World Health Organization
REGIONAL OFFICE FOR Europe

Eighteenth Standing Committee of the Regional Committee for Europe
Second session

Andorra, 18–19 November 2010

EUR/RC60/SC(2)/REP
4 April 2011
110102
ORIGINAL: ENGLISH

Report of the second session

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE
Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark Telephone: +45 39 17 17 17 Fax: +45 39 17 18 18
Electronic mail: rc@euro.who.int World Wide Web address: http://www.euro.who.int/en/who-we-are/governance

Introduction

1. The Eighteenth Standing Committee of the WHO Regional Committee for Europe (SCRC) held its second session at the Congress Centre in Andorra La Vella on 18 and 19 November 2010. Apologies for absence were received from Zita Kucinskiene, Lithuania (replaced by alternate member Viktoras Meizis) and from Vladimir Lazarevik (Executive President of the sixtieth session of the WHO Regional Committee for Europe – RC60).

2. In her opening statement, the Regional Director noted that all the newly appointed directors of divisions at the WHO Regional Office for Europe were attending a session of the SCRC for the first time. Reorganization of the Regional Office had been completed, and attention was now focused on recruitment (or secondment) of staff to fill mission-critical senior technical positions. Members of the Regional Office's executive management team had participated in a number of events organized by the country holding the presidency of the European Union (EU) and hearings at the European Parliament, as well as in a conference organized by the Organisation for Economic Co-operation and Development (OECD) and the World Health Summit (Berlin, 23–26 October 2010). In addition, the Regional Director had attended a meeting of the Organization's Global Policy Group (comprising the Director-General, assistant director-generals and regional directors), at which subjects discussed had included priorities for the coming year (notably noncommunicable diseases – NCDs) and the future financing of WHO.

3. The report of the Eighteenth SCRC's first session (Moscow, 16 September 2010) was adopted without amendment.

4. On the second day of the session, an address was delivered by the Minister of Health, Welfare and Labour of Andorra.

Follow-up to the sixtieth session of the Regional Committee

5. The Regional Director reported that work was under way on drawing up a number of the strategies and action plans that she had envisaged in her address to RC60 or which were called for in resolutions adopted at that session. A high-level forum was being established to secure country ownership of strategic developments such as the new European health policy (Health 2020), while working groups had looked at the Regional Office's work in countries and its geographically dispersed offices (GDOs). Changes in the arrangements for governance of the Regional Office had either been made (increased membership of the SCRC, revised subregional groupings) or would be introduced in the course of the year (webcasting and open sessions of the SCRC).

6. The joint declaration between the Regional Office and the European Commission was being put into effect: action plans were being drawn up for six "flagship" programmes and would be finalized for presentation at a meeting of senior officials of both organizations to be held at the end of March 2011.

7. At its seventeenth session (Geneva, 2–5 November 2010), the Committee on Environmental Policy of the United Nations Economic Commission for Europe (UNECE) had appointed four ministers of the environment or their high-level representatives to serve on the European Environment and Health Ministerial Board (EHMB) that had been established at the Fifth Ministerial Conference on Environment and Health (Parma, Italy, 10–12 March 2010). The newly constituted eight-member Board would hold its first meeting in France in April 2011. In the meantime, the Regional Director would invite ministers of health to nominate members of the European Environment and Health Task Force.

Provisional agenda of the sixty-first session of the Regional Committee

8. Introducing the first draft of the provisional agenda for RC61, the Regional Director suggested that items could be brought together into blocks of issues:

- the overarching health policy framework (European review of the social determinants of health and Health 2020);
- strengthening of health systems (including public health and personal care);
- NCDs, including an alcohol action plan;
- communicable diseases (covering areas such as antimicrobial resistance, multidrug- and extensively drug-resistant tuberculosis – M/XDR TB, and HIV/AIDS);
- strategy for the Regional Office's work with countries (including its GDOs);
- partnerships;
- the Organization's programme budget as a strategic tool (including the SCRC's oversight of the work of the Regional Office); and
- communication.

