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INTRODUCTION

Opening of the session

The fifty-first session of the WHO Regional Committee for Europe was held at the Palacio Municipal de Congresos in Madrid, Spain, from 10 to 13 September 2001. Representatives of 48 countries of the Region took part. Also present were observers from one non-Member State and one member state of the United Nations Economic Commission for Europe, and representatives of the United Nations Development Programme, the World Bank, the Council of Europe, the European Commission and nongovernmental organizations.

The inaugural session took place at the Palacio Municipal de Congresos on Monday, 10 September. After a welcome by the WHO Regional Director for Europe, addresses were delivered by Mrs Celia Villalobos Talero, the Spanish Minister of Health and Consumer Affairs, and by Mr José María Álvarez, the Mayor of Madrid.

The session was opened by Dr Jeremy Metters, outgoing Executive President.

Election of officers

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

Mrs Celia Villalobos Talero (Spain)	President
Professor Ayşe Akin (Turkey)	Executive President
Dr James Kiely (Ireland)	Deputy Executive President
Mrs Katrin Saluvere (Estonia)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC51/2 Rev.2 and EUR/RC51/Conf.Doc./1)

The Committee adopted the agenda and a programme of work.

ADDRESS BY THE DIRECTOR-GENERAL

Addressing the Committee on Wednesday 12 September 2001, the Director-General began by saying that she knew all present had been shocked by the events in the United States the previous day and felt deep sorrow at the tragic loss of life and suffering caused. Under the circumstances, it was all the more appropriate to continue working together on the principles and values that guided the efforts for world health.

In her statement to the Regional Committee, she began by addressing the twin challenges of ill health and poverty. The gap between the haves and the have-nots was nowhere so painfully clear as in the European Region. The challenge was for countries to bridge that gap, a challenge that the Organization would help them to take up as best it could. Without sufficient investment, however, little progress would be made, and it was encouraging to see that countries were beginning to invest more in health. The levels of new resources needed were enormous, implying that they must be used as effectively as possible and in a coordinated fashion. The Global AIDS and Health Fund would be an important stimulus in that effort. Also, health system reform was unlikely to succeed without people's involvement in health action at all levels.

The world's leaders had focused on the devastating impact of HIV infection, and preventive efforts needed to be intensified. Linked with HIV/AIDS was the growing epidemic of tuberculosis in the Region, although progress was being made in reaching everybody who needed it with affordable and effective treatment. The European Region had taken the lead in work on the environment and health, and was now

involved with the Organization as a whole in addressing mental health and brain disorders, the theme of the forthcoming World Health Report. However, the Athens Declaration showed that there was still a long way to go in that regard. The Organization had also been at the forefront in demonstrating the potential for alcohol to damage the lives of young people. Tobacco also continued to be a tremendous threat to health in the Region, and food safety was an area that needed constant attention.

Much biomedical research now carried out in the industrialized world was primarily market-driven, a situation that was ethically unacceptable. WHO therefore proposed to establish a global initiative focusing on ethics in public health, health research and biotechnology. The Organization was also committed to improving the capacity of WHO teams within countries. Finally, the exchange of letters with the European Union would permit the establishment of broad and systematic collaboration on a wide range of health issues.

Many delegates thanked the Director-General for her clear and comprehensive presentation. Some also underlined the fact that countries were beginning to feel the effects of the new ways of working, and that the relationship between the Organization and its Member States was consequently stronger.

Replying to interventions from the floor, the Director-General said that there had been a large increase in extrabudgetary funding over the past three years. That had been fortunate, given that the regular budget was now at a level below zero nominal growth. In implementing its corporate strategy, WHO would of course have to compete for funding with other health initiatives. Resources were needed both for WHO to play its facilitating role and for global health programmes. She was confident that as a result of the strategy even more extrabudgetary resources would be generated.

Ethics had always been a component of all health debates, but now the complexity in terms of legal and other aspects had increased. A small unit had therefore been established at headquarters, with a mandate to give advice on ethical matters. Since ethics was such a cross-cutting issue, it had been decided to place the unit in the Director-General's office. It might be six months or so before the unit became fully functional, but in the mean time it could act as a clearing-house of information for Member States. The offer of delegations to share their countries' experience on bioethics was warmly welcomed.

Health ministers and public health officials were beginning to pay more attention to questions of food safety, and were clearly facing major challenges. There was certainly a problem in countries with a strong agricultural base, but governments needed to understand that food safety was not an agricultural but a health issue. Nevertheless, the trend in this respect was in the right direction.

Some speakers pointed out that the European Region no longer comprised 33 largely industrialized countries (as it had some 10 years before) but 51 countries, including several that were classified as developing or less developed, yet the regular budget did not reflect that reality. Although the Region contributed almost half the global budget, it received back only some 7%. The request was therefore made that this proportion should be increased appropriately, by making full use of the opportunities afforded by resolution WHA51.31. The Director-General replied that on taking office she had inherited a formula for interregional transfer of funds that had been largely motivated by the sociopolitical changes in Europe. It had been difficult to find a new formula that would be acceptable to the Executive Board and the Health Assembly, and any change in its principles would therefore also be difficult. She suggested that an attempt at a more fair distribution of extrabudgetary rather than regular budget funds might be a more viable option.

The Director-General confirmed that the input of Member States to the regional consultation on health systems performance recently held in Copenhagen, together with the results of the other five regional consultations, would be rigorously taken into account in reviewing the methodology of the World Health Report, and that she would personally involve herself in the preparation of the report to the Executive Board in January 2002. Moreover, there would be an expert peer review of the methodology, and advice would be sought from other sources before a final decision was taken by the Executive Board. She also confirmed that the Organization was preparing its contribution to the World Summit on Sustainable

Development, to be held in Johannesburg in 2002, and finally that the membership of a WHO advisory committee on alcohol policy had been finalized.

ADDRESS BY THE REGIONAL DIRECTOR

In his address to the Committee, the Regional Director outlined several events, many of them positive, that had taken place across the Region in the previous year, drawing attention to priority areas on which the Regional Office had focused its efforts. They included mental health, alcohol and young people, depleted uranium, and the Stability Pact. Work continued on the Nutrition Action Plan and on following up the 1999 European Conference on Environment and Health. Progress had been made towards the eradication of some communicable diseases, although there was still much to be done. Tuberculosis and AIDS continued to be causes for concern in both the eastern and the western parts of the Region. The Office was currently engaged in a more collaborative way of working with Member States, in line with the new country strategy. There was also a promising new spirit of cooperation between the Regional Office and the European Commission (EC), the Council of Europe and the World Bank, as well as with WHO headquarters. Two new Centres had been established, one in Bonn (on the environment and health) and one in Venice (on investment in health).

New ways of working had been adopted at the Regional Office: there was more emphasis on staff involvement in the decision-making process and use of initiatives such as quality circles. In tackling future challenges, the work of WHO would be based wherever possible on the best available evidence, and every effort would be made to provide Member States with information that was relevant and would help them to make the best possible policy decisions.

With regard to challenges in technical areas, the Framework Convention on Tobacco Control would clearly be of key public health importance in the coming biennium. However, the Regional Office's resources did not always meet the needs and demands of the Member States, and the Regional Director emphasized that the regional budget must be increased accordingly.

In the ensuing discussion, representatives expressed their belief that the Office was moving in the right direction, in line with the health needs of contemporary societies. Several delegations welcomed the Director's decision to place greater emphasis on providing better information for policy-making in countries.

The technical support that WHO provided to countries was also commended, but many delegates noted that it was not enough. Several representatives made a plea for more intensive technical support for countries in economic transition. Many speakers believed that the realization of WHO policies was dependent on the role the Office played at country level. Acknowledging that the Office's resources were limited, they called for budgetary redistribution to regions in line with resolution WHA51.31 to be effected in full as a matter of urgency.

There was broad support for the progress the Regional Office had made in improving its collaboration with the Council of Europe, the EC and the World Bank. However, it was felt that there was a real need for the Office to be more pro-active and to assume a higher profile in health leadership. Several speakers requested the Regional Director to provide information on the agreements with the 23 countries in central and eastern Europe, the outcome of the London Conference, and the letters exchanged between WHO and the Council of Europe. One speaker emphasized the important contribution that collaborating centres made to the work of WHO, while several delegates from the newly independent states (NIS) urged the Regional Office to assume the role of coordinator on health issues with international agencies at country level. The representative of Ukraine expressed his concern, and that of other affected countries, that the Office had invested insufficient resources in those countries in the aftermath of the Chernobyl disaster.

There was warm support for the Stockholm Conference on Young People and Alcohol, and for the meeting on mental health held in Athens in June. The countries of south-eastern Europe had endorsed the Athens Declaration at their recent conference in Dubrovnik. Member States were urged to adopt a draft

resolution that would be submitted in the course of the session. The proposal to hold the Fourth Ministerial Conference on Environment and Health in Budapest in 2004 was also commended for ensuring that the momentum of the London Conference and the signing of the Water Protocol would not be lost.

Many delegates welcomed the attention being focused on poverty, believing that it was a subject which would be of relevance to the Office for many years to come, as it affected all 51 countries in the Region. It was accordingly suggested that WHO should have a higher profile in working with other international agencies on a specific poverty reduction agenda.

Other subjects raised by delegates as worthy of inclusion in both WHO's programme of work and agendas of future Regional Committee sessions included globalization and its impact on health, education as a social determinant of health, and bioethics. The increasing incidence of HIV/AIDS and sexually transmitted infections was also highlighted as a worrying trend that WHO should take more seriously at the European level. In addition, the Regional Office was urged to tackle the problem that work on the health of the elderly had not been included in the global budget, despite the large projected increase in that population in the Region. Lastly, one representative expressed disappointment that a Centre for Environment, Health and Tourism had not been established in Malta, as endorsed by the London Conference in 1999, and requested that the matter be dealt with as a matter of urgency.

In reply, the Regional Director thanked the representatives for the positive response to the work he had presented. His brief reference to the Nutrition Action Plan had been solely owing to time limitations and in no way reflected a lack of commitment by the Office to the Action Plan and the work of the Task Force. A fuller report on the issue would be presented to the Regional Committee at its fifty-second session.

He confirmed that WHO was increasingly concerned with the social determinants of health, and it was anticipated that the newly established Venice Centre would have a major role to play in that work. Case studies from the various Member States on how they were tackling those issues would be an important first step.

He noted the concern expressed by several speakers about the omission of several key topics from WHO's programme of work. It was important to have an open dialogue between the Regional Committee, its Standing Committee and the Regional Office on the role that WHO should play vis-à-vis other international organizations in areas such as bioethics and globalization. AIDS was a particular case in point, and the Regional Office had an urgent role to play in alerting the whole Region to the deteriorating trends. A regional adviser had recently been appointed to lead that work.

With regard to establishment of the Centre for Environment, Health and Tourism, it was pointed out that work had been commissioned on the role of centres, and a report on this work would be discussed by the SCRC later in the year. Thereafter, it was hoped the Regional Office would be in a position to develop a more coherent strategy on the use of centres outside Copenhagen.

In conclusion, the Regional Director expressed the hope that the Regional Committee would help the Regional Office to continue along the right lines.

Following the discussion, the Executive Director, Office of the WHO Director-General described the newly established Global Fund for AIDS and Health, noting that there had been growing support in the two previous years for a new funding mechanism to tackle HIV infection, malaria and tuberculosis. Agreement had currently been reached on many features of the Fund, a Transition Working Group (drawn from 35 governments and organizations) had been set up, pledges totalling US $1.4 billion had been made, and wealthy European Member States were urged to continue to support the Fund. However, the Transition Working Group still had a number of issues to resolve, including those related to accessing resources, governance, and secretariat and banking arrangements.

MATTERS ARISING OUT OF RESOLUTIONS AND DECISIONS OF THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD

(EUR/RC51/4)

A European member of the Executive Board presented an overview of the sessions of the Board held in January and May 2001. He explained that he had been invited by the SCRC, as an Executive Board Member in the second year of his mandate, to attend meetings of the SCRC and to report to the Regional Committee. That experiment, intended to improve communication between the Board and the Regional Committee, would be evaluated by the European Board members and the SCRC after a year.

The Director, Division of Administration and Management Support said that in the spirit of "one WHO" the relationship between the global and regional governing bodies had gained considerably in significance. Of the items discussed by the Fifty-fourth World Health Assembly, four areas were of particular interest to the European Region: the proposed programme budget for 2002–2003; financial, administrative and management matters; matters related to governing bodies; and various technical and health matters.

The Health Assembly had adopted the General Programme of Work for 2002–2005 and had welcomed the progress being made in budgetary reform, the integrated presentation of the budget and the improvements in transparency, accountability and effectiveness. It had decided to appropriate the same amount as in previous biennia and had commended the efforts to increase efficiency savings. The Director-General had submitted a new proposal on assessments for the financial period 2002–2003, which had been found both politically and financially acceptable. It provided, *inter alia*, for a relief facility for those countries whose contribution would increase as the result of the new United Nations scale. Those Member States who did not wish to avail themselves of the facility were encouraged to contribute an equal amount to miscellaneous income. In the European Region, there were 24 countries eligible for such relief; should they all choose to forego the facility, the foreseen deficit could be reduced by some US $11 million.

