, revitalizing its networks, chairing the WHO steering committee on relations with the EU, working with countries holding the EU Presidency and making road maps for the six areas of cooperation agreed with the European Commission (EC) in 2010. The Regional Office had also strengthened cooperation with the European Centre for Disease Prevention and Control (ECDC), the World Bank, the Organisation for Economic Co-operation and Development (OECD), the Global Fund and other United Nations agencies, as well as cooperation within WHO. The Regional Office's income for 2010–2011 was expected to be comparable to that in previous biennia. For the following biennium, it had a solid macro financial situation for all WHO's strategic objectives, except 12 and 13. The high level of earmarking was expected to cause many challenges, however, so the WHO reform process needed to address that issue. As the Regional Office received the smallest share of the corporate resources mobilized by WHO headquarters, it had published advocacy papers detailing its plans under each strategic objective.

In the debate that followed, most speakers thanked the Government of Azerbaijan for its hospitality and congratulated the Regional Director on her report and strategic guidance, and on the work of the Regional Office. In particular, a representative of the country currently holding the Presidency of the Council of the EU said that full implementation of the seven strategic directions and continued focus on the five priority issues identified by the Regional Director could have very positive effects on health in the Region. While the work to strengthen the Regional Office's functions, structure and relations with Member States and partners was welcome, the question of establishing new geographically dispersed offices (GDOs) needed further consideration, and more details were requested of the Regional Director's plans for existing country offices. Cooperation with Member States needed to be proactive, carefully negotiated and delivered in a more comprehensive and coordinated manner. The approach to partnership should be in line with that adopted at WHO headquarters. More information should be given about how the Regional Office would work with the EC to ensure complementary research agendas and how it was collaborating with ECDC. WHO reform should be the Regional Committee's major priority to ensure an effective WHO, with fair distribution of funds among the regions. He looked forward to the Regional Committee's discussion and asked for information on the budgetary implications of all the proposed initiatives on the agenda.

As to the Regional Office's five priority issues, he praised efforts to address NCDs (particularly the focus on disease prevention, health promotion, the social determinants of health and strengthening of the health-in-all-policies approach). He recognized the importance of communicable diseases, particularly HIV/AIDS and vaccine-preventable diseases, where cooperation with partners such as ECDC was vital, and would welcome more emphasis on a particular health determinant, the ageing of the population. The Regional Office's work to strengthen health systems, support the implementation of the Tallinn Charter and address reproductive health was welcomed.

Most of the other speakers supported that statement, and all expressed praise and support for the work of the Regional Office. Some mentioned the seven strategic directions and five priorities in general terms, while others focused more specifically on Health 2020, the strengthening of health systems, and public health and health financing. The work on NCDs (the proposed action plan and European and global meetings) was welcomed, and it was hoped that the forthcoming United Nations General Assembly meeting would lead to a global political statement. Particular attention was drawn to the Regional Office's response to poliomyelitis, implementation of the IHR, work on antibiotic resistance, support to the South-eastern Europe Health Network (SEEHN) and evaluation of the GDOs.

While praising the Regional Office's effectiveness and commitment, however, many speakers offered suggestions or sounded a note of caution, particularly in the current economic climate. The WHO reform process was seen as necessary to ensure flexibility, effectiveness, global controls and proper distribution of responsibilities and resources, and alignment of reforms at the global and regional levels. Member States emphasized that regional actions should be aligned with the decisions of the World Health Assembly through the Regional Committee and its Standing Committee, and countries should show restraint calling on the Regional Office to take on new strategies that would further strain its resources. The governance of the Regional Office should focus on results: the Regional Committee should remain the regional governing body of reference, with tighter coordination

with headquarters on normative and surveillance work. Quick and coordinated action was needed on communicable diseases as a priority. One representative wondered whether the Regional Office had supplied the Regional Committee with too much documentation for the session, and another called for GDOs to have a firm financial framework, including support from the host countries. Suggested additions to the Health 2020 development process included an evidence-based review as background, the addition of new elements to add value, coordination with other European initiatives to avoid duplication of effort and waste of resources, and review in the context of WHO reform and the three levels of the Organization. Regarding that reform, another speaker underlined the importance of having the ministry of health's voice heard, in coherence with the views of the respective ministry of foreign affairs as well as of the ministry or agency responsible for development cooperation.

Finally, representatives described successful initiatives in their countries, mainly focusing on the strengthening or reform of their health systems and on public health strategies or structures. Examples of past and planned work with the Regional Office included the Moscow Declaration from the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and European input to the United Nations meeting on NCDs; the SEE public health project and the forthcoming Third Health Ministers' Forum of SEEHN; the first meeting of the European Environment and Health Ministerial Board, and the forthcoming conference on Health 2020 in Israel.

In reply, the Regional Director thanked the Member States for their strong support and close cooperation in 2010–2011 and pledged to continue the Regional Office's support to them. She also thanked countries for their parts in the successes and planned activities they had mentioned and welcomed their offers to share experience and help increase the capacity of the Regional Office.

WHO reform was crucial; discussion would take up a half-day of the Regional Committee session and the Regional Director was committed to it. It offered a context in which to ensure coherent action between the three levels of WHO and to use the budget as an accountability tool. One WHO was essential, and the Global Policy Group was the means to secure it. Governance was a key priority for the Regional Director and needed to be linked to WHO reform, which in turn needed to determine the links between global and regional bodies and to distinguish global from regional functions.

The Regional Committee was asked to provide guidance on particular issues related to Health 2020, not make a formal or final decision at the current session. As the Regional Committee would make final decisions on Health 2020 and the proposed public health strategy in 2012, they could take account of WHO reforms. In contrast, issues covered by the proposed action plans needed to be acted on now, so the Regional Director advised that implementation should proceed and be adjusted as necessary in alignment with WHO reform. While the Region's remaining polio-free was good news, the next priority was measles, particularly in the eight high-burden countries in the Region. The Regional Office would also scale up work on mental health and ageing.

The GDOs provided essential technical capacities to the Regional Office, but no new ones were suggested in the paper under consideration at the current session. That policy paper (document EUR/RC61/18) was intended to enable the Regional Committee to reach consensus on the approach for the Regional Office to take; a more specific paper analysing existing gaps in technical capacity and identifying the need for possible new GDOs could be presented at the following session. The new strategy on country offices took account of the strengths and weaknesses identified by the external evaluation. WHO's country work was an issue in which one size did not fit all; owing to their strong institutional capacity and expertise, European countries had always had their specific approach to WHO's country presence. As country offices had to be in line with national capacity, many of the European countries did not need the kind of country office established in other regions. The Regional Director would follow the recommendations of the evaluation group: to retain the country offices in the new EU Member States for the present, while discussing a cost-sharing arrangement and, as soon as the time came, making an exit strategy that included agreed country support, and to seek a mechanism for proactive cooperation with countries that did not make biennial collaborative agreements (BCAs) with the Regional Office.

As to partnerships, there were good links with the EC Directorate-General for Health and Consumers; the WHO Assistant Director-General for Innovation, Information, Evidence and Research was pursuing increased cooperation with the Directorate-General for Research and Innovation, while the Regional Office's Chief Scientist would pursue cooperation with other parts of the EC in his new job in the office in Brussels, Belgium. The new agreement with ECDC would be put into action in October 2011, and WHO, ECDC and the EC had made an agreement on joint risk communication.

A strengthened partnership with the Global Fund



The Regional Director noted that, with financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and technical assistance from WHO, many of the Organization's European Member States had been able to implement effective interventions to tackle those diseases since the Global Fund's establishment in 2002. It was believed, however, that more could be done, more effectively, through a strengthened partnership between the two bodies. In particular, the Global Fund's increased focus of attention on supporting national health strategies and health systems provided an excellent opportunity to reinvigorate the partnership. The Global Fund's and the WHO Regional Office for Europe's mandates were complementary and ultimately they shared a common goal. It was their duty to ensure that the complementarities of their mandates worked not only on paper but also in practice.

To that end, the Executive Director of the Global Fund and the WHO Regional Director for Europe exchanged letters expressing their agreement to a joint operational plan for the WHO European Region for 2011–2012, with the following objectives:

- (a) to develop mechanisms for regular collaboration between the Global Fund and the WHO Regional Office for Europe and its country offices;
- (b) to support the achievement of improved health results at country level through strengthened technical support, oversight and effective and efficient implementation of disease control programmes supported by the Global Fund; and
- (c) to optimize the impact of financing provided by the Global Fund on attainment of the health-related MDGs through sound technical cooperation and integration of the health systems strengthening approach in existing and future programmes at country level.

The Executive Director of the Global Fund was pleased to launch the joint operational plan, which he set in the context of the Fund's strategy framework 2012–2016 that was currently being elaborated. The ambitious targets within that framework included ensuring that 3 million more people received antiretroviral therapy for HIV/AIDS, that there were no malaria deaths as from 2015 and that the Fund financed half the costs of treatment of MDR-TB globally. To achieve those targets would require adequate health systems financing and partnerships between a multitude of stakeholders.

Address by the WHO Goodwill Ambassador for the health-related Millennium Development Goals in the WHO European Region



Ms Sandra Roelofs, First Lady of Georgia and WHO Goodwill Ambassador, noted that the United Nations high-level plenary meeting on the MDGs (New York, 20–22 September 2010) had concluded with Member States adopting a global action plan to achieve the eight anti-poverty goals by their 2015 target date. Scaling up efforts to attain the health-related MDGs was a priority for the whole of

the Regional Office and an integral part of the Regional Director's vision. A number of subjects to be discussed at the session, such as Health 2020, European experiences in addressing the social determinants of health and health systems strengthening in the WHO European Region, would undoubtedly accelerate progress towards those goals.



Report of the Eighteenth Standing Committee of the WHO Regional Committee for Europe

(EUR/RC61/4, EUR/RC61/4 Add.1, EUR/RC61/Conf.Doc./1)

The Chairman of the Standing Committee of the WHO Regional Committee for Europe (SCRC) noted that the Eighteenth SCRC had met five times during the year. Following guidance given by the Regional Committee at its previous session, the Eighteenth SCRC's fourth meeting (Geneva, May 2011) had been an open one that representatives of all European Member States had been invited to attend as observers. In addition, and in accordance with the provisions of Regional Committee resolution EUR/RC60/R3, the composition of the SCRC had been increased to 12 members, thus facilitating a wider and more balanced geographical representation of Member States.

Most of the key items on the agenda of the current session of the Regional Committee had been reviewed and discussed by the SCRC during its 2010–2011 work year. In particular, the SCRC strongly supported Health 2020, which it believed would be an inspiration for all Member States that wished to embark on an update of their own national policies. The SCRC also fully supported the Regional Director's intention to recommit the Regional Office to full implementation of the Tallinn Charter and, within that framework, to strengthen and revitalize work in the area of public health. It welcomed the initiatives to prevent and control NCDs, including the action plan on alcohol, and to tackle M/XDR-TB, HIV/AIDS and antibiotic resistance.

The SCRC endorsed the Regional Director's views on the need for a strong regional office in Copenhagen as a resource for all European Member States, with specific supportive functions carried out by GDOs and country offices that were fully integrated in the regional structure. Equally, the SCRC saw the Organization's regional governing bodies as playing an important role in supporting the best possible global corporate decisions within a decentralized framework.

With regard to two specific governance issues that had been entrusted to it by the previous SCRC, the Eighteenth SCRC recommended that the linkages between its officers and those of the Regional Committee should be formalized, and that Member States should apply a number of criteria concerning experience and areas of competence when nominating candidates to serve on the WHO Executive Board and the SCRC.

The representative of one country, referring to the decision taken by the Regional Committee the previous year to lift the ban on dual membership of the Executive Board and the Standing Committee, suggested that the rule concerning subregional grouping of countries might be relaxed at some point in the future, with the aim of securing candidates who could best present the Region's concerns at global level.

The Committee adopted resolution EUR/RC61/R9.

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

(EUR/RC61/6)



The European member of the Executive Board from Estonia, designated to attend sessions of the SCRC as an observer, noted that the Secretariat had prepared a comprehensive overview of all the 28 resolutions adopted by the Sixty-fourth World Health Assembly in May 2011 (document EUR/RC61/6). She drew the Regional Committee's attention in particular to resolution WHA64.2 on WHO reform for a healthy future, which was a major item on the agenda of the session. The Health Assembly had also adopted a number of technical resolutions, notably those on implementation of the IHR (2005) (WHA64.1), pandemic influenza preparedness (WHA64.5), health workforce strengthening (WHA64.6), sustainable health financing structures (WHA64.9) and drinking-water, sanitation and health (WHA64.24). The latter three resolutions had been initiated by European members of the Executive Board and delegates from the European Region had contributed actively to all the debates in the World Health Assembly.

Address by the WHO Director-General



After praising the progress made by Azerbaijan and the commitment of its government at the highest level to a multisectoral, interministerial approach to health development, the Director-General (Annex 5) made three general observations on the Regional Committee's programme and documentation. First, its ambitious and courageous agenda, particularly the work on the Health 2020 policy, aimed at the rejuvenation of public health and of the Regional Office's ability to support health ministries in tackling extremely complex current and oncoming challenges, many of which were collateral damage done by other sectors' policies. Second, the Region was addressing not only inequity but its root causes, as in the proposed action plans on HIV/AIDS and drug-resistant TB, and seeking to improve health capacities and services in order to improve access to services and the efficiency of their delivery. Third, the proposed action plans showed that evidence-based interventions of proven impact could maximize measurable and equitable health gains in times of stagnant or shrinking health budgets. Equally, the implementation of the Tallinn Charter had demonstrated that ambitious commitments could be operationalized even in a climate of financial constraint.

As shown by the proposed action plan on alcohol, evidence-based interventions and smart policy choices could enable countries to maintain the momentum for health, but that required multisectoral collaboration, support from civil society organizations and greater clout for health ministries. Two troubling trends requiring high-level government action could provide opportunities to acquire such clout. First, long-standing social inequalities that could generate social unrest, state failure and conflict testified to the need for greater equity to become the new political and economic imperative for a stable and secure world. Second, the growing health and economic burden of NCDs showed the need for multisectoral action; the tough and targeted proposed European action plan on NCDs therefore included fiscal policies and marketing controls to reduce the demand for unhealthy products, and aimed to rationalize the use of scarce resources to bring the greatest benefit to the largest number of people.

As the Regional Committee was rejuvenating the Region's public health agenda, WHO's programme of reform sought to rejuvenate the Organization, which needed to evolve to keep pace with the changes in global health needs since its founding, to align its priorities and funding to urgent health needs that it was uniquely well placed to address, and to change its budget and staffing to improve efficiency, flexibility and impact. To ensure stronger leadership by WHO – which in turn could promote more coherent action by multiple partners that was better aligned with countries' priorities and capacities – the Organization was making a plan for reform that would be comprehensive, ambitious (with improved health outcomes in countries as the most important measure of its performance) and guided by Member States. Above all, WHO needed to be well positioned to meet current and future challenges to improving health in a complex world. The Director-General thanked the Regional Committee for bringing greater clarity to many of those challenges and devising workable solutions that reaffirmed the value system driving WHO's activities at all levels.

Many European countries – traditionally WHO's most generous financial supporters – were reshaping development assistance to emphasize value for money as demonstrated by measurable results. That trend brought two problems that WHO must overcome in its reform process. It had to articulate better the value it added to health development, particularly in view of the rise of high-profile global initiatives focusing on a single issue or cluster of issues, but the impact of its work was difficult to measure or even to see until a crisis arose. For example, WHO was right to use evidence to streamline AIDS treatment guidelines, urge the banning of inaccurate commercial blood tests for TB diagnosis and oppose monotherapies for malaria, but how could the impact of such work be measured? In conclusion, the world needed a global health guardian; the Director-General was determined to ensure that reform would strengthen WHO's unique functions and assets, and looked forward to hearing the Regional Committee's views on the process.

In the discussion that followed, all speakers expressed eagerness for Member States to participate in a successful process of WHO reform that would maintain a democratic Organization as the global leader in health. Member States should ensure that WHO was well financed, with economic flexibility to act, and make more consistent and coherent demands on the Organization. One speaker called for the reform to include instituting an independent external audit of WHO. Another suggested that European Member States should increase WHO's capacity to deal with natural disasters, such as earthquakes and famine, by supplying their expertise and other resources, as his country had recently done. In addition, WHO should help health ministers question the cuts to health budgets that usually followed financial crises.

In reply, the Director-General reiterated her commitment to a democratic WHO and a reform process driven by Member States. WHO was already working creatively in using European experts in its work: that benefitted the Organization and the experts, as well as the countries assisted. While Member States were WHO's owners, they were very diverse. For example, European countries wanted fast action on the reform process, but an equally large group of other countries wished first to have more details on what it would mean for the support they received from the Organization. How would Member States therefore agree on priorities globally and act on them regionally and in countries? European countries had recently helped WHO supply health assistance in the Horn of Africa and North Africa; how could the impact of its role as an honest broker be measured? If the six WHO regions differed in their views on reform, the Director-General remained willing to suggest options and give advice to help them make their choices.

Developing the new European policy for health – Health 2020

(EUR/RC61/9, EUR/RC61/Conf.Doc./2 Rev.1, EUR/RC61/Inf.Doc./4, EUR/RC61/Inf.Doc./5, EUR/RC61/Inf.Doc./6, EUR/RC61/Inf.Doc./7, EUR/RC61/TD/1)



Vision, values, main directions and approaches

The Regional Director recalled that the Region had a long, proud tradition of policies for health. The documents before the Committee were meant to provide inspiration for countries that wished to change their health policies, as was the case in many Member States. The proposed draft health policy for 2020 responded to new challenges to health in the 21st century and uneven progress in achieving health equity in the Region. The vision of the proposed policy was “a WHO European Region where all peoples are enabled and supported in achieving their full health potential and well-being, and in which countries, individually and jointly, work towards reducing inequalities in health within the Region and beyond”. The values on which Health 2020 was based were the universal right to health and health care, equity, access to care and opportunities for health gain, solidarity, sustainability, the right to participate in decision-making relating to the health of the individual and of the society in which people lived, and dignity, as stated in the Tallinn Charter, with a new emphasis on health as a fundamental human right. Six main goals were being proposed: to work together, to create better health, to improve health governance, to set common strategic goals, to accelerate knowledge sharing and to increase participation.

The strategic approaches to Health 2020 were emphasis on health and well-being and on the right to health and access to care, placing people at the centre, addressing the social determinants of health, involving the whole of society and the whole of government, including health in all policies and using solutions that worked to address the challenges to public health and health systems in the European Region. The policy would be based on a participatory process and systematic collection of evidence. Seven questions that should be addressed by Health 2020 were listed in the documentation. Member States could become involved in developing the new policy by supporting it; endorsing its vision, values, main goals and approaches; and collaborating in its development. Feedback from Member States was essential with regard to all aspects of the proposed policy.

Governance

Ministerial panel discussion: governance for health in the 21st century

The moderator, the former Chair of the Health Committee of the Parliament of Hungary, said that Health 2020 was a response to the need to change the culture of and attitudes to governance and to move health up the political agenda. Governance involved many more stakeholders than government itself, and all were necessary for more open management of the complex determinants of health and well-being. The panel would hold a preliminary debate as part of a mid-term evaluation, to determine whether the Regional Office was on the right track in terms of values, goals and directions.

The Head, Policy, Cross-cutting Programmes and Regional Director’s Special Projects, said that a number of surprises had been encountered in preparing the new policy. For instance, interpretation of terms such as “public health” and “intersectoral action” was found to differ widely. Furthermore, although evidence for aspects of the policy existed, it was fragmented, and, although strategies and plans had been drawn up, there had been no evaluation of what worked best. The draft policy was intended to concentrate the available knowledge from all relevant sectors into one consistent framework, which in itself would result in financial savings.

The Director, Global Health Programme at the Graduate Institute of International and Development Studies, Geneva, Switzerland, described the new approaches to governance identified in the study conducted at her institute. Although governments remained at the centre of decision-making, the diffusion of governance meant input from more people. New approaches had to be found to address economic realities and unhealthy behaviour in daily life, which were beyond the competence of ministries of health.