9. The Standing Committee believed that the provisional agenda was very ambitious. It agreed to consider its overall structure once it had reviewed the individual items in more detail.

Health 2020: the new European health policy

10. Health 2020 would be developed through a participatory process that would engage diverse communities of practitioners, stakeholders, sectors and partners. It would be informed by two key scientific studies: a European review of the social determinants of health and the health divide, and a study of governance for health. The process would culminate in the launch of the new policy at the Regional Committee session in 2012. A steering group to guide the process had held its first meeting in mid-October 2010, and the two studies were currently being commissioned. Consultations would be held with constituencies of important stakeholders before a conference was held in the spring of 2011; the feedback information generated would be incorporated in a "white paper" that would be submitted to RC61; the definitive guidance given by the latter would shape the final policy document.

11. Members of the Standing Committee underlined the importance of the new health strategy for the WHO European Region, especially in view of the fact that the European Commission had recently issued a European strategy for smart, sustainable and inclusive growth[1]. It would be important for the Regional Office to engage in a sustained communication campaign around Health 2020 at an early stage, disseminating clear definitions of key concepts and terms. More specifically, one member of the SCRC pointed out that sustainability should be viewed as a guiding principle, rather than as a value underpinning the strategy, and that the expression "core health capabilities" might need to be explained.

12. Another member of the SCRC said that lessons might be learned from the experience of his country: it had recently engaged in a similar exercise, prior to issuing a white paper (draft legislation) to reform its public health system[2]. "Engagement events" had been organized with representatives of stakeholders such as nongovernmental organizations, industry, the public health profession, and families and children. Formal consultation on issues such as accountability, monitoring and evaluation would be undertaken once the white paper had been published.

13. The Regional Director confirmed that, in addition to setting up the forum of high-level representatives of all 53 European Member States of WHO, she intended to engage in consultations with bodies such as the European Public Health Association (EUPHA), the Association of Schools of Public Health in the European Region (ASPHER), the European Forum of Medical Associations (EFMA) and the World Medical Association (WMA). It would be important to underpin the stewardship role of ministries of health in leading on a whole-government approach to improving people's health.

Strengthening health systems

Public health strategy

14. The public health strategy for Europe would be complementary to Health 2020 but more action-oriented. Based on a clear statement of the relationship between public health, essential public health functions and health systems, the aim would be to define a framework for action in areas such as governance, community involvement, advocacy, investment and information systems. A small expert meeting would be held later in November 2010, and an initial consultation meeting was planned to be held in the third week of January 2011. A second consultation would be held after the SCRC's next session, in mid-April 2011.

15. The Standing Committee was concerned to establish a clear "hierarchy" between the overarching policy document, Health 2020, on the one hand, and action plans to deliver work on components of a health system (such as public health), on the other. The paper should be clearly labelled as an action plan and designed to update the essential public health functions first identified some ten years previously, taking

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[1] *EUROPE 2020. A strategy for smart, sustainable and inclusive growth.* Brussels, European Commission, 2010 (COM(2010) 2020).

[2] Department of Health. *Healthy lives, healthy people: our strategy for public health in England.* London, The Stationery Office, 2010 (CM7985).

account of recent developments such as the need to measure the health effects of policies implemented in a wide range of sectors.

16. The SCRC also noted that the 128th session of the Executive Board was due to take place in the third week of January 2011 and emphasized that it would be important to synchronize the preparation and finalization of Health 2020 with that of its constituent parts, such as an action plan on public health.

Tallinn Charter

17. At a meeting on health in times of global economic crisis: implications for the WHO European Region, held in Oslo in April 2009, the view had been expressed that the commitments set out in the Charter adopted at the WHO European Ministerial Conference on Health Systems (Tallinn, Estonia, June 2008) could guide countries' responses to the crisis. The proposed paper for RC61, prepared with the assistance of the European Observatory on Health Systems and Policies, would accordingly focus on assessing health systems' performance and their success in sustaining equity, solidarity and health gain in the context of the crisis. Following two expert consultations in October 2010 and January 2011, a high-level meeting would be held in Andorra in March 2011, at which a steering committee could be established to guide future work in the area.