Countries in arrears of their contributions, 11 of which were in the European Region, were encouraged to make use of special arrangements for settlement. With regard to the Real Estate Fund, the Regional Office was in consultation with the Danish Government concerning refurbishment of its buildings in Copenhagen and the development of a planned maintenance programme.

Of the ten resolutions adopted on technical and health matters, five were of special relevance to the European Region: infant and young child nutrition, scaling up the response to HIV/AIDS, the WHO medicines strategy, strengthening nursing and midwifery, and global health security – epidemic alert and response. As to health systems performance assessment, the Office had organized a regional consultation in early September 2001 to review the methodology for the 2001–2002 update of the World Health Report.

Although it was not mentioned in the paper, one delegation commented on resolution WHA54.16 on the International Decade of the World's Indigenous Peoples. The resolution requested regional committees to pay urgent attention to the adoption of regional plans of action on the health of indigenous peoples. In view of the fact that at the previous session the Regional Director had mentioned in his report the "challenge to the health of certain population groups", it would be interesting to know how the needs of indigenous peoples were being taken into account in the development of the new country strategy for Europe. The Regional Director promised to provide the Regional Committee with a report on the matter.

One delegation reminded the Committee of the concern expressed at the Health Assembly about the limited resources allocated to updating the International Health Regulations, and the consequent slow pace of the work. Another considered that in the spirit of "one WHO", headquarters should give as much weight to regional issues as the regions were expected to give to global ones.

In reply to queries on the outcome of the recent European regional consultation on a health systems performance assessment framework, it was stated that the report on the consultation would shortly be made available and that the consolidated materials from the regional consultations would be placed on the Internet.

It was also confirmed that all European Member States in arrears of their contributions had been approached with a view to discussing, in the near future, ways and means of developing mutually acceptable solutions to the problem.

REPORT OF THE STANDING COMMITTEE OF THE REGIONAL COMMITTEE

(EUR/RC51/3, /3 Add.1, EUR/RC51/Conf.Doc./2, EUR/RC51/Conf.Doc./3 and EUR/RC51/Inf.Doc./1)

The Chairperson of the SCRC introduced only those areas of the SCRC's past year's work that were not items on the agenda of the current session. In accordance with past practice, individual Members of the Standing Committee would present its views on the other areas under the appropriate agenda items.

The Standing Committee had met formally on five occasions since the previous session of the Regional Committee, and its discussions could be grouped under three main topics: the role of the SCRC; policy items; and procedural items.

The SCRC had agreed with the Regional Director that one of its major roles was to support him and the Regional Committee by giving its opinion in open and "strategic" discussions, with space for free discussion. Another role was to function as a governing body per se, acting for and representing the Regional Committee between sessions, as laid out in its Rules of Procedure. As an experiment, the SCRC had started to place its reports, once approved, on the Regional Office Web site.

Under policy items, the SCRC had discussed follow-up of the Food and Nutrition Action Plan since its endorsement by the Regional Committee the previous year. The establishment of a European task force, its design and its *modus operandi* had not found favour with the constituent organizations. In order to avoid obstacles to enhanced cooperation and in view of the success of the subregional workshops, the suggestion had been made to reconfigure the Task Force along subregional lines. A formal progress report would be submitted to the Regional Committee at its fifty-second session.

The certification of the European Region as poliomyelitis-free was scheduled for early 2002, despite the three cases reported in Bulgaria and some concern that laboratory containment issues might cause slight delay. High-quality surveillance would be necessary for three years after certification, and continued close cooperation with the Regional Office for the Eastern Mediterranean (through the MECACAR programme) on preventing importation should be maintained. The regular budget funding allocated to the programme was relatively small but there were good prospects of extrabudgetary contributions in 2002. A formal progress report would also be submitted to the Regional Committee at its next session.

Based on the experience of the external evaluation of the EUROHEALTH programme in 1999/2000, the SCRC had decided that it would not be feasible to submit to the Regional Committee at its current session a report on a similar evaluation of the Office's activities in the field of health care reform. Instead, it had reviewed a discussion paper and was of the opinion that the evaluation should assess the impact of the Regional Office's activities on the implementation of appropriate health care reforms in a limited number of countries. The external evaluators should work out a suitable methodology. The evaluators had been selected and their findings would be reported at the session the following year.

In the case of bioethics, the SCRC subgroup's meeting in Warsaw in March had confirmed the Regional Office's main role to be in relation to the effects on health policy and health care systems. Ethical issues should be considered in conjunction with the Council of Europe, for example through association with the Council's forthcoming Conference on Human Rights (Oslo, 2003). The composition of the subgroup would be reviewed after the current session, and the subject of bioethics should be on the Regional Committee's agenda in 2002.

With regard to procedural issues, work was still in progress by a subgroup of the SCRC on the question of criteria for membership of the Executive Board. The subgroup had identified five such criteria. The SCRC had noted, however, that the effect of applying the proposed criteria would be to preclude semi-permanent membership of the Board in the future. The Standing Committee therefore felt that it was as yet unable to make any firm recommendation about questions of semi-permanent membership and geographical grouping. Further consultations would take place with European Member States, specifically on those two issues, and the SCRC would report back to the Regional Committee the following year.

The outgoing Executive President of the Regional Committee presented the Standing Committee's proposals on a number of amendments to its own Rules of Procedure and those of the Regional Committee concerning nominations of officers of the Regional Committee, the Regional Search Group process and a provision whereby all candidates for the post of Regional Director (as was the case for the Director-General) could give an oral presentation at a meeting to which all Member States of the Region would be invited.

In accordance with previous practice, the work of the European Environment and Health Committee (EEHC), which had previously been considered by the SCRC, was also presented to the Regional Committee. Dr Alán Pintér, speaking on behalf of the co-Chairpersons of the EEHC, informed delegates that the process of ratifying the Protocol on Water and Health had started in a number of countries, and by the end of August 2001 three countries (Hungary, Romania and the Russian Federation) had ratified it. However, ratification by 16 countries was needed if the Protocol was to enter into force, and delegates were accordingly requested to urge the responsible authorities in their countries to accelerate that process.

The continued development and implementation of national environmental health action plans (NEHAPs) was one of the items from the London Conference that needed focused attention. It was the opinion of the EEHC that, in order to build on the investment of the Member States and the EEHC, one country should take the lead if effective work was to be done in that area. Similar efforts were also needed to accelerate the work on environment and health research and on children's health and the environment. A programme for rapid assessment of the risks from industrial accidents for the environment and health had gained the interest of several countries and had been tested in Bulgaria and Hungary.

Dr Pintér also called on delegates to support and help in the process of preparing for the Fourth Ministerial Conference, which was scheduled to take place in Budapest in 2004, and asked them to fill out the questionnaire on environmental health priorities that would be used in preparation for the Conference. In conclusion, he noted that both the Environment for Europe and the Environment and Health processes had common aspects and needed to be brought together to avoid parallel activities. Several collaborative efforts had been initiated, and suggestions had even been made to merge the two processes, possibly at the highest government level, after the Kiev and Budapest Conferences.

Concluding her presentation, the Chairperson of the SCRC informed the Committee that the President of the European Region's Staff Association had addressed the SCRC at its third session, when the Standing Committee (on behalf of the Regional Committee) had confirmed the importance of the existing good staff/management relationship and had paid tribute to the courage and dedication of the staff, especially those serving in hazardous and war-torn areas.

In the ensuing discussion, delegates commended and thanked the SCRC for all the work it had done during the year. For many of the areas covered (for example the role of the SCRC, bioethics, the changes to the Rules of Procedure and the work of the EEHC) there was general support for and agreement with what had been presented. On the question of membership of the Executive Board, however, a number of speakers expressed regret that no agreement had been reached so far, especially in view of the long period since the issue had first been raised. Some delegates, in attempts to find compromises, suggested additional criteria (such as the level of financial contributions), reaffirmed some of the proposed criteria (for example, that all Member States had an equal right to membership of the Board), suggested interim solutions (e.g. extending the present one-year period during which semi-permanent members could not stand for re-election), or requested further information on where the "bottlenecks" lay (for instance, did all SCRC members agree on some criteria?). Other delegates subsequently rejected some of the

suggestions made, however, and there was support for a further consultation on a multilateral basis, as had been done in July 1999. The Executive President confirmed that Annex 3 was not part of the SCRC report.

The Regional Committee welcomed the information it had been given on the work of the EEHC, and one delegation proposed an additional draft resolution on health and sustainable development. Among the relevant factors to consider were the fact that a healthy environment was essential for good health and poverty alleviation. Therefore, the inter-linkages between poverty, environment and health needed to be at the centre of attention at the World Summit on Sustainable Development, to be held in Johannesburg the following year.

The Committee subsequently adopted resolution EUR/RC51/R7.

The Regional Committee endorsed the SCRC's views on the issue of bioethics, a subject that was gaining in importance in medicine and also in the public arena. Further work, appropriately coordinated with other actors such as the Council of Europe, was important and the Regional Committee looked forward to receiving further information the following year.

Representatives endorsed the rationale underlying the proposed amendments to the Rules of Procedure, and the Committee accordingly adopted resolution EUR/RC51/R1.

In response, the Chairperson of the SCRC thanked all delegates for their comments, which were very important for drawing up the SCRC's programme of work for the coming year, and took note of their concerns regarding membership of the Executive Board. On that issue, further suggestions included the possibility of involving the countries' permanent missions in Geneva, obtaining written responses from all delegates and holding an informal meeting for all delegates later in the session.

The Regional Director shared the concern that had been expressed by one delegate about the imbalance between short-term and long-term staff and related issues of continuity, morale and ethics. The Regional Office had the largest imbalance in WHO, and any proposals to remedy the situation made at the level of the United Nations system as a whole would be rapidly applied in consultation with WHO headquarters and the Director-General, who was also personally concerned about that issue.

The Committee adopted resolution EUR/RC51/R8.

PARTNERSHIPS FOR HEALTH

(EUR/RC51/6)

The Director of the WHO Office at the European Union (WEU) chaired a round-table discussion on the agenda item. The four partners represented were the European Commission, the Council of Europe, the World Bank and the United Nations Development Programme (UNDP).

WHO had had broad and long-standing bilateral and multilateral collaboration with each of those partners, extending beyond the European Region. A new exchange of letters had been signed by the Director-General and the European Commissioner for Health and Consumer Protection on 14 December 2000. That had established a new framework for collaboration with the EC. Another very positive development was the tripartite commitment to cooperate in selected areas, which had been documented in an exchange of letters in June 2001 between the Council of Europe, the EC and the Regional Office. That commitment was currently being translated into action, with clear objectives and targets.

The Regional Director pointed out that the round table was symbolic of a partnership. Cooperation required respect, friendship and institutional ties, as well as an identification of what was common and where the partners differed. The Stockholm Conference had shown how well the agencies could work together.

The representative of the EC noted that each agency had to better understand the mandates, work programmes and organizational tools of its partners, and that networking, personal relationships and mutual trust were essential. Good mechanisms currently existed, with quarterly meetings between the WEU and the EC in Brussels and Luxembourg, with the Council of Europe participating in the latter.

Health was an integral part of the new Treaty on European Union, leading to the development of a new six-year public health action programme and budget that were currently being discussed by the appropriate EU institutions. The programme was aimed at improving health information, developing systems to respond rapidly to health threats and tackling health determinants. The new programme would also require organizational and structural changes, and those could be reported at the next session of the Regional Committee.

New EU legislation had been passed in the areas of tobacco and blood. The mandate to take account of health in other EU policies had started to have an effect in the area of pharmaceuticals and would soon do so with respect to nutrition and microbiological resistance. Patients' rights also had to occupy a prominent place.

Cooperation with the Regional Office had been centred on a number of topics, such as alcohol, health-promoting schools (together with the Council of Europe), and information (notably the Highlights on health and Health status reports). A high-level technical workshop with WHO headquarters and the Regional Office would take place in October 2001, at which communicable diseases and information would be discussed. At the global level, cooperation continued on, among other things, the Tobacco Convention. For the future, it was clear that more specific actions would need to be developed and duplication of data collection from Member States avoided.

The representative of the Council of Europe pointed out that Member States were demanding more from cooperation, including strong common messages on major issues. A breakthrough had come in the 1990s, with the first joint Council of Europe/EC/Regional Office project on health-promoting schools. Not only did the project entail sharing resources but a particularly important subject had been chosen, it was being carried out together and, most importantly, a common message was being sent out. That gave all the agencies concerned visibility and credibility. Tripartite cooperation had started in unofficial meetings that had created trust and willingness.

Based on that experience, criteria for enhancing cooperation included a common desire to place health high on the political agenda, concentration on a specific mandate, the courage and discipline to forego activities that clearly overlapped with others, and a willingness to make full use of what others had already done. Given the interest of all three agencies in the issue of poverty and the Council's experience in that field (albeit not directly related to health), perhaps that could be another area for concrete collaboration. While noting with interest the other agencies' concern about in bioethics, he recalled the work already done by the Council of Europe in that field and hoped it would be taken fully into account in future plans.

The representative of the World Bank agreed that a common purpose and recognition of the added value and advantage of cooperation were essential and indeed formed the basis of the Bank's cooperation with the Regional Office.

