



**EUROPE**

**Regional Committee for Europe  
Fifty-fifth session**

**Bucharest, Romania, 12–15 September 2005**

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# **REPORT OF THE FIFTY-FIFTH SESSION**

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## Opening of the session

The fifty-fifth session of the WHO Regional Committee for Europe was held at the JW Marriott Bucharest Grand Hotel in Bucharest, Romania from 12 to 15 September 2005. Representatives of all 52 countries of the Region took part. Also present were observers from two Member States of the Economic Commission for Europe and one non-Member State, and representatives of the Food and Agriculture Organization of the United Nations, the United Nations Children's Fund, the United Nations Population Fund, the World Bank, the Council of Europe, the European Centre for Disease Prevention and Control, the European Commission and nongovernmental organizations.

The session was opened by Sir Liam Donaldson, outgoing President. Participants were welcomed by Mr Theodor Stolojan, Presidential Adviser, on behalf of the President of Romania, and by the WHO Regional Director for Europe.

## Election of officers

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

Mr Eugen Nicolaescu (Romania)	President
Dr Godfried Thiers (Belgium)	Executive President
Dr Jens Kristian Gøtrik (Denmark)	Deputy Executive President
Dr Klara Yadgarova (Uzbekistan)	Rapporteur

The incoming President noted that it was a great honour for his country to host the fifty-fifth session of the Committee.

## Adoption of the agenda and programme of work (*EUR/RC55/2 Rev.1 and EUR/RC55/3 Rev.1*)

The Committee adopted the agenda and programme of work.

## Address by the Director-General

The Director-General began by informing delegates about the new International Finance Facility for Immunization (IFFIm), which had been launched on 9 September 2005 with the support of several European Member States. The creation of IFFIm was significant not only because it would greatly increase the numbers of children that could be protected from disease by vaccination, but also because it represented a united commitment to protecting health. It was critical for ministries of health to work together, and with counterparts across disciplines, if the current threats to health were to be tackled.

The importance of emergency preparedness and rapid response had recently been demonstrated following the flooding in Romania and other parts of the Region. Outbreaks of avian influenza had been reported in Kazakhstan and the Russian Federation, and WHO had recently issued guidelines to help countries prepare for an influenza pandemic; in the current pre-endemic phase, it was essential to reduce opportunities for human infection, to strengthen early warning systems and to take the best medical precautions available. Rapid deployment of assets and resources, including appropriately trained health workers, antiviral medicines and vaccines against influenza, and other measures (such as the culling of infected livestock) would be needed to contain outbreaks. International cooperation was required to prepare global antiviral stockpiles and to develop a pandemic vaccine. Poultry farmers affected by outbreaks would need support and compensation. It was therefore critical for health leaders to interact with other sectors, to share information and to plan strategically. He asked the European Commissioner for Health and Consumer Protection to transmit those messages to the Commission, and to meet with him to discuss how to take them forward.

Universal access to treatment was the main goal of WHO's efforts to combat disease, as exemplified by the "3 by 5" initiative. Disease outbreaks in one country were the concern of all countries, as had been recognized in the International Health Regulations 2005. The European Region had been certified as polio-free, but the African and Eastern Mediterranean regions were still reporting ongoing transmission and re-infection, so it was vitally important to maintain high population immunity and strong disease surveillance to minimize the risk of importing the disease. Such measures were needed for all potential outbreaks of disease or infection, and were dependent on prompt sharing of information. Efforts to control tuberculosis would benefit from a similar commitment, as the burden of disease in central Asia and eastern Europe was contributing significantly to the global burden of tuberculosis.

Levels of obesity and related chronic conditions were increasing in the Region, and the problem of binge drinking was growing. Drug and alcohol abuse by adolescents led to life-threatening activities, such as drink-driving or unprotected sex. There had been a rapid rise in the number of people living with HIV in eastern Europe, particularly among intravenous drug users. While eastern Europe also had some of the highest injury rates in the world, other parts of the Region had some of the lowest rates and success stories that could be replicated elsewhere.

The Regional Committee would be discussing the draft Eleventh General Programme of Work, which proposed that the future of public health demanded a wider frame of reference through relationships with those outside the conventional health sector, such as experts in patent issues.

Thanking those governments who had already ratified the Framework Convention for Tobacco Control (FCTC), he urged all those who had not yet ratified the Convention to do so.

During the discussion that followed, several speakers praised the Director-General for encouraging Member States to prepare for an influenza pandemic. Referring to the natural disasters that had recently occurred in the Region and elsewhere, one speaker commented on the importance of cooperation between countries and of investment in local disaster preparedness and response activities and local infrastructure. The methods by which international organizations such as WHO could enter disaster areas to provide immediate assistance needed to be refined; there was also a need to identify ways in which the military and civilian society could cooperate in any relief operations.

Speaking on behalf of the Member States of the European Union (EU), the accession countries and the candidate countries, one speaker commended WHO for securing a stockpile of antiviral medicines for use in the event of an influenza pandemic. Contingency planning must continue, and the joint EU/WHO meeting scheduled for October 2005 would provide the opportunity to focus on key areas, such as assessment of national plans, risk assessment, vaccine production and access to antiviral medicines. International cooperation and capacity-building were vital to ensure the necessary preparedness and response.

The EU was committed to working to achieve the health-related Millennium Development Goals (MDGs), but in view of the slower than anticipated progress, it called for WHO to consider alternative approaches to securing their attainment. Strengthening health systems was a key element in reducing the disease burden in all countries. The work of the Commission on Social Determinants for Health would provide much-needed evidence on where to focus efforts to secure improvements.

Referring to the Eleventh General Programme of Work, the speaker noted that further elaboration of the priorities and direction was still needed. The outbreaks of severe acute respiratory syndrome (SARS) and the prospect of an influenza pandemic indicated the need for flexibility and for WHO to concentrate on issues linked to its core mandate. There was considerable scope for synergy with current EU policies.

The speaker recalled that the Director-General would be launching a global strategy for the prevention and control of noncommunicable diseases in October 2005. Many of the issues being discussed by the Regional Committee were highly relevant to the strategy and indicated the importance of that area of activity in the Region. In February 2006, the first meeting of the FCTC conference of the parties would be

convened. The EU Member States were strongly committed to controlling the harmful effects of tobacco consumption and would be keen to ensure that the meeting set out a clear timetable for agreeing protocols. The European Commission (EC) had played a key role in the negotiations concerning the FCTC and the International Health Regulations. EU Member States were willing to work with WHO to ensure that the Commission could effectively fulfil its mandate in future global negotiations.

Other speakers congratulated the Director-General on his role in improving the management of the Organization, the positive results achieved in the main areas of work and the adoption of the International Health Regulations and resolution WHA58.26 on alcohol and health. One speaker asked WHO to step up its efforts on tackling the health risks of alcohol consumption and emphasized the need for a comprehensive health systems approach.

In his reply to a question about the regional budgetary allocation, the Director-General confirmed that allocations to both regions and countries were being increased. Referring to the report of the Independent Inquiry Committee on the Management of the United Nations Oil-for-Food Programme (the Volker Report), he said that the oversight function of WHO headquarters would have to be strengthened.

### **Address by the European Commissioner for Health and Consumer Protection**

The European Commissioner for Health and Consumer Protection, speaking at the invitation of the Regional Director, said that his participation in the Regional Committee session, the first by a Commissioner, clearly signalled the EC's commitment to closer cooperation with the Regional Office and WHO as a whole. He called on the representatives of Member States to join him in convincing their governments that spending on health was an investment that was essential to growth. In particular, investment in preventing disease and promoting health saved money, as well as lives, in the long run. Working with WHO, the EU was tackling lifestyle problems – such as tobacco, obesity and alcohol – and mental health. Because health threats such as communicable diseases knew no borders, the EU was also committed to working with WHO to prepare for the possible influenza pandemic, including setting up national action plans.

Increased cooperation between the EU and WHO brought two important benefits; it enabled them to overcome the problem of decreasing resources and to win wider political support for their shared agenda and values from all sectors and stakeholders. The European Centre for Disease Prevention and Control (ECDC) would work closely with WHO in fighting communicable diseases; the new International Health Regulations would be another important tool. He looked forward to advancing the EU's and WHO's shared agenda: health for all.

### **Address by the Regional Director**

The Regional Director began his address by identifying three guides for the work of the Regional Office: the programme for 2004–2005 adopted by the Regional Committee, his vision for developing the Office into a modern, more credible and adaptable organization, and the strategy for matching services to countries' needs, which was the heart of the Regional Office's mission.

The Regional Office had pursued the strategy in five ways: helping countries respond to health crises, contributing to global initiatives, conducting more specifically regional activities, making the Regional Office's support more effective and further expanding its partnerships.

First, it had helped to coordinate the response by the EU to the tsunami in Asia in 2004 and helped countries to cope with catastrophes in the European Region, including floods, fires and an earthquake. The Regional Office was also working with WHO headquarters and other regions to respond quickly and appropriately to the possible influenza pandemic.

Second, the Regional Office had worked with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and its co-sponsors to help the Region meet the “3 by 5” initiative goal of 100 000 more patients’ receiving treatment by the end of 2005, and was currently pursuing the goal of universal access to treatment. It was also helping countries to develop proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria, to lower drug prices and strengthen health systems. It was supporting the implementation of the FCTC, had contributed to the new International Health Regulations and had defined strategic goals for work on the MDGs.

Third, within the Region, the Regional Office had held a successful conference on mental health, followed up the 2004 conference on the environment and health, and alerted health ministries to the tuberculosis situation. It was currently preparing the first European Immunization Week in October 2005 and a conference on obesity in November 2006. The Regional Director stressed that sound, sustainable health systems were essential to success in all of those areas.

Fourth, the Regional Office had drawn lessons from the process of making biennial collaborative agreements (BCAs), trained 245 field staff, continued the Futures Forum programme and conducted specific activities. A new type of country office had been opened in Germany. The second phase of programmes for eight Balkan countries under the Stability Pact for South Eastern Europe had been launched with nine donor countries and four international organizations, including the Council of Europe (CE). He also called for US\$ 1 million to help people in Kosovo move away from camps in areas contaminated with lead.

Fifth, the Regional Office has strengthened its partnerships with, for example the CE, the World Bank and United Nations organizations, notably the United Nations Children’s Fund (UNICEF), and with national development agencies, particularly those of Germany, the Nordic countries and the United Kingdom. It had increased its cooperation with the EC at its recent conferences and with the EU focused on the programmes of the countries holding the presidency. He looked forward to continued cooperation with the ECDC and other EU agencies, including those for the environment, food safety and drugs. He felt that such cooperation benefited all the countries in the Region, and he planned to strengthen collaboration with groups of countries such as the Commonwealth of Independent States (CIS) and the Stability Pact countries. WHO headquarters and other regions were also important partners. Partly to strengthen partnerships, the Regional Director had, as requested by the Regional Committee the previous year, set up a working group on the future of the Regional Office.

In the subsequent discussion, many speakers praised the Regional Director’s comprehensive, high-quality report, and his leadership of the Regional Office. Several congratulated him on his reappointment and others commended the Regional Office for its work on alcohol and a wide range of communicable diseases, its insistence on the long-term human and economic value of disease prevention and health promotion, its framework approach to issues (formulating the central principles and leaving the choice of means of implementation to countries) and its publications.

Most speakers endorsed the country strategy and its results in their countries. Several representatives welcomed the Regional Office’s assistance in their countries’ work, for example, to develop their health systems, increase access to drugs and health care, cope with the threat of influenza and participate in European Immunization Week and other efforts to fight communicable diseases.

In addition, several speakers described successes in their countries, particularly the achievements of the projects under the Stability Pact. Those included the creation of a coalition for health in the countries, strong partnerships, and health policy and legislation in line with EU and international standards, as well as work on strengthening health systems and fighting smoking. The participating countries were currently seeking to convert the projects into long-term programmes. In addition, representatives announced a seminar on toxic oil syndrome and the hosting of a CE conference on palliative care. Finally, they described the success of immunization programmes supported by the Global Fund.



A wide range of suggestions were made for further development of activities, mostly focusing on the country strategy. Several representatives urged the Regional Office to ensure that the strategy helped countries to strengthen their health services, build up capacity and increase resources for disease prevention and health promotion, and use evidence in making their improvements. Some called for the Regional Office to continue supporting Member States in preparing for influenza, to draw up a comprehensive strategy on communicable diseases, to support the fight against AIDS and to strengthen its cooperation with the EU, CE and other partners, while ensuring that the benefits of those partnerships reached all countries in the Region. One speaker requested that more Regional Office publications be issued in Russian, and another asked for one of the members of the working group on the Regional Office's future to be Russian.

A representative speaking on behalf of the Member States of the EU and the accession and candidate countries welcomed the presence of the Commissioner as a symbol of the EC's and WHO's shared interest in public health. He noted the role of partnership between the EU and WHO, and including the Organisation for Economic Co-operation and Development (OECD) and the CE, in recent EU action on rare diseases, zoonoses, mental health and HIV/AIDS vaccines. Avoiding duplication of efforts and action was of paramount importance to the partnership. During its EU Presidency, the United Kingdom would build on those efforts and press for further collaboration, for example, on exploring action on the social and lifestyle determinants of health, making health care services and products safer for patients, and preparations for an influenza pandemic. The Northern Dimension partnership and the ECDC would make valuable contributions to the fight against TB and HIV/AIDS. The speaker welcomed the working group on the Regional Office's future and the Regional Committee's planned discussion of the Health for All policy update, alcohol and the Eleventh General Programme of Work as enabling stronger cooperation between WHO and the EU.

A speaker representing the CE noted that efficiency savings had resulted in proposals for the transferral of some of its health activities, but no decision would be made before November 2005. Recent activities in the health field included a seminar on counterfeit medicines, a book on nutrition in schools, which was to be disseminated to the healthy schools project and the obesity conference, and the making of an action plan on disability. The valuable synergy between the Regional Office, EC and CE would continue.

A speaker representing the Global Fund to Fight AIDS, Tuberculosis and Malaria said that the Fund had allocated US\$ 700 million for the European Region, and that US\$ 136 million had already been put to use. WHO was the Fund's foremost partner in its work in 18 countries and territories in the Region. It was opportune to evaluate the Fund's work with the Regional Office and WHO headquarters, focusing on applications for and the use of grants by countries.