Noncommunicable diseases and alcohol

18. NCDs and alcohol-related conditions shared a number of characteristics, such as the role played by social and economic determinants of health, the importance of adopting an approach based on "health in all policies" (HiAP) and the need to focus attention on risk factors. However, each also had its own specific issues: cancer, diabetes and cardiovascular diseases (CVD) in the case of NCDs, or violence and injury related to alcohol use. An NCD action plan would build on the strategy endorsed by the Regional Committee in 2006[3], while an alcohol action plan would give effect at regional level to resolutions adopted by the World Health Assembly, most recently in May 2010[4].

19. Preparation of the European Alcohol Action Plan was more advanced: a second draft had been sent out to countries, organizations and WHO collaborating centres for comments, a consultation meeting would be held in Rome in mid-December 2010, and global and regional policy meetings would take place in February and May 2011, respectively. For NCDs, a steering group and national focal points would be appointed in January 2011, steering group members and selected representatives of Member States would draft the action plan in February 2011, and consultation on it would take place through a web-based process and at a global ministerial conference on healthy lifestyles and NCD control to be held in Moscow on 28–29 April 2011.

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[3] *Gaining health. The European Strategy for the Prevention and Control of Noncommunicable Diseases.* Copenhagen, WHO Regional Office for Europe, 2006 (document EUR/RC56/8).
[4] Resolution WHA63.13, Global strategy to reduce the harmful use of alcohol.

20. The Regional Director confirmed that the NCD action plan would advocate a comprehensive approach, also covering areas such as mental health. However, certain specific features of alcohol use (such as drink–driving) were not related to NCD and therefore justified a separate action plan.

Communicable diseases

Antimicrobial resistance

21. Owing to the misuse of antibiotics in the health and agriculture sectors, and poor infection control, the percentage of cases of infection that demonstrated antimicrobial resistance (AMR) was as high as 25% in some Member States. There were very few new antibiotics "in the pipeline". In offering countries guidance on the subject, a regional action plan would describe a number of strategic objectives to be attained in areas such as multisectoral coordination, monitoring and surveillance of antibiotic consumption, prevention of emerging resistance, research promotion and awareness-raising. European Antibiotic Awareness Day (organized by the European Centre for Disease Prevention and Control – ECDC) was marked annually on 18 November; consideration could be given to extending it to cover the whole of the WHO European Region. The topic would also be the subject of World Health Day 2011. Action (including country assessment missions in 2011–2012) would be carried out in partnership with a large number of agencies, including ECDC, the United States Centers for Disease Prevention and Control (CDC), the Gates Foundation Center for Global Development (CGD) and the Trans-Atlantic Task Force on Antimicrobial Resistance (TATFAR).

22. The Standing Committee recommended that the title and focus of the paper should be changed to "antibiotic resistance" and that it should take the form of a strategy, rather than an action plan. Although a considerable amount of work in that area had already been done by ECDC (including establishment of surveillance systems and assessment of implementation), it would be important to extend the experience gained to the eastern and south-eastern parts of the WHO European Region. Intersectoral cooperation (with the areas of food safety, agriculture, veterinary practice and academia) would be essential.