From very low levels of activity in health in Europe up to the early 1990s, the Bank was currently financing 32 projects or programmes in 23 countries of the Region valued at about US $1.3 billion. The best service to Member States was rendered when work was done in effective partnerships, and those with WHO, both headquarters and the Regional Office, had grown in number and complexity. The specific relationship with the Regional Office was built on sharing information and technical expertise, joint programming and participation by WHO staff in the Bank's financial projects and training activities, participation in larger partnership activities such as the European Observatory on Health Care Systems, UNAIDS theme groups and many other fora, and working with common frameworks such as those related to poverty reduction. On the latter subject, it was perhaps important to point out that poverty

figured in both the Bank's mission statement and the strategic objectives of the Health, Nutrition and Population Directorate.

Increasingly, the Bank was seeking ways to include WHO technical experts in its project teams, often in leadership roles, while Bank staff were to visit the Regional Office in the near future to discuss a wide variety of technical matters and collaboration opportunities. The Bank was also proud to have been a founding partner of the European Observatory, which was a unique European partnership and a valuable regional public good.

Although the two organizations were different, with different mandates and modalities, there was also much that bound them together. The outlook was for continued development of the partnership with the Regional Office, not as an end but as a means of better carrying out the respective missions of the two organizations.

The UNDP Resident and Humanitarian Coordinator in Tajikistan pointed out that there were many potential partners in health, including WHO, other United Nations bodies, government agencies, the International Red Cross and Red Crescent movement, nongovernmental organizations such as Médecins sans frontières, Pharmaciens sans frontières, Merlin and Action against Hunger, as well as local authorities and associations.

Depending on the situation in a given country, cooperation took place within one (or several) "frameworks". United Nations Development Assistance Frameworks were based on "common country assessments", where WHO had an important role to play in defining the relevant health-related indicators. Consolidated interagency appeals were launched for countries undergoing a humanitarian crisis and included a sectoral analysis to determine what activities and projects were needed. Poverty reduction strategies (as had been mentioned by the representative of the World Bank) endeavoured to identify priority issues, while peace-building strategies for post-conflict countries aimed at restoring or ensuring equitable access to resources and services such as health care, institution-building, and the establishment of transparent market mechanisms, especially for pharmaceutical products and contraceptives.

UNDP's national human development reports were based on the Human Development Index, which took account of measures of life expectancy, basic health indicators and access to services, including reproductive health services. That entailed making an analysis of specific indicators and factors affecting them, when relevant, an activity in which WHO had a clear role to play. Lastly, and again as mentioned by the World Bank representative, there were HIV/AIDS theme groups.

Some suggestions and examples of possible partnerships and WHO roles were given. The Organization could convene and lead sectoral theme groups, as fora in which all participated under a neutral United Nations "umbrella". WHO, as the internationally accepted lead agency in health, could ensure that international standards, guidelines and protocols were understood and used consistently at the country level. Health statistics were needed to understand changing demographic, health and disease patterns. WHO had to ensure that the statistics used were credible and reflected the real situation, rather than being merely extrapolations of historical patterns or official targets.

Presence on the ground was essential, and in almost all countries in the eastern part of WHO's European Region there were serious health and health service issues. WHO staff were therefore core members of United Nations country teams, and that called for professionally respected, independent-minded representatives who understood both local conditions and constraints and the priorities based on international experience and best practice.

Examples of the kind of partnerships that worked included the HIV/AIDS multisectoral programme in Poland, the UNDP rehabilitation, reconstruction and development programme in Tajikistan and the Health InterNetwork in Kazakhstan to provide free or cheap on-line access to leading medical journals.

All the delegates who took the floor commended the Regional Director on the unique and even historic initiative of the round-table discussion, as evidenced by the participations of all the partners and the

candour and quality of the discussions. There was general agreement that much progress had been made in international cooperation and partnerships in recent years. However, several delegations also emphasized the fact that cooperation had to be pro-active and go beyond the avoidance of duplication.

The many examples of good joint projects (such as that on health-promoting schools) also demonstrated the value of such cooperation for Member States. The importance of collaboration based on an identification of what did and did not work could also be seen in the Stability Pact countries' efforts to develop joint and common projects.

One delegate called for additional support to be given to the WHO European Centre for Health Policy in Brussels. The Centre had an essential role to play in providing advice on health care reform to countries of central and eastern Europe, and it had good collaboration and connections with the European Observatory; support from and collaboration with the World Bank and the EC should be envisaged.

At the end of the discussion, statements were delivered orally or in writing by representatives of the following organizations: the International Confederation of Midwives, the International Council of Women, the International Federation for Medical and Biomedical Engineering, the International Federation of Pharmaceutical Manufacturers Associations, the World Confederation for Physical Therapy, the World Federation of Acupuncture-Moxibustion Societies and the World Federation for Mental Health, as well as by an observer from the Association of Schools of Public Health in the European Region.

It was pointed out that two of the organizations, the European Region of WHO and the Council of Europe, shared the same membership. Many representatives were therefore of the view that particular care needed to be taken to ensure effective use of resources and avoid duplication of effort and action between those two organizations. To that end, a draft resolution was submitted from the floor on coordination of work with the Council of Europe in the field of health. The draft contained a request to the Regional Director to aim – in the further development of cooperation with the Council of Europe – at a clear and transparent distinction of tasks and to report on progress made at the following year's session of the Committee.

The Committee adopted resolution EUR/RC51/R9.

POLICY ITEMS

Information and knowledge management: the European Health Report
(EUR/RC51/7 and EUR/RC51/Conf.Doc./4)

The Director, Information, Evidence and Communication noted that the paper under consideration gave an overview of health status and the burden of ill health in Europe. A more detailed document was in an advanced stage of preparation and would be sent to Member States in October for comments.

The European Health Report (EHR) highlighted the disparities in health and related socioeconomic factors in the Region and reviewed the health problems and needs of vulnerable groups of people. Income disparities between and within countries were reflected in related health indicators. The so-called "east-west divide" was evident in all major health indicators and determinants of health, and for many of them the gap had increased during the 1990s. That observation applied to life expectancy, mortality, the quality of life, and a number of infectious diseases (such as tuberculosis).

The widening health gap in Europe resulted primarily from noncommunicable diseases, with cardiovascular diseases accounting for about 40% of the total difference in mortality, external causes (accidents, suicide, homicide) for some 30%, other diseases (respiratory, digestive, etc.) for about 25% and cancer for about 5%.

However, there was now a vast body of knowledge and experience regarding the prevention of communicable and noncommunicable diseases. Many of them shared similar factors and circumstances in their development, which could be related to socioeconomic circumstances, health service coverage, public health infrastructures, lifestyles and the environment, physiological risk factors, or psychosocial effects.

Those public health issues and related policies would be discussed in detail in the EHR especially since, in the context of the 1998 World Health Declaration, such differentials in economic and health experience were also significant in terms of human rights.

The reconfirmation of equity and solidarity as the main goals of public health also meant that attention should be focused on providing policy-makers with the health-related information they needed to draw up policies aimed at reducing inequalities in health. Existing routine data collection systems in most countries were not designed to reach vulnerable and marginalized population groups. Nevertheless, many countries in Europe had begun monitoring health inequalities, had already established research programmes to investigate those issues or had set targets and defined indicators in that area.

The challenge was to facilitate the sharing of experience and, ultimately, to make the data and indicators relevant, accurate, more discriminatory and fully comparable across countries. Making more integrated use of all the assets available in Europe could help to meet that challenge. Firstly, the Regional Office would improve its own capacity to collect, analyse, package and distribute information and knowledge and extend, improve and adapt the Health for All (HFA) database. In addition, the Regional Office would work constructively with those international and national organizations in Europe that had significant health information assets. At the same time, national institutions, professional associations, research bodies, nongovernmental organizations and others entities throughout the Region would be important as both users and producers of information. The new biennial budget for 2002–2003 provided an opportunity to launch many such actions.

The initiative was timely since the Regional Committee at its previous session had endorsed (by resolution EUR/RC50/R5) a framework for the new European country strategy that matched services to needs. Information and knowledge management systems would accordingly have to be re-thought, to strengthen the Regional Office as a knowledge-based organization. Three major issues had been identified. First, what did the Office now need to do to meet the expectations of the Member States? Second, how could the Office increase its capacity to produce knowledge of good quality, in order to meet those expectations? And third, what were the best ways to associate other producers and users of information, to ensure complementarity?

Dr Jarkko Eskola reported that during the year the SCRC had debated three questions related to the EHR: was there really a need for such a report; was there "room" for it; and if so, how often should it be produced? The answers to those questions had been considered in the light of the controversy surrounding the new World Health Report (WHR) and the fact that the European Commission (EC) was currently producing its own health reports. The SCRC was of the firm opinion that there should be such a report for the European Region of WHO, as it collected and presented information on long-term trends that enabled health policy to be better understood. On the question of duplication, the SCRC had noted that the WHR and the EHR had different focuses, with different data requirements. Most importantly, no other body had a mandate for the collection and dissemination of information using endorsed indicators.

The SCRC therefore advised that the Office's evolutionary approach should be maintained and complemented by innovative measures to ensure that the EHR became the leading tool for health policy discussions at national and regional level. The SCRC also advised that the three-year reporting cycle of the EHR should be maintained and complemented by the new concept of an "information warehouse" (from which regular annual updates would be accessible).

In the ensuing discussion, delegates acknowledged the opening of a "health divide", the implications of poverty and its impact on health, the continued effects of communicable diseases and the success of surveillance strategies. The effects of risk factors and their "migration" to young people, as well as mental

health and vulnerable groups, were identified as major public health issues. The central importance of the health sector and health systems, including health policy assessment and links to the European Health Observatory, was reiterated by many speakers.

There was specific endorsement of the SCRC's view that there was definitely a place for the EHR, alongside the WHR and the reports of other organizations such as the Organisation for Economic Co-operation and Development and the EC. Since the EC reports had been drawn up in collaboration with the Regional Office, perhaps it would be worth discussing the sequencing and coordination of future reports, especially since the EC one would soon include the accession countries. Delegates also emphasized the need for consultation and participation of Member States in the WHR and the EHR. An amendment to the draft resolution was proposed to link the EHR and the WHR more closely.

Many delegates also commended the Regional Office on providing flexible access to good quality information, irrespective of source. They endorsed the SCRC's suggestion of building on the existing HFA database, which was widely used by countries. Other specific suggestions concerned including data on the economic consequences of diseases, omitting comments on fairness and financing, drawing up a plan of action to reduce the "health divide", placing greater emphasis on health determinants, making a more detailed analysis of causes and providing information at both national and subnational levels. The need to make analytical information available in Russian was specifically stressed. In addition, it was pointed out that information was required to assess the impact of harmonization policies as part of the EU accession process.

The representative of the International Federation of Hospital Engineering offered concrete proposals for collaboration in the areas of information (through a field survey of infrastructures to guide health service delivery) and knowledge management (assistance with educational programmes in engineering technology).

The Director, Information, Evidence and Communication welcomed the support given to the proposals concerning information and knowledge management and coordination with other international organizations that also produced health reports. With respect to the links between the WHR and the EHR, the intention was to make them compatible and complementary, and to link monitoring and decision-making.

The Regional Director noted that the EHR was only one element in the Regional Office's medium- and long-term information strategy, albeit the most visible part. A number of entities such as the Observatory, technical units, WHO headquarters and other agencies also collected and used data, and that sometimes caused duplications and overlaps, as some delegates had pointed out. That was why the question of ensuring better coordination with partners was being carefully studied. A survey had been made of Member States' information needs and the Regional Office would now look at its findings, together with the users and producers of information.

The Committee adopted resolution EUR/RC51/R3.

Poverty and health – Evidence and action in WHO's European Region
(EUR/RC51/8 and EUR/RC51/Conf.Doc./6 Rev.1)

The Director, Technical Support noted that poverty encompassed a multitude of dimensions, including material deprivation, low educational achievement, poor health, vulnerability and exposure to environmental and occupational risks, as well as voicelessness and powerlessness. Poverty deprived people of the ability to satisfy their basic human needs, such as having access to a clean water supply, adequate and safe nutrition and health care, which as a consequence prevented them from achieving their full potential and could lead to ill health through increased personal and environmental risk, increased malnutrition, and less access to knowledge, information and health care. Ill health could cause poverty by reducing household income and lowering people's educational opportunities, productivity and quality of life. The individual and cumulative effects of poverty and ill health hampered economic development.

There was increased awareness of the vicious circle linking ill health and poverty, and of the need to address the issue if progress was to be made in improving the overall health of populations and achieving sustainable growth and development. However, although life expectancy was known to increase sharply with gross national product per capita up to a level of about US $4000 and then to level off, that was not the only factor: social support (in the form of food security, health care, education, etc.) was also necessary to attain a substantial increase in life expectancy and health.