The aim of the new approach to governance was to bring together regulatory and participatory mechanisms, with tools to analyse countries' policies.

In the ensuing discussion, ministers of health and their representatives described the extent to which the principles of Health 2020 had been incorporated into their national plans. The Under-Secretary of State at the Ministry of Health of Poland reported that progress in achieving a "whole-of-society" approach to health had been slow; nevertheless, cooperation with the social and economic sectors was increasing steadily. The Director-General for Health of France said that his country was addressing inequalities in health pragmatically, through laws and regulations on access to health care and by establishing regional health agencies. Collaboration had been instituted among relevant ministries, where appropriate.

The Minister of Health of Kazakhstan described a number of successes that had been achieved in reducing the burden of NCDs in her country and said that she fully supported the draft of Health 2020. It would still be necessary to increase synergies between the public and private sectors, to pay more attention to risk factors and to form new partnerships with neighbouring countries. The Deputy Minister for Health and Social Development of the Russian Federation described the numerous changes in her country's health system over the past 20 years, with increasing numbers of private entities and private–public partnerships. The new approach was based on coherent, mandatory standards for high-quality health care, regional access to such care, improved training in medical faculties and in continuing education, and a national registry of public and private health care establishments in all 83 regions of the country. Financing was an essential component of expanded access to high-quality health care. Information technology was to be emphasized, with due attention paid to the confidentiality of personal data. Priority was to be given to prevention, with the involvement of both the state and society. Those historic reforms, which could serve as a model for other countries, were in full harmony with the objectives being pursued in the European Region. They might inspire other Member States to reduce inefficiencies in health system administration, particularly in the context of the financial crisis.

The Minister of Health of Latvia said that the recent financial crisis, which had severely affected his country, had led to a drastic reconsideration of health policy at the highest political level. The health strategy for 2011–2017 was therefore based not on high-technology, hospital-based health care but on public health, health in all policies and health in the whole of government. The next step would be to set measurable goals and to determine how to reach them.

The Chief Medical Officer of Ireland spoke of new structures set up in Ireland in recent months. A new government had been in place since earlier in the year. A new government department for children and youth affairs had been established, and primary health care was under the direction of a minister of state at the Department of Health. A cabinet subcommittee on social policy, chaired by the Irish Prime Minister, had been established. The Health 2020 approach provided guidance to the Department of Health in developing its new Framework for Public Health and was useful in engaging with the political system. Health 2020 confirmed his country's emphasis on fair access to health care, yet at the same time revealed how much needed to be done in that and many other areas.

The Minister of Health of the Republic of Moldova said that there were two reasons why intersectoral partnerships and integrated approaches were needed: governments had difficulty in keeping pace with the constant increase in prices for hospital stays, medications and health care services; and 85% of the factors that affected health were not within the competence of the health care system. His country's current health policy had many synergies with Health 2020, including the emphasis on improving life expectancy and reducing health inequities. At present, for example, only 80% of the Moldovan population was covered by compulsory health insurance. On the other hand, the country had a very workable primary health care system based on bringing communities together in efforts to improve the quality of life.

The Mayor of Cherepovets in the Russian Federation said that his city was an active participant in the Healthy Cities programme, together with 1000 other cities worldwide. At a recent meeting of mayors of healthy cities in Liège, Belgium, it had been pointed out that raising public awareness of Health 2020 would stimulate debate on raising the quality of life in cities. Ministries of health were instrumental in bringing about such improvements, but so were the educational institutions, transport networks and other facilities administered by municipal authorities.

The Chairman of the Nineteenth SCRC, speaking as chair of the working group responsible for defining the targets for Health 2020, reported that, at the technical briefing earlier that day, strong support had been expressed for the targets at a European level and for Health 2020 in general. Attention had been drawn to the need to build on the experiences of the past, particularly with the Health for All strategy and the Tallinn Charter, and to develop targets in all Health 2020 areas, including new ones such as well-being and governance. The European Region should lead the way in target setting, thereby serving as inspiration

for similar actions in other regions. The targets should be relevant, specific and achievable, as well as relative and absolute, enabling all countries to contribute to the process. Speaking as Director-General of Health of Sweden, he said that although the responsibility of the former public health minister had been moved to the Minister of Health, that was indicative not of less emphasis on public health but of greater emphasis on working with the health care sector and of the need for a stronger public health perspective.

The representative of the Netherlands, referring to the policy recommendations in the study on social determinants of health, said that addressing the broader social determinants of health was not the task of health ministers: they were preoccupied with keeping health care affordable and accessible, dealing with chronic diseases and ageing, and facilitating healthy behaviour – aspects of their work that should be better reflected in Health 2020. The focus should be on interventions that were evidence based and that facilitated rather than prescribed.

To further the common goal of having Health 2020 make a difference, his country proposed that the draft resolution contained in EUR/RC61/Conf.Doc./2 should be amended by the replacement of operative paragraphs 3 to 8 with the following paragraph: “REQUESTS the Regional Director to pursue the consultations among Member States before the sixty-second session of the Regional Committee, to develop [the policy] according to the guiding framework and concept and [to] submit to Member States by the time of the Sixty-fifth World Health Assembly the final Health 2020 policy draft, as well as evidence-based tools and best practices to inform capacity-building and accelerate implementation”.

In the ensuing discussion, most speakers supported that amendment. Several representatives reported that their countries would use Health 2020 as the basis for national health strategies. The importance of a common approach to common challenges across the European Region was emphasized.

Other remarks focused on the timely nature of Health 2020, for a number of reasons. Mortality from NCDs remained a persistent challenge; the risk factors for NCDs – sedentary lifestyles, unhealthy diets, alcohol consumption and smoking – had delayed effects. Prevention, awareness-raising efforts and education were pivotal in improving health, yet there was likewise a time lag before positive results from such efforts were seen. Governance for health was increasingly complex, necessitating the involvement of various governmental institutions and sectors. Better solutions to transport problems, for example, would improve not only health and well-being, but also the environment. The values of Health 2020 would be achieved through enhanced capacity for delivering essential public health services, strengthened subregional and intersectoral cooperation and stronger political commitment. Health 2020 could serve as a catalyst for efforts to expand and ensure fair access to health care.

Health 2020 had to be seen against the background of WHO reform, which some speakers felt to be of higher priority. The content of the policy must be sharpened through consultations with countries, sectors and stakeholders. In view of the diversity of all European countries, it was crucial that countries were not burdened with additional data collection and that the number of indicators was kept manageable. Existing indicators should be used; the burden of reporting should not be increased. Health 2020 was an ambitious strategy, and Member States must be informed about the financial consequences for the Regional Office. The need for transparency and improved efficiency and for appropriate data and evidence based on best practices must be addressed. Also needed was the capacity to communicate health arguments while respecting other sectors’ and stakeholders’ agendas. Health 2020 should have a strong emphasis on primary health care and prevention.

The moderator, summing up, said that the Health 2020 document could serve as a compass, but that it was too early to predict whether it could become a global positioning system for selecting the right road to the best health decisions.

The health divide

Ministerial panel discussion: European experiences in addressing the social determinants of health

The Managing Editor, The Economist Intelligence Unit, London, United Kingdom, the moderator, commented on the timeliness of the discussion in a climate of social change and restructuring. Social determinants were the cornerstone of health policies that sought to remove inequities. The Regional Director reiterated that there was a huge divergence in health within the Region.

The report on the social determinants of health had been commissioned in order to assemble the right evidence and links for building health policies in all Member States.

The Head, Division of Population Health, University College London, United Kingdom, said the health inequalities made it morally imperative to act. Although it was clear that such inequalities could be addressed only by tackling the underlying causes, the medical profession and health ministers were unprepared for that task. They should not only “stand up for doctors” but stand up for patients and for health in general, by guaranteeing universal access to high-quality primary care, with greater emphasis on prevention and health promotion; by advocacy and cross-sectoral work; and by using the best evidence on social determinants of health. The report on social determinants of health had been taken up in a number of countries and cities and had stimulated an unstoppable movement in the service of equity.

The President of the Belgian Federal Public Service for Health, Food Chain Safety and Environment described a report on inequalities in health prepared by the King Baudouin Foundation in 2007, which showed that educational level, social status and income affected people's health. The recommendations were for an integrated policy, with reinforcement of primary and preventive medicine; a holistic, life-course approach to health; facilitated access to health care; action at national level; use of evidence-based policy; and promotion of a healthy lifestyle. In order to gain approval for the budgetary cost of attacking social determinants, it was essential to raise awareness. He also stated that Belgium had increased the health budget annually by 4%, despite the difficult economic circumstances.

The Minister of Health of Turkey said that the concept of health as a basic human right was the basis of equity, and it was the job of ministers of health to make that clear at national and international levels. He proposed that the United Nations address health as a fundamental issue, as mortality from NCDs was as serious as that from terrorism and war. In the recent financial crisis, the first cuts in government budgets had been for health; priorities should be changed on the basis of the values of Health 2020. Drawing attention to rising costs and measures to increase cost–efficiency in the Region, he noted that in his country per capita spending on all health care was US\$ 600, which had proved sufficient to provide sustainable health care throughout the country.

The Minister of Health and Social Solidarity of Greece affirmed that living conditions had a greater effect on health than medicines and the health system. His country was undergoing the worst financial crisis since the Second World War; furthermore, he was facing a 30% increase in the number of patients since 2009 with only 80% of the budget. Half of those new patients were legal and illegal immigrants and homeless people with chronic health problems. The situation was being addressed by reorganizing the public health system, emphasizing health promotion and prevention, introducing health education in schools, screening vulnerable populations, enacting labour regulations, taxing products such as sweet beverages, promoting physical activity and a healthy Mediterranean diet, and fighting malpractice, profligacy and irrational prescription of medicines.

The Chief Medical Officer of the United Kingdom said that in her country, public health and social determinants were being addressed by a Cabinet committee. The ministry of health would become a social ministry, and a new health bill would ensure equality in access to and outcomes of health care. The social determinants of health should be framed in such a way that all of government understood the concepts. Thus, not only economic arguments but also “socialized” concepts should be put forth in a simple way. In her country, bipartisan support had been engendered by such a process of “socialization” of health in discussions with other ministries.

The Minister of Health and Social Welfare of Republika Srpska, Bosnia and Herzegovina said that, in their daily work, ministries of health dealt with disease, hospital management and the provision of medicines and technology and not with the determinants of health. In his country, social welfare was the responsibility of the Ministry of Health, and not the Ministry of Labour, as in other countries. The Government was urging local communities to provide welfare in primary health care centres, in order to address the real needs of the population.

The Minister of Health of Malta said that advocacy was the most important tool for improving health equity. Health was wealth, and tackling NCDs in Europe would improve the economic situation, in view of the huge drain on resources that those diseases represented. Migration was bringing new illnesses and conditions into Europe, accompanied by new social norms. Those new citizens required help, and the burden must be shared, throughout the Region and more widely.

The Chief Medical Officer of Denmark said that her country had used the report on the social determinants of health as the basis for its response to health inequalities. Although Denmark had a highly developed welfare system, social inequalities had

doubled over the previous 20 years. The Government had identified 12 determinants of health inequality and 58 policy initiatives to address them, with indicators. Concerted action to reduce inequalities required close collaboration, political prioritization and leadership and advocacy.

The representative of the SCRC, the Director-General of the Health Improvement and Protection Directorate of the United Kingdom, described the extensive discussions and consultations that had been held by the SCRC during the first phase of preparation of Health 2020. Health was “everybody’s business”, requiring integrated interventions and strengthened health systems performance with agreed goals, targets and indicators. He recognized that Member States required time to consider the draft Health 2020 policy and to give their views; however, panel members had clearly shown how useful the draft policy could be in helping them to meet health challenges.

The Head of the European Office for Health Investment and Development, Venice, Italy, said that work on addressing social determinants of health had received momentum from a number of initiatives. His Office received more and more requests for assistance in addressing social determinants of health. More knowledge was needed to analyse the practical implications of policies and strategies, to adapt evidence to specific situations, to develop policies and tools and to provide training and capacity-building in countries.

The Minister of Health and Social Solidarity of Greece, describing his strategy for gaining popular support for efforts to overcome health inequities against the backdrop of the financial crisis, said he simply told the truth: he announced the amount spent on health and compared it with the value of health services provided to the population. He presented himself as a minister of health, rather than of diseases and hospitalization, emphasizing not only curative treatment but also exercise, the Mediterranean diet and tobacco control efforts. His strategy, in fact, was working: telling people the truth paid off.

One speaker suggested that health care providers should be moving to address health inequities even before consensus with sectors other than health was achieved, so that time would not be lost. Another speaker welcomed the remarks by the Minister of Health of Malta on migrants and said that the human rights of migrants, funding for measures to help them and seasonal migration were serious challenges. His country was very keen for Health 2020 to be launched, as it was urgently needed to provide impetus for solving social problems, as the health for all strategy and the Tallinn Charter had done.

Evidence suggested that the growing disparities in the health of populations within the European Region were attributable to gradients in the delivery of health care: the lower a person’s social position, the worse his or her health. Action to reduce health inequalities must accordingly be proportionate to the level of disadvantage. Health inequalities were avoidable, but only when a realistic approach was taken and political choices were made by States. An interesting comparison by one country of health in the Roma community with that of the population as a whole was described, and that country’s success with efforts to reduce road traffic accidents and tobacco consumption was mentioned.

A number of amendments to the Regional Director’s proposals on Health 2020 in document EUR/RC61/9 were put forward. Reference should be made to the challenge of internal collaboration within national health systems. On accelerating knowledge sharing and innovation, mention should be made of transparency concerning quality. Indeed, quality should be included among the values of Health 2020. The concept of sustainability should be expanded to include cost–efficiency. The list of strategic assumptions should be supplemented by references to confirming fundamental changes to health systems over the coming decades and the need for the health sector to present the evidence, the economic case and to listen to and communicate with other sectors. Targets and indicators must be chosen based on globally relevant and tested parameters, and the way in which they were applied must be feasible for actors at each level.

A proposal was made to include reference in the draft resolution to paying particular attention to vulnerable groups. Another speaker however argued that the policy should be applicable universally, without stigmatizing certain people.

The Head, Division of Population Health, University College London, commenting on the discussion, said that the endorsement of a holistic approach to overcoming health inequities was encouraging. Regarding the call for immediate action pending the achievement of intersectoral consensus, he warned against substituting short-term interests for long-term solutions. The perspective of civil society was crucial: policies should be informed not only from the governmental level down but also from the grassroots up. Lastly, he cited former WHO Director-General Dr Lee Jong-wook, who in 2005 had said that the Alma-Ata

conference and the founding of WHO had been moments of great clarity: he himself hoped that the same was true of the current moment of work to combat health inequities. As the current Director-General had said, equity must be placed at the heart of everything that WHO did.

The Head, Policy, Cross-cutting Programmes and Regional Director's Special Projects, said that the discussion had been valuable for having brought in real-world experiences and having shown how Health 2020 related to the challenges that Member States faced. The policy paper was not an academic exercise: it must be rooted in a common vision based on the reality experienced by countries. Efforts would be made to collect much more evidence to inform the document. Numerous references had been made to the divergent and changing social landscape in Europe: Health 2020 could provide a framework for dealing with exceptional circumstances and new challenges. All the suggestions made by Member States would be taken into account in further work on the policy. The targets outlined were not a prescription or blueprint to be imposed on countries but were to be used by them for their own purposes. Consultations would be as widespread as possible, but it would be useful if countries themselves could consult stakeholders, NGOs and other sectors and report back on their input.

The Regional Director, responding to the panel discussion, said it truly showed the new momentum that was building for dealing with social determinants in a new way, a momentum that she herself saw in her travels throughout the European Region. The ministers from Greece and the Republic of Moldova had both acknowledged that the financial crisis had provided an impetus for tackling rising health costs. It had been music to her ears to hear the emphasis placed on a long-term public health vision, which was very much part of WHO's mandate.

The fact that Health 2020, if properly conceived, could be an example to other regions had been highlighted. The Regional Office had been cautioned against placing any additional reporting burdens on Member States, and that warning would be heeded. It had been reminded that the minister of health's main responsibility was to deliver on his portfolio, not to seek to influence other sectors. However, the whole-of-government approach was about reaching out politically with a view to enhancing the health sector's political clout, in the words of the Director-General.

Care should be taken not to be overoptimistic about outcomes: hence the need for monitoring mechanisms, tools and instruments for charting the intersectoral process. The need for Health 2020 to be coherent with WHO reforms had been mentioned, and she agreed with that remark. It had been pointed out that the right to health was a fundamental right, and that must not be forgotten in tackling issues relating to equity. She thanked all speakers for their valuable comments. The Regional Office had heard what it needed to hear: that it was on the right track.

The moderator, in closing the panel discussion, expressed the hope that the World Conference on Social Determinants of Health, to be held in Rio de Janeiro in October 2011, would be an "Alma-Ata moment".

A statement was made by a representative of the European Public Health Alliance.

The Committee adopted resolution EUR/RC61/R1.

Health systems strengthening in the WHO European Region

(EUR/RC61/10, EUR/RC61/11, EUR/RC61/Conf.Doc./3 Rev.2, EUR/RC61/Inf.Doc./1, EUR/RC61/Inf.Doc./2, EUR/RC61/Inf.Doc./9)



Interim report on implementation of the Tallinn Charter and the way forward

The Director, Health Systems and Public Health briefly described what European countries had done to implement the Tallinn Charter and how the Regional Office had supported them (giving examples of action by a wide range of countries), the process that would lead to the final report on implementation in 2015, and links with Health 2020. Countries were putting the values and policy objectives in the Charter into practice, with the Regional Office as a key partner, even though the financial crisis had put those values to the test: promoting or maintaining solidarity and equity in their health systems, increasing or maintaining their pro-health and pro-poor investments, focusing on health system performance and its feedback to decision-making, and trying to put patients at the centre of their systems. The key role for WHO was to foster cross-country learning through such means as publications, training, meetings and networks. In particular, studies of out-of-pocket expenditures, supported by the Regional Office, and the forthcoming Region-wide review of policy responses, by the European Observatory on Health Systems and Policies, would help to protect the poor and protect health systems from external shocks, respectively.

To prepare the 2015 report to the Regional Committee, the Regional Office sought input from Member States to document progress, identify lessons learnt from health reforms and assess the Tallinn Charter's impact. The Regional Office's "beyond Tallinn agenda" was to ensure that health system strengthening led to improved health outcomes by pursuing an approach focused on expected results, core services and barriers to optimal delivery; providing Member States with a support package, presented in draft form to the Regional Committee (document EUR/RC61/Inf.Doc./9), and designing a strategy to ensure that country offices, with support from national experts and partners, could offer expertise in health system strengthening to their host countries. While the lessons learnt in implementing the Charter had informed the development of Health 2020, the two had many synergies, and Health 2020 would lead to progress in several areas in the Charter, particularly governance for health and rejuvenating public health.

Ministerial panel discussion: critical health system challenges in the WHO European Region and the role of the WHO Regional Office

The moderator, a Senior Fellow at the King's Fund in London, United Kingdom, noted that his research revealed poor coordination of care in many countries, yet the public and politicians expected ministries of health to be more transparent and strive for better health system performance across the whole spectrum of their responsibilities. All panellists would be asked to respond to a generic question: what did they consider to be the most important issue in health system strengthening to address in their country, and how could WHO best support them in doing so? In addition, each panellist would answer a second, individual question.

The Minister of Social Affairs of Estonia recalled that the Tallinn Conference in 2008 had brought together representatives of ministries of health and finance to discuss health systems, health and wealth. The economic crisis had hit shortly afterwards, and the Tallinn Charter had proved to be a useful tool for countries to use in making the necessary changes to health systems, especially with regard to performance assessment. He informed the Committee that health systems strengthening was a likely topic for his country's presidency of the Council of the EU in 2018. On the specific question of health financing in the context of the crisis, his country had been fortunate to have built up reserves, so that the health budget had actually been increased from 5.3% to 7% of GDP. In addition, excise taxes on tobacco and alcohol had been increased. The main lesson learned was that countries had to react fast during an economic downturn.