Tuberculosis

23. The WHO European Region included the top six countries in the world where MDR-TB was found in more than 50% of previously treated TB cases; 20% of the global burden of MDR-TB was in the Region, and many countries were reporting cases of XDR-TB. There was a need to move to integrated programmatic approaches, which would include strengthening the health system response, addressing upstream and downstream determinants, and monitoring and assessing progress towards targets. A regional action plan would call for interventions in line with those approaches, in order to reach the goal of reversing the spread of drug-resistant TB. Specific objectives could be to provide universal access to diagnosis of drug-resistant TB for the whole population of the Region by 2015 and to provide universal access to treatment for all M/XDR TB patients in the Region by the same date. Following an expert meeting and a web-based stakeholder consultation, the draft action plan would be finalized in March

2011 for submission to the SCRC and despatch to all Member States. A high-level donor meeting was planned for May 2011.

24. The SCRC recommended that the action plan should make explicit reference to and build on the numerous strategies already approved, notably the Stop TB strategy[5]. The objectives of the action plan should be carefully set in realistic, rather than aspirational, terms. While there were some arguments, on conceptual grounds, for linking tuberculosis and antibiotic resistance, there were practical and operational reasons for preparing two separate documents: antibiotic resistance was a "horizontal" problem related to drug delivery, while TB was addressed (by countries and funding partners) using a vertical approach, and the two issues were covered under different strategic objectives within WHO's Medium-Term Strategic Plan (MTSP) 2008–2013.

HIV/AIDS

25. Eastern Europe had the fastest growing HIV epidemic in the world, yet harm reduction initiatives and access to antiretroviral therapy were insufficient there. Overcoming the structural barriers to prevention, diagnosis, treatment and care would require a fundamental shift in service design and delivery. A regional action plan could identify agreed global and regional targets for an accelerated response to HIV/AIDS; provide practical guidance to Member States on which health sector policies, interventions and approaches they should give priority to; and be aligned with World Health Assembly resolution WHA63.19, which requested the Director-General to develop a WHO HIV/AIDS strategy for 2011–2015. Web-based, expert, in-country and regional consultations would be held in the period up to March 2011, when the draft action plan would be finalized for submission to the SCRC at its next session.

26. The SCRC recommended that the countries in the Region should be categorized by their risk profile and the dynamics of their HIV epidemic, rather than by geography. There was a need to improve second-generation HIV surveillance, especially in groups at highest risk. More generally, WHO could play a useful role in bridging the gap between technical experts and policy-makers by disseminating best practices and experience (both positive and negative) and by advocating for the adoption of evidence-based policies in all countries.

Partnerships

27. In its resolution EUR/RC60/R4, the Regional Committee had asked the Regional Director to develop a strategy for partnerships for health in the WHO European Region, to be presented to RC61. That strategy would encompass a number of strategic directions or areas, such as reviewing and strengthening relations with partners, increasing cooperation with civil society and the private sector, ensuring regional coordination, and deepening partnerships at country level and with the EU. Milestone partnership events due to take place in the months to come included a visit to the Regional Office by the Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, a visit by the WHO Regional Director to the World Bank,

[5] Resolution WHA60.19, Tuberculosis control: progress and long-term planning

and meetings of senior officials of the European Commission and WHO and of European regional directors of United Nations bodies (hosted by the Regional Office).

28. The Standing Committee suggested drawing on the experience of other international organizations in order to find ways of involving civil society more fully in the work of the Regional Committee, perhaps by organizing a pre-session day of discussion with their representatives, the conclusions of which could be fed into the Regional Committee's deliberations. In addition, nongovernmental organizations should be fully engaged in the process of developing the new European health policy, Health 2020, and in consultations on other strategies and action plans.

Communication

29. Not only was communication of growing importance as a determinant of health in its own right, communication capacities in Member States were also underdeveloped and underresourced, while the emergence of many new sources of health information was leading to an information overload. The aims of a new communication strategy for the European Region would therefore be to strengthen WHO as the source of reliable and easily accessible health information, to broaden the reach of quality health information to every person in the Region and to enhance the functional "health literacy" of policy-makers and the general public. Areas covered by the new strategy could include defining target audiences, matching capacities to needs, developing communication networks, making use of new media and tools, and building partnerships. Office-wide, web-based and subregional consultations would be organized before and after the draft strategy was presented for review by the SCRC at its next session.

