

Report of the sixtieth session
of the WHO Regional Committee
for Europe



World Health
Organization

REGIONAL OFFICE FOR Europe



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Opening of the session

The sixtieth session of the WHO Regional Committee for Europe was held at the Holiday Inn Solkolniki, Moscow, Russian Federation from 13 to 16 September 2010. Representatives of 52 countries of the Region took part. Also present were representatives of the Joint United Nations Programme on HIV/AIDS, the United Nations Children's Fund, the United Nations Development Programme, the United Nations Economic Commission for Europe, the United Nations Environment Programme, the United Nations Population Fund, the World Bank, the Council of Europe, the European Union, the Organisation for Economic Co-operation and Development and of nongovernmental organizations (see Annex 3).

The first working meeting was opened by Dr Christos Patsalides, outgoing President.



Election of officers and adoption of the agenda and programme of work

(EUR/RC60/2 Rev.2 and EUR/RC60/3 Rev.2)

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

Dr Tatiana Golikova (Russian Federation)	President
Dr Vladimir Lazarevik (The former Yugoslav Republic of Macedonia)	Executive President
Dr Josep M. Casals Alís (Andorra)	Deputy Executive President
Mr Haraldur Briem (Iceland)	Rapporteur

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

Address by the Regional Director

(EUR/RC60/4, EUR/RC60/8, EUR/RC60/9,
EUR/RC60/Conf.Doc./1, EUR/RC60/Conf.Doc./4)



The Regional Director began her address (Annex 4) by thanking the Regional Committee for the trust it had placed in her a year previously by nominating her for her post. Then she described the seven strategic directions and priorities that the Regional Office was pursuing, in order to adapt to the challenges it faced, and the work that the Regional Office had done or planned to address the most pressing health issues in the WHO European Region.

The first new strategic direction was to develop a new European health policy – Health 2020 – with Member States and partners. Second, the governance of the WHO Regional Office for Europe would be continuously reinforced by strengthening its governing bodies, establishing a high-level forum of government officials, continuing to hold ministerial conferences and using the programme budget to ensure accountability. Third, in becoming a centre of technical excellence, the Regional Office would concentrate core corporate functions in the office in Copenhagen, Denmark, fully integrate the geographically dispersed offices (GDOs) and country offices, and revitalize existing networks and establish new ones. It was reviewing the GDOs and country offices. Fourth, the Regional Office would further strengthen collaboration with Member States by providing different types and levels of support, depending on countries' needs. It was exploring options such as subregional arrangements, using the model of the South-eastern Europe (SEE) Health Network. Fifth, the Regional Office would develop a strategy on partnerships for presentation to the Regional Committee in 2011. Work was under way to strengthen its relations with European Union institutions, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Organisation for Economic Co-operation and Development (OECD). Sixth, the Regional Office was working to improve its use of information and communication technology. The seventh task was to create a positive and empowering working environment and sustainable funding for the Regional Office.

In discussing the five most pressing priorities for the Regional Office, the Regional Director described work done in the 2008–2009 biennium and in the seven months since she had taken office, as well as activities planned for the future. First, the Regional Office had provided risk assessments, guidance and various forms of tangible support to health services in countries affected by emergencies and public health crises, such as the volcanic eruption in Iceland, the civil unrest in Kyrgyzstan, severe floods in the Republic of Moldova and the heat-wave and wildfires in the Russian Federation.

Second, the Region had an unfinished agenda for communicable disease control, despite great progress in some areas. When a poliomyelitis (polio) outbreak in Tajikistan had endangered the Region's polio-free status, WHO, the United Nations Children's Fund (UNICEF) and other partners had supported the governments of Tajikistan and neighbouring countries in developing response strategies and carrying out supplementary immunization activities for children and young people. The regional reference laboratory in the Russian Federation had provided valuable support. Similarly, a new target date needed to be set for the elimination of measles and rubella from the Region.

On the positive side, the success of European Immunization Week had led the WHO regional offices for Africa and the Western Pacific to ask the WHO Regional Office for Europe for assistance in starting sister initiatives. In addition, the Region had made good progress towards eliminating malaria: the number of affected countries had fallen from nine in 2005 to five in 2009. Further, WHO's and countries' efforts during the influenza pandemic that had started in 2009 had borne fruit and provided some useful lessons, including the need for flexible preparedness plans and good communication with the public. The Regional Office was working with the European Centre for Disease Prevention and Control (ECDC) to evaluate the pandemic in seven countries, and had agreed on means to avoid double reporting of influenza surveillance data. In addition, the Regional Office was taking action in the Region against three global health threats. It was preparing a comprehensive action plan on multidrug-resistant and extensively drug-resistant tuberculosis (M/XDR-TB) and a regional strategy on antimicrobial resistance (AMR) building on the good work done by the EC and ECDC and other partners, and would develop a regional strategy for HIV/AIDS, aligned with the 2011–2015 Global Health Sector Strategy. Nevertheless, the Region had delivered antiretroviral therapy to 90% of HIV-positive pregnant women in low- and middle-income countries in 2008.

As to the Regional Office's third priority, the Fifth Ministerial Conference on Environment and Health, held in Parma, Italy in March, was a milestone in the European environment and health process. The regional framework for action on climate change, endorsed at Parma, would guide the Regional Office's work in the area and on the greening of health services.

Because noncommunicable diseases (NCDs) accounted for an important share of the burden of disease on the European Region, they remained a priority for the Regional Office. In 2008–2009, it had helped eight countries develop comprehensive national programmes for cancer control. It planned to help countries take action against mental ill health. It had continued working on health determinants, to address the shared risk factors for NCDs, and begun work on an action plan to implement the European strategy for the prevention and control of NCDs. In 2010, countries agreed that the Regional Office should develop a regional plan to implement the global strategy on harmful alcohol use and the European framework for alcohol policy. In contrast, the Region had made substantial progress in tobacco control. To combat overweight and promote good nutrition, the Regional Office had worked with Member States to reduce salt intake, facilitated six action networks, and recently discussed with industry ways to implement WHO standards and guidelines in food and drink production.

Finally, as part of efforts to strengthen the health and public health system, the Regional Office had helped countries plan their responses to the financial crisis and responded to requests for support with health reforms. Good progress had been made in implementing some provisions of the Tallinn Charter: "Health Systems for Health and Wealth", and the Regional Office would continue to help countries develop new national health policies and strategies, and implement and assess existing ones. In addition the Regional Office had supported health financing reforms in a number of countries. It was working to develop a strategy and help Member States to implement the new WHO code of practice on the international recruitment of health personnel, and had conducted several activities to improve the use of health technology and pharmaceuticals.

In closing, the Regional Director reaffirmed the Regional Office's determination to be relevant to every Member State in the diverse European Region and paid tribute to the staff's dedication to that goal.

Address by the Prime Minister of the Russian Federation



The Prime Minister said that the choice of his country as the venue for the sixtieth session of the Regional Committee reflected WHO's intention to make use of the Russian Federation's potential for cooperation in health care and in international programmes. The country's spending on health care had increased nearly fourfold since 2001. In 2005, federal and regional financial and administrative resources had been consolidated, and over 590 billion roubles had since been invested in health care, with another 440 billion roubles to be invested over the coming three years. Centres had been established in nearly all the regions of the country for the victims of cardiovascular disease and traffic accidents, oncology centres were being re-equipped, and centres for perinatal and high-technology medicine were being built.

Contrary to the warnings of a number of experts, competent specialists were willing to work in such centres in regions far from major cities. Since 2005, child mortality had been decreased by one third, despite an increasing birth rate, and, although life expectancy in the Russian Federation was lower than that in some other European countries, a clear positive trend could be seen. New legislation had been drafted concerning pharmaceuticals, and the law on mandatory health insurance would be amended to guarantee patients' right to choose a doctor, a medical establishment and an insurance company. The number of health centres was increasing rapidly, with 190 new centres opened in 2010 specifically for children and adolescents. Russian citizens were encouraged to take a more responsible approach to their own health, by rejecting harmful habits such as tobacco and alcohol use and dangerous driving.

Infectious diseases knew no frontiers, and the Russian Federation was ready to share its experience and technical assistance with neighbouring countries to establish an international monitoring system. His government had contributed the equivalent of more than US\$ 250 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and more than US\$ 430 million to public health worldwide between 2006 and 2011. He wished the participants in the meeting success in their deliberations.



General debate

In the debate that followed, many speakers thanked the Russian authorities for their warm hospitality, and several congratulated the Regional Director on taking office and praised the speed and effectiveness of the action taken under her authority thus far, particularly in the areas of partnerships, the response to the polio outbreak and action against influenza.

Almost all speakers, however, expressed strong support for the Regional Director's vision for change in the Regional Office and better health for Europe. In particular, a representative speaking on behalf of the European Union (EU) strongly endorsed both the vision and the seven strategic directions for its implementation, calling for strategic planning to include clear goals in a roadmap and time frame. Tackling the complex health challenges facing the world, the European Region required resolute leadership from the Regional Office and concerted action from Member States throughout the Region. The EU was committed to be guided by the Declaration of Alma-Ata, the Tallinn Charter and the Parma Declaration on the Environment and Health, and believed that a new European health policy, developed with Member States and other partners, would enable the Region both to respond to current challenges and to prepare for the future. In its work, the Regional Office should give more emphasis to the social determinants of health, health promotion and disease prevention, with particular focus on NCDs, mental health and the impact of the environment on health, all integrated with work on health systems. Other important issues included implementing the International Health Regulations (IHR) and tackling emerging health threats and infectious diseases such as MDR-TB. It was important for the Regional Office to focus on activities that would provide substantial added benefit to the Region, while taking advantage of synergies and avoiding duplication of work. The current study on social determinants would provide the necessary basis for the health policy. The speaker urged that the policy development process be in line with WHO's reform agenda and global strategies, and asked how Member States and other partners would take part in it during 2011 and 2012.

Governance of health in Europe and stronger collaboration with partners were vital to adapting to a changing environment; the speaker appreciated the Regional Director's emphasis on the roles of the Regional Committee and the Standing Committee of the Regional Committee (SCRC), and governance in the Regional Office, and asked whether the proposed high-level forum's functions would overlap with those of the SCRC. The EU fully agreed that the Regional Office's core strategic policy functions should be located within the Copenhagen office and welcomed the reviews of the GDOs and country offices. To allow sufficient time for discussion, the speaker proposed that the Regional Office share the results and proposals of the reviews with Member States during or before the World Health Assembly in May 2011.

Many other representatives, including one speaking on behalf of the countries in the SEE Health Network, joined the EU in endorsing the Regional Director's agenda for change and reform. They particularly welcomed the proposed European health policy, for reasons including countries' interest in developing their own policies; and action for better governance of the Regional Office, especially financing aspects and the notion of health as a broad governmental responsibility. One representative wondered how the programme budget could function as a contract between Member States and WHO when it represented only 30% of total resources; that showed the need to reform the budget process. Speakers welcomed the evidence-based approach to Health 2020, including the social determinants study, and endorsed the initiative led by the Director-General on financing for WHO. Others also valued the renewed emphasis on public health, strategic collaboration with Member States and the need for revitalized networks, particularly collaborating centres.

Representatives welcomed the renewed commitment of the Regional Office to public health and endorsed the priority issues identified by the Regional Director, stressing the importance of action on NCDs (including such problems as alcohol abuse), followed by health system strengthening (including support tailored to Member States), the environment and health, communicable diseases and health crises, where a coordinated response was particularly valuable. Various speakers raised additional issues of special importance in their countries. Several mentioned the impact of the global financial crisis on health; one thought the Regional Committee's discussion of evidence-based solutions for health inequalities was particularly relevant, and two thanked the Regional Office for supplying evidence and support to protect health resources from cuts. Others looked forward to the discussion of health

cooperation in foreign policy and stressed the importance of coordinated action on the Millennium Development Goals (MDGs). Representatives noted the harmful effects of climate change on health around the Aral Sea, expressed concern for the development of the European environment and health process and called for the environment and health sectors to cooperate on the sound management of obsolete chemicals, including pesticides.

A range of speakers offered suggestions and advice to the Regional Office and Member States on taking forward their ambitious agenda for change. One hoped that the Regional Office would maintain its speedy pace of work in dealing not only with health crises but also with tasks such as eliminating measles. Several focused on governance issues, calling for the Regional Office to continue to evolve its roles and management, optimize its management, rethink its relations with WHO headquarters and country offices, and keep the organization of its governing bodies simple and political considerations out of the process. One speaker highly praised the work of the country office in his country and asked that the Regional Office's new country strategy give special consideration to the relevance and value of country offices. Another suggested that subregional arrangements or partnerships would be particularly effective structures to address country needs. Representatives urged that partners be chosen on the basis of the value that their contributions would add to the work, welcomed the further advance of cooperation between the Regional Office and the EU and urged that ministers of health be included on the boards of organizations key to health cooperation such as the Global Fund, UNICEF, the World Bank, the European Investment Bank, OECD, the Council of Europe and the United Nations Economic Commission for Europe. A speaker noted the importance of partnership with the Global Fund, as the criteria for countries' eligibility for support needed review, and hoped that the issue would be raised not only in the Regional Committee but also at the Global Fund's board meeting in Bulgaria in December. Further, speakers called for priority issues to be selected based on health data, not resource availability, and hoped that the high-level meeting on NCDs scheduled to be held in Moscow in 2011 would be useful preparation for the United Nations summit to be held later that year.

Finally, speakers described successful initiatives of their countries in such areas as improving population health through strengthening the health system, developing health policies and programmes, reducing malaria, controlling tobacco and supporting the transition process in the Regional Office.

In reply, the Regional Director thanked Member States for their strong support of the seven strategic directions and the priority issues, assured them that all the proposed action would be taken and thanked all the countries that had raised issues. She responded to some of those. First, she was sure that Turkmenistan would be certified malaria-free by the end of 2010 and malaria elimination would be achieved in the Region by 2015. She thanked Switzerland for its financial support of the transition process and the study of the needs for change in the Regional Office.

For the proposed high-level forum, the Regional Director would ask each health ministry to appoint one person, at the level of the chief medical officer or equivalent, to help her with new developments, such as the European health policy and the study of social determinants. The forum would not bypass existing governing bodies but feed into their work and ensure Member States' involvement in policy development. The reviews of GDOs and country offices were under way and the Regional Office would provide Member States with the results for discussion during its meeting with them before the World Health Assembly. The first step would be discussion with the SCRC in November. The new country strategy would definitely safeguard valuable tools such as the biennial collaborative agreements (BCAs), but those needed to be balanced with other priorities and made more efficient. Further, considering the unpredictability of the programme budget, it was a challenge to use it as a strategic tool of accountability between the Regional Director and the Regional Committee but she would discuss the issue with the SCRC to seek a solution.

In addition, the Regional Office was happy to support countries in their responses to the economic crisis, which posed a danger to health. The Regional Director thanked the Minister of Health of Uzbekistan for his leadership in the response to the polio outbreak and for confirming the usefulness of the meeting organized by the Regional Office with the ministers of health of the central Asian countries and the Russian Federation the evening before the Regional Committee session started. She hoped another such meeting could be held before the World Health Assembly, to evaluate the poliomyelitis outbreak in Europe and to address such topics as measles and rubella and capacity-building for the IHR. She was aware of the health problems related to climate change around the Aral Sea and would be happy to discuss more WHO involvement in helping countries combat them.

The Regional Office was committed to making progress against the damage done to health by alcohol. The issue should be added to the list of priorities, and she hoped that the Regional Office would develop a policy on alcohol for 2011. She wanted to give more priority to NCDs and disease prevention within the approach of strengthening health systems.

The Committee adopted resolutions EUR/RC60/R1 and EUR/RC60/R2.



Report of the Seventeenth Standing Committee of the Regional Committee for Europe

(EUR/RC60/5, EUR/RC60/5 Add.1, EUR/RC60/Conf.Doc./2)

The Chairman of the Standing Committee noted that the Seventeenth SCRC had met six times during the year; in the interests of transparency, the reports of its individual meetings were made available on the Regional Office's web site. On the second day of the Seventeenth SCRC's second meeting, held in Ohrid, the former Yugoslav Republic of Macedonia in November 2009, the Regional Director nominee had outlined her vision of how best to tackle the priorities and challenges facing the Region and the Regional Office. The priorities she had identified included social inequities, the financial crisis, climate change and noncommunicable diseases. By reorganizing the Regional Office while ensuring that core functions remained in Copenhagen, and by strengthening the governance of the Organization at regional level (notably through sessions of the Regional Committee that attracted the participation of ministers and high-level representatives), she intended to make sure that the Regional Office would continue to be a leader in public health.

In addition to reviewing the action taken by the Secretariat to follow up resolutions adopted by the Regional Committee, the SCRC had been involved in reviewing papers prepared on technical and policy subjects for discussion at the current session. Individual members of the SCRC would present its views on those subjects under the corresponding agenda item.

The Committee adopted resolution EUR/RC60/R11.



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

(EUR/RC60/6)

The European member of the Executive Board designated to attend sessions of the SCRC as an observer noted that over two thirds of the resolutions adopted at the Sixty-third World Health Assembly in May 2010 were directly relevant to the WHO European Region. The Standing Committee wished to draw the Regional Committee's attention in particular to the following areas, in the context of the current session: partnerships (resolution WHA63.10), monitoring of the achievement of the Millennium Development Goals (WHA63.15), the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHA63.16), the WHO HIV/AIDS strategy for 2011–2015 (WHA63.19), infant and young child nutrition (WHA63.23), establishment of a consultative expert working group on research and development: financing and coordination (WHA63.28) and counterfeit medical products (decision).

One representative expressed the view, shared by the Regional Director and the Director-General, that an intersectoral approach was needed at both national and European levels to give effect to the Code of Practice on the International Recruitment of Health Personnel.

Governance of the WHO Regional Office for Europe

(EUR/RC60/11, EUR/RC60/Conf.Doc./5)



The Chair of the SCRC Working Group on Health Governance in the WHO European Region recalled that by resolution EUR/RC53/R1 the Regional Committee had requested the Standing Committee to report back at its sixtieth session on experience gained with the use of geographical grouping of countries for the purposes of selecting candidatures for nomination as members of the Executive Board and with a reduced periodicity of Board membership for those Member States in the European Region of WHO that were permanent members of the United Nations Security Council. In addition, the Regional Committee at its fifty-ninth session the previous year had requested the SCRC to report back at the current session on the governance of health in the European Region.

The Standing Committee had accordingly set up a four-member working group which had met on five occasions, held consultations with the Director-General and the Organization's Legal Counsel and made a presentation at a meeting of European delegations to the World Health Assembly in May 2010. The comments received from European Member States had been incorporated in its final recommendations.

Those recommendations, as reflected in an annex to the report of the Seventeenth Standing Committee (document EUR/RC60/5), could be grouped under six main headings:

- governance functions of the Regional Committee and the SCRC, including a stronger oversight role for the Standing Committee;
- membership of the Executive Board and the Standing Committee, including the use of four subregional groups of countries in nominations or elections to both bodies and maintenance of the current periodicity of semi-permanent membership of the Board;
- increased transparency of SCRC proceedings;
- a more streamlined process for nomination of the Regional Director, including changes to the name and role of the Regional Search Group;
- the timing and location of sessions of the Regional Committee and the Standing Committee; and
- harmonization of the Rules of Procedure of the Regional Committee and its Standing Committee with those of the World Health Assembly and the Executive Board.

The full text of the Rules of Procedure of the Regional Committee and its Standing Committee, showing the proposed amendments, was contained in an annex to the working paper under consideration (document EUR/RC60/11).

