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Draft report of the Sixty-third session of the WHO Regional Committee for Europe

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Resolutions

1. Opening of the session

1. The sixty-third session of the WHO Regional Committee for Europe was held at the Sheraton Çeşme Hotel in Çeşme Izmir, Turkey, from 16 to 19 September 2013. Representatives of 51 countries of the Region took part. Also present were representatives of the Council of Europe, the European Union (EU), the Food and Agriculture Organization of the United Nations, the International Atomic Energy Agency, the United Nations Children's Fund (UNICEF), the United Nations Economic Commission for Europe (UNECE), the United Nations Population Fund (UNFPA), and the World Meteorological Organization, and of nongovernmental organizations.

2. The first working meeting was opened by Dr Lars-Erik Holm, outgoing Executive President.

1.a. Election of officers

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

Dr Mehmet Müezzinoğlu (Turkey)	President
Dr Daniel Reynders (Belgium)	Executive President
Dr Raymond Busuttil (Malta)	Deputy Executive President
Mrs Dagmar Reitenbach (Germany)	Rapporteur

4. Participants were welcomed by the President, Dr Mehmet Müezzinoğlu, Minister of Health of Turkey, who emphasized Turkey's strong commitment to developing people-centred, sustainable, evidence-based policies on health. Turkey was particularly engaged in promoting and strengthening multisectoral responsibility for health and recognized the importance of cross-border commitment on health issues. Despite the global economic and financial crisis, Turkey had continued to invest in human resources and infrastructure for health. A national strategic action plan had been developed in line with the principles and values of Health 2020. Turkey advocated equal access to health for all and, in that regard, considered that countries should not develop health policies exclusively for their own citizens. Particularly sensitive to international humanitarian health situations, Turkey was extending assistance to its neighbouring country, the Syrian Arab Republic. The present session of the Regional Committee, he believed, would afford an important opportunity to strengthen efforts to improve the health of all people in the WHO European Region.

1.b. Message from the Director-General

5. The Deputy Director-General, conveying a message from the Director-General, thanked the Government of Turkey for hosting the Regional Committee's session. Health issues were

prominent on the international agenda. The programme for the current session was packed with major health issues, on which the European Region would provide leadership for others. Historically, the European Region had been visionary: it had been ahead of the rest of the world by at least two decades in calling for lifestyle changes to tackle the spread of noncommunicable diseases (NCDs), and had pioneered the practice and promotion of universal health coverage.

6. Of particular significance during the present session would be the launch of the *Review of social determinants of health and the health divide in the WHO European Region* and the consideration of the European Mental Health Action Plan. Mental health care was a question of human dignity, which was especially relevant in the current climate of economic uncertainty. The Regional Framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases was another important item on the Regional Committee's agenda; those vectors were threatening to introduce diseases such as dengue into the European Region. The Region could not be isolated from the problems of the rest of the world. Climate change was a factor in that regard, contributing to the changing landscape of communicable diseases. It was an indictment that measles and rubella continued to exist in the Region. Paying tribute to the Regional Director for her leadership and foresight, to the staff of the Regional Office for their hard work and to Member States for their support, he wished the Regional Committee a fruitful and productive session.

1.c. Adoption of the agenda and programme of work
(EUR/RC63/2 Rev.2 and EUR/RC63/3 Rev.2)

7. The Committee adopted the agenda and programme of work.

1.d. Other matters

8. The Regional Committee agreed to invite the EU delegation to attend and participate without vote in the meetings of any subcommittees, drafting groups and other subdivisions taking place during the sixty-third session addressing matters within the competence of the EU.

2. Address by the WHO Regional Director for Europe
(EUR/RC63/5, EUR/RC63/Conf.Doc./1 Rev.1)

9. The Regional Director said that since work on giving effect to her 2010 vision for the Regional Office (document EUR/RC60/8) was either complete or well advanced, she would focus her address on the Regional Office's activities to implement the Health 2020 policy framework, action plans and other initiatives.

10. Health 2020 was a European initiative, closely aligned with WHO reform. The Regional Office was using national and international platforms to spread awareness of both the framework and the

evidence on which it was based. The two Health 2020 documents had been published in the four official languages of the European Region, and the *Review of social determinants of health and the health divide in the WHO European Region* would be launched at the current session. Other works issued had included a new study on governance for health in the 21st century, the European health report 2012 and the study on the economic case for public health action conducted with the Organisation for Economic Co-operation and Development (OECD).

11. The Regional Office was supporting Member States' efforts to adapt Health 2020 to their national circumstances. To that end, a package of tools and resources had been developed, as well as a monitoring framework. The Regional Office had strengthened its capacity to support implementation by creating a new technical division, continuing the work of its WHO European Office for Investment for Health and Development, applying the Health 2020 lens to all aspects of its work and integrating its strategic priorities into the operational planning for 2014–2015.

12. The Regional Director described the Regional Office's other technical work in the context of the four priority areas for policy action identified in Health 2020. In the first priority area, investing in health through a life-course approach and empowering citizens, the Regional Office had helped countries to reduce inequity in risks related to pregnancy and childbirth by improving women's and infants' access to high-quality primary health care (PHC), with support from the Russian Federation, and to improve the quality of hospital care, especially in central Asia. It was also working through the Healthy Cities network to promote age-friendly environments, in a project with the European Commission (EC).

13. Under the second key priority area, tackling Europe's major disease burdens of noncommunicable and communicable diseases, the Regional Office had led in drafting the revised Global Actıon Plan for the Preventıon and Control of Noncommunıcable Dıseases 2013–2020 and its monitoring framework. On World Health Day 2013 the Regional Office had mapped countries' efforts to address hypertension and one of its root causes, salt intake. It was strengthening action on NCDs in many countries, supported by the Russian Federation, had assessed barriers to and opportunities for NCD prevention and control in five countries and would hold a conference on that topic in Turkmenistan in December 2013. The Regional Office was also taking action on NCD risk factors, supporting countries in policy-making on alcohol and initiatives for tobacco control, and had pledged support for revision of the EU Tobacco Products Directive. It had helped countries tackle the challenges of unhealthy diets and obesity by organizing the WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020, hosted by Austria, which had adopted the Vienna Declaration, calling for coordinated action on aspects of those problems.

14. In addition, the Regional Office and its partners were implementing action plans on public health threats and pursuing or maintaining disease elimination. Activities had included establishing an antimicrobial resistance (AMR) surveillance network for non-EU countries, to complement the EU system, with the National Institute for Public Health and the Environment in the Netherlands and the European Society of Clinical Microbiology and Infectious Diseases; and expanding European Antibiotic Awareness Day, with the European Centre for Disease Prevention and Control (ECDC) and support from the Patron of the Regional Office, Crown Princess Mary of Denmark. With support from the EC, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and ECDC, Regional Office staff had made 71 country visits and conducted 9 in-depth programme reviews to promote a health-system approach to multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB). The Regional Office was working to eliminate both mother-to-child HIV transmission and congenital syphilis in Europe, with the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF and UNFPA; and would hold a consultation on the use of antiretroviral drugs in October 2013. With outbreaks imperilling the achievement of measles and rubella elimination by 2015, the Regional Office had developed a package of accelerated action and a call for stronger commitment. Israel's detection of and response to the importation of wild poliovirus into the environment, supported by the Regional Office, showed both the high quality of its surveillance and response and the need for vigilance by all European countries. She pledged WHO's full support for countries' immunization and surveillance work and proposed a regional action plan, in line with the Global Vaccine Action Plan 2011–2020 and Health 2020. Finally, while Europe could be the first WHO region to eliminate malaria, the Regional Office was proposing a regional framework for action – developed with Member States, ECDC and the European Mosquito Control Association – on the growing problem of re-emerging vector-borne diseases.

15. In the third priority area, strengthening people-centred health systems and public health capacity and emergency preparedness, surveillance and response, the Regional Office had intensified its support for universal health coverage (UHC). In 2013, it would hold meetings in Estonia to discuss implementation of the Tallinn Charter and determine future strengthening of health systems, and in Kazakhstan to celebrate the thirty-fifth anniversary of the Declaration of Alma-Ata and discuss integration of essential public health operations into PHC. The Regional Office had supported policy decisions to reduce the adverse health effects of the economic crisis at a conference hosted by Norway, promoted dialogue between the health and finance sectors with OECD, and offered training to build policy-makers' capacities, such as the Barcelona Course on Health Financing. It had supported comprehensive health system reforms in Greece, with EU funding, as well as in Cyprus, Ireland and Portugal. Further, the Regional Office was helping countries prepare for and cope with health emergencies; upgrading and testing its new emergency operations centre; helping

countries such as Azerbaijan, the Russian Federation and Slovenia prepare for the health consequences of mass gatherings; and helping Turkey deal with an influx of refugees from the Syrian Arab Republic. At a meeting in Luxembourg it had assessed implementation of the International Health Regulations (2005) (IHR) and proposed criteria for granting extensions to the 2014 deadline for developing core capacities.

16. With regard to the fourth priority area, creating supportive environments and resilient communities, she said that the Regional Office was supporting the European Environment and Health Ministerial Board (EHMB) and Task Force (EHTF) in guiding the European environment and health process. It had increased technical support to countries for achieving their commitments under the Parma Declaration and had established new networks on chemical safety and economics.

17. The Regional Director concluded her address with an overview of major managerial and governance developments in WHO, noting that the Regional Office had moved to the new UN City in April 2013. She commended the unprecedented engagement of Member States and the contributions and collaboration of staff at the three levels of WHO, which had resulted in significant progress in WHO reform. Guidance from the Regional Committee and the Standing Committee of the Regional Committee (SCRC) were ensuring coherence and better governance in the European Region; the Regional Committee would discuss further SCRC proposals on governance issues. The Twelfth General Programme of Work (GPW12) and the Programme budget (PB) 2014–2015 gave the Regional Office a vision and a plan of action. The lessons learnt from the 2012–2013 "contract" had contributed to the global process, and Health 2020 would guide transformation of the programme budget into European operational planning. Having co-chaired the WHO task force on resource mobilization and management, she hoped that the Financing Dialogue would ensure a fully funded programme budget. She described measures taken to reduce costs in the Regional Office without affecting delivery of commitments to Member States. The Regional Office continued to extend its partnerships, including strengthening cooperation with the EU, its institutions and holders of the Presidency of the Council of the European Union, and signing a joint framework for action with UNICEF and UNFPA.

18. In the discussion that followed, speakers thanked the government of Turkey for its hospitality in hosting the Regional Committee session. Representatives praised the Regional Director for the excellence of her report, which demonstrated the Regional Office's move from planning to implementation, her leadership of the Regional Office, its achievements and the support it provided to Member States. Speakers described the uses they made of Health 2020, endorsed its four priority areas, described their countries' achievements in pursuing those priorities and called for further action in those areas. Speakers also commented on the new initiatives proposed to the Regional Committee and suggested ways in which the Regional Office, Member States and partners could

improve their work, individually and together, towards better health for all in the WHO European Region.

19. A representative speaking on behalf of the EU and its member countries called for concerted action on implementing Health 2020 according to countries' needs and capacities and supported the Regional Office's focus on NCDs and their risk factors, strengthening health systems and WHO reform. The proposed European Mental Health Action Plan, accelerated action on measles and rubella, and the Regional Framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases were welcome new initiatives. The Secretariat was asked to include the financial and administrative implications with draft resolutions, keep the number of resolutions to a minimum and implement current initiatives before proposing new ones. The EU and its member countries would take part in the forthcoming informal consultation on the Executive Board agenda item on the health and well-being of lesbian, gay, bisexual, transgender and intersex people and would welcome other countries' views.

20. Subsequent speakers endorsed that statement and urged the Regional Office not to let new initiatives overshadow those already under way, such as implementation of the IHR (2005) and the WHO Framework Convention on Tobacco Control (FCTC), especially in view of lack of information on the financial implications of new initiatives and the apparent imbalance between the core tasks assigned to the Regional Office and the resources available to carry them out. Further, while Member States welcomed the timely arrival of most Regional Committee documentation, some called for wider use of all four of the Region's official languages.