30. Members of the Standing Committee questioned whether it was advisable for the Regional Office to target the general public with its communication activities. In any case, social marketing tools should be chosen with care, once a specific need for information had been identified, and any initiatives taken should be thoroughly evaluated. In addition, ministries of health would require from WHO tools that they could use to work with the media in an authoritative way. In response, the Regional Director noted that WHO and ministries of health shared the same concern to counterbalance disinformation on the internet, in social media or in traditional channels, and would work together to get across the same messages.

Programme budget, and oversight functions and transparency of the SCRC

31. Within the Organization's MTSP 2008–2013, its biennial programme budgets were structured around 13 strategic objectives (SOs) which in turn comprised 82 Organization-wide expected results (OWERs). Regional refinements and adaptations of the OWERs were expressed as regional expected results (RERs). The "value chain" in WHO stretched from inputs through processes to outputs and outcomes, and ultimately to health impacts. While contributors of resources, Member States and the Secretariat were jointly accountable for outcomes (measured in terms of the effectiveness of achieving results), the Secretariat alone was accountable for outputs and processes (measured on productivity and efficiency). In order to use the programme budget as a

strategic tool for accountability, it was proposed that RC61 would endorse 20–30 priority RERs, for which baseline and target indicators would be developed and the required resources and contributions (from both the Secretariat and Member States) defined. Those priority RERs (or outcomes), together with 10–20 key outputs and 3–4 processes, would then form a "contract" between the Regional Director and the Regional Committee. An annotated draft outline of the contract would be presented to the SCRC at its next session; quarterly and six-monthly reports would be presented to the SCRC, while annual reporting would be made to the SCRC, the Regional Committee and contributors of flexible resources.

32. The following seven standardized management reports could therefore be submitted to the SCRC at regular intervals:

- Quarterly
  - Programme budget implementation by major segment (base programme, special programmes and collaborative arrangements, and outbreak and crisis response)
  - Programme budget implementation by SO
  - Implementation by source of funds and expenditure category
  - Comparative biennium-to-biennium implementation
  - Projected expenditures versus estimated available resources
- Six-monthly
  - Summary report of key outputs and deliverables
  - Summary of impediments to delivery of SOs.

33. With regard to the transparency of the SCRC's proceedings, some of the proposals endorsed by RC60 had been acted on immediately, while others would be implemented as from the SCRC's next session. Guidelines (on time limits for and order of interventions, voting rights, etc.) would need to be elaborated for application at the SCRC's open session in May 2011, before the opening of the Sixty-fourth World Health Assembly.

34. The Standing Committee agreed that the "contract" should be viewed as a tool for making more transparent the key results inherent (but not explicit) in the programme budget as adopted by the World Health Assembly, and for increasing the Regional Office's accountability for delivering them. Its members confirmed that it was useful for them to have access to the same information as the senior management team at the Regional Office. However, they would need guidance in interpreting the information presented.

35. While receptive to the idea of carrying out in-depth reviews of Regional Office programmes, the SCRC called for criteria to be presented at its next session, on the basis of which it could select programmes for review. The Regional Director suggested that such reviews might be carried out in cooperation with the Chief Scientist at the Regional Office and the European Advisory Committee on Health Research.

36. The Standing Committee recommended that representatives of Member States attending its open session in May 2011 should be regarded as having observer status and should therefore be invited to ask questions for clarification, but not to make extensive country statements.

The work of the WHO Regional Office in countries

37. The Chair of the external Working Group to Review Strategic Relations with Countries presented its report. The methodology adopted by the Working Group had included a documentary or desk review, meetings and interviews with delegations from 7 countries at the Sixty-third World Health Assembly and RC60 and visits to a further 11 countries, and interviews with selected senior staff at the Regional Office.