One representative, speaking on behalf of the EU, thanked the Working Group for its achievements. She welcomed the efforts to strengthen the oversight role of the SCRC and valued the consideration that it should be accompanied by greater transparency. The SCRC was encouraged to invite representatives of Member States and nongovernmental organizations to attend its meetings, as appropriate. An increased number of members of the Standing Committee would contribute to the involvement of all European Member States in the governance of the Organization; in the case of such an expansion, Rule 21 of the SCRC's Rules of Procedure (governing the constitution of a quorum) should also be amended. The EU was pleased that the use of subregional groups of countries was being formalized; that would ensure equitable geographical distribution for the membership of both the Executive Board and the SCRC. Lastly, the EU expressed explicit support for better coordination among European Member States during WHO governance meetings, notably at the Executive Board and the World Health Assembly.

Other representatives echoed those views, while calling for greater coherence between the agendas and priorities of the Organization's governing bodies at global and regional levels, and for more involvement of the Director-General in the process of electing regional directors. Another concern was that lifting the ban on dual membership of the SCRC and the Executive Board might paradoxically limit the involvement of a greater number of Member States. In response, the Director-General noted that the question of her involvement in the election of regional directors could only be discussed at global level.

The Committee adopted resolution EUR/RC60/R3 and agreed to increase the quorum for the Standing Committee (as set out in Rule 21 of its Rules of Procedure) from six to eight members.



Partnerships for health in the WHO European Region

(EUR/RC60/12, EUR/RC60/12 Add.1, EUR/RC60/Conf.Doc./6 Rev.1)

The Strategic Adviser to the Regional Director said that with the aim of building an alliance for better health in Europe, a strategic partnership with the European Commission – a shared vision for joint health action – was being proposed. Through the partnership, one health security system to protect Europe and one health information system to inform Europe would be developed; good practice and innovations would be shared; key research priorities would be jointly identified to maintain Europe's cutting edge in research; coalitions of different sectors would be created to tackle health inequalities; investment in health to mitigate the effects of the economic crisis would be advocated; and in-country cooperation would be strengthened. Such partnerships generated added value at the global and regional levels and were essential at country level. The framework for the future collaboration between the European Commission and the Regional Office, reflected in a joint declaration, gave new impetus to their longstanding collaboration and moved it from a project-based approach to a strategic one.

A member of the Standing Committee of the Regional Committee said that its members enthusiastically welcomed the fact that partnerships for health figured strongly in the Regional Director's vision. A lack of effective partnerships could compromise population health and heighten inequity in the distribution of services. Even between stakeholders with similar mandates and goals, partnership-building did not happen naturally: their individual structures and governance styles could be barriers to collaboration. Common goals and strategies must be sought through negotiations and a consultative approach. The partnership being forged with the European Union and its members was a good example of coalitions that resulted in health improvements for all countries. Good collaboration and dialogue with the European Commission was also central to achieving better policy coherence in the European Region. The key question to be discussed by the Regional Committee was how the various actors could ensure commitment to a common vision for health in Europe and make collaboration work to improve health in Member States.

In the panel discussion that followed, the Regional Director clarified her vision of the partnership strategy that she was to propose in 2011 by citing the need to adapt to changes affecting public health in Europe. With many more actors in the public health field, policy coherence at the regional level was all the more necessary: hence the idea of reviewing existing and new partnerships to see how to improve collaboration in Europe. The Regional Office's cooperation with the European Commission had so far been project-driven, but it seemed time to take it to a new level by focusing on priorities. For example, a single joint disease surveillance system in Europe should be created. Early warning and response systems should be unified and expanded, and work to counter antimicrobial resistance should be coordinated.

The European Commissioner for Health and Consumer Policy cited three salient issues. First, preventive measures were an investment in the future, yet European spending on them was extremely low: only 3% of overall health expenditure. Second, thanks to medical progress, people were living longer, but they must also have a healthy and active old age. Third, poor people were suffering poor health on a disproportionate basis: such inequities were an anathema to European values and must be redressed. The move from a project-by-project approach to a more structured one, based on priorities, would streamline reporting and the provision of statistics by Member States. The Executive Director, Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria said the Global Fund was the quintessential partnership, all parties working together to fight three diseases. Partnerships in health had been talked about for many years, but it was only fairly recently that they had been put into practice, with the formation of the Global Fund, the GAVI Alliance, the Stop TB Partnership and the Roll Back Malaria Partnership. Such partnerships had been spurred by the globalization of health threats and the recognition that joint efforts were needed to achieve success in combating them. Donors and those who carried out the work were equally represented in the governing bodies of many such partnerships. In such a context, policy coherence was important. The Fund provided only the financing requested by countries, on the basis of decisions by WHO on the nature of the intervention.

The Head, Health Division, OECD said his organization's focus was on the economic ramifications of health: in many countries, the health sector was larger than that of manufacturing. Much experience had been gained in devising ways for health information systems to share information, thereby conserving resources. While all partners did not always agree on what policies to adopt, open discussion generally reduced contradictory messages. Work was also being done to help countries learn from their health policy mistakes, for example, inadequate investment, low salaries and long waiting times. In view of the heavy flow of international migration, it was counterproductive to look solely at national policies on workforce issues and pharmaceuticals pricing. When players with various strengths as well as weaknesses brought them to the table, they could be capitalized upon and compensated for, respectively. His organization's strengths were in data development, cost effectiveness and links to various sectors, far less in public health.

A recent Member of the European Parliament said that he had seen the relationship of that institution with WHO become stronger and more effective over the past several years. While the link between poverty and health in developing countries had long been acknowledged, it had often been overlooked in Europe. Yet there, too, the objective should be healthy people in a healthy environment. Partnerships should be established between WHO and European institutions, between WHO and Member States and with nongovernmental organizations (NGOs), which represented the patients themselves. Patients were often the best experts on disease, as they lived with it every day. The impact of climate change on health could also not be ignored: it was creating new diseases and increasing the incidence of respiratory diseases, skin cancers and eyesight problems. Neglected diseases, for which small amounts of funding would make life so much more liveable for so many people, should be the target of the equivalent of the Global Fund.

The Chair, Steering Committee, European Observatory on Health Systems and Policies said its experience had conclusively shown the value of partnerships. The question was not whether to enter into a partnership but how to make it work. One of the lessons learned was never to compromise on good governance. All players must feel they were part of the decision-making process. Good will, trust and mutual respect were also among the keys to a good partnership. Like a marriage, a partnership was easy at the start: the hard part was to keep it going strong.

In the ensuing discussion, various examples were given of successful partnerships between ministries of health and technical and financing organizations. A representative speaking on behalf of the EU recalled that the World Health Assembly had adopted resolution WHA63.10, which outlined a policy for entering into health partnerships. She therefore supported the Regional Director's proposal to review the Regional Office's partnerships and clarify its relations with its main partners in order to reduce duplication of effort and unnecessary reporting. The European Commission and the Regional Office shared the same values and goals, which had been strengthened during their 10-year partnership, and the start of the mandates of both the Regional Director and the Health Commissioner was an auspicious moment for entering into a new phase of that relation. Mutual cooperation between the two would contribute to more efficient delivery of health actions to millions of people. She welcomed the draft resolution on partnerships in health but proposed an amendment to the fourth preambular paragraph.

A number of speakers endorsed the remarks of the representative who had spoken on behalf of the EU, emphasizing the usefulness of partnerships in work to remove health inequalities. Partnerships should be used in the most effective way, by setting priorities and clear, measurable objectives. The fundamental principle behind them should be clarity and transparency, with oversight maintained by Member States. Several speakers suggested that consideration should also be given to integrating initiatives with those of other bodies, including organizations outside the Region.

The representative of the Council of Europe said that the partnerships in south-eastern Europe had been so successful that various different projects had been transformed into a common programme. That had been accomplished by good governance, transparency and management of conflicts of interest.

The representative of EuroPharm Forum and the International Pharmaceutical Federation made a statement.

The Committee adopted resolution EUR/RC60/R4.

The shared vision for joint health action of the European Commission and the WHO Regional Office for Europe was formalized by an exchange of folders, which contained the joint declaration of the two organizations.



Address by the WHO Director-General



After giving the Regional Director best wishes for the first Regional Committee of her mandate, the Director-General said (Annex 5) that current crises outside the health sector required public health to be smarter, more strategic and more resourceful than ever before. The WHO European Region continued to pioneer policies and approaches that served public health everywhere, such as the Tallinn Charter, and to exercise leadership in the quest for a coherent global health policy, demonstrated at the EU high-level conference in June 2010. As acknowledged by the Parma Declaration, health officials needed to engage effectively with non-health sectors, which could be both the sources of solutions to and the unwitting causes of ill health.

Multiple global crises threatened the welcome but fragile health gains made since 2000. The MDGs had boosted international health development and evidence showed that investing in health was working. Great gains had been made in reducing under-5 and maternal mortality, TB and malaria, and increasing access to antiretroviral therapy. The global financial crisis and climate change in particular, however, endangered those global gains, as well as the European Region's work to eliminate measles and rubella and remain polio-free. In the current economic environment, the health sector, including WHO, had to fight not only for funding but also against fatigue and complacency, and the temptation to shift priorities. The information revolution had fuelled two new challenges: the rising public demand for high-quality care and the wider array of information sources that people used to form their views on health and health care. The latter had reduced the authority of public health advice, as shown by experience with the measles–mumps–rubella vaccine and the influenza pandemic.

WHO welcomed the scrutiny of its work during the pandemic by the Review Committee, set up under the IHR, as a means to improve its performance in preparation for the next public health emergency requiring an international response. While WHO was grateful that the pandemic had only been moderate, it recognized that many things could have been done better. Nevertheless, she had never seen any evidence that pharmaceutical or financial interests, rather than public health concerns or data, had influenced any of WHO's advice or decisions.

In conclusion, she repeated her call for public health to become smarter, more strategic and more resourceful. First, economic arguments were currently more effective in making the case for investing in health. Second, the right priorities and policies had to be chosen. This required strategic engagement at three levels, at each of which European countries and health ministries had done pioneering work: the delivery by the international community of life-saving interventions, strengthening fundamental health care capacities and infrastructures, and influencing the policy environment as shaped by all sectors. Third, innovative ways had to be found to finance health development and to cut waste and inefficiency. The 2010 world health report emphasized the latter, along with universal coverage, and the Director-General hoped that countries would use it and the Tallinn Charter to improve the financial sustainability of health systems in the European Region and beyond.

In the discussion that followed, all speakers reaffirmed their support for and trust in WHO. One representative urged WHO to redouble its efforts to help achieve the MDGs by the 2015 deadline, particularly MDG5 on maternal mortality. The forthcoming United Nations General Assembly session on the MDGs showed the importance of that task. Global challenges, such as the financial crisis and climate change, encouraged countries to cooperate to fight inequalities and support health systems. An actor such as WHO was essential to that work and its leading role should be strengthened to increase its authority. An informal meeting of EU health ministers in July had drawn lessons from the influenza pandemic, including the need for cooperation to complete the implementation of the IHR; for a mechanism for pooled vaccine purchase and negotiation of contracts with industry by Member States; for better coordination of public communication and risk analysis; and for a review to ensure that planning for a pandemic was flexible, proportionate and adapted to the seriousness of the threat. The ministers had also given priority to seeking a better response to cancer.

Other speakers agreed with the Director-General's analysis of current and future health challenges (particularly NCDs), the importance of learning from the pandemic, the global crises that threatened health and the growing links between health and politics. Lessons from the pandemic deserved public debate as part of preparation for the next public health emergency. In addition to proving the value of the IHR, the pandemic had shown the need for fundamental response capacity in countries, for countries' evaluation of their own responses, for exchange of information on the virus, its effects and medical countermeasures, and for international cooperation on vaccine procurement (in which international organizations should assist).

The General Assembly session on the MDGs and the 2011 summit on NCDs showed the growing importance of health in politics. Health ministers should make important contributions to each country's preparations for those, with strong leadership from WHO.

In reply the Director-General thanked countries for their support and, from her own experience, drew some lessons from the pandemic. The IHR provided a valuable framework, and countries needed to improve their surveillance and response capacity. The knowledge gap between technical experts and health ministers needed to be reduced. The challenge with vaccines arose from limited supply and capacity, which were based on limited regular demand. In one WHO region, pooled procurement had worked well, preventing both shortages and price differences. Communication was a challenge in two areas. First, countries needed to be able to explain to citizens why their responses differed from their neighbours'. Second, Member States and WHO needed to cope with the new information media and sources, which lacked validation but worked faster than traditional sources and health authorities. WHO needed to improve its skills in that area.

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Addressing key public health and health policy challenges in Europe

(EUR/RC60/13, EUR/RC60/Conf.Doc./7)

The Director, Programme Management at the Regional Office said that the proposed new European health policy would be formulated by adapting the Organization's Eleventh General Programme of Work to meet the epidemiological, political and institutional specificities of countries in the Region. The core of the new policy would be the revitalization of public health on the basis of existing commitments, such as HEALTH21, Health for All and the Tallinn Charter. To launch the participatory process that would be fundamental to formulating the new policy, a panel discussion had been organized, involving the Belgian Secretary of State for Social Affairs responsible for disabled persons; the Secretary of State for Health of Croatia; the Minister of Health and Social Services, Finland; the Chief Medical Officer, France; the Hungarian Secretary of State for Health Affairs; the Norwegian Minister of Health and Care Services; the Under-Secretary of State for Health, Poland; the High Commissioner of Health, Portugal; the Spanish Secretary-General of Health; the Slovenian Minister of Health; the Chief Medical Officer, Sweden; the Dean, Nordic School of Public Health; and the Director, International Institute for Society and Health, University College, London.

Throughout Europe, only 3% of health budgets was available for prevention; therefore, spending must be carefully targeted, especially towards vulnerable groups. In the face of the global economic crisis, health spending must be rationalized, with increased spending on prevention, while at the same time maintaining solidarity and equity. Panellists expressed support for the proposed European health policy, emphasizing that transparency was of paramount importance. That could be achieved through intersectoral consultations, public hearings and other means for ensuring participation. The 'health in all policies' approach, which Finland had introduced during its presidency of the EU, required health administrations to communicate with other sectors, making arguments for health while respecting the agendas of others.

Legislation was essential for equity in relation to the determinants of NCDs. Comparisons with policies in other countries were also useful, as in the case of the ban on tobacco smoking in public places, when one country could learn from the experience of others.

One speaker said the main challenge was to ensure a stable health policy and to sustain it through successive governments. In the face of reduced health spending owing to the global financial crisis, the public health approach to NCDs could be adapted by initiating prevention activities, centralizing specialized treatment and reorganizing care.

Policy must be based on evidence, which itself was derived from surveillance data. In order to make better use of such data, policy options should be based on research findings. Although clinicians would not prescribe a drug that had not been proven to be effective, they appeared to be willing to apply untested policies. The only way to be sure of the quality of the evidence linking broad social policies to population health was to conduct systematic reviews of the studies on which the evidence was based.

Public health was central to health policies, both for national health services and for dealing with emergencies. Although reform of primary health care could result in national health gains, national averages did not reflect disadvantaged groups, and one speaker recalled the words of the Director-General at the Sixty-third World Health Assembly: "If we miss the poor, we miss the point." WHO played an essential role in raising political commitment.

The collection of evidence was not enough; it must be packaged for use in advocacy and decision-making. Furthermore, good indicators to evaluate policies were still lacking. As most health outcomes changed only slowly, indicators were needed that were quickly sensitive to policies and others that were sensitive to long-term policies in which health was only one outcome. "Implementation science" was needed, which would include ways of convincing politicians that the addition of health equity to their policies would advance their own agendas.

Even in global crises, the basic values of universal coverage, solidarity and equity must be respected. Scarce resources should be used even more carefully, by investing in prevention, promotion and protection and in appropriate, high-quality, accessible care. Crises should be considered opportunities to introduce assessment tools and more cost-effective interventions.

Primary health care was more than a level of care in a health system, it was a process for health, and health for all was a vision: health systems were tools to materialize the vision. Health and medical services should be part of a comprehensive system in which the basic elements were linked by fair financing, universal access, efficient organization, good political governance and monitoring and evaluation. The voice of citizens was an unexploited resource for designing health services that met the needs and demands of society, and alliances should be built with other sectors, such as education. In 2006, the Regional Committee had approved a strategy for "Gaining health" by preventing and controlling NCDs. Unfortunately, that strategy had not yet been fully implemented.

On the subject of how citizens and civil society could be brought into the development and practical implementation of health policies, it was pointed out that people had different needs at different ages. In trying to change people's behaviour, it was important to integrate their perspectives.

The Director, International Institute for Society and Health, University College, London, recalled that health inequalities had been documented in the mid-nineteenth century, but the link between social policy and health was only now being made. He welcomed the fact that WHO had made social determinants of health a priority and noted that 23 countries in the Region had asked for assistance in such activities. The topic had been ignored through lack of understanding and lack of processes for implementation. The preceding panel discussion had shown that a movement towards health equity existed; it should now be fostered.

The European Commissioner for Health and Consumer Policy reiterated that health inequalities in, for instance, child mortality and life expectancy could not be tolerated. Prevention was a pillar on which health equity should be built; it was a reserve on which health for all could count. The operational hurdles of financial and human resources would have to be overcome by concerted planning and action within partnerships.

The Regional Director said that she was encouraged by the positive responses of panel members to the proposed European health policy. Although life expectancy in the Region had increased, there was a 20-year difference between the lowest and highest rates.

An integrated policy framework would improve health status while at the same time reducing inequities. It was clear that more resources should be invested in prevention, but they should be invested well, in such a way as to address the risk factors for NCDs, which represented the main disease burden. She agreed with panel members that intersectoral health policies were needed that were sustainable from one government to the next.

A representative speaking on behalf of the SEE Health Network said that the setting up or strengthening of public health services in the countries in the Network was a priority. He endorsed the draft resolution and the five health challenges identified in the document. Other representatives described the important place that public health held in their countries and welcomed the proposal for a new European health policy, which would provide a coherent framework for national policies. It should be based on a systematic review of the activities of all relevant organizations, including the Regional Office. Studies of the social determinants of NCDs would be faced with long-term challenges owing to demographic developments.

Statements were made on behalf of the European Coalition for Diabetes, the European Forum of National Nursing and Midwifery Associations, the Thalassaemia International Federation, the International Insulin Foundation and Alzheimer's Disease International.

The Committee adopted resolution EUR/RC60/R5.

Health in foreign policy and development cooperation

(EUR/RC60/14, EUR/RC60/Conf.Doc./8)

The Special Adviser to the Regional Director said that the way health systems were organized was a national concern, but because of the transnational nature of most health risks, foreign affairs increasingly entered into the protection of a population's health. United Nations General Assembly resolution A/RES/64/108 recognized the impact of foreign policy on global health, and the Oslo Ministerial Declaration went a step farther: the impact on global health should be a defining feature of foreign policy. By commissioning research, encouraging the development of global health diplomacy and supporting the Oslo Declaration Group, WHO had taken steps towards a deeper understanding of the relationship between foreign policy and global health. The Regional Office intended to continue the dialogue on foreign policy and health among key stakeholders; promote the systematic collation and analysis of information on foreign policy and health in the Region; and institute closer links with academia engaged in the interdisciplinary field of health and foreign policy.

A member of the Standing Committee of the Regional Committee said that the interaction of health, foreign and development policies was a challenge to policy coherence in several ways. First, coherence often needed to be established at national level between at least three ministries – health, foreign affairs and development cooperation – and sometimes those of trade, finance, the environment, science and planning. Second, there must be a continuum between national, European and global health policies; national policies could no longer be defined in isolation. Third, there must be coherence among the various international organizations and fora dealing with global health. Several Member States had taken steps to improve policy coherence in global health; he described the measures taken by his government towards that end. Policy coherence required specific commitments as well as patience, trust, capacity-building and exchange of experience.