21. Representatives praised the Regional Office's contribution to progress in WHO reform, particularly in financing and governance, and the clarification of the responsibilities of the three levels of WHO. They called for further action and pledged to support the Organization in becoming more efficient and effective. The new budget arrangements allowed for more transparency and accountability in the use of resources, and the Financing Dialogue should provide detailed information on the strategic use of resources.

22. A representative speaking on behalf of the 10 Member States participating in the South-eastern Europe Health Network (SEEHN) said that the Regional Office had supported those countries' efforts to improve the financial sustainability of their health systems by conducting analyses to build the evidence base, disseminating evidence and ideas with policy responses and providing technical assistance. SEEHN had proved to be an excellent vehicle for health diplomacy; the Regional Office supported it by providing innovative tools for SEEHN Member States to strengthen their capacities in that area and allocating a coordination officer. Such work led to cross-fertilization between WHO and SEEHN countries. The latter would report on their work to

implement Health 2020, the Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 and Regional Committee decisions at SEEHN's fourth ministerial forum.

23. Several speakers praised the Regional Office's various ways of working with countries. Those included country offices as well as subregional mechanisms, such as SEEHN and the new arrangements being made for a group of small countries, and country cooperation strategies; WHO had signed such a strategy with Switzerland and was developing them for several other European countries.

24. In addition to action at national level, speakers identified priorities requiring further action at international level, to consolidate and follow up on progress made by WHO, Member States and partners. One speaker thanked Member States for contributing to the United Nations Economic and Social Council resolution to establish a WHO-led United Nations interagency task force on the prevention and control of NCDs. The Regional Office should strengthen cooperation with partners, and Member States should take more coordinated action against M/XDR-TB and AMR. In the face of increasing HIV infection rates, health ministers should seek additional resources from their governments. Speakers also called on countries and partners to follow the Regional Office's lead on strengthening health systems, providing UHC, achieving the United Nations Millennium Development Goals (MDGs) and including health in the United Nations post-2015 development agenda. Priority setting was key.

25. A representative of the Global Fund described its activities in the European Region, noting that eastern Europe and central Asia's unique TB and HIV situation required a specific, bold response. The Global Fund invested in highest-impact interventions and vulnerable populations based on the action plans adopted by the Regional Committee. The Global Fund had to work in overarching partnerships, and Member States were urged to increase their support over the coming three years. Investing resources in WHO-recommended public health policy would enable countries and partner organizations to control the TB and HIV epidemics.

26. In reply, the Regional Director thanked Member States for their support and excellent collaboration over the previous year, especially their support for the Health 2020 priorities. She congratulated them on the achievements they had described, thanked them for supporting the activities detailed in her report and noted that full collaboration with countries and partners such as the Global Fund was essential to all progress. She would follow Member States' guidance on priorities, particularly those that they had identified as requiring additional effort. The strengthening of the Regional Committee had made the Regional Office truly Member State-driven, and the SCRC had provided invaluable guidance. The fact that tools for accountability developed by the Regional Office had

been included in the global budget process was gratifying. The technical capacity of the Regional Office would continue to be strengthened.

27. The Deputy Director-General noted that the Regional Director's report showed how the European Region had moved from strategy to action. Monitoring was needed, however, to guide implementation and hold the Secretariat accountable. Guidance on governance would ensure that Member States and the Regional Office would consider the financial implications of proposed action. Member States should constantly give WHO feedback; current feedback indicated that the WHO Regional Office for Europe was on track.

28. The Committee adopted resolution EUR/RC63/R2.

3. Report of the Twentieth Standing Committee of the WHO Regional Committee for Europe

(EUR/RC63/4, EUR/RC63/4 Add.1, EUR/RC63/Conf.Doc./2)

29. In the absence of the Chairperson, the Vice-Chairperson of the Standing Committee presented the report of the Twentieth meeting of the SCRC. He noted that, along with its five regular meetings, the SCRC had held four intersessional teleconferences and one electronic consultation on a number of issues. The SCRC had established two working groups, one on governance, the work of which was complete, and the other on strategic allocation of resources, which would begin work after the current session of the Regional Committee. To ensure adequate preparation for the session, the SCRC had advised the Secretariat on various issues, revised all the documents and resolutions being submitted for the Regional Committee's consideration and made efforts to increase the transparency of its own work.

30. The SCRC had supported the Secretariat in finding a new host country for the Regional Committee after Portugal had had to withdraw its offer to host the sixty-third session. He expressed the SCRC's gratitude to Turkey for its generous offer and the hard work done to organize the session at such short notice. The SCRC had supported efforts to promote Health 2020 implementation and had underscored the importance of practical and structured support for Member States. The Standing Committee had worked closely with the Secretariat to finalize the Health 2020 monitoring framework and had emphasized that the reporting system should be used to support Member States, rather than increase the burden on them.

31. Agreeing with the Regional Director that the current session of the Regional Committee should focus on reviewing the implementation of previously adopted policies, strategies and action plans, the SCRC had discussed progress reports to be presented to the Regional Committee and the review of the European Environment and Health Process. It had also been informed about the

outcomes of recent high-level and ministerial meetings. Guidance had been given to the Secretariat on the two new issues on the Regional Committee's agenda: the European Mental Health Action Plan and the Regional Framework for the surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases.

32. In light of lessons learnt from the Regional Committee's sixty-second session, the SCRC working group on governance had discussed transparency, communication between the SCRC and Member States, procedures with regard to draft resolutions and the process for elections and nominations to the governing bodies. The Standing Committee fully supported the Secretariat's work to review the 46 resolutions adopted by the Regional Committee since 2002, which had been an important exercise to increase policy coherence and governance in the Region.

33. The SCRC had been presented with oversight reports on budgetary and financial matters and had been informed about austerity measures being taken by the Regional Office, in particular to reduce staff costs. The SCRC had welcomed proposals to streamline spending, which would improve the financial sustainability of the Regional Office. Difficulties in funding staff salaries remained a concern, and the SCRC hoped that the Financing Dialogue would prove helpful in solving that problem.

34. On the issue of geographically dispersed offices (GDOs), the SCRC had emphasized that GDOs should only be established when a gap in the Regional Office's technical capacity had been identified. Technical profiles and business cases had been developed for the proposed new GDOs. The SCRC had reviewed all details to ensure that those GDOs would work in line with regional priorities and had discussed at length the elements to be included in the host agreements. The SCRC fully supported the establishment of a GDO on PHC in Kazakhstan and a GDO on preparedness for humanitarian and health emergencies in Turkey.

35. He thanked all members of the SCRC for their commitment and in particular the Chairperson for her dedication and enthusiasm.

36. Responding to a question from a member of the Regional Committee, the Regional Director confirmed that the list of national counterparts, as soon as it was finalized, would be published on the Regional Office's password-protected web site for Member States.

37. The Committee adopted resolution EUR/RC63/R1.

4. WHO reform – implications for the Regional Office for Europe *(EUR/RC63/15)*

4.a. Overview of the impact of the WHO reform on the Regional Office for Europe

38. The Regional Director recalled that in May 2013 the Sixty-sixth World Health Assembly had approved both the Organization's GPW12 and PB 2014–2015. The programmatic reform that had marked their preparation and adoption testified to the corporate spirit of the Organization, involving all six regions together with WHO headquarters. It had been driven by Member States, with European countries heavily involved in providing guidance to the Secretariat.

39. GPW12 embodied the vision and "road map" for the Organization for the coming three bienniums, while PB 2014–2015 (the first budget to be approved in its entirety: covering both assessed and voluntary contributions) set out the roles of all three levels of the Organization and laid the foundation for strengthened transparency, accountability and oversight by the Organization's governing bodies. Performance indicators developed by the European Region were being pilot tested during the current biennium; the Regional Office's results chain had inspired the global PB 2014–2015; and the Regional Office's key and other priority outcomes matched the global deliverables in PB 2014–2015. Operational planning for the 2014–2015 biennium was well advanced, on the assumption that the budget would be fully funded at the level approved by the World Health Assembly, although the final allocation of resources would not be made until the Financing Dialogue with donors had been completed at the end of 2013.

40. Operational planning and reform-related activities as a whole in the European Region were informed by two specific features: the particular business model of the Regional Office and the Health 2020 policy. The former was characterized by the requirement to serve a large number of countries with a modest share of flexible resources, which primarily entailed addressing their common needs through Region-wide approaches and an intercountry or multicountry mode of programme delivery. The latter constituted the guiding framework for all policies, strategies and programmes in the Region, and it was facilitating priority-setting within each programme area. Its values were fully aligned and integrated with global policies.

41. With regard to governance reform, the Regional Office hosted a partnership with the European Observatory on Health Systems and Policies, as called for by the policy on WHO's engagement with global health partnerships and hosting arrangements (resolution WHA63.10). It chaired the WHO steering committee on relations with the EU and had agreed joint road maps with the EC; its annual workplans were harmonized with those of the ECDC; and it was strengthening its partnerships with a number of intergovernmental organizations. A European strategy on

partnerships would be elaborated once the comprehensive operational framework for WHO's engagement with non-State actors had been elaborated at global level.

42. Further work on reform of internal governance had been done by the Twentieth SCRC, following up on the decisions taken by the Regional Committee at its sixtieth session (resolution EUR/RC60/R3). The Standing Committee's recommendations on, inter alia, the process for nominating members of the Executive Board and the SCRC, submitting amendments to draft resolutions and ensuring the transparency of SCRC proceedings, as well as a draft code of conduct for nomination of the Regional Director for Europe, would be considered later in the session (see paragraphs 146–157 below).

43. Managerial reform efforts had been concentrated on securing the predictability, transparency and flexibility of future WHO financing. The Financing Dialogue with potential donors had been initiated: comments on that mechanism by regional committees would provide structured input into the second dialogue, to be held in November 2013, and the lessons learnt would be reviewed by the Executive Board and the World Health Assembly in 2014.

44. A new and improved bottom-up planning process would be developed for use in preparing PB 2016–2017. Other challenges for the two years ahead included the development of methodologies for strategic result-based allocation of resources, better management of overhead costs, and the inclusion of a capital master plan in PB 2016–2017.

4.b. Implementing the programme budget 2014–2015, including strategic resource allocation, and financial situation of the Regional Office for Europe

(EUR/RC63/21, EUR/RC63/21 Corr.1, EUR/RC63/Inf.Doc/3, EUR/RC63/Inf.Doc/4)

45. The Director, Administration and Finance reported that European Member States were being consulted about their needs for the outputs or deliverables in PB 2014–2015. In an iterative process, demand from Member States was being aligned with the supply of technical expertise (financial and human resources) and fitted into the budgetary framework approved by the World Health Assembly. While some minor adjustments could be made to inputs, efforts would necessarily continue to be focused on the demand side.

46. Preliminary analysis of the need for WHO's technical work revealed high demand from countries with biennial collaborative agreements (BCAs); further prioritization would be required in order to ensure delivery. The same process of consultation was being followed with non-BCA countries and a gradual, voluntary roll-out of country cooperation strategies was envisaged. Given that PB 2014–2015 had been drawn up on the basis of historic budget figures, rather than as a result of a comprehensive bottom-up approach, it was not surprising that there was a mismatch between the

allocated budget and the demand for services in certain areas of importance to the Region (such as NCDs).

47. PB 2014–2015 was currently 98% planned; staff costs accounted for 56% of the total regional budget, a marked decrease from the level of 70% in PB 2012–2013. Most technical categories of work were programmed up to their approved budget. One exception was category 5 (Preparedness, surveillance and response), which was 6% "overplanned" in response to increased demand for WHO technical assistance in the areas of AMR and health security.

48. The funding currently (August 2013) available to the European Region for the 2014–2015 biennium amounted to approximately US$ 6.5 million, and it was estimated that the carry-forward from the 2012–2013 biennium would be some US$ 25 million. The Regional Office expected to have the same level of funds in 2014–2015 as in 2012–2013 (US$ 141 million), and it was aiming at a fully funded PB 2014–2015, thanks to the recently instituted Financing Dialogue.