The Minister for Health and Social Solidarity of Greece identified three critical issues to be addressed in his country: (a) the effects of the economic crisis, and notably the reduction in private spending on health and the resultant increase in demand for public sector services; (b) the importation of communicable diseases by illegal immigrants, of whom Greece received 100 000 each year; and (c) the increase in NCDs. With regard to the latter, he looked forward to inauguration of the Athens Office on NCDs by the Regional Director in 10 days.

The Minister of Health of Lithuania believed that the most severe difficulty his country was facing was in ensuring practical implementation of strategies that had been adopted on paper. It was also important to change people's attitudes so that they valued health more highly and made the necessary changes to their health behaviour. The WHO Regional Office for Europe and the European Observatory on Health Systems and Policies had offered valuable assistance in both those areas.

In response to the specific question raised, the Minister of Health of the Republic of Moldova acknowledged the importance of the coordination of care, focusing on chronic diseases, and said that his country had set short- and medium-term objectives in that area. A mechanism would be established for coordinating local service provision, the role and functions of primary care would be strengthened, and reforms of the public health service would continue. Quality assurance mechanisms and health system performance assessment were being introduced, with advice received from the Regional Office's Barcelona Office.

The Minister of Health of Turkey identified health workforce shortages as the main obstacle to strengthening the health system in his country. Health services were widely accessible, and demand for them was rising, so existing staff were overburdened. When comparing countries' health systems, the lack of standardized statistics was another obstacle; if WHO were to publish guidelines on standards for data collection, cross-country comparison would be facilitated.

In the ensuing discussion, speakers described the steps taken to strengthen health systems in their countries. Areas improved included the prevention and control of MDR-TB (which also entailed working on the social determinants of health), the development of networks and "care circuits" in mental health, follow-up of AIDS patients by general practitioners and coordination of antibiotic policy.

Expressing the SCRC's views, a member recalled that the Regional Director had the previous year made a renewed commitment to public health and health system strengthening. A considerable amount of strategic thinking had since been done by the Secretariat, and a useful package of support had been compiled and made available to Member States. It was evident from the examples given by countries' representatives that they were well on the way in putting the principles underlying the Tallinn Charter into practice.

Commenting on the discussion, the Director-General commended Estonia on its counter-cyclical investment in health and agreed that good data had to be collected in order to assess health system performance and feed back the results to the entity responsible for setting policy. While there was a worldwide shortage of some 4 million doctors, it was important to demystify care and demonstrate that non-doctors could, for instance, treat AIDS patients and people with NCDs (diabetes, hypertension). Countries could only afford one health system, so both vertical and horizontal integration were needed. If results, resources and responsibilities were clearly defined, successful alliances could achieve much for people.

Strengthening public health capacities and services in Europe: a framework for action

The Director, Programme Management, listed the health challenges for Europe in the 21st century and said the framework for action on strengthening public health was designed to guarantee that those challenges were met. It proposed clear definitions of public health and the health system and put forward 10 essential public health operations (EPHOs) that should become the basis for monitoring strategies and actions for public health reform.

The Director, Health Systems and Public Health, described the development of a self-assessment tool for improving public health operations that had been tested in 14 eastern European countries. The focus of the framework for action was on improving health outcomes through disease prevention and health promotion, developing a competent public health workforce and organizational structures for public health services.

Panel discussion: way forward in strengthening public health services and capacities in the WHO European Region and the role of the WHO Regional Office

A panel discussion was held, moderated by the Professor of Public Health at the University of St Andrews, Scotland, United Kingdom, and involving the Director-General for Social Affairs and Health of Finland, the Chief Medical Officer of Ireland, the state secretaries for health of Kyrgyzstan and Portugal, the Minister of Health of Slovenia and a representative of the SCRC.

During the discussion, the Chief Medical Officer of Ireland described EPHOs as a programmatic guide for the reorganization of health systems. In his country, the paradigm had changed from a disease orientation to one aimed at health. The Director-General for Social Affairs and Health of Finland said that the purpose of government policy should be to provide health care strongly focused on health promotion, disease prevention and early intervention. The roles of NGOs, academia and industry in policy-making must be carefully specified, because the responsibilities and resources of those entities differed greatly from those of government. Legislation and fiscal measures had proved to be most effective in combating alcohol and tobacco use and unhealthy food consumption. The use of multisectoral teams such as nutritionists, social workers, nurses and physicians in providing care had been very beneficial.

The State Secretaries for Health of Kyrgyzstan and Portugal emphasized, respectively, the integration of all public health programmes through a sector-wide approach, and the training of health professionals and reconsideration of their rates of pay. The Minister of Health of Slovenia said he was a strong believer in prevention, but his proposals for investment in that area had been opposed by the finance ministry. With determination and the help of the Regional Office, that opposition had been overcome and he had succeeded in increasing taxes on tobacco and alcohol and the budget for health promotion and healthy lifestyles.

In the ensuing discussion, representatives described a number of their countries' public health initiatives. Cancer screening programmes were being implemented with strong support from the political sector; cancer prevention also entailed the promotion of healthy lifestyles at schools and new policies in environmental protection, transport, agriculture and energy. Epidemiological surveillance, the identification of community health risks and efforts to ensure the safety of food products were other public health initiatives being pursued.

Public health should not be seen merely in terms of expenditure, since a small investment yielded large benefits. The framework for action should be supplemented with an analysis of the economics of prevention. In developing public health capacities, attention should be paid to initiatives at the national, regional and local levels. The framework for action could be translated into a road map to be used in reorienting health systems, implementing reforms and starting up partnerships.

A representative of the SCRC said that the framework for action was a good sign for the Regional Office and the countries of the Region. It aimed at conceptual clarity and brought a practical perspective to the challenge of strengthening public health in Europe. A systematic approach to public health services would permit measurable indicators to be developed to convince other sectors of the crucial role of public health.

The moderator, summing up the debate thus far, said the area of public health, which appeared to have been neglected for some time, was being rediscovered under the leadership of the Regional Director. Strong support had been expressed for strengthening public health systems and building capacity, and the framework for action would be one tool for achieving the goals of Health 2020.

One representative reported that the public health system in one part of her country was being reformed in order to tackle unacceptable health inequalities by bringing together the functions of a number of public health bodies into one entity that would provide expert advice and leadership in public health. Ministers would have a clear responsibility to protect the health of the population, particularly in emergencies, while local government would be given new responsibilities, supported by protected budgets, as they were best placed to make appropriate decisions. The public health system as a whole would continue to advise the national health service on population health. Ministers would retain responsibility for national policy and strategy, with a new approach to public health policy based on tiered interventions, which would ensure that the Government did not immediately use regulation to resolve public health problems.

The Director, Programme Management briefly summarized the key points of the interventions by panellists and representatives. In response to a comment that the document lacked a section on the favourable cost–benefit balance of public health, he said that a study was under way, in line with the precepts of Health 2020. Commenting on two interventions that had emphasized the importance of public health at the local level, he recalled the successful WHO Healthy Cities project.

The Regional Director agreed with representatives that public health appeared to have been forgotten both at the Regional Office and by Member States. The topic had been included on the agenda of the current Regional Committee session at the request of countries, to ensure close cooperation between public health and health care. The word "operations" had been chosen to describe the essential public health roles, rather than "functions", as the latter was already used in the Tallinn Charter. She welcomed the comment that public health could be seen as an investment rather than an expense, and that reality must be proved to politicians. She also welcomed the full support of the SCRC for the new emphasis on public health and its proposal that public health be introduced in 2012 as an operational means for implementing Health 2020.

The representative of the Association of Schools of Public Health in the European Region made a statement.

In the discussion on the draft resolution, appreciation was expressed for the renewed emphasis on public health within health systems. The proposed framework for action, and especially widespread use of EPHOs, should be presented as options for Member States to use in strengthening their health systems, in order to improve health and reduce health inequalities. Furthermore, it should be made clear that any endorsement of the EPHOs was limited to their use within the European action plan on public health. There appeared to be an imbalance between the focus on social determinants and intersectoral action described in the information documents and the proposed activities in the EPHO framework. The EPHOs required further development, testing and monitoring to ensure that they matched the specificities and challenges of all the health systems in the Region and that they reflected the guiding principles of equity, social determinants of health and intersectoral action. The documents nevertheless presented practical tools that countries could use in identifying gaps in public health services and resources, designing reforms and setting priorities.

Health in all policies was a key concept in public health, and capacity building for taking intersectoral action and tackling the social determinants of health was essential for strengthening the role of public health in health systems. Sufficient numbers of well-qualified, motivated professionals were needed for both health care and public health in order to tackle the burden of NCDs, although the crucial role of primary health care should not be undermined in the shift to patient-centred care, with its strong emphasis on health promotion, disease prevention and better coordination of care. While health promotion and disease prevention should become as important as the availability and quality of care, individual Member States were responsible for managing their own national health systems.

It was pointed out that, as Health 2020 had not yet been endorsed, it should not be referred to in the resolution. Furthermore, any overlap with previous resolutions should be eliminated. Opposition was expressed to the proposal at the end of document EUR/RC61/10 to establish a high-level forum for policy development; rather, existing networks and governance structures should be used for that purpose. It might be established as an advisory body within the established regional governing bodies of the Organization.

European countries had to act jointly to combat NCDs and new infectious diseases, tackle the social determinants of health and counter the financial, demographic and strategic pressures on the health systems of all Member States. In view of the current financial crisis, it was important to maintain appropriate support for populations at risk, in order to counteract the deepening inequities in health in the Region. The renewed emphasis on public health and implementation of the 10 EPHOs would ensure that public health became a "visible" part of the health system.

The Regional Director, responding to comments, reiterated that the framework for action on strengthening public health capacity was work in progress and would be considered again at the next session of the Regional Committee. The EPHOs would be revised to better reflect the values of equity and intersectoral cooperation, as well as the social determinants of health, and the aspect of monitoring would be emphasized. Countries could conduct self-assessment to determine whether they were implementing the 10 EPHOs, or could request assistance from the Regional Office, and that exercise would result in an evidence-based action plan in 2012. In reply to a comment that the tools for strengthening public health in a centralized health system would be different from those for a federal system, she concluded that the EPHOs were totally flexible.

The Committee adopted resolution EUR/RC61/R2.

WHO reform for a healthy future

(EUR/RC61/21)



The Regional Director summarized the background and aims of the WHO reform process, which were to refocus WHO on its core business, reform its financing and management, and transform governance to strengthen public health. That included sharpening the Organization's priorities and articulating more clearly what WHO could do better than other partners and stakeholders in the five core areas of business identified by the World Health Assembly: health systems and institutions, health development, health security, convening for better health, and evidence on health trends and determinants.

The success of the reform process would depend on Member States giving the necessary guidance and support, and the Secretariat translating that policy guidance into practical management. Many topics on the agenda of the session would inform the discussion of reform, including the Regional Office's efforts to use the programme budget as a tool for accountability. The most important objective of the Regional Committee's discussion was to provide input from the European perspective into the special session of the WHO Executive Board to be held in November 2011, and to shape the reform of WHO through it. The Regional Committee's advice, engagement and support were needed to ensure that a package of reforms, with an implementation plan and an independent evaluation, could be submitted to the Sixty-fifth World Health Assembly in May 2012.

The WHO Director-General provided feedback from two other regional committees' discussion of WHO reform. The responses to a web-based consultation received from the EU, the United Kingdom and Mexico had been welcome and used to structure the concept paper on management. Nevertheless, they did not constitute the inclusive consultation with Member States that had been requested, so the three concept papers had not yet been revised. The regional committees for Africa and South-East Asia comprised 57 Member States, which both endorsed the reform process and urged that it not move too fast. As to governance, those regional committees wanted better alignment between global and regional governing bodies, to enable Member States to set priorities for WHO while recognizing regional specificities, and to reduce repetitive discussion by governing bodies; better alignment between the three levels of the Organization, including better work with partners and resource mobilization for countries; and better recognition of roles and responsibilities by Member States and the Secretariat, to ensure that Member States' decisions in resolutions could be implemented. While some countries feared that large and rich countries would exercise undue influence and country offices would be closed, the Director-General had reassured them that the process would be democratic.

While Member States supported consultation with partners, they feared that the proposed World Health Forum would erode the governing bodies' authority and suggested other models. Dealing with global health initiatives and partners resulted in a large burden of work, along with fragmentation and duplication; were transaction costs too high for donor and recipient countries alike? What was the value added? In addition, some countries misunderstood the proposed independent evaluation of health system strengthening; it was intended to audit the capacity of the three levels of the Organization to assist countries in this area. The Director-General had recently issued a draft document on the headquarters web site to answer Member States' questions.

In the subsequent general debate, after agreeing that NGOs could join the working groups as observers, Member States fully endorsed the WHO reform process and were eager to participate in each step; they made suggestions on the aims and content of each of the three areas (core business, financing and management, and governance) and gave advice on the speed and handling of the next steps in the process. In particular, one representative welcomed the discussion being held by the Regional Committee, although he was disappointed at the absence of updated concept papers, and requested that its results be reflected in a report to be shared with Member States for comment and then submitted to the Executive Board. While the EU's web-based comments remained valid, some additional points were offered to the Regional Committee discussion. First, the reform process needed to aim at ensuring that WHO concentrated on its core business and had strong management tools, adequate and competent staff, better results-based budgeting and planning processes, effective risk management and a robust internal control environment to increase transparency and accountability. The new managerial reforms, detailed in a new paper, were essential to make WHO more efficient and effective. The independent evaluation should start soon, so that its results could inform the reform process, and it

should focus on the managerial, governance and fiscal aspects, as well as work on health system strengthening. Reform of strategic management and financing should address the inconsistencies between resource allocation and strategic priorities agreed by governing bodies, and achieve more predictable funding, while bearing in mind discussions on its core tasks and relations with other United Nations agencies. In addition, WHO needed better alignment – coherence, hierarchy and synergy – and division of labour between its global and regional levels, and between its global and regional governing bodies. While a discussion of the proposed World Health Forum was welcome, the current stage of reform should focus on management issues.

The Secretariat should present the Executive Board at its special session in November with the various options for action on the whole range of problems addressed by the reform process, linking the concept papers with those presented to the Executive Board and World Health Assembly, and including the financial and resource implications and probable consequences and impact. WHO should also provide the evidence base for decision-making and streamline the specific policy options, in order to simplify the puzzle of reform for Member States' final decision. As reform was essential for WHO to meet all Member States' expectations, the speaker urged all Member States to voice their expectations, participate constructively in the process, and stick together to keep the process on track and fully support the Director-General.

Most of the other speakers endorsed those views, particularly the requests for a clear delineation of the options for reform and their costs and time frame and for the chance to comment on the report to the Executive Board, while making some additional points. Work on the five core functions, for example, should delineate core tasks; identify areas in which WHO should do less, as well as those in which it should do more and better to support Member States; and include a system to set priorities within the core functions, related to the way in which Member States adopted resolutions in the World Health Assembly. Speakers valued the normative and standard-setting work done by WHO headquarters, the technical assistance provided by headquarters and the Regional Office (including its GDOs and partnership with the European Observatory on Health Systems and Policies) and the excellent work done by country offices. Further, several representatives stressed the importance of NCDs, urging that WHO step up its efforts in funding, skills and coordination (to retain its leadership in NCD prevention and control, in order to achieve the ambitious aims expected to be agreed at the United Nations high-level meeting); focus on standard-setting to guide Member States, and on strengthening health systems to fight NCDs and communicable diseases; and establish a database of best practices against the common risk factors. One called for a mechanism to ensure a rapid and coordinated response to emergencies and disasters, and another suggested focusing on the use of information technology in health systems to ensure effective care. Another representative stated that the reform was an excellent opportunity to give a 21st-century interpretation of the visionary WHO Constitution, an idea that he illustrated by quoting and commenting on the last paragraph of its preamble.

As to financing and management, WHO must find ways to increase the level of flexible funding, and donors should support the Core Voluntary Contributions Account; in addition, WHO should seek innovative means of resource mobilization by the Organization as a whole, indicate how a "replenishment model" could be further developed, ensure that all new financing models were democratic, ensure sufficient involvement of Member States in the process and explore new ways of negotiating with donors, with greater transparency and clear criteria. One speaker called for a unified WHO to coordinate donor support. Other useful measures could include strengthening financial control and administrative systems to ensure the efficient use of existing resources; determining the costs of personnel through feasibility studies; recruiting staff that would help WHO maintain its technical expertise and cost-effectiveness, and submitting data and reports in good time for review by bodies such as the Programme, Budget and Administration Committee of the Executive Board.

Speakers endorsed the independent external evaluation and suggested that it should be carried out soon in order to contribute to the reform process by analysing WHO's contribution to strengthening health systems. Countries would carefully examine its proposed terms of reference.

As to governance, WHO should be the lead normative organization in the global health architecture, a function that should be properly resourced and carried out by WHO headquarters. WHO's three-level structure and the diversity of its regions were assets. As WHO strategies and plans were translated into action in country offices, mechanisms were needed to strengthen cooperation between the three levels of the Organization, and the lines between the Director-General and the regional directors, and between the agendas of the global and regional governing bodies. Nevertheless, the European Region should still be able to take the lead, when appropriate, in the future as it had in the past. The governing bodies should be more focused and strategic, more transparent and accountable, and more practical and less theoretical in their work. Several representatives wanted the Executive Board to have a stronger role, and another suggested strengthening the Programme, Budget and Administration Committee to support the Board. The vision of one WHO should be realized, and WHO should play a stronger role in its partnerships and in

the United Nations family. In addition, one speaker praised the new draft Regional Office country strategy; another called for WHO to use multicountry, subregional and interregional approaches and initiatives to improve the efficiency and cost-effectiveness of its work.

Furthermore, Member States should exercise self-discipline and cooperate to identify priorities better. They needed to agree on the general principles for WHO's cooperation with partners, particularly the principle of neutrality and perhaps the value of health as an organizing principle. Some representatives suggested increased cooperation with the private sector. While better coordination with partners, including civil society and the private sector, and delineation of tasks between governing bodies were needed, representatives doubted the usefulness of a World Health Forum and suggested that existing consultation structures or another proven framework be used.

As to the reform process itself, representatives praised the concept papers, particularly that on managerial reform. A speaker called for the process to be guided by the WHO Constitution and conducted through consensus. Another urged the European Region to continue to lead it, as well as for all Member States to participate; they needed to set its pace, whether fast or slow. He expected the Executive Board to make interim decisions in November. Representatives suggested that WHO could learn from the management practices of partners such as the Global Fund, examples of evaluations made for such organizations as the World Bank and the reform efforts of other United Nations agencies, and that the reform process should be used to explore new forms of country work and partnership.

In reply, the Director-General thanked Member States for their support and pledged that, after all Member States' input had been received, the Global Policy Group would provide a consolidated paper, encapsulating all elements of the reform, in October, before the meeting of the Executive Board. While reform was a continuous process, she had already taken action, such as instituting the global management system for the Organization; nevertheless, input from Member States, the owners of WHO, remained essential. The Director-General asked the Regional Committee to look at the draft terms of reference for the evaluation: the issue was its sequence in relation to the reform; she needed countries' input in the next couple of weeks in order to get the terms of reference from the Executive Board and issue a request for proposals. WHO would make detailed proposals on internal governance, as Member States had reached broad agreement, but because views differed on the World Health Forum and engagement with the private sector, the Director-General would propose other mechanisms for consultation with civil society and the private sector. Finally, WHO would provide more information about how a replenishment model could be developed in a democratic organization. Furthermore, the Director-General informed the Committee that she was also seeking to create a better evaluation culture in the Organization.

Three working groups then discussed the question of WHO reform in more detail.

