EUROPE

Regional Committee for Europe
Fifty-fourth session

Copenhagen, 6–9 September 2004

EUR/RC54/REC/1
5 October 2004
41879
ORIGINAL: ENGLISH

REPORT OF THE FIFTY-FOURTH SESSION

Keywords

REGIONAL HEALTH PLANNING
HEALTH POLICY
HEALTH PRIORITIES
STRATEGIC PLANNING
RESOLUTIONS AND DECISIONS
WORLD HEALTH ORGANIZATION
EUROPE

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Opening of the session

The fifty-fourth session of the WHO Regional Committee for Europe was held at the WHO Regional Office for Europe in Copenhagen from 6 to 9 September 2004. Representatives of 51 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 (FAO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Council of Europe (CE), the European Commission (EC), the European Environment Agency and nongovernmental organizations.

The first working meeting was opened by Dr Jarkko Eskola, outgoing Executive President, on behalf of Mrs Maria Rauch-Kallat, outgoing President, who could not be present.

Election of officers

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

Sir Liam Donaldson (United Kingdom)	President
Dr Božidar Voljč (Slovenia)	Executive President
Dr Godfried Thiers (Belgium)	Deputy Executive President
Dr Zhanna Tsenilova (Ukraine)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC54/2 Rev.1 and EUR/RC54/3 Rev.1)

The Committee adopted the agenda and programme of work.

Address by the Director-General

The Director-General opened his statement by expressing shock and dismay at the tragic events in the Russian Federation, and emphasized the need for organizations such as WHO to work towards preventing such tragedies and mitigating their health consequences.

He set out the three principles that guided WHO's work – security, equity and unity – recognizing that putting them into practice needed sufficient resources and the exercise of realism. The proposed programme budget for 2006–2007 built on the Organization's experience of results-based budgeting and the evaluation of the implementation of previous budgets. It also reflected the priorities of Member States and reinforced and accelerated the process of decentralization, which was being accompanied by measures to maximize efficiency in the use of resources through transparency and accountability.

Budgetary reliance on voluntary contributions to the current extent was unsustainable and, for the implementation of policy that would be expressed in the General Programme of Work 2006–2015, an increase in the regular budget would be indispensable. The Regional Committee's input on the proposed programme budget 2006–2007 and the General Programme of Work 2006–2015 would be essential for the Executive Board at its 115th session in January 2005 and its recommendations to the Health Assembly in May 2005.

Major outbreaks of disease still constituted a threat to security, as severe acute respiratory syndrome (SARS) and avian influenza had reminded society, and the revision of the International Health Regulations sought to minimize the danger. The Director-General urged the fullest participation in the session of the Intergovernmental Working Group on the revision that would meet in November in Geneva. Once adopted, the revised Regulations would need effective response systems, to which WHO's Global Outbreak Alert and Response Network and the recently opened operations room at WHO

headquarters would provide support. Major and sustained investment was needed, with involvement of all information hubs and relevant partners at various levels, such as the planned European Centre for Disease Control.

Lack of access to treatment for HIV/AIDS exemplified inequity, and in 22 Member States in the Region access was partial or nonexistent, even though triple antiretroviral therapy was financially within the reach of more people than ever and more than US$ 20 billion had been committed globally to prevention and care. Commitment was vital to improve the situation. Twelve Member States in the Region had set their own targets within the "3 by 5" Initiative. WHO had issued guidelines on simplified clinical management and was strengthening training and systems for delivery of treatment, including the greater involvement of nursing staff. The Initiative had galvanized action, with financial pledges or payments already made by Canada and Sweden, and would be accelerated, with planning for further work beyond 2005.

The Region had demonstrated its strength through the eradication of poliomyelitis and its support for African and Asian countries towards the same goal. Prevention and control of tuberculosis remained a high priority, with the urgent need to expand the directly observed treatment, short course (DOTS) strategy. Strong health services were vital but should be part of a Health for All approach with focus on socially determined risk factors and intersectoral action. Progress towards ratification of the WHO Framework Convention on Tobacco Control (FCTC) was slow, and Member States were urged to follow the example of the six countries in the Region that had taken that step; the European Union's (EU) lead should be followed. The Region was also in a strong position to contribute to the implementation of the global strategy on diet, physical activity and health and the fight against noncommunicable diseases.

Closer cooperation with partners, exemplifying unity, must focus, for instance, on mental health and maternal and child health. The approach would be reinforced by the country cooperation strategies to strengthen health systems, and the Region had shown a good start with a strong sense of direction. Across the board, the Regional Committee had a vital role to play through its recommendations and suggestions.

In the ensuing debate, many speakers commended the simple, strong principles enunciated by the Director-General and the need for international cooperation under WHO's leadership. The Organization's priorities were well supported. The needs of WHO had never been so great, especially given the globalization of risks.

Several representatives, including one speaking on behalf of the Member States of the EU, called for a more equitable and transparent allocation of resources and looked forward to the outcome of work on a set of guiding principles with objective criteria. In particular, there were calls for the provisions of resolution WHA51.31 on regular budget allocations to regions to be fully implemented, especially as the Fifty-seventh World Health Assembly had not decided to change the policy introduced in that resolution. Likewise, specific information on direct transfers during the current biennium, as part of the decentralization agenda, was called for.

Generally, the strengthening of activities at country level was welcomed, although much remained to be done. Examples were quoted of a minister of health implementing reforms based on WHO's policies and the reduction of maternal and infant mortality rates through the introduction of WHO's policies. WHO had changed the perception of public health, putting the individual at the centre of sustainable development, and to continue to raise that profile needed increased efforts with Member States.

Most speakers highlighted and welcomed the "3 by 5" Initiative, with one speaker asking how it was being monitored and evaluated. The support of the Regional Office and headquarters was acknowledged, for example, in preparing successful applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria, the creation of a regional information centre for AIDS (a "knowledge hub") and technical assistance in setting up treatment centres and introducing treatment protocols. Speakers called for vigorous promotion of established preventive measures, especially since the epidemic in the Region was associated with recognized risk behaviours, and greater cooperation between the health and development

sectors at national level. The need to increase access to treatment was noted. Requests were made for support for improved health services and better training, the provision of information on best practices, and both prevention programmes and increased access to treatment. One speaker emphasized the importance of WHO's authority.

HIV/AIDS was not alone in facing structural challenges; there were many people in the Region who could not afford basic health services. Countries with economies in transition with few resources for improving health systems needed support and assistance.

Several speakers, recognizing the threats posed by international travel and new or re-emerging diseases, welcomed the broad consultative process for revision of the International Health Regulations, although one representative regretted the fact that the draft of the revised Regulations had not been available in time for the session.

One speaker argued for the need for continuity in the work of the Organization, especially as the importance of WHO grew. Another, welcoming the consolidation of the drive towards one WHO, commented that Member States shared that responsibility with the Director-General and all his staff, including those in regional offices.

With regard to the proposed programme budget 2006–2007, most speakers welcomed the profile of its content, especially in terms of work towards meeting the health-related Millennium Development Goals. However, resolution WHA57.16 on health promotion and healthy lifestyles, in particular its provisions on the harmful use of alcohol, should be better reflected in the document, and much needed to be done in the area of environment and health. Concern was also expressed that the proposed programme budget for a period covered by the General Programme of Work 2006–2015 was being considered before adoption of that programme, which should remain the Organization's corporate strategy, stabilizing and directing the budgetary process, in particular in relation to voluntary contributions.

In response, the Director-General cited the guiding principle of Health for All, the initiative on the revision of the International Health Regulations, the follow-up on the FCTC, and the drive towards one WHO as evidence of continuity in the work of the Organization. He reiterated his commitment to decentralization but recalled that WHO's purpose was to provide services, namely setting norms and standards; how best to realign and reorganize the Organization's programme budgets and human resources was not just a question of increasing human and financial resources in a region, but of providing more and better services, and that would come through moves towards one WHO. Currently WHO, with its unique regional structure, was one of the most decentralized international organizations and should serve as a model of its kind, even if some fine tuning remained to be done.

With regard to allocation of resources, he emphasized the need to protect headquarters ability to continue to produce norms and standards but confirmed the target of directing 75% of financing from all sources to regional and country offices. He commented on the unpredictability of voluntary contributions. He observed that WHO's resources were targeted at technical and scientific support and policy advice, with the aim of being catalytic and enabling WHO to maximize its impact at country level.

In terms of content of the proposed programme budget he commented on the Director-General's limited power to move funds across areas of work but noted the new emphasis on biosafety issues, response to disease outbreaks and the need to increase activity in the area of maternal and child health.

Responding to questions about the "3 by 5" Initiative, he said that WHO had recommended treatment regimens and, contrary to some expectations, had removed three antiretroviral formulations from its prequalification list. Ensuring the quality of generic drugs was essential. The new funding he had mentioned would go to training large numbers of health care workers in developing countries to deliver and supervise treatment. He stressed the need for countries to take ownership of their plans and strategies, and support would be so directed.

The Assistant Director-General, General Management, explaining in more detail the linked issues relating to resolution WHA51.31 and decentralization, said that the aim was to use resources in the most effective way. Proposals on the allocation of resources, which would take performance into account, would be posted on the WHO web site the following month for a period of four weeks for comment. One approach was to consider a broad range covering more than one biennium rather than fixed figures.

He acknowledged the need to improve the proportion of resources allocated to regional and country offices and was monitoring figures every month. He urged those offices to do more in terms of resource mobilization, which was not the responsibility solely of headquarters. Work was in hand to align voluntary contributions with the priorities set out in the proposed programme budget 2006–2007. Member States could raise issues through the governing bodies.

Although it was unfortunate that the General Programme of Work 2006–2015 was not ready before the proposed programme budget, it was evident that time was needed for full consultation with Member States and partners such as the European Union.

Address by the Regional Director, including report on the work of the Regional Office in 2002–2003

(EUR/RC54/6, /Inf.Doc./1 and /Inf.Doc./3)

The Regional Director began his address by expressing his certainty that the suffering of those wounded in the recent violent and criminal acts in the Russian Federation, and the grief of their relatives, would remain in the minds of everyone involved in the session, as it was for such people that WHO worked. Those events showed the need to step up WHO's humanitarian assistance programmes to cope with the terrible threat of terrorism to health.

He then described five salient features of the Regional Office's work since the Regional Committee's fifty-third session and the future action needed or proposed for each. The first four were: the need to make best use of the increased resources given to 18 Member States in the WHO European Region to tackle HIV/AIDS; the making of global and regional strategies on noncommunicable diseases; the Region's contribution of clear and specific comments on the draft of the revised International Health Regulations, in contrast to slow ratification of the FCTC; and the successful Fourth Ministerial Conference on Environment and Health, held in Budapest, Hungary.

Partnerships focused on practical action formed the fifth salient feature. That included increasingly broad, pragmatic and tangible cooperation with the EC in such areas as information, communicable diseases, health promotion, mental health and environmental health. Partnership with the enlarged European Union (EU) was a fundamental priority that the Regional Office would pursue, using the principle of complementary action by its technical programmes and their equivalents in the EC's public health plan. In addition, the Regional Office would build bridges between the EU and the Member States in the Region that were now its neighbours, particularly the Commonwealth of Independent States. Further, the Regional Office had deepened its relations with other partners whose values and objectives it shared, including the World Bank; the CE; the development agencies of such countries as Germany, the Netherlands, the United Kingdom and the Nordic countries; nongovernmental organizations; and other members of the United Nations family, such as the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and UNAIDS. In addition, the Regional Office had forged closer links with WHO headquarters, working within the framework of one WHO.

The Regional Office had also continued to strengthen its services for countries. The work of the Health Evidence Network (HEN) and the European Observatory on Health Systems and Policies showed the high priority given to supplying countries with analysed, validated and accessible information. The Regional Director thanked the staff of the Regional Office, in all locations throughout the Region, for their contribution to those successes.

The Regional Office needed more resources to respond fully to Member States' needs. At present, lack of funds hindered activities in many areas. Improved fundraising, along the lines set by the WHO programme budget, was essential. In conclusion, the Regional Director thanked the Standing Committee of the Regional Committee (SCRC) for its support in preparing the fifty-fourth session of the Regional Committee.

In the subsequent discussion, almost all speakers praised the Regional Director's comprehensive report and clear presentation. Several praised the Regional Office staff for their preparation of the Regional Committee session and their dedication.

Several representatives endorsed the Regional Director's choice of salient events in the preceding year. Others commended many Regional Office initiatives, particularly mentioning the extension of partnerships with the EU, the CE, the World Bank and United Nations organizations, and work towards realizing the goal of one WHO; the usefulness of the products of the evidence programme, HEN and the European Observatory on Health Systems and Policies and of the European Health for All database and other databases; work on noncommunicable disease control and the development of a European strategy; the content and process of the update of the European policy framework for Health for All; and work on tobacco control, the FCTC and the environment and health, especially the success of the Budapest Conference.

A representative speaking on behalf of the Nordic countries also praised the reorganization of both the Regional Office's structures and functions, the restructuring of its country offices and improvement of their services, and work to strengthen the skills of the Office's staff. Further, a substantial number of speakers agreed that the Regional Office needed more resources; some noted areas that were neglected as a result: tobacco policy, ageing, occupational health and human resources for health.

The largest number of speakers, however, identified successes in the implementation of the Regional Office's strategy to match its services to countries' needs. Most commended the strategy and biennial cooperation agreements, and their success in building countries' capacities to protect and maintain health in general, but some sited particular examples from their own experience. Those comprised instances of successful health system reforms in individual countries and in the group in south-eastern Europe, work with one country's development agency to prevent HIV/AIDS and control tuberculosis in several other Member States, and work on noncommunicable disease control, health policy development and the FCTC. One speaker highly valued his country's partnership with a country office.

In addition, several speakers described their countries' progress in such areas as communicable and noncommunicable diseases, health promotion and disease prevention, children's and adolescents' health and environmental health. Some reported improvements in health indicators, while others noted the remaining gap in life expectancy and the continuing burden of HIV/AIDS and noncommunicable diseases, in particular.

Representatives made a wide range of suggestions for further development, mostly focusing on the country strategy. They urged the Regional Office to continue to extend and increase the effectiveness of the strategy, optimize the approaches used and improve its capacity for rapid response; to give more support to implementation strategies; and to further strengthen country offices and improve their coordination with technical programmes. The Regional Office was also called on to evaluate the impact of the strategy, develop objective criteria for that task, and devise a mechanism to enable countries to share their experience.

In addition, speakers encouraged the Regional Office to extend its partnerships and improve their coordination and quality, taking advantage, for example, of the work of the Organisation for Economic Co-operation and Development on biological resources. One representative recommended more interdisciplinary cooperation between technical programmes: for example, between those for young people and for sexual and reproductive health, to prevent HIV.

Many speakers called for thorough consultation of Member States on the draft update of the European policy for Health for All. A representative speaking on behalf of the Nordic countries stressed the importance of three of the four pillars: the underlying values (perhaps including trends contradicting them), practical tools for policy-makers, and guidelines and good practice. One representative urged that the update examine the management of health services for health gain, looking in particular at how to improve both services and access to them.

Finally, speakers called on the Regional Office to maintain its leadership in the health field, specifically in such areas as public health-oriented policy on alcohol, and in developments in communicable disease, environmental health and lifestyles.

Two invited speakers representing partner organizations addressed the Regional Committee. Mr Fernand Sauer, Director for Public Health, EC Directorate-General for Health and Consumer Protection, thanked the Regional Director for his commitment to the dramatically developing partnership between the Regional Office and the European Commission (EC). In July 2004, the WHO Director-General, the Regional Director and five European commissioners (for health, the environment, research, development and trade) had continued their series of annual meetings; similarly, the next meeting of WHO and senior EC staff would take place in November. Current and planned achievements of the partnership included EC support for rapid ratification of the FCTC, a role for the EC in accelerated negotiations on the International Health Regulations, participation of the EC in WHO's ministerial conferences on environment and health and mental health, and the creation of the new European Centre for Disease Control. Mr Sauer invited the Regional Director to the launching of the Centre. It was hoped that a formal agreement on enhanced cooperation could be made in 2005.