In reply, the Regional Director thanked all the Member States and organizations for their support of the work of the Regional Office. He noted that health systems were much broader than health care alone. Thanking two countries for their participation in European Immunization Week, he urged all Member States to take part. Finally, he promised that, so far as possible, more Regional Office publications would appear in French, German and Russian, as well as English.

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

*(EUR/RC55/12 and RC/2005/1)*

The European member of the Executive Board invited by the SCRC to attend its meetings as an observer noted that, although the 11 decisions and 34 resolutions adopted by the World Health Assembly were all of great importance to public health, their increasing number and complexity placed a heavy burden on both the Organization and the Member States. A way needed to be found to concentrate more on the main priorities to ensure implementation of those very worthwhile instruments.

Two resolutions represented milestones in the history of the Organization: that on the new International Health Regulations, where health had finally prevailed over political arguments and a compromise had been reached; and the second on adoption of the programme budget 2006–2007, resulting in a 4% increase in the regular budget after a 10-year period of zero growth, in recognition, it was felt, of the greater transparency and optimized management achieved by the Organization in recent years.

The Assistant Director-General, General Management presented the guiding principles for strategic resource allocation, as submitted for consultation with the WHO regional committees prior to their finalization for the Executive Board session in January 2006. WHO continued to focus on a results-based management framework with a six-year medium-term strategic plan that would set out strategic objectives (rather than areas of work), and with performance monitored over time.

There were three perspectives to resource allocation: programmatic, or what should be done; organizational, i.e. where it should be done; and functional, or how it should be done. Those perspectives related respectively to the Organization's strategic direction and objectives, the roles and responsibilities of the various levels of WHO, and its core functions. A validation mechanism would take into consideration three components: a core component mostly reflecting the normative functions, an inherent part of the Organization; an engagement component to allow for variations in the number of countries served; and a needs-based component reflecting relative health and socioeconomic status and population size.

In the ensuing discussion it was pointed out that the more precise planning was, the less flexibility would be possible to take account of unforeseen circumstances. Further, there needed to be consensus not only on areas where there should be increases, but equally on those where decreases would have to be made. When discussing the needs-based component, it would be useful to have previous as well as predicted figures, for purposes of comparison.

The Regional Director for the Eastern Mediterranean agreed with representatives on the appropriateness of the guiding principles but warned that care would be needed in implementation; the indexes used in the past had produced some anomalies. He agreed that increased planning reduced flexibility, and pointed out that funds used for emergencies could be substantial and should not be included in the proposed model.

The Assistant Director-General, General Management, in response to questions on the management of resources and priorities, said that it had been decided that all governing body decisions would be linked to their financial implications. Transparency in the budget was an objective, and it should not be forgotten that many activities organized by WHO were in fact funded from elsewhere. Health emergencies were a special case and were difficult to provide for in the budget. The Organization was investing in improving accountability, in terms of both funding and results. Flexibility had to be maintained to cope with unforeseen circumstances, such as the appearance of a new disease or of new knowledge.

The Regional Director welcomed the regular budget increase for 2006–2007: after a long period of being asked to do more with less, there was now a link between the budget and what was expected. However, he emphasized the need for transparency in what was to be produced and the funds needed. He called for the framework to take account of extrabudgetary funds, in addition to regular budget resources.

In conclusion, the Assistant Director-General, General Management assured representatives that WHO was working on continuous budget monitoring, both by itself and with Member States. A continuing dialogue was needed, but the work had begun.

When considering matters arising out of the World Health Assembly, one representative, speaking on behalf of the Nordic countries, noted the omission from the document of resolution WHA58.17 on international migration of health personnel and also requested clarification regarding resolution WHA58.27, on improving the containment of antimicrobial resistance. Another speaker highlighted the omission concerning the resolution on ageing (EB115.R7). Regarding the large number of resolutions

now being adopted, it was suggested that the financial and workload implications of each be analysed before they were tabled. Clarity and brevity were assets that must be maintained in resolutions.

## **Report of the Twelfth Standing Committee of the Regional Committee** *(EUR/RC55/4, /4 Add.1 and /Conf.Doc./1)*

The Chairman of the Standing Committee noted that the Twelfth SCRC had met five times during the year. The reports of its individual sessions were available on the Regional Office's web site, and a consolidated report was prepared for the Regional Committee each year. They contained full details of the work done by the Standing Committee, but the Chairman felt it might be useful to summarize the outcomes of that work with the help of a slide presentation.

In order to work out a strategic vision of the role and position of the Regional Office (as suggested at the fifty-fourth session of the Regional Committee), the SCRC had set up a working group consisting of four of its members, two WHO staff and six outside experts. It was planned to hold four meetings of the working group, with reporting back to the SCRC after each, and to submit the group's report to the Regional Committee in 2006. On the subject of WHO collaborating centres, the SCRC had asked the Secretariat to prepare an information paper for the Regional Committee at its current session (see document EUR/RC55/13, pages 40–42).

The SCRC had adopted a firm position with regard to the Organization's proposed programme budget 2006–2007; partly as a result, the European Region's regular budget for the forthcoming biennium had been increased by 6% when the budget had been adopted by the Fifty-eighth World Health Assembly. Similarly, the SCRC had urged Member States to comment on the draft principles for budget allocations to regions in future biennia, and it had been agreed that such allocations would in future consist of three elements (a core component, an "engagement" component and one that took account of a country's socioeconomic situation). The SCRC had also been involved in the process of consultation on the Eleventh General Programme of Work (2006–2015).

Relations with the European Union were another area that the SCRC had reviewed during the year, finding that there was good cooperation, although mainly on an ad hoc basis. It had accordingly pointed out the need to formalize the arrangements and to make clear what the Regional Office could offer to the EU, as well as recommending that the subject should be looked at by the working group on the long-term strategic vision for the Regional Office.

Other items dealt with by the SCRC during the year included the outcome of the WHO Ministerial Conference on Mental Health (on which a draft resolution would be submitted to the Regional Committee), obesity (where the SCRC had endorsed the proposal to hold a conference in Turkey in 2006), and influenza preparedness (where it had noted the progress made in some central European countries in developing new vaccines based on cell culture techniques).

Lastly, as was customary, the SCRC had done a considerable amount of work on preparing the agenda for the current session of the Regional Committee, reviewing the draft resolutions that would be submitted, and reaching consensus on recommendations concerning membership of WHO bodies and committees.

The Committee adopted resolution EUR/RC55/R5.

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

*(EUR/RC55/13 and /Conf.Doc./8)*

### ***Annual Report of the European Environment and Health Committee (EEHC)***

The Chairman of the EEHC noted that the members of the newly mandated EEHC were elected from ten Member States, seven intergovernmental and four nongovernmental organizations. Their task was to monitor and facilitate implementation of the commitments made at the Fourth Ministerial Conference on Environment and Health in Budapest, and to support and promote that work in countries. The EEHC had met twice in 2005. Currently there were 80 national focal points on environment and health from 50 countries. Each meeting took as its special focus one of the four Regional Priority Goals in the Children's Environment and Health Action Plan for Europe (CEHAPE). All Member States were invited to attend EEHC meetings. The EEHC had set up a CEHAPE Task Force which also met twice a year.

Development of the environment and health information system was essential to the effective protection of children. It was being coordinated by an international group of 30 countries, as well as the EC and other international organizations, and four Member States were taking the lead in different areas of work. As part of the communication strategy for the EEHC, a web map was being developed to show the progress that Member States were making in the implementation of the Budapest commitments. Countries were urged to use it and update it. Another initiative was to improve the participation of young people themselves, a project which was being undertaken with the support of several Member States.

The ministerial conference in Budapest had given rise to many expectations and it was important that they were fulfilled, despite some difficulties with finance that the EEHC was facing. The second meeting of the CEHAPE Task Force was to be in Edinburgh on 20 and 21 October 2005, the 20th meeting of the EEHC in Helsinki on 12 and 13 December 2005 and the 21st meeting of the EEHC in Norway in spring 2006. He hoped that all countries would attend.

In subsequent discussion, it was agreed that consideration would be given to the CEHAPE and EEHC meetings being held at the same time to reduce cost, and that the full financial picture would be clarified so that further finance could be found.

The Regional Director expressed his gratitude to the EEHC for its work and for its Chairman's recent assistance in carrying out, at the Regional Director's request, a visit to Kosovo to report on a group of children living in hazardous conditions. He hoped that countries would help to find the funds to solve that serious problem.

### ***Follow-up to the WHO European Ministerial Conference on Mental Health***

The Regional Adviser for Mental Health thanked Member States for their commitment and contribution to the success of the ministerial conference. The challenge of the next five years would be implementation, improving the mental health and well-being of the population. The Mental Health Declaration for Europe identified five priorities and countries were aiming to reach specific milestones by 2010, supported by the Regional Office which had also taken on responsibilities as specified in the Declaration. Five WHO collaborating centres were leading activities in particular work areas and other partnerships were being forged through country activities. A task force of professional organizations was being set up, and NGOs were forming a federation to work with the Regional Office. The Regional Office was working closely with the EC on the forthcoming "green paper" on mental health, and with the CE. The foundations had been laid for improvement of mental health in the European Region: the challenge now was the delivery.

In the discussion that followed, representatives agreed that the ministerial conference had been just the starting point. It was illustrative of the creative partnership between researchers and policy-makers. It had highlighted the need for mental health services to be better included in health systems, and for health policy-makers and health professionals to improve their technical competence in the delivery of mental

health services. Service users and carers should be involved in planning mental health services. The representative of one Member State which had organized one of the pre-conference events declared his country's willingness to participate actively in follow-up measures.

Some representatives described their country's reforms in mental health, such as the closing down of large asylums, the development of a mental health referral network to facilitate access to local health systems, and national programmes for depression and post-traumatic stress disorder, as well as new national mental health plans. One representative of a country in transition said that modernizing the mental health system was a huge task, but there was an opportunity to break out of a vicious circle of failures and develop modern community-based services.

The Committee adopted resolution EUR/RC55/R2.

### ***Scaling up the response to HIV/AIDS in the WHO European Region***

The Director, Technical Support, Reducing Disease Burden, reported that the Regional Office now had 34 full-time staff working on HIV/AIDS in 12 countries. They were needed because the epidemic had not slowed down, and there was now an increase in deaths from HIV/AIDS: twice as many deaths in the first 8 months of 2004 as there had been in the whole of 2003. Thirty of the 52 countries had reported an increase in HIV cases, including some in western Europe for the first time in some four years. There were differences between the different parts of the Region, with transmission mostly sexual in western and central Europe, and related mainly to intravenous drug users (IDU) in eastern Europe. In western and central Europe, up to 65% of all cases were men having sex with men, up to 75% of heterosexual cases were among immigrants and up to 50% of those were women. In eastern Europe, up to 85% of cases were male, up to 50% of infected females were partners of IDU, and up to 50% of all HIV infections were among people under 25.

The regional goal of the "3 by 5" Initiative, launched in 2003, had been to put 100 000 more patients on antiretroviral treatment by the end of 2005, and it looked likely that this goal would be exceeded, with those treated in the Region increasing from 242 000 in mid-2003 to 381 000 by the end of 2005. In March 2003 only 27 Member States could ensure universal access to treatment, but by the end of 2005 it was likely that this number would have risen to 49. In those important areas, the goals would be met.

Representatives expressed their support for an integrated approach and for targeting those people at higher risk of infection, and described the challenges of HIV/AIDS in their countries, such as a lack of well trained epidemiological staff. Those issues were being addressed by national plans. It was important that this work was done in partnership with UNAIDS and many other agencies and with a harmonized approach, as underlined by the setting up of the Global Task Team and the 17th meeting of the UNAIDS Programme Coordinating Board.

An EC representative said that HIV/AIDS was to be put on the agenda of the European Council and that the EC was preparing a communication to be finalized at the end of 2005 to continue and intensify the fight against HIV/AIDS.

One representative proposed that, since in some parts of the Region the rates of new infection were very dramatic, a draft resolution should be presented to the Regional Committee in 2006 with concrete and comprehensive proposals for action on HIV/AIDS prevention. He asked that the Standing Committee should discuss that at its next meeting.

### ***Occupational health***

Some representatives welcomed the prompt action by the Regional Office in funding and setting up an occupational health programme following discussions at the fifty-fourth session of the Regional Committee. The network of collaborating centres would provide effective and useful assistance to Member States in tackling the health challenges and threats presented to workers. It was important that

the work should continue. There were striking inequities within the Region between conditions of work and occupational health services, and a regional strategy would be welcomed.

### ***Towards a European strategy on noncommunicable diseases***

The development of this strategy was welcomed, with one representative stressing the need to take action against cancer, cardiovascular disease and chronic respiratory disease, for example. Consultation was important, as was coordination with other strategies (such as the nutrition strategy) and other bodies, such as the EC.

### ***Reproductive health***

Several speakers expressed their concern about the growing rates of sexually transmitted infections and teenage pregnancy and their support for a draft proposal for a regional strategy to improve maternal and perinatal health. Such a strategy should also be integrated into other programmes, including those for strengthening health systems. It was essential for achieving the MDGs, and one speaker outlined the excellent results seen in his country as a result of the national reproductive health strategy.

A statement was made by a representative of the International Commission on Occupational Health, and written statements were received from the International Stroke Society and the International Council for the Control of Iodine Deficiency Disorders.

## **Policy and technical items**

### **European strategy for child and adolescent health and development, including strengthening national immunization systems through measles and rubella elimination and prevention of congenital rubella infection in WHO's European Region**

*(EUR/RC55/6, /7, /Conf.Doc./2 Rev.1 and /Conf.Doc./3 Rev.1)*

The Director, Technical Support, Reducing Disease Burden described the process of consultation, pilot schemes and meetings through which the Strategy had been developed since a concept paper had first been presented to the Regional Committee in 2003. There was a moral and legal obligation to protect and promote the rights of children. A healthier future society depended upon children's health, and investment in the early stages of life affected economic development and sustainability.