Reports to plenary by working groups

A facilitator for working group A, which had discussed the question of governance, said that a number of provocative questions had been asked, resulting in a stimulating discussion of several key issues. The distinction between the Executive Board and the Health Assembly had been blurred, with the Board turning into a mini-Assembly. The Executive Board's executive functions needed to be strengthened. The Board's political legitimacy was being questioned, and an open-ended working group might be established to review that issue. It was suggested that training might be needed for the Executive Board's chairmen and other officers; that the Board might need to have more than one full set of meetings a year in order to do its work properly; and that its membership should be based on regions, not countries. Lastly, better interaction among regional committees should be sought and different sequencing of their meetings might be considered.

A facilitator for working group B, on core business, said that WHO was based on a democratic model, with joint financing and decision-making by all Member States. Under its Constitution, it had a very broad mandate, yet the core functions usefully emphasized what were the most important areas of WHO's work. Linguistic clarity was needed, as references were made variously to core areas, priority areas and core functions. The use of the vocabulary of business, however, was to be avoided. While WHO was not a development agency, it did a great deal of work at country level, and its ability to help national authorities with norms, standards and health systems depended on the availability of skilled staff at country level. It was suggested that the Organization's ongoing tasks should be dealt with differently than short-term functions. Priorities, however, should be the same globally and regionally. Lastly, countries should not change their attitudes to the Organization in different situations: sometimes they spoke as Member States, and at other times as donors.

A facilitator for working group C, on managerial reforms, said that it had considered a suggestion to break down the budget into two parts: core activities and projects. Some countries said that programme support costs did not suffice to cover expenditure on operations. WHO should estimate and better substantiate the real cost of projects. Another point raised was how to attract unearmarked funds from sources other than Member States. Programme priorities and income received from donors were not well matched. WHO should try to learn from the experience of other agencies. The Constitution provided the necessary flexibility for changes.

A statement was made by a representative of Medicus Mundi International.

Elections and nominations

(EUR/RC61/7, EUR/RC61/7 Corr.1,
EUR/RC61/7 Corr.2)

The Committee met in private to nominate four candidates for membership of the Executive Board, to elect three members of the SCRC, to elect one member of the Policy and Coordination Committee of the Special Programme of Research and Development and Research Training in Human Reproduction and to award the Jo Asvall Public Health Research Fellowship.

Executive Board

The Committee decided that Azerbaijan, Belgium, Croatia and Lithuania would put forward their candidatures to the World Health Assembly in May 2012 for subsequent election to the Executive Board.

SCRC

The Committee selected Belgium, Malta and the Russian Federation for membership of the SCRC for a three-year term of office from September 2011 to September 2014.

Policy and Coordination Committee of the Special Programme of Research and Development and Research Training in Human Reproduction

In accordance with the provisions of the Memorandum on the Administrative Structure of the Special Programme of Research, Development and Research Training in Human Reproduction, the Committee selected Germany for membership of the Policy and Coordination Committee for a three-year period from 1 January 2012.

Jo Asvall Public Health Research Fellowship

The Committee selected Ms Yelena Rozental as the recipient of the first Jo Asvall Public Health Research Fellowship.

Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016

(EUR/RC61/12, EUR/RC61/Conf.Doc./4, EUR/RC61/Conf.Doc./5)



The Director, Noncommunicable Diseases and Health Promotion said that there had been many calls for action on NCDs. The draft plan proposed concrete actions that could be taken to meet the objectives outlined in previous WHO decisions and resolutions. Attention to NCDs had been increased by the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases held earlier in the year in Moscow, which had resulted in the Moscow Declaration. The draft action plan was the product of ample consultation with Member States and was therefore strongly based on evidence and experience. The plan emphasized planning and oversight with the use of health information systems, the incremental incorporation of health into all policies, healthy settings and secondary prevention with clinical approaches such as cardio-metabolic surveillance and early detection of certain cancers. The plan recognized that all the proposed actions were not applicable across the Region and should be adapted locally.

The representative of the SCRC said that NCDs were a severe problem in the Region, and the proposed action plan set out the directions for addressing the social and economic determinants and risk factors of those diseases. A number of initiatives were available, such as the FCTC and global strategies with respect to alcohol, diet and physical activity; however, concerted action on NCDs had been lacking. The draft plan would turn good policies into action, after it had been adapted to countries' needs. Although some of the actions might initially be unpopular, the health gains would become obvious on evaluation. The SCRC had seen successive drafts of the plan and supported its focus. The current concern for global governance, exemplified by the upcoming high-level meeting on NCDs at United Nations headquarters in New York, would give further credence to the systematic, integrated approach outlined in the document.

In the ensuing discussion, most speakers supported the view that some of the identified priorities should be redrafted and adjusted on the basis of the available evidence and of national priorities. Countries of the Region were starting from different baselines with regard to implementation of certain proposed actions. The representative of one Member State suggested taking one more year in order to improve the action plan, instead of adopting it at the current session.

The outcome of the high-level meeting on NCDs at the United Nations should be taken into account, and questions were raised about how the Secretariat would do that. Furthermore, the Secretariat was asked to provide an analysis of the financial implications of the proposed action plan, especially for the Regional Office. It was proposed that the guiding targets and indicators should be finalized after the United Nations meeting, at the Sixty-fifth World Health Assembly in 2012, in order to ensure alignment with the plans of other WHO regions, and that the plan should be considered at the sixty-second session of the Regional Committee. Several amendments were proposed to the draft resolution to reflect those views, which were supported by many speakers.

Other speakers urged the Committee to adopt the action plan as soon as possible, in view of the increasing burden of NCDs in most countries of the Region. Tackling NCDs was a primary development goal. In the BCAs that many countries signed with WHO, NCDs were a high priority. WHO should provide strong arguments that would help health ministries to enter into real dialogue with other sectors in order to work together on tackling NCDs and also give guidance on how to affect sectors, including those that were not completely under national competence, such as agriculture, trade and traffic. One speaker described the step-by-step approach that her country had taken to reduce tobacco consumption, starting from more readily acceptable measures to a legislative ban on indoor smoking.

The prevention of NCDs should be based on international cooperation, a whole-of-government approach and health systems strengthening. It was therefore important to ensure coherence, and a link between regulatory and global action should be demonstrated at the forthcoming high-level meeting on NCDs in New York, where strong support for WHO should be shown.

The Director, Noncommunicable Diseases and Health Promotion, responding to an offer by the representative of Turkmenistan to host a further high-level meeting on NCD prevention, said that it would be timely to consider a further meeting on NCD prevention after the high-level meeting at the United Nations, as a follow-up to the Moscow Declaration. The targets and indicators in the draft action plan were not new but rather reflected those in the draft Health 2020 policy document. The targets would be developed in line with the global monitoring framework. In response to those speakers who had recommended that approval of the draft action plan be deferred, he said that the Regional Office should be ready to report before completion of the global action plan in 2013.

With regard to the financial implications, the proposed plan had five dimensions: implementation of the operational plan, which would involve collaboration between the Secretariat and countries; the costs in countries, which might be offset by imposing taxes on tobacco and some foods; targeted treatment, which would reduce costs; actions at population level, with generic medicines and income generation; and the inclusion of deliverables and logistics in national plans. On that basis, the estimated cost of the total plan for the 2012–2013 biennium would be about US\$ 6.5 million. That sum excluded actions with respect to nutrition, alcohol and tobacco but included collaboration with 22 European countries to support their NCD action plans and with 9 others for actions against specific diseases.

The action plan was framed in such a way as to allow Member States to choose whether population measures were imposed by the State or whether behaviour change was made a personal responsibility. An integrated approach was needed to such NCDs as injury, mental health, oral health and musculoskeletal disorders, many of which were related to ageing. A life-course approach was envisaged, which would keep the ageing population active and productive.

The Regional Director welcomed the rich debate on the proposed NCD action plan. She agreed that it would be important to consider the outcome of the high-level meeting at the United Nations, and she would be taking the Moscow Declaration, the report of the high-level consultation on NCDs held in Oslo in late 2010 and the European action plan, if approved, to that meeting. The year 2011 was the year of NCDs, and she considered that the Region had a moral imperative to act. The documents that had been prepared for the Regional Committee were in synergy; thus, those that the Committee had approved in the past few days contained many of the actions that were being proposed in the document under consideration. Countries' choices about activities for preventing NCDs required a supportive policy environment; for example, regulation, personal choices and other measures were all covered in the FCTC.

Statements were made by the EU representative on behalf of Alzheimer's Disease International and the International Pharmaceutical Federation.

A drafting group was established and agreed on a number of amendments to the draft resolution. The Committee adopted resolution EUR/RC61/R3.

Endorsement of the European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families

The Declaration was the outcome of a conference organized by the Regional Office, UNICEF and the Government of Romania and held in Bucharest in November 2010, and of consultation with Member States, the leading NGOs and self-advocates and their families.

The Committee adopted resolution EUR/RC61/R5 by acclamation.

Ottawa Charter



A ceremony was held to commemorate the twenty-fifth anniversary of the signing of the Ottawa Charter for Health Promotion.

European action plan to reduce the harmful use of alcohol 2012–2020

(EUR/RC61/13, EUR/RC61/Conf.Doc./6)



The Director, Division of Noncommunicable Diseases and Health Promotion described the proposed European action plan as a new iteration of a long tradition of addressing the harmful use of alcohol, a risk factor that required specific attention and different responses to match the circumstances in different countries. Convincing evidence justified policy measures to control the pricing, availability and marketing of alcohol; the Regional Office had therefore developed the action plan on the basis of regional policy guidance since 2005, in line with the global strategy adopted by the World Health Assembly in 2010 and in consultation with the network of technical counterparts in Member States. The plan's 10 action areas reflected health ministries' leadership in developing intersectoral action and policy, and it was supported by a framework for monitoring and evaluation. The draft plan had been changed to meet counterparts' requests: the language of the global strategy was consistently used, the stepwise and escalating approach had been changed into a menu of actions from which countries could choose, and amendments had been made to specific paragraphs. The action plan offered a chance for effective action against the leading killer of young people.

A member of the SCRC congratulated the Regional Office on the consultation process and the high-quality document that had resulted. The SCRC endorsed the plan, taking the position that it should advocate stronger regulation and higher pricing of alcohol products; underline the need to consult with all sectors, including the alcohol industry, while recognizing states' complete authority to decide on national action; and pay special attention to the regulation of marketing as an effective option. The action plan had four particular strengths: its relevance as guidance to countries; alignment with other international instruments, such as the global and EU strategies; evidence-based options for action, and a framework for monitoring and evaluation.

In the ensuing discussion, a representative of the country currently holding the Presidency of the Council of the EU welcomed the draft action plan, which was needed to address the particular situation in Europe and to reinvigorate action in the Region by offering options in the form of a flexible approach. EU countries would implement the plan, along with global, EU and national strategies and without prejudice to other international agreements, in order to build a coordinated response to alcohol-related harm in the Region. That would also contribute to the prevention and control of NCDs. WHO should support countries' work by focusing on the most effective measures and pressing issues, while setting priorities and continuing the fruitful cooperation with the EU on monitoring and surveillance. Member States and international organizations needed to turn strong commitment into action. When would the Regional Office issue the publication containing the proposed indicators, and how would it consult Member States' alcohol counterparts?

Most of the other speakers endorsed those views, welcoming and expressing commitment to the action plan. Some stressed the importance of flexible implementation, in accordance with countries' policies and circumstances, and of consultation with all stakeholders, which WHO could facilitate. One representative described his country's efforts to reduce the availability of alcohol to young people and counteract the effects of marketing; another described consumption in her country, which showed the need for action. A third said the action plan was needed to implement the global strategy in the European Region, reduce the unacceptably high level of alcohol-related harm, particularly to young people, benefit work against noncommunicable and communicable disease and for maternal health, and reduce related harm to the children of excessive drinkers and the costs to health care and the workplace.

Speakers praised the consultative nature of the process of developing the action plan, and particularly the revitalization of the network of counterparts, which enabled dialogue both with WHO and with other countries in similar circumstances. One representative identified WHO's role as helping Member States to secure high standards of public health protection; another urged WHO to focus on the biggest issues and priorities, avoid duplication of work between the Regional Office and headquarters, and make effective use of its resources. Two speakers identified aspects of the action plan that disagreed with their national policies and strategies, such as the points on health warnings and the ineffectiveness of education programmes, and suggested that the document could usefully give information on moderate levels of consumption.

In reply, the Director, Division of Noncommunicable Diseases and Health Promotion thanked the EU Member States for their support for and cooperation on the action plan, and described the Regional Office's plans to operationalize the indicators for monitoring and evaluation and to publish them with a checklist of questions before the next session of the Regional Committee. The indicators were already used in the regional alcohol information system, which was aligned with both the EC and WHO headquarters systems. The Regional Office's aim was to simplify and recategorize them in line with the action plan; political consultation could be included in that process if requested. While agreement on the evidence could not be universal, the balance of evidence very strongly supported policy measures to counteract such powerful influences on young people as peer pressure, aggressive marketing and the availability of low-priced alcohol products. The Regional Office would stress the measures indicated by the evidence, but it would also track the issue through its network of health-promoting schools and the Health Behaviour in School-aged Children study. The relative emphasis to be placed on different measures could be decided at the implementation stage.

The Committee adopted resolution EUR/RC61/R4.



European strategic action plan on antibiotic resistance

(EUR/RC61/14, EUR/RC61/Conf.Doc./7)

The Director, Communicable Diseases, Health Security and Environment, said that the scourge of bacterial and viral resistance to antimicrobial agents was an increasing problem in the Region, with the emergence of newly resistant strains. Misuse of antibiotics in both human and veterinary medicine and poor infection control were responsible for the problem, which was exacerbated by a lack of new drugs. Designation of antimicrobial resistance (AMR) as the theme of World Health Day 2011 reflected the importance that WHO attached to the problem. The regional focus was on bacterial infections, particularly in health care establishments, and on M/XDR-TB.

An action plan was needed because AMR increased health care costs, the length of hospital stays and patient morbidity and mortality, and it also threatened future health programmes and health security. Many Member States already had action plans, policies and surveillance tools to combat AMR (with some success), which they could share with other countries. Much of the problem of infection with methicillin-resistant *Staphylococcus aureus* was associated with insufficient hygiene measures in health care establishments, including the simple act of hand-washing. Not only the general public but also politicians and health professionals were insufficiently well informed about the issue.

The overall goals of the proposed strategy were listed in the document. They were to be attained by work towards seven strategic objectives, which were also described, together with examples of good practices that had been used by individual countries. A timetable was to be drawn up for implementation of the plan, with an estimate of the resources required. Indicators would be defined in order to monitor the progress made in Member States. The first step would be to make an inventory of the available data and practices, for instance with regard to surveillance of resistance and access to antibiotics. WHO and its partners would support Member States in drawing up their own plans of action and in establishing mechanisms for intersectoral coordination and surveillance.

Several speakers in the ensuing discussion emphasized that the European strategic action plan should be seen as a tool for implementing the WHO global strategy for the containment of AMR in the Region. Several amendments to the draft resolution were proposed to reflect that view. The plan outlined a holistic approach to preserving the efficiency of antibiotics, covering public health, food safety and animal health, and it emphasized closer cooperation with international partners. Concerted action was required, with coordination among government ministries; education and training in surveillance of AMR was also needed. It was suggested that an expert group be set up to identify research problems associated with AMR.

Antibiotic-resistant bacteria did not respect national boundaries. It was therefore important to share information, design effective interventions to prevent or slow the emergence of AMR, and work together to develop new drugs and diagnostics. There were a number of EU-wide policy and legislative initiatives for the prevention and control of AMR, which were being implemented by countries in collaboration with ECDC, the European Food Safety Authority and the European Medicines Agency.

The Committee adopted resolution EUR/RC61/R6.

Action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015

(EUR/RC61/15, EUR/RC61/Conf.Doc./8, EUR/RC61/Inf.Doc./3)



The Director, Health Systems and Public Health, who was also the Regional Director's Special Representative to Prevent and Control M/XDR-TB in the WHO European Region, showed a film in which people described their experience with TB and its MDR and XDR forms. The trend in TB cases in the Region was worrying, as new cases were occurring in 18 countries; the Region had the lowest treatment coverage after the African Region. The increase was due largely to late detection and inadequate health systems. The action plan therefore proposed prompt diagnosis with newly endorsed diagnostic tests and appropriate treatment. It also proposed investigation of the social determinants of TB and monitoring, evaluation and follow-up of patients. The goal of the plan was to contain the spread of the disease by achieving universal access to prevention, diagnosis and treatment of M/XDR-TB in all Member States in the Region by 2015.

A member of the SCRC described the wide consultative process that had been held to prepare the action plan, both with representatives of national TB programmes and with many external partners. The SCRC supported the ambitious targets and emphasized the importance of care for migrants and other marginalized populations.

In the ensuing discussion, speakers recalled the primordial role of WHO in containing TB and its drug-resistant forms, which had resulted in common goals and instruments. That commonality would help the countries of the Region in the long battle for containment, even though they were starting from widely different baselines. It was noted that the action plan was in line with the commitments made in the 2007 Berlin Declaration on Tuberculosis. The increased role for primary health care in the early detection and follow-up of cases foreseen in the plan was welcomed, as was the proposed exchange of experience among countries.

Lessons learnt in health financing could usefully be applied to improving TB treatment outcomes, and the announcement at the current session by the Global Fund that it would provide financial assistance to 12 of the 15 high-burden countries in the Region was noted with appreciation.

The cross-border threat of M/XDR-TB should be a priority for all Member States in the Region. The importation of cases to countries that had previously seen a decline in prevalence posed new challenges to their health systems and required adjustment of TB control measures. The focus should be on all vulnerable populations, not only on migrants, however: good TB control could be achieved by eliminating opportunities for transmission within national borders. Follow-up of asylum-seekers who moved from country to country within the Region was a particular challenge and would require close international collaboration.

The emphasis in the proposed plan on TB in prison populations was especially welcome. The WHO Health in Prisons Project would help ministries of justice and of health to work together on issues such as the continuity of care.

The Chair of the Global MDR-TB Working Group of the Stop TB Partnership commended the Regional Office for its leadership in preparing the proposed action plan and for establishing a functional Green Light Committee. Member States should remain committed to achieving the goal of the draft plan, which would require major policy changes in their health care systems and the further engagement of civil society. The Green Light Committee for the WHO European Region would support countries in implementing the plan and in annual monitoring of progress. The proposed response to MDR-TB was a highly cost-effective intervention in all settings, and both bilateral and multilateral donors and governments should continue to support the proposed activities.

The Director, Health Systems and Public Health thanked speakers for their positive comments and suggestions. A concrete proposal would be sent to the Global Fund for consideration during its eleventh round of project funding. Further, the Government of Turkmenistan had offered to host an interministerial meeting on TB in 2012.

A statement was made by the KNCV Tuberculosis Foundation.

The Committee adopted resolution EUR/RC61/R7.



European Action Plan for HIV/AIDS 2012–2015

(EUR/RC61/19, EUR/RC61/Conf.Doc./11,
EUR/RC61/Inf.Doc./8)

The Director, Communicable Diseases, Health Security and Environment said that, during the 30 years of battling the HIV/AIDS epidemic, the different responses used in different parts of the European Region had yielded success in treatment but had failed to slow the spread of infection. The number of people living with HIV was growing particularly rapidly in eastern Europe and central Asia, having tripled from 1990 to 2009. In terms of modes of transmission, the highest percentage in eastern Europe and central Asia was attributable to injecting drug use, and in western Europe, to men who had sex with men.

A key to combating the epidemic was antiretroviral treatment (ART), but ART coverage in eastern Europe and central Asia was among the worst globally. Throughout the European Region, key populations (people who injected drugs and their sexual partners, men who had sex with men, prisoners and migrants, among others) were prevented from accessing HIV treatment services by social, cultural and legal barriers.

The Regional Office had accordingly developed the European Action Plan for HIV/AIDS 2012–2015: Framework for Urgent Action. The Plan gave impetus to international initiatives such as the the Joint United Nations Programme on HIV/AIDS (UNAIDS) strategy 2011–2015, built on existing European experiences and relied on partnerships, including with the Global Fund and civil society. The objectives were to halt and reverse the spread of HIV in Europe and to achieve universal access to comprehensive HIV prevention, treatment, care and support. The Plan's four strategic directions were to optimize HIV prevention and diagnosis; to mobilize broader health outcomes, such as the results of programmes to combat TB and drug dependence; to build strong and sustainable health systems; and to reduce vulnerability and structural barriers to accessing systems.