There were sufficient European data to show that poverty was a matter of concern for the Region. A film shown to complement the presentation of the agenda item highlighted the different dimensions of poverty. Living in poverty was associated with lower life expectancy, high infant mortality, poor reproductive health, higher levels of infectious diseases (e.g. tuberculosis and HIV infection), and higher rates of substance abuse, noncommunicable disease, depression and suicide. While only 2% of the population of the Region lived in absolute poverty, a further 165 million people were living in relative poverty. The evidence also suggested that poverty was a gender issue, with women and children being most at risk. Unemployment, as a major determinant of poverty and ill health, was increasingly becoming a pan-European problem. In short, poverty (whether defined by income, socioeconomic status, living conditions or educational level) was the single largest determinant of ill health.

The unified framework for action on poverty that had been proposed at the Executive Board session in May 2001 would allow all key United Nations and international agencies to undertake more intensified action in the health sector among poor communities. However, its success was dependent on goodwill from all concerned and a long-term commitment from the international community and, as importantly, from Member States.

The proposed shift in focus would mean placing greater emphasis on the health conditions that prevailed among different groups in society, particularly the poor and disadvantaged, rather than on average population measures. That approach would have major implications for health policies, such as developing health systems that were more equitable and reached the poor more effectively, rather than those that were more efficient in serving society at large.

It was in this context that the Regional Office, in consultation with the SCRC, had considered the appropriateness of initiating activities to address the poverty and health agenda. To that end, the following suggestions concerning the role of the Regional Office were put forward for consideration by the Regional Committee:

- raise awareness in Europe of the centrality of health in the fight against poverty;
- help countries to make progress towards poverty reduction by improving access to health services and addressing the most important disease and determinants linked to poverty;
- improve the information base and the data available to support policy development and monitoring, with special reference to the most vulnerable population groups;
- strengthen the commitment of the international community to invest resources in poverty reduction and research.

It was further proposed that the Venice Centre should initiate a process of analysing and disseminating knowledge on effective action taken by Member States to reduce poverty, and that a first report (including an analysis of the data provided) could be submitted to the Regional Committee at its fifty-second session.

Dr Jacek Piatkiewicz informed the Regional Committee that the SCRC had actively participated in the preparation of the document and welcomed the initiative. Poverty was a vitally important issue for all Member States and there was a clear need for the vicious cycle of poverty and ill health to be broken.

There was overwhelming support from delegates for the decision to include poverty on the agenda of the session. Although poverty was a global issue, it was also of major importance for the European Region. Several delegates drew attention to the work being done on the subject by other agencies, including the

EC and the Council of Europe, and stressed the importance of WHO contributing to rather than duplicating that work. WHO was urged to move beyond the stage of description and engage in more analytical work, to develop indicators as well as to collect and share examples of good practice. There was a particular need to focus on disease prevention and health promotion strategies, rather than just on the alleviation of poverty. Several delegates gave examples of how poverty was being addressed in their respective countries, at both policy-making and operational levels. One speaker cited experience of positive discrimination towards vulnerable population groups, an approach that had yielded very favourable outcomes.

One representative, speaking on behalf of the Nordic countries, stressed the fact that all Member States and not just the poor ones should address poverty, and he accordingly proposed including references to equity and human rights in the draft resolution. A drafting group was subsequently established to ensure that due account was taken of all the comments made.

Concern was expressed about the negative effects of globalization and market economies on people who were already vulnerable, yet those were the very policies that had been introduced to create more efficient health systems. However, it was pointed out that if the issue of poverty was to be taken seriously, then a health system's performance should be judged on its ability to provide equitable and accessible health care, rather than efficient services. One representative called for solidarity regarding the prohibitive cost of drugs for countries in transition. Another speaker raised the issue of debt relief and stressed the importance of the WHO's advocacy role in that regard.

One delegate expressed the view that poverty and health should be tackled at the highest level in countries and that civil society and nongovernmental organizations should be involved in the evaluation of policies with respect to their impact on poverty. Concern was expressed about the increasing effects of poverty on the middle classes, who were emerging as a new vulnerable group. WHO was urged to take a lead role in identifying a "basket" of services to ensure that the groups most affected by poverty were properly protected.

It was noted that several important issues had not been mentioned in the background documentation, including mental health, women and violence, and occupational health. The representative of the International Council of Women emphasized that the empowerment of women was a key factor to be addressed if the poverty agenda was to be successfully tackled. Women were not a vulnerable group, however, but should be seen as a group with special needs. The representative of the International Commission on Occupational Health drew attention to the importance of occupational health as a priority area when addressing poverty.

The establishment of the Venice Centre was perceived to be a crucial development in taking work forward, although one delegate suggested that it might be more appropriate for its functions to be carried out by an independent organization.

In conclusion, the Regional Director admitted that he had been somewhat sceptical when the subject had first been mooted, but he was now fully convinced of its importance. The subject of poverty was a very complicated one, however, with no "quick-fix" solutions. Case history material from countries would help to build up an evidence base on that important subject.

The Committee adopted resolution EUR/RC51/R6

The 2002–2003 programme budget and consultation on the budget process for 2004–2005
(EUR/RC51/9)

The Director, Division of Administration and Management Support said that the purpose of the item was to keep the Committee fully informed on all issues within the context of the new budgetary process. More specifically, it addressed the steps taken since the fiftieth session as part of the global budget preparation, the distribution of country allocations as part of operational planning, and the process of preparing the strategic programme budget for 2004–2005.

Following guidance provided by the Regional Committee in 2000, the regional budget submission had been revised. In so doing, regional priorities had been safeguarded, country allocations had been maintained at a high level, and the salary component had been recalculated to cover all contractual commitments. Also, discussions at the Health Assembly and the Executive Board had allowed the regional secretariat to clarify several points. Activities were indeed ongoing in all 35 areas of work, despite the fact that the global budget included zero allocations in several areas for some regions, including the European Region. That apparent anomaly was due to difficulties of comparison between the large global programme and the smaller regional ones, and also to the fact that the country budget had not been distributed when the programme budget had been finalized. The 10% shift in intercountry funds towards global priorities (some US $4 million) would be matched by a similar shift of 10% from country funds. Finally, the evidence base for the implementation of resolution WHA51.31 was being constantly monitored to ensure its full and speedy implementation.

The country funds in 2002–2003 would be distributed under three main headings: biennial collaborative agreements (BCAs), liaison office expenses and a new heading, "priority public health initiatives". The latter would in turn be allocated in three main areas: priority public health actions in countries; multi-country public health actions; and strengthening of the Office's country presence as required. Those funds could only be distributed once the distribution of BCA funds was complete and a total overview of priority areas had been obtained. It was expected that some US $63 million would be received from other sources and voluntary donations during the biennium.

Finally, strategic planning for 2004–2005 would soon begin through a "bottom-up" approach. To that end, Member States would be consulted by various mechanisms on their priorities for the biennium, and a consolidated document would then be provided to the Director-General to be used during the meeting of the Executive Board in January 2002 on global priority-setting.

The Deputy Executive President reported that the SCRC had been kept informed of budgetary developments during the year and had been anxious, in a year in which the budget might not otherwise be discussed, that a debate should take place at the Regional Committee. The SCRC had been pleased to note that the level of financing for country activities would be increased, but had been disappointed that a continued increase in country work could be limited by the failure fully to implement resolution WHA51.31. Finally, the SCRC had been concerned that all Member States and the secretariat should engage fully in a serious and constructive endeavour to further improve the planning, monitoring, evaluation and presentation of the budget, to ensure effective use of what would continue to be limited resources.

Delegates welcomed the decision to brief the Committee on budgetary developments over the past year, and several urged that the practice be institutionalized so that budget discussions were held each year rather than biennially. The content of the document and the presentation were also appreciated, and the move towards greater emphasis on country work was warmly welcomed. As for the global budget, it was felt to be an important instrument in cementing the "one WHO" philosophy.

Many delegates expressed disappointment that the European Region had received only half the amount expected according to resolution WHA51.31, and trusted that the matter would be taken up with the Director-General with a view to rapid and full implementation of the resolution. Others, however, took a broader view of the problem, emphasizing that the regional budget itself was inadequate and that even full implementation of resolution WHA51.31 would have little real effect. The only solution would be to look towards increasing extrabudgetary contributions. One delegate suggested that the whole question of the formula by which resources were allocated needed scrutiny with a view to finding a more coherent approach, and thought perhaps the SCRC might take up the issue in the near future.

The Executive Director, Director-General's Office, said he appreciated and understood the profound sense of disappointment and frustration expressed from the floor over the failure to fully implement resolution WHA51.31. He explained that in 1998 nobody had foreseen the continuation of a zero growth budget or even a budget cut, and the predictions made at that time of the amount to be transferred to the European Region just could not be realized. At the same time, most of the regions from which funds were

to be taken were experiencing rampant inflation, another situation that had not been foreseen. Thus the Director-General had been faced with a terrible dilemma and had had to accept the current compromise. He considered the solution, at least in the short term, was that the more wealthy European Member States should make contributions of unearmarked voluntary funds. He assured the Committee that WHO headquarters would do its utmost to alleviate the situation.

European Alcohol Action Plan and follow-up to the WHO European Ministerial Conference on Young People and Alcohol
(EUR/RC51/10 and EUR/RC51/Conf.Doc./7)

The Regional Adviser, Psychoactive Drugs informed the Committee of developments with regard to implementation of the European Alcohol Action Plan. The Action Plan continued to be a high priority for many Member States, and several had introduced legislative and policy changes to help reduce the disease burden. Evidence from a ten-year study suggested that one third of countries had succeeded in achieving a reduction in alcohol consumption. However, there was now a worrying trend of increased alcohol consumption by young people, and at increasingly younger ages. Alcohol, as a major determinant of ill health, could only be tackled with strong political will. The aggressive tactics of the alcohol industry made political commitment all the more important.

One notable achievement during the year had been the Stockholm Conference. Young people had been actively involved in that unique event, both in preparatory work and in the Conference itself. More than 40 ministers of health or their deputies had participated, and a declaration had been unanimously adopted. Since the Conference, the issue of alcohol and young people had been given high priority in many Member States. However, the evidence base on alcohol needed to be further strengthened and the European alcohol information and monitoring system had an important role to play to that end.

Dr Constantinu, speaking on behalf of the SCRC, said that the Stockholm Conference had been a very successful event. It demonstrated a true partnership approach of working not only with other key organizations but also with young people themselves. It was the SCRC's considered view that the Stockholm Declaration was so important that the Regional Committee should be requested to endorse it. With reference to relationships with the alcohol industry, the SCRC advised that this was a country-specific matter, so it was difficult to advocate a uniform approach. The SCRC also believed that public health policy with regard to alcohol should be made by the public sector alone, independent of the alcohol industry.

In the ensuing discussion many delegates endorsed the Stockholm Conference and the resulting declaration. For many countries, the Conference had acted as a catalyst for changes in policy and legislation. Delegates remarked on the novel approach adopted of involving young people in a spirit of true empowerment. It was emphasized that this involvement must continue, and the commitment made to young people in Stockholm had to be honoured. Several speakers stressed the importance of linking alcohol and poverty. Intersectoral action was called for, and WHO was urged to continue to work closely with the EC, the Council of Europe and other relevant agencies.

The development of an information and monitoring system was perceived to be crucial. That would allow comparable data to be obtained for monitoring developments in drinking patterns and alcohol-related problems across Europe. The Regional Office was requested to develop a few reliable and valid indicators to aid that process. One delegate urged the adoption of a tougher stance on the whole alcohol issue and called on WHO to play a stronger advocacy role with governments, as it was in danger of giving mixed messages.

The issue of advertising and marketing was raised, and the need for much greater controls was emphasized. Some representatives shared information on raising the minimum age for alcohol consumption, as well as on their controls on advertising.

The representative of Estonia informed the Committee of the tragic accident that had taken place in his country during the week. As a result of the illegal production and distribution of alcohol drinks which contained methanol, 42 people had died and 68 people had been hospitalized.

The Regional Director believed that the advertising issue was of real concern, as it touched on the issue of human rights. He agreed that the involvement of young people was an innovative approach that would be used as a model in the future. He assured delegates that alcohol would continue to be a high priority for the Regional Office.

The Committee adopted resolution EUR/RC51/R4.

ELECTIONS AND NOMINATIONS

(EUR/RC51/5 and /5 Corr.1)

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

Executive Board

The Committee agreed by consensus that the Russian Federation and Spain would put forward their candidatures to the Health Assembly in May 2002 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee by consensus elected Greece, Latvia and Slovenia for membership of the SCRC for a three-year term of office from September 2001 to September 2004.

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 secret ballot elected Armenia for membership of the JCB for a three-year period from 1 January 2002.

OTHER MATTERS

Date and place of regular sessions of the Regional Committee in 2002 and 2003

(EUR/RC51/11 and EUR/RC51/Conf.Doc./5)

The Regional Committee adopted resolution EUR/RC51/R2, confirming that its fifty-second session would be held at the Regional Office for Europe from 16 to 19 September 2002 and deciding that its fifty-third session would be held in Vienna, at the kind invitation of the Government of Austria, from 8 to 11 September 2003.

Other business

As mentioned during the discussion following the address by the Regional Director, a WHO meeting for countries of south and south-east Europe on “Mental health and stigma in a world of crisis” had been held in Athens in June. A draft resolution on the subject was submitted by the Greek delegation.

The Committee adopted resolution EUR/RC51/R5.