A core concern underlying the Strategy was that there were striking differences across the Region, with a ten-fold difference in infant and child mortality between countries. Furthermore, inequalities within countries were on the increase: no country was currently able to guarantee all its children equitable rights to health. The goal was to enable children and adolescents to reach their full potential for health and development and to reduce the burden of avoidable disease and mortality. Four principles were followed: a life-course approach that considered the full course of prenatal life to adolescence; putting the needs of the most disadvantaged at the top of the agenda to ensure equity; working through intersectoral action, and facilitating public and youth participation.

There was no blueprint which would fit all Member States: countries would need to adjust the Strategy to their own needs, and an implementation toolkit had been produced for that purpose, on information, action and assessment.

He highlighted five of the seven priority areas in the Strategy: HIV/AIDS, obesity, violence and injuries, measles and rubella, and mental health. Over the previous six years the newly diagnosed cases of HIV/AIDS had been mostly in eastern Europe: in that major epidemic, 80% of the cases were people aged under 30. Obesity was a silent epidemic that had crept across the Region since the 1970s, but huge differences could be found, and in some Member States over 30% of children suffered from malnutrition. Rates of violence and injuries also varied enormously.

Immunization rates in the Region were generally good, but in 2004 nearly 600 000 one year-olds were not protected against diphtheria, tetanus and pertussis. Measles could be eliminated but there were still outbreaks in developed countries, and it was being exported across borders and into the Americas. The elimination of rubella, a preventable cause of birth defects, was feasible and the aim was to eliminate both measles and rubella by 2010.

Mental health was another priority area targeted by the Strategy: 4% of 12–17 year-olds suffered from depression, and 9% of 19 year-olds. Suicide was the third leading cause of death among young people. In conclusion, he emphasized that promoting and protecting the health of children and adolescents was an investment in tomorrow's society.

In the subsequent discussion, all speakers expressed their support of the Strategy, seeing the issue as a high priority. One representative said that child health was the most important indicator for a health ministry and, because children represented the future, policy-makers would not be forgiven if it was not addressed. Many representatives commended the Strategy as a good, comprehensive framework that would assist Member States in formulating their own policies and programmes.

Some speakers outlined the special areas of concern in their countries: from declining child populations, rising rates of diabetes mellitus, increases in asthma and food allergies to alcohol abuse, lack of mobility, female genital mutilation and child-centred marketing. It was important that local needs and services were taken into account and that other sectors beyond the health sector were involved: empowerment and the promotion of healthy lifestyles were also key elements in the Strategy, as was the use of evidence.

A reduction of child mortality had already been seen in some countries as a result of policies of support for pregnant women, children and adolescents, and particularly from interventions targeting vulnerable populations. Several representatives described their countries' progress in areas such as reducing maternal death rates, reaching teenagers and young adults, promoting breastfeeding, increasing the use of child safety seats in cars, and other policies for children. One Member State had a "green paper" which set out five key outcomes for children and young people. Another had a national programme which stressed autonomy and self-determination, and adequacy and continuity in service delivery, among other things. Several representatives of countries that had experienced a time of economic transition described how children's policies had been a priority for their governments and how the importance of the family was enshrined in their legislation. Several speakers considered that the Strategy would be essential in reaching the MDGs. Some suggested that the Strategy could more closely reflect some of the other areas of work carried out by the Regional Office in Member States, such as the network of Health Promoting Schools, the commitments made at the Fourth Ministerial Conference on Environment and Health, and gender. One representative mentioned the need for support for good parenting and the importance of well functioning primary health care services. Another pointed that there would always be some children who would have accidents or fall ill, and that improvement of child treatment, including in hospitals, should not be ignored.

The immunization objectives by 2010 won wide support. Several speakers outlined their countries' successful experiences in strengthening national immunization systems. One Member State had vaccinated nearly 20 million children in a two-year period. Some countries had recently set up networks of laboratories and improved surveillance. One speaker said that his country had borders with other WHO regions and would need more support: he would welcome a donor conference to give assistance. One representative was concerned at the proposed European Immunization Week, considering it inappropriate to treat immunization as a subject for a campaign once a year: vaccination was essential and not to be compromised. However, another speaker outlined the problems in some countries where parts of the population were refusing to have their children vaccinated. For those circumstances, different strategies needed to be developed and implemented.

A representative of the EC said that although most young people were in good health, the health of many children was harmed by poor diet, poor parenting, poor environment, lack of exercise and lack of love. Those were often linked to low income, education and quality of work, which led to unacceptable health

inequalities. The Commission would be publishing a green paper on nutrition, diet and physical activity, proposals on alcohol, and a communication on mental health.

A representative of UNICEF said that the needs of children and adolescents should be addressed in a holistic manner, including the psychosocial aspects essential to their health. Countries were obliged to provide essential services to those who were most vulnerable, and children and adolescents were suffering the most. Lessons could be learnt from each other, about for example, child survival and HIV/AIDS. Efforts to achieve universal salt iodization should be accelerated.

The Director of the ECDC described the setting up of the new Centre which would work in partnership with WHO and Member States in areas such as risk identification, risk assessment, risk communication, preparedness and response, as well as prevention and control of communicable disease. The Centre would give full support to the elimination of measles and rubella.

Under the agenda item, statements were made by representatives of the European Forum of National Nursing and Midwifery Associations and the Medical Women's International Association.

The Committee adopted resolutions EUR/RC55/R6 and EUR/RC55/R7.

### **The Health for All policy framework for the WHO European Region: 2005 update** *(EUR/RC55/8 and /Conf.Doc./4)*

The Regional Director introduced the item by describing the process of updating the policy framework for Health for All. The SCRC had requested an update, not a new policy, that would be as specific and concrete as possible and retain the original values of Health for All.

The update had four parts. The first was based on the results of a study by the European Observatory on Health Systems and Policies, which showed that Health for All had influenced the health policies of many Member States (although there had been a gap between policy-making and implementation), that its values were widely accepted and that setting targets for all the diverse countries of the European Region was unrealistic.

The second part of the update reaffirmed the three key values of Health for All – equity, solidarity and citizen participation – and set them in the context of the instruments on human rights already adopted by Member States and of ethical governance in health. The third part recommended the use of 10 tools for policy-makers that fell into four categories: defining a framework to ensure ethical governance, integrating the most recent data in health policy, ensuring the alignment of policies with Health for All values, and basing policy and action on evidence. The fourth part proposed a set of open-ended questions that policy-makers could use to ensure that the content and implementation of policies were in line with their stated values.

Fifteen countries had provided detailed responses to the draft update during the formal consultation period between January and May 2005. Some of their suggestions were incorporated in the update. Others concerned the future of Health for All, asking the Regional Office to work on the financial aspects of the policy and the follow-up of the process, to include comparisons between countries and to suggest a communication strategy to make the policy better known. Rather than issuing future updates, the Regional Office therefore proposed to create a continuous Health for All process enriched by the experiences of Member States.

Speaking for the SCRC, its former Chairman expressed the Standing Committee's support for the update, which was necessitated by the continuing major changes in the Region, and its approval of an open-ended process in which countries could democratically confirm the Health for All values as the foundations for their health care reforms and programmes. Health for All was the central point around which programmes and activities revolved at lesser or greater distances, and action on health was both vital to the progress of the Region as whole and the collective responsibility of everyone present.



All the speakers addressing the item welcomed the update, particularly for such strengths as its analysis of and building on the achievements of the past, its usefulness in guiding policy-making in the present and future, its linking of core values to action through the concept of ethical governance, and such features as the toolbox and check-list for policy-makers. A representative speaking on behalf of the Nordic countries welcomed the update as an important tool in securing the ethically sustainable development of health policies, praising in particular its comprehensive definition of equity, its call for broad strategies and intersectoral action to build healthier societies and its provision of concrete tools for policy debates in Member States.

Suggested additions to the update included: a greater focus on concrete actions and the Regional Office's continued leadership of the Region-wide Health for All movement in the future, more attention to exchanges of information on and experience with public health strategies in countries, more stress on continuity with the HEALTH21 policy, the inclusion of public health research in the list of types of programme efforts contributing to health improvement, and a requirement for regular reporting of progress to the Regional Committee. In addition, the Health for All indicators should be harmonized with those of other organizations, such as Organisation for Economic Co-operation and Development (OECD), to reduce the burden of requests for information on Member States.

A statement was delivered by a representative of the International Council of Nurses, and supported by the European Federation of Nurses Associations and the International Catholic Committee of Nurses and Medico-Social Assistants.

In reply, the Regional Director thanked Member States for their support of the document and the process, especially their understanding of the aims of the update. The Regional Office's documentation on the update would pay proper credit to HEALTH21, and the Regional Office would pursue harmonized Health for All indicators. Regional Office documentation used the term "health professionals" to cover the wide variety of professions involved in health, including nurses, whose role needed to be stressed.

The Committee adopted resolution EUR/RC55/R4.

### **Framework for alcohol policy in the WHO European Region**

*(EUR/RC55/11, /Conf.Doc.7 and /BD/1)*

Introducing the item, the Director, Technical Support, Reducing Disease Burden noted that the European Region had the highest alcohol intake and thus the highest burden of alcohol-related disease in the world; alcohol was the third most important risk factor for death and disability in the Region and the leading risk factor among young people. Consumption patterns varied across the Region: high and rising in northern countries, declining more slowly than before in the south-west, and very high in eastern countries.

WHO initiatives against alcohol in the European Region included two action plans made in the 1990s, policy statements from two conferences and World Health Assembly resolutions in 2004 and 2005. In addition, the EC was developing a strategy to reduce alcohol-related harm. While activities in the Region since 2001 had seemed rather limited, the Regional Office was submitting the Framework for adoption by the Regional Committee.

The Framework's objectives were: to strengthen alcohol policy in the Region, to summarize the situation and identify needs for policy responses, to create a common platform for the initiatives of WHO and other actors, such as the EC, and to create strong links to national and local strategies and action plans not only on alcohol but also on related topics, such as noncommunicable diseases and young people. The advantages offered by the new Framework included: addressing recent and re-emerging challenges, clearly formulating the guiding principles for action, clearly describing the roles of different players, addressing issues under dispute or needing more definite formulation, and identifying international tools for action and follow-up.

A member of the SCRC said that the scale of alcohol-related harm gave the issue high priority. The SCRC had noted the need for an update of the European Alcohol Action Plan (EAAP) for 2000–2005 and the extensive discussion and resolutions on alcohol by the Executive Board and the World Health Assembly. Given alcohol's role as a risk to health and a factor in co-morbidity, the SCRC had accordingly endorsed the Executive Board's focus on the harmful use of alcohol and asked the Regional Office to prepare the Framework. Average figures on consumption and harm hid wide differences between and within countries and between social groups, which indicated the need for strategies targeting the groups with the heaviest burdens. Other important issues to address included drinking (and increasing "binge" drinking) by young people and the pressures on countries' control efforts exerted by the globalization of the alcohol trade. The Framework built on the progress already achieved by the WHO action plans and conference statements.

In the subsequent discussion, all speakers endorsed the Framework. In particular, representatives praised its potential to elicit increasingly needed international cooperation and action, as well as action by Member States to reduce alcohol-related harm; its application of global ideas to the European context; the clarification of the roles of the various players; and the strong case made for controlling the availability of alcohol, although one speaker said such controls would not work in his country. In addition, most representatives described particular problems in their countries (including high and increased consumption and related harm, drinking by young people, and the targeting of young people with alcohol marketing and products such as "alcopops") and successful responses such as national strategies, plans, legislation and taxation policies.

Various ways of strengthening the Framework were suggested. A representative speaking on behalf of the Nordic countries urged that the Framework should more clearly call for the reflection of public health interests in all international agreements related to alcohol, such as those on trade and taxation, and that it should use terminology in line with that of World Health Assembly resolution WHA58.26 on Public health problems caused by the harmful use of alcohol. In addition, speakers suggested that the Framework should: acknowledge the role of social and genetic factors in alcohol problems; recognize the need to train health care providers in detecting and treating those problems; call for age limits on the purchasers of alcohol and on alcohol advertising, particularly on the Internet and that aimed at young people; call for programmes to support the families of those dependent on alcohol; support research to provide sound information for alcohol education in schools; and pay more attention to the factors related to the declining consumption in south-west Europe.

Further, the representative speaking on behalf of the Nordic countries called for the Regional Office's future work on alcohol to receive sufficient resources and strong support from both the Regional Director and WHO headquarters to fulfil the objectives of World Health Assembly resolution WHA58.26. Others suggested close cooperation with the EU on such events as a summit on inequalities that would promote responsible marketing, the connection of the Framework with other sectors' policies to improve the status of the most vulnerable groups, the reiteration of the message that less alcohol consumption is better, and the consideration of alcohol-related obesity in young people in the preparation of the 2006 obesity conference.

A representative of the EC thanked WHO for its leadership in alcohol policy. Owing to the harm related to drinking and the EU's obligation to protect health in all its activities, the EC was preparing, in cooperation with WHO, a strategy on alcohol-related harm to be issued in 2006. The eight key areas for action were: drink-driving, underage drinking, commercial communication, consumer information, the availability and pricing of alcohol, the protection of children and families, treatment, and information exchange, data and research. An approach involving all stakeholders but distinguishing between their roles was needed.

The WHO Regional Director for the Eastern Mediterranean reported that the Regional Office for the Eastern Mediterranean had been alcohol-free since the 1980s. As six countries in that region had increasing problems with alcohol, some activities resembling those that had already succeeded with

tobacco might be helpful; for example, the Regional Office for Europe could call for a framework convention on alcohol, and the World Bank could report on the economics of the alcohol trade.

The Assistant Director-General, Noncommunicable Disease and Mental Health, WHO headquarters praised the Framework as an opportunity to spark multisectoral action guided by public health interests, to strengthen WHO's work on alcohol at all levels and to ensure the complementarity of action by the Regional Office and headquarters, as well as other players such as those with economic interests.

In his reply, the Director, Technical Support, Reducing Disease Burden thanked all Member States taking the floor for their good guidance. Terminology would be harmonized with that of the global resolutions. As to the role of the alcohol industry, the Framework called on it to meet the highest standards of business ethics. The Regional Office would discuss with WHO headquarters how to involve the industry in the consultations called for in World Health Assembly resolution WHA58.26. He welcomed the EC's support of the Framework and thanked Sweden for hosting the meeting of the European network of national alcohol counterparts, which had made an essential contribution to preparing the Framework.