A representative of the country currently holding the Presidency of the Council of the EU welcomed the Action Plan's emphasis on human-rights-based approaches, civil-society involvement and evidence-based interventions, and on differing responses to HIV in different parts of Europe. Co-morbidities, especially TB and hepatitis co-infections, called for a tailored approach in each geographical region. In view of the particularly alarming situation in eastern Europe and central Asia, the emphasis placed on action in the countries of eastern Europe was appreciated. All Member States should scale up their investment in prevention measures and implement approaches that targeted young people, people who injected drugs and other key populations. Since the early days of the epidemic, people living with HIV/AIDS had taken bold action, often at significant risk. They needed to be involved in the development and implementation of the action plan.

In the ensuing discussion, many representatives fully supported the Action Plan. Some particularly welcomed the inclusion of the fourth strategic direction, which addressed the social determinants of health. Since the European Region was exceptionally diverse, the Plan should allow for the adoption of national strategies that were tailor-made for the unique circumstances of particular countries. While monitoring the implementation of the Action Plan was important, no new reporting obligations should be introduced: countries were already overburdened.

On the grounds of incompatibility with their domestic legislation or the domestic handling of the epidemic, a number of countries objected to certain portions of the Action Plan (such as the sections on harm reduction interventions for drug users, opioid substitution therapy, and laws and regulations related to the response to HIV infection, notably those on decriminalizing sex work and removal of mandatory HIV testing). The targets set for the European Region by 2015 in areas 1.1 ("More than 90% of individuals in key populations will have been tested") and 1.5 ("All countries in the Region will have scaled up ART coverage to at least 80% of people in need") were deemed to be overly ambitious. The suggested indicators for areas 1.2, 1.3, 1.4, 2.2 and 3.2, set out in Annex 1 to the Action Plan, were singled out as needing further discussion.

Speaking as an observer, a representative of the United States of America commended the European Region for moving rapidly towards a regional strategy to combat HIV/AIDS and emphasized the importance of partnerships and of the collective response to HIV/AIDS.

A statement was made on behalf of six European organizations working for access to treatment and services for people living with HIV and for the defence of their human rights.

Amendments were proposed to the draft resolution, to emphasize tackling the obstacles to effective HIV prevention and to ensure concordance among the various language versions. The Committee adopted resolution EUR/RC61/R8.

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Confirmation of dates and places of regular sessions of the Regional Committee in 2012–2015

(EUR/RC61/Conf.Doc./12)

The Committee adopted resolution EUR/RC61/R10, by which it reconfirmed that it would hold its sixty-second session in Malta from 10 to 13 September 2012 and its sixty-third session in Portugal from 16 to 19 September 2013, and decided that its sixty-fourth session would be held in Copenhagen from 15 to 18 September 2014. It also decided that its sixty-fifth session would be held from 14 to 17 September 2015 (exact location to be defined).

Resolutions

EUR/RC61/R1. The new European policy for health – Health 2020: Vision, values, main directions and approaches

The Regional Committee,

Having considered the report on the new European policy for health – Health 2020: vision, values, main directions and approaches;¹

Recognizing the WHO Regional Office for Europe's extensive experience of working on comprehensive approaches to health development, including Health for All, the Ottawa Charter for Health Promotion, HEALTH21, the European environment and health process and the Tallinn Charter: Health Systems, Health and Wealth, and of working with other sectors (including environment, transport, education, justice, finance and agriculture) and with subnational levels of government;

Recalling resolution EUR/RC60/R5, which requested the Regional Director to develop a European policy for health – Health 2020 to act as a unifying and coherent action framework to accelerate attainment of better health and well-being for all, adaptable to the realities that make up the European Region;

Bearing in mind that this was launched as a two-year process, with the final Health 2020 policy to be presented to the Regional Committee at its sixty-second session in 2012;

Acknowledging past commitments, made through global and regional policies, strategies and plans (as reflected in resolutions and other collective political statements), to address public health challenges in the Region;

Noting the Regional Director's commitment to develop Health 2020 through a highly participatory and inclusive process;

Conscious of the essential roles and contributions of various sectors and all levels of government, as well as of international, intergovernmental, nongovernmental and government organizations and bodies, in efforts to address equity in health and well-being in the Region;

1. THANKS the Regional Director for the report on the Health 2020 concept which covers the goals, values, framework and outline of the policy, as well as the main approaches and proposals for targets;
2. AGREES that a new European policy for health should focus in particular on policies and interventions that work and which make the greatest difference to the health and well-being of people in the Region; on universal policy and technical innovations that hold the greatest promise; on accelerating action to reduce inequalities in health, with special emphasis on the poorest and most vulnerable groups; on preparing for and anticipating change in the next decade; on supporting and being relevant to all Member States in the Region; and on offering a unifying policy framework for action in which the Regional Office and Member States join forces and work together with international partners;
3. REQUESTS the Regional Director to continue to consult all Member States² before the sixty-second session of the Regional Committee and to develop, according to the guiding framework as presented at the sixty-first session, taking into account

¹ Document EUR/RC61/9

² And, where applicable, regional economic integration organizations

comments made by delegations, the final draft of the Health 2020 policy, with specific written consultations with all Member States in early 2012, in order to ensure adequate time for full responses and to submit to Member States by the time of the Sixty-fifth World Health Assembly and to the Regional Committee at its sixty-second session for adoption.

EUR/RC61/R2. Strengthening public health capacities and services in Europe: a framework for action

The Regional Committee,

Having considered the reports on Strengthening public health capacities and services in Europe: a framework for action;³

Mindful of the shared health challenges described therein and in the document submitted at its sixtieth session on "Addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region";⁴

Acknowledging the progress in health policy made through past initiatives, including Health for All, HEALTH21 and the Tallinn Charter: Health Systems for Health and Wealth;

Recognizing the continuing need to renew the commitment to comprehensive and coherent health policies and to focus on public health policies, functions and structures, the further development of primary health care, and health promotion and disease prevention, as well as to strengthen European health systems and foster interregional collaboration;

1. ENDORSES the eight avenues identified in the report for strengthening public health capacities and services in Europe, as a basis for the Regional Office's proposal to formulate a European action plan embedded in the vision of the Regional Director, including:
 - (a) wide use of essential public health operations, where appropriate;
 - (b) strengthening regulatory frameworks for protecting and improving health;
 - (c) improving health outcomes through health protection;
 - (d) improving health outcomes through disease prevention;
 - (e) improving health outcomes through health promotion;
 - (f) assuring a competent public health workforce;
 - (g) developing research and knowledge for policy and practice; and
 - (h) organizational structures for public health services;
2. ENDORSES a further process of examining and developing the essential public health operations described in the reports as a basis for the Regional Office's proposal to formulate a European action plan embedded in the vision of the Regional Director;
3. REQUESTS Member States⁵ to collaborate in the development of a European action plan, led by the WHO Regional Office for Europe, for strengthening of public health capacities and services;

³ Documents EUR/RC61/10 and /Inf.Doc./1

⁴ Document EUR/RC60/13

⁵ And, where applicable, regional economic integration organizations

4. REQUESTS the Regional Director:
- (a) to ensure that the framework for action is aligned with the strategies of WHO globally and with decisions made in the World Health Assembly;
 - (b) to assess public health services and capacities and gaps in Member States with the WHO web-based assessment tool and to report back to them and the Regional Committee with conclusions and recommendations;
 - (c) based on the outcomes of the above-mentioned assessments, to develop a European action plan for strengthening public health capacities and services in Europe, as part of the approach of strengthening health systems, through a participatory process involving Member States and partners;
 - (d) to submit the European Action Plan to the sixty-second session of the Regional Committee for consideration, together with and under the umbrella of the new European health policy, Health 2020.

EUR/RC61/R3. Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016

The Regional Committee,

Reaffirming that noncommunicable diseases (NCDs) are the greatest cause of preventable mortality and morbidity in the WHO European Region;

Recalling its resolution EUR/RC56/R2, by which it adopted 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;

Recalling its resolution EUR/RC57/R4 by which it adopted the Second European Action Plan for Food and Nutrition Policy (2007–2012) and endorsed the European Charter on Counteracting Obesity;

Recalling its resolution EUR/RC60/R7 by which it endorsed the decisions of the Fifth Ministerial Conference on Environment and Health, as included in the Parma Declaration on Environment and Health;

Recalling World Health Assembly resolutions WHA53.17, WHA60.23 and WHA61.14 by which the Health Assembly endorsed the Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases;

Recalling World Health Assembly resolution WHA64.11 by which the Health Assembly endorsed the Declaration of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28–29 April 2011) and called on the Director-General of WHO to undertake concerted action and report on progress;

Acknowledging the ongoing processes to raise the priority of NCDs as a global health issue, in particular the Regional High-level Consultation on NCDs (Oslo, 25–26 November 2010), the First Global Ministerial Conference on Healthy Lifestyles and NCD Control (Moscow, 28–29 April 2011), the forthcoming high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases (New York, 19–20 September 2011) and the publication of the global status report on NCDs;⁶

⁶ *Global status report on noncommunicable diseases 2010*. Geneva, World Health Organization, 2010 (http://www.who.int/nmh/publications/ncd_report2010/, accessed 22 July 2011).

Having considered the report containing proposals for an action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016;⁷

Recognizing that the European NCD Action Plan 2012–2016 aims to give guidance on concrete evidence-based actions for the prevention and control of NCDs adaptable to Member States' varying levels of experience and existing policy and legislation, within a framework amenable to monitoring and evaluation;

Fully recognizing that the European NCD Action Plan 2012–2016 could need adjustments in order to become coherent with the comprehensive monitoring framework to be adopted at the World Health Assembly in 2012;

Further recognizing that the European NCD Action Plan 2012–2016 is in line and coordinated with Member States' existing commitments to implementation of the Global Strategy and Action Plan for the Prevention and Control of Noncommunicable Diseases, the WHO Framework Convention on Tobacco Control, the Global Strategy for the Reduction of the Harmful Use of Alcohol and the Global Strategy on Diet, Physical Activity and Health;

Affirming that an appropriate approach to NCDs should address, inter alia, their social and environmental determinants and focus in particular on the causes of inequities in vulnerable groups and across the life course;

Further affirming that the causes and consequences of NCDs are connected to mental health, violence and injuries, and musculoskeletal and other chronic conditions, as well as to certain infectious diseases, and that responses to NCDs should seek synergies with programmes directed at these conditions;

Recognizing that the European NCD Action Plan 2012–2016 will be in line and coordinated with the Public Health Framework for Action and the new European policy for health (Health 2020);

1. AGREES that the European NCD Action Plan 2012–2016 offers guidance and policy options for Member States on a series of concrete actions that can be taken in the European Region to achieve measurable improvements in NCD control using existing comprehensive, integrated approaches while taking into account existing national legislation and policies as appropriate;
2. URGES Member States:⁸
 - (a) to use the Action Plan according to national needs to identify core actions for strengthening comprehensive, integrated national approaches to NCDs and as a basis for international collaboration;
 - (b) to strengthen national capacity for health systems to respond to NCDs, including the development of national plans and integrated approaches to surveillance;
 - (c) to promote and support intersectoral policies to reduce the risks of NCDs including behavioural and environmental risk factors as outlined in the Action Plan;
 - (d) in accordance with national policies to strengthen their actions for behaviour change and community empowerment in the area of NCDs;
 - (e) to strengthen the management of NCDs in primary care, providing universal access to clinical prevention and care, using evidence-based approaches and appropriate financing;
3. CALLS ON international, intergovernmental and nongovernmental organizations, as well as self-help organizations, to support the Action Plan and where appropriate to work jointly with Member States and with the WHO Regional Office to strengthen national policies and plans to respond to NCDs;

⁷ Document EUR/RC61/12

⁸ And, where applicable, regional economic integration organizations

4. REQUESTS the Regional Director:
- (a) in collaboration with Member States⁹ and building on the outcome of the United Nations High Level Meeting on NCDs and the targets and indicators to be decided upon at the World Health Assembly in 2012, to refine and complete targets and indicators for the core action areas in the NCD Action Plan;
 - (b) to synchronize monitoring with the comprehensive monitoring framework to be adopted by the World Health Assembly in 2012;
 - (c) to cooperate with and assist Member States and organizations in their efforts to implement the priority actions and interventions described in the NCD Action Plan;
 - (d) to promote collaboration with governmental and nongovernmental organizations and between Member States, as well as with WHO, other international organizations and regional actors in support of the Action Plan;
 - (e) to deliver a progress report to the Regional Committee at its sixty-third session in 2013 and to report back to the Regional Committee at its sixty-sixth session in 2016 on the implementation of the Action Plan.

EUR/RC61/R4. European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020

The Regional Committee,

Reaffirming that the harmful use of alcohol is a major public health concern, with the highest levels of consumption and harm in the WHO European Region;

Recalling its resolution EUR/RC42/R8, by which it approved the first and second phases of the European Alcohol Action Plan, and the European Charter on Alcohol adopted at the European Conference on Health, Society and Alcohol in Paris in December 1995;

Recalling its resolutions EUR/RC49/R8, by which it approved the third phase of the European Alcohol Action Plan, and EUR/RC51/R4 by which it endorsed the Declaration on Young People and Alcohol adopted at the WHO Ministerial Conference on Young People and Alcohol in Stockholm in February 2001;

Recalling World Health Assembly resolution WHA58.26 on public health problems caused by harmful use of alcohol;

Recalling its resolution EUR/RC55/R1, by which it approved the Framework for alcohol policy in the WHO European Region;

Recalling World Health Assembly resolutions WHA61.4 on strategies to reduce the harmful use of alcohol and WHA63.13 on a global strategy to reduce the harmful use of alcohol;

Having considered the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020;¹⁰

Affirming that the Action Plan aims to give guidance about action to fight alcohol-related harm at all levels and to set priority areas for European action, for increased international cooperation and for the participation of all Member States in a cost-effective, appropriate and comprehensive response that takes due account of religious and cultural diversities;

Recognizing that the Action Plan will be in line and coordinated with the European Action Plan on Noncommunicable Diseases 2012–2016, the Framework for action on public health and Health 2020, the new European policy for health;

⁹ And, where applicable, regional economic integration organizations

¹⁰ Document EUR/RC61/13

Recognizing the threats posed to public health by the harmful use of alcohol and the importance of ensuring that in implementing the Action Plan, Member States seek the support and engagement of all the sectors involved in a multidisciplinary approach;

Aware that public health concerns regarding the harmful use of alcohol need to be duly considered in the formulation of economic, marketing and trade policy at national and international levels;

Acknowledging the leading role of WHO in promoting international collaboration for the implementation of effective and evidence-based alcohol policies;

1. AGREES that the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 offers guidance and policy options for Member States in the WHO European Region, taking into account existing commitments as well as new developments, challenges and opportunities for national and international action;
2. RECOMMENDS Member States:¹¹
 - (a) to use the Action Plan to formulate or, if appropriate, reformulate national alcohol policies and national alcohol action plans;
 - (b) to strengthen international collaboration in the face of increasing levels of common and transboundary challenges and threats in this area;
 - (c) to promote and support policies and interventions to decrease the harmful use of alcohol that preserve and protect public health interests while ensuring that measures to this effect remain proportionate and evidence-based;
 - (d) to promote an evidence-based approach that includes all levels of government, as well as all affected sectors and stakeholders involved including communities, civil society and the private sector in the actions needed to prevent or reduce alcohol-related harm;
 - (e) to promote alcohol-free policies in an increasing number of settings and circumstances such as the workplace, means of public transport, the environments of children and youth and during pregnancy;
 - (f) to reduce exposure to alcohol marketing, and in particular to protect children and youth from alcohol marketing of all kinds;
 - (g) to ensure, that in doing so, the measures aiming at reducing the harmful use of alcohol comply with international treaties and agreements;
3. CALLS UPON international, intergovernmental and nongovernmental organizations, as well as self-help organizations, to support the Action Plan and to work jointly with Member States and with the WHO Regional Office to develop and implement national policies to reduce the negative health and social consequences of the harmful use of alcohol;
4. REQUESTS the Regional Director:
 - (a) to exercise leadership in tackling this public health problem and support policy-makers in Europe with formulating national policies and plans as part of their overall response to noncommunicable diseases;
 - (b) to monitor the progress, impact and implementation of the Action Plan, use the information collected to revise and update the European Information System on Alcohol and Health, and use data to compile regular progress reports of alcohol consumption, harm and responses in the Region;
 - (c) to mobilize resources in order to ensure adequate health promotion, disease prevention, disease management, research, evaluation and surveillance activities in the Region, in line with the aims of the Action Plan;

¹¹ And, where applicable, regional economic integration organizations

- (d) to cooperate with and assist Member States and organizations in their efforts to develop and implement national policies that prevent or reduce the harm resulting from alcohol consumption and alcohol related harm in the Region;
- (e) to promote partnerships with governmental and nongovernmental organizations and between Member States, as well as with WHO, other international organizations and regional actors in support of the Action Plan; and
- (f) to mobilize other international organizations in order to pursue the aims of the Action Plan.

EUR/RC61/R5. WHO European Declaration and Action Plan on the Health of Children and Young People with Intellectual Disabilities and their Families

The Regional Committee,

Recognizing that children and young people with intellectual disabilities are equal citizens, with the same rights to health and social care, education, vocational training, protection and support as other children and young people;

Also recognizing that these children should have equal opportunities to live stimulating and fulfilling lives in the community with their families, alongside their peers;

Acknowledging the remaining challenges as illustrated by the deprivation of rights and incidents of neglect and abuse in both long-stay residential institutions and local communities;

Recognizing that people with intellectual disabilities are often disadvantaged in their health care from childhood onwards, and that stigma and discrimination due to intellectual disabilities lead to even greater inequalities in their health and development;

Reaffirming its support for the relevant United Nations instruments, particularly the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities;

Welcoming recent European initiatives on further action to secure the rights of people with disabilities, drawing upon the Council of Europe Disability Action Plan 2006–2015, the European Union Disability Strategy 2010–2020 and the WHO Disability and Rehabilitation Action Plan 2006–2011;

1. COMMENDS the WHO Regional Office for Europe on organizing the high-level Conference on Children and Young People with Intellectual Disabilities and their Families, in successful partnership with the United Nations Children's Fund (UNICEF);
2. WELCOMES with great satisfaction the strong and fruitful collaboration with nongovernmental organizations, self-advocates and family members, experts, health professionals and other partners;
3. WISHES to express its gratitude to the Government of Romania for hosting the Ministerial Conference;
4. THANKS the Government of Serbia for hosting the meeting to negotiate the Declaration and the Action Plan in advance of the Ministerial Conference, which made a significant contribution to the successful preparation of the Conference;
5. ENDORSES the European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families¹² adopted at the WHO European High-Level Conference held in Bucharest in November 2010;

¹² *European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families*. Copenhagen, WHO Regional Office for Europe, 2011 (document EUR/51298/17/6, http://www.euro.who.int/__data/assets/pdf_file/0015/121263/e94506.pdf, accessed 18 April 2011).