49. PB 2012–2013 was fully funded at both global and regional levels, but there were still "pockets of poverty" at the Regional Office for Europe. Strategic objectives (SOs) such as those on child, adolescent and maternal health and ageing, risk factors for health, and nutrition and food safety had low levels of funding. Even fully funded SOs, chronic NCDs, for instance, could have salary gaps.

50. Representatives commended the detailed information provided by the Regional Director and the Director, Administration and Finance. They believed that the reform process was making WHO more effective, transparent, accountable and financially consistent, and they congratulated the Member States and the Secretariat on the progress achieved to date. Nonetheless, reforming the way in which WHO planned its work, obtained its finances and distributed resources within the Organization remained a key challenge. In particular, the uneven distribution of resources among SOs was problematic; WHO must not end up in a situation where it was unable to carry out tasks that were vital to the Member States.

51. Strong support was expressed for the new bottom-up planning process and the new strategic resource allocation methodology, as well as for the principles on which the PB 2016–2017 would be developed. It was recognized that, while WHO had to provide the Member States with the oversight they needed in terms of accountability and transparency, it was incumbent on countries and donors to participate actively in the Financing Dialogue. Member States had a responsibility to follow up on the resolutions they adopted and to give WHO the support it needed in order to take action on priorities set by the governing bodies.

52. The resource mobilization efforts being made by the Organization were welcomed. In particular, support was expressed for the key positions adopted during the Financing Dialogue: aligning

resources with national priorities, increasing transparency and accountability through the establishment of a web portal and extending the donor base. It was important to ensure, however, that WHO reform did not impose a heavy burden on Member States and did not lead to an increase in their assessed contributions.

53. WHO had the qualifications to play a leading role in changing the health paradigm, as it had done with PHC at the Alma-Ata Conference 35 years before, and, by continuing to promote the reform process, WHO could strengthen its position as the most important champion of global health. The European Region with its progressive approach had important responsibilities in that regard. It was unique in having developed its health policy framework, Health 2020, not merely as a visionary document, but also and above all as a tool for practical work in the context of the current and forthcoming programme budgets.

54. A statement was delivered on behalf of the International Federation of Medical Students Associations.

55. The Committee adopted resolution EUR/RC63/R2.

4.c. Process for developing the programme budget 2016–2017 *(EUR/RC63/20)*

56. The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters, said that approval of PB 2014–2015 had been the first major step in programme and managerial reform at WHO, although it was transitional. That activity had shown that the two main areas to be addressed in preparing PB 2016–2017 were planning based on countries' priorities and a standardized approach to costing outputs. Six major lessons had been learnt from preparation of PB 2014–2015:

- country priorities should be better defined, with a common approach to identifying them;
- resources for country priorities should be allocated strategically;
- country priorities for technical cooperation should be aligned with budget allocations;
- the country prioritization process should be aligned with the proposed sequential planning at regional offices and WHO headquarters;
- a standardized approach to planning and costing outputs and deliverables at all three levels of WHO was required, which represented the most challenging aspect of the reform;
- such costing should include both direct costs for outputs and indirect costs, including for administration.

57. Between January and June 2014, consultations would be held with Member States to define their priorities; those would then be reviewed in the context of regional and global priorities; and the

budget would be finalized with costing of outputs and deliverables. PB 2016–2017 would be further discussed by the Executive Board and the World Health Assembly, allowing further input from Member States.

58. A representative speaking on behalf of the member countries of the EU and expressing their support for WHO reform said that it would enhance WHO's credibility and independence as a public health organization. Work on results-based management, the results chain and costing of outputs must continue to be a priority in order to ensure a fully costed budget for 2016–2017. The principles for strategic resource allocation endorsed by the Executive Board at its 118th session would be a useful basis for discussion. Allocation of resources must be driven by strategic planning and results-based budgeting, with budgets planned from the bottom up, standardized costing of outputs and robust, measurable output indicators that did not overlap with outcome indicators. The summary report of the task force on the roles and responsibilities of different levels of the Organization should be considered by the Executive Board in its discussions on PB 2016–2017 and strategic resource allocation. That work was central to efficient management of WHO and "One WHO". He welcomed the Director-General's commitment to allocate flexible funding to ensure that core programmes were operational and looked forward to a full report on allocation of such funding to the Executive Board in January 2014.

59. Other representatives corroborated previous remarks that both bottom-up and top-down approaches were needed to reflect countries' priorities and also to ensure a strategic approach and the authority of the WHO governing bodies. One representative commented that, although preparation of the PB 2014–2015 had not been perfect, it had provided a strong, rational basis for allocating funds in line with agreed priorities. Work must continue to ensure transparent, fair allocation of funds.

60. Several representatives welcomed the introduction of the Financing Dialogue with countries, which would increase transparency and add to the credibility of WHO. One representative said that his country had planned to adapt its contributions to WHO's priorities, thus providing entirely flexible funding. Such funding should not be used to cover overheads of projects but should be used as official development assistance, to meet priorities. External evaluations of projects by countries should be given a greater role.

61. One representative said that while it was understood that the PB 2014-2015 was a transitional one, proposals for a programme of work for the 2016-2017 biennium should be presented at the Regional Committee's sixty-fourth session as the basis for discussion, in order to guarantee the foreseen bottom-up approach in budgetary planning. He called for a detailed regional budget proposal to be made at the sixty-fifth session, based on the assumption that it would be fully funded, costed on the basis of the results chain and include clear deliverables and outputs. The

Secretariat's deliverables and their indicators should be separated from joint outcomes to be achieved by WHO in collaboration with Member States. Discussion should begin at an early stage on action to be taken with regard to priorities that had not received adequate funding during the biennium.

62. One representative commented that WHO reform in the European Region included making peripheral offices more responsible and transparent. The Regional Committee should set objective criteria for the establishment, maintenance and closure of country and geographically dispersed offices (GDOs) in order to limit financial outlay and risks. It was crucial to define the responsibilities of the three levels of WHO. The Regional Office could lead the way by establishing a culture of evaluation and dynamic policy for human resource management. Country offices should not spend time on mobilizing resources to the detriment of their core activities. The Code of Conduct for the Nomination of the Regional Director and amendments to the Rules of Procedure would improve governance of the Regional Office.

63. The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters, said that he had identified several themes in the comments made. The first was that the results chain should be used to derive a fully costed PB 2016–2017, with detailed descriptions of deliverables and outputs. Secondly, resource allocation should be strategic, transparent and results-based, with bottom-up planning and subsequent evaluation of outputs. The Committee had also asked for more strategic use of flexible resources. Lastly, the discussion held at the 118th session of the Executive Board could be a useful basis for discussions on resource allocation.

64. The Regional Director said that the Regional Office would continue to provide input to WHO reform. The SCRC had decided to set up a working group on the strategic allocation of resources, to support the Director-General; the terms of reference of the working group were being discussed. Country cooperation strategies had been found to be important in the Region and would be extended to other countries without country offices. The timeline of the country-focused policy at headquarters was not yet clear, but the regional policy would be aligned with global policies.

4.d. Outcome of the first Financing Dialogue
(EUR/RC63/19)

65. The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters, said that the Financing Dialogue had been designed to ensure a match between WHO's agreed deliverables and the resources required to finance them. During a meeting in June 2013, Member States had made commitments to certain characteristics of financing that were important to WHO, including aligning funding to the programme budget, increasing the predictability and flexibility of funding and broadening the range of contributors. Operational planning since that meeting was well

under way, a prototype web portal was being set up and bilateral meetings were being held with Member States that had expressed interest. Countries in the BRICS (Brazil, Russian Federation, India, China and South Africa) group and Gulf states were also being approached. A meeting to be held in November 2013 would allow contributors to express their financing commitments or intentions, and would indicate areas that were still under-funded; solutions to any under-funding could then be discussed. The meeting would require information on PB 2014–2015, which would be placed on the web portal, and on the distribution of voluntary contributions for 2014–2015 by category, programme and major office, which would require substantial input from Member States and other contributors. The next steps were for Member States to confirm bilateral meetings with the Secretariat and to encourage attendance at the meeting of senior representatives from development agencies and ministries of foreign affairs.

5. Implementing Health 2020: progress and developments since RC62 and launch of the *Review of social determinants of health and the health divide in the WHO European Region*

(EUR/RC63/Inf.Doc./1)

66. The President commented that, although reporting on Health 2020 to the Regional Committee was not required in 2013, the SCRC had nonetheless agreed to include it on the agenda to allow Member States to share their experiences in its implementation. Since the adoption of Health 2020 by the Committee in 2012, the Regional Office had taken action to raise awareness and to support Member States in creating the necessary conditions for implementation. Capacity must therefore be created in applying the basic values of Health 2020, social determinants of health, governance and intersectoral cooperation with the aim of establishing universal health coverage for better health outcomes. A number of Member States had or were preparing national policies based on Health 2020, which was also relevant subnationally, as in the WHO Healthy Cities and Regions for Health networks.

67. The Regional Director said that Health 2020 had been intended for practical implementation, with new tools and resources, including web-based platforms. The policy had been widely publicized at high-level events, and meetings had been held at country offices to foster its uptake. A clear sign of its acceptance was that most countries in the Region had requested technical support for setting up multisectoral partnerships. One country had tested the implementation plan, and several others had embarked on various aspects of the Health 2020 framework to guide policy-making at national level. The Regional Office itself was working in a holistic manner to provide support to countries, with consultants hired to complement existing staff. Targets and indicators had been proposed in order to measure and evaluate outputs, and those proposals would be discussed by the Committee.

68. The *Review of social determinants and the health divide in the WHO European Region* provided evidence that inequalities in health could be reduced. Although there were still discrepancies in, for instance, life expectancy within the Region, the causes were now known, and it had been shown that they could be reduced by universal access to high-quality health care and linkage to social policies. The practical implications of implementation of the recommendations of the review would be discussed in 2014. The publication was therefore being launched at the current session of the Regional Committee. It would be officially launched in London in late October. A further important publication was *Implementing a Health 2020 vision: governance for health in the 21st century*. Governance was closely linked to social determinants of health, and new forms were needed. Although countries might use different approaches, they would remain united in purpose while maintaining their particularities.

69. A video presentation was shown on inequities in social determinants of health.

70. The Director, Division of Policy and Governance for Health and Well-being reiterated that Health 2020 had been crafted as a strategy for action and innovation in national health policies, providing practical solutions to public health challenges that were based on evidence and information. It could also be used to compare policies and strategies among countries. Processes and mechanisms to engage other sectors in health-in-all-policies, whole-of-government and whole-of-society approaches were described as a means of developing health and resilience and empowering communities. The evidence base legitimized action, thereby providing a basis for political commitment, and made the case for the moral and economic aspects of health. Links had been forged between Health 2020 and every aspect of the work of the Regional Office, and cross-sectoral teams were working in countries. The implementation package contained tools, guides and services for communication and advocacy to involve other sectors; it would be important to develop use of social media in that respect.

71. A member of the SCRC, presenting the Standing Committee's position on implementation of Health 2020, said that the SCRC had expressed its strong satisfaction with the work of the Regional Office during the preceding year in supporting countries in introducing Health 2020. They had noted the impressive volume of activity expended to create the necessary preconditions: spreading awareness throughout the Region, integrating the values, principles and approaches of Health 2020 into all aspects of the Regional Office's work and capacity-building for implementation at Regional and country levels. The SCRC had been impressed by the commitment of the Regional Director and her team in operationalizing Health 2020. The Standing Committee welcomed the implementation package and particularly those elements for introducing the policy to other sectors, drawing up national health policies, introducing intersectoral and life-course approaches, systematically addressing inequalities and strengthening health systems and public health services,

the last of which was particularly important. The SCRC commended the Regional Office on the quality of the evidence and the practical guidance presented in the various publications that were being launched, which formed the backbone of Health 2020.