RESOLUTIONS

EUR/RC51/R1

AMENDMENTS TO THE RULES OF PROCEDURE OF THE REGIONAL COMMITTEE AND THE STANDING COMMITTEE OF THE REGIONAL COMMITTEE

The Regional Committee,

Having considered the recommendations of the eighth Standing Committee of the Regional Committee (as contained in Annex 2 to document EUR/RC51/3) regarding amendments to the Rules of Procedure of the Regional Committee and the Standing Committee of the Regional Committee;

ADOPTS the changes contained in EUR/RC51/3 Annex 2, to be effective forthwith.

EUR/RC51/R2

DATE AND PLACE OF REGULAR SESSIONS OF THE REGIONAL COMMITTEE IN 2002 AND 2003

The Regional Committee,

Having reviewed the decision taken at its fiftieth session, as expressed in resolution EUR/RC50/R6;

1. CONFIRMS that the fifty-second session shall be held at the Regional Office for Europe in Copenhagen from 16 to 19 September 2002; and

2. DECIDES that the fifty-third session shall be held in Vienna, at the kind invitation of the Government of Austria from 8 to 11 September 2003.

EUR/RC51/R3

THE EUROPEAN HEALTH REPORT – INFORMATION AND KNOWLEDGE MANAGEMENT

The Regional Committee,

Having considered document EUR/RC51/7 (*The European Health Report, Summary of preliminary findings*);

Recalling resolution EUR/RC49/R10, whereby the Regional Director was requested *inter alia* to report on the health situation in the Region to the Regional Committee at its fifty-first session;

1. THANKS the Regional Director for the summary of preliminary findings;

2. WELCOMES the new approach used to describe the health situation and trends, determinants of health, and relevant health policies in the European Region of WHO;

3. URGES Member States to continue to improve and expand their health information and knowledge management systems, and to assume their responsibilities for the preparation and implementation of such policies;

4. REQUESTS the Regional Director:

(a) to continue to develop new and more effective ways of managing and using information, in order to meet changed circumstances in the domain of health knowledge, to enable the Regional Office to operate as a knowledge-based body and to provide better information services to the Member States and the international community;

(b) to aim at developing the European Health Report in a way consistent with the World Health Report, its basic data and its further elaboration;

(c) to make use not only of data related to the key indicators of health status and other qualitative information provided to WHO by Member States, but also of good quality information available from other organizations and, in order to achieve this, to strengthen the collaboration of the Regional Office with relevant international organizations;

(d) to publish a report on the main health concerns and considerations in Member States every three years, and to update the basic statistical data on the Regional Office's Web site each year;

(e) to finalize and issue the European Health Report in due course, taking account of comments made at the present session.

EUR/RC51/R4

PROGRESS REPORT ON THE EUROPEAN ALCOHOL ACTION PLAN, INCLUDING FOLLOW-UP TO THE WHO MINISTERIAL CONFERENCE ON YOUNG PEOPLE AND ALCOHOL

The Regional Committee,

Recalling the Health for All policy framework for the European Region for the twenty-first century that it endorsed in 1998 (by resolution EUR/RC48/R5);

Recalling resolution EUR/RC42/R8, by which it approved the first and second phases of the European Alcohol Action Plan;

Recalling the European Charter on Alcohol endorsed at the European Conference on Health, Society and Alcohol (Paris, 12–14 December 1995);

Recalling also resolution EUR/RC49/R8, by which it endorsed the third phase of the European Alcohol Action Plan (2000–2005);

Noting document EUR/RC51/10, which reviews the progress on the European Alcohol Action Plan, including the WHO European Ministerial Conference on Young People and Alcohol (Stockholm, 19–21 February 2001), and contains proposals for the follow-up to the Conference;

Having considered the Declaration on Young People and Alcohol that was unanimously adopted at the Ministerial Conference;

1. ENDORSES the Declaration as the leading policy statement of the European Region of the World Health Organization on young people and alcohol;

2. URGES Member States:

(a) to continue to carry out the European Alcohol Action Plan and to give effect to the policy laid down in the Declaration, namely to protect the health of young people from the hazards of alcohol and other psychoactive drugs;

(b) to formulate and monitor progress towards the targets as identified in the Declaration;

(c) to involve young people's organizations in developing, implementing and evaluating policies and programmes that are particularly relevant to their own health and wellbeing;

(d) to involve young people and adolescents in the integration of policies and programmes on young people and alcohol in comprehensive intersectoral public health policies on alcohol, in line with the European Alcohol Action Plan;

(e) to consider strengthening the national legislation on providing alcohol to young people;

3. REQUESTS the Regional Director:

(a) to stress the close link between the spread of alcohol consumption and socioeconomic factors, and especially the problem of worsening poverty in countries undergoing economic transition;

(b) to strengthen the development of a European alcohol information system, including data of evaluated alcohol prevention programmes, as an important part of the public health evidence base;

(c) to reinforce partnerships with other international and supranational organizations, as well as with youth movements, in order to pursue the aims of the European Alcohol Action Plan and the Declaration;

(d) to make provision for strengthened support from the Regional Office to Member States for implementation of the European Alcohol Action Plan;

(e) to ensure continued strong support for implementation of the Action Plan and the Declaration, by allocating adequate resources for this purpose;

(f) to implement a system for monitoring the promotion of alcoholic beverages to young people in the European Region.

EUR/RC51/R5

THE ATHENS DECLARATION ON MENTAL HEALTH AND MAN-MADE DISASTERS, STIGMA AND COMMUNITY CARE

The Regional Committee,

Noting with satisfaction all activities undertaken in the European Region in 2001 within the framework of the Year of Mental Health, which offers a new opportunity to renew the commitment in this important area of public health;

Recalling that events will continue throughout the year, including the launch of a global, as well as regional, mental health reports;

Noting with satisfaction the efforts that countries in the European Region have made to formulate policies and action on mental health;

1. WELCOMES the attached Athens Declaration on Mental Health and Man-Made Disasters, Stigma and Community Care, signed by all participants in the WHO meeting organized in Athens, Greece on 8 and 9 June 2001;

2. INVITES Member States to give effect to the policy laid down in the Declaration;

3. REQUESTS the Regional Director to include mental health as a technical subject on the agenda of the fifty-third session of the Regional Committee.

The Athens Declaration on Mental Health and Man-Made Disasters, Stigma and Community Care

WE, THE UNDERSIGNED,

Mental health professionals linked to national governments and members of mental health organizations of south and south-eastern Europe, gathered at the

WHO meeting for the countries of south and south-east Europe: Mental health and stigma in a world of crisis, Athens, Greece, 8–9 June 2001

held in collaboration with the Ministry of Health of Greece and in cooperation with the European Commission,

EXPRESS OUR DEEP CONCERN ABOUT:

I the ongoing violence within and outside the Region and its impact on the mental health of the populations;

II the persistence of stigma and discrimination against persons with mental disorders and their families; and

III the limitations of mental health care and social support provided by outmoded institutions.

CONSIDERING THAT:

- mental health problems are becoming increasingly important in the public health agenda in Europe, whereas other health concerns are under greater control;
- older as well as more recent preventable socio-environmental causes, such as war, rapid economic changes, disruption of family networks, and forced and economic migration, are having a devastating effect on the mental health condition of large population groups in Europe;
- the World Health Day and other activities related to this Year of Mental Health 2001 have greatly contributed to raise societal awareness in regard to the relatively major contribution of mental disorders to the global burden of disease and the existence of effective interventions;
- the Ministers of Health from the world over unanimously agreed during the 2001 World Health Assembly that mental health should have greater priority in their national health programmes; and
- the medical profession has been enlightened worldwide by the Hippocratic rules originally born in ancient Greece, and that the principles laid down in these remain valid for health professions all over the world.

HAVING NOTED THAT:

I Solid evidence exists on the deleterious effects of stigma and discrimination on the course and outcome of mental disorders and the welfare of the persons affected by them and their families, but that activities aimed at reducing stigma can be implemented with good results;

II governments and the public at large are becoming aware increasingly that violence is destroying the social fabric of their communities, but studies have shown that health promotion and other social interventions, including the promotion of peaceful communication, can be effective;

III many and large groups of individuals are deprived of mental health care, particularly immigrants, the displaced and refugees; the WHO Regional Office for Europe, the European Union and several European governments and NGOs are making decisive efforts to include all population groups in mental health policies, programmes and services; and

IV outmoded mental institutions are often a source of human rights violation and fail to meet modern criteria of service provision, and that, from all points of view, community-based care is preferable.

WE CALL UPON:

I governments and peoples of our countries, in particular those facing a crisis situation, engaging all relevant sectors of society and science to intensify their efforts in promoting a climate of reconciliation, of respectful acceptance of differences, and of collaboration and solidarity to prevent man-made disasters and their adverse consequences on people of all ethnic, national and social affiliations. There is no mental health without peace;

II governments of our countries, the World Health Organization, the European Union, professional organizations and NGOs to cooperate and form the networks necessary to promote the exchange of information, experiences and other resources and offer mutual help in combating the consequences of man-made disasters;

III governments of our countries, the World Health Organization, the European Union, professional organizations and NGOs to implement programmes aimed at reducing stigma and discrimination; to uphold the principle of equity in their mental health policies, programmes and services; and to accelerate the transfer of mental health care into the community;

IV governments of our countries, the World Health Organization and the European Union to pursue vigorously and systematically the process of destigmatization and the development of community mental health services that will lead to guarantees of patients' civil and human rights to the appropriate mental health services, as well as to education, housing and employment, so that their reintegration into society is based on solidarity, humanity and pragmatic grounds.

Done in Athens, Greece, on the ninth day of the month of June in the year two-thousand and one

EUR/RC51/R6

POVERTY AND HEALTH – EVIDENCE AND ACTION BY WHO'S EUROPEAN REGION

The Regional Committee,

Having considered the contents and recommendations of document EUR/RC51/8 (*Poverty and health – Evidence and action in WHO's European Region*);

Recognizing the overwhelming evidence of the close relations between poverty, both absolute and relative, and ill health;

Being aware of the responsibility of the health sector to contribute to the reduction of poverty, as part of comprehensive multisectoral efforts;

1. THANKS the Regional Director for proposing that the subject of poverty and health should be included on the agenda of the present session;

2. EMPHASIZES that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being;

3. ACKNOWLEDGES that the issue of poverty and health is a central concern both of WHO and of its Member States, which are all affected, although to different degrees;

4. URGES Member States to accelerate the formulation and further development of actions to combat poverty;

5. REQUESTS the Regional Director:

(a) to establish a process to develop, analyse and disseminate knowledge on the causes of poverty and on effective actions to decrease the effect of poverty on health status;

(b) to mobilize resources in order to carry out activities on poverty and health within a coherent regional framework;

(c) to put this item on the agenda of the fifty-second session of the Regional Committee.

EUR/RC51/R7

HEALTH AND SUSTAINABLE DEVELOPMENT – WORLD SUMMIT ON SUSTAINABLE DEVELOPMENT

The Regional Committee,

Being aware of the preparatory process for the World Summit on Sustainable Development, as decided by United Nations General Assembly resolution A/RES/55/199 (December 2000);

Recalling that Agenda 21 (the global programme of action on sustainable development) *inter alia* highlights the importance of protecting and promoting human health and invites countries to develop plans for priority actions in programme areas such as (a) meeting primary health care needs, (b) control of communicable diseases, (c) protecting vulnerable groups, (d) meeting the urban health challenge and (e) reducing health risks from environmental pollution and hazards;

Noting the European Regional Ministerial Meeting, which is scheduled to be held in Geneva on 24 and 25 September 2001, to review progress made since the United Nations Conference on Environment and Development in 1992 and to outline key policy issues, priorities and follow-up, in order to provide input to the preparatory process for the World Summit in Johannesburg (South Africa) in September 2002;

Recognizing that health has become a major central concern in development, both as a contributor to and as an indicator of sustainable development;

Stressing that protecting and promoting health are central to the entire process of poverty eradication and human development;

Recognizing that many health problems will continue to be exacerbated by air pollution, including environmental tobacco smoke, noise, inadequate water and sanitation, improper waste disposal, chemical or radioactive contamination, poisonings, crowding and physical hazards associated with the growth of densely populated cities, and that climate change may have profound long-term health consequences;

Believing that the Fourth European Ministerial Conference on Environment and Health, scheduled to be convened in 2004 in Hungary, will serve as a catalyst for further actions;

1. URGES Member States:

(a) to actively involve the health sector in national preparations for the World Summit on Sustainable Development;

(b) to address in the preparatory process the multiple linkages between health, the environment and development, and in particular the linkages between health and poverty alleviation;

(c) to also address the underlying determinants of health in order to ensure sustainable development and sustained health improvements;

2. REQUESTS the Regional Director to take into consideration the recommendations and conclusions of the World Summit on Sustainable Development when presenting to the Regional Committee in 2002 for approval the preliminary agenda, drafted by the European Environment and Health Committee, of the Fourth Ministerial Conference on Environment and Health.

EUR/RC51/R8

REPORT OF THE EIGHTH STANDING COMMITTEE OF THE REGIONAL COMMITTEE

The Regional Committee,

Having considered the report of the eighth Standing Committee of the Regional Committee (documents EUR/RC51/3 and EUR/RC51/3 Add.1) and the proposed actions and recommendations contained therein;

1. THANKS the Chairperson and 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-first 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 changes agreed by the Regional Committee at its fifty-first session, as recorded in the report of the session.