6. NOTES the ten priority areas which need to be addressed to enable young people with intellectual disabilities and their families to live healthy and full lives:
 - (a) Protect children and young people with intellectual disabilities from harm and abuse;
 - (b) Enable children and young people to grow up in a family environment;
 - (c) Transfer care from institutions to the community;
 - (d) Identify the needs of each child and young person;
 - (e) Ensure that good quality mental and physical health care is coordinated and sustained;
 - (f) Safeguard the health and well-being of family carers;
 - (g) Empower children and young people with intellectual disabilities to contribute to decision-making about their lives;
 - (h) Build workforce capacity and commitment;
 - (i) Collect essential information about needs and services and assure service quality;
 - (j) Invest to provide equal opportunities and achieve the best outcomes;
7. URGES Member States to progressively realize these priorities by planning, adopting and implementing policies according to their responsibilities as stated in the Declaration;
8. REQUESTS the WHO Regional Director for Europe to ensure that adequate priority and resources are given to activities and programmes to fulfil the requirements of the Declaration and the Action Plan, according to WHO's mandate, by:
 - (a) exercising leadership concerning the role and functioning of health systems in accordance with all relevant European and global standards and policies, in order to meet the needs of children and young people with intellectual disabilities and their families;
 - (b) providing technical support to Member States in order to promote quality in service provision and to establish sustainable capacity;
 - (c) supporting research initiatives that will result in ethical and evidence-based policy and practice;
 - (d) monitoring the health status of children and young people with intellectual disabilities and their families and assessing progress towards the implementation of this Declaration and Action Plan;
 - (e) engaging in partnership with UNICEF, the European Commission and the Council of Europe and other intergovernmental and nongovernmental organizations where joint action can facilitate implementation;
9. SUPPORTS the Action Plan that is endorsed by the Declaration, providing a framework for policies and activities towards achieving the aims of the Declaration by 2020;
10. REQUESTS the Regional Director to report to the Regional Committee on progress made in 2016.

EUR/RC61/R6. European strategic action plan on antibiotic resistance

The Regional Committee,

Recalling World Health Assembly resolutions WHA51.17 on emerging and other communicable diseases: antimicrobial resistance, WHA58.27 on improving the containment of antimicrobial resistance and WHA62.15 on prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis;

Acknowledging Member States' existing commitments and the ongoing work under the WHO Global Strategy for Containment of Antimicrobial Resistance, as well as the fact that task forces and informal networks at global and regional levels are aiming to address elements of the challenges posed by antimicrobial resistance (rational use of antimicrobials, surveillance of antimicrobial resistance, etc.);

Concerned by the increasing emergence of antibiotic resistance, including against last-resort antibiotics such as carbapenems, and the lack of research and development of new antibiotics;

Further concerned that the death toll due to resistant bacterial infections acquired in hospital is more than 25 000 people each year in the European Union alone, leading to increased health care and societal costs;

Taking into consideration the facts that bacterial resistance and hospital-acquired infections are closely linked and that comprehensive measures to improve infection control and stewardship of antibiotic use call for an integrated approach in health care settings;

Recognizing that infection control practices, and especially hand hygiene, are very cost-effective interventions to prevent many infections and antibiotic resistance;

Recognizing further that antibiotic resistance will occur when antibiotics are used, but particularly when they are overused or misused, that antibiotics are used not only in human health but also extensively in food animal production, and that information on consumption is lacking from many countries;

Mindful that over-the-counter sales of antibiotics are common in many countries and that education on the prudent use of antibiotics is missing or insufficiently addressed during medical and medical science training;

Aware that there is increasing evidence of the close link between the emergence and spread of antibiotic resistance between humans, animals and the environment and that possible solutions should address all sectors;

Recognizing that surveillance of and information about antibiotic resistance in bacterial infections and antibiotic consumption is scattered and incomplete;

Having considered the European strategic action plan on antibiotic resistance;¹³

Aware that multidrug- and extensively drug-resistant tuberculosis has very high prevalence rates in some countries and should be included in most of the comprehensive approaches as outlined in the European strategic action plan on antibiotic resistance;

1. ADOPTS the European strategic action plan on antibiotic resistance as a strategic intersectoral framework in the WHO European Region for implementation of the WHO Global Strategy for Containment of Antimicrobial Resistance;
2. URGES Member States¹⁴ in the WHO European Region to:
 - (a) ensure political commitment and resources to implement the WHO Global Strategy for Containment of Antimicrobial Resistance through the European strategic action plan on antibiotic resistance, identifying key national priorities from the seven strategic directions in the European strategic action plan and developing national plans;

¹³ Document EUR/RC61/14.

¹⁴ And, where applicable, regional economic integration organizations

- (b) analyse the national situation of antimicrobial resistance and antibiotic use in a comprehensive approach covering the community, health care settings and food animal production;
 - (c) support the development of national systems for surveillance and monitoring of antibiotic resistance and consumption;
 - (d) initiate and formalize national intersectoral and all-inclusive coordinating mechanisms, linking to national professional associations, patient safety groups and other relevant nongovernmental actors;
 - (e) review and ensure adherence to national recommendations for infection control in health care settings;
 - (f) develop cooperation with the pharmaceutical industry, academia and other relevant sectors to address research and development of new antibiotics and diagnostic tools to contain antibiotic resistance;
 - (g) support national campaigns that raise awareness of the causes of antibiotic resistance, including through participation in an expanded European Antibiotic Awareness Day;
3. REQUESTS the Regional Director to:
- (a) continue to exercise leadership in addressing the public health importance of antibiotic resistance and provide tools, guidance and technical support to Member States;
 - (b) support Member States¹⁵ in assessing their current situation with regard to antibiotic resistance, antibiotic consumption, and their capacity to develop and implement national action plans;
 - (c) facilitate exchanges of information and Region-wide analysis of trends and drivers of antibiotic resistance, including through the creation of regional platforms for sharing and analysing data;
 - (d) in collaboration with Member States,¹⁶ engage in regional and global partnerships in efforts to foster the regional mobilization of human and financial resources to improve national and regional capacities to contain antibiotic resistance;
 - (e) engage with regional partners in reviewing and promoting tools and guidance on the use of antibiotics outside human populations and supporting innovation and research into antibiotic agents and diagnostic tools;
 - (f) engage with relevant nongovernmental organizations and patient safety groups to foster heightened awareness of antibiotic resistance and the importance of prudent use of antibiotics;
 - (g) report to the Regional Committee on the progress made in implementing the European strategic action plan each year until 2014 and every second year thereafter, with final reporting in 2020.

EUR/RC61/R7. Multidrug- and extensively drug-resistant tuberculosis in the WHO European Region

The Regional Committee,

Having considered the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015¹⁷ and the comprehensive version of the Action Plan;¹⁸

¹⁵ And, where applicable, regional economic integration organizations

¹⁶ And, where applicable, regional economic integration organizations

¹⁷ Document EUR/RC61/15

¹⁸ Document EUR/RC61/Inf.Doc./3

Recalling World Health Assembly resolutions WHA58.14 on sustainable financing for tuberculosis prevention and control and WHA62.15 on prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis, the Berlin Declaration on Tuberculosis adopted by the WHO European Ministerial Forum and the Beijing "Call for action" on tuberculosis control and patient care;

Noting with concern that multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB) has emerged as an increasing threat to public health and health security in the WHO European Region, with 20% of the global burden of MDR-TB in the WHO European Region and the vast majority of the countries in the Region reporting extensively drug-resistant TB (XDR-TB);

Noting further that of an estimated 81 000 MDR-TB patients in the Region each year, only about one third are notified (owing to the low availability of bacteriological culture and drug susceptibility testing) and less than half are reported to receive appropriate and adequate treatment;

1. ADOPTS the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015 and its targets of diagnosing at least 85% of estimated MDR-TB patients and successfully treating at least 75% of them by 2015;
2. URGES Member States:¹⁹
 - (a) to harmonize as appropriate, their national health strategies and/or national M/XDR-TB response with the Consolidated Action Plan;
 - (b) to identify and address the social determinants and health system challenges related to the prevention and control of M/XDR-TB, and in particular to adopt sustainable financial mechanisms, involve primary health care services and provide psychosocial support as appropriate;
 - (c) to scale up access to early diagnosis and effective treatment for all drug-resistant TB patients, and to achieve universal access by 2015;
 - (d) to scale up TB infection control and strengthen surveillance of drug-resistant TB and monitoring of treatment outcomes;
 - (e) to expand their national capacity to scale up the management of drug-resistant TB, involving civil society organizations and other partners and sectors;
 - (f) to address the needs of specific populations through the introduction of patient-centred initiatives and mechanisms and the provision of psychosocial support to patients as appropriate;
 - (g) to closely monitor and evaluate implementation of the actions outlined in the Consolidated Action Plan;
3. REQUESTS the Regional Director:
 - (a) to actively support implementation of the Consolidated Action Plan by providing leadership, strategic direction and technical support to Member States;
 - (b) to facilitate the exchange of experiences and know-how between Member States by establishing and strengthening knowledge hubs, centres of excellence and WHO collaborating centres;
 - (c) to make national and international partners more aware that TB and M/XDR-TB is a priority issue in the Region;
 - (d) to establish a European StopTB partnership platform and/or related mechanisms to strengthen the involvement of national and international partners, including civil society organizations, in the prevention and control of TB and M/XDR-TB;

¹⁹ And, where applicable, regional economic integration organizations

- (e) in collaboration with national and international partners, to establish adequate mechanisms, involving civil society organizations, communities and the private sector, among others, to assess progress in the prevention and control of M/XDR-TB at regional level every other year, starting from 2013, and to report back to the Regional Committee accordingly;
4. URGES civil society organizations, national and international partners and development agencies, and in particular the Global Fund to Fight AIDS, Tuberculosis and Malaria, the European Centre for Disease Prevention and Control and the European Commission, to fully support implementation of the Consolidated Action Plan.

EUR/RC61/R8. European Action Plan for HIV/AIDS 2012–2015

The Regional Committee,

Recalling the Declaration of Commitment on HIV/AIDS adopted by the special session of the United Nations General Assembly in June 2001;

Recalling the Political Declaration on HIV and AIDS adopted by the United Nations General Assembly at the High-Level Meeting on AIDS in June 2011;

Recalling World Health Assembly resolutions WHA54.10 and WHA55.12 that called for scaling up of the response to HIV/AIDS, and resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19, which endorsed a series of strategies that have guided WHO's work on HIV/AIDS;

Considering that the WHO "3 by 5" strategy, launched in 2003, which focused on expanding access to antiretroviral treatment, was developed in the context of the Global Health Sector Strategy for HIV/AIDS (2003–2007), endorsed by the Fifty-sixth World Health Assembly (resolution WHA56.30);

Recalling that in 2006 the United Nations General Assembly adopted the target of universal access to HIV prevention, treatment and care by 2010, and that WHO developed the Universal Access Plan 2006–2010, welcomed by the Fifty-ninth World Health Assembly, which has guided WHO's work since then;

Taking account of the Joint United Nations Programme on HIV/AIDS (UNAIDS) HIV/AIDS Strategy for 2011–2015, the Global Health Sector Strategy for HIV/AIDS 2011–2015 and the European Commission Communication on combating HIV/AIDS in the European Union and neighbouring countries 2009–2013;

Recalling its resolution on scaling up the response to HIV/AIDS in the European Region (EUR/RC52/R9);

Acknowledging Member States' existing commitments to the 2004 Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia and to achieving the Millennium Development Goals;

Concerned that HIV remains an increasingly serious public health challenge in the WHO European Region, with (in its eastern part) the fastest growing epidemic in the world;

Recognizing that HIV in Europe disproportionately affects key populations (people who inject drugs and their sexual partners, men who have sex with men, transgender people, sex workers, prisoners and migrants) who are socially marginalized and whose behaviour is socially stigmatized or illegal;

Concerned that key populations most at risk of HIV face structural barriers to accessing HIV prevention, treatment and care services, which further widens social inequalities, and that access to life-saving antiretroviral therapy in low- and middle-income countries of the Region is among the poorest globally;

Recognizing that HIV impacts the control and health outcomes of other communicable diseases, particularly tuberculosis, and that HIV poses a considerable resource burden on health systems;

Acknowledging the over-dependence on external international funding for HIV programmes in some parts of the Region;

Acknowledging that all countries in the Region can seize opportunities for action by using existing evidence and experience derived from successful projects and interventions implemented throughout the Region;

1. ADOPTS the European Action Plan for HIV/AIDS 2012–2015 as a plan for the European Region for the implementation of the Global Health Sector Strategy for HIV/AIDS 2011–2015 and the UNAIDS 2011–2015 strategy as adopted by the UNAIDS Programme Coordinating Board (PCB) as well as the resolutions adopted at the World Health Assembly as call for urgent action to the Member States in the European Region to respond to the public health challenge of HIV/AIDS in Europe;
2. RECOMMENDS Member States:²⁰
 - (a) to reinforce their political commitment and ensure the financial and human resources required to achieve the European goals of halting and beginning to reverse the spread of HIV and achieving universal, equitable access to comprehensive HIV prevention, treatment and care by 2015, in line with Millennium Development Goal 6 and linked with other health-related goals (MDGs 3, 4, 5 and 8);
 - (b) to ensure that prevention programmes target key populations at higher HIV risk and include a comprehensive harm reduction package of interventions for people who inject drugs and interventions to reduce sexual transmission of HIV in sex workers and men who have sex with men;
 - (c) to further develop integration and linkage of HIV programmes with other health programmes, particularly those on tuberculosis, drug dependence, sexual and reproductive health, maternal, child and adolescent health, viral hepatitis and noncommunicable and chronic diseases;
 - (d) to increase efforts to strengthen health systems to benefit HIV and the broader public health response, including strong HIV strategic information systems, delivery of services that meet patients' and clients' needs and uninterrupted quality-assured supply of affordable HIV medicines, diagnostics and other commodities;
 - (e) to take any necessary action on laws and regulations that present obstacles to effective HIV prevention, treatment and care, and support, and to strengthen the implementation of protective laws and regulations, including those addressing stigma and discrimination, in line with principles of public health and human rights;
 - (f) to engage in partnerships, public and private, using a multisectoral approach and to increase the participation of people living with HIV, key populations and civil society actors in policy development, decision-making and coordination, service delivery, and monitoring and evaluation of national HIV strategies and plans;
3. REQUESTS the Regional Director:
 - (a) to actively support the implementation of the Plan in the Region by providing leadership, strategic direction and technical guidance to Member States;
 - (b) to engage in global and regional partnerships and to advocate for commitment and resources to strengthen and sustain the response to HIV;
 - (c) to identify and facilitate the exchange of best practices and experiences among Member States and to produce evidence-informed tools for an effective HIV response;
 - (d) to monitor and evaluate Member States' progress towards reaching European goals and targets through a harmonized process of data collection, reporting and analysis;
 - (e) to report back to the Regional Committee at its sixty-fourth and sixty-sixth sessions in 2014 and 2016 on the implementation of the European Action Plan for HIV/AIDS 2012–2015.

²⁰ And, where applicable, regional economic integration organizations

EUR/RC61/R9. Report of the Eighteenth Standing Committee of the Regional Committee

The Regional Committee,

Having reviewed the report of the Eighteenth Standing Committee of the Regional Committee (documents EUR/RC61/4 and EUR/RC61/4 Add.1);

Recalling its resolution EUR/RC60/R3 concerning governance of the WHO Regional Office for Europe;

Recalling further that some elements of governance were delegated by it for further study by the Eighteenth Standing Committee, notably issues concerning linkages between the Standing Committee and the Regional Committee;

1. THANKS the Chairperson and the members of the Standing Committee for their work on behalf of the Regional Committee;
2. ADOPTS the amendments to the Rules of Procedure of the Regional Committee and Standing Committee of the Regional Committee contained in the annex to this resolution;
3. CALLS ON Member States to apply the full set of criteria referred to in that annex and in resolution EUR/RC60/R3 when nominating candidates to serve on the WHO Executive Board and on the Standing Committee;
4. INVITES the Standing Committee to pursue its work on the basis of the discussions held and resolutions adopted by the Regional Committee at its sixty-first session;
5. 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 sixty-first session, as recorded in the report of the session.

Annex. Proposed changes to the Rules of Procedure of the Regional Committee and the Standing Committee

Regional Committee

Rule 14.2.2 (b)

"The Officers of the Standing Committee, in consultation with the Executive President of the Regional Committee, shall seek consensus among Member States submitting nominations. In so doing the Standing Committee shall seek to achieve the criteria enumerated in Rule 14.2.1, as well as the additional criteria for subregional grouping of Member States and experience and areas of competence of candidates as decided by the Regional Committee.²¹ Member States having submitted nominations may ..."

Rule 14.2.2 (c), fifth line

"... which, in the Standing Committee's opinion, would best meet – if elected – the criteria enumerated in Rule 14.2.1, as well as the additional criteria for subregional grouping of Member States and experience and areas of competence of candidates as decided by the Regional Committee.²² The Standing Committee ..."

²¹ Resolution EUR/RC60/R3

²² Resolution EUR/RC60/R3

Standing Committee

Rule 9, first line

As specified in Rule 14.2.4 of the Regional Committee's Rules of Procedure, the Deputy Executive President of the Regional Committee shall be ex officio the Chairperson of the Standing Committee:

Rule 9, third line

"The Standing Committee itself shall elect a Vice-Chairperson from among its members each year at its first scheduled session. For the purposes of continuity, strengthened governance and better linkages between the Regional Committee and the Standing Committee, the Vice-Chairperson of the Standing Committee will normally, unless the Regional Committee decides otherwise, be elected Deputy Executive President of the Regional Committee at the session of the Committee held in the year following his/her election. At such time, he/she will also – in accordance with Rule 14.2.4 of the Rules of Procedure of the Regional Committee – become ex officio the Chairperson of the Standing Committee."

The rest of Rule 9, starting on the fourth line with "These officers ..." could then become a new Rule 9bis.

EUR/RC61/R10. Date and place of regular sessions of the Regional Committee in 2012–2015

The Regional Committee,

Recalling its resolution EUR/RC60/R10 adopted at its sixtieth session;

1. RECONFIRMS that the sixty-second session shall be held in Malta from 10 to 13 September 2012;
2. RECONFIRMS that the sixty-third session shall be held in Portugal from 16 to 19 September 2013;
3. DECIDES that the sixty-fourth session shall be held in Copenhagen from 15 to 18 September 2014;
4. FURTHER DECIDES that the sixty-fifth session shall be held from 14 to 17 September 2015, exact location to be decided.