In the panel discussion that followed, the Norwegian Ambassador on HIV/AIDS said that tremendous progress had been made in the three years since the Oslo Ministerial Declaration. The move towards health diplomacy and global governance for health must focus on trade, migration, humanitarian affairs and human rights.

The French Ambassador to the Russian Federation noted that diplomacy and health intersected in political and humanitarian crises like those in the Great Lakes region and Somalia; in development financing, free trade and intellectual property and marketing of medicines; and natural disasters and epidemics. In all those areas, the pragmatic expertise of health professionals could supplement the efforts of diplomats.

The Estonian Minister of Social Affairs cited the need for decisive action on both the national and international levels as a way of contributing to better health in Europe and worldwide. Even a small country like his own could play its part, given sufficient good will and energy, as evidenced by Estonia's involvement in disaster relief in Haiti, building up the hospital system in Afghanistan and developing the Tallinn Charter.

A Deputy Minister of Health of the Russian Federation enumerated some of the financial contributions her country had made, both individually and as part of the group of eight most industrialized nations (G8), towards the goal of global health. Obviously, that goal could not be achieved by financial contributions alone: her country had also established mobile epidemic prevention units and teams for intervening in emergency situations and introduced a comprehensive programme of training and organizational measures for the reduction of maternal and child mortality.

The Director-General for Health and Consumers of the European Commission pointed to some innovative aspects of the Treaty of Lisbon which, by enabling Europe to speak with one voice in foreign policy, would reinforce efforts to counteract transboundary threats to health. The EU considered trade, migration, security, development aid and climate change to be priorities for global health and looked to WHO for strong leadership in those areas.

The Head of the Convention Secretariat, WHO Framework Convention on Tobacco Control, suggested that the growing role of health in development policies should be analysed and that recent public health instruments should be reviewed for their links with foreign policy. The Framework Convention was the first concrete example of such links. Trade and intellectual property were addressed in the Convention, but most importantly, international law had been brought into the global health agenda, since the Convention was an international instrument.

The Director of the Global Health Programme, Graduate Institute of International and Development Studies, Geneva, said that the relationship between health and foreign policy could be viewed from four angles: foreign policy hindering health; health as an instrument for foreign policy; health as an integral part of foreign policy; and foreign policy as a means to achieve health. WHO should look into how health could be an outcome of or an entry point to good foreign policy.

In the discussion that followed, one representative, speaking on behalf of the EU, said that while efforts to achieve global health should be spearheaded by WHO headquarters, the European Region could develop its own instruments, while avoiding duplication. European priorities in the field of global health included universal access to high quality health care and policy coherence in the areas of trade and finance, security, immigration, food security and climate change. The strengthening of health systems and implementation of preventive measures were the best way to achieve global health. While the EU welcomed the draft resolution now before the Regional Committee, it would like to see the text aligned with the title through the replacement of the words "foreign policy" throughout with the phrase "foreign policy and development cooperation".

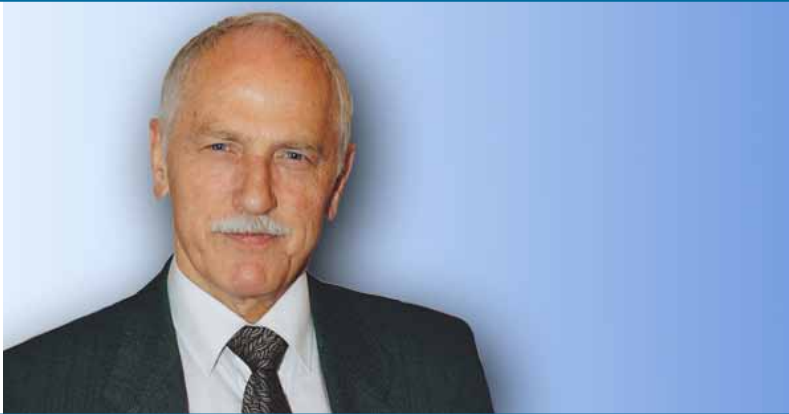
Two speakers referred to the special situations of countries whose health systems were stretched to cover much larger contingents than the national population, by virtue of migratory flows or for other reasons. One went on to describe how the link between foreign policy and health was manifested in small measures, such as the training of foreign students of medicine who could then return to their homelands to improve health care for their compatriots.

Another speaker, whose country was the beneficiary of international health initiatives, hoped to continue learning from other countries about their positive and less positive experiences. Capacity-building to train diplomats and health officials on foreign and health policy would be particularly welcome.

The Regional Director, replying to comments, affirmed that public health was increasingly global in nature. Its links with environmental issues were long established; the Tallinn Charter had marked the start of collaboration between the health and financial sectors. However, the intersection of public health and foreign policy was a relatively new topic, and the Regional Office was committed to promoting coherence in that area.

The Legal Adviser noted that the practical interaction between public health and foreign policy was actually played out in the arena of international law, as mentioned by one speaker. Such interplay was evident in the areas of trade, intellectual property, migration, the environment and human rights. The draft resolution before the Committee proposed tools to help public health officials deal with foreign policy matters, but in the negotiation of the Framework Convention, the need for legal tools for health professionals had also come to the fore.

The Committee adopted resolution EUR/RC60/R6.



Commemoration of Dr Jo Eirik Asvall

In commemoration of the Regional Director Emeritus, the late Dr Jo Eirik Asvall, two video films about his life and work were shown. The Regional Director and the Minister of Health and Care Services of his home country, Norway, made addresses describing his achievements and leadership in strengthening public health in Europe, as well as his life, and his daughter thanked the Regional Director for the commemoration on behalf of his family. Two speakers said that their schools of public health had established grants in his name. A memorial publication was distributed.



Future of the European environment and health process

(EUR/RC60/17, EUR/RC60/Conf.Doc./10)

The Coordinator, Environment and Health at the Regional Office recalled that the Fifth Ministerial Conference on Environment and Health, an important milestone in the 20 years of the European environment and health process, had been held in Parma, Italy, in March 2010. The Conference had adopted the Parma Declaration and Commitment to Act, supported by declarations from the European Commission and youth representatives. The two outcome documents addressed a number of areas for priority action, including the health risks to children and other vulnerable groups posed by poor environmental, working and living conditions, socioeconomic and gender inequalities, climate change, NCDs and toxic chemicals. For the first time, measurable targets were set for access to safe water and sanitation, opportunities for physical activity and a healthy diet, improved air quality and exposure to harmful substances.

Since the Conference, the Region had experienced volcanic eruptions, floods and numerous other extreme weather events (including, most recently, a heat-wave and extensive wildfires in the Russian Federation). Those underlined the importance of heightening preparedness, building technical capacity and rapidly exchanging and transferring knowledge and information, areas where WHO had a role to play as a broker in mobilizing expertise and providing support to Member States.

The European environment and health process was a very successful example of a “health in all policies” approach involving a multitude of stakeholders. Its continuation required appropriate political leadership, so the Conference had designed a strengthened governance mechanism: increased national ownership of and accountability for the Parma commitments, on the one hand, and a new international ministerial board to raise the political profile and leadership of the process, on the other. The accompanying task force would serve as a forum for exchanging best practices, steering work on meeting the commitments and identifying new challenges.

A member of the Standing Committee of the Regional Committee said that the SCRC had noted with pleasure the success of the Conference, which had generated great interest. It had been the culmination of a long preparatory process that had begun with a mid-term high-level review meeting in Vienna in 2007. Agreement had been reached by consensus at the Conference on the need to ensure an effective governance structure for the European environment and health process for the years to come. High-level political leadership should be exercised by a ministerial board, while a task force would be a way of sharing experience, networking and providing mutual support. The Standing Committee fully supported and endorsed the outcomes of the Conference.

A panel discussion was held, involving the Minister of Health, Cyprus; a representative of the Russian Ministry of Health and Social Development; the Permanent Secretary, Icelandic Ministry of Health; the Serbian Minister of Health; the Regional Director for Europe of the United Nations Environment Programme; the Deputy Executive Secretary of the United Nations Economic Commission for Europe; the Director-General for Health and Consumer Protection, European Commission; and the Head, International Relations, Belgian Federal Ministry of Food Chain Safety and Environment.

International cooperation was essential in environmental protection, as were effective partnerships across sectors, including the scientific community and professional associations. Mechanisms that could be used to promote political will included the formation of advisory committees, action plans with clear timeframes and the participation of ministers of health in the EU Council.

In the Russian Federation, health norms had been established in all sectors, including the commercial sector, with health monitoring in all regions. As an example of intersectoral cooperation, a government committee on biological and chemical safety comprised representatives of 10 ministries, although it was chaired by the Ministry of Health. Intersectoral cooperation had been put to the test in August, when a heat-wave and consequent fires in the countryside around Moscow had mobilized numerous services. The most important rule in intersectoral collaboration was clear definition of roles. Two other panellists gave examples of useful collaboration. The Permanent Secretary, Icelandic Ministry of Health described the response in her country to the eruption of the Ejaflajallayokul volcano, which had closely followed the procedures outlined in the IHR. Furthermore, the Regional Office had immediately set up an advisory group; the European Commission and ECDC had also provided advice. The Serbian Minister of Health described an energy efficiency programme in his country conducted in 2002 with the educational and social welfare sectors, which had resulted in the closure of numerous facilities in the centre of Belgrade or their conversion to natural gas. That had resulted in a 40% saving in energy and a 50% decrease in carbon dioxide emissions.

The representative of the United Nations Environment Programme said that, before instituting new initiatives, it would be important to strengthen existing ones, such as the pan-European initiative to help end poverty, the clean fuels initiative, negotiations to eliminate the effects of exposure to mercury, the strategic approach to international chemicals management, organic agriculture policies and environment and security initiatives.

Although some aspects of health were not directly related to the environment, people working in environmental protection could become involved in health if the priorities of both sectors were redefined. Links had already been made between health and water, transport pollution and heavy metals. A strong policy on the environment benefited health. The EU was the only region in which the health effects of all agricultural chemicals had been reviewed, and all carcinogenic, teratogenic and mutagenic chemicals had been phased out; industrial chemicals were now under review. In the fight against obesity and other lifestyle diseases, legislation had been passed on food content, reformulation of foods and advertising for children. Youth participation was emphasized in particular, to ensure increased awareness and understanding.

In order for the Parma Declaration and Commitment to Act to be implemented, politicians must familiarize themselves with their content. One message was that the environment and health were equally important and should move forwards simultaneously. Intersectoral cooperation would be advanced by establishment of the proposed European Environment and Health Ministerial Board. Partnerships must be formed with other bodies, including nongovernmental, youth and local organizations, to concretize political statements.

The Regional Director commented that the panel discussion had been an outstanding example of intersectoral cooperation. She noted that there was a clear consensus on the priorities set in Parma and on the continuance of partnerships. Action was urgent in view of the growing health inequalities of vulnerable groups and the effects of climate change.

In the ensuing discussion, the representative of one country, speaking on behalf of the EU, commended the Organization and the Member States on the Declaration and Commitment to Act. The EU had set some important targets in its recently adopted "Europe 2020" strategy, including raising the employment rate, investing more in research and innovation, increasing energy efficiency and the share of renewables in final energy consumption, and lifting people out of poverty and social exclusion. Those objectives were wholly in line with the targets set in the Commitment to Act. The EU welcomed the proposals for the future of the European environment and health process, including stronger political leadership.

Other representatives all congratulated the Regional Office and the host country, Italy, on the success of the Conference and welcomed the Parma Declaration, together with the Commitment to Act. Progress towards the targets set in the latter document should be monitored by means of predetermined indicators, while the work done as part of the European environment and health process should emphasize the link between environmental factors and the prevalence of NCDs.

The Conference had sent a clear signal that work on environment and health should continue: it was now up to all actors – not only from different sectors but also from different countries – to take up the challenges. Better information should be obtained about the main determinants of the health status of vulnerable groups (such as children, the elderly and the socially disadvantaged), in order to target interventions and even out social inequalities. The effects of climate change and natural disasters underlined the urgent need for adaptation measures and better public information; the Regional Office could give impetus and promote the exchange of experience in those areas.

The work of the Regional Office should be integrated in existing global mechanisms under the United Nations system. In that connection, the representative of one country welcomed the establishment of a "Friends of Public Health" group of negotiators working on the United Nations Framework Convention on Climate Change. Another speaker reaffirmed his country's commitment to raising awareness of the negative health impact of obsolete pesticides and other obsolete chemicals, as had been highlighted in World Health Assembly resolution WHA63.26 of May 2010.

A statement was made by the representative of the WHO Children's Environment and Health Action Plan for Europe (CEHAPE) Youth Network.

The Committee adopted resolution EUR/RC60/R7.

Address by the WHO Regional Director for the Eastern Mediterranean



The Regional Director for the Eastern Mediterranean recalled that that Region was experiencing a number of complex emergencies, such as in Afghanistan, Iraq, Pakistan, Somalia and the Sudan. The extent of the emergency in Pakistan following the recent flooding, in which nearly 19 million people had been displaced, was only beginning to be appreciated. After the catastrophic earthquake in Pakistan in October 2005, in which more than 35 000 people were killed within 7 minutes, it had been possible to prevent epidemics of infectious diseases such as cholera and poliomyelitis. In the current emergency, the main problem was a lack of safe drinking-water and the presence of huge amounts of water that provided breeding sites for mosquitoes. Malaria had therefore resurged, and epidemics of cholera and vector-borne diseases were expected. All stocks of insecticide-impregnated bednets and tents had been mobilized, but thousands more were needed. The first appeal for donations had been modest, as the extent of the aftermath of the flooding had not been foreseen. Many more resources were needed rapidly.

The Eastern Mediterranean Regional Office had for many years enjoyed a good relationship with the Regional Office for Europe. One example was the organization of concurrent immunization days in order to prevent epidemics in countries with shared borders. The Eastern Mediterranean Regional Office had long recognized the growing importance of NCDs and health security, and it had identified the central roles of poverty reduction and the empowerment of women in its community-based health initiatives.

One representative commented that the Regional Director for the Eastern Mediterranean had opened the eyes of the Committee to the extent of the challenges he faced. Many of the members represented countries that were leading donors, and they would take the message to the appropriate agencies. He was gratified to learn that, despite the catastrophic situations with which it had to deal, the Regional Office for the Eastern Mediterranean continued to address public health challenges. Long-term programmes to address NCDs formed the basis for ensuring prosperity and growth.

The Director-General added that the situation in Pakistan was the most severe that many humanitarian agencies had ever seen. The crisis was still evolving, requiring the mobilization of multiple sectors to provide clean water, sanitation, shelter and food, which would be required for at least 6–12 months. An interagency steering committee had therefore been set up to complement the activities of the emergency relief coordinator. The threat of cholera was being addressed with disease surveillance by a cholera control command centre. Only 50–60% of the necessary resources for relief and reconstruction were available, and she urged the Committee members to make further contributions.

One representative thanked the Regional Director for the Eastern Mediterranean for the support that he had provided for a meeting in Kabul in 2009, which had resulted in cooperation between Afghanistan and Turkmenistan on the prevention and treatment of infectious diseases.

The Regional Director for Europe welcomed the ongoing cooperation between the two regional offices. She expressed the hope that the MECACAR (Middle East, Caucasus and central Asian republics) project, for coordinated vaccination of children against poliomyelitis in 18 countries in the two regions, might be extended to other areas. She also recalled that common projects were helping the European Region to become malaria-free.



The future of financing for WHO

(EUR/RC60/18, EUR/RC60/Conf.Doc./12)

The Regional Director recalled that, during discussions on the budget at the sessions of the Executive Board and the World Health Assembly in 2009, the main issues raised had been ensuring better alignment of the priorities agreed upon by WHO's governing bodies with the available financial resources and ensuring more predictable financing to allow realistic planning and effective management. The Director-General had followed up by using the results of an informal consultation with senior officials from a representative group of countries to formulate a questionnaire, which had been posted on the Organization's website. The responses to the questionnaire would be combined with the outcomes of discussions in all the regional committee meetings in 2010, and a report would be prepared for the Executive Board at its 128th session. The Director-General had sent a note to all the regional committees asking them to highlight a few important issues.

Financing WHO was of particular relevance to European Member States because they played an active role in WHO's policy debates and overall strategic development and provided 53% of WHO's overall voluntary contributions from Member States and 43% of its total assessed contributions. Although the Eleventh General Programme of Work 2006–2015 laid down six core functions for WHO, the responses to the questionnaire showed that nearly all the Member States wanted a sharper definition of the Organization's role and a narrowing of priorities. That was of particular importance in the European Region, where there were also strong international and national partners.

It was suggested that the key functions of the Regional Office for Europe were carrying out normative and standard-setting work, offering evidence-based policy options to support national decision-making, engaging in partnerships and providing technical support to Member States. One country suggested that drafting international agreements in public health was another core function of WHO. Priority areas for the Region were NCDs, lifestyle-related conditions and social determinants of health; infectious diseases and related issues; maternal and child health; health systems development and environmental health.

The Regional Office's support to countries should be flexible but effective. A revised country strategy would be presented to the SCRC and discussed by the Regional Committee at its sixty-first session. It would include supporting Member States in translating the decisions of global and regional WHO governing bodies into national action and in coordinating aid from other partners.

With regard to the question of how the priorities agreed by WHO's governing bodies could be better aligned with the available financial resources, the Regional Director noted that there was currently a strong disconnect, with, for instance, 40% of all voluntary contributions going to communicable diseases, whereas chronic and noncommunicable diseases received 1.5% and social and economic determinants of health received only 0.6%. One reason for the obvious disparity might be global recognition of WHO's performance in communicable diseases and health security. Better communication and public information were therefore needed concerning its work in other fields.

The Regional Committee should address three basic issues to guide the Regional Director: the core functions and priorities that were particularly relevant to the Regional Office in the years ahead; what the Regional Office must do to secure adequate funding for those functions and priorities, and how the Regional Office could communicate the relevance and impact of its work and its value for health development to a wider European audience. Interesting, innovative schemes existed, which could be used by Member States to further their work with the Regional Office.

The SCRC member for Sweden noted that Member States in the Region had provided by far the most responses to the questionnaire, despite its complexity. At its meeting in June 2010, the Standing Committee had decided that, in view of the importance of the issue, European Member States might sponsor a resolution on the subject of the Organization's future financing. A resolution had been drafted by the Chairman of the SCRC and the Chair of the SCRC Working Group on Health Governance and circulated to the European members of the Executive Board and other members of the SCRC. Adoption of the resolution would demonstrate solidarity with the Director-General's search for a better, more sustainable mode of financing for the Organization in the years ahead.

The Chair asked the Assistant Director-General for Administration to share his impressions on how the topic had been addressed in the two regional committee meetings that he had so far attended. The Regional Office for Africa had received only a few responses to the web-based questionnaire, often because of technical difficulties. The consensus appeared to be, however, that the six core functions were clear and need not be changed. Similar conclusions had been reached at the meeting of the Regional Committee for South-East Asia. The consensus achieved so far from the responses to the questionnaire and the two regional committee sessions was that WHO should limit its actions to those for which it was best equipped, especially at a time of financial austerity. All agreed that its main role was in standard-setting and health security. A number of countries had suggested that WHO should play a more assertive role in public health globally, and others, especially in the African Region, considered that it should concentrate on health development. Views diverged on the approach that WHO should take in attracting financing.

A representative speaking on behalf of the EU said that the Council of the European Union in May 2010 had supported a strengthened leadership role for WHO at global, regional and national levels, in its normative and guidance functions and in technical support to health systems. It had asked EU member states to move away from earmarked funding for WHO towards funding its general budget. The priorities selected by the Council were therefore the same as those set out by the Director-General of WHO. The Organization should act more as a facilitator or a broker and less as a provider, so that technical support was given at a strategic rather than an operational level. Although it was important to involve nongovernmental organizations and private constituencies in the work of WHO, decisions must rest with Member States; further thought must be given to the involvement of regional economic integration organizations. WHO was urged to develop one, common, coherent approach for resource mobilization and to communicate it clearly to Member States through all levels of the Organization.

Other speakers reiterated that, in a climate of limited financial and human resources, the focus must be on core activities, which were standard-setting, coordination and health security, with a clear delegation of responsibility. Member States should ensure a certain coherence in the activities and priorities that they set for WHO, to reduce the number of unnecessary consultations and meetings and to remain effective; and WHO should reject demands from Member States that were not consistent with the set priorities. It was the responsibility of Member States to ensure that there was financing for the work plans they adopted.

A number of representatives announced that they would “un-earmark” as many of their contributions as possible to enable the Organization to implement the programme budget. WHO should be given more flexibility to use the funds it received and to reallocate unspent sums as it saw fit. One innovative form of partnership was described, in which the ministries of both health and foreign affairs had entered into a four-year funding agreement with WHO, bringing coherence and lack of duplication and resulting in concrete collaboration.

Several speakers raised the issue of the balance of funding from governments and other sources. The Organization must remain credible to the public in issuing guidelines and advice on public health issues. It must also remain credible to donors and Member States, by ensuring transparency and consistency in following up decisions taken in the governing bodies, especially with regard to allocation of funds. Clear objectives and priorities and thorough, timely performance reviews were of central importance. The proposed draft resolution was an important step in establishing a sustainable, predictable system for the future financing of WHO.

The Chair said that, in the document on the future of financing for WHO (EUR/RC60/18), attention should also be paid to improving nutritional practices in Member States by exploring options for food fortification to prevent micronutrient deficiency conditions. Furthermore, infectious diseases and related issues included harmonization of immunization programmes across the Region by using practical guidelines on best practices, and a further priority programme was that on poliomyelitis, in addition to those mentioned in the document.

The Director-General welcomed the guidance that had been given. Awareness was growing that Member States were the owners of WHO, and they were working more and more closely with the Secretariat in the management of WHO. She agreed with the comment that WHO should have the courage to say “No” to donors who offered funds for projects that were not priorities set by Member States, and she asked for their authorization to do so. The fault also lay with the donors. Member States should ensure coherence among different ministries, so that they were aware of the funding being proposed to all the United Nations agencies. She agreed also that better communication was needed, with the involvement of nongovernmental organizations and civil society. She hoped that the process would result in a more focused, more efficient and more credible Organization.

The Regional Director said that the current mismatch between funding and priorities reduced the credibility of WHO. That had come about partly owing to bilateral collaborative agreements. The draft resolution offered a way forwards. She agreed that a strategy for resource mobilization was needed, both at the level of WHO and for the Regional Office, to ensure that the different priorities would

be addressed. Furthermore, criteria were being drawn up for deciding on the allocation of funding. Technical programmes that were no longer priorities would be phased out, to make room and provide financing for programmes that met the needs of Member States. Transparency in both allocation of funding within the Organization and the coherence of work at different levels would be increased.

The Committee considered a draft resolution on the future of financing for WHO submitted by the former Yugoslav Republic of Macedonia, cosponsored by Andorra, Estonia, Germany, Monaco, Norway, Sweden and Switzerland and supported by Azerbaijan, the Russian Federation and the other countries of the European Union.

The Committee adopted resolution EUR/RC60/R8.

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Proposed programme budget 2012–2013

(EUR/RC60/10, EUR/RC60/10 Add.1,
EUR/RC60/Inf.Doc./1,
EUR/RC60/Conf.Doc./3)

A member of the Standing Committee said that two significant changes had been introduced in the draft proposed programme budget 2012–2013 as compared with 2010–2011: the budget breakdown was presented at strategic objective (SO) by major office level only; and a narrative section outlined the priorities and emphasis for each SO for 2012–2013, key achievements and challenges to date, new areas of work, areas to be given emphasis and changes required in the allocation of functions and staff throughout WHO. The proposed programme budget was presented in three segments: base programmes, comprising core programmes and functions of WHO; special programmes and collaborative arrangements (SPA); and outbreak and crisis response (OCR).

In the allocations for the Regional Office itself, the most prominent changes were increases in the budgets for SOs 3 and 6, which addressed NCDs, owing to their high contribution to the disease burden in European Member States; and in funding for SO 7, relating to the social determinants of health and specifically addressing health inequities. Efficiency gains in SOs 12 and 13 were being sought, their budgetary allocations being 5% below the level of expenditure in 2008–2010. In order to make the new vision for the Regional Office a reality, a new business plan had been prepared. It tackled the key issues of how better to align agreed priorities with the resources available to finance them and how to ensure greater predictability and stability of financing. The four pillars of the business plan were space to manoeuvre, financial risk, resource management, and accountability and transparency.

The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters, said the current global economic crisis had critical implications for health. The managerial priorities addressed in the draft proposed programme budget 2012–2013 included scaling up the impact of WHO's work at country level; review and alignment of the distribution of functions Organization-wide; and better allocation of resources. Programmatic focuses included redoubled efforts for maternal, newborn and child health, scaling up the work on NCDs, health systems strengthening and emergency preparedness and response. The overall budget for base programmes was largely unchanged from 2010–2011, while minor increases had been made in the SPA and OCR segments. Nevertheless, the draft proposed programme budget represented a reduction in real terms from the previous biennium, owing to the impact of inflation and increased operational costs, for example for staff and security. He drew attention to tables 1 and 4, entitled Budget summary by segment and Financing of the Programme Budget, respectively. WHO would continue its efforts to improve organizational efficiency through results-based management, cost reduction and management reforms.

The Director, Programme Management at the Regional Office said the draft proposed programme budget was aimed at linking ends with means and channelling funds where Europe needed them. However, the uncertainty caused by the fact that only the amount of assessed contributions for 2012–2013 was known was a major challenge for forward planning.

The Director, Division of Administration and Finance at the Regional Office said that since the Regional Office's budget for base programmes was to remain unchanged from the level of the previous biennium, the objective of focusing on certain SOs could be achieved only by making certain adjustments. There might be a resulting lack of coherence between the priorities set by Member States and the contributions available from donors. The budget was currently aspirational – only about 30% would be available at the start of the biennium. That threatened financial planning and implementation and made it difficult to attract the best staff, potentially resulting in a loss of quality in the Regional Office's work.

One representative speaking on behalf of the EU said that the continuing efforts to align results, available resources and programme implementation were very welcome. However, the underlying principles for budgetary allocation were not at all transparent. The imbalance between the commitments to communicable and noncommunicable diseases in the current and proposed programme budgets was regrettable, especially in light of the current strong emphasis on the latter. The reduced allocation for SO 4 was unfortunate in view of the urgency of addressing Millennium Development Goal 5, on maternal mortality. In the aftermath of the financial crisis, and with the need for budget restrictions in many Member States, voluntary funding for the Organization might well decrease, and caution should be exercised with regard to budgeting based on such funding. Despite the crisis, the Regional Office's budget should remain at the same level, and it was therefore regrettable that its share of assessed contributions was lower than that of any comparable regional office.

She requested clarification on the potential impact on planned activities of the significant reductions planned for SOs 10 and 11. It was unclear how the shift from policy to action and from research to implementation could be correlated with the Organization's core functions, on which the EU believed it should focus. The proposed increase in intergovernmental meetings should not raise travel costs to the Organization: the latest means of communication should be used in preference to travel. The efforts to reduce the budget for SOs 12 and 13 were therefore welcome. With regard to SO 6, she said the standard-setting work being done under the WHO Framework Convention on Tobacco Control should not be duplicated, and she called for clarification of the cooperation between the Tobacco Free Initiative and the Convention Secretariat.

Another speaker warned that assessed contributions were unlikely to increase, given the difficult worldwide economic situation, and that the trend towards the earmarking of voluntary contributions, which distorted the process of budgeting for WHO's priorities, should not be allowed to get out of hand. The major shortfall in funding was expected to be filled by core voluntary contributions from outside sources, but was that a realistic expectation against the backdrop of the financial crisis?

In other remarks, the need to finance the Capital Master Plan was emphasized. Clarification was sought on the rationale for the proposed reduction of funding for maternal health, in view of the current focus on that problem, and on how funding for SOs 12 and 13, which seemed at a fairly high level, was to be brought into line with organizational targets. Further improvements could be made in key performance indicators, in order to facilitate assessment of project delivery; the performance report should emphasize both outcomes and outputs.

The Assistant Director-General, General Management, WHO headquarters, responding to comments, said that the underlying assumptions for resource allocation had been set out in the validation mechanism agreed upon by the Executive Board. The problems cited with the alignment of resources with priorities could be solved by moving away from the earmarking of voluntary contributions, on the understanding that the Director-General would be held strictly accountable for resource use. The carry-over was due not to poor implementation but to uncertainty of future funds. The shift from research to action was in fact in line with the desire expressed by Member States to see how findings were translated into policies and interventions at country level. The shift did not imply that WHO's support for research was waning: on the contrary, a global research strategy had been adopted that very year.

Strategic objectives 12 and 13, for which the allocations had been said to be high, were often perceived as merely encompassing administrative functions, but they actually underpinned the Organization's essential policy functions: the meetings of governing bodies and intergovernmental working groups, negotiations, dissemination of information, scientific exchanges, country offices, translation and publications. On the use to be made of core voluntary contributions, he said a meeting was to be held very soon on that subject and all Member States had been invited to attend. Earmarking of voluntary contributions was not a problem in itself, but only when it impeded the matching of funds to priorities.

The Director, Planning, Resource Coordination and Performance Monitoring said the valuable comments made would be taken into account in refining the draft proposed programme budget. Concern had been expressed about the achievement of Millennium

Development Goals 4 and 5. It was SOs 4 and 9 that were crucial in that respect, and they would both receive much higher overall budget allocations than in 2008–2009: the budget proposed was an increase of 88% and 132%, respectively, against the implementation rates for those two SOs in 2008–2009. Noncommunicable diseases were covered by SOs 3 and 8, and the budget proposed allowed expansion of activities of 64% and 60%, respectively, in comparison with the implementation rates in 2008–2009. Participants who had expressed concern could rest assured that core voluntary contributions were allocated solely to SOs 1 to 11, the technical objectives. Of the total budget increase of US\$ 264 million proposed for 2012–2013, US\$ 51 million was for base programmes, while US\$ 213 million would go to special programmes and collaborative arrangements and to outbreak and crisis response, less than what was spent on those two segments in 2008–2009. He acknowledged the need to provide more information about the financing of the Capital Master Plan.

The Director, Programme Management welcomed the support expressed for the efforts to establish a logical correlation between SOs and resources and for increasing the volume of un-earmarked voluntary contributions. He took the comments on the discrepancy in funding for SOs 1, 2 and 3 to mean not that funds for the latter should be reduced but that those for the former two should be increased. He fully agreed on the need to do the utmost in the prevention and control of NCDs. Strategic objective 4, relating to children and the aging, also required increased attention. Synergies might be established between SOs 3, 4 and 6, dealing with the social determinants of health.

The Director, Division of Administration and Finance recalled that in 2008–2009 the implementation rate for SO 4 had been almost 100%, but the budget for 2012–2013 was much larger, so all of the funds might not be used. On the other hand, less funding was allocated for SO 10 in 2012–2013 than in 2008–2009. A study carried out by WHO headquarters on the allocations for SOs 12 and 13 in various regions had shown that the number of Member States in the region had a strong influence on the size of allocations. The European Region was the one with the largest number of countries as well as of languages used, which increased the costs of translation and publication. Nevertheless, everything possible would be done to reduce the “red tape” element in those SOs in the Region. The policy on travel and telephone use there was already the most restrictive in the Organization.

The Director-General, offering her thoughts on the overall nature of the budgeting process, said it was a planning exercise, with all the cumbersome aspects that that entailed. It was also somewhat unrealistic. Although she was grateful for the 20% of the budget that was assured funding – assessed contributions – as well as for the 80% that came from voluntary contributions, she was finding it increasingly difficult to deliver the goods. She needed help from Member States to keep WHO going as it had in the past. That was why the business model needed to be seriously rethought. The criteria used for allocations had to be revisited once decisions on the future of financing for WHO were taken.

The budget situation at present was not sustainable. The increase of US\$ 51 million in the financing for the base programme would not even offset the effect of currency fluctuations and meet operational and security needs. Her staff was projecting that the apparent budgetary increase would in fact come down to a decrease in funding. The shortfall for the previous biennium had been around US\$ 100 million, and for the current one, to date a US\$ 110 million deficit was projected. The danger was that the next biennium would begin with no resources for contract renewals, resulting in the need to close programmes down.

In order to turn that situation around, the way WHO operated must be changed: fewer meetings, more teleconferencing, less travel, fewer publications. Yet even those measures would result only in small savings. The Organization was doing its best to close the financing gaps: for example, she had put a freeze on recruitment at headquarters. However, Member States had decided to create new bodies – for example, to deal with the International Health Regulations and tobacco control – and that militated against savings. Progress had been made in reducing duplication of efforts, and partnerships would continue to be sought. But to make the financing of WHO viable, to make the Organization a better one, she needed the help of Member States. Together, they must embark on a journey of change.

The Regional Director warmly thanked the Director-General for attending so much of the current session of the Regional Committee and for her inspirational words and guidance.

The Committee adopted resolution EUR/RC60/R9.

Elections and nominations

(EUR/RC60/7 Rev.1, EUR/RC60/7 Rev.1 Add.1, EUR/RC60/7 Rev.1 Add.2, EUR/RC60/7 Rev.1 Add.3, EUR/RC60/7 Rev.1 Add.4)

The Committee met in private to nominate two candidates for membership of the Executive Board, to elect six members of the SCRC, one member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases and four members of the European Environment and Health Ministerial Board, and to nominate members of the Consultative Expert Working Group on Research and Development: Financing and Coordination.

Executive Board

The Committee decided that Switzerland and Uzbekistan would put forward their candidatures to the World Health Assembly in May 2011 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee selected Bulgaria, Croatia, Poland, Spain Turkey and the United Kingdom for membership of the SCRC. By drawing lots, it decided that the member from Bulgaria would serve a four-year term of office from September 2010, the member from Spain would serve a two-year term of office, while members from the remaining countries selected would serve a three-year term of office.

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 for Research and Training in Tropical Diseases, the Committee by consensus selected Portugal for membership of the Joint Coordinating Board of the Special Programme for a three-year period from 1 January 2011.

European Environment and Health Ministerial Board

The Committee selected France, Malta, Serbia and Slovenia for membership of the European Environment and Health Ministerial Board.

Consultative Expert Working Group on Research and Development: Financing and Coordination

The Regional Committee decided that the candidatures of the following experts would be forwarded to the WHO Director-General for consideration as members of the Consultative Expert Working Group:

Dr Ara Ter-Grigoryan (Armenia)
Professor Flemming Konradsen (Denmark)
Dr Meri Tuulikki Koivusalo (Finland)
Dr Jean Edmond Deregnacourt (France)
Ms Ursula Schaefer-Preuss (Germany)
Dr Benny Leshem (Israel)

Ms Ruzica Milutinovic (Montenegro)
 Dr John-Arne Røttingen (Norway)
 Dr Isabel Carvalho-Oliveira (Portugal)
 Professor Aurel Grossu (Republic of Moldova)
 Dr Antó Boqué (Spain)
 Dr Fernando Rodríguez-Artalejo (Spain)
 Dr Paul Linus Herrling (Switzerland)
 Mr Saul Walker (United Kingdom)
 Professor Albrecht Jahn (European Union).



Dates and places of regular sessions of the Regional Committee in 2011–2014

(EUR/RC60/Conf.Doc./11)

The Committee adopted resolution EUR/RC60/R10, by which it reconfirmed that it would hold its sixty-first session in Baku, Azerbaijan from 12 to 15 September 2011, its sixty-second session in Malta from 10 to 13 September 2012, its sixty-third session in Portugal from 16 to 19 September 2013 and its sixty-fourth session in Copenhagen in 2014 (on dates to be confirmed), and decided that, as from 2014, its sessions should be held in Copenhagen in even-numbered years whenever the proposed biennial programme budget was to be considered, as well as in years of nomination of the Regional Director.

A video projection was shown by the delegation of Azerbaijan.



Poliomyelitis eradication in the WHO European Region

(EUR/RC60/16, EUR/RC60/16 Add.1,
 EUR/RC60/Conf.Doc./9)

Introducing the item, the Director, Division of Communicable Diseases, Health Security and Environment described the current threat to the European Region's polio-free status and the steps needed to protect it until poliomyelitis (polio) could be eradicated worldwide. The Region needed to improve population immunity, increase its capacity to rapidly detect remaining transmission or new importation of wild poliovirus, and ensure credibility and trust between countries. Since the outbreak in Tajikistan had started at the beginning of 2010, the WHO regional reference laboratory in Moscow, Russian Federation had confirmed 456 polio cases in several countries, which comprised 73% of total cases worldwide. Both detection and response had been rapid. The vaccination

campaigns quickly organized by the Government of Tajikistan had had spectacular results, thanks to support from WHO, UNICEF and other partners in the Global Polio Eradication Initiative (GPEI). The reasons behind the outbreak were problems with immunization coverage, acute flaccid paralysis (AFP) surveillance, commitment and resources. Governments had made a multipronged response, supported by GPEI partners such as WHO, UNICEF, Rotary International and the United States Centers for Disease Control and Prevention (CDC).

The action plan to protect the European Region's polio-free status included short- and long-term elements. Action for 2010–2011 including stopping the outbreak in Tajikistan, preventing its spread to neighbouring countries, strengthening polio surveillance in high-risk countries and proving to the WHO European Regional Certification Commission for Poliomyelitis Eradication (RCC) that the outbreak was over. Action for 2011 and beyond would include ensuring certification-standard surveillance in all Member States, strengthening demand for routine immunization (particularly for isolated or vulnerable populations) and mobilizing resources.

A member of the SCRC echoed the call on the European Region to unite to address the current outbreak and maintain its polio-free status until the disease could be eliminated globally. The affected countries and GPEI partners deserved appreciation for their response and preventive activities. The fragility of the Region's polio-free status and the risk to all Member States required a united and mutually supportive response from the Region, including financial support and improved surveillance and reporting. Each Member State needed to ensure that its action plan on poliovirus importation was updated and ready to implement, to carry it out if needed and to review the status of and carry out catch-up immunization of susceptible groups of children aged under 5 years.

The Chair of the RCC explained its place in the global certification structure, methods and terms of reference, as well as the requirements for regional certification, as the basis for presenting its conclusions. Sadly, events in 2010 had justified the RCC's 2009 concerns about immunization and surveillance in Tajikistan and Uzbekistan. The 2010 RCC assessment showed that transmission risks continued in the European Region, with seven countries at high risk; action was needed right away. Member States needed to work with international partners to secure the necessary resources. They needed strong political commitment to stop poliovirus transmission and secure sustained financial support for eradication at the regional and global levels. The RCC appreciated the hard work of the regional reference laboratory in Moscow. Uzbekistan should supply the RCC with data to confirm the absence of polio cases in the country. Ukraine was at high risk of a large outbreak if polioviruses spread there. The Region needed to raise surveillance back to certification levels if it was to be certified polio-free when global certification was considered. The RCC would increasingly challenge unconvincing reports from national certification committees. Member States must complete and should test their national action plans for responding to importation of wild polioviruses.

A representative challenged the RCC's assessment of his country as at high risk of poliovirus transmission, stressing its commitment to improving health and particularly to reducing communicable diseases.

Speakers from several countries affected by the 2010 outbreak described their measures for response and prevention, including conducting supplementary immunization activities (SIAs) and strengthening surveillance and immunization. They thanked their partners in these tasks, particularly UNICEF, the regional reference laboratory in Moscow and the Regional Office. Especially helpful WHO initiatives included the meeting of central Asian countries and the Russian Federation before the 2010 World Health Assembly and the continuing work of the MECACAR programme. They emphasized their countries' commitment to keeping the Region polio-free. Another speaker described how her country had expressed its commitment to polio eradication by conducting SIAs in regions near other affected countries and donating resources to WHO, and expressed pride in the work of the regional reference laboratory.

Endorsing many of the points made in the discussion, the UNICEF Regional Director for Central and Eastern Europe and the Commonwealth of Independent States described UNICEF's contribution to the response to the 2010 outbreak, which included leading the vaccine supply, social mobilization and communication activities with GPEI partners. The outbreak was a wake-up call for all governments and partner agencies, alerting them to the continuing threat of vaccine-preventable diseases to the Region's children and the need to complete the unfinished agenda of ensuring equity, access and quality in immunization programmes. Disease outbreaks showed that protecting the most disadvantaged groups benefited the whole community. Countries in the Region had key assets, such as strong expertise in disease prevention and dedicated health staff. Coupled with political will and adequate funding, those would pave the way to eradicating vaccine-preventable diseases to the benefit of all.

In reply, the Director, Division of Communicable Diseases, Health Security and Environment identified the main message of the meeting as being that all parties recognized the seriousness of the situation in the Region and were determined to take the action required over the next few years. Rehabilitation services were needed for children who had been paralysed. Any country dissatisfied

with the RCC risk assessment was welcome to send data to the Regional Office that would correct the picture. Thanks were due to the Russian Federation for the work of the reference laboratory, and to other partners, including UNICEF, and staff working in the field. The Regional Director stressed that both WHO and Member States were fully committed to polio eradication. The response and prevention activities she had seen on her visits to Member States were very impressive. She endorsed the RCC's conclusions and had seen good progress in central Asian countries; action needed to be stepped up in other countries at risk. She thanked UNICEF for its productive partnership and praised the excellent work of Regional Office staff.

Renewed commitment to measles and rubella elimination and prevention of congenital rubella syndrome in the WHO European Region by 2015

(EUR/RC60/15, EUR/RC60/Conf.Doc./9)

The Director ad interim, Division of Noncommunicable Diseases and Health Promotion, said the elimination of measles and rubella in the Region remained an unfinished but reachable goal. High routine vaccination coverage supplemented by campaigns targeting the remaining susceptible groups had led to a 96% decrease in the number of cases of measles and a 97% reduction in rubella cases since 1990. Four proven strategies had been used. The first was to achieve and sustain over 95% coverage with two doses of measles vaccine and at least one of rubella. Owing to a combination of political and public complacency towards vaccination, however, many countries in the Region, especially in the EU, had low coverage. Moreover, low coverage of certain high-risk and vulnerable populations resulted in pockets of un-immunized or under-immunized people and outbreaks of measles.

The second strategy was to strengthen surveillance for measles, rubella and congenital rubella syndrome, and the third was to provide a second opportunity for measles vaccination through SIAs. The fourth strategy was to ensure the availability of good information for both health professionals and the public on the benefits and risks of vaccination, through, for instance, European Immunization Week. The Regional Office was creating further innovative approaches, including the use of social media.

Progress towards elimination of measles and rubella in the Region had thus been substantial, and the goal was technically attainable; however, the 2010 target would not be met, owing to pockets of low coverage and substandard surveillance. Elimination could be achieved by 2015 if action was accelerated and commitment was renewed. Emphasis should be placed on vaccinating high-risk and vulnerable populations with limited access to primary health care services for geographical, cultural, ethnic or sociocultural reasons. Furthermore, the public's trust in immunization must be restored through communication of evidence-based arguments to counter rumours. The Regional Office and its partners were ready to support Member States in achieving elimination.

A member of the SCRC said that the significant reductions in cases of measles and rubella in the Region since 1994 had been due to Member States' commitment to meeting the goals of the Measles Initiative and the funds provided for SIAs. Nevertheless, outbreaks of measles had occurred in the western part of the Region, and vaccine coverage for both diseases had declined gradually, for reasons that included religious beliefs, poor access to health care and anti-vaccination movements. Increased political commitment and financial resources were needed to reach the new goal of elimination by 2015.

One representative said that political commitment was the most important element in combating outbreaks of infectious diseases. It was unfortunate that the value of vaccination was being questioned, and he was not sure that WHO was in a position to address it by advocacy and technical support to countries. He proposed an amendment to the draft resolution, charging the proposed regional measles and rubella elimination verification commission with verifying the absence of indigenous measles and rubella transmission at country level.

Two representatives described the situations in their countries and the steps that were being taken towards elimination. Another representative underlined the importance of a well-executed, sustained vaccination programme in a well-organized public health system, in which surveillance, monitoring, notification, prevention and treatment were vital elements. One speaker said that a number of specialists considered that use of monovalent vaccines would be preferable to the trivalent products used currently, in order to increase the specificity of campaigns.

The Director ad interim, Division of Noncommunicable Diseases and Health Promotion, welcomed the expressions of political commitment to elimination of measles and rubella. In answer to questions regarding the feasibility and financial implications of acting on the proposed amendment to the draft resolution, she recalled that the term "elimination" was defined as the interruption of indigenous transmission in a large, defined geographical area. Each country would provide evidence of high coverage and effective surveillance to the regional verification commission, and interruption of transmission in each country would lead to elimination in the Region.

The Regional Director assured representatives that verification at country level would be feasible.

The Committee adopted resolution EUR/RC60/R12.

Resolutions

EUR/RC60/R1

Report of the Regional Director on the work of WHO in the European Region 2008–2009

The Regional Committee,

Having reviewed the Regional Director's report on the work of WHO in the European Region in 2008–2009 (document EUR/RC60/4) and the related information document on implementation of the 2008–2009 programme budget (document EUR/RC60/Inf.Doc./1 (PBPA/2008-2009));

1. THANKS the Regional Director for the report;
2. EXPRESSES its appreciation of the work done by the Regional Office in the biennium 2008–2009;
3. REQUESTS the Regional Director to take into account and reflect the suggestions made during the discussion at the sixtieth session when developing the Organization's programmes and carrying out the work of the Regional Office.

EUR/RC60/R2

Better health for Europe

Adapting the Regional Office for Europe to the changing European environment: the Regional Director's perspective

The Regional Committee,

Having considered the report Better health for Europe – Adapting the WHO Regional Office to the changing European environment: the Regional Director's perspective;¹

Recalling its previous resolutions on proposed changes to the Regional Office and its governance (EUR/RC49/R1, EUR/RC50/R1, EUR/RC51/R1, EUR/RC53/R1, EUR/RC58/R3), on renewal of the Health for All strategy (EUR/RC49/R9, EUR/RC53/R3, EUR/RC55/R4), on developing strategic partnerships (EUR/RC56/R3), on country offices and geographically dispersed offices (EUR/RC49/R5, EUR/RC50/R5, EUR/RC54/R6, EUR/RC55/R8) and on regular reporting and feedback to the Regional Committee (EUR/RC58/R5), as well as the report² and resolution (EUR/RC56/R3) it adopted on the future of the WHO Regional Office for Europe;

¹ Document EUR/RC60/8

² Document EUR/RC56/11

Mindful of the changing global and regional context in which the WHO Regional Office for Europe must work and the changing epidemiological environment, in which noncommunicable diseases have come to the fore, and mindful also of the increased scientific and technological opportunities for the prevention and management of disease;

Noting the seven key strategic priorities that have been proposed by the Regional Director, including most notably work to develop a new European health policy; changes to the arrangements for governance of the WHO Regional Office for Europe; transformation of the structure and content of its work; renewal of external relationships, most particularly those with its Member States; the building of diverse partnerships and coalitions for health in Europe; and the development of new information and communications activity;

1. ENDORSES the vision of "Better health for Europe," as outlined by the Regional Director, including the seven strategic priorities set out in her report, while taking into account existing national legislation and policies, as appropriate;
2. URGES Member States to support the further development and implementation of the vision and the European health policy;
3. NOTES and SUPPORTS the Regional Director's intention to review and adapt the Regional Office to present needs and opportunities;
4. REQUESTS the Regional Director to:
 - (a) implement her proposals for strengthening the work of the Regional Office and its dispersed and country offices in full respect of national competencies;
 - (b) promote relevance and excellence in the development of its technical programmes;
 - (c) further strengthen collaboration with Member States and other partners, particularly the European Union, with a view to making such collaboration more strategic and while taking advantage of synergies and avoiding duplication of work;
 - (d) take initiatives to mobilize the human and financial resources required for effective implementation of the vision;
 - (e) report back to the Regional Committee at its relevant sessions on the progress made, in line with the road map and time frame set out in the paper.

EUR/RC60/R3

Governance of the WHO Regional Office for Europe

Amendments to the methods of work and Rules of Procedure of the Regional Committee and of the Standing Committee of the Regional Committee

The Regional Committee,

Recalling the discussion which took place at its fifty-ninth session on governance of health in the WHO European Region, and the ensuing request that further consultations be undertaken by its Standing Committee on that issue;

Noting that, as a consequence, the Seventeenth Standing Committee decided at its session in November 2009 to establish an ad hoc working group on health governance in the WHO European Region;

Further noting that the Standing Committee has fully endorsed the whole set of recommendations regarding the methods of work and amendments to the Rules of Procedure of the Regional Committee and of the Standing Committee of the Regional Committee emanating from the Working Group's reviews and discussions with the Regional Director;

Having itself considered those recommendations, as contained in the report of the Regional Director on this subject (document EUR/RC60/11);

Mindful of the principle that all Member States in the European Region of WHO should have an equitable opportunity over time of participating in the work of both the Executive Board and of the Standing Committee;

Recalling its resolution EUR/RC53/R1 concerning membership of the Executive Board, and especially operative paragraph 5, in which it requested the Standing Committee to assess the experience gained in implementing the resolution and to report its findings to the Regional Committee in 2010;

1. ENDORSES the changes to the methods of work of the Regional Committee and of the Standing Committee of the Regional Committee outlined in document EUR/RC60/11;
2. ADOPTS the amendments to the Rules of Procedure of the Regional Committee and of the Standing Committee of the Regional Committee contained in the annex to document EUR/RC60/11, to be effective from the end of this session;
3. CONFIRMS that, in light of the experience gained in the implementation of resolution EUR/RC53/R1, the periodicity of membership of the WHO Executive Board for those Member States in the European Region of WHO that are permanent members of the United Nations Security Council should remain three out of six years;
4. RECOMMENDS that, in order to ensure an equitable geographical balance of membership, the selection of Member States in the European Region to submit candidatures for membership of the Board and of the Standing Committee should in future be governed by the subregional groupings of countries contained in part 1 of the annex to this resolution;
5. DECIDES that, notwithstanding the provisions of paragraphs 2 and 4 above, the increased membership of the Standing Committee, based on revised subregional groupings, shall take effect as from 2010;
6. CALLS ON Member States in the European Region of WHO to take account of the criteria contained in part 2 of the annex to this resolution when designating persons to serve on the Executive Board and on the Standing Committee;
7. REQUESTS the Standing Committee to initiate a cycle of comprehensive reviews of governance in the WHO European Region and to report back to the Regional Committee on lessons learned in this regard at such intervals as the Standing Committee itself deems appropriate.

Annex

Criteria for membership of the WHO Executive Board and of the Standing Committee of the WHO Regional Committee for Europe

Part 1: Subregional grouping of Member States

Group A: (17 Member States)

Belgium, Czech Republic, Denmark, Estonia, Finland, Germany, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Slovakia, Sweden, United Kingdom of Great Britain and Northern Ireland

This group would at all times have four members of the Standing Committee and two seats on the Executive Board, plus a third seat alternating with Group B.

Group B: (17 Member States)

Andorra, Austria, Bulgaria, Croatia, Cyprus, France, Greece, Hungary, Italy, Malta, Monaco, Portugal, Romania, San Marino, Slovenia, Spain, Switzerland

This group would at all times have four members of the Standing Committee and two seats on the Executive Board, plus a third seat alternating with Group A.

Group C: (19 Member States)

Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Israel, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, Uzbekistan

This group would at all times have four members of the Standing Committee and three seats on the Executive Board.

Part 2: Criteria for the selection of candidates to serve on the Executive Board and on the Standing Committee

A broad mix of skills and practical experience from public health as well as from national administration is desirable when considering the selection of candidates to serve on the Executive Board and on the Standing Committee.

The following criteria regarding experience and areas of competence are proposed:

- (a) current position in health administration in his/her country (or the position held in the near past) close to the political decision-making level;
- (b) experience of working with international organizations, WHO or other United Nations organizations;
- (c) ability to collaborate, coordinate and communicate within the country and between countries;
- (d) experience of coordinating high-level political and/or technical programmes, nationally (interregional, interministerial) or internationally (bilateral or intercountry);
- (e) availability and commitment;
- (f) gender (female candidates encouraged).

EUR/RC60/R4

Partnerships for health in the WHO European Region

The Regional Committee,

Having considered documents EUR/RC60/12 and EUR/RC60/12 Add.1 on partnerships for health in the WHO European Region;

Recalling its resolution EUR/RC56/R3 on the future of the WHO Regional Office for Europe, which endorsed the development of strong partnerships with other organizations;

Mindful that, in the light of the changing European and global environment, there is a need to review and adapt the work of the Regional Office, to develop a European health policy relevant for a diverse Europe and to build partnerships and coalitions for health in Europe;

Noting with satisfaction the ongoing reform of the Regional Office and the increased emphasis being placed on strengthening technical programmes, governance in the Region and partnerships by taking advantage of synergies, avoiding duplication of work, using harmonized data and reducing the burden of reporting;

1. ENDORSES and warmly supports the Regional Director's initiatives to improve strategic relations with key partners in public health in the European Region, starting with the European Commission;
2. URGES Member States to support the further development and implementation of a strengthened partnership for health in Europe and the building of coalitions for health;

3. WELCOMES the Joint Declaration by the European Commission and the WHO Regional Office for Europe.
4. REQUESTS the Regional Director to take note of the discussions and comments of the Regional Committee in:
 - (a) ensuring that partnerships should benefit all the Member States and emphasizing that cooperation at country level is essential to improving health;
 - (b) further negotiating and investigating modalities for strengthening relations with all partners for health, including the European Union and its institutions;
 - (c) developing a strategy for partnerships for health in the WHO European Region, to be presented to the Regional Committee at its sixty-first session.

EUR/RC60/R5

Addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region

The Regional Committee,

Having considered the report on Addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region;³

Mindful of the shared health challenges described therein;

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

Recognizing the continuing need to renew the commitment to comprehensive and coherent health policies and to focus on public health policies, functions and structures, as well as to strengthen European health systems and foster interregional collaboration;

1. AGREES that:
 - (a) a new European health policy inspired by the Organization's Eleventh General Programme of Work 2006–2015 (GPW), taken together with the strengthening of public health policies, strategies, functions and structures, offers an appropriate way to frame cohesive Region-wide action on future health policy;
 - (b) the most effective way to reduce health inequity, tackle health determinants, improve population health and ensure the sustainability of health systems is to pursue an approach based on Health for All, including Health in All Policies, that takes account of sound public health research, evidence-based policy and practice, and a health systems orientation;
 - (c) a common, adjustable framework for national health policies and strategies should be developed with the participation of Member States, to facilitate collaboration among a range of national and international partners and stakeholders;
2. ENDORSES the five avenues identified in the report for addressing key public health and health policy challenges in Europe, as a basis for the Regional Office's proposal to formulate a European health policy embedded in the vision of the new Regional Director, including:
 - (a) fostering partnerships with global, regional and national health actors;

³ Document EUR/RC60/13

- (b) improving health through a renewed commitment to strengthening health systems;
 - (c) strengthening public health capacity and services, including prevention;
 - (d) tackling structural issues in health systems, including consideration of the demographic shift (linkages between public health, health care services and intersectoral action); and
 - (e) carrying out a thorough review of the effectiveness of the public health instruments that are currently available;
3. REQUESTS Member States to collaborate in the development of a European health policy led by the WHO Regional Office for Europe and of a common framework for national health strategies and policies;
4. REQUESTS the Regional Director:
- (a) to develop a European health policy, as a coherent policy framework, through a participatory process involving Member States, the European Union and other partners (this policy framework will include a vision statement with values and principles as well as targets, goals and objectives and strategies);
 - (b) to promote renewed political commitment to the development or renewal of comprehensive national policies, strategies and plans, as a project driven by the Organization's Global Policy Group, and to ensure that WHO works hand in hand with its Member States to support them in their strategic developments to improve health outcomes and strengthen their health systems;
 - (c) to develop a renewed focus and rejuvenated commitment to public health capacity, function and services, and to make a real commitment to and investment in prevention and health promotion;
 - (d) to maintain a commitment to strengthening health systems (by building consensus, further clarifying, if necessary, the definitions, concepts, functions, and linkages involved, and developing practical tools and instruments for implementation);
 - (e) to review the public health tools and instruments for the 21st century;
 - (f) to make critical assessment of all ongoing activities, especially those in the area of standard setting and creating norms with a view to make best benefit of experiences and structures that exist in the region;
 - (g) in meeting all the above commitments, to work closely with Member States and other partners to guide this process.

EUR/RC60/R6

Health in foreign policy and development cooperation: public health is global health

The Regional Committee,

Recalling United Nations General Assembly resolutions A/RES/64/108 and A/RES/63/33 on Global health and foreign policy, and report A/64/365 submitted by the Secretary General, in close collaboration with the Director-General of the World Health Organization and in consultation with Member States, on *Global health and foreign policy: strategic opportunities and challenges*;

1. ACKNOWLEDGES the recommendations of the United Nations General Assembly on global health and foreign policy and development cooperation;
2. RECOGNIZES that global health is an integral component of achieving security, prosperity, equity and dignity at national level, across the WHO European Region and across the international community, and as such is a strategic interest of foreign, health and global policies;

3. URGES Member States to:
 - (a) consider health issues in the formulation of foreign policy and development cooperation;
 - (b) create stronger coherence between health and foreign policy and development cooperation;
 - (c) increase the training of diplomats and health officials in global health and foreign policy and development cooperation;
 - (d) improve foreign policy and development cooperation efforts on global health by working within existing health and non-health diplomatic forums to promote policy coherence and make health an integral dimension of other global policies;
 - (e) strengthen the political commitment to, and institutional foundations for, foreign policy and development cooperation action on global health;

4. REQUESTS the Regional Director to:
 - (a) support Member States in better integrating global health in foreign policy and development cooperation aims and processes and helping health ministries and health personnel to form a better understanding of foreign policy and development cooperation dynamics;
 - (b) identify priority issues for a health sector/foreign policy and development cooperation dialogue and assist with conducting such dialogues at regular intervals;
 - (c) analyse innovations in cross-government strategies and coordination processes that offer promising ways of improving foreign policy and development cooperation acumen, capabilities and performance in the area of global health;
 - (d) support research and analysis to generate a comprehensive picture of how global health and foreign policy and development cooperation are linked throughout the WHO European Region and to engage with national and regional schools of diplomacy and foreign affairs;
 - (e) contribute to strengthening the capacity of diplomats and health officials in global health diplomacy and develop training standards and open-source information, education and training resources for this purpose.

EUR/RC60/R7

The future of the European environment and health process

The Regional Committee,

Recalling its resolutions EUR/RC49/R4 and EUR/RC54/R3 on Environment and health, which endorsed the outcomes of the Third and Fourth Ministerial Conferences on Environment and Health, held in London in 1999 and in Budapest in 2004, respectively;

Recognizing that high priority should be given to achieving an environment conducive to health for all, particularly children and other vulnerable groups, in the European Region of WHO;

Appreciating the progress made towards achieving this aim over the past 20 years through the European environment and health process (EEHP), supported by the work of the WHO Regional Office for Europe and steered by the European Environment and Health Committee (EEHC) in partnership with Member States, bodies of the United Nations system and other intergovernmental and nongovernmental organizations, as well as the European Commission;

Acknowledging the need to continue and strengthen the EEHP, which will continue to make a major contribution to the health of people in the WHO European Region in the 21st century, especially by reducing the burden of noncommunicable, infectious and chronic diseases attributable to current and emerging environmental risk factors;

1. EXPRESSES ITS GRATITUDE to the EEHC for its role in steering the environment and health process in the WHO European Region in the past;
2. EXPRESSES ITS GRATITUDE to the Italian Government and the Municipality of Parma for hosting the Fifth Ministerial Conference on Environment and Health in Parma from 10 to 12 March 2010 and for their organizational and financial contribution to it;
3. EXPRESSES ITS GRATITUDE to the WHO Regional Office for Europe for its role in the successful organization of the Fifth Ministerial Conference on Environment and Health and as the secretariat of the EEHP since 1989, and in particular for the technical work of its European Centre for Environment and Health (with offices in Rome and Bonn) in providing expertise and assistance to Member States and other stakeholders and partners with the implementation of the commitments made through the EEHP and the series of ministerial conferences on environment and health;
4. ENDORSES the decisions of the Fifth Ministerial Conference on Environment and Health, as included in the Parma Declaration on Environment and Health and the working paper entitled *The European Environment and Health Process (2010–2016): Institutional framework*,⁴
5. WELCOMES the support for the EEHP and the Parma commitments expressed through the Declaration of the European Commission and the Parma Youth Declaration;
6. RECOGNIZES the need to establish effective mechanisms for coordinating technical and financial collaboration across sectors, among countries and among all stakeholders and partners, in order to stimulate legislative and institutional reforms, strengthen countries' capacities and effectively reduce exposures to environmental hazards, while focusing on those activities that will deliver a substantial added benefit to the region without duplicating activities and resources;
7. RECOGNIZES the need to provide an adequate political profile and leadership to the EEHP;
8. ENDORSES the establishment, as set out in The European Environment and Health Process (2010–2016): Institutional framework, of:
 - (a) the European Environment and Health Task Force (EHTF) as the leading international intersectoral body for implementation and monitoring of the EEHP; and
 - (b) the European Environment and Health Ministerial Board (EHMB), which will be the political face and driving force of international policies in the field of environment and health for implementation of the commitments made within the EEHP;
9. REQUESTS the EHMB and EHTF to convene according to the schedule endorsed at the Fifth Ministerial Conference and the EHMB to report annually to the WHO Regional Committee for Europe and the United Nations Economic Commission for Europe (UNECE) Committee on Environmental Policy on achievements and areas needing greater efforts, as well as on the EHMB's and EHTF's activities, work plans and financial requirements;
10. URGES Member States⁵ to:
 - (a) make every effort, in cooperation with all other stakeholders and partners, to realize the commitments agreed upon at the Fifth Ministerial Conference;
 - (b) pay particular attention to achieving the five measurable targets set out in the Parma Declaration on Environment and Health and the Commitment to Act;

⁴ Document EUR/55934/7, http://www.euro.who.int/__data/assets/pdf_file/0016/104443/Parma_EH_Conf_edoc07.pdf.

⁵ And, where applicable, regional economic integration organizations.

- (c) act on the key environment and health challenges of our time, which include:
 - (i) the health and environmental impacts of climate change and related policies;
 - (ii) the health risks to children and other vulnerable groups posed by poor environmental, working and living conditions (especially the lack of water and sanitation);
 - (iii) socioeconomic and gender inequalities in the human environment and health, amplified by the financial crisis;
 - (iv) the burden of noncommunicable diseases, in particular to the extent that it can be reduced through adequate policies in areas such as urban development, transport, food safety and nutrition, and living and working environments;
 - (v) concerns raised by persistent, endocrine-disrupting and bio-accumulating harmful chemicals and (nano)particles, and by novel and emerging issues;
 - (vi) insufficient resources in parts of the WHO European Region;
 - (d) set up or strengthen existing mechanisms or structures that can ensure effective implementation, promote local actions and ensure active participation in the EEHP, foster strategic partnerships and networks and ensure that youth participation is facilitated across all Member States at both national and international levels;
 - (e) intensify efforts to develop, improve and implement health and environmental legislation and to continue health system reforms as necessary, particularly in the newly independent states and countries of south-eastern Europe, aimed at streamlining, upgrading and strengthening the performance of public health and environmental services;
 - (f) advocate for and invest in sustainable and environmentally friendly and health-promoting technologies, emphasizing the opportunities created by these activities, such as energy-efficient health services and green jobs;
 - (g) share in providing the necessary financial support to the WHO Regional Office for Europe's environment and health activities, and in particular to the WHO European Centre for Environment and Health;
11. REQUESTS the Regional Director to:
- (a) continue to support implementation of the decisions taken at previous ministerial conferences on environment and health, and in particular the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes, and the Charter on Transport, Environment and Health, as developed in the joint WHO-UNECE Transport, Health and Environment Pan-European Programme;
 - (b) continue to provide leadership to the EEHP by further promoting the Regional Office's and country offices' activities in relation to environment and health, with special attention to vulnerable population groups and particularly addressing the social and gender inequalities in environment and health;
 - (c) pay special attention to fostering strategic partnerships and networks, so that environment and health issues are better integrated across the policies of all sectors;
 - (d) continue to act as secretariat of the EEHP as set out in the Parma Declaration and *The European Environment and Health Process (2010–2016): Institutional framework* and, for that purpose, to provide the necessary human, financial and organizational resources and capacity;
 - (e) mobilize international resources to support country implementation of the decisions taken at the Parma Conference.

EUR/RC60/R8

The future of financing for WHO

The Regional Committee,

Having considered the report by the Regional Director on the future of financing for WHO;

Recalling WHO's role as the directing and coordinating authority on international health work, and the active role that European Member States play in WHO's policy debates and overall development;

Recalling further the fact that contributions from European Member States account for more than 50% of the Organization's overall financing and that the topic, as a consequence, is of particular relevance to this Region;

Recognizing that the current mode of financing WHO, with around two thirds of the overall budget coming from highly specified voluntary contributions, poses serious challenges to WHO;

Recognizing further that better mechanisms need to be found to align the priorities agreed by WHO's governing bodies with the monies available to finance them, thus ensuring greater predictability and stability of financing;

Supporting an increased leadership of WHO at global, regional and country levels in its normative and guidance functions addressing global health challenges, as well as in its technical support to health systems governance and health policy;

1. REQUESTS the Regional Director:
 - (a) to convey to the Director-General its views, comments and suggestions on the future of financing for WHO and related global health governance challenges for inclusion in the Director General's report to the Executive Board at its 128th session on this issue;
 - (b) to support the Director-General and European Member States in a results-oriented process to clarify and strengthen WHO's role in global health governance, as well as in the development of mechanisms to facilitate adequate long-term funding of the Organization's priorities;
2. URGES Member States:
 - (a) to collaborate actively in regional and global efforts to clarify and strengthen WHO's role in global health governance, as well as in the ongoing debate on the Organization's future financing;
 - (b) to the extent that national budgetary processes permit, to gradually move away from earmarked WHO funding towards funding its general budget, which better reflects policies and strategies collectively agreed in the Organization's governing bodies.

EUR/RC60/R9

Proposed programme budget for 2012–2013

The Regional Committee,

Having reviewed the proposed programme budget for the biennium 2012–2013 (document EUR/RC60/10) and the regional perspective thereon (EUR/RC60/10 Add.1), and having taken note of the comments made in this respect by the Standing Committee of the Regional Committee and the Regional Committee;

Welcoming the continuing efforts made throughout the Organization to present a more focused budget aligned to a longer-term strategic vision covering three biennia, as articulated in the medium-term strategic plan through its objectives;
Noting that the budget proposals are in accordance with resolution EUR/RC47/R9, which requested the Regional Director to prepare the regional perspective of the programme budget in accordance with the principles used for presentation of the global programme budget, while at the same time reflecting the regional priorities and specificities;

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

Noting with concern the continuing imbalance between key health priorities endorsed by European Member States of the Organization and the designated voluntary funding for such priorities;

1. NOTES the global proposed programme budget 2012–2013 contained in document EUR/RC60/10, which is to be financed by assessed contributions and voluntary contributions, to the extent that the latter become available;
2. ENDORSES the strategic directions contained in the document "Proposed programme budget 2012–2013 – the European Region's perspective" (EUR/RC60/10 Add.1);
3. REQUESTS the Regional Director to convey to the Director-General the views, comments and suggestions expressed by the Regional Committee on the proposed programme budget document, for these to be taken into consideration during its finalization;
4. REQUESTS the Regional Director also to convey to the Director-General that the Regional Committee suggests a further strengthening of the mechanisms and principles used to allocate centrally managed resources among the Organization's major offices;
5. REQUESTS the Regional Director (following the approval of the global programme budget by the World Health Assembly in 2011) to prepare and submit (in collaboration with the Standing Committee of the Regional Committee) a package of performance indicators and a list of key deliverables to the Regional Committee at its sixty-first session in order to strengthen the governance and oversight function of the Regional Committee;
6. URGES Member States to keep agreed priorities in mind whenever voluntary contributions are to be attributed to the work of WHO.

EUR/RC60/R10

Date and place of future sessions of the Regional Committee in 2011–2014

The Regional Committee,

Recalling its resolution EUR/RC59/R6 adopted at its fifty-ninth session;

1. RECONFIRMS that the sixty-first session shall be held in Baku, Azerbaijan from 12 to 15 September 2011;
2. RECONFIRMS that the sixty-second session shall be held in Malta from 10 to 13 September 2012;
3. RECONFIRMS that the sixty-third session shall be held in Portugal from 16 to 19 September 2013;
4. RECONFIRMS that the sixty-fourth session shall be held in Copenhagen in 2014, on dates to be confirmed;

5. DECIDES that, as from 2014, sessions of the Regional Committee should be held in Copenhagen in even-numbered years whenever the proposed biennial programme budget is to be considered, as well as in years of nomination of the Regional Director.

EUR/RC60/R11

Report of the Seventeenth Standing Committee of the Regional Committee

The Regional Committee,

Having reviewed the report of the Seventeenth Standing Committee of the Regional Committee (documents EUR/RC60/5 and EUR/RC60/5 Add.1);

1. THANKS the Chairperson and the members of the Standing Committee for their work on behalf of the Regional Committee;
2. INVITES the Standing Committee to pursue its work on the basis of the discussions held and resolutions adopted by the Regional Committee at its sixtieth session;
3. REQUESTS the Regional Director to take action, as appropriate, on the conclusions and proposals contained in the report of the Standing Committee, taking fully into account the proposals and suggestions made by the Regional Committee at its sixtieth session, as recorded in the report of the session.

EUR/RC60/R12

Renewed commitment to elimination of measles and rubella and prevention of congenital rubella syndrome by 2015 and Sustained support for polio-free status in the WHO European Region

The Regional Committee,

Recalling World Health Assembly resolutions WHA41.28 on global eradication of poliomyelitis by the year 2000; WHA56.20 on reducing global measles mortality; WHA58.15 on global immunization strategy (in which the Health Assembly welcomed the Global Immunization Vision and Strategy as the framework for strengthening of national immunization programmes and noted *inter alia* that a reduction in measles mortality would help towards attainment of Millennium Development Goal 4 of reducing the under-five mortality rate), and WHA61.1 on poliomyelitis: mechanism for management of potential risks to eradication, as well as its resolutions EUR/RC50/R3 on poliomyelitis eradication and maintaining polio-free status in the WHO European Region and EUR/RC55/R7 on strengthening national immunization systems through measles and rubella elimination and prevention of congenital rubella infection in WHO's European Region; all of which respond to the need for immunization to improve the health of all through the reduction of morbidity and mortality due to vaccine-preventable diseases;

Appreciating the progress made by Member States towards the European regional goals of eliminating measles and rubella in 2010 by implementing the components of the strategic plan while ensuring ongoing high-level advocacy through the annual European Immunization Week, but concerned by the alarming threat to the European regional goal posed by the increasing number of measles cases and outbreaks, specifically in the central and western part of the Region;

Acknowledging that the European regional goals of eliminating measles and rubella are achievable but that there are remaining challenges that need to be addressed by Member States through high-level political commitment and sustained mobilization of resources;

Remembering that the European Region was declared poliomyelitis-free on 21 June 2002 and alarmed therefore by the recent polio outbreak in Tajikistan through importation of the virus from an endemic country;

Recognizing the potential risk of the further spread of poliomyelitis in the Region owing to existing gaps in immunization coverage, especially among vulnerable populations, and the need for financial resources to respond rapidly to future outbreaks;

Appreciating the rapid measures taken by Tajikistan in response to the recent importation of wild poliovirus, and commending the central Asian republics and other countries on their preventive measures to strengthen surveillance and increase coverage with polio vaccine;

Having considered the reports on renewed commitment to measles and rubella elimination and prevention of congenital rubella syndrome in the WHO European Region by 2015⁶ and on poliomyelitis eradication in the WHO European Region;⁷

1. EXPRESSES REGRET over the deaths and disabilities due to poliomyelitis;
2. URGES Tajikistan and all other countries in the Region to maintain high-quality surveillance of acute flaccid paralysis (AFP) and strengthen immunization coverage;
3. ENDORSES:
 - (a) the new target date of 2015 for the European regional goals of eliminating measles and rubella while renewing its commitment to achieving those goals;
 - (b) the need to reaffirm its commitment to sustaining polio-free status in the European Region;
4. URGES all Member States:
 - (a) to review and reinforce their political commitment and the human and financial resources required to accelerate actions to achieve the goals of measles and rubella elimination;
 - (b) to review and reinforce their political commitment and the human and financial resources required to maintain polio-free status, including responding rapidly to importation of wild poliovirus;
 - (c) to achieve high immunization coverage⁸ at subnational levels and monitor progress towards targets by:
 - (i) strengthening routine immunization services and conducting supplementary immunization activities, as needed, focusing on high-risk and vulnerable populations and ensuring the use of effective risk communication strategies;
 - (ii) ensuring the continuous availability of quality vaccines administered through safe injection practices; and
 - (iii) utilizing European Immunization Week as an advocacy tool, especially to respond to anti-vaccination strategies;
 - (d) to engage in partnerships, public and private, using a multisectoral approach, to ensure that polio-free status is maintained and that the European regional goals of eliminating measles and rubella are attained;
 - (e) to achieve measles and rubella elimination by:
 - (i) implementing and strengthening case-based surveillance using the existing WHO-accredited laboratory network for measles, rubella and congenital rubella syndrome, in order to monitor indicators for verifying attainment of the elimination goals;

⁶ Document EUR/RC60/15

⁷ Document EUR/RC60/16

⁸ 90% or greater for polio vaccine; and 95% or greater for two doses of measles and rubella vaccine.

- (ii) developing or revising national elimination plans to address all components of the measles and rubella elimination strategy, especially immunization of susceptible populations, and conducting supplementary immunization activities as required to ensure two doses of a measles-containing vaccine; and
 - (iii) establishing a national measles and rubella elimination verification committee to document progress towards measles and rubella elimination and report to a regional verification commission;
 - (f) to sustain polio-free status by:
 - (i) maintaining and reinforcing certification-level surveillance for polioviruses, using the existing WHO-accredited laboratory network for poliomyelitis, in line with the core capacity requirements of the International Health Regulations;
 - (ii) maintaining requirements for laboratory containment of wild poliovirus; and
 - (iii) updating national preparedness plans to respond rapidly in the event of an importation of wild poliovirus;
5. REQUESTS the Regional Director:
- (a) to provide leadership, strategic direction and technical guidance to Member States and specifically in coordinating the annual European Immunization Week, in order to achieve the regional immunization goals;
 - (b) to engage in global and regional partnerships, to advocate for commitment and resources to strengthen and sustain immunization services, and to prevent and control vaccine-preventable diseases, including poliomyelitis eradication and measles and rubella elimination;
 - (c) to establish a regional measles and rubella elimination verification commission in order to review Member States' documentation and verify elimination of measles and rubella in the Region and at country level verify that each country is free from indigenous measles and rubella transmission;
 - (d) to facilitate the exchange of best practices and experiences among Member States on poliomyelitis eradication and measles and rubella elimination, and to use standardized indicators to monitor progress towards elimination targets;
 - (e) to monitor and evaluate Member States' progress towards reaching immunization targets through assessments and surveys to validate the quality of data on immunization coverage rates; and
 - (f) to provide the Regional Committee with an update on progress towards measles and rubella elimination at its sixty-third session in 2013.

Annex 1 Agenda

1. Opening of the session

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

2. Address by the Director-General

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

- Better health for Europe. Adapting the WHO Regional Office for Europe to the changing European environment: the Regional Director's perspective

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

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

6. Policy and technical topics

- (a) Proposed programme budget 2012–2013
 - Global basis
 - Regional level
- (b) Governance of the WHO Regional Office for Europe
- (c) Future of the European Environment and Health Process
- (d) Health in foreign policy and development cooperation: public health is global health
- (e) The future of financing for WHO
- (f) Addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region
- (g) Partnerships for health in the WHO European Region
- (h) Renewed commitment to measles and rubella elimination and prevention of congenital rubella syndrome in the WHO European Region by 2015
- (i) Poliomyelitis eradication in the WHO European Region

7. Private meeting: Elections and nominations

- (a) Nomination of two members of the Executive Board
- (b) Election of three members of the Standing Committee of the Regional Committee
- (c) Election of a member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases
- (d) Election of four members of the European Environment and Health Ministerial Board
- (e) Nomination of members of the Consultative Expert Working Group (CEWG) on Research and Development: Financing and Coordination

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EUR/RC60/TD.5	Progress towards the health-related Millennium Development Goals in the WHO European Region

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Professor Sir Michael Marmot

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Annex 4

Address by the Regional Director

Better health for Europe: adapting the WHO Regional Office for Europe to the changing environment

Madam President, honourable ministers, excellencies, distinguished delegates, colleagues, ladies and gentlemen,

Let me start by thanking you again for the trust you placed in me exactly one year ago. You called my aspirations ambitious, but necessary. Today I stand in front of you to reassure you of our full commitment to meet the manifold challenges and to earn your respect and support. Please allow me to share with you what we have achieved to date and what are our plans. Your guidance in this Regional Committee is vital for us to move ahead and to shape our work for the years to come.

WHO as an organization is known for its public health work all over the world. In Europe, just as in many other parts of the world, the Regional Office needs to earn leadership and ensure excellence in addressing health and public health issues.

I will therefore do my utmost to strengthen the Regional Office in the unique role of WHO in the European Region, to support you in your important work to continue to improve the health of the European population and ensure a high standard of agency governance, together with scientific quality and excellence in our technical work.

The new challenges that we are facing in the European Region make us stop to take stock, to renew our vision, to earn recognition of our leadership in health and to further strengthen our collaboration with you, the Member States, and to make it more strategic. We need to renew and revitalize our partnerships for better policy coherence in Europe, and we need to build further on the tremendous technical and professional capacity, as well as the institutional capacity, that exists throughout Europe.

In order to achieve this, my main objective is to further strengthen the Regional Office for Europe, and for this reason I have set out seven main strategic directions and priorities for discussion at this and future Regional Committee sessions. We have started our work on all of them, but your active involvement as European Member States is crucial to their successful implementation. Allow me to lead you through some of the main ones already at this stage and seek your guidance.

Seven new strategic directions and priorities

A new European health policy – Health 2020 – will be developed through a participatory process involving Member States and other partners. The objective is to ensure an evidence-based and coherent policy framework that will address the recent challenges to health and health equity and develop evidence-based and cost-effective policies and strategies to respond to them in an effective way. This policy will be informed and underpinned by evidence – among other things – a European study on social determinants.

Health 2020 will provide an opportunity to renew the commitment of the Regional Office to public health, an area with long and proud traditions in many European countries. Renewed emphasis on the further development of public health systems, capacities and functions in Europe, along with adequately trained human resources to promote public health effectively, are of the greatest importance. Investment in prevention must be stepped up to decrease the disease burden and the pressure on health care systems.

Through Health 2020, we will aim to further clarify the strategic linkages between public health and health care systems, in particular primary health care, as foreseen in the holistic approach to health systems articulated in the Tallinn Charter. The new policy will also position health as a critical domain in development, demonstrate how far the territory of health has expanded and make linkages with the other sectors and settings, thereby promoting health as a governmental responsibility advocated and led by ministers of health.

Health 2020 will also be an inspiration to Member States to develop, renew and update their national health policies and strategies. The Organization as a whole is committed to working with countries to do this and this is a project directly led by the Global Policy Group (GPG), chaired by the Director-General, to which I am fully committed.

Work in this field has already started internally to devise the process. I am looking forward to your guidance tomorrow in the ministerial panel.

Governance of the WHO Regional Office for Europe will be continuously strengthened. WHO is a coalition of Member States and therefore its governing bodies play a crucial role in formulating policies and strategies of a regional character.

A strong and well-supported Regional Committee (RC) is the arena for the important policy dialogues and decisions that shape the work of WHO in the Region. Several proposals will therefore be put forward to you in the afternoon during the session on governance. The aim is to find ways to attract high-level decision-makers, and make the agenda both relevant and interesting enough for them, for you, to attend future sessions of the Regional Committee. Active participation of Member States will be fostered, to ensure ownership and commitment for implementation.

Ministerial conferences on common priority issues have been very successful and will continue, mainly in areas that require intersectoral collaboration.

I also envisage the establishment of a high-level forum of government officials to ensure full engagement in the development of a number of policies and strategies, including Health 2020, the European study on social determinants, a renewed commitment of the Region to noncommunicable diseases, public health development and disease prevention and other issues.

In order to strengthen the oversight function of the RC, I recommend using the Programme Budget as a strategic tool to ensure accountability for the delivery of jointly agreed results and outcomes.

The role of the Standing Committee of the Regional Committee (SCRC) also needs to be further developed to effectively deal with items delegated to it by the RC; to be the advisory body for the Regional Director (RD); and to help the RD to effectively prepare the RC sessions and also to play its oversight function. We also have to ensure increased transparency around the work of the SCRC. I suggest an increased membership to ensure an adequate geographical representation of the Member States in the Region.

The Regional Office will be a centre of technical excellence, with all core technical, strategic and health diplomacy functions integrated at the office located in Copenhagen, and with the technical centres (geographically dispersed offices – GDOs), as well as the country offices, fully integrated. Corporate core functions – like policy, strategy and technical programme development, strategic relations with you, Member States, partnerships, work of the governing bodies – will be guided from Copenhagen.

The GDOs will continue to play an important role by providing technical evidence and knowledge, advice on policies and technical programmes, and by building capacities in countries and – following agreement with the Regional Office – supporting implementation of our work in Member States. To further improve the full integration of such activities, a review of the GDOs is under way – building on the excellent work done in this Region 10 years ago; the results will be presented to the RC in 2011.

The Regional Office will also renew and revitalize its networks and establish new ones where required: the health-related networks within the settings approach are alive but dormant. The collaborating centres approach needs a fresh look, and efficient relations with public health institutions, schools of public health and other institutions need to be established and renewed. The potential is great and the gain is huge if we engage fully with existing capacity and expertise in Europe.

Further strengthening collaboration with Member States is a key role of WHO. Different parts of our Region need different types and levels of support. All countries need WHO's normative and standard-setting work, as well as its evidence-based policies, strategies and programmes. Some countries also need advocacy and partnership. However, not all countries need technical cooperation.

WHO will support every country in the Region in its national health policy and health system development. Technical cooperation should continue with the Commonwealth of Independent States (CIS) and south-eastern Europe (SEE) countries in a spirit of solidarity. A training programme for high-level decision-makers, as well as technical experts, on commitments in international health and global and regional policy issues, is also envisaged, together with training in health diplomacy.

A review of the work of the Regional Office with and for the Member States, including a review of the work of our country offices, has already started and will be presented to the RC in 2011, where a new country strategy will be put forward. During this review we are also exploring options such as subregional arrangements, using the model of the SEE Health Network and the experience of other organizations. For this reason, during the ministerial lunch today I have decided to describe to you the advantages of such networks.

Strategic partnerships for policy coherence are vital today in Europe, with all the many players actively involved in health development. WHO has to position itself in this complex environment, and has to progressively strengthen its cooperation with all partners. A partnership strategy will therefore be developed and submitted to the RC next year. A first but very important step is foreseen this year: to launch a joint declaration on a shared vision for health with the European Commission. The WHO Regional Office for Europe will continue to strengthen relations with other European Union (EU) institutions. Discussions have also started with the Global Fund and the Organisation for Economic Co-operation and Development (OECD) and these will continue in the coming months.

Regarding information and communication technology, I see this is one of the most vital strategic assets that the Regional Office must develop in order to work efficiently and to facilitate an integrated delivery of results. We must embrace the new technologies, and explore how they can be adopted to further the public health agenda in the Region. We have already started actively working on this.

A core element of our new information and communication strategy – which will be presented at one of the forthcoming RC sessions – will be the vision of a common health information system, with joint data collection, analysis and dissemination shared between international partners.

Moreover, there are certain key communication technologies that I see as changing the way we work, for example:

- social media as a platform for exchange of knowledge, ideas and opinions;
- an increased and interactive web presence for the Office, coupled with a strong communication function; and
- a suite of consolidated databases to support evidence-based decision-making.

We have made a major step forward with a comprehensive redesign of the Regional Office web site earlier this year, and further work will continue intensively in this area.

Creating a positive, supporting and empowering working environment and sustainable funding for the Regional Office is one of our strategic priorities. We have set up several working groups to improve the effectiveness of the Office and to help it adapt to the new priorities and ways of working. A new organigram was put in place on July, flattening the structure of the Office and creating a more efficient division of labour.

In June, we held an Office-wide review of our technical work, in which senior management and technical programme managers studied their progress to date, identified gaps and bottlenecks, and proposed the way forward. The new priorities will be integrated into our workplans after the RC.

To ensure sustainable financing for the Regional Office, I considered it an urgent priority to strengthen our fundraising capacities. A new dedicated unit was set up to look after budget planning and resource mobilization. This work is aligned to the Director-General's initiative on the future of financing for WHO.

Priorities

Priorities for our work will be further considered during the course of the development of Health 2020. Please, allow me at this stage, however, to highlight the most pressing priorities for our Region.

A number of emergencies and public health crises have hit our Region since I took office in February. This will continue to be the case and therefore WHO must be prepared for this, both in its work with its Member States but also internally.

- During the volcanic eruption in Iceland, we regularly monitored the situation and issued risk assessment, advice and guidance on the potential health consequences of possible exposure to the volcanic ash.

- Following the civil unrest in Kyrgyzstan and the mass displacement triggered by ethnic violence, donor appeals were launched in Kyrgyzstan and Uzbekistan and we mobilized support to health authorities in both countries to provide essential health services to the affected communities.
- Following the severe floods that hit parts of the Republic of Moldova in July, WHO supported the damage and needs assessment and, with very generous financial support from the Italian Government, we mobilized essential medical supplies and pharmaceuticals to cover the health needs of flood-affected communities.
- During the heat-wave and wildfires in the Russian Federation, we compiled situation reports and, using the excellent resources of the Russian Ministry of Health and Social Development, disseminated public health advisories with key recommendations, which we updated daily, on the WHO European web site.

Flooding at the Regional Office headquarters was another, more recent emergency that hit us. On Saturday, 14 August, following heavy rainfall, our premises in Copenhagen were flooded. All our basement and ground-floor offices were filled with dirty water, which entered with enough force to displace our furniture and to destroy parts of the buildings. The power supply, telephone and e-mail services, as well as our Internet connectivity, were all disrupted. Everything stored in the basement (including equipment and documents for the RC, books from the library and our print shop) was destroyed. An emergency committee was immediately set up and worked round the clock to make the Office safe and clean to enable staff to return as quickly as possible. From the beginning, I gave instructions that made clear that the first priority was the safety and well-being of our staff. We were extremely lucky that the flood happened on a Saturday night, when there were no staff in the building, and thus no one was hurt.

I am very proud of the excellent work that has been done by all, round the clock, to respond to these exceptional challenges, and I would like to express my gratitude to my staff. I would also like to thank WHO headquarters and the United Nations in Copenhagen, as well as the Danish authorities, for all their help and support.

Our Region has been polio-free since 2002, a status that we are all determined to maintain by all means. In response to the poliomyelitis (polio) outbreak in Tajikistan, which also required preventive responses by neighbouring countries, WHO, the United Nations Children's Fund (UNICEF) and other partners acted swiftly and effectively to support the Government in the implementation of supplementary immunization campaigns targeting 2.7 million children aged less than 15 years. Fifth and sixth rounds are due to take place over the coming months.

Since 4 July, no new acute flaccid paralysis (AFP) cases have been detected. I visited the country myself, as soon as the first polio cases were reported, to work out a joint response strategy with the Minister of Health, Mr Salimov, and to launch the first round of the immunization campaign. I would like to thank the President and the Government of Tajikistan, and you, Mr Minister, for your openness, transparency and leadership in taking immediate and appropriate action in close collaboration with WHO and for the active communication to reach out to every family and child in the country.

I also visited Uzbekistan, with the Deputy Regional Director of UNICEF, to launch the second round of the immunization campaign with the Minister of Health, Dr Ikramov. In Uzbekistan, 2.85 million children aged less than 5 years were targeted with 3 rounds of supplementary immunization activities. The campaigns and the communications around them were conducted very professionally. I would like to thank Dr Ikramov for his leadership.

I would like to take this opportunity to thank the Government of the Russian Federation for all the support it gave to us throughout this outbreak through the quick and efficient work of the regional polio laboratory, to which all the samples were sent for analysis.

However, despite all those efforts, but also thanks to effective surveillance systems in all countries, imported polio cases have been detected outside Tajikistan, including 3 cases in Turkmenistan and some cases in the Russian Federation, for which control measures have rapidly been put in place.

As to the polio outbreak and response ... "It's not over till it's over". This polio outbreak in Tajikistan and the cases detected in neighbouring countries show the Region's vulnerability, and it is a clear signal to us that we have an unfinished agenda which needs full commitment and determination. The Region therefore needs strong public health systems/functions, strong surveillance, high immunization coverage and full transparency and compliance with the International Health Regulations to avoid similar outbreaks. Countries' full political commitment and leadership are of utmost significance to maintain the polio-free status of the European

Region, which we have enjoyed since 2002! I am looking forward to a more in-depth discussion with you on this subject later in the agenda, together with Professor Salisbury, the Chairman of the European polio certification committee.

In communicable diseases (other than polio) – we also have an unfinished agenda! For measles elimination in Europe, 2010 was the target, but we did not manage to reach it! There are several main challenges: unequal vaccination coverage in countries leads to outbreaks; some vulnerable population groups are not covered by immunization programmes; anti-vaccination groups have been active in many countries. Today nearly 1 million children born each year in our Region are not fully immunized. A renewed commitment to measles and rubella elimination will be on our agenda on Thursday: I would like us to set a new elimination date of 2015 and for us to do everything we can to reach it! This is doable!

I also have to mention the highly successful and participatory European Immunization Week, in which 47 countries participated this year, with a broad range of activities. Many partners joined the new EIW online social network site, which encouraged an interactive dialogue across the Region.

On the invitation of the WHO Regional Office for Africa, the Regional Office for Europe will be actively assisting with the planning of the first African vaccination week. We are also advising the Regional Office for the Western Pacific on initiating a vaccination week in that region next year.

I also have good news for you: we are making good progress towards malaria elimination in 2015.

Since 1995 there has been a substantial reduction in the number of reported malaria cases: from nearly 91 000 in 1995 to only 285 cases in 1999. In 2005 we had 9 affected countries; in 2009, only 5. The transmission of malaria was interrupted in Armenia, the Russian Federation and Turkmenistan. The last cases of locally acquired malaria in Kazakhstan were reported in 2001.

It is quite likely that Turkmenistan will be certified as a malaria-free country by the end of 2010, and Armenia, by the end of 2011.

Good collaboration with the Global Fund is taking place: the Global Fund fully supports the Tashkent Declaration and the malaria elimination efforts of WHO. Our collaboration with the Global Fund in the field of malaria is an outstanding model for other areas, as well.

During the influenza pandemic that started in 2009, our collective efforts did bear fruit: all the countries in the Region prepared well, and we were also collectively better prepared due to the International Health Regulations (IHR). We therefore have to build IHR core capacity with great vigour. WHO is truly committed to support you in this task!

WHO is undertaking a formal review of the global response to the pandemic and the functioning of the IHR, by the IHR Review Committee. In the European Region, the Regional Office has initiated, in partnership with the European Centre for Disease Prevention and Control (ECDC), a review in 7 countries: Armenia, Bosnia and Herzegovina, Denmark, Germany, Portugal, Switzerland and Uzbekistan.

Preliminary results suggest that crucial factors in a country's ability to respond are the presence of well-informed health care professionals in primary and secondary care, close links between public health professionals and the professionals of the health care systems, and coordination at the local level.

We also learned other lessons: it is important to be prepared for multiple scenarios, to envisage the worst but also to be ready to rapidly adapt to a much better situation. Flexibility must be embedded in our preparedness plans.

The pandemic showed us clearly how crucial and difficult communication can be. Communication, which today widely involves social media, should inform the public of possible difficulties ahead, but also prepare the public for changes in risk assessment and create acceptance for measures taken, especially vaccination.

Following long negotiations between the Regional Office and ECDC in September 2009, the two organizations managed to find a solution to avoid double reporting of influenza surveillance data. I am sure this will come as good news to you.

Multidrug-resistant/extensively drug-resistant tuberculosis (M/XDR-TB) is a global health threat in Europe and therefore I made it a regional priority! Out of the 27 high-burden MDR-TB countries that collectively account for 85% of the cases globally, the first 15 are in

the European Region. We are now in the process of preparing a comprehensive action plan to fight M/XDR-TB in the WHO European Region in 2010–2015.

Continued support from the Global Fund for all the countries in the world affected by M/XDR-TB is vital to counteract this global threat!

Another global threat is antimicrobial resistance (AMR). We are happy to announce, with the Director-General, that the topic of the next World Health Day in 2011 will be AMR. In the European Region we have started preparation by developing a regional AMR strategy in close collaboration with our partners, in particular the EU/ECDC, who have done so much to move this agenda forward. The focus on AMR is timely, in view of the emergence and spread in the Region of resistant bacteria including the recent cases of NDM-1 (New Delhi metallo- β -lactamase-1), which are of serious public health concern. The “superbug”, which has received considerable press coverage, shows the pressing need for coordinated international response in surveillance and research, building on strong national initiatives for AMR surveillance, the prudent use of antibiotics and effective programmes against health-care-associated infections.

HIV/AIDS remains another major public health challenge in our Region, with rapidly increasing transmission in many European countries. Eastern Europe now has the fastest-growing HIV epidemic in the world, and is the only region where the annual number of reported cases of HIV is still increasing. There is a need to stabilize and decrease the epidemic in the east and prevent re-emergence in the west.

To achieve universal access to HIV prevention, treatment and care requires approaches that sometimes go against well-established policies and practices in Member States. This represents a challenge and requires additional efforts to mobilize political commitment for evidence- and human-rights-based prevention measures, such as harm reduction interventions, including opioid substitution therapy for injecting drug users.

Under these circumstances it is a challenge to halt the spread of HIV by 2015, as set out in Millennium Development Goal 6. Sufficient scientific evidence is available; what is needed is political commitment! A regional strategy for HIV/AIDS, aligned with the 2011–2015 Global Health Sector Strategy that is under consultation, will be developed.

The Region has achieved one important goal: in 2008, 90% of HIV-positive pregnant women in low- and middle-income countries received antiretroviral therapy for prevention of mother-to-child transmission. This was possible due to integration of HIV prevention into maternal and child services.

Moving to another area, the environment and health have always been an important and highly visible part of our work.

The Fifth Ministerial Conference on Environment and Health, held in Parma, Italy in March this year, has been a major event of the year in our Region, and a milestone in the European environment and health process.

For the first time, measurable and time-defined targets that can be worked towards and monitored have been set. Also, a new governance structure has been proposed to strengthen implementation at the national and European levels. A ministerial board will be the political face and the driving force of international policies in this field.

The European environment and health process has been going on for over 20 years. It is one of the best examples of a cross-sectoral partnership and I am strongly committed to the further successful development of this process and its use as a model for other sectors and other areas.

Lastly, I mention climate change, which is a real and serious matter of concern, vividly illustrated by severe weather events in our part of the world. The framework for action on climate change that was endorsed in Parma will provide appropriate guidance for our continuous work in this area, and for our work on greening health services, to maximize our contribution to reducing greenhouse-gas emissions.

The main disease burden on the Region comes from noncommunicable diseases. Cardiovascular diseases (CVD), cancer, chronic respiratory diseases and diabetes mellitus account for the majority of deaths in our Region: 86% of deaths and 77% of the disease burden in the WHO European Region are caused by this group of disorders, which are linked by common risk factors, underlying determinants and opportunities for intervention.

Although western nations have made great progress in lowering the mortality rates for CVD, these rates are rising quickly in different areas of the Region, such as central Asia. With them, related conditions, including diabetes, undermine population health and human development, particularly in low-income contexts, where the active working population is the hardest hit.

In the western part of the Region, cancer stands out as one of the biggest threats both to health and to health systems. Indeed, it has replaced CVD as the main cause of death in at least 28 of the Region's 53 countries, requiring sharp adjustments to health systems to address the complex needs of cancer patients. In 2008–2009, the WHO Regional Office for Europe worked with 8 countries to help them develop national cancer control programmes incorporating primary and secondary prevention, palliative care and research.

Mental ill health has been called a "silent epidemic", because conditions such as depression or anxiety often go undetected and untreated, despite the fact that depression is the leading cause of disability worldwide, while 86% of suicides occur in low-income countries. Other mental disorders, such as Alzheimer's disease, arise from the rapid population ageing throughout the Region, and these conditions, too, must receive proper attention. The WHO Regional Office for Europe is committed to helping Member States put mental disability on the public health agenda, integrating treatment into primary care, tackling social stigma and defending the rights of those with mental disabilities.

Behind these main killer diseases are a number of risk factors. Prevention, promotion and strong health systems, including public health, are needed to eliminate these risks. Action on just 7 of them – high blood pressure, high cholesterol, high blood glucose, overweight, physical inactivity, tobacco smoking, and alcohol abuse – would reduce nearly 60% of disability-adjusted life-years (DALYs) in the WHO European Region and 45% in high-income European countries. Work has been ongoing on health determinants, primarily lifestyle issues, but in some areas renewed political commitment is required.

An integrated regional strategy on noncommunicable diseases (NCD) was adopted by the Regional Committee in 2006. We at the Regional Office have now started to work on an action plan for its implementation, which will come to the Regional Committee in 2011. We want to step up our work in this very important area!

A regional alcohol policy is needed, as the disease burden attributable to harmful use of alcohol is significant. I'm not proud of this, but the Region is the leader in alcohol consumption.