Mr Alexander Vladychenko, the Council of Europe's Director-General for Social Cohesion, explained that, on health issues, the CE acted in synergy with its closest partners, WHO and the EU. All three had signed letters of intention in 2001 and concrete action followed, including making health a bridge to peace among the countries comprising the South East Europe Health Network, run by WHO and the CE within the framework of the Stability Pact. In addition, the CE would take part in the update of Health for All and the mental health conference in 2005. WHO and the CE also cooperated in specific fields, such as the European Network of Health Promoting Schools, pharmaceutical practice and nutrition. Mr Vladychenko invited WHO and the EC to the Human Rights and Disability Conference (November 2004) as well as to help organize the CE's 2005 conference on palliative care. He also invited the Regional Director and Mr Sauer personally to attend a special meeting on the occasion of the 50th anniversary of the CE's European Health Committee in November 2004. To mark the event, a book on "Health, ethics and human rights" was being prepared.

In his reply, the Regional Director thanked the Member States for their support of the work of the Regional Office, and noted that representatives' remarks referred to future priorities. As to the update of Health for All policy framework, the draft would be sent to Member States as soon as possible, for 3–4 months' consideration. He reminded the Regional Committee that the draft would add new features to HEALTH21, which had been retained at the request of the SCRC, and noted that the first pillar comprised study of the use of the policy. That study had shown that the policy was used and appreciated.

As to health system reform, WHO wanted to work hard with Member States to strengthen health services, especially so that countries could spend the new resources on AIDS appropriately. WHO's task would be to gather knowledge and experience and ensure they were shared among Member States, focusing on how to improve systems' responsiveness and ensure their quality and safety. WHO was also helping Member States to design health policies that should be clear and well known to citizens.

The Regional Director appreciated representatives' approval of the improvements in country offices. Now the priority was to ensure that the Regional Office made the best use of all its resources in Member States. The Regional Office would make detailed proposals commensurate with needs.

Further, some material on occupational health would be included in the mental health conference. In the absence of funds, the Regional Office was trying to use a collaborating centre for some functions and was searching for a mechanism to enable it to regain expertise in this area.

The Regional Director welcomed countries' support for the priority given to information. The goal was to integrate numerous systems into a "one-stop shop", mainly supplying public health information that had been analysed and was adapted to users' needs.

The Regional Director said that the Regional Office would continue to improve the coordination of partnerships at country level, and thanked Mr Sauer and Mr Vladychenko for their invitations. The development of new types of partnerships was a very important issue. The cooperation through the Stability Pact had been exemplary.

In conclusion, the training of WHO staff was designed to help them develop new competences in such areas as understanding political factors and skills in giving advice. The Regional Director thanked the Regional Committee for its appreciation of the Regional Office's devoted staff.

The Committee adopted resolution EUR/RC54/R1.

Report of the Eleventh Standing Committee of the Regional Committee

(EUR/RC54/4 and /4 Add.1)

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

With regard to the strategy for the Regional Office's geographically dispersed offices (GDOs), the Chairman noted that SCRC members had been invited to participate in a subgroup established by the Regional Director. On the issue of the proposed programme budget for 2006–2007, the SCRC had discussed the proposal put forward to the World Health Assembly to discontinue implementation of resolution WHA51.31, on regular budget allocations to regions, and had recommended that Member States from the European Region should urge the Health Assembly to find alternative solutions.

The SCRC had initiated the collection of information from European Member States with regard to ratification of the amendments to Articles 24 and 25 of the WHO Constitution. To date, 110 Member States throughout the world (including 31 European ones) had ratified the amendments, but a further 18 ratifications were required to enable the European and Western Pacific Regions to each have an additional seat on the Executive Board.

The SCRC had also discussed the voting rights of some of the newly independent states in connection with their arrears in making contributions to the regular budget of the Organization and had expressed its interest in either writing off those debts or making special arrangements for repayment.

Commenting on the report of the SCRC, one representative noted the comprehensive work done by the SCRC and recognized that it gave the Secretariat valuable orientation and guidance. Many of the SCRC's recommendations and conclusions could be supported, notably the one that WHO had not yet set up systems to assess how it performed in countries. In some cases, however, the recommendations were apparently not final or it was unclear what follow-up measures had been taken. In reply, the Chairman explained that many of the Secretariat's follow-up actions were described in the relevant working papers for the Regional Committee.

The Regional Director acknowledged the fact that evaluating the impact of WHO action in countries was a difficult exercise, but an initial attempt to do so had been made when drawing up the report on implementation of the Regional Office's country strategy (document EUR/RC54/Inf.Doc./2). The Standing Committee would, he was sure, study carefully any proposals made for improving its method of work.

The Committee adopted resolution EUR/RC54/R8.

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

(EUR/RC54/7)

Dr Sergei Furgal, who had been invited by the SCRC to attend its meetings as an observer and to present its views on the item under discussion, noted the new format of the working paper. Among the 23 resolutions and 14 decisions adopted by the Health Assembly and the Board, the document focused on those with regional implications and set out the relevant actions and comments on each. Those to be discussed at the session related to the Global strategy on diet, physical activity and health; cancer prevention and control; disability, including prevention, management and rehabilitation; sustainable financing for tuberculosis control; and the revision of the International Health Regulations. Other resolutions with regional implications concerned road safety, scaling up treatment and care responses to HIV/AIDS, and international migration of health personnel.

On financial and budgetary matters, the number of Member States in arrears in the payment of their contributions that resulted in loss of voting rights had been reduced to six. The Regional Office had that matter in hand and would also continue to update Member States with information on global and regional budgets as the Region's share of the global resources increased in line with implementation of resolution WHA51.31.

Three resolutions required action at regional level: that on the draft strategy to accelerate progress towards the attainment of international development goals and targets, in particular with regard to reproductive and sexual health (resolution WHA57.12); health promotion and healthy lifestyles (resolution WHA57.16); and genomics (resolution WHA57.13). The need was stressed to re-establish collaboration on genomics with the CE and the EC, in particular on aspects not well covered by other organizations and those directly relevant to Europe.

In the ensuing discussion, one representative, speaking on behalf of the Nordic countries, underlined the importance of alcohol consumption as a public health issue and noted that WHO's initiatives were not commensurate with the burden of disease resulting from its misuse. It was recalled that the Director-General had been requested to issue a report in 2005 outlining WHO's projected work in the area, and the need was stressed for leadership and adequate resources at all levels of the Organization.

With regard to resolution WHA57.19, initiatives on international migration of health workers should be coordinated with existing European ones, particularly the work of the CE on transborder mobility of health professionals and its implications for health care systems. Cooperation with the Council's Committee of Experts, which was drafting recommendations, would optimize the use of limited resources.

Among the issues raised by the Global strategy on diet, physical activity and health, the increasing prevalence of obesity in the Region called for concerted action, targeted especially at children and adolescents. Healthy choices needed to be made easier and policies in other sectors such as agriculture and transport needed to be consistent with public health goals. Responsibility for facilitating physical activity and ensuring the provision of health-supporting environments lay with parents, school authorities and other adults. Incentives needed to be judiciously balanced with restrictive measures. The European strategy on noncommunicable diseases and a task force on obesity were welcome developments.

The importance of political will and administrative coordination in improving road safety was exemplified with statistics showing a decrease of more than 12% in the number of deaths on the roads in one country in the first seven months of the current year. The need to ensure follow-up to the resolutions adopted was emphasized, with a note that, in the area of reproductive health, the Plan of Action adopted at the United Nations International Conference on Population and Development (Cairo 1994) and the Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women (Beijing 1995) still had to be followed up and implemented. The need was also confirmed for joint action to implement resolutions and tackle specific regional matters.

In reply, the Director, Division of Administration and Finance noted the improvement in the number of Member States in the Region in arrears in the payment of their contributions. It was intended to resolve the matter by the end of 2006 through individual visits to Member States concerned in order to help formulate proposals.

The Regional Director expanded on the reasons for European plans such as the proposed European strategy on noncommunicable diseases. The specificities of the Region offered opportunities for greater efficiency and also the chance to explore new avenues. The Regional Office was able to capitalize on the great experience of its Member States (the example of the approach to obesity was a case in point) and so to contribute leadership at the global level.

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

(EUR/RC54/12, /Inf.Doc./2, /Inf.Doc./2 Corr.1, /Inf.Doc./2 Corr.2 and /BD/1)

The Director, Division of Information, Evidence and Communication described the Regional Office's progress in implementing Regional Committee resolution EUR/RC51/R3 on the European health report and information and knowledge management. The Office had developed tools that enabled it to provide decision-makers with better information, evidence and policy options for health. Those included an integrated system of databases, and the use of the Regional Office's web site to present analysed information on countries, linking country profiles (such as the Highlights on Health series); the options for public health policy offered by HEN, the European Observatory on Health Systems and Policies and technical programmes; Regional Office publications; and documents from countries.

The Regional Office's strengthened health information and evidence functions were contributing to preparation of the European health report, to be published in May 2005. Its theme was the translation of knowledge into action through improved infrastructures for public health; its main topic, child health and development; and its message, that poverty and inequality prevent people from taking advantage of existing interventions for disease prevention, health promotion and health care. In addition, the report resulted from wide cooperation between all relevant programmes in the Regional Office, the Evidence and Information for Policy cluster at WHO headquarters and Member States. Representatives were welcome to examine the first draft.

The Director, Division of Country Support brought participants up to date with the progress of the country strategy, which had been adopted in the year 2000. The country support services had been undergoing changes, and a new system was being built which was under assessment in terms of how far leadership was being provided while servicing Member States. Despite the absence of well-defined baselines or indicators to measure impact, it appeared that progress was being made with better coordination of country activities, staff with more competencies in health systems and management, country-specific workplans and strategies with clear objectives, close integration with the Office's wider workplan, and improved partnerships. The key challenges came from developing country work performance indicators, the assessment of direct customer satisfaction, and sustainability issues. The Help Desk was a key instrument to help coordinate country work. Country programmes would be evaluated on a six-monthly, annual and biennial basis to ensure that there would be continuous improvement in how WHO worked with countries and in the relevance and quality of service provided.

The Regional Director described the status of and further plans for the update of the regional Health for All policy framework. It comprised four pillars: assessing the policy's influence on policies in countries, determining the values reflected in a Health for All policy (equity, solidarity and citizen participation, along with ethical governance), identifying 10 core tools for policy-makers, and developing guidance for policy-makers on determining the conformity of their policies with Health for All values. The next steps were to finalize a draft document of about 50 pages, which would be sent to Member States for their consideration and comments in January 2005, and then revised for presentation to the Regional Committee in 2005.

In the subsequent discussion, representatives welcomed the follow-up session, although one expressed concern about overlapping content in Regional Committee documentation. Another warmly endorsed the European health report and hoped that his country would participate as much as possible in its creation.

Several speakers discussed aspects of the implementation of the Regional Office's country strategy. One representative described the large and powerful country office in his country, which was yielding positive practical results, and called for closer links between technical programmes and country offices. Another speaker offered to host a conference in 2008 on health system reform. One specific partnership highlighted was the Social Cohesion Initiative of the Stability Pact and the South East Europe Health Network, a valuable initiative for peace and reconciliation.

Most speakers addressed the theme of cooperation or partnership underlying the topics discussed. As to partnership in general, one representative highlighted the need to identify just what each partner would do in acting on resolutions and implementing strategy, in order to increase the effectiveness of all contributions. Another detailed the positive results of partnership with WHO in acting on resolution EUR/RC52/R8 on controlling the serious problem of tuberculosis in his country; much more could be done, with WHO and other partners, to halve mortality from the disease by 2015 and achieve targets within the Millennium Development Goals. A third representative commended the Regional Office for its interest in and cooperative work on mental health; she hoped that the forthcoming WHO conference in Finland, in which the EC and CE would play important roles, would lead to a policy and action plan enabling governments in the Region to address all the determinants of mental health. One speaker called on the Regional Office to explain why 16 institutions in his country were losing their status as WHO collaborating centres, which seemed to reduce partnership with WHO. In view of the importance of the subject, he suggested that consideration should be given to including a separate item on the agenda of the next session of the Regional Committee on the activities of WHO collaborating centres in the European Region.

On the issue of values, one representative noted that the heads of two European Member States had signed a declaration – to be presented to the United Nations Secretary-General at the forthcoming celebration of the tenth anniversary of the International Conference on Population and Development – to support the values of genetic health and the rights of women. The speaker urged all other Member States join in that initiative, and another representative echoed that call.

An invited speaker representing the World Bank welcomed the country support provided by WHO, particularly in the newly independent states, in the fields of health financing, civil service reform and public administration and health reform. Experience had been gained in some parts of the Region which could be used in others, for example on improving primary health care and working towards attainment of the Millennium Development Goals.

In addition, statements were made by representatives of the World Psychiatric Association, outlining areas in which collaboration with WHO would be beneficial, and of the International Planned Parenthood Federation.

In reply, the Regional Director apologized for overlapping content in the documentation. He said that the great number of collaborating centres hindered their management and WHO's cooperation with them. The solution could be that Member States worked with WHO to seek ways to maximize the centres'

effectiveness, and that they asked WHO to make a clear global policy on dealing with them. The issue should be discussed by the Executive Board.

In conclusion, the Director, Division of Information, Evidence and Communication pledged that the Regional Office would continue working to improve the vital statistics in the European health report and to help Member States improve their statistics and their national health information systems.

Policy and technical items

European strategy on noncommunicable diseases
(EUR/RC54/8)

The Director of Technical Support – Reducing Disease Burden, introducing the item, said that the term noncommunicable diseases (NCDs) covered cardiovascular disease, cancers, respiratory disorders and diabetes, as well as mental illness and many other disorders. NCDs were a major public health challenge for Europe and the main cause of premature and preventable death. They accounted for 77% of morbidity and 86% of mortality in the Region, putting heavy burdens on patients, their families, countries' health systems and economies. These burdens were increasing and, of the WHO regions, the European Region was the one most affected by them. The world was in transition: ageing populations, increasing global influences, changing lifestyles and growing urbanization. There were worrying trends, particularly the widening gaps between Member States. For example, although cardiovascular disease caused over half of all deaths in the Region in people under 64 years old, that figure had been declining steadily, except in the newly independent states, where average mortality from cardiovascular disease in 2001 was three times higher than in the Member States that then made up the European Union.

Seven leading risk factors accounted for most of the burden of disease and for 75–85% of all new cases of coronary heart disease. They were tobacco use, alcohol abuse, raised blood pressure, raised cholesterol, overweight and obesity, low fruit and vegetable intake, and physical inactivity. Smoking was increasing, particularly among women, and poor men were more likely to smoke than rich. Europe had the highest per capita consumption of alcohol in the world, and by the age of 15, 24% of young people reported smoking and 29% reported drinking on a weekly basis. Thirty per cent of adults were insufficiently active. In most European countries, over half the population was overweight, with up to 27% of children obese in some regions. Eighty per cent of Type 2 diabetes could be attributed to obesity. Overall, people in low socioeconomic groups had at least twice the risk of serious illness and premature death as those in the higher groups. Closing the gap between these groups offered great potential for reducing mortality from NCDs.

A European NCD strategy was needed as a regional response to the global strategy, to reduce that burden of disease and give support to countries. Ten principles for action were identified, ranging from political commitment to NCD policy as part of the broader public health effort. There were important interventions available, including reducing consumption of tobacco, salt, sugar, fat, and alcohol; increasing consumption of fruit and vegetables; encouraging physical activity; and tackling risk factors such as high blood pressure and body mass index. An integrated approach was required, building on existing action plans and strategies, with a wide mix of measures and a cross-sector approach. Major changes could be seen within short time spans. The time was right for such a strategy.

On behalf of the SCRC, Dr Hubert Hrabcik said that the causes of NCDs were complex: they could, for example, be linked to great prosperity or extreme poverty. WHO had an important role in finding solutions and acting as a bridge through both regional and country approaches, particularly with respect to young people's use of alcohol and tobacco. Pan-European action was needed to put health above all else. There was the pressure of time because lives which could have been saved were being lost every day.