Annex 1 Agenda

1. Opening of the session

- Election of the President, the Executive President, the Deputy Executive President and the Rapporteur
- Adoption of the provisional agenda and programme

2. Address by the Director-General

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

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

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

6. Policy and technical topics

- Developing the new European policy for health – Health 2020
 - Governance of health in the 21st century
 - The health divide: European experiences in addressing the social determinants of health
- Health systems strengthening in the WHO European Region
 - Interim report on implementation of the Tallinn Charter and the way forward
 - Strengthening public health capacities and services in Europe: a framework for action
- Action plan for implementation of the European strategy for the prevention and control of noncommunicable diseases 2012–2016
 - Endorsement of the European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families
- European action plan to reduce the harmful use of alcohol 2012–2020
- European strategic action plan on antibiotic resistance
- Action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015
- European action plan for HIV/AIDS 2012–2015
- Strategic coherence of the work of the WHO Regional Office for Europe

- The Regional Office's country strategy
- Policy on the WHO Regional Office for Europe's Geographically Dispersed Offices (GDOs) and the European Observatory on Health Systems and Policies

7. Private meeting: elections and nominations

- (a) Nomination of four members of the Executive Board
- (b) Election of three members of the SCRC
- (c) Election of a member of the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction
- (d) Award: the Jo Asvall Public Health Research Fellowship

8. WHO reform for a healthy future

- The programme budget as a strategic tool for accountability

9. Partnerships

10. Confirmation of dates and places of regular sessions of the Regional Committee in 2012–2015

11. Other matters

12. Approval of the report and closure of the session

Ministerial lunches

Governance for health in the 21st century

Social determinants of health

Progress made towards attaining the Millennium Development Goals in the WHO European Region

Decade of Vaccines

Technical briefings

Health 2020 – Targets for health

WHO reform for a healthy future

Annex 2

List of documents

Working documents

EUR/RC61/1 Rev.1	Provisional list of documents
EUR/RC61/2 Rev.1	Provisional agenda
EUR/RC61/3 Rev.1	Provisional programme
EUR/RC61/4	Report of the Eighteenth Standing Committee of the WHO Regional Committee for Europe
EUR/RC61/4 Add.1	Eighteenth Standing Committee of the WHO Regional Committee for Europe: Report of the fifth session
EUR/RC61/5	Report of the Regional Director on the work of WHO in the European Region, 2010–2011
EUR/RC61/6	Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC61/7	Membership of WHO bodies and committees
EUR/RC61/7 Corr.1	Membership of WHO bodies and committees
EUR/RC61/7 Corr.2	Membership of WHO bodies and committees
EUR/RC61/8 Rev.2	Overview of issues to be considered at the sixty-first session of the WHO Regional Committee for Europe
EUR/RC61/9	The new European policy for health – Health 2020: Vision, values, main directions and approaches
EUR/RC61/10	Strengthening public health capacities and services in Europe: a framework for action
EUR/RC61/11	Summary interim report on implementation of the Tallinn Charter
EUR/RC61/12	Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016
EUR/RC61/13	European action plan to reduce the harmful use of alcohol 2012–2020
EUR/RC61/14	European strategic action plan on antibiotic resistance
EUR/RC61/15	Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015
EUR/RC61/16	Coherence of the Regional Office's structures and functions
EUR/RC61/17 Rev.1	A country strategy for the WHO Regional Office for Europe

EUR/RC61/18	Strengthening the role of the Regional Office's geographically dispersed offices (GDOs): a renewed GDO strategy for Europe
EUR/RC61/19	Summary of the European action plan for HIV/AIDS 2012–2015
EUR/RC61/20	Governance issues related to the European Observatory on Health Systems and Policies
EUR/RC61/21	WHO reform for a healthy future

Conference documents

EUR/RC61/Conf.Doc./1	Report of the Eighteenth Standing Committee of the Regional Committee
EUR/RC61/Conf.Doc./2 Rev.1	The new European policy for health – Health 2020: Vision, values, main directions and approaches
EUR/RC61/Conf.Doc./3 Rev.2	Strengthening public health capacities and services in Europe: a framework for action
EUR/RC61/Conf.Doc./4	Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016
EUR/RC61/Conf.Doc./5	WHO European Declaration and Action Plan on Children and Young People with Intellectual Disabilities and their Families
EUR/RC61/Conf.Doc./6	European action plan to reduce the harmful use of alcohol 2012–2020
EUR/RC61/Conf.Doc./7	European strategic action plan on antibiotic resistance
EUR/RC61/Conf.Doc./8	Multidrug- and extensively drug-resistant tuberculosis in the WHO European Region
EUR/RC61/Conf.Doc./9	A country strategy for the WHO Regional Office for Europe
EUR/RC61/Conf.Doc./10	Strengthening the role of the Regional Office's geographically dispersed offices (GDOs): a renewed GDO strategy for Europe
EUR/RC61/Conf.Doc./11	European action plan for HIV/AIDS 2012–2015
EUR/RC61/Conf.Doc./12	Date and place of regular sessions of the Regional Committee in 2012–2015

Information documents

EUR/RC61/Inf.Doc./1	Developing a framework for action for strengthening public health capacities and services in Europe
EUR/RC61/Inf.Doc./2	Interim report on implementation of the Tallinn Charter
EUR/RC61/Inf.Doc./3	Roadmap for the implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011–2015
EUR/RC61/Inf.Doc./4	The new European policy for health – Health 2020
EUR/RC61/Inf.Doc./5	Interim second report on social determinants of health and the health divide in the WHO European Region
EUR/RC61/Inf.Doc./6	Governance for health in the 21st century: a study conducted for the WHO Regional Office for Europe

EUR/RC61/Inf.Doc./7	Setting targets for Health 2020
EUR/RC61/Inf.Doc./8	European Action Plan for HIV/AIDS 2012–2015
EUR/RC61/Inf.Doc./9	Health systems for better health: the WHO/Europe package of support for health systems strengthening
EUR/RC61/Inf.Doc./10	Programme budget as a strategic tool for accountability
EUR/RC61/Inf.Doc./11	The Rome Office of the WHO European Centre for Environment and Health (1991–2011): 20 years of experience
EUR/RC61/Inf.Doc./12	Consolidation of WHO/Europe's environment and health programmes

Technical briefings

EUR/RC61/TD/1	Technical discussion on developing the new European policy for health – setting targets for Health 2020
EUR/RC61/TD/2	Technical discussion on WHO reform for a healthy future

Background documents

EUR/RC61/BD/1	Report of the Working Group to Review Strategic Relations with Countries
EUR/RC61/BD/2	Report on the review of geographically dispersed offices
EUR/RC61/BD/3	Review of the European Observatory on Health Systems and Policies in Brussels

Annex 3

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Annex 4

Address by the Regional Director

Mr President, Mr Executive President, dear Director-General, dear friends, ladies and gentlemen,

I warmly welcome you to this session of the WHO Regional Committee for Europe and would like to express our determination to continue our work for better health and well-being and a fairer distribution of health in the WHO European Region that we jointly decided at last year's session in Moscow, Russian Federation. Although life expectancy in our Region has continuously improved over the last 20 years, we have to continue this trend and reduce inequalities. With the present level of knowledge and evidence, we can do more and we can achieve better results.

Now let me briefly describe our collective achievements and plans, as well as some of the most pressing challenges and the opportunities we have for overcoming them. I will spend less time on achievements and successes, which are described in detail in my report, and would like to concentrate more on the remaining challenges.

Before doing so, however, let me express our deep condolences to Norway for the tragic events during the summer and for the loss of innocent lives. Our hearts go out to those who lost their lives and to their families. In WHO, we have lost three dear colleagues in a cowardly attack on the United Nations office in Abuja, Nigeria. Our sympathy also goes to those who lost their lives or were injured in other emergencies in the Region.

First I would like to focus on the health threats in our Region that we have successfully tackled since the Regional Committee last year, beginning with emergencies, public health crises and major communicable diseases.

Everyone in this room knows that, when an emergency strikes, citizens demand the most rapid and effective response possible from their health authorities. In events like this, countries can always count on support from WHO.

As proven during the North Africa crisis, the issue of migration and health is an evolving priority. Italy therefore organized a ministerial meeting in Rome in April, to coordinate efforts for refugees from North Africa. The draft action plan I presented during that meeting was finalized immediately afterwards; implementation began right away, and will continue, hopefully leading to a long-term programme on migration and health in the Regional Office.

Emergencies do not happen only in Member States. During the past year, the Regional Office experienced emergencies on its premises. Since the flood right before the 2010 Regional Committee, we have experienced two more floods in July and August this year. It was a difficult summer for us.

The Emergency Steering Committee, chaired by me, took immediate measures to ensure the safety of staff, the continuity of the work, cleaning of the premises and reopening of the Office as soon as possible. At the same time, we interacted with the Danish Government to seek short-, medium- and long-term solutions.

I would like to thank the Regional Office's staff for their dedicated work in difficult times, and the Danish authorities for taking immediate short-term action and making long-term plans with us to avert floods in the future. We are looking forward to the full implementation of this plan by 1 October this year.

The Regional Office does all its emergency-related work within the framework of the International Health Regulations (IHR). We continuously monitor potential events of public health concern in the Region. During 2010–2011, we followed up with Member States 3–4 events every week, which shows that Europe needs to continue to be vigilant and emphasizes the importance

and urgency of the full implementation of IHR in our Region. One of our continued priorities is to support Member States in developing and strengthening their IHR core capacities by the deadline of June 2012, in partnership with the European Union (EU) and other institutions and agencies.

Last year I stood before you and reported on the unfortunate outbreak of wild poliovirus in Tajikistan, which affected three other countries – Kazakhstan, the Russian Federation and Turkmenistan – causing paralysis in 475 people and 30 deaths. Since then, countries have done great work, supported by us and other partners. The last reported case was at the end of September 2010, and 45 million doses of oral polio vaccine were administered through very successful synchronized campaigns in the affected countries and their neighbours. Under the leadership of WHO, strongly supported by the United Nations Children's Fund (UNICEF) and other global partners, we were able to mobilize more than US\$ 9 million for this effort.

In addition, I am delighted to inform you that the European Regional Certification Commission for Poliomyelitis Eradication confirmed the polio-free status of our Region, but cautioned that the risk of transmission if wild poliovirus is introduced remains high in nine Member States. I hope you will look at the map in the lobby to see the status of your countries, as we have to be vigilant and sustain our efforts until global polio eradication is achieved. Thanks to the ministers in affected and neighbouring countries for their fantastic leadership and great collaboration!

Similarly, all your commitment and leadership are needed to address the large measles outbreaks in the Region, and we need to scale up efforts to reach the targets for measles and rubella elimination set by the Regional Committee last year. The highly successful European Immunization Week, in which 52 Member States took part this year, is an instrument in these efforts. Azerbaijan has made great achievements in this regard.

I now turn to three additional alarming problems and one success story in our Region. Our Region has historically been in the forefront of tuberculosis prevention and control, but now faces an alarming problem: multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB). In response, I established a special project to prevent and combat M/XDR-TB in the Region, which also pays special attention to the previously neglected childhood TB. To scale up activities and ensure a comprehensive response to prevent and control M/XDR-TB, a Consolidated Action Plan for 2011–2015 is being submitted for endorsement by the Regional Committee.

Europe is the first WHO region to establish a Green Light Committee at the regional level (on 1 July and it is operational) to oversee the efforts and assist Member States in developing and implementing national plans to address MDR-TB. The Regional Office works closely with all partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Stop TB Partnership and EU institutions. As the Consolidated Action Plan was developed with our partners and Member States, we will implement it jointly, working hand in hand with Member States.

Another alarming phenomenon is that the number of people living with HIV has tripled in eastern European and central Asian countries since 2000. HIV affects most seriously the populations that are socially marginalized and whose behaviour is socially stigmatized or illegal. Those key populations face structural barriers in access to HIV services and evidence-based strategies are not fully implemented in all Member States. As a result, although antiretroviral therapy (ART) has proved to be important in preventing HIV transmission, access to ART in eastern Europe and central Asia is unfortunately among the lowest globally. According to recent research, ART is 96% effective in reducing heterosexual transmission in couples where one partner has HIV. This further demonstrates the need to scale up access to ART and increase early HIV diagnosis and treatment.

To address this situation, on Thursday the Regional Committee will be presented with the European Action Plan for HIV/AIDS 2012–2015; its aims for the Region are to halt and reverse the spread of HIV, and achieve universal access to HIV prevention, diagnosis, treatment and care by 2015.

Another growing health threat – antimicrobial resistance – was the focus of World Health Day 2011. On this occasion, we supported a number of key activities across the European Region, such as the main launch event in Moscow, and other launch events in Copenhagen, Strasbourg, Rome, Kyiv and London. We also published a book on antibiotic resistance from a food safety perspective.

The problem is huge and driven by complex factors, including misuse of antibiotics (not only in humans but also in the agriculture sector), weak regulations and lack of awareness in many countries. Unfortunately there are no new drugs in the pipeline, and we do not want to lose our powerful weapon to against infectious diseases.

The Regional Office therefore developed a European strategic action plan on antibiotic resistance, which will be presented to you on Thursday. This builds on WHO's work for and before World Health Day 2011, and the excellent work done by the EU.

And here is the success story. Extraordinary progress towards malaria elimination has been made across the WHO European Region, and now we are on course to meet the goal of the Tashkent Declaration: eliminating malaria by 2015. In 2010, only 5 countries in the Region reported only 176 locally acquired cases of malaria. WHO certified Turkmenistan as malaria free last year; we hope Armenia will be certified by the end of 2011, and experts are optimistic that malaria transmission was interrupted in Georgia in 2010. I would like to acknowledge the achievements of our host country, Azerbaijan, in working towards the elimination of malaria.

Let me now turn to the major burden of disease in the Region, "the silent killers" spreading via the evolution of culture and environments and policies that facilitate unhealthy behaviour.

As you know, the burden of noncommunicable diseases (NCDs) is the predominant public health challenge in each of your countries. Among the six WHO regions, Europe and the Americas share the dubious honour of having the highest proportion of deaths from NCDs and injuries. Further, Europe is leading in nearly all risk factors.

Nevertheless, Europe has also been a leader in prevention and health promotion, and we have experience that suggests that we can achieve measurable improvements in the period covered by the action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016, which will be submitted to you at this Regional Committee session. The action plan builds on evidence accumulating across the world that the burden of NCDs is not a chronic burden at population level, and many countries and trials have shown quick results, including the rapid fall in deaths from ischaemic heart diseases in many European countries in the last two decades.

The year since the 2010 session of the Regional Committee has been an extraordinary year of immense progress against NCDs, globally and in Europe. The regional consultation in Oslo, Norway brought forth vigorous debate but also a deep consensus on the global priority to be accorded to NCDs; this constitutes the Region's input into the United Nations high-level meeting on NCDs to be held next week. European leadership was also strongly apparent in the formulation of the Moscow Declaration at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, which contains a commitment to action that is very much the foundation of our European action plan.

A concrete action plan is being proposed to implement the European Strategy for the Prevention and Control of Noncommunicable Diseases, which was approved unanimously in 2006. Its aim is to make a measurable impact on the epidemic and its determinants in our Region. This will be discussed on Wednesday. The action plan will be fully coherent with the outcome statement of the United Nations meeting, with one difference: target setting has been dropped and we will drop it, too.

I believe we could build on the proud traditions and experiences of our Region and – with the recent endorsement of the Moscow Declaration by the World Health Assembly, the launch of the *Global status report on noncommunicable diseases 2010* in April and the United Nations high-level meeting – the stage is set for a strong implementation of the European action plan, which I hope the Regional Committee will adopt.

In addition, mental health is high on our list of priorities and next year we will bring this topic to the Regional Committee's attention. The Regional Office's Athens centre on NCDs, which is hosted by the Greek Government and will be launched this month, will provide additional capacity to this important area of work. I thank the Greek Government for its commitment and support.

I will now highlight the exposure to health determinants that lead to the appearance or prevention of disease. The burden of NCDs arises from a complex but well-understood sequence of causation with multiple points of intervention. The four diseases and their biological risk factors on which we focus arise from a modifiable set of behaviours that are socially determined and, within larger globalized trends, increased urbanization and the ageing of the population.

Our solutions, both regional and national, cannot therefore focus on only one point of entry to this network of causes. We need to alleviate the consequences of the four diseases, especially among disadvantaged groups. We must influence behaviour and risk factors, and we must act on the social and environmental determinants of NCDs, as with our work on the new European health policy. The WHO Regional Office for Europe has always been strong on addressing these determinants, playing a leading role in Europe through its offices in Venice, Rome, Bonn and now Athens.

Our overall goal must be to create an intersectoral policy environment in which the healthy choice is the easy choice, as said in the Ottawa Charter for Health Promotion, and in line with the health-in-all-policies approach promoted so robustly under the Finnish Presidency of the EU, to which we are fully committed.

Good progress in tobacco control was made in our Region in 2010–2011, with many countries acceding to the WHO Framework Convention on Tobacco Control (FCTC) and making strong smoke-free policies. It is an honour for our Region that the WHO Director-General gave her special recognition award to the Prime Minister of Greece for his leadership in tobacco control through a whole-of-government approach very strongly supported by the Minister of Health and Social Solidarity, Mr Loverdos.

And there is one determinant for which now is the time to make much more progress, and this is alcohol. We need a renewed commitment to address the harmful use of alcohol, which is the second most important risk factor for deaths and disability in our Region, just after tobacco use. The Regional Office's *European status report on alcohol and health 2010* (published in January 2011) gives clear evidence for this. This is why the European action plan to reduce the harmful use of alcohol 2012–2020, which is fully compatible with the global strategy and the World Health Assembly resolution, has been put forward. The action plan proposes many evidence-based options for action as a menu for you to choose from. The main areas for policy interventions in both the alcohol and NCD action plans are intersectoral in nature and include some regulatory issues.

The Fifth Ministerial Conference on Environment and Health, held in Parma, Italy, gave new impetus to the Regional Office's activities in this important area and strengthened the governance of the European environment and health process, building on the excellent long-standing collaboration between the two sectors. This led to the establishment of the European Environment and Health Ministerial Board, which met for the first time in Paris, France in May 2011, and agreed on how to monitor progress in achieving the commitments and targets endorsed by the Parma Declaration. This will be followed by the meeting of the European Environment and Health Task Force – bringing together national counterparts, stakeholders and partners, who are steering implementation of the Parma commitments at the national level – which will be hosted by Slovenia in October.

With other United Nations agencies, the Regional Office is participating in the development of the European regional report on sustainable development for the United Nations Conference on Sustainable Development, to be held in Rio de Janeiro, Brazil in 2012; our Office is leading, in cooperation with partners, the joint writing of a chapter on the social and health dimensions.

A major review of the Regional Office's work on environment and health took place, prompted by the necessity to close the Rome Office by the end of 2011, owing to a change in priorities of the Italian Government. I would like to take this opportunity to emphasize the important role the Rome Office played and its contribution to 20 years of the environment and health process, and to thank the Italian Government for its generous support to the centre over the past two decades.

An agreement with the German Government will enable the expansion of the Bonn Office, consolidating the environment and health programmes in Bonn by January 2012, supported by a small core presence in Copenhagen. I thank the German Government for its support.

Significant progress is being made towards achieving the health-related Millennium Development Goals (MDGs) in certain areas. As progress in the European Region varies significantly, however, I have made them a cross-Office priority and appointed a special representative for them.

WHO is the leading agency in the United Nations interagency working group on tackling inequities in progress towards the health-related MDGs, to agree on a coherent and coordinated approach by the United Nations system. A first draft of the group's report is available as an information document for your comments at this Regional Committee session. In addition, we have been privileged to work with the First Lady of Georgia, Ms Sandra Roelofs, after her appointment as WHO Goodwill Ambassador in the European Region for the health-related MDGs.

Now I would like to concentrate on health systems – including the public health dimension, which has been revitalized in our work.

The full implementation of the Tallinn Charter: Health Systems for Health and Wealth is a priority and will go hand in hand with the new European health policy, Health 2020. The two reinforce each other: under the influence of Health 2020, work to strengthen health systems has focused more on health outcomes, and Health 2020 will take a great step further, rejuvenating public health and governance.

An interim report on the Charter's implementation is on the agenda of the Regional Committee for Tuesday. Exchanges with Member States have confirmed that the Tallinn Charter had led to a more vigorous policy dialogue on preserving, reforming and investing in health systems and that countries were putting its values and policy objectives into practice.

As mentioned, we are developing a new approach that focuses on health systems for health outcomes by, for example, applying the health systems approach, or systems thinking, to diseases and conditions such as NCDs, M/XDR-TB, etc. This fresh health systems and public health approach comes from 15 years of generic work to strengthen health systems, putting the building blocks in place to ensure health systems' strategic orientation towards health outcomes. This approach requires putting service delivery in the centre, on three pillars:

1. starting with expected health outcomes and priorities;
2. then focusing on optimal service delivery strategies, in which the content comes from technical areas; and
3. identifying barriers that prevent health systems from providing effective services, which can be grouped under the headings of service delivery, governance, financing and resources.

We are also developing a consolidated package of strategies and services in health system strengthening, which includes the tools and instruments to assist Member States now and in the future; this is available to the Regional Committee as an information document.

The European and global health contexts have changed. The financial crisis calls on us all to scrutinize health expenditures, and the rise in NCDs, coupled with other challenges, highlights once again the need for comprehensive system responses. Against this background, national health policy frameworks with system-wide analysis become more important than ever. This is a project led by the Global Policy Group, and is a priority.

For the most efficient use of scarce resources, it is vital that preventive measures take a more prominent role, public health functions be strengthened and the health-in-all-policies approach promoted and advanced. These are also core elements of our new European health policy, Health 2020. As you will have seen, there is evidence that prevention can bring more immediate returns than previously thought. I have commissioned a study on the economics of prevention by the Observatory, supported by the Regional Office's Chief Scientist.

Public health services are a priority for us because they are essential in protecting and promoting health and preventing disease, and perhaps the most efficient and economic way to improve the health of the whole population. I therefore decided to reposition public health services as an essential component of the health systems approach, and a framework for action complementary to Health 2020 will be presented to you on Tuesday for a first discussion. We plan to present the final result to the Regional Committee next year.