72. A panel discussion was held, moderated by the Professor of European Public Health, London School of Hygiene and Tropical Medicine, London, United Kingdom, and involving the Director-General for Public Health and Chief Medical Officer of Austria, the Ministers of Health of Latvia, Lithuania, Serbia, Turkey and Ukraine and the Deputy Minister of Health of Montenegro.

73. The Minister of Health of Turkey said that a multisectoral approach to health required strong overall leadership if other ministries were to become involved. In Turkey, equitable access to health care for the population had been assured during the past decade and the introduction of Health 2020 two years previously had added new dynamism to those efforts. Other sectors were finding that investment in human health led to improvements in their own spheres.

74. The ministers of health of Latvia, Lithuania and Serbia described the different bodies that had been set up to coordinate ministries in discussions on health in all policies. In Latvia and Serbia, ministers of other sectors had been persuaded that good health was the basis for social and economic development, whereas in Lithuania it had been difficult to involve all sectors and the involvement of the economic sector had been undermined by industry arguments.

75. The Minister of Health of Ukraine said that each government had to find its own methods for involving all sectors; however, political will was required to implement all the provisions of Health 2020. That was the case in her country, where binding legislation had been passed to implement the policy throughout the health system.

76. The Chief Medical Officer of Austria acknowledged that even though life expectancy was very high in her country, healthy life expectancy remained a challenge. The Government and Parliament had approved intersectoral policies for the development and achievement of health targets. A multi-stakeholder committee with involvement of civil society had been established to develop and prioritize 10 targets. The question now being addressed was the implementation and financing of intersectoral activities.

77. The Deputy Minister of Health of Montenegro stressed the usefulness of collaboration among small countries such as hers. Serbia had also developed collaboration with neighbouring countries, especially with regard to PHC. The Minister of Health of Ukraine, noting that resources to implement Health 2020 would always be scarce, said that emphasis should be placed on the quality of implementation. It was also important to choose the right partners, including community and voluntary organizations, and to approach international organizations.

78. Several participants referred to the strictures imposed by the recent financial crisis. In Latvia, elements of the public health infrastructure had had to be closed down; however, that had led to more efficient, more creative use of resources and to prioritization of PHC. The Minister of Health of Lithuania commented that during his country's presidency of the Council of the European Union he had noticed a basic misunderstanding that investment in health was considered an "expenditure", whereas it led to economic growth.

79. Several speakers mentioned the lack of practical tools for overcoming difficulties in implementation and for determining whether their results were comparable with those of other countries. Indicators and algorithms were needed to measure the effectiveness of health systems, with good examples. The Chief Medical Officer of Austria suggested that a dictionary of the words used by other political sectors be produced, so that convincing messages could be drafted.

80. In the ensuing plenary discussion, participants expressed their deep enthusiasm for Health 2020. It had given the European Region a powerful tool to reach the objectives of improving health for all, reducing health inequalities and strengthening leadership and governance for health. Its goals (such as disease prevention, healthy lifestyles, solidarity, accountability and intersectoral cooperation) were mirrored in many countries' health system priorities. Stimulated by that policy framework, countries were also adopting innovative policies, especially for vulnerable population groups such as children and people over 50 years old. The policy also afforded guidance when reforms to health care systems had to be made in response to the economic crisis. Focusing efforts on health promotion and disease prevention generated well-being and fostered social cohesion, while contributing to the sustainability of health systems in the medium and long terms. Developing community services and extending health insurance coverage were also being found to be cost-effective measures. Enhancing the role and functions of, an approach being adopted by several countries, would be the subject of a conference to be held in Almaty, Kazakhstan, in November 2013.

81. Nevertheless, intersectoral approaches to tackling health determinants, like those involving the whole of government or requiring the incorporation of health in all policies, were feasible only if a country already had a strong health sector. It was necessary to find ways of making health a key factor on the development agenda. One promising avenue had been to incorporate health in regional (subnational) development plans, in one case using the national Healthy Cities network for that purpose. Representatives recommended that the Regional Office provide countries with more opportunities to share such experience and exchange best practices of Health 2020 implementation. One cooperation platform was being provided through a five-year project for countries with a population of less than 1 million.

82. The Regional Director and her staff were thanked for the support they were providing. In particular, one representative said that he appreciated the assignment of an international expert to work with national personnel on policy development. The implementation of Health 2020 was forging closer links between Member States and the Regional Office.

83. The launch of the *Review of social determinants of health and the health divide in the WHO European Region* was warmly welcomed. It would be important for the findings of the review to be fully taken up and monitored in the strategic, technical and political areas of WHO's work. The Secretariat was therefore asked to start drawing up a draft resolution on that subject, for consideration by the Regional Committee at its sixty-fourth session.

84. Written statements were submitted by the Association of Schools of Public Health in the European Region, the International Association for Medical Education, the International Bureau for Epilepsy, the International Society of Physical and Rehabilitation Medicine, the Standing Committee of European Doctors and the World Federation of Acupuncture-Moxibustion Societies.

85. Responding to comments, the Regional Director informed participants that the Regional Office was reviewing the tools designed to assist with implementation of Health 2020, including those developed by partners and Member States, in order to identify any possible gaps. A forthcoming study by OECD and a web-based tool and sectoral briefs being developed at the Regional Office would complement the instruments available to Member States. In order to build capacity in Member States, she suggested that an expert group could be formed to promote Health 2020 implementation and carry out the necessary capacity-building activities, perhaps in cooperation with a wider network of specialists.

86. The Regional Director agreed that a draft resolution on social determinants and the health divide should be presented to the Regional Committee at its sixty-fourth session. The Director, Policy and Governance for Health and Well-being suggested that countries might consider local and subnational launches of the European review.

6. Health 2020 monitoring framework, including indicators
(EUR/RC63/8, EUR/RC63/Conf.Doc./7)

87. The Director, Information, Evidence, Research and Innovation recalled that when the Regional Committee had adopted the Health 2020 policy framework the previous year, it had also adopted "a set of regional goals … and the appropriate indicators for the European Region" (resolution EUR/RC62/R4). Building on the work done by a working group of the SCRC, an expert group (including representatives of OECD and EC) had accordingly met at the Regional Office in February 2013 and had proposed a set of quantified targets and a short-list of 20 indicators.

Following their review by the Standing Committee, a written country consultation on the indicators had been conducted in April 2013. Thirty Member States had responded to the consultation, expressing overwhelming support for the core and additional indicators. Many excellent and detailed comments had been made on their operationalization and further elaboration. The Standing Committee, at its May 2013 session, had subsequently agreed on the revised indicators and the accompanying draft resolution to be submitted to the Regional Committee.

88. In order to harmonize data requirements and reduce the reporting burden, nearly all indicators were routinely reported; two would be collated by the Regional Office through the health for all reporting process. The indicator of subjective well-being (life satisfaction) was also used in EU surveys; agreement had been reached with a survey provider to receive data on that indicator for all European Member States. Objective well-being indicators would be finalized by a working group and Member States by the end of 2013.

89. Reporting would be the responsibility of the Regional Office Secretariat. In addition to the annual report of the Regional Director, an annual publication on core health indicators had been launched, and it was planned to issue a new European health statistics publication and to set up a new European Regional health information platform in 2014. The *European health report 2012* also contained extensive statistical data, focusing on well-being.

90. A member of the SCRC paid tribute to the exemplary consultative process by which the list of proposed indicators had been drawn up. That process had been overseen by the SCRC targets working group. It was essential for the Regional Committee to adopt the indicators and monitoring framework, in order to monitor whether Health 2020 was making a difference to health and well-being in Europe. He stressed that the indicators were aligned with the Global Monitoring Framework on Noncommunicable Diseases, and that the burden of reporting on Member States would not be increased. The Standing Committee accordingly recommended that the draft resolution be adopted in its entirety.

91. All speakers in the ensuing discussion commended the excellent work done by the Secretariat in coordinating the work of various expert groups and engaging in extensive consultation with Member States. They were pleased to learn that steps had been taken to harmonize data requirements, rely on existing data and avoid double reporting. The creation of a unified information system would significantly reduce the workload of national specialists. Setting targets at regional level was sensible, since that would allow each country to determine actions based on its own starting points. One speaker, speaking on behalf of five countries, called for more of the indicators to be disaggregated by socioeconomic dimensions.

92. The proposal to complete elaboration of objective indicators of well-being by the end of 2013 was welcomed. The representative of one Member State drew attention to the importance of supporting families as the foundation of the physical and mental health and well-being of future generations. Another speaker asked for an explanation of the statement in the document, in the column headed "Core indicators", that "diseases of the digestive system (ICD-10 codes K00-K93) [are] suggested also but to be reported separately".

93. One representative, speaking on behalf of the EU and its member countries, proposed a number of amendments to the draft resolution, in order to support future work in that area. The Regional Director appreciated the fact that those proposals, which had strengthened the draft, had been circulated in advance and confirmed that they were in line with the "road map" agreed by the EC and the Regional Office for moving towards a unified health information system.

94. A written statement was submitted by the International Federation of Medical Students' Associations.

95. The Director, Information, Evidence, Research and Innovation thanked representatives for their comments. Countries were encouraged to submit indicator data disaggregated by, for instance, age, sex and ethnicity and by socioeconomic, vulnerable and subnational groups, where such data were available. Data on diseases of the digestive system should be regarded as an additional indicator. The Secretariat would be pleased to continue consulting with Member States in order to reach agreement on indicators of objective well-being by the end of 2013.

96. The Committee adopted resolution EUR/RC63/R3.

7. WHO European Ministerial Conference on nutrition and noncommunicable diseases in the context of Health 2020 (Vienna, Austria, 4–5 July 2013)

(EUR/RC63/14, EUR/RC63/Conf.Doc./10 Rev.1)

97. The Director, Noncommunicable Diseases and Life-course said that 15 of the 20 most important risk factors in the global burden of disease were related to nutrition and physical activity. Over half the population in 46 countries in the WHO European Region was overweight or obese, and all countries had per capita salt consumption levels far above those recommended by WHO. While many countries had taken policy action in areas related to information and awareness-raising, relatively few had engaged in environmental and legislative changes. To follow up the 2006 European Charter on Counteracting Obesity and the WHO European Action Plan for Food and Nutrition Policy 2007–2012, there had been a need for a renewed mandate for action by the Regional Office.

98. The Vienna Declaration adopted at the Ministerial Conference held in July 2013 covered five priority areas:
    - create healthy food and drink environments and encourage physical activity for all population groups;
    - promote the health gains of a healthy diet throughout the life-course, especially for the most vulnerable;
    - reinforce health systems to promote health and to provide services for NCDs;
    - support surveillance, monitoring, evaluation and research of the population's nutritional status and behaviours;
    - strengthen governance, alliances and networks and empower communities to engage in health promotion and prevention efforts.

99. In the Declaration, Conference participants had also urged the WHO Regional Committee "to mandate the development of a new food and nutrition action plan" and "to mandate the development of a physical activity strategy, alongside the new food and nutrition action plan." The action plan and strategy would be brought before the Regional Committee at its sixty-fourth and sixty-fifth sessions, respectively.

100. A member of the SCRC reported that, following a web-based technical consultation, a meeting of the Region's national focal points for nutrition had been held in Tel Aviv, Israel in March 2013, an "action network" meeting had taken place in Ankara in June 2013, a drafting group consisting of representatives of 16 Member States had been established, and the Regional Director had set up a "senator group" to advise on the scientific dimension and ensure that the Vienna Declaration was evidence-based. The Ministerial Conference had attracted more than 300 participants, with delegations from 43 European Member States, 28 of them at ministerial level. The outcome document fully incorporated the principles of Health 2020 and was in line with the United Nations Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases (2011) and the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, as well as the Global Strategy for Infant and Young Child Feeding. The SCRC accordingly encouraged the Regional Committee to endorse the Vienna Declaration.

101. In the ensuing discussion, representatives wholeheartedly thanked the Government of Austria for hosting the Ministerial Conference and expressed their support for the Vienna Declaration, noting that it represented a very relevant, timely and strategic milestone. They described some of the actions their countries were already taking to promote a healthy diet and reduce obesity, especially among children and adolescents, and to promote physical activity, two areas that should be taken forward in parallel. Preventive measures could only be effective if they addressed as many risk

factors as possible in a complex manner. That was why reducing nutritional risk factors for childhood obesity required coordinated action. High-level government commitment and multisectoral cooperation was crucial. One speaker drew attention in particular to the potential benefit to be derived from promoting physical activity and suggested that WHO collaborating centres could make a significant contribution to such work. The SEEHN Regional Health Development Centre for NCDs also had a role to play in increasing countries' capacity to implement agreed national and European commitments to reducing NCDs.

102. The proposal to draw up an action plan on food and nutrition and a strategy on physical activity was welcomed, especially in view of the need for cross-border action. New strategies that fell under the broad "umbrella" of Health 2020 should be complementary with it and support its horizontal approach, focusing on the root causes of ill health. Any engagement with non-State actors in developing the draft action plan on food and nutrition should be based on the principles for WHO's engagement with non-State actors to be decided by WHO's governing bodies in 2014, thereby avoiding any potential conflicts of interest. In addition, future proposals for action plans and strategies should be supported by information on the rationale behind the proposal, including the added value and the financial and other implications, when the proposal was first made.

103. One representative speaking on behalf of the EU and its member countries proposed a number of amendments to the operative paragraphs of the draft resolution.

104. Written statements were delivered by the International Federation of Medical Students' Associations and the World Cancer Research Fund International.

105. The Committee adopted resolution EUR/RC63/R4, as amended.

8. Eighth Global Conference on Health Promotion: the Helsinki statement on Health in All Policies: a call for action; including Europe Day – Promoting Health in All Policies – experiences from the European Region (Helsinki, Finland, 10–14 June 2013)

106. A participant from Finland explained that the Eighth Global Conference on Health Promotion had explored how to implement the health-in-all-policies (HiAP) approach throughout government, with special focus on its role in achieving the MDGs and in line with the process for defining the post-2015 development agenda. The Conference's Europe Day had showcased specific examples of problems and solutions in the European Region, addressing topics based on the priority areas of Health 2020. Its outcomes included the Helsinki Statement on Health in All Policies, with recommendations to governments and WHO, and the HiAP Framework for Country Action. The

main message was that governments should assign a place to health, among various competing priorities, in a transparent way.

107. In the discussion, speakers thanked the Finnish Government and WHO for organizing the Conference. The Helsinki Statement reaffirmed the need to include health in all policies in order to reduce social inequalities in health and improve the effectiveness of health policies. It could also be regarded as a logical follow-up to the Moscow Declaration from the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control held in 2011. Mental health had been a welcome inclusion in the Conference programme and one representative hoped it would also be included in a World Health Assembly resolution on the Conference. Another speaker identified a whole-of-government commitment to health promotion and HiAP as essential to securing priority for health.

9. High-level meeting on health systems in times of global economic crisis – an update of the situation in the European Region (Oslo, Norway, 17–18 April 2013)

(EUR/RC63/13, EUR/RC63/Conf.Doc./9)

108. The Director, Health Systems and Public Health described how the Regional Office was supporting Member States in responding effectively to the economic crisis by providing technical support, including robust new evidence. The outcome document of the high-level meeting set out 10 policy lessons and recommendations. The Regional Office's next steps would be to facilitate dialogue between the health and finance sectors, with partners such as OECD and the International Monetary Fund, to complete the generation of evidence with the European Observatory on Health Systems and Policies, to hold country policy dialogues, and to improve systems for monitoring the health impact of economic crises. All activities and staffing needs for that work were reflected in PB 2014–2015 under category 4, health systems.

109. The representative of Norway described the high-level meeting in 2013 as a follow up to the high-level meeting on "Health in times of global economic crisis: implications for the WHO European Region" that his country had hosted in 2009. Norway supported the 10 policy lessons and recommendations from the 2013 meeting, which had been developed through a consultation process. The proposed Regional Committee resolution built on them and on the 12 recommendations from 2009. Each additional year of budgetary restrictions made it more difficult to safeguard access to quality services and maintain UHC, so Norway strongly urged the Regional Office to continue its leadership and support to Member States.

110. In the ensuing discussion, all speakers thanked the Government of Norway and the Regional Office for holding the high-level meeting and welcomed the adoption of the Oslo outcome document.

Representatives also thanked the Regional Office and the Observatory for providing evidence and other support to countries facing the challenge of sustaining or even improving their health systems' performance during the current economic crisis. Speakers drew important lessons from the 10 recommendations in the outcome document and from their own achievements in sustaining and protecting their health systems and people's health.

111. A representative speaking on behalf of the SEEHN countries welcomed the timely presentation at the Oslo meeting of evidence on the health impact of the crisis. SEEHN would base its next consolidated actions on the 10 lessons and recommendations, which were aligned with the values of Health 2020 and the Tallinn Charter: "Health Systems for Health and Wealth". Its member countries invited the Regional Office to join their multipartner pilot project to deliver high-quality health promotion services at all levels of the health system.

112. Drawing on the outcome document and their experience, representatives reaffirmed that resilient health systems were better able to weather crises and reduce their negative effects on health. As well as threats, crises offered opportunities to make structural reforms of health systems and to explore new ways to generate resources, such as fiscal measures to control the use of tobacco and alcohol. Countries needed to take short-, medium- and long-term action to strengthen and protect health systems during crises, including balancing budgets and rationalizing services, but better resource management and allocation were not panaceas. Health systems also needed investment, and those that could prove their value in health and economic terms were more likely to secure sustainable financing.

113. Dialogue between the health and finance sectors and intersectoral mechanisms were important means of making the case for health, but supporting evidence was essential. Evidence brokers, such as the Regional Office and the Observatory, were needed to provide arguments tailored to support decision-making. In a complex environment, WHO's facilitation of the exchange of effective policies was valuable. Influential actors in Europe – such as WHO, the EU and OECD – should increase their cooperation to enhance the usefulness of health-system data from Member States and offer better tools to support countries.

114. A written statement was submitted by the International Council of Nurses.

115. In reply, the Director, Health Systems and Public Health thanked the Government of Norway and many other Member States for their strong call for the Regional Office to continue its leadership in health financing and the financial sustainability of health systems. Member States' most important message about the interplay of health and fiscal policies was that governments could choose where to allocate more or fewer funds, even within a restricted funding envelope. Priorities therefore

mattered, and they could be influenced through good intersectoral dialogue, evidence and listening to the voice of the people. That message was in line with the Tallinn Charter and echoed the call of the 2009 high-level meeting for every minister to be a health minister. WHO would continue to advocate health as a fundamental right, based on the values of solidarity and equity enshrined in Health 2020.

116. The Committee adopted resolution EUR/RC63/R5.

10. Progress in implementing the European Environment and Health Process – report of the European Environment and Health Ministerial Board

(EUR/RC63/10)

117. The Executive President introduced the report of the EHMB, which presented the work carried out on the commitments undertaken at the Fifth Ministerial Conference on Environment and Health in Parma, Italy, in 2010. The Board's work was closely related to Health 2020: the creation of resilient communities and supportive environments for health was one of the Health 2020 priority areas. Furthermore, through the European Environment and Health Process (EHP), WHO had pioneered the HiAP and whole-of-government approaches central to Health 2020. The EHP had led to the establishment of legally binding instruments on environment and health issues and had been instrumental in including the health dimension of climate change on the agendas of ministries of health and environment. A new governance mechanism for the EHP had been in place since 2010; the EHTF and the EHMB represented all Member States and stakeholders and led implementation of the Parma Conference commitments.

118. A member of the SCRC said that the Standing Committee had reviewed the report of the EHMB and noted with appreciation the efforts of Member States and other stakeholders, as well as the Secretariat, since the Fifth Ministerial Conference in Parma. Orienting Member States in their implementation of the Parma Conference commitments had been at the core of the EHP's renewed governance. That guidance was particularly important in the current economic climate; the effects of the financial crisis had significantly impacted on Member States' capacities to invest in primary prevention through a safer and cleaner environment. Although such investment was a strategic necessity with very high returns in health gains, it was often sacrificed as a dispensable luxury or perceived as an obstacle to economic growth. At the same time, the voluntary nature of the EHP made it dependent on the political interests of Member States and their active engagement.

119. In order for the EHP to remain relevant to both of its constituencies, steps should be taken to redefine the criteria underpinning the identification of its priorities. Mechanisms should also be developed to allow Member States to select and act on their own sets of priorities, in preparation

for the next Ministerial Conference on Environment and Health in 2016. Priorities should be set in the context of the main international policy frameworks undertaken since the Parma Conference, and account should also be taken of the interdependence of economic, social and environmental objectives. Turning to the issue of governance of the EHP, he said that new institutional arrangements had been made to optimize effectiveness, including the establishment of an intersessional programme of work.

120. A panel discussion was held, moderated by the Coordinator, Environment and Health, Division of Communicable Diseases, Health Security and Environment and involving the Minister of Health of Serbia, co-Chairperson of the EHMB, a representative of the Ministry of Health of Israel, the Deputy Director-General, Federal Ministry of Environment, Nature Protection and Nuclear Safety of Germany, the co-Chairperson of the EHMB, and a representative of the UNECE Executive Secretary.

121. The Minister of Health of Serbia, co-Chairperson of the EHMB, gave an overview of her Ministry's efforts to respond to the challenge of monitoring NCDs through cost-effective primary prevention, in line with the Parma Conference commitments. Joint action with the Ministry of Energy, Development and Environmental Protection had included two studies in the town of Zajača, the first on management of contaminated sites and the second to monitor lead exposure in children. A training workshop had been held on the elimination of asbestos-related diseases in southeast Europe. A national children's environment and health action plan had been drawn up, leading to a school survey project that aimed to improve indoor air quality in schools, ensure access to sanitation for children and promote physical activity. Air quality plans had been drafted for four cities. Lastly, Serbia was implementing a project for sustainable urban transport in Belgrade and had expressed its interest in signing the Amsterdam Declaration of the Transport, Health and Environment Pan-European Programme.

122. A representative of Israel, speaking on behalf of the Minister of Environmental Protection, acknowledged that health was an important factor in defining environmental priorities. Evidence of the health impacts of air, water and soil pollutants were leading to strengthening of environmental regulations. Reports on West Nile virus infection and leishmaniasis had led environment authorities to consider how to prevent the breeding of mosquitoes and sand flies. Joint environment and health sector efforts were important for promoting social and environmental equity by ensuring the right of all to a healthy and safe environment. Transboundary issues, such as air quality, vector control and waste water management could only be addressed through joint action between sectors and between nations.

123. On the question of whether investment in the environment could be viewed as de facto investment in health, he said that environment and health were closely linked and consideration should be given to the health consequences of environmental and development policies.

124. The Deputy Director-General, Federal Ministry of Environment, Nature Protection and Nuclear Safety of Germany, co-Chairperson of the EHMB, said that health was the key motivation for environmental regulation; environmental measures tended to receive greater support when they contributed to human health. The importance of the EHP was therefore beyond doubt. Health could not be achieved in a contaminated environment. Many multilateral agreements from the environment sector, such as those banning certain chemicals and pesticides or prohibiting the transport of hazardous substances, had implications for health. The environment and health sectors faced common challenges and shared common goals and should thus work together to seek solutions. Since contaminated water, polluted air, increasing traffic and climate change did not stop at national borders, they could only be addressed through international cooperation. The EHP provided a platform for both intersectoral and multilateral cooperation.

125. The representative of the UNECE Executive Secretary said that intersectoral cooperation and an integrated policy approach were the mainstay of UNECE's core business. The nexus of environment and health encompassed critical issues: the impact on human health of air pollution and greenhouse gas emissions in increasingly urbanized environments; the impact of climate change; and the increasing awareness of the importance of healthy lifestyles to overcome NCDs. The five multilateral environment agreements – UNECE's flagship product – addressed those concerns and should be viewed as health promotion tools, the implementation of which would contribute directly towards putting Health 2020 into practice.