Alcohol is the second largest risk factor for DALYs, and in low-income European countries it is the main risk factor. For this reason, it is my intention to develop a regional implementation plan, which builds on the recent global strategy on the harmful use of alcohol and on the European framework for alcohol policy. In June, we organized a national counterpart meeting at the kind invitation of Spain, where all countries agreed to such a plan.

Substantial progress has been achieved in tobacco control throughout the Region. Several countries adopted or strengthened tobacco legislation and improved its enforcement. Momentum was created by the entry into force of the WHO Framework Convention on Tobacco Control (FCTC), which was reinforced by concrete actions in countries. This year marks the fifth anniversary of the FCTC, and we will celebrate by highlighting its main achievements during the lunch break on Tuesday.

One of the highlights of the tobacco control efforts this year was the Director-General's special World No Tobacco Day award, given to the Turkish Prime Minister for his outstanding and continuous leadership nationally and internationally, which I had the honour and privilege to present to him on 19 July this year in Ankara.

Overweight is one of the biggest public health challenges of the 21st century: all countries are affected to a different extent, and this poses serious problems, particularly in the lower socioeconomic context. The WHO European Action Plan for Food and Nutrition Policy 2007–2012 sets goals and targets related to food safety and nutrition in the Region. More than 90% of European Member States have developed a national policy. The Regional Office worked with Member States to reduce salt intake and provide information to consumers, and facilitated six action networks. In recent weeks we also had discussions with the food and drink industry to define coordinated efforts to implement WHO policies, guidelines and standards in the production of food and drink. There is great potential in this collaboration and therefore we are willing to explore it further.

Finally, ladies and gentlemen, let me mention the strengthening of the health and public health system, as highlighted earlier, the Regional Office will renew its commitment to public health and rejuvenate its work in this important area. Without this commitment the Region will not be able to respond to the double disease burden: on the one hand, it will become vulnerable to infectious

diseases and, on the other hand, it will not be able to deal with the NCD epidemic. Public health developments therefore will be put high on the list of priorities in the health-system-strengthening approach. Links will also be developed with primary health care, as well as with other parts of the health care system.

The Regional Office will continue to honour the commitments made at the Tallinn Conference in 2008, and will implement the associated resolutions. It will place particular emphasis on using performance measurement to ensure public accountability and adjusting policies based on country-specific evidence. In addition, the Office responded to several countries' requests for support with their response plans for the financial crisis (e.g. Armenia, Estonia, Latvia), and to new requests for more general support for health reforms (Bulgaria, the Republic of Moldova, the former Yugoslav Republic of Macedonia).

As to country work guided by the Tallinn Charter, good progress has already been registered in fully implementing some provisions of the Charter. The latest accomplishments include the development and synthesis of evidence from a very diverse Region in such important areas as health-system financing reforms, health insurance schemes and financial sustainability.

Other Member States that were assisted in developing national health policies included Bosnia and Herzegovina, Finland, Kyrgyzstan, Portugal, the Republic of Moldova and Tajikistan.

In Tajikistan the WHO Regional Office for Europe helped facilitate and lead a multistakeholder process to develop a new national health strategy, while in Kyrgyzstan WHO long-term technical assistance helped strengthen the link between evidence and policy in the implementation of the national health strategy. An assessment of the national health plan of Portugal, which builds on recent work in national health strategy development, has recently been undertaken, and work started in Lithuania and Turkmenistan on new national health plans and strategies.

Under the umbrella of the guidance of the GPG, chaired by the Director-General, and in line with established criteria, the following priority Member States have been chosen to be included in the first round of capacity building and intensified technical assistance for the development of national health policies, strategies and action plans: Armenia, the Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

In health financing visible progress has been made. The book on implementing health care financing reforms – *Lessons from countries in transition* – has been finalized and will be launched during this Regional Committee. Our Office was also fully involved in the production of this year's world health report on financing for universal coverage, which will be launched in Berlin, Germany in November.

The Regional Office has also been very active within countries in supporting health financing reforms, e.g. Bulgaria, the Republic of Moldova and the central Asian countries.

As to human resources for health, the WHO code of practice on the international recruitment of health personnel, adopted unanimously by the World Health Assembly this year, is a historic step forward both to protect migrant workers and to tackle the catastrophic shortage of health professionals in the developing countries. It demonstrates a significant international commitment of Member States to addressing these issues. The European Region made a significant contribution to the process of developing the code. We are working on a regional strategy for the implementation of the code and its principles, and we will provide technical support to Member States for its implementation.

In the field of health technologies and pharmaceuticals a lot of important work has been carried out to survey the quality of TB medicines in the CIS, review access to treatment and care for HIV/AIDS patients in the Baltic states and support the German Institute for Quality and Efficiency in Health Care, to strengthen the Institute's work as a leading institute of patient-centred and evidence-based work to empower patients and the general public. The Regional Office also supported the SEE countries in participating in European Antibiotic Awareness Day.

Honourable ministers, excellencies, distinguished colleagues, ladies and gentlemen,
With your support, we have worked hard over this year to address issues and identify opportunities in public health, but there is a lot still to be done. All parties have the goal of achieving better health for Europe. The WHO Regional Office for Europe will continue to coordinate and carry out evidence-based action with partners, to ensure attainment of the highest possible level of health by all peoples in our Region.

In closing, I want to reaffirm that we recognize the importance of being relevant to each and every Member State in this rich and diverse European Region. I am confident that, on our part, the high-calibre and motivated staff in the Regional Office are dedicated to adding value to the work in your countries.

I am sure that, by playing our unique role in the Region, and by adhering to our principles, we will continue to earn your respect and support over the coming years.

Thank you.

Annex 5

Address by the Director-General

Madam President, honourable ministers, distinguished delegates, Ms Jakab, ladies and gentlemen,

Let me begin by expressing my warm wishes to your Regional Director, Ms Jakab, as this first regional committee of her administration gets under way.

This is a time of reckoning, and this is a fragile time. Public health must be smart, strategic, and resourceful as never before.

I welcome the initiatives, described in your documents, for making this regional office more responsive to the needs of its Member States and the expectations of their citizens. As noted, some traditional solutions, and some traditional ways of thinking, no longer match the complex realities of today's public health landscape.

The environment for health in Europe is changing, and so is the global environment. It is good to see that strengthening the European contribution to global health, also through foreign policy, is among the top priorities for the future.

For decades, this region has been the bellwether for health trends and challenges that eventually affect the rest of the world. As such, you have pioneered policies and approaches that serve public health everywhere. The Tallinn Charter, for example, is a landmark achievement with relevance well beyond Europe.

European countries are also leading the quest for a coherent global health policy. Doing so makes sense. The public health community counts European countries as among its most generous, and frankly, its most innovative and forward-looking donors. This leadership was particularly evident at the European Union's high-level conference on global health held in June. In seeking policy coherence, European countries expressed commitment to universal coverage and emphasized capacity-building in developing countries as a foundation for sustainable solutions, self-reliance, and more effective aid. I was particularly heartened by the importance given to strengthening health systems.

I have no doubt that the Tallinn Charter helped give health systems this high place on the political agenda. I am equally certain that the Charter will serve this effort well as an action-oriented policy instrument.

The need for a coherent global health policy becomes all the more important given the diverse and complex health challenges facing public health. These days, politics must be the bedside manner of health officials if they want to get results. Risks that have been present throughout history have become much larger, and more universally disruptive, in a highly interdependent and interconnected world.

Threats to health are increasingly created, or amplified, by policies made in non-health sectors. To tackle many root causes of ill health, officials need to diagnose causes and consequences in a language that speaks to the core interests of these non-health sectors.

The importance of doing so is explicitly acknowledged in the recent Parma Declaration on Environment and Health. That document recognizes the increasingly critical role of economic arguments in developing sound policies across all sectors.

The phrase "health is wealth", that could have been copyrighted by this regional committee, has an important corollary. Not only does investment in health contribute to national wealth. Policies that fail to consider the impact on health can backfire. They can create or aggravate costly health problems that cancel out any net gains for human progress.

This need to take the health impact into account pertains to policies at the international as well as the national level. More and more, health is the unwitting victim of policies made in the international systems that tie countries, economies, commerce, trade, and foreign affairs together. This is the new source of setbacks for health in the 21st century.

Let me illustrate with a single set of policies, for food, and a single disease, diabetes.

The industrialization of food production has, up to now, made it possible to feed the world's growing population, and this is good. But this trend, combined with the globalization of food marketing and distribution, has brought processed foods, rich in fat, sugar, and salt, yet low in essential nutrients, into every corner of the world, including cities throughout the developing world. These are, of course, the foods that contribute to the rise of chronic diseases.

Mounting evidence shows that obesity and type 2 diabetes, strongly linked to unhealthy diets, have reached epidemic proportions in Asia, where the nutritional transition has been exceptionally rapid. People in that part of the world are developing diabetes in greater numbers and at a younger age than diabetics in industrialized countries, and unfortunately they are dying sooner. Diabetes is an especially costly disease: costly for societies, costly in terms of chronic care, and extremely costly in terms of hospital bills for well-known complications.

Some economists have described this rising prevalence of obesity and diabetes as a "side effect of progress", a consequence of economic development. But I would raise one question: is this progress at all? What is the net gain when economic development sets health development backwards?

Ladies and gentlemen,

This is a time of reckoning, and this is a fragile time. Deadlines are looming. The bills for past extravagance are falling due.

The current economic downturn is global. It is the worst seen in a generation. It is by no means over. And it was seeded by greed, compounded by a failure of risk management at every level of the financial system.

Climate change is the price being paid for policies that favoured the growth of economic wealth over the protection of ecological health.

Multiple global crises, on multiple fronts, reshaped the first decade of a century that began with so much promise, especially for public health. The Millennium Development Goals boosted international health development. The past decade saw the creation of numerous global health initiatives, new funding mechanisms, and new financial instruments. Commitments of official development assistance for health more than tripled.

The results tell us clearly: investment in health development is working. Finally, we are coming closer to reaching one of the most elusive goals in public health: scaling up of coverage with life-saving interventions.

The number of under-five deaths dipped below 10 million for the first time in nearly six decades, and then dropped again to under 9 million. Later this week, UNICEF and WHO will issue new estimates showing another decline of nearly 1 million deaths.

The number of people in low- and middle-income countries receiving antiretroviral therapy for AIDS moved from under 200 000 in late 2002 to well over 5 million today, an achievement unthinkable just a decade ago.

The number of people newly ill with tuberculosis peaked and then began a slow but steady decline. For the first time in decades, data from sub-Saharan Africa suggest that the steadily deteriorating malaria situation might be turned around. Countries that have achieved high coverage with recommended interventions are seeing malaria deaths decline by more than 50%. Research is now documenting related drops in all-cause young-child mortality of 60% and higher.

Tomorrow, WHO will release, jointly with UNFPA, UNICEF, and the World Bank, new estimates indicating a significant worldwide drop in maternal mortality, with the greatest declines, of around 60%, reported in Eastern Asia and Northern Africa.

Progress in all these areas is significant and very welcome. But progress is also fragile, for reasons largely beyond our control. The first decade of the 21st century may very well go down in history as the time when nations came face to face with the perils of interacting in a world of radically increased interdependence.

Sceptics who doubt the reality of climate change would do well to look closely at recent events in China, Pakistan, and here in the Russian Federation. The downpours, mudslides, floods, heat waves, drought, wildfires, and ruined crops match closely the predictions of climate scientists. These scientists have repeatedly warned the world to expect an increase in the frequency and intensity of extreme weather events, and this is what we are seeing.

More and more, these events are being described as the worst on record, or the worst in the entire history of a country. Records are being broken a record number of times.

The stress is felt internationally. The United Nations has struggled to secure emergency funds on a scale that matches the magnitude of suffering and loss in Pakistan, and the very real threat of epidemics. As a matter of fact, I was working till 2 a.m. discussing with New York how to respond to this situation. Grain prices on the international markets already reflect the huge crop losses in that country and in the Russian Federation. Russia is the fourth largest wheat exporter and Pakistan is in the top ten. We have to anticipate another global crisis of soaring food prices that will hit poor households the hardest.

The future of financing of WHO is on your agenda, as is the proposed programme budget for 2012–2013. Countries in this Region have suffered disproportionately from the economic downturn, and your budgets are under close scrutiny.

Money is tight and public health is feeling the pinch. It is being felt at levels ranging from national health budgets, to commitments of official development assistance, to funds available to support the work of the Global Fund, the GAVI Alliance, and other global health initiatives.

I can assure you: the austere economic outlook is also affecting WHO. The aspirations set out in the proposed programme budget may need to be adjusted in line with the reality of the global economic situation.

Ladies and gentlemen,

Good will and commitment remain steadfast. The momentum continues to build, especially for reducing maternal and neonatal mortality. But, as I said, money is tight.

Initiatives such as the Global Fund and the GAVI Alliance have done great good and are widely praised as models of success. These initiatives introduced the principle of results-based funding. And yet despite their own excellent, measurable results, they are now strapped for cash.

Other initiatives speeded the development of new vaccines to prevent pneumonia and diarrhoeal disease, the two biggest killers of young children in the developing world. Yet the introduction of these life-saving vaccines into routine immunization programmes is now in jeopardy because of funding shortfalls. A shortage of funds likewise threatens to curtail introduction of a powerful new conjugate vaccine for reducing epidemics in Africa's meningitis belt.

What will it mean if a financial crisis, seeded by greed, cancels out fragile health gains made possible by so much good will and innovation? Does the worst in human nature win over the best? These are big-picture issues, and they need to be raised.

Two weeks ago, at a conference in Australia, Michel Sidibe, the Executive Director of UNAIDS, expressed his view that the world has grown numb to HIV/AIDS. The response, including financial support, no longer matches the reality of 7400 people becoming infected every day.

As you will be discussing during this session, the 2010 target set for eliminating measles and rubella and preventing congenital rubella syndrome will almost certainly not be met. Though perfectly feasible from a technical perspective, prospects for elimination have been dampened by political and public complacency, including unfounded concerns among parents about the safety of vaccines.

Progress towards polio eradication is likewise fragile, as underscored by the recent importation of the poliovirus into Tajikistan, jeopardizing this region's polio-free status. Your Regional Director has updated you on the current situation.

We have to fight for money, but we also have to fight against complacency and fatigue. In times of economic austerity, a dangerous calculus can emerge. How many lives can be saved, how much poverty can be reduced, by a finite amount of money? We have to be very careful about shifting priorities. Antiretroviral therapy for HIV/AIDS is a life-line for a lifetime. The only ethically acceptable exit strategy is to prevent new infections from occurring in the first place.

And there are other challenges.

Aided by new communication technologies and social media, public demand for good quality health care is rising everywhere. While this is a welcome trend, can health systems afford to meet these expectations?

Moreover, decisions that affect health and health care are now subject to a new form of electronic scrutiny, whereby individuals draw instant information from a range of different sources. They make their own decisions about which information to trust and which advice to follow. They develop their own expertise. The days when public health can issue advice, based on the best scientific evidence, and expect the public to comply may be coming to an end.

We experienced this with the MMR vaccine, and we experienced this during the influenza pandemic.

Ladies and gentlemen,

WHO is under scrutiny for its response to the 2009 influenza pandemic. To some, response measures now look excessive compared with the moderate impact of the pandemic. Such scrutiny is understandable, and these concerns are being addressed.

We are grateful for the moderate impact. Had the H1N1 virus mutated to a more deadly form, we would be under scrutiny of a different kind, for having failed to protect large numbers of people.

Response plans, put together during years of nervously watching the highly lethal H5N1 avian influenza virus, prepared the world to anticipate a much more severe event. Scaling down these plans proved difficult, in part because no one could answer, with certainty, a fundamental question. Is it safe to do so? Are we sure? Do we dare?

The phased approach to pandemic alert, introduced in 1999 as a strategy for reducing public anxiety, actually had the opposite effect. It dramatized the steps leading to the declaration of a pandemic in the eyes of the public and the media. Adjusting perceptions to match a much less severe event proved problematic.

The finite capacity and long production times of vaccine manufacturers reduced the flexibility of the response. Orders had to be placed before data were available to support evidence-based projections of need. For example, some orders were based on the assumption that two doses would be needed. The procedures for getting donated vaccines to developing countries proved far more cumbersome and timely than anticipated. You may need to hear that the vaccine deployment process will benefit 83 countries that would not otherwise have vaccines. I thank many of your countries for this, as well as partners.

There are many things that could have been done better. I am relying on the findings of the Review Committee, set up under the International Health Regulations, to advise WHO on necessary changes.

I do not want to prejudice the outcome of this review, which is being conducted very rigorously and taken very seriously. But I can respond to at least one burning question. Was WHO influenced by ties to the pharmaceutical industry?

I was, of course, deeply involved in the discussions that led WHO to announce phase changes. I can assure you: never for one moment did I see a single shred of evidence that pharmaceutical interests, as opposed to public health concerns, influenced any decisions or advice provided to WHO by the experts. Never did I see a shred of evidence that financial profits for industry, as opposed to epidemiological and virological data, influenced WHO decisions.

I will have an opportunity, later this month, to present my views to the Review Committee, together with the full records, both public and confidential, of all WHO deliberations and decisions. We kept meticulous records. As I have said, we welcome this scrutiny as an opportunity to improve our performance. The 2009 influenza pandemic will not be the last public health emergency requiring an international response.

Ladies and gentlemen,

As I mentioned, this is a time when public health must be smart, strategic, and resourceful as never before.

Smart means using economic arguments to make the case for investing in health, as you are doing here in Europe. While the basic right to health is enshrined in the WHO Constitution, economic arguments are likely to carry greater weight in times of austerity.

Strategic means getting the priorities and the policies right. One level of strategic engagement is what the international community has been doing over the past decade: delivering life-saving interventions on a massive scale. I thank the countries of this region for their financial support in this effort, and for the innovative initiatives they helped spearhead.

A higher level of strategic engagement involves the strengthening of fundamental capacities and infrastructures, like procurement and delivery systems, the health workforce, information systems, financing systems, and regulatory capacity. This is where the engagement of the European Region and the European Union is especially appreciated.

Arguably, the highest level of strategic engagement aims to influence the policy environment, as shaped by all relevant sectors. It aims to create the opportunities, and the conditions that favour better health, and thus address the root causes of ill health as far upstream as possible. This is an area where European health ministries have done some of their greatest pioneering work, long before the Commission on Social Determinants of Health issued its report. As Dr Jo Asvall liked to say, in his typically sharp way: creating such a policy environment makes healthy choices the easy choices.

Resourceful means finding innovative ways to finance health development, but also cutting waste and inefficiency.

The financial sustainability of health systems is cited as one of seven main challenges faced throughout the region. Again, what European countries are experiencing is a trend seen around the world. Though resources available to invest in health care are vastly different, the main health problems facing wealthy and developing countries are becoming remarkably similar. All around the world, people are living longer, and the technologies that prolong life and improve its quality are increasingly costly.

The year's World Health Report, on health systems financing, offers a menu of options for raising sufficient resources and removing barriers to access, especially for the poor. The emphasis is firmly placed on moving towards universal coverage.

In a key achievement, the report estimates that from 20% to 40% of all health spending is currently wasted through inefficiency. It points to ten specific areas where better policies and practices could increase the impact of health expenditures, sometimes dramatically. At a time of economic austerity, cutting waste and inefficiency is a far better option than cutting health budgets.

The report will be launched in Berlin in November. I hope it can work, hand-in-hand with the Tallinn Charter, to improve the financial sustainability of health systems, in this region and elsewhere.

Thank you.

The WHO Regional Office for Europe

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

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Bulgaria	Republic of Moldova
Croatia	Romania
Cyprus	Russian Federation
Czech Republic	San Marino
Denmark	Serbia
Estonia	Slovakia
Finland	Slovenia
France	Spain
Georgia	Sweden
Germany	Switzerland
Greece	Tajikistan
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