I invite countries in our Region to join in assessing their essential public health operations, functions and capacities, using the tool developed for this purpose. This is needed to provide evidence that will form the basis of the action plan to strengthen public health capacities and services in Europe, which will be presented to you at the 2012 session of the Regional Committee in Malta, hand in hand with the final version of Health 2020.

As another step towards strengthening public health, I am very pleased to inform you that the Kazakhstan School of Public Health has fulfilled its pledge to the Regional Committee in 2010 and has set up an annual scholarship in public health. I am also pleased to report that *Jo Eirik Asvall's memorial guide* has truly been a best seller.

I consider the assessment of health systems' performance an increasingly used and critical tool for health governance in the 21st century, and we call on all Member States to do their own performance assessment to ensure a country-owned and participatory process. This is because such assessments underlie and support national strategies, and improved health outcomes and equity are mainstreamed in the assessment process and the report.

Supporting Member States to move towards universal coverage and sustain it in the face of fiscal pressures has been at the heart of the Regional Office's work on health financing; landmark publications brought this topic into the limelight in 2010–2011, such as *Implementing health financing reform: lessons from countries in transition* and the report on sustaining equity, solidarity and health gain

in the context of the financial crisis. In addition, the WHO Regional Office for Europe contributed to the development of *The world health report 2010 – Health systems financing: the path to universal coverage*. Our efforts in 2011 continued with preparation of an action plan to follow the 2010 world health report, which will guide our work on health financing in the next biennium.

The renewed emphasis on universal coverage helped countries focus on minimizing the adverse effects of fiscal austerity measures on health and health systems. For example, the Regional Office has worked closely with Estonia, Ireland and Latvia. In this regard, I am proud to mention that the first WHO Barcelona course on health financing was held in 2011, with universal coverage as a special theme. In addition, the Regional Office continued courses for the Baltic countries and Poland, central Asia, the Caucasus and the Republic of Moldova. All these courses had extensive participation by policy-makers from across the Region, who expressed a high level of satisfaction and appreciation of the strong links to country work.

The penultimate strategic direction covered in my report deals with health information and communication. The Regional Office has made much progress in health information in 2010–2011; this is crucial as it provides the underlying evidence for our work in all areas. I invite you to the daily demonstrations taking place in the foyer during the breaks.

We are working with all our partners, including the EU, to develop a common health information system and a health information strategy for Europe will be on the Regional Committee agenda in 2012. Similarly, we have also worked on communication, using many new tools such as social media, which leads to more effective communication.

In this final part of my address to you, I would like to first emphasize the overarching priority, Health 2020. Then I will briefly mention our new organizational structure and strategic partnerships, and finally touch upon governance and financing, which are aligned with the WHO reform process.

We have done substantial work on the overarching European health policy initiative, Health 2020, which we will discuss later today and tomorrow. As many of you remember, Europe has had a European health policy since 1982, when the Regional Committee approved the Health for All strategy. Then 38 targets were adopted in 1984.

Following two updates in 1991 and 1998, the 2005 Regional Committee, in resolution EUR/RC55/R4, approved a further update and requested a report on the Health for All policy framework in 2008. In addition, you requested me last year to make a report by 2012, and do this work through a truly participatory two-year process. That is what we have been doing.

I am very pleased to report to you that your request and decision have struck a chord across Europe. I believe we have started a movement that will take us not only to 2012 but also far beyond. This feeling comes from the feedback that has been personally communicated to me at many countries' conferences: that such a policy is very timely, long overdue, just what people are looking for and what is needed to help them in what they do. It is this feedback that perhaps should be the most gratifying to the Regional Committee, as it shows that what you decided last year is indeed both useful and historic.

In 2010–2011, the Regional Office worked to strengthen itself by concentrating core policy, strategic and technical functions in the office in Copenhagen, fully streamlining and integrating the geographically dispersed offices (GDOs) and integrating the work of country offices. To support decision-making about the better integration of the GDOs and country offices in the Regional Office, I set up two groups of external experts to conduct independent reviews of each. Both reported their findings in November 2010. Intensive collaboration with all countries continued, and remains an outstanding priority.

The Regional Office conducted an in-depth analysis of its core functions and completed its reorganization, aligning its structures and human resources with its new priorities. Staff were recruited (or seconded) to fill mission-critical senior technical positions. Financial uncertainties have not helped (as I am sure you have also found), and I am grateful to all Member States that have supported us despite their own difficulties. In addition, we established an internal committee to foster an enabling working environment; it made recommendations that were approved and are now being followed.

Networks – of, for example, WHO collaborating centres and national institutes and schools of public health – are excellent vehicles for public health, and are being renewed and revitalized. This is work for the upcoming months.

The WHO Director-General, Dr Chan, asked me to take on a global function on relations with the EU and to chair the WHO steering committee on this topic. As in 2010, the Regional Office continues to establish and strengthen close collaboration with countries

holding the EU presidency, both before and during their terms, for coherence and synergy; we worked with Spain and Belgium in 2010, Hungary and Poland in 2011 and have begun work with Denmark and Cyprus for 2012.

The ninth meeting of senior officials of WHO and the European Commission took place in March 2011, with the Director-General and three regional directors attending. After a very productive discussion, full agreement was reached on six roadmaps for the strategic priorities for collaboration. In addition, the Regional Office has renewed the memorandum of understanding with the European Centre for Disease Prevention and Control (ECDC). We also took action for enhanced collaboration with the World Bank, the Global Fund and the Organisation for Economic Co-operation and Development (OECD), and joined the United Nations regional development team.

There have been great improvements in relations with other United Nations agencies, ensuring coherence and coordination. Within WHO, the Regional Office hosted the meeting of regional directors' teams in Copenhagen in March 2011. We have also improved our collaboration with associations and forums.

We are now developing a strategy on partnerships to be submitted to the Regional Committee in 2012, in line with WHO reform. Also in line with WHO reform, we have focused on improving governance functions within WHO. This included strengthening the Region's governing bodies: referring European policies, strategies and action plans for decision to the WHO Regional Committee for Europe, making the programme more participatory for representatives and adding such events as ministerial days.

To improve oversight and transparency, membership of the Standing Committee of the Regional Committee (SCRC) was increased from 9 to 12 countries in 2010. All Member States were invited to attend the fourth session of the SCRC. A meeting of European delegations preceded the Sixty-fourth World Health Assembly in May 2011, and daily coordination meetings are held with European Member States during the Health Assembly and meetings of the Executive Board, to strengthen the links between the global and regional governing mechanisms. It is quite important that all the 53 Member States attend these, as was discussed with health ministers during the pre-meeting for this session of the Regional Committee.

Finally, a few words about financing: based on our current income of US\$ 228 million, as of August 2011, it is expected that, by the end of the 2010–2011 biennium, our income will be comparable to that in previous biennia. As to income/expenditure per strategic objective for 2010–2011, the Regional Office has a solid macro financial situation for all strategic objectives except 12 and 13. During the biennium, however, we faced critical financial gaps for nearly all strategic objectives. This was due to the high level of earmarking, which continues to be an issue both globally and in the European Region. We have overcome this problem through regular progress reports, scrutiny of awards and follow-up by executive management. Nevertheless, the high level of earmarking – often without proper provision for paying salaries and enabling the managerial and administrative support needed for technical work and country offices – will cause numerous challenges in the next biennium.

As shown by the distribution of funds mobilized by WHO headquarters among the regions, the WHO Regional Office for Europe receives the lowest amount of corporate resources in WHO, so its self-reliance is highest. This issue needs further discussion, for which the reform process offers a good opportunity; Member States say that they do not want to pay WHO twice – and they are right.

To support our efforts to mobilize the resources required to support our Member States, the Regional Office developed advocacy papers for each of WHO's strategic objectives. These papers specify the actions we will take if we receive the necessary funds, and I call for your continued support, including from new donor countries.

Your continuous support for our work is much appreciated and welcomed, and I look forward to excellent discussions during this Regional Committee session. Thank you.

Annex 5

Address by the Director-General

Mr Chairman, excellencies, honourable ministers, distinguished delegates, Ms Jakab, ladies and gentlemen,

Let me take the opportunity once again to begin by thanking the Government of the Republic of Azerbaijan for acting as such a gracious and accommodating host for this session.

I officially visited this country in 2008. I was personally very impressed, and still am, by the warmth of its people, the richness of its cultural heritage, and the strong commitment of its government to health development, and can see the great progress this country has made in the past five years.

As the country's Prime Minister told me during that visit and others, the responsibility for creating a healthy society extends well beyond the actions of the health sector.

A government that spreads a country's wealth among its people is the best possible. Your investment in health care is impressive, but don't forget the importance of primary health care and noncommunicable diseases. Your Government's interministerial approach to health development, with leadership in different sectors, complements the overall drive for better health.

Ladies and gentlemen,

Why is the Regional Committee session so important? Despite the diversity of items being considered during this session, I believe I can make three general observations about your agenda and supporting documents.

First, your agenda is ambitious and courageous. I might even say daring, especially at a time when many countries in this Region face severe financial constraints.

With work towards the Health 2020 policy, you are aiming at nothing less than a rejuvenation of the public health agenda in the European Region.

You are aiming to rejuvenate the capacity of this Regional Office to support ministries of health as they tackle some extremely complex challenges, or to use your vocabulary, some very "wicked" problems.

You are also preparing to cope with some heavy new problems heading our way as the climate changes, the globalization of unhealthy lifestyles spreads with a stunning sweep and speed, populations age, health costs soar, and the economic downturn deepens.

Many problems currently facing this Region represent collateral damage to health caused by policies made in other sectors, or in the international systems that govern the way our highly interconnected and interdependent world works.

As we all know, these systems, whether for trade or global finance, create benefits, but the fair distribution of these benefits is almost never an explicit policy goal.

This brings me to my second observation. In line with the traditional values of this Region, you are deeply concerned about fairness and equity. But you are also deeply determined to tackle the root causes, the real reasons for today's vast and growing gaps in health outcomes, in access to care, and in opportunities to lead a better life.

Your determination to influence the social determinants of health is readily apparent throughout the agenda, but especially so in the action plans for HIV/AIDS and for combating drug-resistant forms of tuberculosis.

You plan to reach the migrants, the homeless, people marginalized by stigma and discrimination, and people with difficult lifestyles, such as alcoholics and injecting drug users.

In a complementary move, ways of improving health capacities and services, including through primary health care, are put forward as the route to greater fairness in access to care and greater efficiency in service delivery.

This must be the greatest challenge of them all: maximizing measurable and equitable health gains at a time when budgets for health, nationally and internationally, are stagnant or shrinking.

And this is my final general observation. It can be done. Your documents show how to do this with a limited number of smart, evidence-based interventions with a proven impact.

If we want to maintain the momentum for better health that marked the start of this century, health programmes must show a thirst for efficiency and an intolerance of waste. Your documents, and especially your action plans, do this admirably.

Equally important, the interim report on implementation of the Tallinn Charter tells us that ambitious commitments can indeed be operationalized, even in the current climate of financial constraints.

I agree. The Tallinn Declaration on Health Systems for Health and Wealth was a landmark achievement for health policy in the European Region and a flagship product of this Regional Office.

It was immediately put to a severe test. It was issued in 2008, if you recall, right at the time when the world abruptly shifted from an outlook of prosperity to belt-tightening austerity.

As noted, several countries turned the financial crisis into a political opportunity to shift priorities and achieve efficiency gains that reduced the adverse effects on the poor and vulnerable. At a time when public spending is critically scrutinized, efforts to sustain health system performance also produced evidence about the efficiency of that performance, demonstrating the accountable use of funds.

Let me single out this Region's Pharmaceutical Pricing and Reimbursement Information Network as a smart and powerful way to save money in one of the biggest areas of health expenditure.

As famously stated in the Tallinn Charter, "Today, it is unacceptable that people become poor as a result of ill health."

Progress in meeting the Charter's commitments maintains the truth and conviction of that statement today. This is extremely encouraging in a world beset by one global crisis after another.

Ladies and gentlemen,

I agree with the upbeat sentiment in many of your documents: countries can radically change the health situation by seizing the right opportunities for action. With evidence-based interventions and smart policy choices, it is perfectly feasible to maintain the momentum for better health.

Multisectoral collaboration, especially for the prevention and control of chronic noncommunicable diseases, is one such opportunity. In fact, many of you alluded to whole-of-government approaches, which are essential for many of those "wicked" problems you aim to address.

For example, as your action plan on alcohol makes clear, reducing the harmful use of alcohol depends on the concerted action of national authorities, traffic police, licensing officers, the criminal justice system, and safety authorities, in addition to health officials.

It further depends on support from civil society organizations, especially as such groups can exert pressure for stricter controls and compliance with measures to counter drink-driving.

But, as you have also noted, health ministries often do not have sufficient authority within the government hierarchy to initiate changes outside their own portfolios. As the Health 2020 policy takes shape, it is clear that ministries of health need more political clout.

Ironically, health ministers may be in an unprecedented position to gain this political clout because of two especially troubling trends. These are trends that command the attention of the international community and require action at the highest level of government.

The first touches the top political priorities of international stability and security. This is not health security, or human security, or epidemiological security. This is security against the threats of social unrest and state failure.

This is security against the start of conflicts that may require international intervention and always require massive humanitarian assistance. These days, this assistance can be especially difficult and dangerous to deliver.

Like the 2008 financial crisis, this year's Arab awakening took much of the world by surprise. With the advantage of hindsight, many experts and analysts view the events that started in Tunisia and Egypt as predictable.

They cite long-standing inequalities, in income levels, in opportunities, especially for youth, and in access to social services as the root cause of the struggle for change. They refer to the so-called "rising tide of expectations" that has historically fuelled protests and revolutions.

They refer to countries where the economy is steadily growing while each year more and more people fall below the poverty line. They refer to countries that have lost their middle classes.

And they conclude that greater equity must be the new political and economic imperative if we indeed strive for a stable and secure world.

Public health, which is so well-positioned to improve equity, would welcome such a change in top-level thinking.

The second trend, which you will be addressing, comes with the rise of chronic noncommunicable diseases (NCDs). Next week's high-level meeting during the United Nations General Assembly must be a wake-up call, not for public health, but for heads of state and heads of government.

These are the diseases that break the bank. A recent World Economic Forum and Harvard study estimates that, over the next 20 years, NCDs will cost the global economy more than US\$ 30 trillion, representing 48% of global gross domestic product (GDP) in 2010. Left unchecked, these costly diseases have the power to devour the benefits of economic gains, sending millions of people below the poverty line.

The health and medical professions can plead for lifestyle changes and tough tobacco regulations, treat patients and issue medical bills, but the health and medical professions cannot reengineer social environments to make healthy behaviours and choices the easy ones.

When a problem, like obesity, is so widespread throughout a population, the cause is not a failure of individual will power but a failure of political will at the highest level.

Your action plan for the prevention and control of NCDs deserves special mention. With 86% of deaths in this Region caused by this broad group of diseases, I can understand why the plan is so tough and targeted.

It has teeth, especially in its call to use fiscal policies and marketing control to full effect to influence the demand for tobacco, alcohol, and foods high in saturated fats, *trans* fats and sugar.

As noted, salt in processed foods is a major reason why daily salt intake in most countries exceeds the WHO recommendation. I fully agree: salt reduction is one of the most cost-effective and affordable public health interventions.

The approach taken in the action plan is similar to what WHO aims to do with its model lists of essential medicines. That is, rationalize the use of scarce resources in ways that bring the greatest benefits to the largest number of people. I look forward to the adoption and implementation of the action plan, and this Region will show the way.

Ladies and gentlemen,

As I said, you are rejuvenating the public health agenda for the European Region. WHO is also undergoing a rejuvenation process in its ongoing programme of reform.

Global health needs have changed considerably since WHO was established more than 60 years ago, and have evolved with exceptional speed during the first decade of this century. WHO continues to play a leading role in global health but needs to evolve in pace with these changes.

Priorities need to match urgent health needs which WHO is uniquely well-placed to address, and funding needs to align with these priorities. Budgetary discipline and changes in staffing and recruitment procedures are needed in WHO to improve efficiency, flexibility, and impact.

Stronger leadership from WHO can promote greater coherence in the actions of multiple health partners and better alignment of these actions with priorities and capacities in recipient countries.

For these reasons, I launched a consultative process in 2010 on the future of financing for WHO that will shortly culminate in a plan of reform for the Organization.

The proposed reforms are comprehensive, encompassing the technical and managerial work of WHO as well as the governance mechanisms that guide and direct this work.

The reforms are ambitious, with improved health outcomes in countries regarded as the most important measure of WHO's overall performance.

Most importantly, reforms are driven by the needs and expectations of Member States and respond to their collective guidance.

I am fully aware of the challenges, but I remain highly committed, enthusiastic, and confident that working closely with Member States, staff and partners will result in a WHO that is more efficient, transparent and accountable, stronger on areas where WHO is badly needed and sharper on priorities where WHO is uniquely effective.

Above all, the result must be a WHO well-positioned to meet the current and future challenges for improving health in a complex world.

I thank this Regional Committee for bringing greater clarity to many of these "wicked" challenges, and also for devising workable solutions. Perhaps most important, these solutions reaffirm the value system that drives the work of WHO at all three levels of this Organization.

Ladies and gentlemen,

There is one last point I need to make.

In addressing this Regional Committee, I am fully aware that I am also addressing representatives of countries that have traditionally been the most generous financial supporters of WHO. I want to thank you for all the support you have given to the Organization.

Intense domestic pressure in many of your countries is reshaping development assistance with a firm emphasis on value for money and a growing demand to demonstrate that investment brings measurable results. The work of the Commission on Information and Accountability for Women's and Children's Health, facilitated by WHO, responded to that trend.

This trend brings two problems that WHO must overcome as we undergo reform.

First, we need to do a better job in communicating the nature of our work and the impact it has. Even our biggest supporters tell us this. If we want parliamentarians to fund the work of WHO, their constituents need a much better understanding of what we do and why it is important.

Clear articulation of WHO's value-added contribution to health development is critically important with the rise of high-profile global health initiatives, like the Global Fund, GAVI, PEPFAR, several malaria initiatives and many others.

The second problem is closely related. The impact of much of our work is difficult to measure, or behind the scenes and out of the headlines, or even largely invisible until something terrible goes wrong, like a disease outbreak or when air pollution or water contamination or the level of additives in food exceeds our safety standards.

For example, WHO does not purchase or distribute antiretroviral medicines. But the AIDS community largely credits the technical work of WHO, especially our constant efforts to simplify and streamline treatment guidelines, as making it possible for nearly 7 million people in low-resource settings to see their lives revived and prolonged by these medicines.

Obviously, it is far easier to count the number of vaccines, bednets, and medicines distributed by single-disease initiatives than it is to measure the impact of WHO's technical work. Now let me emphasize that WHO is not in competition with these initiatives. We work together as partners. But it is important for WHO to do a better job in communicating what we do to you.

I will conclude with a last example. In July, WHO urged countries to ban the use of inaccurate and unapproved commercial blood tests to diagnose active tuberculosis. WHO meticulously gathered and verified solid evidence that these tests are inconsistent, imprecise, and put patients' lives at risk.

The tests are unreliable. False-positives mean that patients take toxic medicines for months, for no reason. False-negatives mean that people take no precautions to prevent infecting others.

More than a million of these inaccurate blood tests are carried out each year, often at great financial costs to patients, who may have to pay up to US\$ 30 per test.

Certainly, it is the right thing for WHO to sound an evidence-based alarm and urge a ban on these tests, just as it is right for WHO to campaign against the continuing use of monotherapies for malaria, especially in the private sector. But how do we measure the impact of such work?

Ladies and gentlemen,

The world needs a global health guardian, a protector and defender of health, including the right to health.

Reform in WHO, in my view, starts from a position of strengths: the unique functions and assets of the Organization.

I am personally determined to see that the reform process strengthens these functions and assets. And I very much look forward today and tomorrow to hearing your views on this process.

Thank you.



The WHO Regional Office for Europe

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

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