126. UNECE's Transport, Health and Environment Pan-European Programme was a unique policy platform run jointly with the WHO Regional Office for Europe, which encouraged Member States to pursue an integrated policy approach to sustainable mobility. It had received renewed impetus and political support in 2009, with the adoption of the Amsterdam Declaration and its four priority goals. Preparations were currently under way for the Fourth High-Level Meeting on Transport, Health and Environment, which would take place in Paris in 2014.

127. The Deputy Director-General, Federal Ministry of Environment, Nature Protection and Nuclear Safety of Germany, co-Chairperson of the EHMB , speaking on the question of how governance and institutional mechanisms could be improved, said that an intersessional work plan was particularly important, with preparatory meetings for the EHTF. Member State input into how to shape EHP governance should be sought in future. Subregional meetings were being considered as a means of preparing for the upcoming midterm review. Host countries for the annual meetings of

the EHTF were required. Efforts should be made to strengthen communication with Member States, so that those not represented on the EHMB were fully included in the EHP. Emphasis should be placed on the implementation of the Parma Conference commitments, which should not be compromised by efforts to address emerging issues. The monitoring indicators for implementation of the commitments should be revised and the EHP governance process as a whole should be streamlined.

128. In the ensuing discussion, representatives welcomed the report of the EHMB. They expressed their commitment to the EHP and the implementation of the Parma Conference commitments. Several representatives shared their experiences and achievements, particularly with regard to improving sanitation and drinking-water quality. The implementation of the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes was particularly important in that regard.

129. Climate change posed considerable environment and health challenges, which required a consolidated response. In that regard, the United Nations Framework Convention on Climate Change (UNFCCC) was an excellent example of a multisectoral approach, and Member States should ensure that the health impacts of climate change were widely understood and reflected in UNFCCC negotiations. One representative, while acknowledging the link between the Rio+20 process for sustainable development and the EHP, underscored the importance of consolidating the EHP through streamlined governance procedures, focusing on deliverables, with the Parma Declaration as the point of departure.

130. The moderator said that the discussion had been an opportunity to reflect on the effectiveness of the institutional arrangements adopted in Parma, which aimed to bring a strong policy and political dimension to the HiAP process. Participation in and support to the EHP should not be seen as peripheral to the health agenda; it should be understood as an important means to address multiple challenges. The burden of disease in the European Region was determined by how and where people lived and worked, what they ate and drank and the air they breathed. A large part of well-being was determined by surroundings. Thanking the participants for their contributions, he said that the discussion had underscored the EHP's relevance and value added to both the environment and health constituencies.

11. Regional Framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases

(EUR/RC63/9, EUR/RC63/Conf.Doc./6)

131. The Director, Communicable Diseases, Health Security and Environment said that vector-borne diseases were both an old and a new problem in the WHO European Region: old, because

previously they had been mostly eradicated, and new because their presence, in the south of the Region in particular, had increased significantly during the latter half of the 20th century. The introduction of chikungunya fever in the north of Italy in 2007, locally transmitted dengue cases in the south of France and Croatia and the recent dengue epidemic in Madeira, Portugal were evidence that conditions in the Region were already suitable for transmission. The *Aedes albopictus* mosquito was established in the Region, and the return of vector-borne diseases would be even more likely if *Ae. aegypti* were reintroduced.

132. In order to prevent and tackle these diseases, WHO had developed a global strategy for dengue prevention and control, 2012–2020 and had held several meetings on invasive mosquito species. The Regional Office had provided technical support to Member States where necessary and had drafted the Regional Framework for the surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases, currently before the Regional Committee. The Framework was intended to support interventions in line with Health 2020; it required an integrated approach, through intersectoral activities in partnership with key actors in countries. It also required interregional action, in particular with the WHO Eastern Mediterranean Region. The Framework, which had been prepared in collaboration with ECDC and the European Mosquito Control Association (EMCA), aimed to raise awareness, integrate surveillance, prevent introduction and transmission and strengthen capacity to address re-emerging vector-borne diseases, particularly dengue and chikungunya fever. As well as *Aedes* mosquito species, the threat of other invasive insect vectors was increasing, owing to climate change, international trade, migration and rapid urban development. World Health Day 2014 would be organized on the theme of vector-borne diseases.

133. A member of the SCRC said that the Standing Committee, agreeing that a coordinated response between Member States was necessary to address the increasing incidence of vector-borne diseases in the Region, had reviewed the draft Regional Framework, which it fully supported. The Framework provided valuable technical guidance for surveillance and control and would support partnerships and coordinated action in affected areas. The SCRC recommended that the Regional Committee adopt the draft resolution.

134. In the discussion that followed, representatives agreed that the increasing threat of vector-borne diseases in the WHO European Region, which was being exacerbated by international trade and travel, required a coordinated response within and between countries. They therefore welcomed the development of the Framework, and expressed their support for the draft resolution. Several participants expressed their commitment to tackling the reintroduction of invasive mosquito vectors and vector-borne diseases into the Region and shared their experiences and efforts in that regard.

One representative drew attention to the successful public health response to a recent dengue epidemic in his country; a high level of preparedness had prevented any fatalities.

135. One representative proposed that the draft resolution be amended to include references to the *Culex* mosquito species and West Nile fever. Another offered support for future work undertaken in the context of the Regional Framework.

136. The Director, Communicable Diseases, Health Security and Environment said that the Framework was not exclusive to *Aedes* mosquito species. He underscored the need to improve monitoring and surveillance and drew attention to the fact that many countries no longer had functioning entomological services. Coordinated efforts were required at national and regional levels, and implementation of the IHR (2005) could play significant role. Collaboration with the ECDC and the EMCA would be key to the implementation of the Framework. While addressing the establishment of mosquito vectors was a very positive step, measures would also be required to address other vector threats emerging in the Region.

137. The Committee adopted resolution EUR/RC63/R6, as amended.

12. Progress report on measles and rubella elimination and the package for accelerated action to achieve elimination by 2015

(EUR/RC63/12)

138. The Director, Communicable Diseases, Health Security and Environment, recalled that progress towards meeting the 2015 target for elimination of measles and rubella in the Region was under threat. While major progress had been made against measles until 2009, in the absence of a high immunization coverage rate, pockets of unvaccinated populations remained and new outbreaks had occurred, especially in the western part of the Region. Therefore, the Regional Office had decided rapidly to strengthen certain country activities. Although elimination of rubella had appeared to be within reach in 2011, the disease had reappeared suddenly in parts of eastern Europe in 2012 and 2013. Neither disease was benign and both could result in death or complications, even though they were vaccine-preventable. More and more cases of measles were being seen in adolescents and young adults who had not been vaccinated as infants.

139. The criteria for verifying elimination of both diseases in the Region were: vaccine coverage of at least 95% and the absence of endemic cases in all Member States for at least three years. Progress must be documented with high-quality data on surveillance and immunization coverage sent to WHO; however, not all countries had established a national verification committee or sent annual reports to the Organization. The package of accelerated action for elimination of measles and rubella in the Region had six components: strengthening of vaccination, surveillance, outbreak

prevention and response, communication and advocacy to all sectors of society, resource mobilization and partnerships and verification of elimination. Cross-border and inter-regional coordination would be strengthened, particularly with the WHO Eastern Mediterranean Region.

140. The former WHO Regional Director for the Americas shared the experience of that Region, which showed that transmission of measles and rubella could be halted. That had been made possible by political commitment, creative solutions, determination, solidarity and unity of purpose. By 1993, cases of measles were concentrated in the United States of America and Canada, and the First Lady of the United States had involved other first ladies in the goal of elimination. After a substantial decrease in the number of cases, however, outbreaks began, and it was found that cases were occurring among adolescents and young adults and on country borders in unvaccinated or under-vaccinated groups. Therefore, targeted vaccination programmes, through national or subnational immunization campaigns had been set up to reach those populations, and vaccine against rubella was included. On the basis of analysis of the outbreaks, the vaccination target age was raised to 14 years and then to 39 years, when young and adult males were identified as an important source of infection of women and children. Therefore, vaccination posts were set up at the entrances to all places at which young men gathered. The last case of indigenous measles had been recorded in 2002 and the last case of rubella in 2012.

141. The lessons to be learnt were that political will and support could be gained by demonstrating that vaccination was one of the simplest measures of protection; communities should be mobilized for health and not for disease; and a good surveillance system was needed to provide good, timely information. The elimination of measles and rubella would demonstrate progress in addressing the social determinants of health and good governance, as elimination of the two diseases was cost-effective and operationally feasible. Anti-vaccine movements should be counteracted by active involvement of medical and health professionals. Constant vigilance was required to prevent importation of the viruses, especially in view of the exponentially growing numbers of vulnerable people in the European region due to ageing, chronic diseases and long-term treatment of AIDS.

142. A representative speaking on behalf of the member countries of the EU raised the possibility that the 2015 target for elimination of measles and rubella be extended and asked the Secretariat to propose options at the sixty-fourth session of the Regional Committee. Large outbreaks of measles represented a serious cross-border threat in the Region, and congenital rubella remained a problem. The EU and its member countries would continue efforts to achieve the target, with high vaccination coverage of all groups, including those that were hard to reach and those with ideological objections to vaccination. They would also improve preparedness for outbreaks, monitor vaccination coverage and establish national verification committees; strengthen public

trust in and the commitment of health care workers to vaccination; and challenge misinformation spread by anti-vaccination groups.

143. Representatives welcomed and strongly supported the package for accelerated action to achieve elimination of measles and rubella by 2015, which provided a timely coordinated strategy for elimination that was applicable to the entire Region. Several described activities undertaken in their countries to strengthen vaccination, especially among groups with low coverage, to improve epidemiological surveillance and laboratory support and to increase awareness and communication on the benefits of vaccination. One representative proposed that a guide on the safety of vaccination be prepared for the public.

144. A statement was made on behalf of the GAVI Alliance.

145. The Director, Communicable Diseases, Health Security and Environment, responding to representatives' comments, welcomed the renewed momentum for elimination of the two diseases and thanked the former Regional Director for sharing the positive experience of the Region of the Americas. Recalling that the criteria for elimination required a period of three years after reporting of the last indigenous case of disease, he nevertheless urged countries to strive for an end to transmission by 2015. Importation of cases by migrants was perhaps unavoidable; however, if the recipient population was adequately covered by immunization, there would be no outbreaks of the diseases. He welcomed the call for greater emphasis on communication about the safety of vaccination, for both the general population and the medical community. The elimination target could only be met through strong political will and concerted, coordinated measures.

13. Governance of the Regional Office for Europe

13.a. Amendments to the Rules of Procedure of the Standing Committee of the Regional Committee and of the Regional Committee

(EUR/RC63/16 Rev.1, EUR/RC63/Conf.Doc./5 Rev.1,)

146. The Chair, SCRC Working Group on Governance, said that the Working Group had consisted of SCRC members from Finland, Israel, Malta, Poland, Russian Federation, Turkey and United Kingdom. Set up at the Twentieth SCRC's second session in November 2012, it had held meetings in February, March and April 2013 and had reported back to the SCRC at its sessions in March and May 2013.

147. At the outset, the Working Group had been tasked with reviewing six areas of governance:

- procedure for nomination of members of the Executive Board and the SCRC
- transparency of SCRC proceedings

- procedure for submission and amendment of Regional Committee resolutions
- credentials screening mechanism at Regional Committee sessions
- communication by SCRC members with Member States
- amendments to the Rules of Procedure of the Regional Committee.

148. Two further issues had been added in March 2013:
    - election of members of the EHMB
    - Code of Conduct for the nomination of the Regional Director.

149. The Working Group's recommendations, as endorsed by the SCRC and set out in document EUR/RC63/16 Rev.1, had been reflected in the draft resolution under consideration by the Regional Committee (EUR/RC63/Conf.Doc./5 Rev.1). They included amendments to the Rules of Procedure of the Regional Committee and of the Standing Committee of the Regional Committee, as set out in Annex 6 of the draft resolution.

150. The Chair, SCRC working group on governance, proposed two additional amendments to the draft resolution. SCRC members' contact details should be posted on the password-protected web site (paragraph 43 of the document and operative paragraph 5 of the draft resolution should be amended accordingly). Furthermore, with the aim of promoting transparency of SCRC proceedings, the first bullet point in Annex 4 of the draft resolution should be amended to read: "The agenda of each SCRC meeting and a list of the documents to be discussed will be published on the password-protected web site well ahead of the meeting and, in the case of the May meeting of the SCRC, draft documents will be made available to Member States at the same time as to members of the Standing Committee".

151. In the ensuing discussion, one representative, speaking on behalf of 13 Member States, expressed satisfaction at the institutionalization of proposals that had originally been put forward at the sixtieth session of the Regional Committee. In order to facilitate common medium- and long-term planning, she called on the Secretariat and the SCRC to share work plans with all Member States. Welcoming the clarity provided by the annexes to the draft resolution concerning criteria for candidates (Annex 2) and overviews of vacant seats on the Executive Board and the Standing Committee (Annex 3), she requested that they should always be circulated together with the call for nominations. In line with discussions at the sixtieth session, she pointed to the need for draft documents to be available to non-SCRC members, on request, in the language(s) in which they had been prepared for the SCRC.

152. Another speaker thanked the SCRC for its work and for taking into account comments made by Member States at a late stage. She called for the financial implications of measures proposed in

draft resolutions to be quantified, and for multilingualism to be scrupulously respected. She asked whether the Credentials Committee would consist of one representative from each subgroup of countries as used for nominations to the Executive Board and the SCRC. Lastly, she called for paragraph IV.4 in section B of the Code of Conduct for the Nomination of the Regional Director of the European Region of the World Health Organization (as contained in Annex 6 to the draft resolution) to be amended to read: "The Regional Director may suggest that the Director-General consider applying Staff Rule 650 concerning special leave to staff members who have been proposed for the post of Regional Director", since the current wording was not in line with the Staff Rule cited.

153. One outgoing member of the Standing Committee, who had also served on the Working Group, strongly supported the proposals of the SCRC and was proud of the increased transparency that had been achieved during her term of office. She urged countries that were not members of the SCRC to continue to pay attention to governance issues, since they were a question of building and strengthening the foundations of integrity and trust between the Member States and the Secretariat.

154. In response, the Chair, SCRC Working Group on Governance endorsed the proposals to facilitate common medium- and long-term planning, to make specific draft documents available to Member States at their request, and to circulate overviews of vacant seats with the call for nominations. He explained that the proposed composition of the Credentials Committee was not linked to the subregional groupings of countries.

155. The Regional Director noted that in recent years good progress had been made in strengthening the decision-making role of the regional governing bodies and increasing their transparency as well as the Secretariat's accountability to them. Although the agenda of sessions of the Regional Committee was sometimes extensive, she welcomed the increasing number of items being referred to it from the Organization's global governing bodies, as evidence of closer linkages between the various levels of governance. The question of how best to present the financial implications of draft resolutions would be reviewed by the SCRC, given the new financial context in place with the adoption of PB 2014–2015. In the meantime, members of the Secretariat, when presenting draft resolutions, had been indicating how the proposed actions fitted into the World Health Assembly-approved budgetary framework.

156. The Organization's Legal Counsel confirmed that Staff Rule 650 was exercised at the Director-General's discretion. The proposed amendment to the Code of Conduct for nomination of the Regional Director was fully in line with, and indeed clarified, that provision.

157. The Committee adopted resolution EUR/RC63/R7, as amended.

13.b. Review of the status of resolutions adopted by the Regional Committee during the past ten years (2003–2012) and recommendations for sunsetting and reporting requirements
(EUR/RC63/17 Rev.1, EUR/RC63/Conf.Doc./12 Rev.1)

158. The Deputy Director, Communicable Diseases, Health Security and Environment recalled that at its fifty-eight session the Regional Committee had called for clear reporting requirements, specific end dates for each resolution and discontinuation of open-ended reporting (resolution EUR/RC58/R5). In 2012 the Regional Committee had been presented with a review of commitments (resolutions, ministerial-level policies and legal instruments) made in the period 1990–2010. It had welcomed the review and requested the Secretariat to submit, at the current session, a document reviewing the resolutions currently in force and proposals for reporting schedules and sunsetting.

159. The working paper under consideration accordingly contained a review of the 83 resolutions, in their entirety, adopted by the Regional Committee between 2003 and 2012, presented according to the categories used in the Twelfth General Programme of Work. Forty-six resolutions requiring action were identified for new reporting requirements, while it was proposed to sunset 18 resolutions that had been superseded by subsequent resolutions.

160. A member of the SCRC reported that the Secretariat had presented drafts of the document at the Twentieth Standing Committee's second and third sessions. The resulting paper reflected the discussions and input from the two SCRC sessions, as well as from a web-based consultation with Member States. The SCRC recommended that future resolutions should reference the past resolutions that they superseded, and that they should be reviewed for compatibility with the approved programme budget and should be in line with Health 2020. The SCRC also requested the Secretariat to develop a searchable database, with links to relevant supporting documents, so that resolutions in force could be easily monitored. The Standing Committee endorsed the proposals for reporting and sunsetting contained in the working paper and asked the Secretariat to discontinue the practice of open-ended reporting in the future.

161. In the discussion, one representative called for the proposal concerning resolution EUR/RC60/R3, Governance of the WHO Regional Office for Europe, as set out under category 6 in document EUR/RC63/17 Rev.1, to be amended to read: "The Standing Committee to initiate a comprehensive review of governance at least every five years and report back to the Regional Committee subsequently." Another speaker, recognizing that sunsetting was a good practice for alleviating the workload on national health authorities, suggested that a similar exercise could usefully be carried out with regard to indicators. While sunsetting could be regarded as "secondary prevention", it was important to engage in primary prevention by limiting the number of new resolutions that were added in future.

162. Responding to the comments made, the Deputy Director, Communicable Diseases, Health Security and Environment confirmed that the proposed amendment to the document was fully in line with the views expressed by the SCRC working group on governance and WHO reform on governance. The resolution on Indicators for Health 2020 targets (resolution EUR/RC63/R3) was a good example of application of the sunsetting approach in another area.

163. The Committee adopted resolution EUR/RC63/R8, as amended.

14. Elections and nominations

(EUR/RC63/7 Rev.1, EUR/RC63/7 Add.1, EUR/RC63/Conf.Doc./4, EUR/RC63/Inf.Doc./2)

164. The Committee met in private to nominate two candidates for membership of the Executive Board, to elect four members of the SCRC, to elect four members of the EHMB and to appoint three members and three alternates to the Regional Evaluation Group.

14.a. Executive Board

165. The Committee decided that the Russian Federation and the United Kingdom would put forward their candidatures to the World Health Assembly in May 2014 for subsequent election to the Executive Board.

14.b. Standing Committee of the Regional Committee

166. The Committee selected Belarus, Estonia, France and Latvia for membership of the SCRC for a three-year term of office from September 2013 to September 2016.

14.c. European Environment and Health Ministerial Board

167. The Committee selected Croatia and Georgia for a two-year term of office (2014–2015) on the EHMB and Lithuania and Spain for a three-year term of office (2014–2016), exceptionally.

14.d. Regional Evaluation Group

168. The Committee appointed Dr Daniel Reynders (Belgium), Ms Outi Kuivasniemi (Finland) and Dr Svetlana Axelrod (Russian Federation) as members of the Regional Evaluation Group, and Professor Maksut Kulzhanov (Kazakhstan), Professor Vilius Grabauskas (Lithuania) and Mr Mykhailo Statkevych (Ukraine) as alternates.

15. Partnerships for health

169. The Executive President recalled that the Regional Committee, at its sixtieth session, had passed a resolution on partnerships for health in the European Region, asking the Regional Office to develop partnerships that benefitted all Member States and to strengthen strategic relations with partners. Excellent progress had been made in strengthening relations with the EC, the OECD and the Global Fund, along with many other partners, including nongovernmental organizations. In order to accelerate progress towards achieving the MDGs, relations with two United Nations partners – UNICEF and UNFPA – would be scaled up. To that end, the Regional Director would sign a joint framework for action with the UNFPA Regional Director for Eastern Europe and Central Asia and the UNICEF Regional Director for Central and Eastern Europe and the Commonwealth of Independent States.

170. The Regional Director reported that excellent progress had been made with existing partners. She elaborated on implementation of joint road maps with the EC, ongoing collaboration with the Global Fund, including joint missions and greater use by the Global Fund of WHO norms. She also described joint work with the OECD on indicators, common information systems for health, and meetings with the Senior Budget Officials network. Good coordination and synergy among United Nations agencies was essential for reaching common goals, and to work more effectively and efficiently, including through the Regional Coordination Mechanism and the Regional United Nations Development Group (UNDG) Team, to which she was committed. The interagency working group on the MDGs had issued reports on progress towards meeting the MDGs and on the United Nations post-2015 development process, as well as a number of advocacy and issue briefs. Many WHO country offices were members of United Nations country teams, working on United Nations Development Assistance Frameworks (UNDAFs). Under the auspices of the UNDG, United Nations agencies were collaborating through a regional working group on Roma, and WHO was working with other agencies to include Roma issues in work on MDGs 4 and 5.

171. The signature of the framework agreement for joint action would be timely for several reasons. Health 2020 had been recognized by other agencies as providing excellent entry points for their work with governments, parliamentarians, civil society and communities to mobilize broad-based political and cultural support for equitable, sustainable, accountable approaches to health development. The year 2015, the deadline for achieving the MDGs, was approaching fast, whereas there remained large disparities in and between countries in, for instance, maternal and infant morbidity and mortality, the availability of effective family planning, sexual and reproductive health services, vaccination coverage for communicable diseases and control of HIV infection and M/XDR-TB.

172. In the joint framework for action, the three agencies committed themselves to consolidating their work to improve the quality of health care delivery for women and children and ensure universal health coverage, especially for underserved and vulnerable populations. The framework also contained priorities for bilateral action and made a commitment to strengthen mutual accountability and monitoring of implementation.

173. The UNICEF Regional Director said that much had been achieved in the Region with regard to mortality rates among children under five years and the maternal mortality ratio. Close partnerships had been established between governments, United Nations agencies and other development partners to support implementation of several programmes and initiatives, and the Regional Coordination Mechanisms, United Nations country teams and UNDAFs had resulted in more effective support to countries. Challenges persisted, however, with respect to disparities in child and maternal mortality rates, which were often masked by national averages. Coverage with health services was not effective if the services were not of high quality, and that remained a concern in some countries. The fast-growing HIV epidemic and problems of nutrition in children were persistent challenges. Emerging issues concerning children included impaired development, neglect of disabilities, abandonment, abuse, institutionalization and mental health, while it was well recognized that adverse childhood experiences had a long-lasting impact on well-being later in life. Those challenges called for stronger partnerships for policy-setting, innovation, knowledge generation and cooperation among countries. A pledge to meet the target of 20 or fewer deaths per 1000 live births by 2035 had been signed by 157 governments, more than 400 civil society organizations and over 1100 individuals; the Region could be the first to attain that ambitious target.

174. The joint action framework with WHO and UNFPA would consolidate their efforts to achieve equity, enhance the capacity of public health systems to focus on and be responsive to people, particularly in early childhood, through integration of care systems. UNICEF was therefore pleased to be signing the framework that would allow each agency to capitalize on the comparative advantages of all. UNICEF was committed to translating the framework into operational plans, with regular communication and periodic reviews.

175. The Regional Director for Eastern Europe and Central Asia of UNFPA said that the joint action framework was being signed at an important time for the health and development agenda. It would contribute to ensuring social equity, with better alignment of the contributions of United Nations agencies and their member states. The scientific information underpinning Health 2020 and UNFPA’s review of achievements in the programme of action of the International Conference on Population and Development showed that societies could prosper under conditions of slow or no population growth and ageing if they adapted their institutions and invested equitably in education,

health and employment opportunities. The inequalities that existed in the Region, particularly as they affected young people, would require strong political leadership and engagement of a broad range of stakeholders.

176. UNFPA was committed to advancing MDG 5 and ensuring universal access to sexual and reproductive health and reproductive rights, including redressing disparities in access, the rising rate of HIV infection and other sexually transmitted infections, and the high incidence of cervical cancer. The joint framework for action would provide an opportunity to do more together and to optimize working methods.

177. A representative of the country that would next hold the presidency of the Council of the European Union said that its work would include addressing cross-border health threats and tobacco products, pharmaceutical and medical products and drugs and drug addiction. It would support the work of the high-level working group on public health with regard to establishing modern, viable health care systems in times of economic crisis and for chronic diseases, as well as migration and public health. All this would be achieved through events, including a series of high-level conferences. She said that support from the Regional Office and Member States would be required to achieve those objectives.

178. The WHO Regional Director and the regional directors of UNICEF and UNFPA signed the joint framework agreement for action.

16. Geographically dispersed offices: business cases and progress reports

(EUR/RC63/22 Rev.1, EUR/RC63/Conf.Doc./11 Rev.1, EUR/RC63/23, EUR/RC63/23 Corr.1, EUR/RC63/Conf.Doc./13, EUR/RC63/Inf.Doc./5, EUR/RC63/Inf.Doc./6, EUR/RC63/Inf.Doc./6 Corr.1, EUR/RC63/Inf.Doc./7, EUR/RC63/Inf.Doc./8, EUR/RC63/Inf.Doc./11, EUR/RC63/Inf.Doc./13)

16.a. GDO on Primary Health Care

179. The Director, Health Systems and Public Health, recalled the historic declaration on PHC signed in Alma-Ata, Kazakhstan, in 1978, which had called for more social justice, more grassroots involvement and greater investment in human health. PHC had been one of the pillars of Health 2020. The workplan of the Health Service Delivery Programme of the Division of Health Systems and Public Health covered strengthening the coordination and integration of people-centred health services, ensuring high-quality systems and the performance of health providers, enhancing management and leadership and strengthening care settings; however, the Programme had inadequate human resources to cover all those areas. The proposed GDO would support the gathering of information on PHC, develop technical skills, increase the capacity of Member States

and the Regional Office and engage in partnerships. The work of the GDO would be fully aligned with that of the Regional Office. The offer made by Kazakhstan met all the essential requirements for hosting a GDO, including sustainable funding. The host government had specified that the premises would be in Almaty and confirmed the privileges and immunities of GDO staff. If the Regional Committee approved the offer, the announcement of the office could coincide with the 35th anniversary of the Alma Ata Declaration on PHC. He thanked the Government of Kazakhstan for its generous, timely proposal.

180. A representative of the government concerned said that it fully supported the report and the business plan. Accessible, high-quality PHC was essential in all WHO regions, especially in rural areas, and played an important role in reducing risks for NCDs. She was convinced that her Government had met all the necessary requirements for setting up the GDO and looked forward to it becoming operational.

181. A member of the SCRC said that PHC was the cornerstone on which people-centred, integrated health systems were built, and was a priority for WHO; however, the Regional Office lacked sufficient capacity to respond to the many requests by Member States for technical assistance. She described the process whereby the technical profiles and business cases for new GDOs had been developed, reviewed and finalized with the full involvement of the SCRC. She commended the transparency of that process, and said that the SCRC fully supported the business case and offer from Kazakhstan.

182. Representatives welcomed the offer from Kazakhstan, which was particularly timely in view of the current financial crisis.

183. The Director, Health Systems and Public Health, thanked representatives for their support. The GDO on PHC would allow the Regional Office to respond to the increasing requests for technical assistance in PHC and promote the achievement of UHC in the Region.

184. The Committee adopted decision EUR/RC63(1).

16.b. GDO for preparedness for humanitarian and health emergencies

185. The Director, Communicable Diseases, Health Security and Environment, described the many humanitarian and health emergencies that had occurred in the Region between 1990 and 2012. Similar situations had been seen in other WHO regions, which had led the Health Assembly to request Member States to strengthen all-hazards health emergency and disaster risk management. Furthermore, the new WHO emergency response framework defined a greater role for regional offices in improving national preparedness for public health emergencies. The capacity of the

Regional Office had been limited in that regard, and therefore had to be expanded. Consultations with the SCRC had led to a change in the name of the proposed GDO from "humanitarian crises" to "humanitarian and health emergencies" to better reflect the scope of the office's work. The activities of the GDO would be fully integrated into the Regional Office's work on health security and would be coordinated with that at headquarters and, as needed, country offices. It would undertake assessment of health systems for emergency preparedness, facilitate training of human resources, provide support for hospital emergency preparedness, support preparedness in mass gatherings and organize national and regional exercises to test emergency preparedness. The GDO would also constitute surge capacity if WHO required further resources in response to humanitarian or health emergencies.

186. The Government of Turkey had offered to host the GDO and met all the necessary conditions, including the provision of sustainable long-term funding. It would also maintain the premises, which would be in Istanbul. Turkey had also offered the possibility of providing additional means in the technical area of supporting the programme for country emergency preparedness at the Regional Office.

187. A representative of the country concerned said that he would like to see WHO playing a leading role in the response to global emergencies. He assured the Committee that the activities of the GDO would be fully integrated with those of the Regional Office. Increased cooperation was the only means of minimizing the tragic loss of human life due to humanitarian emergencies, and his country attached importance to transmitting the valuable lessons it had learnt from events on its borders, in the Region and globally.

188. A member of the SCRC described the process whereby the technical profiles and business cases for new GDOs had been developed, reviewed and finalized with the full involvement of the SCRC. She commended the transparency of that process, and said that the SCRC fully supported the business case and offer from Turkey.

189. The Committee adopted decision EUR/RC63(2).

16.c. GDO for Noncommunicable Diseases

190. A representative of the country that was to host the GDO for NCDs described the series of consultations that had led up to approval of the budget and financing of the GDO and the work plan. The Ministry of Health, having fulfilled all the requirements, including those related to sustainable funding, had committed to opening the GDO in Moscow in the first half of 2014.

191. The Regional Director said that when the Government of Greece had had to withdraw its offer to host the GDO for NCDs, the technical profile of the proposed GDO had been discussed with the SCRC, and a decision had been taken that it would focus on epidemiological surveillance and disease management, to complement the work performed at the Regional Office. A business case and a timetable for opening the GDO had also been agreed.

192. A representative of the country that had originally offered to host the GDO on NCDs congratulated the Russian Federation on its offer. She was convinced that its operation would be fully supported and that it would provide valuable technical assistance in gathering evidence and implementation of actions to combat NCDs. Hosting the GDO had been a high priority for her country; however, economic difficulties had made it impossible to follow through the offer. Her Government had expressed its willingness to host a WHO country office.

16.d. Barcelona Office for Health System Strengthening

193. The Head, ad interim, Barcelona Office for Health Systems Strengthening presented the work of the Barcelona Office, which had been operating since 1999 under a five-year renewable agreement with the Regional Autonomous Government of Catalonia. The Office and its workplan were fully integrated into the Regional Office. In 2007, the Office's main sphere of activity had changed from integrated health service delivery to health financing. The Office had a strong country support programme, and demand from Member States was increasing. The Barcelona Office conducted two flagship courses each year, one on health systems strengthening with a focus on NCDs and the other on health financing policy with a focus on UHC. The Office was fully funded by the host, and attracted additional donor funding. The Office was due to relocate to the Hospital Sant Pau UNESCO heritage site with a number of other United Nations agencies.

194. A representative of Spain acknowledged the important support that GDOs provided for the Regional Office. Although her Government appreciated the work being carried out by the Barcelona Office in respect of health systems strengthening, it regretted the irregular administrative situation of the Office. While the Ministry of Health was committed to finalizing the host agreement for the Office, the current circumstances were not conducive to obtaining a swift resolution of such a long-standing and complex situation. The conclusion of the agreement remained, however, a priority for the Spanish Secretary-General of Health.

16.e. WHO European Centre for Environment and Health

195. The Acting Head, WHO European Centre for Environment and Health, said that the Centre was the largest of the existing GDOs. It had been established in 1990 as the key European technical institution for environment and health. Since the end of 2011, after the closure of the Rome office,

environment and health activities had been consolidated in Bonn, Germany, and the previous 10-year agreement had been replaced by one ensuring indefinite support. The contribution of the German Government represented about 40% of the Regional Office's budget for environment and health, aligned with the WHO biannual programme budget cycle. Since 2010, it had been financed entirely by voluntary contributions. After the closure of the Rome office, overall administrative and operational costs had been significantly decreased, with a shift of funds to technical areas, and it was now a centre of excellence providing scientific information that was used as a basis for legislation and policies. The Centre was fully integrated into the Regional Office structure and provided a wide spectrum of expertise as a basis for policy-making and raising awareness about issues of public health concern. The Centre also supported Member States in achieving national priorities in environment and health in line with the Parma Declaration, including the health and economic impacts of climate change, and conducted numerous capacity-building activities.

196. A representative of the host country said that his country was committed to improving the environment and health and attached great importance to its commitments under the Parma Declaration on Environment and Health. He emphasized that the post of director of the Centre would soon be filled.

16.f. WHO European Office for Investment for Health and Development

197. The Head, WHO European Office for Investment for Health and Development, Venice, said that the Office had two main functions: monitoring, review and systemization of evidence on the social and economic determinants of health, and provision of services to and cooperation with Member States to act on that evidence. The Office had opened in December 2003 under a 10-year host agreement; the renewal agreement for the period 2013-2017 had been signed and was awaiting ratification. The Office was an integral part of the Regional Office. Its achievements could be grouped into three areas: scientific products, consisting of over 60 publications; technical assistance, especially training in conducting country-wide assessments, with a steady increase in requests; and follow-up of Regional Committee and World Health Assembly resolutions and global commitments, such as Regional Committee resolution EUR/RC62/R4 on Health 2020 and World Health Assembly resolution WHA62.14 on reducing health inequities through action on the social determinants of health. The budget of the Office was provided through an agreement with the Italian Government and had been predictable for 10 years. Like other GDOs, the Office contributed much valuable work. As the social determinants of health were a key element of Health 2020, he foresaw an increase in the number of requests for technical assistance, most of which would be for medium- or long-term support. The Regional Office would have difficulty in meeting those requests if the GDOs did not exist.

198. A representative of the host country said that all the necessary preparations had been made for ratification of the renewal agreement, which had involved inter-ministerial meetings and consultations with other national administrations and the Veneto Region as co-signer of the agreement. The delay was due partly to a change in government. He was confident that the issue would be resolved shortly.

199. One representative, speaking on behalf of seven countries, thanked the governments of Kazakhstan and Turkey for offering to host and finance GDOs, thus furthering the work of the Regional Office. New GDOs were based on a 10-year commitment from the host country, and similar financing commitments could be made for the existing GDOs. The reports had shown that the GDOs employed competent, hard-working staff, who produced good work and formed an essential part of the Regional Office's expertise. However, that was not fully in line with WHO reform, in which secure, predictable funding for core areas of WHO's work was a feature. He believed that sustainable and secure funding would be assured through centralized, coordinated financing. That would enable WHO to have the technical expertise it needed without the risk of having to dissolve teams at the end of their GDO hosting contract. It would also ensure centralization of normative and technical expertise and avoid fragmentation of competence. WHO's normative guidance must come from its major offices; therefore, the GDOs must remain fully integrated with the Regional Office. If WHO reform was successful, the Regional Office would rely less on GDOs in its business model. He urged all Member States to participate actively in the Financing Dialogue and to support WHO reform. Only by securing predictable financing and coordinated resource mobilization could WHO be enabled, both globally and within the Region, to maintain its technical expertise and normative authority.