38. The findings from the desk review were that the Regional Office's country work was organized in a very clear manner, with attention focused on administration, procedures and guidelines. However, while there was intensive reporting back from country offices to the Regional Office, there was no evidence that the latter made use of the huge volume of information generated. There was no provision for local partners to evaluate the work of country offices. The efforts made to strengthen the technical staff in country offices had resulted in a corresponding weakening of technical capacity at the Regional Office.

39. From the interviews with country delegations and visits to countries, it was apparent that international staff members in country offices had the most impact on country work. Positive findings included WHO's role as a coordinator of in-country work by different agencies and the rapid support it provided during emergencies. Negative comments related to the mismatch between the countries' need for strategic and policy "influence" from WHO and the current trend towards more technical support; to the lack of skills in some areas (NCDs); and to the delays caused by WHO's bureaucratic human resources procedures. With regard to country offices in EU and candidate countries, delegations interviewed believed that changes were required in staff numbers and type of input, in order to meet the EU's rising health standards and to be in line with increasing EU investment.

40. The Working Group's recommendations for improving the work of the Regional Office therefore included paying more attention to content and results than to process; increasing the key technical skills present in or available to the Regional Office; and making significant improvements in administrative and support functions, and in communication and advocacy work.

41. The Working Group believed that all countries in the Region benefited from a relationship with WHO, but it recognized that WHO's "country presence" could take many forms, from a full country office to a desk officer at the Regional Office. The type of presence and level of support should be based on a set of unified criteria:

- health status in comparison with other countries in the Region, and rate of improvement;
- level of development of the health system;
- political stability and support for health system development;
- economic status and capacity for health system development.

42. In countries whose health system was not stable, the WHO country office should continue but increasingly be headed by a highly experienced international staff member with the necessary leadership and political skills; the need for technical skills could be

met by short-term appointments (simpler and quicker recruitment arrangements would have to be developed). In countries with a stable health system, on the other hand (notably EU member countries that had access to the Union's networks and resources), the WHO country office should be withdrawn and replaced by an alternative mechanism, such as a designated person at the Regional Office or subregional arrangements. The latter would bring together countries with common health problems, with the aim of providing technical assistance, promoting networks and sharing experience. Feasibility studies should be made before such arrangements were established. Lastly, the Working Group proposed that, if it proved successful, the pilot scheme to replace biennial collaborative agreements (BCAs) with country cooperation strategies (CCSs) should be rolled out across the Region.

43. The Standing Committee agreed that the main weakness in the Regional Office's country work in the previous period had been the lack of use made of reporting information. Clear criteria were needed for continuously evaluating the work of country offices, including their relations with nongovernmental organizations and their communications and advocacy activities. One member of the SCRC called for the findings from the Working Group's interviews with country delegations to be made available and suggested that an assessment should have been made of the country offices' value to the Organization as a whole. In broad terms, the SCRC agreed that the number of country offices should be reduced and focused in those countries in most need of WHO support, and support was expressed for exploring the feasibility of subregional arrangements.

44. The Regional Director emphasized that the evaluation team consisted of external experts selected by her for their experience of and belief in WHO. The methodology they had used had been jointly agreed by her and the team members. The Working Group had then carried out its review on a wholly independent basis, looking (without preconceptions) at the Regional Office's strategic relations with countries in general, and not at the performance of individual country offices. It was clear that the Working Group's overall consensus recommendations were that the Regional Office needed a new country strategy and that the Organization's technical capacity should be built up again, both at the Regional Office itself and possibly also through subregional arrangements, but not at the level of individual countries.

Geographically dispersed offices of the WHO Regional Office for Europe

45. The Chair of the external Working Group to Review the Geographically Dispersed Offices of the WHO Regional Office for Europe presented its report. Since the opening of the first geographically dispersed office (GDO) in 1991, eight GDOs had been established outside Copenhagen. Three had since been phased out, one had been absorbed by the European Observatory on Health Systems and Policies, and four were currently in operation: Barcelona (health systems), Bonn and Rome (environment and health) and Venice (investment for health). Throughout the duration of their respective agreements, the GDOs had made use of financial resources and in-kind contributions offered by the host countries and other donors. In the previous four biennia (since 2002), GDOs had brought over US$ 100 million to the regional budget; the approach should therefore be seen as a fund-raising mechanism rather than a cost to the Regional

Office. Nonetheless, it was a matter of concern that the Italian Parliament had not yet ratified renewal of the agreement covering the Rome Office (thereby preventing national funds from being released).