The Committee adopted resolution EUR/RC55/R1.

### **Injuries in the WHO European Region: Burden, challenges and policy response**

*(EUR/RC55/10 and /Conf.Doc./6 Rev. 1)*

Introducing the agenda item, the Director, Special Programme on Health and Environment said that injuries, both unintentional and intentional, were a major public health issue in the Region. There was a need to respond in a coherent and effective way. Injuries killed approximately 800 000 people per year, about 8.3% of all deaths. The deaths were just the tip of the iceberg: for every death there were an estimated 30 people hospitalized, and 300 needing emergency hospital treatment, which amounted to 240 million interventions by emergency departments per year.

The burden of injury was unequally distributed across the Region, with the risk of dying from injury over eight times higher in the eastern part of the Region than in the western countries. This disparity across one region was the highest in the world. However, there was in every country a link with poverty, as children of lower social classes were three to four times as likely to die from injuries as those in higher classes.

The cost of injuries to society was enormous: annual costs of not less than €81 billion were borne by the health sector alone. The overall societal costs had just begun to be mapped out, but road traffic injuries alone cost an estimated 2% of the national gross domestic product. Yet if all countries had the "safety performance" now found among some Member States, two out of three injury deaths could be avoided: almost half a million lives would be saved. Many well known and cost-effective measures existed. For example, every Euro spent on child safety seats would save €32; for smoke alarms the figure would be €69, and universal licensing of handguns would save €79 for each Euro spent.

Injury prevention should be part of the core business of the health sector, but it was a shared societal responsibility. As well as playing its traditional role of caring for victims, the health sector was well positioned to engage other sectors in reducing the burden of injuries. Other functions that it could undertake itself included developing research and surveillance systems, and publicizing the problem of injuries among policy-makers and the public. Impressive results could be obtained in only a few years, as could be seen by the 24% reduction in road traffic injury deaths achieved in one country between 2002 and 2004.

A member of the Standing Committee stressed that solutions to the complex issues of injuries and violence had to come from many sectors. Many avoidable accidents were putting a strain on health service resources. Partnership was important, including working with, among others, the EC, the European Conference of Ministers of Transport and OECD. A conference was to be held in 2006 on the prevention of accidents, which would help address the enormous challenge ahead.

In the subsequent discussion, representatives warmly welcomed the initiative on injuries. The timing was good. The framework for action would help policy-makers to address the serious public health problem with synergy and coherence, making best use of resources. In many countries, the number of injuries was increasing and the problem was felt to be urgent.

Speakers agreed that multisectoral solutions were essential. Many forces would need to be mobilized, including the police and rescue services, services providing primary care, occupational health and social welfare, nongovernmental organizations (NGOs) and a wide range of other groups and authorities. Injuries needed to be included in health systems' strategies. Many injuries were connected with alcohol, particularly domestic violence and road deaths, so it was important that national plans should be compatible with strategies on alcohol. One representative noted that the concept of a national focal point was not feasible in his country.

The core of activities would be preventive measures, and some countries described some successful measures they had taken, for example through development of national plans to prevent injury, participation in the WHO "Safe community" programme, strategies against domestic violence, establishing various multisectoral committees and centres and setting up local projects such as "safe road to school" schemes. There was an arsenal of evidence-based strategies awaiting implementation. In ten years, one Member State had achieved a 40% reduction in home and leisure injuries to children.

Some representatives also shared their experiences of investing in professional training, equipment and emergency care for victims, emphasizing the importance of on the spot, prehospital care to improve the outcome of injuries. A prehospital response system was being developed in one local authority. Accurate information was essential: one country had in the past three years developed a very successful countrywide centralized accident register that was used by a host of organizations, all of which contributed their data to it.

It was important to raise public awareness of the issue of injuries, and some communication tools should be developed which countries could adapt for their own use.

Injuries took lives suddenly and unexpectedly, and crippled young people for life: they inflicted enormous damage. Their impact was far-reaching – on people, families, health services, society and the whole economic development of a country. Several speakers mentioned the importance they attached to injuries received by children.

One representative suggested that a global fund be set up to combat injuries. It was suggested that reducing injuries by a quarter in the next 20 years could be a realistic target for the Region. A pre-event for the 2006 conference would take place in Greece in October 2005, and the forthcoming meeting of WHO's European national focal points for violence and injury prevention was to be held in the Netherlands in November 2005.

A representative of the EC said that the Commission was preparing a communication on injury prevention and safety promotion which would be accompanied by a proposal for a Council recommendation, probably in December 2005. Collection and dissemination of information on accidents and injuries was one of the main ways to positively influence health policy-makers, health professionals and the public. Investment to reduce the heavy burden of injuries would be repaid many times over.

The representative of GTZ, the German Agency for Technical Cooperation, said that the World report on violence and health (2002) had provided an impressive evidence base, compiled with the close involvement of scientists and policy-makers. Violence prevention would become ever more important, as there was an increased tendency at every level to resolve conflict through acts of violence. The media had contributed to a climate of violence as part of normal everyday life. Gender-based violence had not improved significantly and needed to be addressed more openly. Support provided to the WHO programme had taken the agenda forward, towards a world in which violence would become the exception.

A speaker from the European Child Safety Alliance (ECSA) outlined the collaboration between that NGO and WHO. Injuries were the number one killer of children in Europe, and they were a cross-cutting issue that required partnership with many different sectors. ECSA provided technical expert support to help countries develop national child safety action plans – already committed to by at least six countries – and maintained a network on implementation and advocacy. The end result would be a safer Europe for children, families, communities and society.

A speaker from WHO headquarters noted that two global initiatives had given impetus to tackling injuries: a programme on the prevention of accidents and injuries had been launched five years before, and the world report had been issued two years later. The European Region had been the first to develop a regional programme and to bring national focal points together. Capacity-building would be essential. A few weeks earlier, new WHO recommendations had been published on first aid in primary health care, and a CD-Rom was now available setting out a curriculum on injury, a 40-hour module for all schools of public health.

The Director, Special Programme on Health and Environment thanked Member States for their warm support and noted that reducing injuries among children would also help to meet Regional Priority Goal II of the Children's Environment and Health Action Plan for Europe.

The Committee adopted resolution EUR/RC55/R9.

### **Next phase of the WHO Regional Office's Country Strategy: Strengthening health systems**

*(EUR/RC55/9 Rev.1, /Conf.Doc./5 Rev. 1 and /Inf.Doc./1)*

A representative of the SCRC introduced the agenda item, noting that strengthening health systems was a critical area for policy development within the Regional Office. This activity was broad-ranging, because of the variations in health systems across the Region. The issue had been brought to the Regional Committee because of its potential for improving the health of the populations served, and because of the importance of health systems in the achievement of the MDGs and the development of health strategies. In addition, the threat posed by outbreaks of disease was best overcome by having national preparedness plans that could be drawn up through effective health systems.

The Director, Country Support gave a presentation on how effective health systems could save more lives. She pointed out that the gap in life expectancy at birth in the 1950s between developed and developing countries had now been replaced by a major gap between developing countries with high mortality rates and all the others (developed and developing countries with low mortality), which indicated that factors other than income played a role in that change. Many countries perceived Europe as rich, yet it was the only region that had experienced a decline in life expectancy, in the Commonwealth of Independent States (CIS). On the other hand, the improvement in global infant mortality rates had exceeded predictions based on income levels. Analysis of the variations in mortality rates in developing countries showed that health care and contextual factors played a key role in improving mortality in those countries, as compared to other factors. That was also true for many western European countries. Technological improvements had greatly reduced mortality rates due to certain diseases, which once again proved the importance of effective health systems, which included knowledge and technology in their broad definition.

It was no longer acceptable to limit health determinants to poverty, etc. Economic development, democracy, societal values and, very importantly, health system effectiveness all affected health outcomes. Research had shown that health system constraints were impeding the implementation of major global initiatives for health and the attainment of the MDGs; it was therefore important to address those constraints. The proposed Regional Office Strategy on the MDGs in Europe and documents EUR/RC55/9 Rev.1 and EUR/RC55/Conf.Doc./5 Rev.1 were aimed at helping Member States overcome such challenges.

WHO's health system performance framework comprised three goals (health gain, level and equity; equity of financial contribution with protection against financial risk; and responsiveness) and four functions (service delivery, financing, resource generation and stewardship/governance). Improved health was the overall health system goal and would be achieved by a mix of interventions targeted at individuals (personal health services), populations at large (non-personal health services), intersectoral action and other contributing factors (social determinants).

The challenge was how to make Member States' health systems as effective as possible in each particular context; it would therefore not be possible to have one strategy for all countries. Better health could be achieved through specific national objectives such as reduced infant and maternal mortality rates, which would then be translated into a set of intermediary objectives such as increased vaccination coverage, better antenatal and delivery care, easier access to safe delivery services and improved maternal and infant nutrition. It would then be necessary to identify reforms across the four functions that could best link to the objectives. For example, the main obstacles to effective implementation of interventions to treat tuberculosis in Europe were not the lack of knowledge; the problems were systemic and required a coordinated, multifunctional response.

The Regional Office was committed to promoting an approach to better support Member States in the health systems field through: improved country work, giving a health systems focus to vertical programmes; building partnerships with other stakeholders, to strengthen health systems; placing emphasis on supporting particular policies and interventions based on evidence; and learning by doing, based on transparent monitoring and evaluation of reforms.

The Chair of the World Alliance for Patient Safety pointed out that a key element of strengthening health systems was improving patient safety. Since 2004, when the Alliance had been created, meetings on that topic had been held in five of the six WHO regions. About 140 Member States had expressed interest in being involved in the work of the Alliance, including many in Europe. Member States faced similar challenges to improving patient safety. The Alliance had an important role to play in helping to coordinate and accelerate improvements in patient safety globally. The progress made since 2004 included the formulation of a Global Patient Safety Challenge that would entail action by Member States over a two-year period. Health care-associated infections had been chosen for the first Challenge, which would be launched by the Director-General of WHO in Geneva, Switzerland, in October 2005. An international awareness campaign on hand hygiene would be conducted, countries would be invited to pledge money to implement measures to reduce health care-associated infections and share results, and implementation of the new WHO guidelines on hand hygiene would be tested in selected districts worldwide.

A second area of action of the Alliance reflected the important role that patients and their families played in improving patient safety. The Alliance was planning to run a workshop on that topic in November 2005, in conjunction with the EU Patient Safety Summit being organized as part of the United Kingdom's Presidency. A third action area was work on an international taxonomy for patient safety, to facilitate the aggregation and analysis of data from different countries. Other action areas were collecting data on patient safety, particularly in developing countries, setting priorities for future research, making available the best evidence on how to reduce the risks of health care and improve its safety, and contributing to the development of WHO guidelines on patient safety reporting systems. Progress in all of those areas would be reported at the second annual Alliance Day in Moscow, Russian Federation in December 2005.

In the ensuing debate, speakers welcomed the timely refocusing of the Regional Office's Country Strategy towards strengthening health systems. Several examples were given of recent health system reforms in the Region and of the need for a systemic approach to be adopted. Information, knowledge and technical assistance from WHO were recognized as vital in implementing reforms, and the experience of other countries should be learned from. However, as indicated in the Regional Office's proposed approach, the differences between situations in different countries should not be forgotten, and a flexible approach was needed.

A representative speaking on behalf of the Nordic countries stressed the importance of health promotion and disease prevention, with a focus on primary health care services. The issue of health personnel was particularly pertinent in the light of the presentation on patient safety, the conclusions of which were applicable to all countries. The complexity of factors affecting health systems was recognized, in particular the fact that many of them lay beyond the scope of health ministries. Intersectoral collaboration was essential.

Several speakers emphasized the need for WHO to work closely with the EU, OECD, the World Bank and other international organizations in the area of health systems in general, and in particular on the harmonization of performance indicators. The idea of a conference was strongly welcomed, and the representative of Estonia proposed his country as host.

Additional issues that demanded consideration in the next phase of the Regional Office's Country Strategy in the health systems domain included the safeguarding of sexual and reproductive health, gender equality, knowledge management systems and the need for concerted action to combat noncommunicable diseases. A number of speakers noted the links between the Health for All targets and some of the MDGs, emphasizing the importance of maintaining clarity. A Regional Office policy on further clarification of proposed working methods would be appreciated.

Several representatives considered that the issues raised by the document on the next phase of the Country Strategy were of such complexity and pertinence in the current situation that there needed to be further discussion, debate and consultation with the Member States in order to produce a more robust strategy, especially in the light of preparations for the ministerial conference.

The CE representative informed the Committee that her organization was currently conducting a study on safety and quality in health care, in respect of which a draft recommendation was to be adopted by the end of 2005, as well as a study on gender equity in access to health care, that would be completed by the end of 2006.

The Director, Department of Country Focus, WHO headquarters spoke of the importance of the Organization's country support policy, saying that health systems reform and strengthening were the priority needs expressed by Member States. Dialogue and partnership, if accompanied by adequate capacity in the Organization and the countries, would ensure the success of the second phase of the Regional Office's Country Strategy.

The Director, Department of Health Systems Financing, WHO headquarters commended the initiative to link health system development to country support work as a very powerful approach advanced by the Regional Office for Europe. He mentioned that WHO, OECD and the EC were working to coordinate their requests to countries for health information. One important outcome that had been achieved was the updating of statistics on private expenditure in health, a collaborative effort of the Regional Office and WHO headquarters with other partners.

In reply, the Director, Country Support said that the document had been intended as a call for action to launch an initiative. Work on the strategy would be continued in dialogue and consultation with the Member States in the process leading up to the ministerial conference.

The Committee adopted resolution EUR/RC55/R8.

### **WHO's Eleventh General Programme of Work 2006–2015** (RC/2005/2)

The Assistant Director-General, General Management, outlined the process by which the Eleventh General Programme of Work was being developed. That process, which had started in May 2004 with the approval of the draft outline by the Executive Board, would include consultations with WHO Member

States, WHO's Secretariat, organizations of the United Nations system and intergovernmental organizations, civil society and major stakeholders. It would conclude with the presentation of the full document to the Executive Board in January 2006 and to the World Health Assembly in May 2006.

He briefly described the main challenges to health that had been identified to date, which were gaps in synergy/responsibility (because of the multisectoral nature of health), in implementation, in social justice (equity and human rights) and in knowledge. The purpose of the proposed global health agenda was to guide the response of Member States, WHO and other partners/stakeholders, to define the priority areas and explore the actions needed in each to overcome the obstacles and help to close those gaps, and to stimulate awareness of how new or revitalized partnerships could better meet global health needs. He invited the Regional Committee to comment on the draft General Programme, in particular on the proposed global health agenda and its implications for Member States and for the future work of WHO.

In the subsequent discussion, many speakers welcomed the work in progress on the draft General Programme. Various amendments were suggested: that the gaps in scientific research and in finance (and political will) should also be listed as challenges to health; that the fourth priority area should be amended to read "Reduce the health effects of poverty" and that the underlying text should refer to efforts by various sectors of society. More information was requested on various topics: the mechanisms for strengthening WHO's leadership role; the tasks that WHO could not currently carry out (its limits), the sectors in which it would like to intensify its work, and the new competencies that would be required; the consequences of globalization (particularly the migration of health personnel); the threat posed by antimicrobial resistance; the importance of patient safety and of using evidence- and knowledge-based interventions; the potential for using information and communication technology; and how the General Programme would be used in practice and serve as a guide for the Organization. It was noted that western European countries also had problems defining the orientation of their health systems. Several speakers emphasized the need for WHO to participate in the reforms being implemented by the United Nations and to promote the General Programme and ensure its ownership by all Member States through a process of consultation.

Speaking on behalf of the Member States of the EU, the accession countries and the candidate countries, a representative expressed regret that the Regional Committee had been given an opportunity to comment only on the executive summary, contrary to what had been expected from discussions during the Executive Board. He asked for more information on related activities, to better understand the vision and direction being followed, and for a clear explanation of WHO's specific role in delivering the proposed global health agenda. Two issues of particular concern to the EU were to promote partnerships while avoiding duplication and overlap with the work of other international bodies, and to define WHO's role in relation to health components of other policy areas such as international trade. Referring to the proposed priority areas presented in the executive summary, he suggested that the main document should include detailed information on the achievement of the health-related MDGs within the terms of WHO's core mandate, the horizontal links between the different priority areas (to ensure a coherent approach), and the importance accorded to prevention and health promotion. Further details would also be appreciated on the financing of health systems (recognizing variations between Member States), issues on equity and reducing health inequalities, the impact of the work of the Commission on Social Determinants of Health, public health research, and gender perspectives. The EU Member States invited the Regional Director to consider ways of consulting them and their main partners (particularly the European Commission) on the further development of the General Programme.

Another speaker suggested that the document should be more strategic and action-based, and include a clear mechanism for implementation and review, which should feed back to an update instrument. Given the crucial role of health promotion in the future work of the Organization, he expressed surprise that it was not included in the draft agenda of the Executive Board meeting in January 2006.

In his reply, the Assistant Director-General thanked the Regional Committee for its support and suggestions, which were very helpful and would be taken into account when the document was revised. Consultations were being held with partner organizations in Geneva, New York and Washington, to



discuss common areas of work. He said that he would try to organize a regional consultation on the General Programme once the draft of the full document was ready.

## **Elections and nominations**

*(EUR/RC55/5 Rev.1)*

The Committee met in private to consider the nomination of members of the Executive Board and to elect members of the SCRC and the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction.

### **Executive Board**

The Committee decided by consensus that Denmark, Slovenia and Turkey would put forward their candidatures to the Health Assembly in May 2006 for subsequent election to the Executive Board. The Committee also agreed by consensus that Latvia should present its candidature at the Health Assembly in 2006, should the amendments to Articles 24 and 25 of the WHO Constitution enter into force before the opening of the Health Assembly.

### **Standing Committee of the Regional Committee**

The Committee agreed by consensus to elect Italy, the Netherlands, and Serbia and Montenegro for membership of the SCRC for a three-year term of office from September 2005 to September 2008.

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

The Committee agreed by consensus to select Armenia for membership of the Policy and Coordination Committee for a three-year period from 1 January 2006.

## **Date and place of future sessions of the Regional Committee in 2006 and 2007**

*(EUR/RC55/Conf.Doc./9)*

The Committee adopted resolution EUR/RC55/R3, confirming that its fifty-sixth session would be held at the Regional Office in Copenhagen from 11 to 14 September 2006 and setting out arrangements for deciding on the place of the fifty-seventh session in 2007.

## **Technical briefings**

In connection with the session, three technical briefings were held: on options for the organization of the health system and health sector financing in Romania, organized by the Ministry of Health of Romania; and on obesity, diet and physical activity, and on strengthening pandemic influenza preparedness and response, both organized by the Secretariat.

## Resolutions

### EUR/RC55/R1

#### Framework for alcohol policy in the WHO European Region

The Regional Committee,

Reaffirming that the harmful use of alcohol is one of the major public health concerns, 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;

Recognizing that the harm done by alcohol is a pan-European problem with serious consequences for public health and human and social welfare affecting individuals, families, communities and society as a whole, that calls for increased international cooperation and the participation of all Member States in a cost-effective, appropriate and comprehensive response which takes due consideration of religious and cultural diversities;

Acknowledging the existence of socioeconomic and cultural differences, specific biological and genetic features, and variations in physical and mental health;

Noting the need to promote and further strengthen the public awareness of and political commitment to effective measures to combat alcohol-related harm;

Recognizing the threats posed to public health by the factors that have given rise to increased availability and accessibility of alcohol in some Member States;

Recognizing the importance of ensuring that a multidisciplinary and multisectoral approach is a governing idea of the implementation of the Framework for alcohol policy in the WHO European Region;

Aware that public health concerns regarding the harmful use of alcohol need to be duly considered in the formulation of economic 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. ENDORSES the Framework for alcohol policy in the WHO European Region outlined in document EUR/RC55/11 as a framework for strategic guidance and policy options for Member States in the European Region, taking into account existing political commitments as well as new developments, challenges and opportunities for national and international action;

2. URGES Member States:
  - (a) to use the Framework 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 a multisectoral and evidence-based approach which recognizes the need for political commitment and the importance of encouraging mobilization and engagement of the community and civil society in the actions needed to prevent or reduce alcohol-related harm;
  - (d) to promote alcohol-free policies in an increasing number of settings and circumstances, such as the workplace, in all traffic, young people's environments and during pregnancy;
3. URGES international, intergovernmental and nongovernmental organizations, as well as self-help organizations, to support the Framework and to work jointly with Member States and with the Regional Office to maximize the impact of the Framework's efforts to reduce the negative health and social consequences of the harmful use of alcohol;
4. REQUESTS the Regional Director:
  - (a) 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 Framework;
  - (b) to cooperate with and assist Member States and organizations in their efforts to prevent or reduce the harm resulting from alcohol consumption and thereby the level of alcohol-related problems in the Region;
  - (c) to mobilize other international organizations in order to pursue the aims of the Framework for alcohol policy in the Region;
  - (d) to continue, revise and update the European Alcohol Information System to reflect the new Framework for alcohol policy in the Region and to include a legal database in the system;
  - (e) to organize the production and publication of a review of the status of and progress achieved in addressing alcohol-related problems and policies in the Region, to be presented to the Regional Committee every third year.

## **EUR/RC55/R2**

### **WHO European Ministerial Conference on Mental Health**

The Regional Committee,

Acknowledging that mental health is currently one of the biggest challenges facing every Member State in WHO's European Region and that mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations;

Recalling resolution EB109.R8 adopted by the WHO Executive Board in January 2002, supported by World Health Assembly resolution WHA55.10 adopted in May 2002, that calls on WHO Member States to establish mental health policies, programmes and legislation based on current knowledge and considerations regarding human rights, in consultation with all stakeholders in mental health;

Recalling its commitment to resolution EUR/RC53/R4, which it adopted in September 2003, expressing concern that the disease burden from mental disorders in Europe is not diminishing and that many people with mental health problems do not receive the treatment and care they need, despite the

development of effective interventions, and requesting the Regional Director to arrange a ministerial conference on mental health in Europe in Helsinki in January 2005;

1. COMMENDS the Regional Office for Europe for organizing the first WHO European Ministerial Conference on Mental Health in successful partnership with the European Commission and the Council of Europe;

2. WISHES to express its sincere gratitude to the government of Finland for hosting the Ministerial Conference;

3. THANKS the governments of Belgium, Estonia, France, Greece, Luxembourg and the Russian Federation for hosting the pre-conference meetings, which made a significant contribution to the successful preparation of the Conference, and the government of Belgium for also hosting a consultation meeting to negotiate the Declaration and the Action Plan in advance of the Ministerial Conference;

4. SUPPORTS with satisfaction the strong and fruitful collaboration with nongovernmental organizations, including those involving users and family members, health professionals and other partners;

5. ENDORSES the Mental Health Declaration for Europe adopted at the WHO European Ministerial Conference on Mental Health, held in Helsinki in January 2005, and the Mental Health Action Plan for Europe, endorsed by the Declaration;

6. NOTES that the five areas of priority for the next decade are to:

- (a) foster awareness of the importance of mental well-being;
- (b) collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
- (c) design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
- (d) address the need for a competent workforce, effective in all these areas;
- (e) recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services;

7. URGES Member States to address these priorities by:

- (a) assuming the responsibilities they committed themselves to in the Declaration, in accordance with each country's constitutional structures and policies and national and subnational needs, circumstances and resources;
- (b) progressing towards reaching the milestones in the Action Plan by 2010;
- (c) developing, implementing and reinforcing comprehensive mental health policies aimed at achieving mental well-being and social inclusion of people with mental health problems by adopting appropriate measures in the twelve areas of action identified in the Action Plan;

8. REQUESTS the Regional Director to take the necessary steps to ensure that mental health policy development and implementation are fully supported in the Regional Office and that adequate priority and resources are given to activities and programmes to fulfil the requirements of the Declaration and the Action Plan through action in the areas of:

- (a) partnership, by encouraging cooperation with intergovernmental organizations, including the European Commission and the Council of Europe, and nongovernmental organizations;

- (b) health information, by supporting Member States in the development of mental health surveillance and the production of comparative data on progress, emphasizing mental health gains and mental health impact assessment;
- (c) research, by establishing a network of mental health collaborating centres that offer opportunities for international partnerships, good quality research and the exchange of researchers;
- (d) policy and service development, by providing governments with expertise to underpin mental health reform through effective mental health policies that include service design and legislation and the setting up of a network of national counterparts and experts;
- (e) advocacy, by informing and monitoring policies and activities that will promote the human rights and inclusion of people with mental health problems, reduce stigma and discrimination against them and empower users, carers and nongovernmental organizations;

9. SUPPORTS the Regional Office's Mental Health in Europe Implementation Plan 2005–2010 that provides a framework for WHO efforts and activities towards achieving the aims of the Mental Health Declaration and Action Plan and identifies the resources required to deliver them, as mandated by Member States at the Ministerial Conference in Helsinki;

10. REQUESTS the Regional Director to report regularly to the Regional Committee on progress made.

### **EUR/RC55/R3**

#### **Date and place of regular sessions of the Regional Committee in 2006 and 2007**

The Regional Committee,

Recalling its resolution EUR/RC54/R7;

1. CONFIRMS that the fifty-sixth session shall be held at the Regional Office for Europe in Copenhagen from 11 to 14 September 2006;

2. FURTHER DECIDES that the fifty-seventh session shall be held at the Regional Office for Europe in Copenhagen from 17 to 20 September 2007, unless the Regional Director receives a firm invitation on acceptable terms from a Member State by 1 January 2006, in which case the Regional Director will report accordingly to the 56th session of the Regional Committee which shall take the final decision on this matter.

### **EUR/RC55/R4**

#### **The Health for All policy framework for the WHO European Region: 2005 update**

The Regional Committee,

Recalling resolution EUR/RC48/R5 on the renewal of the regional Health for All (HFA) policy for the twenty-first century;

Having considered document EUR/RC55/8 on the update of the regional Health for All policy framework;

Reaffirming the core values of Health for All and the need to link these values to practical action, through ethical and values-based governance;

Noting that the update has been developed so as to be consistent with other policies, such as the Millennium Development Goals, WHO's General Programme of Work and the Regional Office for Europe's Country Strategy;

Recognizing the interest that has been expressed in ensuring that the HFA policy framework leads to a continuous, open-ended process throughout the Region;

1. APPROVES the 2005 update of the regional HFA policy framework as a guide for health policy development in Member States;
2. REQUESTS Member States:
  - (a) to use the updated regional HFA policy framework, where appropriate, when they develop or update their national policies, strategies and action plans for health development;
  - (b) to refer to and respect the reconfirmed HFA values and adopt the approach of ethical and values-based governance suggested in the update;
  - (c) to use, where appropriate, in their decision-making process the tools and checklist proposed in the update;
  - (d) to contribute to the open-ended regional HFA process by providing the Regional Office with case studies linked to the HFA update;
3. REQUESTS the Regional Director:
  - (a) to support Member States in using the HFA policy framework when updating their own national health development policies;
  - (b) to ensure dissemination of the update of the regional HFA policy framework among other international organizations;
  - (c) to lead the open-ended regional HFA process by collecting and sharing with countries case studies and other national experiences;
  - (d) to submit to the Regional Committee in 2006 a follow-up paper on indicators coordinated and where possible reported jointly with WHO/HQ, OECD and EUROSTAT that may be used for monitoring the implementation of the regional HFA policy framework in countries;
  - (e) to evaluate the impact of the update in Member States and to present a progress report to the Regional Committee in 2008 for its decision on further action.

## **EUR/RC55/R5**

### **Report of the Twelfth Standing Committee of the Regional Committee**

The Regional Committee,

Having reviewed the report of the Twelfth Standing Committee of the Regional Committee (documents EUR/RC55/4 and EUR/RC55/4 Add.1);

1. THANKS the Chairperson and the members of the Standing Committee for their work on behalf of the Regional Committee;
2. INVITES the Standing Committee to pursue its work on the basis of the discussions held and resolutions adopted by the Regional Committee at its fifty-fifth session;

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

## **EUR/RC55/R6**

### **European strategy for child and adolescent health and development**

The Regional Committee,

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

Recalling its resolution EUR/RC53/R7 requesting the Regional Director to prepare a European strategy for child and adolescent health, in collaboration with Member States, and to present it to the Regional Committee at its fifty-fifth session, resolution EUR/RC52/R9 on Scaling up the response to HIV/AIDS in the European Region of WHO, resolution EUR/RC54/R3 on Environment and health and the Mental Health Declaration for Europe, Helsinki 2005;

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

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

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

Noting that the improvement of child and adolescent health and development is closely related to the achievement of the Millennium Development Goals;

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

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

1. ADOPTS the European strategy for child and adolescent health and development;
2. URGES Member States:
  - (a) to take steps to develop and implement comprehensive strategies for child and adolescent health in line with the regional strategy, taking into account differences in epidemiological, economic, social, legal and cultural environments and practices;
  - (b) to give high priority to making improvements to children's and adolescents' health and development, through advocacy at the highest level, and by scaling up programmes, securing adequate national resources, creating partnerships and ensuring sustained political commitment;

3. REQUESTS the Regional Director:

- (a) to ensure adequate and appropriate support, including the mobilization of resources, from the WHO Regional Office for Europe to Member States in their efforts to develop and implement national policies and strategies for child and adolescent health and development;
- (b) to report to the Regional Committee at its fifty-eighth session on the progress and achievements made in developing and implementing child and adolescent health strategies in the European Region.

## EUR/RC55/R7

### **Strengthening national immunization systems through measles and rubella elimination and prevention of congenital rubella infection in WHO's European Region**

The Regional Committee,

Recalling the United Nations Millennium Development Goals and the *Strategic directions for improving the health and development of children and adolescents* that identify immunization as a strategy to reduce mortality and morbidity in children under five and help address the problems of poverty in high-risk and vulnerable populations, recommendations from the United Nations General Assembly special session on children (2002), and World Health Assembly resolutions WHA56.20 on reducing global measles mortality, WHA56.21 on the strategy for child and adolescent health and development and WHA58.15 on the draft global immunization strategy;

Recognizing that immunization is one of the most cost-effective public health interventions available, and that immunization programmes have been an integral part of public health services and a key prevention component of primary health care in the European Region for decades;

Recognizing that the certification of the Region as poliomyelitis-free in 2002 was the result of concerted activities by all Member States to ensure that all children are protected through vaccination, and that high-quality surveillance for poliovirus must be maintained until global poliomyelitis eradication is declared;

Recognizing that the success of immunization programmes has led to disease control achievements but that these gains can only be maintained and further progress made if continued attention is paid and strong support given to immunization programmes, including through the introduction of new vaccines when supported by scientific evidence;

Mindful that there are high-risk and vulnerable populations within the European Region that still lack adequate immunization coverage because of limited access to primary health care services for geographical, cultural, ethnic or socioeconomic reasons, as well as unfounded mistrust of vaccinations;

Acknowledging the right of children to the highest attainable standard of health and equitable access to health care services, and the need to achieve and maintain high coverage with childhood vaccines to ensure protection of and minimize disease transmission among all children;

Noting that reducing measles mortality will facilitate the achievement of the Millennium Development Goal targets globally and that rubella is a recognized and preventable cause of serious birth defects;

Acknowledging that measles and rubella can be eliminated in the WHO European Region and that congenital rubella infections can be prevented by using combined measles and rubella vaccines in a routine two-dose vaccination schedule within childhood immunization programmes, by achieving and



maintaining high coverage and by targeting susceptible populations, including women of childbearing age;

Having reviewed document EUR/RC55/6 on the European strategy for child and adolescent health and development and document EUR/RC55/7 on strengthening national immunization systems through measles and rubella elimination and prevention of congenital rubella infection in WHO's European Region;

1. URGES Member States:

- (a) to commit themselves and give high priority to achieving measles and rubella elimination and congenital rubella infection prevention targets by 2010;
- (b) to provide routine immunization programmes by achieving and maintaining high vaccination coverage with childhood vaccines and ensuring that all children, adolescents and women of childbearing age have equal access to safe and high-quality immunization services;
- (c) to ensure that surveillance, including the use of the required laboratory networks for measles, rubella, congenital rubella infection and poliomyelitis, is sufficient to achieve and sustain the elimination targets;
- (d) to support, where appropriate, the implementation of an immunization week within the Region for advocacy to promote immunization;
- (e) to foster the appropriate partnerships, including plans for intersectoral cooperation with governmental and intergovernmental agencies, nongovernmental organizations and other relevant partners, including the private sector and industry, to ensure the strengthening of routine immunization services and the achievement of the elimination targets;

2. REQUESTS the Regional Director:

- (a) to support and advocate collaborative efforts with Member States, governmental and intergovernmental agencies, nongovernmental organizations and other relevant partners to commit resources to strengthen routine national immunization systems; to achieve the measles and rubella elimination and congenital rubella infection prevention targets; and to implement an immunization week within the Region;
- (b) to provide strategic direction and technical guidance, as outlined in the *Global immunization vision and strategy 2006–2015*, to Member States to support their progress towards strengthening routine national immunization systems, including analysis of reasons for insufficient vaccine coverage and the introduction of new vaccines and technologies, and achieving the elimination targets;
- (c) to work in partnership with other WHO regions to facilitate communication and common approaches, where appropriate, on achieving elimination targets;
- (d) to provide the Regional Committee with an update on progress at its fifty-eighth session in 2008.

## EUR/RC55/R8

### **Strengthening European health systems as a continuation of the WHO Regional Office for Europe's Country Strategy "Matching services to new needs"**

The Regional Committee,

Recalling previous resolutions of the Regional Committee on cooperation with countries, in particular resolution EUR/RC50/R5 on the WHO Regional Office for Europe's Country Strategy

“Matching services to new needs”, and the principles outlined in the WHO Country focus initiative (document EB111/33);

Mindful of the discussions and comments at the fifty-fourth session of the Regional Committee on further developing and increasing the effectiveness of the Country Strategy to enable countries to strengthen their health systems;

Recalling resolution WHA58.34 which emphasizes that strengthening of health systems should be supported by research, resolution WHA58.30 which emphasizes that rapid progress towards the achievement of health-related development goals including those contained in the Millennium Declaration will require adequately staffed and effective health systems, resolution WHA58.33 which notes that health financing systems need to guarantee access to necessary services while providing protection against financial risk, resolution WHA57.16 that emphasizes the need to enable sustainable and effective health promotion measures, and resolution WHA57.19 on international migration of health personnel;

Having reviewed document EUR/RC55/9 Rev.1 “Next phase of the WHO Regional Office for Europe’s Country Strategy: Strengthening health systems”;

1. AGREES that:

- (a) progress is being made by the Regional Office in its efforts to improve the quality of the services it provides and tailor them to the health needs of Member States, as outlined by the Regional Director;
- (b) the Country Strategy approved by the Regional Committee at its fiftieth session should now be expanded to include the provision of support by the Regional Office to assist Member States to improve their health systems to attain better health, equity and responsiveness for their populations;

2. TAKES NOTE of document EUR/RC55/9 Rev.1, “Next phase of the WHO Regional Office for Europe’s Country Strategy: Strengthening health systems”, as a framework for the Regional Office’s Initiative in this domain and related work to be undertaken in the next five years, in collaboration with partners;

3. REQUESTS Member States to collaborate in this new phase of the Country Strategy by:

- (a) ensuring appropriate attention to the quality and skills of human resources, as well as to other resources needed for the health system and to strive towards self-sufficiency of health personnel as agreed in Resolution WHA58.30;
- (b) implementing effective and high-quality disease prevention and health promotion interventions, incorporating a gender-sensitive approach, and advocating for intersectoral action as integral responsibilities of the health system;
- (c) mobilizing adequate funding in an equitable manner and organizing incentives to promote universal access;
- (d) elaborating their policy objectives guided by the WHO values and principles endorsed by the Member States, supported by transparent processes of monitoring and evaluation;

4. REQUESTS the Regional Director to:

- (a) take steps to mobilize the human and financial resources needed to support Member States in developing and implementing their strategies for strengthening health systems, as described in document EUR/RC55/9 Rev.1;

- (b) organize a European ministerial conference on “Strengthening health systems” in 2007 or 2008, based on a consultative and participatory process with Member States, ensuring collaboration and harmonization with partner agencies;
- (c) report back to the Regional Committee in 2007 and 2009 on implementation of the Initiative for Strengthening Health Systems in the Regional Office’s work with countries in the European Region.

## EUR/RC55/R9

### Prevention of injuries in the WHO European Region

The Regional Committee,

Recalling World Health Assembly resolutions WHA49.25 on prevention of violence – a public health priority; WHA56.24 on implementing the recommendations of the *World report on violence and health*; WHA57.10 on road safety and health; and WHA57.12 on reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets; United Nations General Assembly resolution 58/289 on improving global road safety; the celebration of World Health Day 2004, dedicated to road safety; and the launches of the *World report on road traffic injury prevention*, and the Regional Office for Europe’s report *Preventing road traffic injury: a public health perspective for Europe*;

Recognizing the burden of injuries in WHO’s European Region, which is even increasing in some countries of the Region, and the urgent need for public health action to reduce the relentless daily loss of life and suffering caused by unintentional injury and violence;

Mindful that this response should take into account the diversity of the European Region, the inequalities in the burden of injuries across and within countries, and the opportunities created by adopting a public health approach that promotes multisectoral action in which the health sector plays a coordinating role, as well as by mainstreaming injury prevention across different policies within and outside health systems;

Acknowledging the extensive work already carried out by WHO globally and within the European Region on the prevention and control of unintentional injuries and violence, as well as Member States’ existing commitments to improving reproductive health (as exemplified by World Health Assembly resolution WHA57.12), child and adolescent health (Regional Committee resolutions EUR/RC51/R4 and EUR/RC53/R7), and environment and health (resolutions EUR/RC49/R4 and EUR/RC54/R3), and to addressing the harmful use of alcohol (resolution EUR/RC49/R8);

Having reviewed document EUR/RC55/10 on Injuries in the WHO European Region: Burden, challenges and policy response;

#### 1. URGES Member States:

- (a) to give high priority to the prevention of violence and unintentional injury by developing national action plans that are coordinated with other relevant existing action plans, so as to strengthen their efforts to implement existing World Health Assembly and Regional Committee resolutions;
- (b) to develop injury surveillance, in order to obtain a better understanding and to raise awareness of the burden, causes and consequences of injuries, so that programmes and investments for prevention, care and rehabilitation can be better targeted, monitored and evaluated;

- (c) to strengthen their technical and institutional capacity to address the issue of injuries, both in terms of prevention and along the whole continuum of trauma care, from the prehospital phase, through hospital care to rehabilitation, as well as strengthening social interventions to address interpersonal violence, as appropriate;
- (d) to promote research on effective intervention measures and the implementation of evidence-based approaches for prevention and care, which would also involve establishing effective mechanisms for identifying, disseminating and sharing good practices across and within countries and sectors;
- (e) to take stock of and support the activities of the network of national focal points for violence and injury prevention, to promote the dissemination and sharing of experience in developing and implementing policies and actions to reduce the burden of injury across the Region;

2. REQUESTS the Regional Director:

- (a) to support Member States in their efforts to strengthen injury prevention and to draw up national action plans;
- (b) to facilitate the identification and sharing of good practice in the prevention of violence and unintentional injuries;
- (c) to stimulate and support the network of national focal points and further develop collaboration with other relevant networks of experts and professionals;
- (d) to provide assistance in building capacity at the technical and policy level in order to strengthen national response to injuries to include surveillance, evidence-based practice and evaluation;
- (e) to provide technical assistance to improve prehospital treatment and care for victims of unintentional injuries and violence;
- (f) to promote the development of partnerships and collaboration with the European Union and other international organizations, in particular the Council of Europe, the European Conference of Ministers of Transport, the Organisation for Economic Co-operation and Development, the United Nations Economic Commission for Europe, the United Nations Children's Fund, the International Labour Organization, and nongovernmental organizations, as appropriate, to enhance the response to the challenges posed by different causes of injuries;
- (g) to report back to the Regional Committee in 2008 on progress achieved in the implementation of this resolution by the Secretariat and the Member States.

*Annex 1***Agenda**

- 1. Opening of the session**
  - (a) Election of the President, the Executive President, the Deputy Executive President and the Rapporteur
  - (b) Adoption of the agenda and programme of work
- 2. Address by the Director-General**
- 3. Address by the Regional Director**
- 4. Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board**
- 5. Report of the Twelfth Standing Committee of the Regional Committee**
- 6. Policy and technical items**
  - a) European strategy for child and adolescent health and development, including immunization
  - b) The Health for All policy framework for the WHO European Region: 2005 update
  - c) Framework for alcohol policy in the WHO European Region
  - d) Injuries in the WHO European Region
  - e) Next phase of the WHO Regional Office for Europe's Country Strategy: Strengthening health systems
  - f) WHO's Eleventh General Programme of Work 2006–2015
- 7. Follow-up to previous sessions of the Regional Committee**
- 8. Private meeting: Elections and nominations**
  - (a) Nomination of three members of the Executive Board
  - (b) Election of three members of the Standing Committee of the Regional Committee
  - (c) Election of a member of the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction
- 9. Date and place of regular sessions of the Regional Committee in 2006 and 2007**
- 10. Other matters**
- 11. Approval of the report and closure of the session**

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

EUR/RC55/1 Rev.1	List of documents
EUR/RC55/2 Rev.1	Provisional agenda
EUR/RC55/3 Rev.1	Provisional programme
EUR/RC55/4	Report of the Twelfth Standing Committee of the Regional Committee
EUR/RC55/4 Add.1	Report of the fifth session of the Twelfth Standing Committee of the Regional Committee
EUR/RC55/5 Rev.1	Membership of WHO bodies and committees
EUR/RC55/6	European strategy for child and adolescent health and development
EUR/RC55/7	Strengthening national immunization systems through measles and rubella elimination and prevention of congenital rubella infection in WHO's European Region
EUR/RC55/8	The Health for All policy framework for the WHO European Region: 2005 update
EUR/RC55/9 Rev.1	Next phase of the WHO Regional Office for Europe's Country Strategy: Strengthening health systems
EUR/RC55/10	Injuries in the WHO European Region: Burden, challenges and policy response
EUR/RC55/11	Framework for alcohol policy in the WHO European Region
EUR/RC55/12	Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC55/13	Follow-up to previous sessions of the WHO Regional Committee for Europe

**Information documents**

EUR/RC55/Inf.Doc./1	The WHO Regional Office's Strategy on the Millennium Development Goals in Europe
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**Background documents**

EUR/RC55/BD/1	Report on alcohol in Europe: background paper for the Framework for Alcohol Policy in the WHO European Region
RC/2005/1 (HQ)	Guiding principles for strategic resource allocations
RC/2005/2 (HQ)	Draft Eleventh General Programme of Work 2006–2015: executive summary

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

Mr Chairman,  
Honourable Ministers, Mr Kyprianou, European Commissioner and Dr Gezairy,  
Distinguished representatives,  
Colleagues,

Last Friday several of the governments represented in this room launched the International Financing Facility for Immunization - IFFIm. A cornerstone of the Millennium Development targets is the pledge to reduce the child mortality rate by two thirds, by 2015. Until that day in London, there had been a question mark hanging over how that pledge could be financed. Now we have a partial answer. However, IFFIm's significance is not only in the scale of its funding - which is about US\$ 4 billion over the next 10 years. It goes beyond the great increase in the numbers who can be protected by vaccination, or the children saved from death by diarrhoeal or respiratory diseases, as new immunizations against rotavirus and pneumococcal disease come on stream. IFFIm is important for all these reasons, but also because it is a massive united commitment to protecting health. That goal of health security, with all its associated benefits to our societies, has brought us all here today. Your ability to work together, and with counterparts across disciplines, is critical to tackling the current threats to health.

Good early warning and defence are fundamental to health security. Health systems need to be capable of prompt detection and response. Experience with natural disasters in Romania and elsewhere (Bulgaria, Moldova, Germany, Switzerland, Austria, etc) has shown how vital it is to have the right resources in place to respond quickly, not just to the immediate crisis but to the subsequent public health consequences.

We are closer to a pandemic of flu than at any time since 1968. The warning signs are clearly there. Avian flu virus is already firmly entrenched in poultry in parts of Asia. In late July this year the virus was carried here, with outbreaks in poultry and wild birds reported in the Russian Federation and Kazakhstan.

So far, a total of 112 human cases have been confirmed in four countries: Cambodia, Indonesia, Thailand and Viet Nam, with 57 fatalities. Fortunately, so far the virus has not crossed easily from birds to people, nor has it spread easily among humans. But the geographical range of the virus increases opportunities for human cases to occur. These in turn increase opportunities for the virus to become more contagious.

WHO has recently produced and sent out guidelines to help countries prepare effectively for a pandemic. They detail the strategic actions to take, in three phases. What we have to achieve now, in the pre-endemic phase, is the reduction of opportunities for human infection and a strengthening of the early warning system. This tactical response goes together with taking the best medical precautions available.

Rapid deployment of assets and resources contains outbreaks at an early stage. That means availability of health care workers, antiviral medicines like Tamiflu, vaccines against influenza, and other measures such as the creation of quarantine sites, and closing schools and other public places. Trained health workers are needed, to deal with the pandemic and educate the public in epidemic response.

Rapid increases are needed in the overall production capacity of the vaccine sector, in both developing and developed countries. We know that the demand far outstrips supply. We have therefore to find a way to avoid this bottleneck and expand vaccine manufacturing sites. Currently fewer than 10 countries have domestic vaccine companies engaged in work on a pandemic vaccine.

Poorer countries will not be able to protect themselves as effectively as the wealthy. In the past, developing countries have usually received vaccines after the pandemic has passed. This must not happen

this time. We have an opportunity here to live up to our ideals of health for all. We must make sure, as best we can, that there are sufficient supplies of medicine and vaccine for everyone.

Massive international cooperation is needed now to contribute towards advance preparation of global antiviral stockpiles and pandemic vaccine development. Decisive action is needed now by donors and international partners to help the countries affected to limit the scale of the bird flu outbreak and to reduce the risk for humans.

Planning the public health response goes beyond the immediate medical needs to include the political, social and economic consequences and ramifications. The pandemic we anticipate has an additional important aspect: in its current stage of development, H5N1 virus has a vast potential animal reservoir. Over 140 million birds have already been culled, with estimated associated economic losses of between US\$ 9.7 and 14.6 billion.

The horrors of mass slaughter of livestock are already well known here, as are the social and financial implications of the loss of livelihood, of quarantine, and market disruption. We need to think about incentives for poultry farmers to cooperate in the event of outbreaks. They will need support and compensation. Even the measures taken so far, of sheltering poultry from possible contact with infectious migrating birds, have already had economic implications. However, daunting as the losses are for those compelled to kill their herds or flocks, the alternative, of inaction, of hoping that the worst will not happen, is not an option.

This is a critical moment for you, the health leaders in your countries, to interact decisively with your counterparts in agriculture, finance, education and industry, to share information and plan strategically. Commissioner Kyprianou, I welcome your presence here today, and ask you to take these messages to your fellow Commissioners in Brussels. We must rapidly evolve the levels of communication and coordination that we will need, and ensure equity of access to life-saving vaccines or medicines. I would welcome the opportunity to meet with you to take this forward.

Universal access is a central goal in our efforts to combat disease. The “3 by 5” initiative has made a start in changing the global mind set that access to drugs is only for those who can afford it. The G8 recently set an even more ambitious target at Gleneagles. This was to get “as close as possible to universal access to treatment for all those who need it by 2010”. Access for everyone to the treatment they need is now recognized as not only absolutely necessary for people who live with HIV, but entirely feasible, if everyone plays their part.

Disease outbreaks in one country are everyone’s business. The International Health Regulations 2005 recognized this. It will be increasingly important to coordinate information and activities on disease prevention and control. You are already doing this successfully with your close neighbours in the Eastern Mediterranean Region, in several areas. I am delighted to see here today Dr Gezairy, the Regional Director. Your presence here is testament to a determination to connect our efforts.

Our work in polio is a good example of this. This Region has already been certified as polio-free. Yet your neighbours in both the Eastern Mediterranean and African Regions are still struggling with ongoing transmission, and even re-infection. It is vital to maintain high population immunity and strong disease surveillance to minimize the risk of polio importation. The resources to keep these protective barriers in place are needed not just for polio but for all potential outbreaks of disease or infection. The prompt sharing of information is an essential part of this. So is a recognition that gains made in one country benefit us all. The generous financial support given by European governments to get the task finished, and to protect the investment already made, is a crucial part of the global effort, and I recognize the £ 61 million donated by the British government.

The current battle against tuberculosis would benefit from a similar level of commitment. The burden of disease in the countries of Eastern Europe and Central Asia is contributing significantly to the global

burden of tuberculosis. Control is threatened from several sides, from multidrug resistance and the HIV co-epidemic.

The vulnerability of our young people is a particular concern. The European Strategy for Child and Adolescent Health and Development is an excellent initiative in this regard. I welcome its emphasis on strengthening national immunization systems through work on measles and rubella elimination.

Our current social and cultural environments are resulting in unacceptable health consequences. Obesity is growing, and with it rising levels of chronic diseases like diabetes. Europe continues to record the highest level of alcohol consumption in the world, with increasing binge drinking in both East and West. There is no simple solution to changing these behaviours, which have deadly effects.

Normal adolescent risk-taking behaviour, under the influence of drugs or alcohol - or both - translates into life-threatening activities, such as drunk driving or unprotected sex with infection-carrying partners. The number of people living with HIV in eastern Europe has risen rapidly in just a few years, fastest in Ukraine, with the largest epidemic in the Russian Federation. Eighty per cent of people living with HIV are less than 30 years old. The epidemics are mostly concentrated among intravenous drug users. Young people are the largest group of those newly infected with HIV through injecting drug use. Sexual transmission of HIV is increasing, as is co-morbidity with other sexually transmitted infections and tuberculosis.

Some of the highest injury rates in the world- from road traffic injuries or from interpersonal violence - are found in Europe. Alcohol is one of the contributing factors to both these. Overall, it accounts for more than 10% of disease burden in Europe. This is more than twice the world level. You are leading the way in discussion of these extremely difficult issues.

Europe also has some of the lowest injury rates in the world. There are success stories here that can be replicated: in the use of seatbelts, efforts to control speeding, programmes to prevent child abuse through home visits and to prevent violence against women through promotion of gender equality. Your success provides lessons in multisectoral collaboration; scientific approaches supported by good data collection and evaluation; the value of services for victims; and activities to tackle the root causes of violence and abuse.

It is an uncomfortable truth that many of the factors that are importantly influencing health outcomes are not under our control. We must face squarely how much the profile of health has changed and how consequently our own roles and responsibilities have changed. These concerns underlie our strategic planning for the next 10 years. There are significant gaps in how we are able - or willing - to work together to take responsibility for changing these outcomes.

There are other gaps too - in the ways that systems are working, the ways that we are using the knowledge we gather, and the ways in which we are reflecting considerations of equity, human rights and gender in our work. This overall perspective is driving how we approach and plan our work. On your timetable for this week is a challenging draft general programme of work. The proposed global agenda in that document, that you will review and discuss, proposes that the future of public health demands a wider frame of reference through constructive and purposeful relationships with those outside the conventional health sector.

For example, patent issues have brought public health concerns directly into high-level international trade negotiations. The World Health Assembly this year recognized the danger of bilateral free trade agreements restricting flexibility. These issues require specialized knowledge of the sort that WHO - and the health sector in general - have not traditionally had. That expertise is now becoming part of the technical support that we are able to offer countries wishing to enter into such agreements. For example, Estonia and Latvia are now facing rising numbers of patients who need ARV treatment. These countries will need to review their options for making ARVs available through lowering prices and reviewing the patent issues, but in accordance with their EU obligations.

The Framework Convention for Tobacco Control is a positive example of how we can gather international consensus on damaging health behaviours, and work collectively on solutions. I thank all of you here who have already ratified. In February 2006, the first meeting of the Conference of the Parties to the FCTC will be held. I urge all of you who have not yet signed or ratified, to do so.

The adoption of the International Health Regulations 2005 by the World Health Assembly this year was also a historic step towards building improved health security and improving global coordination. These frameworks set up the structures and the expectations for better collaboration and communication. It is you, here in this room, who have the power to bring these paper agreements to life. The global environment of threats to health security will not change unless we make it change. The challenges are clearly there before us. I wish you well in your discussion of them this week.

Thank you.

*Annex 5***Address by the Regional Director for Europe**

Mr President, participants in the fifty-fifth session of the WHO Regional Committee for Europe, distinguished representatives of Member States and other organizations, dear friends and guests, Dr Lee, Director-General of WHO, Mr Kyprianou, European Commissioner for Health and Consumer Protection, and Dr Gezairy, my colleague and Regional Director for the Eastern Mediterranean,

I have the honour, as I have done for the last six years now, of presenting the report on the work done by the Regional Office in the last year, since September 2004.

This year once again, our work has been dictated by the WHO programme for 2004–2005 that you adopted, and the comments and recommendations you made at past sessions of the Regional Committee. We have also followed the vision of the way that the Office should develop that I put to you when I was reappointed. The objective was, over the five years of my mandate, to make the Office a modern, credible organization, recognized in the world and capable of adapting to changes in the Region.

However, our main guide has been the heart of our mission as contained in the strategy adopted by the Regional Committee in 2000: matching the services of the Office to the needs of the countries in the Region. But we need to know what those needs are and to interpret them, and hence the importance we set on research and the application of evidence in public health. The work that led to the publication of the *European health report*, which is now available, also helped build up our knowledge of the situation in the countries of the Region.

So my presentation today will focus on responding to countries' needs and the themes I have just outlined.

**Responding to countries' needs to deal with health crises**

Responding to the needs of countries means, first and foremost, providing them with support and assistance in dealing with the health crises that are sadly becoming increasingly frequent throughout the world, including in our own Region.

**The tsunami and the floods**

I will begin with the catastrophe that shook us all at the end of 2004 and beginning of 2005: the earthquake and the tsunami that followed it in Asia. As soon as we heard about it, I offered our support to Dr Samlee, the Regional Director for South-East Asia. Members of our Office staff joined the WHO teams working there.

We also helped to coordinate the response of European Union (EU) countries to the call made by Luxembourg, which then held the EU Presidency. I should like particularly to mention the work done by Luxembourg and its minister of health, Mr Mars di Bartolomeo.

Then, this summer, very many fatal catastrophes hit our own Region. Above and beyond the immediate human tragedies they caused, they also put great pressure on the health systems of the countries affected.

Romania, where we are meeting today, was severely affected by the floods, as were Bulgaria, the Republic of Moldova, Germany, Switzerland, Austria, Kyrgyzstan and Tajikistan. We also remember the earthquake in Turkey and the fires in Portugal. In each case, the Office offered its assistance and put its knowledge and know-how, sadly built up from a wealth of experience, at the service of the national governments.



The fact that there have been so many catastrophes has led us to strengthen our humanitarian aid programmes. In addition to the technical publications on climate change, the health consequences of floods, and crisis communication, we are also working on some very practical recommendations that include situational exercises and adaptability trials.

A case-by-case response is completely inadequate, and we must make sure that the systems are ready to produce a quick, adapted reaction to crisis situations that are unexpected by definition and highly variable by nature.

Preparing health systems for health crises has become an unavoidable priority for public health.

## **Influenza**

This outlook has also guided our work with headquarters and the other regions of WHO in responding quickly and appropriately to the potential influenza pandemic that is causing concern throughout the world.

We are collaborating in this context with the European Union and the European Commission, the European Centre for Disease Prevention and Control (ECDC), the United Nations Food and Agriculture Organization (FAO) and the World Organisation for Animal Health (OIE). Practical exercises are being drawn up in six countries in the Region, and a coordination meeting is to be held in Copenhagen in October, for not only the European Union countries, but all 52 countries in the European Region.

Our main objective is that each country should have a sound national plan, consistent with those of the other countries in the Region. We are also ensuring that the surveillance and response structures are ready to function properly.

According to the most recent information we have, there have not been any human cases of avian influenza in the Region, and the animal cases found in Russia and Kazakhstan have been restricted to limited geographical zones that are being monitored by the governments concerned, in collaboration with FAO and OIE. The aim is to minimize the risk of transmission to humans.

However, we must remain vigilant, because if a pandemic were to occur, it would take at least 10 weeks before a vaccine could be developed from the virus responsible; though we hope that that period could be reduced to 6 weeks. It would then take several months for the production and large-scale distribution of large quantities of the vaccine. There would be similar problems in gaining rapid access to large quantities of antivirals. So, despite the encouraging models and the means that are already being put to use, it would be not be correct to think that we have a 100% chance of controlling a pandemic at source.

Good preparations, leading to a rapid response, adapted to the situation, are the only way of minimizing the health consequences of a pandemic. That is why the Office and the countries in the Region consider this issue to be the most urgent priority today.

## **Responding to countries' needs through the regional contribution to global initiatives**

### **HIV/AIDS and the 3 by 5 initiative**

The European Region has fulfilled its commitment to provide treatment for 100 000 more patients by the end of 2005.

However, this encouraging result should not obscure the need for universal access, the next world objective for 2010. Universal access, of course, means the provision of treatment and care for those in need, but it also means prevention. For the Region, it means providing treatment for another 300 000

people, an ambitious but, in human terms, quite incontestable objective. It may be difficult to achieve, particularly in the very large countries, like Ukraine and the Russian Federation, where our teams are working in close collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and all its co-sponsors, particularly the United Nations Children's Fund (UNICEF).

But treatment for all those in need is only one part of the solution. In particular, we must not forget the need to scale up prevention. Since 2002, the number of new cases of HIV/AIDS has increased in 30 countries in both the east and west of the Region. This worsening of the epidemic means that we need to scale up prevention campaigns, including risk reduction efforts.

WHO has supported many countries in developing proposals to be submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Lower prices to ensure better access to treatment is one of the fundamental themes of our collaboration with the countries in the Region that request our support. In the case of the Russian Federation, the result has been to bring down the price of antiretrovirals to one third of its previous level. Once again, I would call on every country in the Region to join in this work because, beyond the technical and scientific aspects, we must have solidarity if we are to beat this devastating disease.

Here again, strengthening health systems is fundamental to the issue, for buying drugs may be important, but getting those drugs through consistently to the people who need them is even more so. We will come back to this issue tomorrow morning during the session on country health systems.

### **Tobacco control**

Tobacco control is another illustration of our regional commitment to a global fight. This year saw the coming into force of the Framework Convention on Tobacco Control. The European Region continues to maintain the determination it has shown since the beginning of the process. Twenty-two countries in the European Region, representing 30% of the global figure, and the European Union, have already ratified the Convention. Ratification is a first step, and now both WHO and the Regional Office for Europe must follow up on implementation. We therefore support and shall continue to support all the countries in the Region, helping them to establish their own action plans, to share their experiences with others and to evaluate and publish their results. By way of example, a meeting on the subject is to be held in Sofia later this month for eight countries in the south-east of the Region.

The process used in the case of the Framework Convention on Tobacco Control was taken as a model in the work on the International Health Regulations. The Regulations, which were adopted by the World Health Assembly, represent a new type of tool that can be used in public health to take account of emerging threats. As in the case of tobacco control, the Office was able to stimulate regional commitment to help achieve the positive outcome we all are aware of.

### **The Millennium Development Goals**

To conclude this section on regional activities in support of global programmes, I would like to mention the Office's work on the Millennium Development Goals. This United Nations programme covers health and development very broadly in areas such as poverty, maternal and child health, HIV/AIDS and the environment. It involves the Region's different countries in different ways. Current information indicates that the weaker countries in the Region will find it difficult to achieve the expected outcomes by 2015. Disaggregation of geographic, ethnic and social data reveals pockets of poverty where the goals will be more difficult to achieve than in other, better off, parts of the Region.

It has not been easy to find the right position for the Region to adopt, taking account of all its particularities, but we do now have a suitable strategy. The Office would like to help all the Member States in the Region, whether in their efforts to achieve the Goals or by encouraging exchanges of information and solidarity. A document showing the areas in which the Office plans to provide assistance has been produced for this session of the Regional Committee and is available to you. A programme

called MDG+ is currently being discussed. It proposes an approach and goals that are relevant to the European Region; it should not, however, be seen as an alternative to the Millennium Programme, but rather as a complement to it for our Region.

Finally, in a closely related area, I should like to mention that, through its Venice centre, the Region contributed to the global Commission on the Social Determinants of Health, chaired by Professor Marmot.

### **Responding to countries' needs through more specifically regional activities**

This year, the Regional Office has continued to work in the various areas of its activities. You will have the opportunity to discuss many of these subjects over the next few days. I cannot discuss them all in detail, and so shall mention only those of particular current or continued interest.

#### **Mental health**

This year 2005 began with the Helsinki Conference on mental health, which emphasized the need to raise awareness in different parts of society, to do away with discrimination and to support the people affected and their families:

- for health officials, this means better inclusion of mental health in health systems and in health policy;
- for health professionals, it means improving their technical competence in the area;
- and finally, for the patients and carers, it means recognizing and making use of the knowledge born of their experience.

#### **Environment and health**

We also paid particular attention this year to the follow-up to the Budapest Conference on environment and health. Professor Dab, chairman of the European Environment and Health Committee, will give you the details tomorrow afternoon. In the area of environment, we should note with satisfaction the recent entry into force of the Protocol on Water and Health to the 1992 Convention on Protection and Use of Transboundary Watercourses and International Lakes.

#### **Tuberculosis**

Tuberculosis is a matter of great concern in our Region today. As the *European health report* points out, the number of cases has grown by more than 50% in 12 years. The main factors behind the epidemic are poverty, multidrug resistance, coinfection with HIV, and its spread within prison populations.

In February, I sent out an alert on the tuberculosis situation to all the ministries in the Region. We must reverse the trend in the Region in this primarily social disease. In particular, it must benefit from the progress achieved in development in the transition countries.

#### **Activities in preparation: Immunization Week and the Ministerial Conference on obesity**

The first European Immunization Week is to take place from 17 to 23 October 2005. The objective is to raise public awareness and political commitment in order to guarantee the right of every child to be immunized against vaccine-avoidable diseases. I am sure that all the countries in the Region will take part in the Week, an event that has proved its worth in other parts of the world.

The subject of obesity is also a priority issue of great current interest. It is not surprising that both WHO and the European Union have included it in their own programmes and in their cooperative work. I proposed a European ministerial conference on the subject, and it is to be held in Istanbul from

15 to 17 November 2006. The European Union will be a partner, but we also plan to include the Council of Europe, FAO, UNICEF and perhaps the World Bank and the Organisation for Economic Co-operation and Development in the partnership. Consultations and pre-conference meetings have already been planned for next month in Denmark and June 2006 in the Netherlands. After the Conference, at the Regional Committee session in 2007, we will be able to submit a revised version of the European action plan for nutrition.

As you can see, our activities cover many different areas but there is an inescapable need today to ensure that they are based on reliable, sound health systems. Progress in health depends to a large extent on the capacity of countries to sustainably strengthen their health systems. For our part, we are strengthening our programme and will present you our strategy tomorrow morning.

### **Responding to countries' needs by making our support more effective**

We have stepped up our activities within countries this year, making them more systematic, better planned and better evaluated. This has concerned all the countries in the Region.

For the 28 countries in which we have an office, we have gained good experience from the negotiations on the biennial collaborative agreements, which now include some very practical activities and funding for them. We also have plans to mobilize resources for each of them. During the year, we have scaled up the training for field staff, of whom we now have 245, and we are in the process of recruiting 8 heads of office at international level. The quality and efficiency of the country teams are often acknowledged by other international organizations and appreciated by the local authorities.

The Futures Forum programme has continued its activities with the 24 countries more to the west of the Region, and has produced a series of reports on crisis communication, unpopular decisions, and patient safety management. We also have specific activities for these countries, such as the work on drafting a law on public health in Greece, that on air pollution in Germany, on health insurance legislation in Cyprus, and on health promotion policy in Luxembourg, and a review of health systems in Switzerland.

The opening of an office in Germany this year brings a new type of Regional Office presence to the group of countries in the west of the Region that did not have one before. We hope that it will serve as a model for other countries in the same group.

### **The Stability Pact**

In this section, I would like to update you on the programme for the Balkans launched in collaboration with the Council of Europe in 2001 after the conflicts that affected that part of the Region. A second phase of the programme, much appreciated by the countries concerned, is to be launched in Skopje in November. The initiative currently covers seven areas: mental health, nutrition, communicable diseases, public health training, tobacco control, blood products and drugs. The programmes are active in eight countries and funded by nine countries and four international organizations.

### **Kosovo appeal**

To conclude this section, I would like to draw the Regional Committee's attention to the tragic situation of a population in Kosovo who have to live in unacceptable and inhuman sanitary conditions with lead emissions in the environment. These are serious health threats for the many pregnant women and children. The United Nations Secretary-General's envoy and head of mission in Kosovo asked me for the Regional Office's support to help bring an end to this situation and transfer these people out of the camps they are living in today. I appeal for your support and your generosity to help us fulfil our duty of technical aid and solidarity. This is a good way of promoting the equity we consider so important to the health of our Region. We need US\$ 1 million to strengthen our team and build up a rapid and effective programme.

## Responding to countries' needs through partnership

This year, we have continued, and indeed strengthened, our cooperation, particularly in the field, with the Council of Europe, the World Bank and with other United Nations organizations, notably UNICEF. We have expanded our work with the national development agencies, in particular the GTZ of Germany and the agencies of the Nordic countries and the United Kingdom. However, we still do not have a clear policy or an action plan for our collaboration with nongovernmental organizations.

In our cooperation with the European Union, we are becoming increasingly involved in the programmes proposed by the country that holds the presidency. This was the case with the Netherlands and Luxembourg in the areas of pharmaceuticals and mental health. We are now working closely with the United Kingdom on patient safety, health inequalities and, of course, influenza. We are already preparing for the Austrian and Finnish presidencies, with the topic of health in public policy, a subject our Health Systems Observatory in Brussels is working on.

With the Commission itself, there has been a significant and visible increase in collaboration in the area of mental health in connection with the Helsinki Conference. Environment and health is another field where we have had a strong partnership since the Budapest Conference. The Ministerial Conference on obesity, nutrition and physical activity in 2006 will provide us with another opportunity to collaborate on a subject fundamental to public health. Alcohol, which we are going to discuss tomorrow, is a further area in which our cooperation has grown throughout the year and will, I hope, continue to do so in the years to come.

The Regional Office was very closely involved in the setting up of the European Centre for Disease Prevention and Control in Stockholm in May of this year. We have already established good collaboration with this new body, particularly in information collection and analysis. We have just signed a protocol on collaboration with the Centre. We are determined to continue in this direction, and the appointment of Ms Jakab, a former member of our team, as director of the Centre will certainly facilitate our joint work.

In addition to the European CDC, we also collaborate with other agencies of the European Union, notably the European Environment Agency in Copenhagen. It would also be useful to establish closer links with the Food Safety Authority and to renew our protocol on collaboration with the drugs agency in Lisbon.

I would particularly like to thank Mr Kyprianou for accepting my invitation to be with us here this morning. You are the first European Commissioner to do so, and I can only interpret your presence as demonstrating your clear wish to collaborate with WHO, at both global and regional levels.

Without being restrictive, our collaboration with the European Union is a priority for us, in addition to being a way of achieving efficiency that is not confined to 25 countries, but also makes it possible to build bridges with other countries in the Region so that they too benefit from the results of our work together. For we consider each country as important as the next, whether it is a member of the European Union or not.

To conclude this section, I should like to pay tribute to my friend Fernand Sauer who is soon to leave his post and who, for many years now, has done much to facilitate our work together.

Our work in collaboration with other organizations that are interested in health and share our values is always the mainstay of the Office's strategy. There is enough room in health, particularly in the field, for each of us to find our own place and avoid pointless competition. With this in mind, we shall continue to build up our cooperation with groups of countries, particularly the Commonwealth of Independent States and the member countries of the Stability Pact that I mentioned earlier.

## Conclusions

Visible progress has been achieved this year in our technical collaboration with most of the divisions at headquarters and in the other regional offices. Dr Lee, I am extremely happy with the support you have always given us and your constant accessibility. I know what a great asset it is for me as a regional director to know that our discussions are always down-to-earth and friendly. Dr Gezairy is also here today, a sign of our determination to maintain unity within the Organization so as to be able to provide our Member States with the best possible services from the whole of WHO. There are many examples of the collaboration between us, of course made much easier these days by the modern means of electronic communication that we are using more and more.

I would like to thank the members of the Standing Committee, and particularly the chairman, Dr Thiers, for their support and accessibility. We have looked at many different topics during the SCRC meetings this year, and you will have a chance to discuss them when the report is presented. I would like, in particular, to mention the setting up of a working group on the future of the Regional Office, in response to a request from the Regional Committee last year. The working group includes experts from various disciplines, and will draw up a report to be submitted to you next year. The report will propose a position for the Office to adopt for the 2020s, based on hypotheses of developments in public health and the international context.

Finally, I am sure you will allow me, and join with me, to thank the staff of the Regional Office for their devotion and their contribution to the work I have described. Quite clearly, the main and perhaps the only asset of a technical organization like WHO is its human resources, its staff. And I must say that, in this respect, the Regional Office is very well off, however limited its budget may be.

I hope that this report has given you enough information to provide a fairly clear and complete picture of our activities since the last session of the Regional Committee. I would be very happy to add to it by answering any questions you might have with the help of the teams from the Regional Office and headquarters who are here this morning.

I hope that this session of the Regional Committee will be both an active and a productive one because, as you know, we set great store by your comments and suggestions. I wish you and ourselves fruitful discussions over the next few days, and thank you for your attention.