The Assistant Director-General for Noncommunicable Disease and Mental Health reminded representatives of the commitment made by the World Health Assembly in 2000 to adopt an integrated

approach to prevent and combat NCDs, highlighting not only the role of individuals but also the community responsibility and that of political authorities. The mechanisms developed included the WHO FCTC, which needed ratification by 10 more Member States to reach the 40 required for it to become law, and the Global strategy on diet, physical activity and health, which had been endorsed by the May 2004 World Health Assembly. National and regional strategies needed to be developed and Europe would be the first to take that step.

In the extensive debate that followed, the proposal for a European NCD strategy was warmly welcomed. A representative speaking on behalf of the Member States within the European Union said that clear, action-oriented best practices were needed to prevent and control NCDs and help Member States put knowledge into practice. Most of the useful measures were known, but implementation was what counted. Most speakers emphasized the need to work across sectors and disciplines. A European NCD strategy would, through a coordinated and comprehensive approach, make it possible to draw on good practice. That would result in considerable health gains throughout Europe.

NCDs were a severe problem which was not easy to tackle, but several speakers described how they had developed national health strategies, programmes or legislation which gave NCDs high priority. They included national programmes on integrated action for healthy diet, and those on the prevention of cardiovascular disease, diabetes and obesity. Some Member States had already achieved successful reductions in NCDs in their populations through various initiatives to lower the risk factors. Significant potential for reducing chronic disease was offered by the integrated approach. One Member State had achieved a decline of 35% in coronary heart disease and of 45% in cerebrovascular disease over a ten-year period through a programme that had received very strong support from primary health care personnel. Another had been successful in reducing tobacco use (18% reduction among young people and women since 1999) by raising taxes. The experience in this case had been that legislation proved to be more effective than general campaigns in achieving a fast reduction in risky behaviour. Morbidity and mortality indicators for NCDs were essential for monitoring progress.

Some speakers mentioned the efforts made since the 1980s to combat NCDs through the countrywide integrated noncommunicable diseases intervention (CINDI) programme. Thirty-three countries participated in the network, and WHO had helped to prepare policy and provide resources. Common protocols and guidelines had been set up, along with publications and a database. The CINDI principles and achievements would be reflected in the NCD strategy.

Several speakers said that, in their countries, NCDs often went undiagnosed and were not cured. Treatment, health system upgrading and rehabilitation should not be forgotten. A balance between prevention and treatment would be needed in the strategy. It was important to make wider use of medication for primary prevention, and not only target lifestyle change. However, when considering lifestyle, people's traditions and attitudes had to be taken into account, as well as their overall situation. In some areas, the quality of life for some populations was so poor that it was hard to make a serious impact on NCDs. Poverty and social exclusion were major underlying determinants behind the distribution of NCDs. Political and economic considerations were essential and WHO was in a position to draw attention to that. There was also a gap between scientific research and what happened on the ground. One speaker outlined the need for diagnostic/treatment centres, with laboratories for research and monitoring, and health promoting centres.

A representative speaking on behalf of the Nordic countries stressed the importance of tackling the harmful consumption of alcohol and use of tobacco in the fight against NCDs, and the need to put practical measures in place with an integrative approach. Wide consultation and involvement were important in the formation of the NCD strategy, with Member States and other stakeholders sharing their experience and expertise. Some speakers emphasized the importance of industry and commerce: one was facing an offensive from alcohol producers in response to successful national interventions to reduce alcohol use. International collaboration was essential to combat the global marketing of tobacco, alcohol and sugary food, and to allow countries to move from disease prevention to health promotion. All stakeholders, and the private sector in particular, had a major role to play in assisting and empowering

individuals to choose a healthier diet and increase their levels of physical activity. Overall more money was currently being spent curing diseases than preventing them.

Other contributions emphasized additional sectors for important consideration in the formulation of the strategy. One factor that cut across diagnostic categories was psychological well-being that made for good quality of life. Mental health promotion was important, as was the prevention of mental illness. Diseases of the musculoskeletal system were important contributors to disability and early retirement. Many participants underlined the principles that underpinned the paper on the proposed strategy: the need to redress inequalities in health and protect the most vulnerable, and the need to mobilize all sectors and levels of society and government. WHO and the health sector had to provide leadership on the issue.

Under the agenda item, statements were delivered by representatives of the World Heart Federation, the World Confederation for Physical Therapy, the International Coalition against Tobacco, Consumers International, the World Association for Psychosocial Rehabilitation and the International Council of Nurses. Written statements were also submitted by a number of nongovernmental organizations.

The Committee adopted resolution EUR/RC54/R4.

Proposed programme budget for 2006–2007

(EUR/RC54/11, /11 Add.1 and /Inf.Doc./4)

The Assistant Director-General, General Management, introducing the proposed programme budget for 2006–2007, outlined the consultative process for its drafting, the underlying principles and the areas that would be the focus of increased activity and investment. The overall strategic direction illustrated continuity in WHO's work but also responded to the increased demands and expectations of Member States and WHO's partners.

The review of results achieved in the biennium 2002–2003 and the comments made during the consultations led to a proposed increase of 12.8% in the overall programme budget compared with the biennium 2004–2005. For six areas of work the average proposed increase was more than 50%, while for three (including Immunization and vaccine development) an average decrease of 10% was being put forward. Areas of work supporting health outcomes accounted for about half the resources being sought, and knowledge management and information technology (in order to enable WHO to support Member States effectively) a further fifth.

Significant changes were being made in the allocation of resources across the Organization in order to work towards the Director-General's goal of decentralization. The largest increase would benefit the African Region, while the largest proportionate growth would be in the European Region; headquarters' share would decrease to 26%.

The unified proposed programme budget would be financed from three sources: assessed contributions, miscellaneous income and voluntary contributions. The budget envisaged a 9% increase in Member States' assessed contributions in order to meet the increasing demands and expectations and to try to restore balance, given that voluntary contributions accounted for 70% of the total sources of funding and that, if zero nominal growth were maintained as in the past, assessed contributions would amount to only 17% of the total. The proposal also reflected more effective use of resources and increased efficiency in management of programmes, finances and staff, as well as the application of a global management system (due to be in place in 2006). Not only were those measures expected to make savings but they would increase accountability.

The Director, Division of Administration and Finance reviewed the main orientations of the proposed programme budget for the Region. It reflected Member States' views, a technical review by the Regional Office and integration at the global level. Fine tuning would follow, with finalization of basic cooperation agreements and intercountry programmes. He too highlighted the decline in the proportion of the total budget accounted for by assessed contributions.

At the current stage, discrepancies between the global budget and the regional figures were apparent. The Region's higher figures reflected its "ambition level", namely they were a target designed to meet countries' stated demands and represented a challenge to donors.

Areas of work had been grouped thematically, with indications of total proposed expenditures, percentage allocation and regional or global priority. The package covering WHO's presence in countries represented the largest allocation (16.9%), followed by that on evidence, organization of health services, the trio of diseases HIV/AIDS, tuberculosis and malaria, and management. The five-fold increase since the biennium 1998–1999 in funding in countries, reaching a proposed US$ 25 million in 2006–2007, illustrated the determination to empower field offices. The key factors in building country presence were improvement in infrastructure and telecommunications, capacity-building and enhanced oversight.

Dr Jens Kristian Gøtrik, a member of the SCRC, expressed the Standing Committee's concern about the imbalance in funding between assessed and voluntary contributions and the consequent decline in influence of WHO's governing bodies. It was important to convince donors to allow funds to be allocated in line with the agreed policies and strategic directions. With regard to the shift in resources to regions and countries, it was to be hoped that that would not impede headquarters' ability to respond at global level to crises like SARS. The Health Assembly had called for guidelines on alternative mechanisms to the provisions of resolution WHA51.31, based on equity, efficiency and performance, to be submitted to the Executive Board. It was of great importance that the Health Assembly had stated in its decision that the guiding principles should be based on objective criteria, and that Member States and regions were to be consulted in the process of drawing them up. In that process, the significant health problems facing countries in the eastern part of the European Region needed to be taken into consideration. The proposed 9% increase in assessed contributions appeared optimistic, especially in view of previous discussions at the Health Assembly. Cuts or reallocations within the budget (as happened in national governments) could be made. Little evidence or detail had been presented on how efficiency savings would be made. A further question related to contingency plans in case voluntary contributions did not materialize. The transfer of resources in the current biennium was at a level that made it difficult for the Regional Office to retain and assign qualified staff, a situation that underlined the need for regular and secure cash flows to regions.

In the ensuing debate, speakers generally welcomed the clear and informative oral presentations and supported the overall strategic directions, especially the efforts to attain the health-related Millennium Development Goals. Results-based budgeting was commended. On the other hand, improved analysis of past performance, linkage with the draft General programme of work 2006–2015, greater stress on quality assurance, and a greater emphasis on health rather than disease were needed. Caution was expressed that implementation of strategies and other resolutions adopted by the Health Assembly could fail if adequate resources were not forthcoming. Some speakers argued that regional specificities should have been given a higher profile. One speaker, stressing the need for transparency in budget matters, regretted that the documents lacked detail, and more information was needed on the proposed General programme of work and the balance between assessed and voluntary contributions.

The need was identified to make transfers within the programme budget. One representative asked whether priorities could be ranked and whether contingencies had been made for sunsetting or top-slicing programmes in case a lower than expected budget was agreed. Were economies of scale possible through partnerships, in particular with the European Commission and the Council of Europe? A further question related to whether resource mobilization at regional and country levels had been considered in the budget preparations. Further detail was also requested in terms of a breakdown of costs, for instance personnel, by task and target; staff costs should be clearly indicated in the proposed programme budget.

One speaker regretted that the information on the Region in the documents submitted was limited and asked for an indication of distribution of extrabudgetary funding, a breakdown by country and a comparison of areas of work between the current biennium and that for 2006–2007. Such information should be routinely submitted to the Committee at future sessions.

Management of health systems and human resources for health were considered as neglected areas that demanded the greatest importance. Monitoring and analysis of such resources would be crucial. One representative proposed the creation of a database of information on successes, failures and lessons learnt in strengthening, financing and management of health services and systems.

Specific areas or topics mentioned for greater support included reproductive and sexual health, ageing, alcohol misuse, environment and health (especially in view of the Children's Environment and Health Action Plan for Europe), violence, injuries and disability, and occupational health. The budgets for nutrition and food safety were apparently being decreased by 25%, an incomprehensible situation given the recent adoption of the Global strategy on diet, physical activity and health and the proposed WHO ministerial conference in the Region on nutrition. Policy priorities should be recognized in budgets. Work on diet and physical activity and on tobacco control needed integration into comprehensive strategies for the prevention and control of noncommunicable diseases and their determinants, and speakers would welcome WHO's advocacy in order to strengthen political commitment at national level. A specific question was raised about WHO's contribution to the Codex Alimentarius Commission and where that featured in the proposed programme budget; resolution WHA56.23 had called for WHO to increase support for and collaboration with the Commission. Clarification was requested about the proposed increase in funding in the areas of work grouped under the heading of Evidence.

Several speakers questioned or criticized the proposed decrease in allocation for the area of work on Immunization and vaccine development. Although poliomyelitis had been eradicated in the Region, surveillance, laboratory containment and other activities needed to be continued. General immunization coverage needed to be maintained, but one representative reported a resurgence of diphtheria in his country. Further, the Health Assembly had urged the eradication of measles, and vaccines existed to prevent other communicable diseases such as hepatitis B and *Haemophilus influenzae* type b meningitis. New vaccines continued to be developed but were expensive. One speaker acknowledged the support of the Regional Office for work on safer injection practices, also covered by that area of work. Communicable disease prevention, control and surveillance needed continued support, and partnership with the future European Centre for Disease Control should be included in the planning. Surprise was expressed at the proposed decrease in resources for HIV/AIDS. One speaker asked whether dialogue had been initiated with the European Commission on HIV/AIDS following the conference on that subject in Dublin in February 2004.

Many speakers commented on the proposed 12.8% increase in the overall programme budget and 9% increase in assessed contributions, an "impressive proposal" in the words of one. An increase in resources would be irresponsible without increased efficiency, reduction of administrative costs, and greater effectiveness in health outcomes; in that context, a transparent system of indicators for measuring the cost–effectiveness of WHO's activities was needed. Therefore, an increase in the regular budget level would be difficult to accept. Also, with several countries in the Region already unable to meet their financial obligations to WHO, such an increase would aggravate the situation. Other speakers noted that new challenges and added responsibilities demanded extra resources, called for a reversal of the decades-long policy of zero nominal growth and supported in principle an increase in the regular budget. Furthermore, some speakers pointed out that assessed contributions were based on the United Nations scale.

In particular, at governmental level, representatives faced substantial difficulties in arguing for increases in health budgets against opposition from finance ministries which were instead looking for savings, and they needed to be able to marshal powerful and cogent arguments. One proposal was to consider more carefully those activities that could be funded from the regular budget and those by voluntary contributions, while distinguishing unavoidable infrastructural and organizational costs.

Many speakers commented on the allocation of resources, one asking specifically for more information to substantiate the statement that the shift from headquarters would pose no threat to WHO's authority, normative work and response to emergencies. Details were requested about how the policy of decentralization would affect the Region and on retention or strengthening of posts at headquarters or

areas of work. If resources were shifted, how would the results at all levels of WHO be demonstrated and presented?

Questions were asked about the current status of implementation of resolution WHA51.31 and whether the guiding principles asked for by the Health Assembly would replace the mechanism described in that resolution. Speakers sought reassurance about the continued flow of resources to the Region and insisted on full implementation of the resolution's provisions. Nevertheless, satisfaction was expressed about the expansion of support at country level, especially the substantial increase in country allocations in the proposed regional budget.

Many speakers also expressed concern about the unpredictability of voluntary contributions, the lack of their alignment with WHO's agreed priorities and the imbalance in sources of funding. The Organization's work could not depend on uncertain funding that did not accord with agreed priorities. Essential functions such as the revision of the International Health Regulations could not be funded by voluntary contributions from private foundations whose support might be unpredictable. Improved administrative and management procedures in handling such contributions could increase efficiency and effectiveness. Demonstration of what had been achieved with voluntary contributions could provide useful arguments for advocacy within countries, and a request was made for such help in dealing with finance ministries.

A statement was delivered by the representative of the International Commission on Occupational Health.

In reply, the Director, Division of Administration and Finance, recalled that the proposed programme budget would be consolidated at headquarters and that comments would be taken into consideration. He also observed that there had been some confusion between the proposed global and regional budgets. Once final data showing the breakdown of operational and staff costs had been received, further information would be provided.

With regard to economies of scale in the allocation of resources, steps were being taken to consolidate country and project offices and to make use of United Nations Common Houses, which was already leading to increased effectiveness and improved health outcomes. With regard to decentralization, he had taken note of the support for capacity-building at country level, but commented that at the same time the ability to monitor and control activities was increasing at regional and headquarters levels.

In the case that voluntary contributions were not received or were inadequate, one approach would be to base funding on the priorities as decided by Member States, so that lower priority areas would be underfinanced. The exposure of the proposed programme budget to the vagaries of voluntary contributions was recognized, hence the moves to restore the balance in the sources of funding to reduce the level of risk.

The Assistant Director-General, General Management commented that WHO was using resources with care and effectiveness, and a favourable report of the Joint Inspection Unit in that regard would soon be published. He was convinced that the high figures for Immunization and vaccine development in the overall budget were realistic, and observed that partners were important in mobilizing resources. The decrease in allocation for HIV/AIDS reflected the transition from start-up in the current biennium to sustained operation.

The proposed increase in the overall budget was the product of a careful results-based process taking account of the achievements, expectations and strengths of WHO compared with other organizations. Reallocation of resources for areas of work had been carefully considered to see how best to meet demand, and significant changes had been made; different emphasis would need either increased funding or changes in priority by Member States. He noted the agreement on the need for balanced funding and was aware of the political difficulties posed by a proposed increase in assessed contributions of 9%, but the actual figure (US$ 78 million) was not large in absolute terms. In terms of the governance implications of voluntary contributions, discussions with partners were positive, with evidence of respect

for WHO's priorities. The costs of handling those contributions were high and were areas where efficiency savings could well be made. Better coordination was being sought not only within the Organization but within the United Nations and with the European Commission and bilateral donors.