46. The Working Group found that the GDOs were doing high-quality work. They had developed and were carrying out a number of outstanding technical programmes; they had produced a number of excellent scientific products of intercountry and global interest; they provided considerable support for key programmes of the Regional Office; and a considerable part of their efforts had been devoted to supporting countries and institutions most in need.

47. The main recommendations of the Working Group included:

- Stronger coordination within the Regional Office
  - Closer technical and managerial links with the responsible Divisions in the Regional Office
  - A solid "home base" at the Regional Office to coordinate relations with GDOs both internally and externally, ensuring strategic guidance and reviewing workplans and budgets
  - Re-establishment of a Division of Environment and Health in Copenhagen
  - Reinforcement of the technical and resource base of the Division of Health Systems and Public Health in Copenhagen (to which the Barcelona Office was attached)
- More effective integration of personnel (staff rights, staff development and training, communication skills, etc.)
- Re-establishment of the GDOs' identity and visibility
  - Indication of the name of the office on important publications and documents
- Greater recognition of host countries and other contributors
  - A proportion of the programme support costs for funds raised by GDOs to remain at their disposal
  - Better compliance by the Regional Office with specific issues foreseen by host country agreements
  - Establishment of a "consultative body" in Copenhagen, chaired by a senior Regional Office staff member and bringing together representatives of the four GDOs, the host countries and other Member States and partners
- Promotion of access to different funding sources
  - Optimization of approaches to access European Commission resources and those of autonomous funding systems for intergovernmental agreements
- Establishment of a proper balance of work between intercountry activities and direct assistance to countries
- Establishment of an external scientific advisory board for each GDO
- Choice of a more suitable name (such as "Specialized Centre of the WHO Regional Office for Europe")
- Extension and intensification of the process of establishing new GDOs (in the medium and long terms)
  - Primary health care (preferably in one of the newly independent states – NIS)
  - Health information

- Mental health
- Ageing
- Migrants and disadvantaged migrant population groups.

48. The SCRC agreed that clear criteria should be established for ensuring that GDOs added value to the core functions being carried out at the Regional Office in Copenhagen. They could be conceived of as a "bridge" between the country offices and the Regional Office, providing technical input to intercountry programmes and helping to build capacity in countries. In any case, GDOs should not be branded as separate entities.

49. The SCRC was hesitant about the proposal to establish new GDOs, since it felt that the focus should be on strengthening the Regional Office. It also expressed concern about the status of the Rome GDO and requested the Regional Director to report back to the Standing Committee at its next session.

50. A member of the Working Group to Review Strategic Relations with Countries suggested that it might be possible to combine the role of a GDO with that of a node of a subregional arrangement, since the aim of the latter would be to provide technical, rather than administrative, support. The Regional Director confirmed that she would consider the recommendations of both working groups in terms of the whole "architecture" of WHO in the European Region.

Regional coordination mechanisms

51. On the issue of linkages between global and regional governing bodies and mechanisms for regional coordination, a draft document listing the arrangements already in place (on the part of both the Regional Office and various groupings of Member States), identifying gaps and setting out proposals to remedy them was discussed at a working lunch on the second day of the session. A revised paper, amended in the light of that discussion, would be presented to the SCRC at its next session.