EUR/RC51/R9

COORDINATION OF WORK WITH THE COUNCIL OF EUROPE IN THE FIELD OF HEALTH

The Regional Committee,

Recognizing the efforts and valuable contributions to the improvement of all aspects of health for European citizens achieved through the cooperation of Member States within the framework of the Council of Europe as well as the WHO Regional Office;

Acknowledging that the World Health Organization and its regions have a global mandate in the field of health;

Recalling that, in the area of health, the specific mandate of the Council of Europe is to protect and improve the respect of human rights;

Observing that the European Region of WHO and the Council of Europe to a large extent share the same membership;

Acknowledging that – as with any kind of international cooperation – making the most effective and efficient use of resources and avoiding duplication of effort and action is of paramount importance;

Noting with interest the exchange of letters of 19 June 2001 between the Director of Social Affairs and Health of the Council of Europe and the Regional Director regarding development of future cooperation, and in particular the emphasis that each organization has a specific vocation and a particular contribution to make and that duplication of work should be avoided;

Mindful of the need for engagement and active participation of Member States in WHO's European Region, as well as of member states of the Council of Europe, in further developing this cooperation;

1. ENCOURAGES each Member State to coordinate its efforts to these ends through its representatives in committees and subcommittees of the two organizations;

2. REQUESTS the Regional Director:

(a) to aim – in the further development of cooperation with the Council of Europe within the mandate of each organization – at a clear and transparent distinction of tasks taking into account the mutual programmes of work;

(b) to report on progress made for discussion at the fifty-second session of the Regional Committee, identifying *inter alia*:

(i) specific areas of cooperation and future cooperation, either bilaterally or in conjunction with the relevant international organizations for development;

(ii) issues on which Member States could assist in strengthening cooperation; and

(iii) the need for any further strengthening of the agreement between WHO and the Council of Europe;

(c) to ensure qualified participation by the WHO Regional Office in sessions of the European Health Committee of the Council of Europe.

Annex 1

AGENDA

1. Opening of the session

(a) Election of the President, the Executive President, the Deputy Executive President and the Rapporteur
(b) Adoption of the agenda and programme of work

2. Address by the Director-General

3. Address by the Regional Director

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

5. Report of the Standing Committee of the Regional Committee, including:

(i) recommendations on criteria for membership of the Executive Board
(ii) recommendations regarding the Regional Search Group process
(iii) annual report of the European Environment and Health Committee

6. Partnership for health

7. Policy items for discussion

(a) Information and knowledge management: the European Health Report
(b) Poverty and health – Evidence and action in WHO's European Region
(c) The programme budget for 2002–2003 and consultation with European Member States on the budget process for 2004–2005
(d) European Alcohol Action Plan – Follow-up to the WHO European Ministerial Conference on Young People and Alcohol (Stockholm, February 2001)

8. Elections and nominations

(a) Nomination of two members of the Executive Board
(b) Election of three members of the Standing Committee of the Regional Committee
(c) Election of a member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

9. Other matters

(a) Date of the fifty-second session and date and place of the fifty-third session
(b) Other business
(c) Approval of the report and closure of the fifty-first session

Technical briefing:

The Spanish health care system
(organized by the Ministry of Health and Consumer Affairs, Spain)

Panel discussion:

Health in countries which are candidates for accession to membership of the European Union
(organized by the Secretariat)

Annex 2

LIST OF DOCUMENTS

Working documents

EUR/RC51/1	List of documents
EUR/RC51/2 Rev.2	Provisional agenda
EUR/RC51/3	Report of the Standing Committee of the Regional Committee
EUR/RC51/3 Add.1	Report of the fifth session of the Standing Committee of the Regional Committee
EUR/RC51/4	Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC51/5	Membership of the Executive Board and various other committees
EUR/RC51/5 Corr.1	Membership of the Executive Board and various other committees
EUR/RC51/6	Partnerships for health
EUR/RC51/7	The European Health Report – Summary of preliminary findings
EUR/RC51/8	Poverty and health – Evidence and action in WHO's European Region
EUR/RC51/9	WHO's Programme Budget 2002–2003 – The European Region's perspective
EUR/RC51/10	Progress report on the European Alcohol Action Plan, including follow-up to the WHO European Ministerial Conference on Young People and Alcohol
EUR/RC51/11	Date and place of the fifty-third session of the Regional Committee in 2003

Conference documents

EUR/RC51/Conf.Doc./1 Rev.1	Provisional Programme
EUR/RC51/Conf.Doc./2	Report of the Standing Committee of the Regional Committee
EUR/RC51/Conf.Doc./3	Amendments to the Rules of Procedure of the Regional Committee and the Standing Committee of the Regional Committee
EUR/RC51/Conf.Doc./4	Information and knowledge management – The European Health Report
EUR/RC51/Conf.Doc./5	Date and place of regular sessions of the Regional Committee in 2002 and 2003
EUR/RC51/Conf.Doc./6 Rev.1	Poverty and health – Evidence and action in WHO's European Region
EUR/RC51/Conf.Doc./7	Progress report on the European Alcohol Action Plan, including follow-up to the WHO Ministerial Conference on Young People and Alcohol

Information documents

EUR/RC51/Inf.Doc./1	Annual Report of the European Environment and Health Committee (EEHC)
EUR/RC51/Inf.Doc./2	Health prospects in countries which are candidates for accession to membership of the European Union

Annex 3

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Mr Matthew Kahane

World Bank

Mr Christopher Lovelace

V. REPRESENTATIVES OF OTHER INTERGOVERNMENTAL ORGANIZATIONS

Council of Europe

Mr Henry Scicluna

European Commission

Dr Fernand Sauer
Mr Lanaras Antonis

VI. REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL RELATIONS WITH WHO

International Commission on Occupational Health

Professor Richard Ennals

International Confederation of Midwives

Mrs Eva Selin

International Council for Standardization in Haematology

Dr Joan Lluis Vives Corrons

International Council of Nurses

Professor Myriam Ovalle Bernal

International Council of Women

Mrs Pnina Herzog

International Cystic Fibrosis (Mucoviscidosis) Association

Mr José Polido

International Federation for Medical and Biological Engineering

Mrs Hiie Hinrikus

International Federation of Gynecology and Obstetrics

Dr Francisco Campillo

International Federation of Hospital Engineering

Mr Francisco Castella

International Federation of Pharmaceutical Manufacturers Associations

Ms Sissel Brinchmann

La Lèche League International

Ms Lavinia Belli
Ms Bettina Gerbeau

Medical Women's International Association

Dr MariLuz Martín Nozal

Soroptimist International

Ms Claire Tedjini

World Confederation for Physical Therapy

Ms Inger Broendsted
Dr José Urrialde

World Dental Federation

Dr José Font Buxo

World Federation for Medical Education

Professor Margarita Baron-Maldonado

World Federation for Mental Health

Dr Mariano Hernandez Monsalve

World Federation of Acupuncture-Moxibustion Societies

Dr Aldo Liguori
Professor Filomena Petti
Dr Christian Rempp
Mr Arne Kausland

World Federation of Hydrotherapy and Climatotherapy

Dr Dmitry Golobev

World Self-Medication Industry

Mr R. García Gutierrez

VII. OBSERVERS

Association of Schools of Public Health in the European Region

Dr Angel Otero Puime

European Forum of Medical Associations and WHO

Dr Marko Bitenc
Dr René Salzberg

European Forum of National Nursing & Midwifery Associations and WHO

Professor Myriam Ovalle Bernal

Order of Malta

Mr Ferdinand Orssich de Slavetich

Royal College of Physicians

Dr Ian Kunkler

Annex 4

ADDRESS BY THE DIRECTOR-GENERAL OF WHO

Madam Chair,
Dr Danzon,
Distinguished Ministers,
Ladies and Gentlemen,

We were all shocked by the dreadful events that took place in the US this week. We feel deep sorrow over the tragic loss of life and terrible human suffering. In these circumstances, it is all the more important that we strengthen ways in which we work together at all times. We must pursue the principles and values that have always guided our work for world health.

You have already heard a detailed report from the Regional Director, and discussed several issues of common concern that he covered. I shall therefore concentrate on a few themes that I know are relevant to this Committee.

The challenges of ill health and poverty have already taken a central place in your discussions. You will not be surprised to hear me reiterate that illness denies millions of people the chance of achieving their life potential. The plight of these "denied millions" is a profound challenge to the world's leaders as they shape the world for future generations.

Within the European Region the number of people who are classed as poor has increased in the past decade. As you have already indicated, poverty features within even the most prosperous Member States. Health inequalities within, and between, societies have repercussions for all who live within them. Globalization means that the consequences of poverty can also be felt far away, influencing both health outcomes and people's perceptions about their prospects for a healthy future.

Yet – as we meet here today – the divide between the haves and the have-nots continues to widen. Only a privileged few have access to the fruits of innovation and new technologies. This gap is painfully clear within the European Region, in countries that are starting to see positive economic growth rates after a decade characterized by dramatic declines. The challenge facing you, the health leaders of the region, is to take advantage of the upturn and start to bridge the health divide.

The WHO Secretariat is helping you as you respond to the challenge. We share your commitment to improving **all** people's access to effective health systems. This means a focus on individuals and communities most in need. Ensuring they can access essential health care. Health promotion. Vital commodities. Means to ensure that health professionals provide good quality care to individuals and populations. Enabling the public, those who make decisions about service provision, to access information that is useful. Supplying the technology which makes this information available. Building the infrastructure and institutions that power health systems. Setting up mechanisms to increase the likelihood that these systems work as they should. We know that you want more of WHO. We are gearing up to support you as best we can.

Colleagues,

However it is defined, poverty is the most significant determinant of ill health. At the same time, there is increasing evidence that unless poor people enjoy good health, their prospects for emerging from poverty are reduced. Hence the growing recognition that freedom from ill health is an important foundation both for poverty reduction and for human security.

Within the last year we have seen growing global awareness of the need to invest much more in the health of all people. Effective investments in equitable health outcomes are now recognized as critical for the human and economic development of disadvantaged societies.

This new thinking has been carefully analysed by WHO's Commission on Macroeconomics and Health and the six working groups that support it. The Commissioners, led by Professor Jeffrey Sachs of Harvard University, are due to publish their report at the end of the year. I expect them to call for a dramatic and rapid increase in the intensity of action to improve the health – and prospects – of the world's poorer people.

Nations are already starting to respond to this call. They are undertaking to invest more in health, building on efforts that are already underway when these are shown to work. They seek additional resources from elsewhere – from donor agencies, foundations, development banks and voluntary organizations. They nurture partnerships based on shared goals and values, bringing together groups within and outside government. They seek new – and principled – alliances with private entities. For they know that no government, agency, voluntary body or pressure group can mount the response alone – certainly not without combining efforts with both civil society and its political leaders.

The international community is responding too, and not just with words. At this year's World Health Assembly, at the UN General Assembly Special Session on HIV/AIDS, and at the G8 Summit in Genoa, we heard firm commitments to an increase in the level of resources available for global health. Governments, voluntary and private bodies are already making new commitments.

The levels of new resources needed for health are enormous. At least ten billion dollars a year. This means that whatever resources are available **must** be used as effectively as possible. To do this, we in WHO bring governments, research institutions, private sector companies and international organizations together. We do this in ways that promote synergy of goals and strategies. We recognize that such alliances are uneven, and may change over time. We appreciate that each party has its own priorities, its need to be seen to be effective, and its comparative advantage.

But when different organizations come together to promote health and well being, they are frequently affected by what each other does. Consequences of poor coordination are measured in human suffering. WHO sees poorly coordinated international assistance as a sign of failure. On the other hand, the power of shared goals and synergy can be quite remarkable.

The Global AIDS and Health Fund will be an important stimulus to coordinated international health action. It is planned that the Fund be operational by the end of the year. WHO sees the need for this Fund to live up to its name and be a **global** fund. This means that it should bring benefits to people in need within all regions, including this one.

We anticipate that the Fund will encourage the **more effective operation of under-funded health systems**. This means improving the capacity of a variety of different provider groups to deliver essential services and goods through a diversity of private, voluntary and public channels. The emphasis must be on stewardship by governments, even in complex emergencies, so that quality is assured and intended benefits reach poor people.

Many countries have initiated health system reform. It is clear that if reforms do not lead to better results, they have not succeeded. There is much experience of focused – and successful – health system reform within this region. The work of the European Health Observatory offers analysis and syntheses from which we are all learning.

Health system reform is unlikely to succeed without **popular involvement in health action** at local, national, regional and global levels. This calls for credible and upbeat programmes of advocacy and catalysis. Experience within this region shows that professional leaders, politicians, the media and public figures all have a critical role to play in movements for health – whether in cities, in workplaces, or in

schools. Typically, governments and local authorities work with NGOs, professional associations and the media. All recognize the need to work together – to "make the forces of globalization work for the secure future of humanity".

Madam Chair, Distinguished Representatives,

The world's leaders have focused on the devastating impact of HIV infection, and acquired immune deficiency syndrome, on our global society. The challenge of AIDS concerns all health professionals. In this region the absolute infection rates are still relatively low. That is good news. But if we do not act now, in a decisive and concerted manner, the news will turn bad very quickly. Several countries in central and eastern Europe and among the newly independent states, are already seeing worrying increases in HIV infection rates. Ten years ago, we saw similar figures in some African countries. Our collective response was not sufficient to halt the increase. The dimensions of the human and economic consequences faced by the people of some nations are extreme. We must prevent a similar catastrophe in this Region.

The UN General Assembly Special Session on HIV/AIDS in June this year addressed the strategies and interventions that can halt the spread of HIV infection. All of us are committed to responding better – helping people protect themselves from infection, and increasing the proportions of HIV-affected people who can access care for their illnesses.

Scaling up calls for an extraordinary and courageous response.

We must intensify prevention efforts that focus on known risks, and be guided through better surveillance of infections. We must do this in ways that respect people's rights and dignity. We must improve access to effective diagnosis and therapy as part of the overall response to HIV.

I have directed that WHO scales up its contribution to the struggle. Our goal is to help identify more effective responses and implement them in ways that take account of people's cultural traditions and social realities.

Linked with HIV/AIDS is the spreading epidemic of TB in this region. Last November in Moscow, I was able to observe personally the tragedy of TB spreading through prison populations and the growth of multi-drug-resistant TB.

Recently, the Global TB Drug Facility has been able to reduce drastically prices of key TB drugs, including some needed to fight multi-drug-resistant strains. Observed treatment regimens are showing their effectiveness. We are making progress in laying the conditions for reaching everyone who needs it with affordable treatment. Countries will be able to draw on this progress as they develop their action plans. We are looking forward to reports of progress at the upcoming Stop-TB Partners Forum in Washington next month.

Colleagues,

WHO has catalysed – and now supports – a range of partnerships for health action. The Global Alliance for Vaccines and Immunization is already having an impact. The polio eradication campaign is making outstanding progress: in large parts of the European Region, polio is already considered a threat of the past. The isolated cases discovered in Bulgaria earlier this year remind us that none of us are really safe until the whole world is declared polio-free.

WHO also facilitates action by others that can have a far reaching impact. This summer we presented a new initiative to improve access to health information. Specifically, WHO has helped to set up an agreement between some of the major international publishers of biomedical literature to make around 1000 journals available free of charge through the internet. Thousands of health professionals and

researchers are thus enabled to access vital information. Several countries in this region are participating in the initiative.

Colleagues,

Within the European Region, WHO has taken the lead in work on environment and health, with particular emphasis on the health of children, transport and health, and – importantly – better access to potable water and safe sanitation. Lessons from EURO are being applied in other WHO Regions by a range of committed partners.

WHO is now working with you all to address the burden of mental ill health and brain disorders. In most countries the resources and the manpower available to tackle mental ill health are sparse. But new and more effective means **are** now available to treat and prevent brain disorders and mental illness. As a result, modern mental health care is focusing more on supporting the family within the local community. It is geared to prevention, early detection and treatment and uses effective and relatively inexpensive medicines.

Europe has come relatively far in developing and implementing new strategies for prevention and treatment of mental ill health. Some countries' efforts stand as models for a more effective, professional and also a more humane approach to mental ill health. But, as most recently pointed out in the "Declaration of Athens" in June this year, there is still a long way to go also in this Region before our knowledge about prevention, effective use of medication, community support and reduction of stigma and discrimination is turned into action that will improve the lives of the millions who suffer from mental illness.

The forthcoming World Health Report, to be released on 4 October, will provide a global overview of the current and future burden of mental ill health and its main contributing factors. The report offers strategies for ensuring that effective prevention and treatment are **both** put in place **and** adequately funded.

This Region has taken the lead in focusing on the potential for alcohol to damage the lives of young people. Many of us met to plan a response in February at the European Ministerial Conference in Stockholm.

The background to that meeting was serious. There are alarming signs of worsening drinking habits among young people across the whole Region. I am very pleased to see signs of a response to this challenge. A clear declaration has been adopted. Some countries have already implemented new policies – involving young people in the policy-making process, and keeping a proper distance from commercial interests.

I am also pleased that the European Union adopted two alcohol-related measures in June that are in line with the European Alcohol Action Plan. The EU called for international cooperation – particularly with WHO – to monitor progress and share experiences.

Colleagues,

Tobacco continues to be a tremendous threat to the health of people throughout the European Region. I am in particular concerned by the rapid increase in tobacco-related diseases and deaths among women.

Many countries in central and eastern Europe and among the newly independent states have become major targets for the tobacco industry in their search for new markets. But I am pleased that WHO is working with countries to implement responses that help reduce the number of young people who begin smoking, or help those who wish to quit to do so. Much more needs to be done. That is why governments must remain fully engaged in negotiations of WHO's Framework Convention on Tobacco Control – until the Convention has been finalized, hopefully in 2003.

We are now confronted, each day, with controversies about access to health care, and to the results of medical research.

Much biomedical research is now carried out in the industrialized world, and is primarily market-driven. This is ethically unacceptable. Unless this pattern is changed, the knowledge and technology gap between industrialized and developing countries will widen. The health needs of poor nations will fail to get the attention they deserve.

WHO's research programmes help bridge this divide through building international networks that involve researchers from all over the world, working together in ways that maximize the probability of success. Researchers from the countries of this Region are playing a key role.

However, health professionals within the Region are constantly involved in difficult choices about how to allocate the resources they control. These are complex, and frequently have ethical dimensions.

WHO's Regional Offices and departments in Headquarters are helping countries start to handle complex ethical issues such as codes of conduct for research involving human subjects. It is now time to draw together this work.

I therefore propose to establish a WHO-wide initiative on health ethics, based – initially – in my office. It will focus on *Ethics in Public Health, Health Research Ethics* and *Biotechnology Ethics*. It will address ethical aspects of work on the human genome, stem cell research, cloning and other ethical areas of biomedical science. It will help increase Member States' capacities to handle ethical issues, and to provide support for intergovernmental action – whether within the UN, regional institutions, or through partnerships with institutions like the Council of Europe. We will work closely with the UN General Assembly, other UN agencies (including UNESCO) and draw on some of the pioneering work being undertaken by this Region's Member States and the European Regional Office.

Colleagues,

In March, I addressed an important meeting on food safety in Uppsala.

There, I outlined three major challenges in the area of food safety for Europe:

- We need to accept that the systems we use in Europe to ensure food safety are not as good as we have come to believe. To improve these systems and re-establish consumer confidence, we must reassess them all the way from the farm to the table;
- We need to ensure reasonable food safety standards that apply throughout the world and assist all countries to reach these standards. In the long run, this is in our own interest. Unless we do so, developing countries cannot participate in global trading systems;
- We must develop global standards for **pre-market** approval systems of genetically-modified food to ensure that these new products not only are safe, but also beneficial for consumers and more efficient than existing products.

I am glad to read of the regional initiatives on food safety that have been taken forward with support from WHO – particularly the role of Ministries of Public Health in championing the interests of consumers within regulatory processes and legal frameworks.

Colleagues,

All WHO's work is **for** countries, but only a part of it is **in** countries. Country work, though, is critical, and our country representatives are at the centre of all we seek to do.

We are committed to improving the capacity of the WHO teams in countries who need us most, so that they are better equipped to contribute to better and more equitable health outcomes. WHO country representatives and Regional Offices will play a central role in making this happen. They will build on our recent experiences with establishing strategies for cooperation with individual countries, and this Committee's decision to increase the emphasis given to effective country-level working.

The work of WHO's Regional Offices and departments in Headquarters is summarized within the corporate strategy for WHO's Secretariat that was agreed by Member States during 1999. This is the basis of the General Programme of Work for 2002–2005.

During 2000, the Secretariat established a Strategic Programme Budget, identifying 35 areas of work across the Organization. This formed the basis for the expected results, milestones, activities and allocation of regular and extrabudgetary resources for the 2002–2003 biennium.

I will be working with the Regional Directors over the coming months to develop a proposed set of global priorities for the next period, 2004–2005. We will draw on your deliberations at this Regional Committee. My proposals will then be presented to the Executive Board when it meets in Geneva in January 2002.

WHO and the European Union are natural collaborators in the field of health, and I am very pleased with the way our cooperation has developed over the past two years. The cooperation is expressed through EU Member States' links with WHO's European Regional Office and our Headquarters in Geneva. In addition, WHO's collaboration with the European Commission is being enhanced through the Exchange of Letters that was signed late last year. This builds on a very open and positive dialogue between us – on the new policy framework for action on major communicable diseases and access to medicines, and in the fields of tobacco control, environmental health and food safety.

The Exchange of Letters will enable us to establish a broad and systematic collaboration on a wide range of issues. It provides for annual meetings at the political and technical levels in order to take stock of the existing cooperation, review priorities and build plans for the future.

Colleagues,

As health professionals, we all face enormous challenges. People's expectations are greater than ever. We respond to their legitimate expectations in ways that promote equity of health outcomes and contribute to reductions in levels of poverty.

These values underlie all our actions – as WHO Member States and as the Secretariat.

Let us work together for a constructive and successful meeting, and for effective health action throughout the Region in the coming year.

Thank you.

Annex 5

ADDRESS BY THE WHO REGIONAL DIRECTOR FOR EUROPE

INTRODUCTION

Madam President, Distinguished representatives of Member States in the European Region, Participants in the fifty-first session of the WHO Regional Committee for Europe, Dear colleagues at WHO headquarters and the Regional Office for Europe, Ladies and Gentlemen,

Since the last session of the Regional Committee, in Copenhagen, the European Region has been the site of numerous events. Some have been dramatic, since our Region is still suffering from numerous conflicts. Some have caused anxiety and fear in people and their leaders, especially in the most precarious areas. I have had the privilege of visiting most of these countries this year, and I have felt the moral and physical suffering being experienced in places directly affected by environmental disasters, epidemics and sudden outbreaks of disease.

But during the year there have also been positive events: conflicts that have been averted or (one hopes) are being settled, scientific progress and genuine, though often less spectacular, advances in public health. My colleagues and I have observed, during our visits and missions, the serious way in which reforms of health systems and their management are being carried out. We see that all sectors of society are showing increasing interest in health issues and in the potential offered by the new approaches of health impact assessment. We are also seeing growing public interest in health professionals' efforts to improve the quality of their work. We are feeling the first effects of the Munich Conference and Declaration on the work of nurses and midwives. The question of health system quality is certainly one that is currently of concern, both to health professionals and to decision-makers. Visible progress has already been made here, thanks to developments with regard to vocational training, teamwork and accreditation.

For the Regional Office, too, this has been an eventful year. Our aim is to improve the quality of our services to countries, and to develop working methods that are more in line with this aim. My presentation will deal with both of these aspects, external and internal, and I will then go on to outline our commitments for the year ahead.

THE MAIN ACTIVITIES CARRIED OUT BY THE REGIONAL OFFICE DURING THE YEAR

Alcohol and young people: the Stockholm Conference

To judge from the number of participants and the attention it received in the media, this Conference has had a major impact. It has put drinking, and especially drinking by young people, back in its rightful place as a major public health priority. One in every four deaths in young men aged from 15 to 29 years is attributable to alcohol.

The Conference highlighted the fact that drinking patterns in young people increasingly resemble those of drug abuse. The Declaration that was unanimously adopted by the participants contains specific proposals for tackling this problem. The fact that young people themselves were taking part in the Conference stimulated a more open and more direct atmosphere, proving the benefits of listening to other voices, not just those of experts. Personally, I will long remember both the young Romanian asking a politician how long people would have to wait before declarations of intent were turned into practical action, and the Minister begging his impatient young questioner for more understanding of the difficulty of his task.

A specific item on young people and alcohol is on the agenda of this session of the Regional Committee, and a draft resolution is being submitted for your consideration.

Mental health

This is another important topic this year, in a global context. The European Region has reacted very positively to WHO's appeal to lift the taboos that often surround mental health. Respect for patients, questions about the use of mental asylums, the integration of mental health in policies on primary health care, and approaches based on prevention and the promotion of mental health – these are all subjects that have been taken up throughout Europe and discussed in meetings with health professionals, the population and patients themselves. Commitments have been made, so that World Health Day on this subject is not an isolated event but one stage in an ongoing process. Personally, I must say that I was deeply moved and strengthened in my conviction when I took part, alongside the President of Finland, in a major public event organized and put on by mental health patients and professionals.

On this subject, I must of course recall the ministerial round tables that were held during the World Health Assembly and which involved many ministers from the European Region. I should also like to mention the declaration adopted in June following the Athens meeting on mental health and violence. This declaration, which was supported by a large number of countries, calls for people's mental health to be protected and, in a crisis-ridden world, for stigmatization to be rejected. The World Health Report, dealing with this subject, will be published in October. We would urge you to give prominence to this report and to organize with us activities that will follow on from those launched in April of this year.

Our Mental health unit in Copenhagen and the Communications team at this session in Madrid are available to help you do this. We also have a summary description of the actions launched in April in each country of the Region.

The Stability Pact

In another field, I should like to refer the recent meeting in Dubrovnik with the Stability Pact countries. In close cooperation with our colleagues at the Council of Europe, we have managed during the year to make health an integral part of efforts for peace and social cohesion in south-eastern European countries. Projects concerning health and vulnerable population groups were presented at the meeting, to obtain international support. This is one example of the Regional Office and the Council of Europe acting as advocates of health for development and peace.

Depleted uranium

Elsewhere, I would cite the role played by the Regional Office in assessing the risks related to depleted uranium in Kosovo. The findings from this mission clearly demonstrate the need for long-term surveillance. For the present, however, we have managed to reassure the populations concerned about the health consequences of exposure to radioactivity due to depleted uranium. One of the functions expected of WHO is the ability to intervene rapidly, scientifically and in an independent way.

Other technical activities

These few examples, which I have chosen for their visibility and their diversity, should not make us forget the whole range of technical activities that have been pursued during the year. In particular, I would refer to work on health systems, networks (such as CINDI and urban health), and nutrition and food safety, as part of the steps being taken to give effect to the action plan that you adopted last year; the numerous activities in many countries related to women's health, pregnancy, childhood and adolescence; and actions to promote health in schools, prisons and workplaces. The opening of the Venice Centre in the near future will doubtless give a new dimension to this field, by including consideration of the factors that determine people's health. We shall be presenting to the Standing Committee in November our proposals concerning the Office's policy with regard to centres located outside Copenhagen.

In the environmental sector, I should like to mention the meeting held in Budapest in November, at which representatives of a very large number of countries in the Region analysed the progress made towards giving effect to the Water Protocol, signed in London in 1999; the meeting in Geneva in May on the health effects of transport policies; the opening of the Bonn Centre on the urban environment, from which

great things are expected; and the further 10-year commitment to the Rome Centre made by the Italian government. Lastly, I should like to note the considerable amount of work done by the European Environment and Health Committee in preparation for the next Ministerial Conference, to be held in Budapest in 2004. We will come back to this subject in one of our meetings this week.

In the area of communicable diseases, we are making progress towards having the eradication of poliomyelitis officially certified in the European Region in 2002, despite the fact that three confirmed cases have been identified in Bulgaria. Once again, I should like to stress the importance of maintaining a high level of immunization and good surveillance throughout the Region, and the need for all countries to draw up an inventory of those laboratories that hold stocks of wild poliovirus, in order to make sure that it is properly isolated. The explosion of AIDS in some countries of the former Soviet Union in the past three years is very worrying. It is officially estimated that there are at least 300 000 HIV-positive people in the Russian Federation. The rise in the incidence of tuberculosis, despite our joint efforts (370 000 new cases in the Region in 1999) is very alarming, too. The rise is being seen throughout Europe, and not only in the eastern part of the Region, even though the rates in the former USSR are 10 to 15 times higher than those seen in western Europe. To end this section on communicable diseases on a note of satisfaction, I would point to the reduction in the number of cases of malaria in countries of the European Region affected by this disease.

Lastly, in a field where WHO's global action has been prominent, namely access to drugs, I would mention the Regional Office's support for the guidance given by the Director-General, and especially its assistance to central and eastern European countries with regard to regulation, price-setting, reimbursement mechanisms and appropriate use.

As you can see, we have been engaged in numerous activities, often supported by your voluntary contributions. However, we are terribly limited by a lack of adequate resources. The European Region of today, with its 51 Member States, is no longer what it was ten years ago, when it covered 30 countries. These Member States need support in tackling their problems. They have confidence in the independence of WHO. I appeal to you to help ensure that our resources from the regular budget and voluntary contributions reflect the needs of the Region and enable us to play, to the full, our specific role in the sole service of health.

CHANGES IN METHODS OF WORK AT THE REGIONAL OFFICE

Our work during the year has been largely guided by the paper on the country strategy that you endorsed a year ago. Let me explain how we have translated this document into action, and where we are now.

I will first consider changes in our work with countries, then our cooperation with our partners, and lastly the developments in our internal organization.

Changes in our work with countries

We have tackled this area with the ambition of responding, in a specific way, to the needs of all the countries in the Region, and in particular helping them to develop evidence-based policies and programmes. The findings from the evaluation of the EUROHEALTH programme, presented at last year's session, have encouraged us to take this approach. In the past few months, we have accordingly reviewed our current collaboration with the 28 countries that have a cooperation agreement with the Regional Office. And with each of them, we are discussing the priority topics and mechanisms for our joint work in 2002–2003. We are, of course, drawing on the knowledge and experience of the technical units at the Regional Office. For the first time, this phase of negotiation with countries, aimed at meeting their needs and priorities, constitutes the first stage in the planning cycle that we must finalize by 1 January 2002 at the latest. We shall come back to this question during our discussion of the budget this afternoon.

The Liaison Officers have an essential role to play in this two-way process between the countries and the Regional Office, and strengthening the Office's country presence is to be a major objective for the years ahead. That is one of the reasons why our Region's budget must be increased, so that we can take strong and effective action in those countries that most need it. The best example is the Office of the WHO Representative in Moscow, which benefits from substantial human and financial resources provided by various countries, thereby making its work visible, valuable and recognized. An evaluation is to be carried out in the next few weeks, and I hope it will show donors and Member States that investing in a country office is worthwhile.

During the year, we have also gained a better understanding of the needs of those countries in the Region with whom we do not have cooperation agreements. A meeting of representatives of these countries took place in London at the beginning of July. At this first "Futures Forum", it was decided that the group would form a network capable of providing a rapid reaction to any crisis affecting a country in the Region. The participants also decided that, each year, four topics (two new subjects and two continuing ones) would be considered at meetings of the Forum. For this first year, the subjects have been the quality of health services, crisis management, the impact of electronic media on people's behaviour and medical practice, and information as a tool for decision-making. With regard to the latter, the London meeting clearly demonstrated how much is expected of WHO in general, and of the Regional Office in particular. We will have an opportunity to discuss this again at our meeting on Wednesday morning.

Also with a view to improving our understanding of countries' needs, two internal studies have been carried out during the year. The first concerns the Stability Pact countries, the second those that are candidates for accession to membership of the European Union. In deepening our knowledge of countries, we have of course also benefited from our meetings with officials, our visits to countries, and the more extensive and systematic missions that we are beginning to carry out. In this area, we can build on the lengthy experience we have gained through the launch and successive phases of the Health for All policy.

Changes in our work with our partners

During the year, we have given prominence to some of our partners, undertaking very specific actions with three of them: the Council of Europe, the European Commission and the World Bank.

Council of Europe

I have already mentioned our cooperation under the Stability Pact and our participation in the group engaged in the Social Cohesion Initiative. We are also working together on health and human rights, bioethics, and more specific topics such as health and the media. In Strasbourg in June, we took part in a meeting of the Council of Europe's European Health Committee, in company with the European Commission. Forty Member States were present at this "first ever" event, and the vast majority of them commented favourably on the initiative and encouraged us to cooperate more closely. An exchange of letters took place at the end of that meeting, and these documents are available to you.

European Union

Here, too, there has been much progress in recent months, in particular owing to the agreement signed by the Director-General of WHO and the President of the European Commission. This framework has acted as a stimulus for clearer and more specific cooperation between the Commission and the Regional Office, although there has been long-standing collaboration of this kind in a large number of areas. One instance took place in September of last year, when a meeting was held to coordinate the work of the European Union and WHO in the field of environment and health, with the participation of the European Commissioner responsible for this area. The agreement signed between the two organizations encourages us to develop this cooperation still further, and we know that the Member States support us in this approach. A meeting in Brussels in October will define in detail the subjects and methods that are to be developed, but I can say already now that the surveillance and prevention of communicable diseases, health promotion and the environment are some of our joint priorities. We will also cooperate closely in the field of information, with the aims of carrying out complementary activities and avoiding overlaps.

World Bank

Our cooperation with the World Bank has been above all at field level, in those countries where both organizations are present. At a meeting in Washington, we carried out individual case studies of how to make our actions more coherent and complementary. At the end of this week, a dozen staff members from the World Bank responsible for eastern European countries are to come to the Regional Office. The aims of their visit are to set up more efficient collaboration mechanisms and to review the priority themes for our cooperation, notably in the areas of infectious diseases, pharmaceuticals, information and the environment. We will also come back to this joint work during the meeting of the Regional Committee on partnerships.

Of course, in addition to deepening our relations with these three partners, we have continued to work with other bodies in the United Nations system, with nongovernmental organizations and especially with professional bodies. The working paper on *Partnerships for health* is devoted to this subject.

Changes in methods of work within the Regional Office

We are steadily taking forward developments in this area, along two main lines. First, we are promoting ways of working that are based on evidence and best practice. This applies to the technical content of our work, to the services we provide to Member States, and to the management and administration of our organization. In this context, we have carried out or commissioned a number of studies and administrative audits in various areas. These concern in particular our centres outside Copenhagen, collaborating centres, liaison offices, humanitarian assistance offices, various aspects of information, human resources, and staff training and development. All these managerial and decision-making tools now give us the evidence on which to base the changes we need to make in order to reorient our activities. We will present all our conclusions in this regard to the Standing Committee at its session in November, so that they can be made fully operational by the end of the year. In fact, however, a number of these reforms have been carried out already. In the transitional phase we are now in, I have decided not to adopt a radical approach; instead, we are taking the time we need to identify problems and bring about gradual changes in our ways of working. To a certain extent, we have applied to the Regional Office the methods of work that we are advocating for public health as a whole.

The second main line of development in our working methods concerns involvement of the staff, not only at a personal level but also from a collective point of view. We have recently launched an initiative based on “quality circles”, whereby the teams at the Regional Office commit themselves to verifying and improving the relevance and quality of their work in a systematic and organized way.

These necessary changes in our ways of working are being accompanied by the investment of considerable resources in a major programme of ongoing training for each member of the staff, and by opening up the Office to experience from the outside world, presented and discussed with the staff at regular intervals by invited speakers and experts (the “Guest of the month” programme).

If I told you that everything was going well, however, you would not believe me. Periods of transition are always difficult and stressful, but I should like to bear witness to the staff’s constant devotion to duty and to the quality and intensity of the work they have done, despite the difficulties they have been facing. I do not intend to devote a separate section of my presentation today to our relations with WHO headquarters. I would simply say that we are contributing loyally to the aim of building “One WHO”, while defending our position and making sure that Europe’s specific features are taken into account in the Organization.

FUTURE CHALLENGES

In my address last year, I described the challenges and opportunities for health in the years to come. Today I should like to emphasize those that I think are of particular importance.

Information

Throughout the year, the question of information for decision-making in health has come up at almost every meeting and discussion we have had. The insistent requests to promote the flow of information, to accredit reliable sources and to produce operational analyses are addressed not only at WHO and its own databases, but also at all the international organizations working in the health sector. We are convinced that a plethora of information actually complicates decision-making, rather than making it easier. With our partners, we are therefore seeking ways of providing our Member States with the information they really need. This is an area where we hope that next year will prove decisive, and where we would welcome your political and technical support. The European Observatory on Health Care Systems is a good example of cooperation generating information that is recognized by its users as being "useful".

Tobacco Convention

The second challenge in the coming year is the Tobacco Convention. We must do more to ensure that the European Region brings its full weight to bear on carrying this initiative through to completion – it is of capital importance for public health and can be an exemplary model of international action. We have an opportunity to do this at the Warsaw Conference in February 2002, for which preparatory meetings are to be held in various countries. I hope we can take advantage of the presence of all Member States at this session of the Regional Committee to strengthen that preparation. That is why the Regional Office team responsible for tobacco control is with us here in Madrid.

THE REGIONAL COMMITTEE

In conclusion, let us look at the Regional Committee itself. Like you, we have high expectations of it. You are our governing body. Your comments, criticism and suggestions are essential for our work. We hope to create the same spirit of openness and interaction that is a feature of our relations with the Standing Committee. Apart from the statutory items that you are familiar with and which are common to all regional committees, four topics have been selected for more in-depth presentations and discussion this year. I have already mentioned them: **alcohol and young people, information and the European Health Report, the budget, and poverty**. In particular, I should like to emphasize the question of poverty – while it is certainly a difficult subject, it was chosen by the Standing Committee to underline the advocacy role that the Regional Committee can play and to obtain its views on the matter. The discussion will continue, however, after our meeting tomorrow morning. We hope that you will be able to feed in to us your experience of action taken throughout the Region to reduce the effects of poverty on health. From the various case studies that you provide, we aim to identify the lessons that can be applied in other countries. For a subject like this, which is so worrying and which deeply affects certain populations and countries in the Region, it is essential that experience gained in one quarter can be drawn on by all.

Outside the formal meetings of this Regional Committee, I would draw your attention to Dr Nabarro's presentation on AIDS and the Global AIDS and Health Fund, to the technical briefing on the Spanish health system, which will be very instructive in view of the reforms that have been carried out in recent years, and lastly to the panel discussion on health in countries that are candidates for accession to membership of the European Union.

As you may have realized, the agenda item on partnership with other organizations will be taken up this year in the form of a round-table discussion. The nongovernmental organizations present at this session of the Regional Committee are invited to raise questions during this discussion, or to take the floor on other, specific agenda items. If they so wish, they may also submit written statements.

CONCLUSION

After this long presentation, my conclusion will be very short – we are counting on you to help us continue along the right lines.