Work was in hand to draw up guidelines on budget allocations to regions, with consideration of the functions of the Organization and where they were done most effectively. When drafted, the guidelines would be issued for consultation and comment. With regard to decentralization, operational plans had been drawn up for each area of work and resource flows were monitored each month as part of a robust operational planning system. Reviews of strategic directions and competences were being undertaken at headquarters and in the regions.

In a forthright reply, the Regional Director made it clear that the implementation of programmes would be seriously hampered by inadequate resources. Difficulty in recruiting and retaining high-calibre staff was leading to a crisis of management. Insufficient voluntary funding limited his ability to offer guarantees of contracts for more than three months at a time. He was grateful for his re-election but was apprehensive that he might be unable to assume his responsibilities through, for instance, not being able to prepare for emergencies.

Staff in the Regional Office had to discuss needs with Member States and foresee what could be done with resources, from whatever source, to meet commitments. Staff members thus had to be at the same time technical experts and fund raisers, but they were having to refuse donations for work not identified as a priority. A rigorous approach to donors and Member States' needs was vital. He was providing support to departments that lacked expertise in fund raising and had himself taken on responsibility for raising funds for a number of projects.

He recalled that for many years the Health Assembly had urged a unified budget; unstable funding created enormous difficulties. He appreciated the conflict representatives faced with finance ministries but pointed out that the enormous decrease in the regular budget over many years put the Organization in danger of asphyxiation. No other organization could have survived such a sustained decrease.

On the positive side, he was armed with strong messages and would stress the European specificities. He confirmed the main areas emphasized by Member States as the following: human resources for health and health systems and services – the top priority; noncommunicable diseases; reproductive health; immunization (and the continuing importance of communicable diseases); environment and health; occupational health; ageing; alcohol misuse; and evidence and information.

The Committee adopted resolution EUR/RC54/R5.

Strategy for the Regional Office's geographically dispersed offices
(EUR/RC54/9)

The Senior Adviser, Programme Management and Implementation summarized the new strategy on geographically dispersed offices (GDOs) that been requested by the Regional Committee at its previous session. It had been drawn up with the assistance of a working group composed of representatives of Member States. The current GDOs were the offices in Barcelona, Bonn, Brussels, Rome and Venice (with hubs in Germany, Greece, Spain and the United Kingdom). The working group had attempted to ensure greater clarity on the specific subjects dealt with by each office, and information on the financial, technical and staffing issues. A GDO had to provide added value, the prime reason for its existence being to enable WHO to tackle priorities that were insufficiently covered. However, clear guidelines needed to be formulated for the establishment and closure of GDOs – opening a new GDO required in-depth analysis, a clear comprehensive agreement with the host Member State, mixed and sustainable funding and a size that gave technical legitimacy. GDOs could only be established or closed down after consultation with the SCRC. Guiding management principles needed to be developed to ensure conformity with normal Regional Office procedures, including those on international staff recruitment, monitoring and evaluation. Copenhagen should retain most technical and administrative functions and not

become simply a coordinating office; there an appropriate balance would need to be struck. However, GDOs had an essential role to play in delivery of services to Member States.

Dr Jarkko Eskola, speaking as a member of the SCRC, said that it had always been clear that GDOs, which had first been set up in 1991, were an integral part of the Regional Office. Until the previous year, all decisions on the establishment or closure of GDOs had been taken by the Regional Director and the Member State concerned. Currently GDOs accounted for 15% of the Regional Office's budget or US$ 25.5 million, but only 4.4% of the regular budget. The SCRC had made various proposals and supported the working group's proposed strategy.

Speakers welcomed the strategy and appreciated the work done by GDOs as an integral part of the Regional Office. One representative, speaking on behalf of the Nordic countries, saw the strategy as a good tool for improved management and coherence of existing and future GDOs, and other speakers supported that view: many of them had worked closely with the GDOs. It was pointed out, however, that the relationship between GDOs and their work on current priorities, on the one hand, and the long-term vision of the Regional Office, on the other, needed to be clearer, in terms of the subjects that the GDOs should be covering.

Many speakers considered that the Regional Committee, and not the SCRC, should have the final decision on the establishment or closure of GDOs. One in every seven dollars and one in every seven working hours of the Regional Office was accounted for by GDOs: that was a significant proportion. An audit of the governance, performance, technical mandates and financing of the current GDOs was suggested. It was felt that the discussion should now be brought to a conclusion, otherwise Member States might be discouraged from setting up new GDOs. One speaker asked that greater emphasis should be placed on providing more publications in Russian, which would increase their usefulness.

While recognizing that the role of WHO collaborating centres and their relationship with the Organization lay outside the scope of the current discussion, some speakers called for their situation, criteria, standards and status to be thoroughly examined at a future session of the Regional Committee. In response, the Senior Adviser, Programme Management and Implementation noted that the Director-General had tasked a senior staff member with redefining the role of WHO collaborating centres.

The Regional Director said that the future of GDOs was now clearer. As for their subject areas, he would welcome new offices in at least the two areas of health systems and human resources, as well as a "one-stop shop" that would extend WHO's database function with the kind of analysis provided by the European Observatory on Health Systems and Policies.

The Committee adopted resolution EUR/RC54/R6.

Environment and health: follow-up to the Fourth Ministerial Conference (Budapest, 23–25 June 2004)

(EUR/RC54/10)

The Director, Division of Technical Support, Health Determinants noted that the burden of disease caused by environmental factors and injuries among children had been the subject of a study which showed that about a third of all deaths (i.e. 100 000 deaths) and about 26% of all disability-adjusted life-years were caused by outdoor and indoor air pollution, unsafe water and sanitation, lead contamination and injuries. The Children's Environment and Health Action Plan for Europe (CEHAPE), which had been negotiated with Member States and adopted in Budapest, was informed by that assessment, and four regional priority goals had been identified to concentrate future efforts. They were to reduce gastrointestinal disorders by improving access to safe water and sanitation; to reduce accidents and injuries; to cut down respiratory disease caused by outdoor and indoor air pollution; and to reduce diseases and disabilities associated with chemical, physical and biological agents and hazardous working conditions.

At Budapest itself, about 1200 delegates had attended the Conference, 18 delegations included young people in their number, and over 130 young people had participated in the Conference through several initiatives including a youth parliament. The media coverage had been extensive, with over 400 articles published, following 15 press conferences before, and 16 press events during, the Conference.

The Conference Declaration set out strong commitments to future action, including follow-up of decisions taken at the previous ministerial conference on issues such as water, transport and climate change; tools for policy-making (particularly environment and health information systems and the precautionary principle); the specific needs of the newly independent states and south-eastern Europe; and the future of the environment and health process, including the European Environment and Health Committee (EEHC).

The EC had also approved an environment and health strategy for the EU countries, and the opportunity existed for strengthened collaboration, and possibly even for legislative enforcement in one part of the Region. A mid-term evaluation was set for 2007 to review progress on the commitments made in Budapest, including national children's environment and health action plans, and the fifth ministerial conference, which Italy had generously offered to host, would be held in 2009.

Commitments made in the Declaration would also mean that the EEHC continued, including youth representation, and a CEHAPE task force would be set up to share best practice. The Regional Office would continue to ensure technical support, from Copenhagen and the Rome and Bonn centres, and strengthen efforts to understand the links between health and the environment, with special emphasis on information and indicators, guidelines for risk assessment and capacity-building. The Conference had set ambitious objectives for the prevention of environmental hazards, and now the commitments made needed to be translated into effective action.

Dr Jaksons, a member of the SCRC, said that high-quality statistics on environment and health, requested by the fifty-third session of the Regional Committee, had been one important part of the preparations for the Budapest Conference. The SCRC had set some guidelines for the process and the work had been well integrated with the main activities of the Regional Office. Follow-up was now crucial. One of the challenges was to work out new tools for policy-making, including a well designed information system, methodologies for health impact and risk assessment, effective multisectoral cooperation and ways of providing examples of good practice. Action plans only worked with political commitment, earmarked money and experienced staff. However, through efforts made in partnership, the activities carried out would make an important contribution to the life of the next generation.

Ms Zsuzsanna Jakab, outgoing Chairperson of the EEHC and representing the host country of the Budapest Conference, Hungary, summarized the extensive consultation with countries that had driven the preparations, providing strong country involvement in a process that had begun two years before the Conference. That should lay a sound foundation for acting on the commitments that countries had made. The youth parliament and their declaration had given the Conference fresh impetus. The necessary financial and human resources should be identified by countries to start the implementation and monitoring activities to which they had committed themselves in the CEHAPE. Hungary had already begun work on those tasks in various ways, including drawing up a second national environment and health action plan.

One representative, speaking on behalf of the EU Member States and candidate countries, thanked the Regional Office for the very professional way in which the Conference had been organized and prepared, with ample involvement of Member States. The outcome documents were comprehensive and impressive, providing a valuable road-map for future action. Cooperation between health and environmental authorities was the basis for future action, and the re-established EEHC should be in close contact with national focal points. That would include the young people who would be represented on the Committee, following the maxim, "Nothing about them without them" – it was their future, their health and their environment at stake. It was important to avoid overlap and duplication through cooperation between different organizations and countries: that could for example include work on a standard set of indicators

for health and environment. The European Environment and Health Action Plan 2004–2010 would be discussed at a meeting in the Netherlands in December 2004. Cooperation and synergy would be the focus, and not only in the health sector: most driving forces of environment and health were outside the health domain, and sectors such as transport, agriculture and energy were also important.

Many speakers congratulated the Regional Office on the success of the Budapest Conference, mentioning particularly the extensive involvement of countries in the preparations and the high standard of the process. The assessment of children's environmental burden of disease provided a strong foundation. The key Conference documents drew their strength from the shared vision of Member States in that area. They not only provided a framework for concerted action across the Region but also allowed for priorities to be met at the local and subregional levels. It had been an excellent Conference and provided a milestone of achievement in environment and health. Many countries had played an active role. Several participants underlined their enthusiasm for the continuing involvement of young people in the process.

Now it was hoped that the follow-up work would result in a measurable improvement in terms of environmental health, nationally and internationally. Several speakers described the progress that was already being made in their countries, through action plans, public health legislation, health promotion, green areas, national registers for potentially harmful chemicals, housing and health projects, measures to reduce child injuries, training on subjects such as pesticides, and increased monitoring. Technical support from the Regional Office was very important to increase the exchange of information, build up capacity in many areas and overall to ensure the future health of children.

A number of speakers stressed the importance of countries ratifying the Water and Health Protocol, which needed only three more ratifications to come into force. Safe drinking-water was a priority. Some countries would need assistance in that regard and in acting on the Budapest commitments. One speaker recommended that the Regional Office should take more financial responsibility for the work done in country offices, with more provision being made in the budget.

A representative of the International Council for the Control of Iodine Deficiency Disorders made a statement drawing attention to the need for considerable efforts in many areas to protect children.

The youth delegate who had been elected to present the Youth Declaration at the Budapest Conference said that young people from 30 countries had come together to discuss their common concerns about health and environmental issues. Youth participation in local, national and international government was critical for implementation of CEHAPE. It gave self-confidence, educated young people in solving problems, and gave them a say in the future they would inherit. It would also restore their trust in the political system. Youth participation in the field of environment and health was just beginning, through the challenging, comprehensive and innovative CEHAPE – and a good start was half the work.

The Director of the European Environment Agency, which was represented on the EEHC, outlined the many ways in which the Agency and the Regional Office had worked together since the Agency's inception 10 years ago, reflecting the vital links between environment and health. Quantifying health impacts could be one of the most persuasive pieces of evidence for policy-makers to take action. Cooperation was set to continue, on topics such as the development of indicators and of an environment and health information service that would make better use of monitoring to see if there were real changes in the health of the population. A project was planned on the environmental burden of disease, and collaboration would continue on the precautionary principle and the presentation of complex evidence.

The representative of the European Public Health Alliance (EPHA), which was also a member of the EEHC, described how cooperation with the Regional Office on the Budapest Conference had focused on raising awareness of the environment and health agenda among the health professionals, voluntary and not-for-profit nongovernmental organizations that made up the members of EPHA, and beyond that to environmental groups across the Region in a new environmental health network. EPHA would be advocating legislative and enforcement measures to reach the regional priority goals endorsed at Budapest, and would facilitate the sharing of information on what Member States were doing to bring

about implementation. What was needed now, however, was not just information or awareness but changes at every level, to move from talk to action. The real challenge would come in two years' time, when Member States would come together to share progress on how they had reduced children's environmentally related disease.

The Director, Technical Support, Health Determinants thanked participants for their supportive statements and for their commitment, which was the best way of increasing the likelihood of real achievements in environment and health. The EEHC would meet before the end of 2004 and the Regional Office would develop a comprehensive workplan.

The Committee adopted resolution EUR/RC54/R3.

Elections and nominations

(EUR/RC54/5, /5 Add.1 and /5 Corr.1)

The Committee met in private to consider the nomination of a candidate for the post of WHO Regional Director for Europe. It subsequently held a further private meeting to nominate members of the Executive Board and to elect members of the SCRC, the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases and the EEHC.

Regional Director for Europe

By resolution EUR/RC54/R2 the Regional Committee requested the Director-General to propose to the Executive Board the reappointment of Dr Marc Danzon as WHO Regional Director for Europe from 1 February 2005.

The Regional Director warmly thanked all representatives for the vote of confidence they had expressed in him and, through him, in all the staff of the Regional Office. One representative, speaking on behalf of the EU Member States and candidate countries, congratulated the Regional Director on his nomination and trusted that the demands and needs of the countries would continue to serve as the guiding principles of his second term of office. The Regional Director was asked to develop a long-term strategic vision on the role and position of the Regional Office for Europe during his second term of office; to reach that vision, it was suggested to establish a working group possibly reporting to the Standing Committee. The President noted that other delegations would have the opportunity to extend their congratulations to the Regional Director during the reception to be held that evening.

Executive Board

The Committee decided by consensus that Azerbaijan and Portugal would put forward their candidature to the Health Assembly in May 2005 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee by consensus elected Estonia, Hungary and the United Kingdom for membership of the SCRC for a three-year term of office from September 2004 to September 2007.

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

In accordance with the provisions of paragraph 2.2.2 of the Memorandum of Understanding on the Special Programme, the Committee by consensus selected Greece for membership of the Joint Coordinating Board for a three-year period from 1 January 2005.

European Environment and Health Committee

The Committee by consensus selected Armenia, Bulgaria, France, Norway and the Russian Federation for membership of the EEHC for a term of office up to the mid-term review in 2007.

Date and place of future sessions of the Regional Committee in 2005 and 2006

The Committee adopted resolution EUR/RC54/R7, confirming that its fifty-fifth session would be held in Bucharest, Romania from 12 to 15 September 2005 and deciding that the fifty-sixth session would be held at the Regional Office for Europe in Copenhagen from 11 to 14 September 2006.

The representative of Romania, on behalf of the Minister of Health, said that Romania assumed the honour and responsibility of hosting the Regional Committee to show its involvement in the work of the Regional Office and aimed to highlight the work of Member States, the Regional Office and other stakeholders towards achieving health for all in the WHO European Region.

Resolutions

EUR/RC54/R1

Report of the Regional Director on the work of WHO in the European Region, 2002–2003

The Regional Committee,

Having reviewed the Regional Director's report on the work of WHO in the European Region in 2002–2003 (document EUR/RC54/6) and the related information document on implementation of the 2002–2003 programme budget (document EUR/RC54/Inf.Doc./1);

1. THANKS the Regional Director for the report;

2. EXPRESSES its appreciation of the work done by the Regional Office in the biennium 2002–2003;

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

EUR/RC54/R2

Nomination of the Regional Director for Europe

The Regional Committee,

Considering Article 52 of the Constitution of WHO; and

In accordance with Rule 47 of the Rules of Procedure of the Regional Committee for Europe;

1. NOMINATES Dr Marc Danzon as Regional Director for Europe; and

2. REQUESTS the Director-General to propose to the Executive Board the appointment of Dr Marc Danzon from 1 February 2005.

EUR/RC54/R3

Environment and health

The Regional Committee,

Emphasizing that high priority should be given to achieving an environment conducive to health for all, particularly children, in the European Region;

Welcoming the progress made towards this aim over the past fifteen years through the Environment and Health process, supported by the work of the WHO Regional Office for Europe and the European Environment and Health Committee (EEHC);

Believing that the Environment and Health process will continue to make major contributions to the health of the people of the European Region in the twenty-first century;

1. ENDORSES the decisions of the Fourth Ministerial Conference on Environment and Health, held in Budapest in June 2004, as included in the Conference Declaration (the Budapest Declaration) and the Children's Environment and Health Action Plan for Europe (CEHAPE), and REQUESTS that particular attention be paid to developing a harmonized environment and health information system, as well as to drawing up policies that will further protect public health from the impacts of major environment-related hazards such as those arising from climate change, housing and chemicals;

2. RECOGNIZES the need to establish effective mechanisms for coordinating technical and financial assistance to the newly independent states and countries of south-eastern Europe, in order to stimulate legislative and institutional reforms, strengthen those countries' capacities and effectively reduce exposures to environmental hazards;

3. NOTES the commitments set out in the CEHAPE and RECOMMENDS:

(a) that child-specific actions are incorporated into ongoing national plans such as national environment and health action plans before the first intergovernmental preparatory meeting for the Fifth Ministerial Conference, to be held by the end of 2007;

(b) that political, technical and financial resources are mobilized, so as to stimulate implementation of the CEHAPE at the subregional level within countries and throughout the Region;

4. AGREES to reconstitute the European Environment and Health Committee (EEHC) with a mandate up to the Fifth Ministerial Conference to be held in Italy in 2009 and to broaden its membership in accordance with the recommendations made and the new terms of reference agreed upon at the Budapest Conference;

5. INVITES the new committee to continue to facilitate and promote the actions set out in the Budapest Declaration, drawing particular attention to the need to:

(a) ensure the exchange and dissemination of information and coordination of the actions required to implement the Budapest Declaration and the CEHAPE among countries, international organizations and civil society;

(b) work with all relevant stakeholders, and particularly countries of the European Region, to ensure reporting back on implementation of the actions decided by the Fourth Ministerial Conference in Budapest;

(c) further develop the Environment and Health process in Europe by facilitating and promoting partnerships with stakeholders in all relevant sectors and ensuring cooperation and coordination with associated organizations such as the United Nations Economic Commission for Europe (UNECE) and related processes, as well as by working closely with the European Union (EU) to ensure full coordination between actions foreseen in the EU Environment and Health Strategy and the commitments made by Member States in Budapest;

(d) report annually to the WHO Regional Committee for Europe on achievements and areas needing greater efforts, as well as on the EEHC's activities, work plan and financial requirements;

(e) organize, together with the secretariat at the WHO Regional Office for Europe, the first intergovernmental preparatory meeting by the end of 2007, as a mid-term review;

(f) provide all Member States, through the WHO Regional Committee for Europe and the UNECE Committee on Environmental Policy, by 2007, with a detailed proposal for the

agenda of the Fifth Ministerial Conference on Environment and Health to be held in Italy in 2009;

6. URGES Member States to share in providing the necessary financial support to the WHO Regional Office for Europe's environment and health activities, and in particular to the WHO European Centre for Environment and Health;

7. REQUESTS the Regional Director to continue to support implementation of the decisions taken at previous conferences, and in particular the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes and the Charter on Transport, Environment and Health, as developed in the joint WHO-UNECE Transport, Health and Environment Pan-European Programme;

8. REQUESTS the Regional Director to continue to provide leadership to the Environment and Health process in the European Region by further promoting the Regional Office's and country offices' activities in the following areas, with special attention to vulnerable population groups such as children:

- supporting effective implementation of the decisions taken in Budapest and the requests of Member States for actions in specific areas detailed therein;
- continuing to address the links between health and the environment and to assess health impacts;
- monitoring trends, conducting research and developing scenarios on exposures, health effects and policy responses and requirements;
- developing evidence-based norms, guidelines and risk assessment tools for application at all relevant levels, with special reference to assessment of the burden of environment-related diseases on health systems;
- identifying appropriate risk management techniques, including those addressing risk communication and perception, through the collection, analysis and interpretation of case studies as well as the identification of best practices;
- supporting further work on health decision-making under scientific uncertainty and the application of the precautionary principle;
- supporting capacity-building at technical and policy levels to facilitate Member States' actions and responses, such as the initiative taken by the Commonwealth of Independent States and a number of countries of south-eastern Europe on reforming and building up the capacity of sanitary/epidemiological surveillance services and strengthening public health systems;
- supporting capacity-building at technical and policy levels to facilitate Member States' actions in establishing practical and institutional mechanisms for effective implementation that meets the legislative requirements for health impact assessments in the Protocol on Strategic Environmental Assessment to the Convention on Environmental Impact Assessment in a Transboundary context;
- advocating the inclusion of environment and health considerations in the policies and actions of other sectors;
- promoting effective emergency preparedness and response capacity on emerging and re-emerging environmental health threats such as those related to extreme weather events.

EUR/RC54/R4

Prevention and control of noncommunicable diseases in WHO's European Region

The Regional Committee,

Recalling World Health Assembly resolutions WHA51.18 and WHA53.17 on the global strategy for the prevention and control of noncommunicable diseases, together with resolutions WHA55.23 and WHA57.17 on the global strategy on diet, physical activity and health and recent resolutions on health promotion (WHA57.16), road safety (WHA57.10), reproductive health (WHA57.12), implementing the recommendations of the World report on violence and health (WHA56.24), the International Conference on Primary Care, Alma-Ata, twenty-fifth anniversary (WHA56.6), mental health (WHA55.10) and child and adolescent health (WHA56.21), and aware of initiatives supported by the Executive Board in documents on cancer prevention and control (EB114.R2 and EB114/3) and disability, including prevention, management and rehabilitation (EB114.R3 and EB114/4);

Recognizing the considerable burden of disease and suffering imposed on Europe by noncommunicable diseases such as cardiovascular diseases, cancer, diabetes, chronic respiratory diseases and mental illness and disabilities, and the need for a response that takes account of the specificity and diversity of the European Region;

Mindful of the economic consequences of this burden, the increasing health inequalities between and within countries, and the resulting threat to the future health and prosperity of the Region;

Conscious that the most prominent noncommunicable diseases are linked to common preventable risk factors such as tobacco, alcohol, overweight and physical inactivity, and that these have economic, social, gender, political, behavioural and environmental determinants, with poverty, social exclusion and inequity being major underlying determinants behind the distribution of noncommunicable diseases in our populations;

Realizing that an integrated approach across the continuum of health promotion, disease prevention, rehabilitation and health care action is required to combat these diseases, with all sectors, and in particular the health system, having a role;

Acknowledging the extensive work already carried out within the European Region on the prevention and control of noncommunicable disease, as well as Member States' existing commitments on alcohol (as expressed in resolutions EUR/RC49/R8 and EUR/RC51/R4), tobacco (resolutions EUR/RC52/R12 and WHA56.1), environment (EUR/RC49/R4), food and nutrition (resolution EUR/RC50/R8), physical activity (resolution WHA57.17) and mental health (resolution EUR/RC53/R4), and including the experience gained through the countrywide integrated noncommunicable disease intervention (CINDI) programme;

Having reviewed the paper relating to a European strategy on noncommunicable diseases (document EUR/RC54/8);

1. URGES Member States to give high priority to addressing noncommunicable diseases, including supportive environments, meeting existing commitments and developing policies that provide multidisciplinary and intersectoral frameworks for comprehensive approaches at appropriate country levels;

2. REQUESTS the Regional Director:

(a) to continue the process of preparing a comprehensive action-oriented European strategy on noncommunicable diseases, in particular based on common morbidity indicators, with a strong focus on implementation, in collaboration with Member States, intergovernmental

agencies, nongovernmental organizations and other relevant partners, including industry, as an integral part of the updated HEALTH21 policy framework, and to present it to the Regional Committee at its fifty-sixth session;

(b) to ensure that the outcomes of the ministerial conferences on environment and health (Budapest, 23–25 June 2004), on mental health in Europe (Helsinki, 12–15 January 2005) and on food and nutrition in 2006, as well as the ongoing work under the European Strategy for Tobacco Control and European Alcohol Action Plan and the forthcoming strategy for the health of children and adolescents, are taken fully into account during that process.

EUR/RC54/R5

Proposed programme budget for 2006–2007

The Regional Committee,

Having reviewed the proposed programme budget for the biennium 2006–2007 (documents EUR/RC54/11 and EUR/RC54/11 Add.1) and taken note of the comments made in this respect by the Standing Committee of the Regional Committee (SCRC) and the Regional Committee;

Welcoming the continuing efforts made throughout the Organization to present a more focused policy and a single global strategic framework, in line with the concept of "one WHO";

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

Noting further that the present budget proposals are still to be regarded as drafts, in view of the fact that Article 34 of the Constitution of WHO stipulates that the Director-General shall submit the final budget proposal of the Organization to the Executive Board;

1. REQUESTS the Regional Director to convey to the Director-General the views, comments and suggestions expressed by the Regional Committee on the proposed programme budget document, to be taken into consideration when finalizing and implementing the programme budget;

2. ENDORSES the strategic directions contained in the document "Proposed programme budget 2006–2007: The WHO European Region's perspective" (EUR/RC54/11 Add.1) and takes note of the proposed budget for 2006–2007 contained in document EUR/RC54/11, which is to be financed with regular funds and funds from other sources, to the extent that the latter become available.

EUR/RC54/R6

Strategy of the WHO Regional Office for Europe with regard to geographically dispersed offices

The Regional Committee,

Recalling the debate at its fifty-third session on the strategic orientations of the Regional Office's work with geographically dispersed offices (GDOs);

Acknowledging the work done by the working group established by the Regional Director on this subject;

Having reviewed the *Strategy of the WHO Regional Office for Europe with regard to geographically dispersed offices* (document EUR/RC54/9);

1. ADOPTS the strategy as contained in document EUR/RC54/9;

2. REQUESTS the Regional Director to:

(a) take action, as appropriate, on the directions and conclusions contained therein, in particular to ensure that the GDOs are fully integrated units of the WHO Regional Office for Europe;

(b) to consult with the Regional Committee when planning to establish a new GDO or to close an existing one; and

(c) as part of his report to the Regional Committee, to report regularly on the work of the geographically dispersed offices.

EUR/RC54/R7

Date and place of regular sessions of the Regional Committee in 2005 and 2006

The Regional Committee,

Recalling its resolution EUR/RC53/R8 adopted at its fifty-third session;

Thanking the Government of Romania for its commitment to host the fifty-fifth session of the Regional Committee, as confirmed to the Regional Director by letter of the Minister of Health of Romania of 20 November 2003 and reiterated by letter of 22 December 2003;

1. DECIDES that the fifty-fifth session shall be held in Bucharest, Romania from 12 to 15 September 2005;

2. DECIDES that the fifty-sixth session shall be held in Copenhagen from 11 to 14 September 2006.

EUR/RC54/R8

Report of the Eleventh Standing Committee of the Regional Committee

The Regional Committee,

Having reviewed the report of the Eleventh Standing Committee of the Regional Committee (documents EUR/RC54/4 and EUR/RC54/4 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-fourth 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-fourth session, as recorded in the report of the session.

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, including report on the work of the Regional Office in 2002–2003

4. Report of the Eleventh Standing Committee of the Regional Committee

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

6. Private meeting: Nomination of a candidate for the post of Regional Director for Europe

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

8. Policy and technical items

(a) European strategy on noncommunicable diseases

(b) Proposed programme budget for 2006–2007

(c) Strategy for the Regional Office's geographically dispersed offices (GDOs)

(d) Environment and health: follow-up to the Fourth Ministerial Conference (Budapest, 23–25 June 2004)

9. Private meeting: Elections and nominations to WHO bodies and committees

(a) Nomination of two members of the Executive Board

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

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

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

10. Date and place of future sessions of the Regional Committee in 2005 and 2006

11. Other matters

12. Approval of the report and closure of the fifty-fourth session

Annex 2

List of documents

Working documents

EUR/RC54/1 Rev.1	List of documents
EUR/RC54/2 Rev.1	Provisional agenda
EUR/RC54/3 Rev.1	Provisional programme
EUR/RC54/4	Report of the Eleventh Standing Committee of the Regional Committee
EUR/RC54/4 Add.1	Report of the fifth session of the Eleventh Standing Committee of the Regional Committee
EUR/RC54/5	Membership of WHO bodies and committees
EUR/RC54/5 Add.1	Membership of WHO bodies and committees – European Environment and Health Committee
EUR/RC54/5 Corr.1	Membership of WHO bodies and committees – Membership of the Executive Board
EUR/RC54/6	Report of the Regional Director on the work of WHO in the European Region, 2002–2003
EUR/RC54/7	Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC54/8	Towards a European strategy on noncommunicable diseases
EUR/RC54/9	Strategy of the WHO Regional Office for Europe with regard to geographically dispersed offices
EUR/RC54/10	The Fourth Ministerial Conference on Environment and Health (Budapest, 23–25 June 2004)
EUR/RC54/11	Proposed programme budget 2006–2007
EUR/RC54/11 Add.1	Proposed programme budget 2006–2007: The WHO European Region's perspective
EUR/RC54/12	Follow-up to previous sessions of the WHO Regional Committee for Europe

Information documents

EUR/RC54/Inf.Doc./1	Regional Director's Report – Implementation of the Programme Budget 2002–2003
EUR/RC54/Inf.Doc./2	Implementation of the Regional Office's Country Strategy
EUR/RC54/Inf.Doc./2 Corr.1	Implementation of the Regional Office's Country Strategy, (Turkey)
EUR/RC54/Inf.Doc./2 Corr.2	Implementation of the Regional Office's Country Strategy, (Armenia)
EUR/RC54/Inf.Doc./3	Partnerships for health: Collaboration within the United Nations system and with other intergovernmental and nongovernmental organizations
EUR/RC54/Inf.Doc./4	Proposed programme budget 2006–2007 – Draft overview of global resource requirements

Background documents

EUR/RC54/BD/1	Scaling up the response to HIV/AIDS in the WHO European Region – Implementation of Resolution EUR/R52/R9
RC/2004/1 (HQ)	Eleventh general programme of work, 2006–2015

Annex 3

List of representatives and other participants

I. Member States

Albania

Representative

Dr Eduart Hashorva
Deputy Minister of Health

Andorra

Representatives

Mrs Mònica Codina Tort
Minister of Health and Welfare

Mrs Montserrat Camps Gallart
Secretary of State for Health, Ministry of Health and Welfare

Alternate

Mrs Carmen Pallarès Papaseit
Ministry of Health and Welfare

Armenia

Representatives

Dr Norayr Davidyan
Minister of Health

Professor Ara Babloyan
General Director, Arabkir Joint Medical Centre, Institute of Child and Adolescent Health

Austria

Representatives

Dr Hubert Hrabcik
Director-General of Public Health, Federal Ministry for Health and Women

Dr Verena Gregorich-Schega
Head, International Health Relations, Federal Ministry for Health and Women

Azerbaijan

Representatives

Professor Ali Insanov
Minister of Health

Dr Alexander Umnyashkin
Head, International Relations Department, Ministry of Health

Belarus

Representative

Dr Liudmila Andreevna Postoyalko
Minister of Health

Belgium

Representatives

Mr Michel Lastschenko
Ambassador of Belgium to Denmark

Dr Godfried Thiers
Director, Louis Pasteur Public Health Research Institute

Alternates

Mrs Leen Meulenbergs
Coordinator, International Relations, Federal Public Service for Public Health, Food Safety and Environment

Mrs Machteld Wauters
International Relations, Department of Health, Ministry of the Flemish Community

Bosnia and Herzegovina

Representative

Mr Zoran Tešanović
Deputy Minister of Civil Affairs of Bosnia and Herzegovina

Alternates

Dr Martin Kvaternik
Minister of Health, Republika Srpska

Mr Tomo Lučić
Minister of Health, Federation of Bosnia and Herzegovina

Advisers

Ms Šerifa Godinjak
Head, Health, Social Care and Pension-Disabled Insurance Department, Ministry of Civil Affairs of Bosnia and Herzegovina

Mr Nudžeim Rečica
Ambassador of Bosnia and Herzegovina to Denmark

Mr Ante Nevistic
Counsellor, Embassy of Bosnia and Herzegovina in Denmark

Bulgaria

Representatives	Mr Slavcho Bogoev Minister of Health
	Mr Branimir Mladenov Head, International Humanitarian Organizations Department, Ministry of Foreign Affairs
Alternate	Ms Valeria Ivanova Head, Minister's Cabinet, Ministry of Health

Croatia

Representatives	Professor Velimir Božikov State Secretary, Ministry of Health and Social Welfare
	Mr Claude Grbeša Head, International Cooperation Department, Ministry of Health and Social Welfare
Alternate	Ms Ana-Marija Besker Ambassador of Croatia to Denmark
Adviser	Professor Marija Strnad Pesikan Deputy Director, Croatian Institute of Public Health

Cyprus

Representatives	Dr Charitini Komodiki Chief Health Officer, Ministry of Health
	Dr Androula Agrotou Chief Medical Officer, Medical and Public Health Services, Ministry of Health

Czech Republic

Representatives	Dr Michael Vít Deputy Minister of Health
	Mrs Marie Koštálová Ambassador of the Czech Republic to Denmark
Alternates	Professor Bohumil Fišer Head, Physiology Institute of the Masaryk University

Mr Ondrej Veselský
Acting Head, Department of International Relations, Ministry of Health

Mrs Jarmila Pexová
Junior Officer, Department of International Relations, Ministry of Health

Denmark

Representative

Dr Jens Kristian Gøtrik
Director-General and Chief Medical Officer, National Board of Health

Alternates

Mr Ib Valsborg
Permanent Secretary, Ministry of the Interior and Health

Mr Mogens Jørgensen
Head of Division, Ministry of the Interior and Health

Advisers

Dr Else Smith
Head of Division, National Board of Health

Dr Lis Keiding
Staff Specialist, Centre for Health Promotion and Prevention, National Board of Health

Ms Marianne Kristensen
Senior Adviser, National Board of Health

Ms Karen Worm
Head of Section, Ministry of the Interior and Health

Ms Kirsten Geelan
Head of Division, Ministry of Foreign Affairs

Estonia

Representatives

Mr Külvar Mand
Deputy Minister of Social Affairs

Mrs Katrin Saluvere
Deputy Secretary-General for Health Policy, Ministry of Social Affairs

Finland

Representatives

Dr Kimmo A.E. Leppo
Director-General, Department of Health, Ministry of Social Affairs and Health

Ms Liisa Ollila
Ministerial Adviser and Head of Section, International Affairs Unit, Ministry of Social Affairs and Health

Alternates

Dr Risto Pomoell
Medical Counsellor, Department of Health, Ministry of Social Affairs and Health

Dr Eero Lahtinen
Senior Medical Officer, Department of Health, Ministry of Social Affairs and Health

Dr Marjukka Vallimies-Patomäki
Senior Officer, Department of Health, Ministry of Social Affairs and Health

Dr Marjaana Pelkonen
Head, WHO Collaborating Centre for Nursing, Nursing Research Institute

Ms Salla Sammalkivi
Counsellor, Ministry of Foreign Affairs

Advisers

Dr Jarrko Eskola
Consultant, Ministry of Social Affairs and Health

Professor Vappu Taipale
Director-General, National Research and Development Centre for Welfare and Health

France

Representative

Professor William Dab
Director-General of Health

Alternates

Dr Jean-Baptiste Brunet
Head, European and International Affairs Unit, Directorate-General of Health, Ministry of Health and Social Protection

Mr Alain Lefebvre
Adviser on Social Affairs for the Nordic Countries, Delegation for European and International Affairs, Ministry of Health and Social Protection

Advisers

Mr Guillaume Delvallée
Ministry of Foreign Affairs

Mrs Isabelle Virem
Adviser, European and International Affairs Unit, Directorate-General of Health, Ministry of Health and Social Protection

Mrs Estelle Sicard
Chargée de mission, Delegation for European and International Affairs, Ministry of Health and Social Protection

Mr Luc A. de Williencourt
Principal Counsellor, Embassy of France in Denmark

Georgia

Representative

Professor Vladimir Chipashvili
Minister of Labour, Health and Social Affairs

Germany

Representatives

Susanne Weber-Mosdorf
Director, European and International Health and Social Policy, Federal Ministry of Health and Social Security

Udo Scholten
Head of Division, International Health and Social Policy, Federal Ministry of Health and Social Security

Alternates

Thomas Hofmann
Head of Section E21, Multilateral Cooperation in the Field of Health, Federal Ministry of Health and Social Security

Dr Ingo von Voss
Counsellor, Permanent Mission of the Federal Republic of Germany to the United Nations Office and other international organizations at Geneva

Dr Christian Luetkens
Head, Division of Prevention, Health Promotion and Epidemiology, Hessian Ministry of Social Affairs

Helene Reemann
Head of Section, Federal Centre for Health Education

Dr Michael Adelhart
Coordinator, Back-up Initiatives, Section 43, German Agency for Technical Cooperation (GTZ)

Dr Michael Siegert
Coordinator, Health, Section 312, Programmes for National Minorities in Eastern Europe and Central Asia, German Agency for Technical Cooperation (GTZ)

Dr Assia Brandrup-Lukanow
Head of Department, German Agency for Technical Cooperation (GTZ)

Greece

Representatives	Dr Athanassios Constantopoulos Director, Mental Health Centre, Regional General Hospital of Athens
	Ms Filomila Raidou Director, International Relations Division, Ministry of Health and Social Solidarity
Advisers	Professor George Christodoulou President, Hellenic Psychiatric Association
	Mr Georgios Iliopoulos First Counsellor, Embassy of Greece in Denmark
	Dr Nikolaos Vakalis Professor, National School of Public Health

Hungary

Representatives	Ms Zsuzsanna Jakab Permanent Secretary of State, Ministry of Health, Social and Family Affairs
	Ms Katalin Novák Deputy Undersecretary of State, Ministry of Health, Social and Family Affairs
Alternates	Dr Zoltán Vokó Head, Epidemiology Unit, Ministry of Health, Social and Family Affairs
	Dr Marianna Szatmári Adviser, Ministry of Health, Social and Family Affairs

Iceland

Representatives	Mr David Á. Gunnarsson Permanent Secretary, Ministry of Health and Social Security
	Mr Sigurdur Gudmundsson Medical Director of Health, Directorate of Health
Alternates	Mr Ingimar Einarsson Director, Ministry of Health and Social Security
	Mr Helgi Mar Arthursson Information Officer, Ministry of Health and Social Security
	Mrs Vilborg Ingolfsdottir Chief Nursing Officer, Directorate of Health

Ms Asthildur Knutsdottir
Adviser, Permanent Mission of Iceland to the United Nations Office and other international organizations at Geneva

Ireland

Representatives

Dr James Kiely
Chief Medical Officer, Department of Health and Children

Ms Mary Aylward
Assistant Principal Officer, International Unit, Department of Health and Children

Alternates

Ms Alison Keogh
Youth delegate

Mr Jack Evans
Youth delegate

Israel

Representatives

Mr Yair Amikam
Deputy Director-General for Information and International Relations, Ministry of Health

Dr Yitzhak Sever
Director, Department of International Relations, Ministry of Health

Italy

Representatives

Dr Francesco Cicogna
Senior Medical Officer, Directorate-General for the European Union and International Relations, Ministry of Health

Dr Emanuele Scafato
Senior Researcher, Centre for Epidemiology, Surveillance and Health Promotion, Istituto Superiore di Sanitá

Alternate

Ms Letizia Leonardo
Economic Attaché, Embassy of Italy in Denmark

Kazakhstan

Representative	Professor Aikan Akanov First Deputy Minister of Health

Kyrgyzstan

Representative	Professor Mitalip Mamytovich Mamytov Minister of Health

Latvia

Representatives	Mr Rinalds Mucinš Minister of Health
	Ms Liga Šerna Director, Department of Strategic Planning, Ministry of Health

Lithuania

Representatives	Dr Juozas Olekas Minister of Health
	Ms Romalda Baranauskiene Under-Secretary, Ministry of Health
Alternates	Professor Vilius Grabauskas Chancellor, Kaunas University of Medicine
	Mr Viktoras Meižis Head, Division of Foreign Affairs and European Integration, Ministry of Health

Luxembourg

Representatives	Dr Danielle Hansen-Koenig Director of Health
	Mrs Aline Schleder-Leuck Principal Executive Adviser, Ministry of Health

Malta

Representatives	Mr Carmel J. Aquilina Ambassador of Malta to Denmark

Dr Ray Busuttil
Director-General for Health, Ministry of Health, the Elderly and Community Care

Alternates

Dr Karen Vincenti
Consultant in Public Health, Ministry of Health, the Elderly and Community Care

Ms Karen Demicoli
Policy Coordinator, Ministry of Health, the Elderly and Community Care

Mr Stephen Borg
Counsellor, Embassy of Malta in Denmark

Monaco

Representatives

Dr Anne Nègre
Director, Health and Social Work, Department of the Interior, Ministry of State

Miss Carole Lanteri
First Secretary, Permanent Mission of the Principality of Monaco to the United Nations Office and other international organizations at Geneva

Netherlands

Representatives

Mr Hans de Goeij
Director-General, Ministry of Health, Welfare and Sport

Mrs Annemiek van Bolhuis
Director, International Affairs Division, Ministry of Health, Welfare and Sport

Alternate

Mr Lejo van der Heiden
Coordinator, Global Unit, International Affairs, Ministry of Health, Welfare and Sport

Advisers

Ms Monique A.C.M. Middelhoff
First Secretary, Permanent Mission of the Kingdom of the Netherlands to the United Nations Office and other international organizations at Geneva

Mr Paul Groenewegen
Senior Policy Adviser, International Affairs Division, Ministry of Health, Welfare and Sport

Norway

Representatives

Dr Bjørn-Inge Larsen
Director-General, Directorate for Health and Social Affairs

Mr Toril Roscher-Nielsen
Director-General, Ministry of Health

Alternates

Mr Sveinung Røren
Deputy Director-General, Ministry of Health

Dr Tharald Hetland
Senior Adviser, Ministry of Health

Ms Eldrid Røine
Adviser, Ministry of Health

Mr Dag Rekve
Senior Adviser, Ministry of Social Affairs

Mr Jens Guslund
Director, Directorate for Health and Social Affairs

Mr Stein Inge Nesvåg
Adviser, Ministry of Foreign Affairs

Ms Turid Kongsvik
Counsellor, Permanent Mission of Norway to the United Nations Office and other international organizations at Geneva

Poland

Representatives

Dr Roman Danielewicz
Acting Director, Department of Science and Higher Education, Ministry of Health

Ms Barbara Bitner
Acting Director, Department of European Integration and International Relations, Ministry of Health

Portugal

Representative

Professor José Pereira Miguel
Director-General and High Commissioner of Health, Ministry of Health

Alternates

Mr José Sousa Fialho
Adviser, Permanent Mission of Portugal to the United Nations Office and other international organizations at Geneva

Dr Maria José Laranjeiro
Technical Adviser, Ministry of Health

Republic of Moldova

Representative

Dr Larisa Catrinici
Deputy Minister of Health

Romania

Representatives

Dr Alexandru Rafila
Director-General, Public Health and State Sanitary Inspection, Ministry of Health

Dr Radu Constantiniu
Adviser to the Minister of Health

Russian Federation

Representative

Dr Anatoly V. Pavlov
Deputy Director, Department of Legal and International Activities, Ministry of Health and Social Development

Advisers

Mr Denis V. Piminov
Third Secretary, Department of International Organizations, Ministry of Foreign Affairs

Dr Sergei M. Furgal
Consultant, Federal Service for Protection of Consumer's Rights and Well-Being, Ministry of Health and Social Development

San Marino

Representatives

Dr Massimo Roberto Rossini
Minister of Health and Social Security, Welfare, Social Affairs and Equity

Mrs Federica Bigi
Ambassador, Permanent Representative of the Republic of San Marino to the United Nations Office and other international organizations at Geneva

Alternate

Mrs Simona Zonzini
Ministry of Health and Social Security, Welfare, Social Affairs and Equity

Serbia and Montenegro

Representative

Professor Tomica Milosavljević
Minister of Health of the Republic of Serbia

Alternates

Mr Vladimir Radulović
Ambassador, Embassy of Serbia and Montenegro in Denmark

	Dr Nevena Karanović Deputy Minister of Health of the Republic of Serbia
Adviser	Ms Marina Jovičević First Secretary, Embassy of Serbia and Montenegro in Denmark

Slovakia

Representatives	Dr Rudolf Zajac Minister of Health
	Dr Svätopluk Hlavačka Ministry of Health
Alternates	Dr Klára Frecerová Ministry of Health
	Mrs Zuzana Červená Ministry of Health

Slovenia

Representatives	Professor Dušan Keber Minister of Health
	Mr Rudolf Gabrovec Ambassador, Embassy of the Republic of Slovenia in Denmark
Advisers	Ms Natalija Raišp Counsellor, Embassy of the Republic of Slovenia in Denmark
	Dr Jožica Maučec Zakotnik State Secretary, Ministry of Health

Spain

Representative	Dr Manuel Oñorbe Director-General of Public Health, Ministry of Health and Consumer Affairs
Alternate	Mr José Perez Deputy Director-General of International Relations, Ministry of Health and Consumer Affairs
Advisers	Ms Isabel Sáiz Martínez-Acitores Ministry of Health and Consumer Affairs
	Mr Juan M. López-Nadal Chargé d'Affaires, Embassy of Spain in Denmark

Sweden

Representatives

Ms Kerstin Wigzell
Director-General, Ministry of Health and Social Affairs

Ms Harriet Pedersen
First Secretary, Permanent Mission of Sweden to the United Nations Office and other international organizations at Geneva

Alternates

Ms Karin Nilsson Kelly
Desk Officer, Ministry of Health and Social Affairs

Ms Birgitta Schmidt
Administrative Director, National Board of Health and Welfare

Mr Bo Pettersson
Deputy Director-General, National Institute of Public Health

Dr Ann Gardulf
Head of Division, Karolinska University Hospital

Ms Ulrika Hertel
Handling Officer, Swedish International Development Cooperation Agency

Switzerland

Representatives

Professor Thomas Zeltner
Director, Federal Office of Public Health

Franz Wyss
Central Secretary, Swiss Conference of Cantonal Directors of Public Health

Alternates

Dr Gaudenz Silberschmidt
Head, International Relations, Federal Office of Public Health

Giancarlo Kessler
Head, Department of International Organizations, Federal Office of Public Health

Tajikistan

Representative

Professor Nusratullo F. Faizullaev
Minister of Health

The former Yugoslav Republic of Macedonia

Representatives

Dr Rexhep Selmani
Minister of Health

Mrs Snezana Cicevalieva
Head, Sector for European Integration and International Cooperation, Ministry of Health

Turkey

Representatives

Professor Dr Recep Akdağ
Minister of Health

Ms Fügen Ok
Ambassador of the Republic of Turkey to Denmark

Alternates

Professor Dr Necdet Ünüvar
Under-Secretary, Ministry of Health

Professor Dr Sabahattin Aydin
Deputy Under-Secretary, Ministry of Health

Professor Dr Turan Aslan
Head, Refik Saydam Hygiene Centre, Ministry of Health

Mr Kamuran Özden
Head, Department of Foreign Affairs, Ministry of Health

Dr Salih Mollahaliloğlu
Head, Public Health School of Ministry of Health

Ms Sevim Tezel Aydin
Deputy Head, Department of Foreign Affairs, Ministry of Health

Ms Engin Asula
Counsellor, Embassy of the Republic of Turkey in Denmark

Mr Barkin Kayaoğlu
Third Secretary, Embassy of the Republic of Turkey in Denmark

Secretary

Mr Ertan Savas
Secretary to the Minister of Health

Ukraine

Representative

Dr Mykhailo Pasichnyk
Deputy Minister of Health

Alternates

Mr Yuriy Pavlov
Chargé d'affaires ad interim of Ukraine to the Kingdom of Denmark

Mrs Zhanna Tsenilova
Head, Department of International Cooperation, Ministry of Health

Ms Iryna Dush
Senior Specialist, Department of International Relations, Ministry of Health

United Kingdom of Great Britain and Northern Ireland

Representative	Sir Liam Donaldson Chief Medical Officer, Department of Health
Alternates	Dr David Harper Director of Health Protection, International Health and Scientific Development, Department of Health
	Mr Nick Boyd Head, International Affairs, Department of Health
	Mr Anthony Kingham Head, International Public Health, Department of Health
	Professor Peter Donnelly Deputy Chief Medical Officer, Department of Health
Adviser	Ms Lorna Demming International Business Manager, Department of Health
Secretary	Ms Siobhan Jones Assistant Private Secretary to the Chief Medical Officer, Department of Health

Uzbekistan

Representative	Professor Feruz Nazirov Minister of Health
Advisers	Dr Abdunumon Sidikov Head, Department of International Cooperation, Ministry of Health
	Mr Tajbai Buranov Head, Health Authority of Syrdarya Region

II. Observers from Member States of the Economic Commission for Europe

Canada

Mr Thomas Townsend
Counsellor, Health and Social Affairs, Canadian Mission to the European Union

Mr Garry Aslanyan
Senior Health Adviser, Policy Branch, Canadian International Development Agency

United States of America

Mr David E. Hohman
Health Attaché, Permanent Mission of the United States of America to the United Nations Office and other international organizations at Geneva

III. Observers from Non-Member States

Holy See

Mgr Jean-Marie Mpendawatu
Pontifical Council for Pastoral Assistance to Health Services

IV. Representatives of the United Nations and related organizations

Food and Agriculture Organization of the United Nations (FAO)

Dr David Sedik

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Mr Henning Mikkelsen

World Bank

Mr Jan Bultman
Ms Monique Mrazek

V. Representatives of other intergovernmental organizations

Council of Europe

Mr Alexander Vladychenko
Mrs Vera Boltho

European Commission

Dr Isabel de la Mata Barranco
Mr Fernand Sauer
Mr Bernard Merkel

European Environment Agency

Professor Jacqueline McGlade
Mr David Stanners

VI. Representatives of nongovernmental organizations in official relations with WHO

Consumers International

Ms Stine Wohl Sem
Ms Beate Kettlitz

Ms Clara Meynen
Ms Irina Danada
Ms Camilla Udsen

International Association for Child and Adolescent Psychiatry and Allied Professions

Dr Kari Schleimer

International Association of Cancer Registries

Dr Hans H. Storm

International Commission on Occupational Health

Professor Otto Melchior Poulsen

International Council for Control of Iodine Deficiency Disorders

Professor Aldo Pinchera

International Council of Nurses

Ms Christine Hancock
Ms Kirsten Stallknecht

International Council of Women

Mrs Nina Saxe

International Federation of Medical Students' Associations

Mr Andreas Rudkjøbing
Ms Zahra Theilgaard

International Federation of Pharmaceutical Manufacturers Associations

Mr Boris Azaïs

International Life Sciences Institute

Mr Nico van Belzen

International Non-Governmental Coalition against Tobacco

Mr Cornel Radu

International Pharmaceutical Federation

Mrs Eeva Terasälmi

International Planned Parenthood Federation

Ms Vicky Claeys

Medical Women's International Association

Dr Vibeke Jørgensen
Dr Aggi Kjaer
Dr Annemette Mygh
Dr Margit Niebuhr

World Association for Psychosocial Rehabilitation

Professor Edvard Hauff

World Association of Girl Guides and Girl Scouts

Ms Estrid Stæhr Hansen

World Confederation for Physical Therapy

Mr Johnny Kuhr
Ms Anne Lexow

World Heart Federation

Ms Susanne Volqvartz

World Psychiatric Association

Professor George Christodoulou

VII. Observers

European Forum of National Nursing and Midwifery Associations and WHO

Ms Sylvia Denton
Ms Merete Thorsén

European Public Health Alliance

Ms Genon K. Jensen

EuroPharm Forum

Ms Ida Gustafsen

Global Fund to Fight AIDS, Tuberculosis and Malaria

Mrs Karmen Bennett
Dr Valery Chernyavskiy
Dr Urban Weber

Regions for Health Network

Dr Ricard Tresserras

Standing Committee of Nurses of the EU

Mr Paul De Raeve

Urbani International

Dr Peter W.S. Chang
Ms Rebecca Mosimann

Annex 4

Address by the Director-General of WHO

Mr Chairman, Honourable Representatives, Members of the Diplomatic Corps, Marc – Bonne chance aujourd'hui.

First of all, I would like to add my voice to the many that have been raised in shock and sorrow at the recent events in southern Russia. Crises, whether naturally or humanly caused, require the utmost effort from all of us, both to prevent them and to be prepared to mitigate the damage they cause.

In May, just after the Czech Republic and nine other states joined the European Union, I had the privilege of meeting President Vaclav Havel in Prague. His concern was that the continuing global advance of technology could end up by creating more health problems than it was solving. He recognized the need for what he called 'a planetary organization' like WHO to help guard against that danger.

Equally important is the presence of realistic but visionary thinkers like him and like many others at work now in the 52 Member States of this Region.

The Regional Committee provides an excellent forum within which to share their concerns and ideas and coordinate strategies. Unprecedented potential for health exists in every country of this region and in the whole world, but mutual support is needed to fulfil it. Now is the time both to clarify the big picture and to work out some of the practical details. I would like to suggest three guiding principles to refer to in your discussions: security, equity and unity.

Security in health means protection both from ill-health and from its causes. As we are all too well aware, building and maintaining that security means responding to the urgent needs and dangers now facing us.

Equity has been WHO's fundamental principle from the very beginning, as our Constitution states. It needs to be strongly reasserted now, as the health effects of disparities between communities, nations and continents become more and more evident.

Unity is indispensable for effective action and, in the coming months and years, we will be working more closely than ever before with our partners.

If we are to put these principles into practice we also need to exercise hardheaded realism. The first thing to do is ensure that we have enough money to do our work. During this meeting, you will be discussing the proposed Programme Budget for 2006–2007. There are several important aspects of this budget we need to be aware of.

First, it builds on our experience with results-based budgeting and the lessons learnt from the performance assessment of the 2003–2004 Programme Budget. Second, it reflects the priorities expressed by Member States in recent World Health Assembly resolutions and has been drafted in consultation between the headquarters, regions and country offices. Third, it reinforces and accelerates the decentralization process I initiated last year. You will note that it proposes an overall increase of 12.8%, all of which will be allocated to countries and regions. The largest proportional increase is for the European Region.

The increase is accompanied by measures to ensure maximum efficiency in the use of resources. These measures delegate responsibility while calling for the highest standards of transparency and accountability.

Previous projections of budget growth have been matched by the generosity of our donors, enabling us to achieve the results to which we were committed. But essential activities cannot depend on generosity alone. I am, therefore, proposing an increase of 9% in assessed contributions from Member States.

The increase represents a break with the practice adopted some years ago of zero nominal growth in the budgets of UN agencies, which has been gradually turning WHO into an organization that depends mainly on voluntary contributions. At present, the Regular Budget, consisting of assessed contributions, represents only 30% of WHO's overall expenditure. If the current trend were to continue, it would be only 17% by 2015.

To carry out a well-balanced global policy, a significant regular budget, based on an equitable system of contributions, is indispensable.

The budget question becomes urgent in the context of our General Programme of Work for 2006 to 2015, which defines our activities and role as an organization. It must not only show how we will achieve the health-related Millennium Development Goals but set the directions for the future of global public health.

The Programme Budget and the General Programme of Work will both be on the agenda of the Executive Board at its next meeting in January. Your input through this session of the Regional Committee will make an essential contribution to the Executive Board's recommendations, which then go to the Health Assembly.

To return to the question of security, major outbreaks of disease continue to be a threat to this region and the world. The International Health Regulations are designed to minimize that danger. The revision now in progress has benefited from a high level of input from Member States through the regional consultations. The next step will be to agree on revisions in the open-ended Intergovernmental Working Group which meets from 1 to 12 November at the UN Palais des Nations in Geneva.

The working draft will be available next month. If progress continues at the current rate, the revised Regulations can be adopted at the World Health Assembly in May 2005. The fullest participation possible of Member States in the Working Group discussions will be our best guarantee of success.

This form of cooperation in health began with the First International Sanitary Conference in Paris in 1851, which met to draw up an international sanitary code, mainly to contain the spread of cholera. The long historical perspective is a valuable asset, which is helping the countries of this region to make a special contribution to the drafting of these regulations. Ultimately, the challenge is to ensure that the regulations are followed. This will require strong commitment within regions and countries, with the necessary investment in early warning and response systems.

These systems will be supported by WHO's Operations Centre, which opened in August at headquarters. Using the most up-to-date technology, it enables us to respond rapidly to the earliest signs of outbreaks, natural or manmade and other health emergencies by circulating the information and coordinating the necessary action.

Recently, we have seen early and effective responses to outbreaks of Ebola and Lassa fever in parts of Africa, and to avian influenza in several Asian countries. Laboratories in this region played an important role in the response to SARS and avian influenza. However, we are still in the early stages of building an adequate global outbreak alert and response system. It will require a major and sustained effort of investment. It involves not only the national, regional and global information hubs but also our many collaborating centres in the relevant areas of expertise. A large and important component of the system will be the European centre for disease control, when it opens in Stockholm next year.

We will shortly be contacting Member States with further information on ways in which you can access and add to the information available through these networks.

Inequity is the root cause of much of the danger we face in the world today. Lack of access to AIDS treatment and prevention methods continues to be a glaring example of both insecurity and inequity.

As we saw in Dublin in February and Bangkok in July, Europe is well aware that it has the fastest-growing HIV/AIDS epidemic in the world. Though 30 European countries have achieved universal access

to antiretroviral therapy, there are still 22 in which access is partial or almost nonexistent. I warmly welcome your commitment to correcting this in the shortest possible time.

At the Bangkok conference there was plenty of debate over methods of prevention and treatment, but absolute agreement about the need for both. We know that prevention bolsters treatment and vice versa, and that they must be integrated in a comprehensive way.

Globally, with all sources combined, almost 20 billion dollars have been pledged for integrated AIDS prevention and care over the next five years. At the same time, drug prices continue to fall, with the lowest-price triple-drug regimen coming down towards $140 per person per year. HIV treatment is now financially within reach for more countries, and more people, than ever before.

Enormous logistical and technical difficulties remain, but there are signs that they too are yielding to the persistent efforts of our many partners working towards the “3 by 5” target within countries and internationally.

Twelve countries have now set targets for 2005 to get treatment to 50% or more of the people who need it. Guidelines for high-quality treatment using standardized regimens and simplified clinical monitoring are now available. We have developed training and monitoring systems to ensure the quality of treatment, and to increase the involvement of nurses and community workers in providing care and support. Fifty-six countries have appealed to WHO through the Regional Offices for technical assistance in scaling up treatment, ten of them in Europe. We are very actively supporting them. We expect the Canadian Government to give us 100 million Canadian dollars this month. We expect to have at least 20 “3 by 5” country officers in place by the end of this year, greatly increasing our effectiveness on the ground.

Improving human resource capacity is one of our most pressing challenges, not only to support HIV treatment but across the health sector. This means retaining, training and deploying health care workers, and creating new types of treatment supporters, including people living with HIV/AIDS themselves.

The “3 by 5” target itself has also provoked much discussion. What seemed to many like an over-ambitious idea one year ago is now a strong commitment made by many countries, many organizations and many individuals. To speculate about whether we will meet the deadline is to miss the point. The point in the AIDS treatment emergency is the same as in other emergencies: to do as much as is humanly possible to save lives and reduce danger in the shortest possible time.

The initiative has helped to focus the world’s attention on dealing with this emergency, and has galvanized action within our own organization. We must not relent in our efforts to reach the target for treatment and to accelerate HIV/AIDS prevention well beyond December 2005. I am committed to continuing to mobilize all the human and material resources at our disposal to support you in this.

On other campaigns, Europe has been a great strength in the polio eradication effort, both by achieving eradication regionally and by supporting the work in Africa and Asia. That continuing support will be indispensable in the coming months.

Tuberculosis control remains a top priority for Europe. Though some countries are progressing well towards full implementation of the DOTS strategy, others are lagging dangerously behind. Rapid scale-up of DOTS is urgently needed. Otherwise, vulnerable populations will be at increasing risk of multidrug-resistant TB, as well as the growing co-epidemic of TB and HIV. In both cases, treatment becomes difficult and expensive.

As we see in the case of HIV/AIDS, malaria and tuberculosis, making adequate health services available where they are needed is an enormous challenge in itself. But it is only one part of what it takes to promote health for all. Health also depends to a very significant extent on socially determined factors such as the environment, education and employment. As we saw in June, in Budapest, at the Conference on Environment and Health, intersectoral action is not only a necessity but an area of enormous potential for health.

Knowledge about how these factors affect health enables us to target our activities for maximum effect. To gather and consolidate the evidence needed for effective policies, the Commission on the Social Determinants of Health will begin its work in December. Europe has already done pioneering work in this area, and your regional and country-level input will make a very important contribution to the Commission's work.

The WHO Framework Convention on Tobacco Control, also aimed at tackling social and economic determinants of health, is proceeding steadily towards coming into force. It has 168 signatories, which include the European Union and 40 of the 52 countries of this region. Globally, 30 countries have become parties to the Convention. With the European Community's formal confirmation of the Convention in June, we now expect to see quick developments. Six of the 30 states parties are in this region: Hungary, Iceland, Malta, Norway, San Marino and Slovakia. I urge all the rest of you to follow their excellent example without delay. When the Convention has been ratified by 40 countries it can start to fulfill its great potential for saving lives.

The value of international negotiations and intergovernmental processes has been made clear in the case of tobacco. For the WHO Strategy on Diet and Physical Activity, the work is still in its early stages. In May, the Strategy was strongly endorsed by the Health Assembly and it too has far-reaching implications for health. As countries take up its recommendations, international knowledge-sharing and mutual support will be a vitally important asset for preventing and controlling noncommunicable diseases. Europe's strong contribution to this effort has been vitally important and will continue to be so, both for this region and for the world. Preventing and controlling obesity, in particular, will require innovative and vigorous intersectoral work.

It is research that has led to public recognition of these problems and of the ways in which they can be tackled. The Ministerial Summit on Health Research, to be held in Mexico in November, will attempt to accelerate the same process for other causal factors of disease, especially those that block the way to the Millennium Development Goals. I urge you to attend this meeting. In addition, the Sixth Global Conference on Health Promotion will be held in Bangkok in August 2005. Its title will be Policy and Partnership for Action. Unity is the key to achieving the security and equity the world so desperately needs now. In the coming months, our focus on maternal and child health will provide special opportunities to achieve it.

A large number of key organizations have combined forces to tackle the problems in this area, especially high mortality rates. Their first step, earlier this year, was to draft a road map for attaining the Millennium Development Goals for maternal and child health. The World Health Report and World Health Day for 2005 will build on this momentum. We are working closely with our colleagues in UNICEF, UNFPA, the Partnership for Safe Motherhood and other organizations.

The focus on maternal and child health is reinforced by our country-specific cooperation strategies, which are aimed primarily at strengthening health systems. Here each programme and each level of activity is defined in terms of how it can contribute to national health development goals through one WHO country budget and plan. The European Region has made a good start on this. While speeding up the decentralization process, it is giving a strong sense of direction to our work.

This Regional Committee itself has made a vital contribution to building unity in Europe over the years. Your wise decisions, recommendations and suggestions, during this session will enable it to continue to do so for many years to come.

I wish you every success. Thank you.

Annex 5

Presentation of the report of the Regional Director

Before I begin my presentation, I would like us to spare a thought for those who suffer from violent and criminal acts, whether they are the victims or their relatives. We all have in mind the unbearable images that have come out of the Russian Federation in the past few days. The suffering of the injured and the bereavement of the relatives will stay in our minds throughout our meeting, because it is in fact for them that we are working. Our humanitarian aid programmes must be stepped up to respond to this terrible threat.

Since the last session of our Regional Committee in Vienna, the Region and the Office have experienced a year of contrasts, with a wealth of activities carried out, lessons learned and opportunities unfolding. A year in which we have done our best to play our European role in a global context and to make our voice heard, even beyond the borders of the Region.

The report that I am presenting to you this morning covers this past year. It complements the documents on the years 2002–2003 that have already been sent to you or which can be provided on request.

1. Salient features since Vienna

a) AIDS: a challenge for public health and health systems

The world has become aware of the spread of AIDS in the European Region and of the threat that this poses. There is a clear determination to take action, as shown by the considerable increase this year in resources allocated to 18 countries in the Region, especially from the Global Fund.

Our common mission now is to ensure that these resources are appropriately and efficiently used, and that they quickly have positive and documented effects on people's health. Failure would be disastrous, first of all for the people concerned but also for the credibility of public health. Conversely, a positive and measurable impact on health indicators, together with a consolidation of health systems, would greatly encourage investors and strengthen public health's credibility.

I am sure that, just like us in WHO, you are all doing and will do your utmost to contribute to taking up this challenge and reaching the goal of the European component of the "3 x 5" programme, which is to have treated 100 000 patients by the end of 2005. Treatment is of course the least we should do, since prevention is still essential for us, too, given the rise in the number of cases from 584 000 at the end of 2002 to 785 000 today.

b) Noncommunicable disease control: a priority for Europe and the world

This afternoon, our Regional Committee will discuss the first phase of the European strategy on noncommunicable diseases, as the World Health Assembly and the Executive Board have already done this year. Apart from testifying to close coordination between the different levels of the Organization, this combined approach demonstrates, if that were needed, the vital importance of proposing effective measures to limit the harm done by these diseases. Progress in this area, as with all risk factors, can be achieved only through complementary action by individuals and society as a whole. The very explicit support that you gave to the strategy proposed by WHO during the World Health Assembly bears witness to your keen interest in this field and to your desire to take action here.

The Region will give prominence and high priority to tackling obesity, which is now a major risk factor as well as a good example of the need to bring together such varied sectors as agriculture, industry and

food distribution, building of course on work being done in the areas of health education and lifestyle interventions.

While on the subject on noncommunicable diseases, I would also like to mention the question of mental health. This year we have continued the actions launched since publication of the World health report 2001. Preparations for and the holding of the Helsinki Ministerial Conference in January 2005 will be a salient feature of the coming year.

c) The International Health Regulations: a joint undertaking

As it did for the Framework Convention on Tobacco Control, the European Region has made its voice heard in the negotiations on updating the International Health Regulations. The programme is global, but preparations have already been made through regional meetings. The one for the European Region, in June of this year, was particularly impassioned and productive. The Region now has a clear and specific position on all points, and adoption of the revised Regulations at global level is scheduled for May 2005, following the global consultation meeting in November of this year. An information session on this topic is to be held during the lunch break on Wednesday, and I invite you all to attend.

I would also like to take this opportunity to summarize the situation with regard to the Framework Convention on Tobacco Control. To date, 168 countries have signed the Convention, including 40 of the 52 Member States in the European Region. Ratification is unfortunately proceeding more slowly: six European countries have already done this, out of a total of 26 countries throughout the world. The process needs to be speeded up and intensive efforts must be made if the Framework Convention is to come into force in December 2004.

d) The Budapest Conference on Environment and Health: A success to be followed up

One of the meetings at this session of the Regional Committee is devoted to discussing and endorsing the outcomes of the Budapest Conference. The fourth in a series that began in Frankfurt in 1989, this conference put forward an action plan on children's environment and health and a declaration on the broader theme of health and the environment, building on declarations issued by previous conferences.

There is no doubt that this conference aroused considerable enthusiasm, both in terms of the number of high-level participants and in the unrivalled press coverage it received. But for us, this success translates first and foremost into a commitment that gives rise to many hopes throughout the Region. With your help, we will take up this challenge together in every country. A mid-term review will be made in 2007, and a final evaluation of our efforts will be presented at the next conference, in 2009. I would like here to thank all the many partners who contributed so efficiently to the preparation and organization of the conference. They will no doubt also be fully engaged in carrying out the plan of action. In particular, I should like to attribute this success to the Government of Hungary and the European Environment and Health Committee which, under the leadership of Mrs Zsuzsanna Jakab, was a valuable and effective partner throughout this undertaking. We will come back to this topic on Tuesday morning, during that part of the Regional Committee's session devoted to this question.

Since road traffic accidents have an environmental dimension, I would like to recall the global report and World Health Day 2004 on this subject. As it does every year, the European Region contributed to the success and visibility of this event by publishing a European version of the report, which can be made available to you if you wish. The idea has gained ground in the Region that road traffic accidents, far from being inevitably linked to progress, are in fact an unacceptable danger that can be avoided through deliberate policy-making. This has led to a commitment to take coherent action, as an integral part of new national and international policies on accident prevention.

e) The European Commission: an enlarged partner, a broader partnership

The geographical and political configuration of our Region has changed this year, with ten new countries joining the European Union.

Since the start of this decade, partnership with the European Commission has been one of the Regional Office's priorities, following the strategy adopted by the Regional Committee. In the past three or four years, our systematic and organized efforts have resulted in increasingly pragmatic and tangible cooperation in such varied domains as information, communicable diseases, health promotion and mental health. The Helsinki Conference that I have mentioned is being organized jointly with the European Commission, which was also involved in the Budapest Conference.

The Commission is making a financial contribution to many of the Regional Office's programmes. I would also remind you that the Regional Office has seconded a staff member to the Commission to work on communicable disease surveillance. Partnership with the European Union, whether it has 15, 25 or even more member countries, will be a fundamental priority for the Regional Office and WHO as a whole. Dr Lee Jong-Wook himself emphasized this at our annual meeting with various commissioners in Brussels in July. I have proposed to Mr Fernand Sauer, who we are pleased and honoured to have with us today, that we should work closely with the new European Centre for Disease Control, to be opened in Stockholm in 2005. We are both determined to make this cooperation genuine and effective, and next month I will be attending the inaugural meeting of the Stockholm Centre's Management Board. The principle of complementary action will guide us in our cooperation, which of course extends far beyond a European CDC. There is no feeling of fear or idea of launching a "turf war" here – these would be unworthy and pointless reactions, in an area that is sorely lacking in resources and where no effort can be spared. Our complementary approach will be implemented through the Regional Office's technical programmes and their equivalents in the Commission's public health plan. In addition, complementarity will be ensured in those areas of competence of the Regional Office that are not, or not yet, part of the Commission's responsibilities. As from this month I have assigned a member of my Executive Management team to Brussels, to ensure liaison between the Regional Office and the European Union.

However, I would like to reiterate that the European Region of WHO consists of 52 Member States, and that we will never neglect those, however many they are, who are not part of the European Union. On the contrary, we want to build bridges and promote exchanges between the Union and those Member States of WHO's European Region who are now its neighbours, and especially the countries of the Commonwealth of Independent States. We are admirably suited to playing this linking and bridging role, since we have worked with each of these countries for many years, we know them well, and in general they have confidence in us, too.

I have dwelt on this subject because the Standing Committee asked me to set out the Regional Office's strategy for its relations with the now enlarged European Union.

Still in the area of partnerships, we have since 2000 steadily developed deeper relations with some partners whose values and objectives we share. In each of these partnerships, collaboration takes place at institutional level within a specific programme that is regularly reviewed and whose main aim is to develop very practical activities, preferably on the ground.

In 2001 and 2002, relations of this kind were developed with the European Union, the World Bank and organizations of the United Nations system such as UNICEF, UNFPA and UNAIDS. I should here like to draw attention to the quality and effectiveness of our cooperation with the Council of Europe, and I welcome the fact that the new Director of Social Cohesion, Mr Alexander Vladychenko, is with us this morning.

More recently, and building on the same foundations, the Regional Office has strengthened its partnerships with development agencies and nongovernmental organizations such as the German technical cooperation agency GTZ, the Dutch development agency and the Soros Foundation. These partnerships complement our agreements with the development agencies of the United Kingdom and the

Nordic countries, especially the Swedish agency SIDA, as well as the International Committee of the Red Cross and Rotary International, to mention only a few.

Although properly speaking it is not an external partnership, since we are fervent advocates of one WHO, I would nonetheless like to say a word here about our collaboration with WHO headquarters and the other regional offices. In the past year we have forged closer links with the new team in Geneva. My personal collaboration with Dr Lee Jong-Wook is frequent, warm and genuine. I regard myself as a member of his team, and I should here like to reiterate not only my own support but also that of the whole Regional Office. We greatly appreciated the visit made this year by all the new assistant directors-general, and I am pleased to see many of them attending this Regional Committee session.

During the year we have also strengthened our links with the other regional offices, especially that for the Americas, which our management team has visited. They are due to return the compliment in October, to take forward our very practical cooperation in numerous technical and administrative areas of common interest.

We have also cooperated more closely with the Regional Office for the Eastern Mediterranean, which I visited this year to take up some issues of common concern to certain of our Member States.

2. Development of the Regional Office's services

During the year we have continued to strengthen the Regional Office's services for countries of the Region, as defined in the strategy adopted by the Regional Committee in 2000. In this presentation, I would like to highlight the improvements we have made in planning our work. The increasingly close relation of trust that we enjoy with each of the 28 countries with whom the Regional Office has a biennial agreement is now yielding benefits when we come to negotiate priorities with them. Regular evaluation of the outcomes of our cooperation means that we can build on the lessons learned, both in emergency operations and during normal programme implementation. A supplementary report will be presented to you during the meeting on Tuesday afternoon, when we take up the agenda item on follow-up to issues discussed at previous sessions of the Regional Committee.

The Futures Fora programme got into its stride this year, after a somewhat slow start. The central theme of "tools for decision-making in public health" has given rise to lively debate on topics such as the use of evidence in public health, crisis communication and response to health crises. The report of the latter meeting, which can be provided on request, encourages us to continue our work, so that we are better placed to handle health crises and prepared to adapt to unforeseen situations. We will continue to make preparations with you and the partners concerned and to improve our own capacity, and that of health systems, to respond to these now all too common situations.

Another activity carried out by the Regional Office in the service of the Member States that I would like to mention is the imminent publication of a report on the situation in the European Region with regard to the Millennium Development Goals and the report of the Commission on Macroeconomics and Health. One of the main conclusions of this work highlights the delay in providing international financial assistance for health in the poorest countries of our Region. This report will be sent to you as soon as it is available. In this way, our work is increasingly integrated in global programmes, while adapting them to the regional situation.

We will come back to the question of collaboration with countries on Tuesday afternoon, during the item on "follow-up" action, but I cannot conclude this section of my presentation without giving one particularly encouraging example of this collaboration: I am referring here to the reform of Portugal's health system, where it appears that the support provided by the Regional Office was highly appreciated by the country and widely commented on in the media. This type of supporting action is an excellent example of what we hope to do with countries in different parts of the Region.

One of the most useful services that WHO can render to its Member States is to provide them with information. As soon as I was appointed Regional Director, I pledged to give high priority to this area. Development of the Office's various information tools, especially the Health Evidence Network or HEN, and the publications and research papers produced by the European Observatory on Health Systems and Policies in Brussels, which are widely acknowledged to be of high quality and are regarded as standard works in their field, are excellent illustrations of the high priority that the Office gives to information as a service to the countries of the Region. In future, closer integration of these various components, perhaps within an information centre for decision-making in public health, will help us reach the goal of providing the key players on the public health scene with analysed, validated and accessible information. You can see some examples of coordinated information systems in the display in the Lobby.

Support with giving effect to the outcomes of ministerial conferences is another service that the Regional Office must provide to countries. At last year's session of the Regional Committee, questions were asked (in particular by representatives of nongovernmental organizations) about the follow-up to the Munich Conference on nursing and midwifery. Since the conference, a positive trend towards taking action has become evident in the Region. Unfortunately, it is not easy for us to make a detailed report on this subject, since there was a poor response to the survey we undertook. However, the information we did receive is currently being analysed, and the findings will be disseminated in 2005. It is worth noting that in June 2004 the European Forum of National Nursing and Midwifery Associations and WHO jointly drew up a declaration on mental health, which testifies to the strong commitment to this subject throughout Europe.

3. The Regional Office

For all the activities that I have just described, which have been carried out by the Regional Office in the past year, I should like to thank (and on your behalf, too, I am sure) all the staff who have worked tirelessly in Copenhagen, in the technical centres and in the countries of the Region. Under the guidance of the Executive Management team, the culture of the Office is moving towards greater transparency in our relations with the Organization's governing bodies and its Member States. We have continued to work this year on making operations at all levels of the Office evidence-based. At the same time, we have been developing a "quality circle" approach, which I hope to be able to report on favourably at the next session of the Regional Committee.

4. The need to match resources to expectations and requirements

What do we need today if we are to do better, or at least more, work? You will not be surprised by my simple answer: more resources. The regular budget for the European Region, like that of WHO as a whole, does not allow us to respond fully to Member States' requests and requirements. It is therefore increasingly essential to improve our fundraising efforts, and I intend to devote myself personally to this. Our fundraising is and will continue to be aligned on the directions you lay down for us when you adopt the Organization's programme and budget which, I hope, will be increased in the future. This means that we need additional resources not to launch new activities, but to carry out those that are already included in our programmes, especially action plans and ministerial conferences. I am sure that the disciplined approach we are developing in our fundraising will increase the "transparency" of the Office and encourage you to help us even more.

I have often told the Regional Committee how much I regret the fact that the Office cannot, owing to a shortage of resources, carry out its mission in numerous areas. I am thinking here in particular of the health of the elderly, but also of alcohol and the commitments made at the Stockholm Conference. In a few weeks we will have a new programme manager in this field. That is good news, but we don't have the resources to enable him to carry out his work in a satisfactory way. We have made considerable efforts this year to increase the resources we devote to noncommunicable diseases and, with your help,

we will continue to do this. In order not to bore you, I will stop here with the list of areas where we lack resources, but there are many others.

5. The fifty-fourth session of the Regional Committee

I should now like to turn to the session of the Regional Committee that has begun today. You will see that the customary agenda items make up the backbone of the programme. The main technical subjects we will consider are noncommunicable diseases and environment and health following the Budapest Conference. We will also discuss the proposed programme budget for 2006–2007 and continue last year's discussion on the technical centres located outside Copenhagen.

This year, at the request of the Standing Committee, we have added an item that might be called "follow-up". Here we will describe the work done by the Office to follow through on particularly important subjects discussed and resolutions adopted at previous sessions of the Regional Committee. For the first trial of this new arrangement, we have decided to focus on the update of the Health for All policy framework, the next edition of the European health report, and implementation of the Regional Office's country strategy. The document related to this item also describes our continuing activities on mental health and a summary of our work on tuberculosis.

We are pleased that the Director-General, Dr Lee Jong-Wook, will be with us tomorrow. May I take this opportunity to remind you forcefully of the need to ratify the amendments to Articles 24 and 25 of the WHO Constitution, since this is of particularly vital interest to the European Region. To date, only 31 countries in the Region have done so; in global terms, 18 ratifications are still needed before this change to the Constitution can come into effect.

6. Conclusion

I hope that this Regional Committee will be able to play its governing body role to the full. I should like to express my heartfelt thanks to the Standing Committee and its Chairman, Dr Božidar Voljč, for helping us to prepare the programme of the session and for giving us the opportunity to have frank and in-depth discussions with its members throughout the year. The Standing Committee's report will be presented to you this afternoon.

In conclusion, I trust that this fifty-fourth session will be particularly interesting and productive for us all. Thank you for your attention, and I am of course ready to answer any questions you may have on this report.