Provisional agenda of the sixty-first session of the Regional Committee (concluded)

Country relations strategy

52. As had been brought to light in the reports of the working groups on relations with countries and on GDOs, there was a need to address cross-border issues in a coherent manner, to ensure that the Organization was relevant to all Member States, and to improve the integration of country offices into the Regional Office. The aim of a new country relations strategy would be to help countries to translate the decisions of the Organization's global and regional governing bodies into national action; to strengthen national capacities in the areas required; and to empower ministers of health with tools, norms and standards, research and evidence. The strategy would examine structural and functional issues and set out, in some detail, the policies, procedures and tools required for effective country work, as well as the institutional framework (country offices,

subregional arrangements, etc.) for supporting that work. Further sections of the strategy would consider strategic partnerships at country level, as well as questions related to monitoring and evaluation. A first draft of the strategy would be presented to the SCRC at its next session, consultations with Member States would be organized between March and May 2011 and the revised draft would be submitted to the SCRC at its fourth session.

53. One member of the SCRC suggested that the draft strategy could include, in an annex, information about current modalities and structures of cooperation with countries, and that the revised draft might be made available to all Member States attending the open session of the SCRC in May 2011. The Regional Director also wished to see details of financing included in the country relations strategy.

Millennium Development Goals

54. In its resolution EUR/RC57/R2, the Regional Committee in 2007 had called on the Regional Director to report every two years on progress made towards the Millennium Development Goals (MDGs) in the European Region. Scaling up efforts to attain the MDGs was an integral part of the Regional Office's priorities, involving technical programmes in areas such as TB, HIV/AIDS and maternal and child health. The Regional Office could lead the first meeting of a United Nations regional coordination mechanism on health-related MDGs in the European Region. A summary version of the report could be presented to the SCRC at its next session, and the full report would be finalized by May 2011.

Selection of agenda items

55. The Standing Committee agreed that Health 2020, the European review of the social determinants of health and the public health strategy were core items for inclusion on the agenda of RC61. The Tallinn Charter and follow-up to the WHO European Ministerial Conference on Health Systems, on the other hand, could be included in the section of the programme on strengthening of health systems. Similarly, action plans on NCDs and alcohol should be presented for endorsement by RC61, as should a strategy on antibiotic resistance and an action plan on M/XDR TB, while HIV/AIDS could be the subject of a technical briefing outside the plenary meeting.

56. It would be valuable to have an initial discussion at RC61 of the use of the programme budget as a strategic tool for accountability. The reports of the working groups on GDOs and strategic relations with countries could be considered together. The subject of partnerships could be covered in the address of the Regional Director, with a formal strategy presented to RC62. The question of submitting a communication strategy to RC61 for endorsement would be reviewed by the SCRC at its next session, in the light of the progress made with elaborating that strategy.

57. The Regional Director explained that the intention behind establishing a high-level forum was to involve Member States in the elaboration of policy documents such as Health 2020, the review of social determinants of health, the alcohol action plan and the public health strategy, and to ensure that the work done on them did not end with the adoption of a resolution by the Regional Committee but was carried through into implementation at national level. The forum would be constituted for a two-year period

(during which most of the major policy documents would be drawn up), after which the initiative would be evaluated.

Executive Board and Programme, Budget and Administration Committee

58. The Regional Director and the Chairman of the Executive Board noted the lengthy agenda of the 128th session of the Executive Board and drew attention to a number of items that might be of particular interest to the European Region, including the future financing of WHO (on which the views expressed at RC60 had been forwarded to the Director-General); NCDs; health security (including the International Health Regulations); counterfeit medical products; and the procedure for election of the Director-General of WHO. The size of the agenda underlined the importance of strengthening regional coordination mechanisms.

Sixty-fourth World Health Assembly and membership of WHO bodies and committees

59. The Standing Committee was informed of the elective posts that the European Region would be entitled to fill at the Sixty-fourth World Health Assembly.

60. A letter would be sent to all European Member States in January 2011 calling for nominations for the four seats for the European Region on the Executive Board that would become vacant in 2012, as well as for the three seats on the SCRC and the one seat on the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction.