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WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark Telephone: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: governance@euro.who.int Web: http://www.euro.who.int/en/who-we-are/governance

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Introduction

1. The Twenty-second Standing Committee of the Regional Committee for Europe (SCRC) held its second session in Helsinki, Finland, on 9 and 10 December 2014.

Opening by the Chairperson and the Regional Director

2. The Chairperson welcomed participants and recalled that the report of the Twenty-second SCRC's first session, which had taken place in Copenhagen, Denmark, on 18 September 2014, had been circulated and approved electronically.

3. In her opening address, which was web streamed in line with resolution EUR/RC63/R7,[1] the Regional Director for Europe briefed the SCRC on the work of the Regional Office since its last session. In the context of the largest and most complex Ebola virus disease outbreak on record, the Regional Office had deployed 10 staff members, including some from senior management, equivalent to 360 staff days, to affected countries in 2014 and additional staff, equivalent to five full-time staff members, would be deployed during the first three months of 2015. Human resources management and administration experts had been sent to WHO headquarters to provide support. At the regional level, numerous activities were under way to ensure preparedness. The Regional Office's activities in response to the outbreak were being conducted in close cooperation with the European Union.

4. Although the Ebola crisis response required considerable attention, the rest of WHO's work must not be forgotten. The Global Policy Group (GPG) had discussed WHO reform, including the report of the Programme Budget and Administration Committee (PBAC) Working Group on Strategic Budget Space Allocation. The PBAC Working Group had developed and agreed an objective, namely, a needs-based mechanism that will be presented to PBAC in January 2015. The mechanism results in an increased allocation for the European Region, which would correct its historically low budget allocations. The GPG had also discussed a new staff mobility and rotation strategy, which would be presented to the Executive Board in January 2015, including proposed amendments to the WHO Staff Regulations and Staff Rules. A written statement by the Staff Association of the European Region of WHO had been circulated to the SCRC. The GPG had considered the revised draft framework for engagement with non-State actors. All Member States should strive to ensure that health remained a key element in negotiations on the post-2015 development agenda.

5. The Regional Office continued its work to promote Health 2020 in countries. Progress towards the establishment of a new geographically dispersed office (GDO) on noncommunicable diseases (NCDs) in Moscow, Russian Federation, and one on primary health care in Almaty, Kazakhstan, was well under way. An event had been held in Moscow to launch the project leading to the establishment of the new GDO; the office in Almaty would be inaugurated in February 2015. Efforts were ongoing to finalize the host agreement for the new GDO on preparedness for humanitarian and health emergencies in Turkey. The Regional Director, together with Her Royal Highness Crown Princess Mary of Denmark, Patron of the Regional Office for Europe, had visited Tajikistan to advocate increased regional and national investment in maternal and child health and immunization. Regarding cooperation with the

[1] WHO Regional Committee for Europe resolution EUR/RC63/R7 on governance of the WHO Regional Office for Europe. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0004/217741/63rs07e_Governance.pdf?ua=1http://www.euro.who.int/__data/assets/pdf_file/0004/217741/63rs07e_Governance.pdf?ua=1, accessed 23 December 2014).

European Union, the Regional Director had met with the European Commissioner for Health and Food Safety and they had agreed to draft a follow-up document to the Moscow Declaration,[2] to be presented to the 65th session of the Regional Committee for Europe (RC65).

6. Responding to questions received from Croatia prior to the session, the Regional Director said that the Ebola virus disease outbreak, which had affected countries with weak health systems, where public health capacity, treatment centres and human resources for health were lacking, had illustrated the importance of health systems strengthening, which would be a substantive item on the agenda at the Regional Committee's next session. Work towards strengthening health systems for better outcomes for NCDs was under way in eight Member States, including Croatia. An unhealthy diet as a contributing factor to NCDs and a global risk to health was also a priority area of action. Following the adoption of resolution EUR/RC64/R7,[3] close cooperation with the European Commission to review its implementation was ongoing. An obesity surveillance system was being conducted from the Regional Office.

Follow-up to the 64th session of the Regional Committee: evaluation and review of actions by the SCRC and the Secretariat

7. The Regional Director said that strong Member State participation and the full engagement of the SCRC in the preparations for the 64th session of the Regional Committee for Europe (RC64) had been a major contributing factor in the success of the session. The discussion of documents and draft resolutions during the open session of the SCRC in May had been particularly useful. The SCRC had played a key role in reaching out to shortlisted candidates for elections and nominations to bodies and committees. At its previous session, the SCRC had discussed how to enhance preparatory meetings in connection with the Regional Committee. Prior to RC64, the meeting on engagement with non-State actors had been particularly well attended, demonstrating the importance of orienting those meetings towards subjects of interest to all Member States. Subregional pre-session meetings had, on the other hand, been underattended, and might therefore be discontinued. In previous years, the Regional Office had held pre-session briefings for health attachés in Geneva, Switzerland, as well as an ambassadors' briefing in Copenhagen, Denmark. Prior to RC64, the Regional Office had changed its approach, holding one meeting in Copenhagen, with online participation from health attachés in Geneva and interested parties in capitals. Consideration should be given to revising the seating arrangements for Regional Committee sessions held at UN City in Copenhagen, owing to the unconventional shape of the meeting facilities. Panel discussions during the Regional Committee's session had also been identified as needing refinement and the SCRC's suggestions in that regard would be appreciated.

8. The SCRC agreed that subregional preparatory meetings required many resources and were often not very well attended. Since the SCRC session in May was open to the public and focal points on each item of the Regional Committee's agenda were appointed for liaison with Member States, those preparatory meetings had become superfluous. Pre-session meetings on complex topics for discussion during the Regional Committee had, on the other hand, proved

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[2] Moscow Declaration. First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, Moscow, Russian Federation, 28–29 April 2011 (http://www.un.org/en/ga/president/65/issues/moscow_declaration_en.pdf, accessed 23 December 2014).

[3] WHO Regional Committee for Europe resolution EUR/RC64/R7 on the European Food and Nutrition Action Plan 2015–2020. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0020/259211/64rs07e_FoodNutAP_140732.pdf?ua=1, accessed 23 December 2014).

very useful for consensus building and should therefore be continued. One member said that the webcast pre-session briefing for representatives in capitals had been greatly appreciated. On ministerial panels, new ministers who were unaccustomed to participating in those meetings often read "prepared" statements. Such an approach was not conducive to dialogue. Despite efforts to increase ministerial participation, the right balance of ministerial involvement had never quite been achieved. Further consideration should be given to how to engage ministers and make more space for ministerial participation in the Regional Committee's programme of work. Efforts to address the Ebola virus disease outbreak should not detract from other areas of the Regional Office's work.

9. The Regional Director agreed that pre-session meetings should address complex issues of global relevance and that greater ministerial involvement in the Regional Committee's sessions should be encouraged. In the recent GPG meeting, she acknowledged the comments with respect to the funds allocated for work on NCDs in the proposed draft Programme budget (PB) 2016–2017 and asked Member States to reiterate these remarks at the Executive Board meeting in January 2015.

Provisional agenda of the 65th session of the Regional Committee

10. The Regional Director presented the provisional agenda and programme for RC65. The first day of the session would follow the usual format, with discussions on WHO reform including issues such as the implications of global reform on the work of the Regional Office, PB 2016–2017 and strategic budget space allocations, staff rotation and mobility, and other reform matters arising from the Executive Board and the World Health Assembly. The second day would be a ministerial day devoted to Health 2020 with a particular focus on promoting intersectoral action for health and well-being in the Region. Technical items would be discussed on the third day, as well as elections and nominations. It would also include a partnership session, with the possible participation of European Union Health Commissioner Andriukaitis. The final day would be devoted to matters arising from the global governing bodies, the remaining technical items on the agenda and the standard items prior to the closure of the session. Two additional items for discussion were women's health and migration and health, both of which would be formal items on the agenda at future sessions. Consideration should be given to the format of those discussions at RC65 and how to fit them into the programme. The issue of evidence-based policy-making and how the Regional Office could support Member States in that regard would also be addressed. The SCRC's guidance was sought as to how that issue would be included on the Regional Committee's agenda.

11. The SCRC welcomed the provisional agenda and programme for RC65. Questions were raised as to whether engagement with non-State actors would be included as an item for discussion in the context of WHO reform, and whether any time would be devoted to discussing the response to the Ebola virus disease outbreak. Ebola could perhaps be discussed in the broader context of threats to public health caused by communicable diseases. Concerns were expressed that the time allotted for the adoption of the European action plan for tuberculosis prevention and control 2016–2020 would not be sufficient. One member said that ministerial participation in the adoption of new strategies and action plans for the Region would be useful; perhaps those items on the agenda could be addressed during the ministerial day.

12. The Regional Director replied that, since it was hoped that the framework for engagement with non-State actors would be adopted by the global governing bodies prior to the Regional Committee's session, it would be discussed in the context of WHO reform. The Ebola virus disease outbreak would be discussed under the item on matters arising from the global governing bodies. The lessons learned from the Ebola outbreak could be discussed under an item on preparedness for public health emergencies and crises, depending on the status of the

outbreak by the time of the Regional Committee's session. The provisional programme for RC65 could still be changed. She noted that it could be useful for ministers to be present for the adoption of strategies and action plans.

Main technical/policy topics and consultation process on the provisional agenda of RC65

Promoting intersectoral action for health and well-being in the European Region

13. The Director, Division of Policy and Governance for Health and Well-being, said that for countries to align their national health policies with Health 2020 an intersectoral approach was essential. Representatives of the health sector must therefore advocate health promotion as a means of contributing to the goals of other sectors. To assist Member States, the Regional Office had elaborated policy briefs for work with other sectors, which would be presented to RC65 in an information document. A working document would be prepared, drawing on the Region's experience of intersectoral cooperation to identify priority sectors for joint action towards Health 2020 implementation. It would be accompanied by a draft resolution and background documents detailing the Regional Office's experiences and legacy on intersectoral action and on foreign policy and health. The second day of RC65 would be devoted entirely to Health 2020 implementation and would include three panel discussions with experts on health and foreign policy, healthy children, and lessons learned from the European Environment and Health Process (EHP). A ministerial lunch was also scheduled.

14. The Regional Director referred to the Regional Office's cooperation with finance ministers to assess the impact of the international financial and economic crisis on health and health systems. Progress was still required to strengthen collaboration with other sectors, whose input was crucial to reduce inequities. It would be useful to hear whether Member States foresaw a need to establish governance mechanisms for collaboration with the education and social welfare sectors, similar to that established for collaboration with the environment sector. A substantial issue for discussion at RC65 in the context of intersectoral action would be early childhood development and the governance implications thereof.

15. While the SCRC agreed that an intersectoral approach was essential for Health 2020 implementation and a strategy in that regard was urgently required, some uncertainty was expressed with regard to the content of the working document under preparation, which seemed to be part progress report and part action plan, as well as containing a draft resolution. Caution should be exercised when organizing the ministerial day to ensure that the discussions were not only relevant and interesting to ministers but also to all participants. Further information was requested on the added value of the draft resolution and on how the Regional Office's work on intersectoral collaboration related to activities being undertaken at the global level, in particular with regard to resolution WHA67.12,[4] which had requested the Director-General to prepare a Framework for Country Action, for adaptation to different contexts, taking into account the Helsinki Statement on Health in All Policies, aimed at supporting national efforts to improve health, ensure health protection, health equity and health systems functioning. It would be useful to encourage impact assessments of decisions and initiatives.

[4] World Health Assembly resolution WHA67.12 on contributing to social and economic development: sustainable action across sectors to improve health and health equity. In: Sixty-seventh World Health Assembly, Geneva, 19–24 May 2014. Resolutions and decisions, annexes. Geneva: World Health Organization; 2014 (WHA67/2014/REC/1; http://apps.who.int/gb/ebwha/pdf_files/WHA67-REC1/A67_2014_REC1-en.pdf#page=25, accessed 23 December 2014).

16. Although ministries of health and social affairs were integrated in several Member States, a lack of coordination between those two sectors remained. Greater public relations efforts were required to overcome language barriers and to enable experiences and information on intersectoral approaches and case studies of good practice to be shared among countries. Cost-benefit analyses should be conducted to show that other sectors would gain from investing in health. In that regard, health information would have a significant role to play. Care should be taken, however, when promoting the investment of other sectors in health to ensure that the health sector did not undermine its own role. Requests for collaboration must, however, be dovetailed with other ministries' priorities, initiatives and concerns. Rather than having ministerial panels comprising only health ministers, WHO might therefore consider inviting ministers from other sectors to participate in the Regional Committee's deliberations. One member pointed out that promoting an intersectoral approach in countries with devolved authorities could be problematic. She would therefore be reluctant to establish a governance mechanism such as had been established for environment and health. Another member agreed that devolved authorities presented special challenges.

17. The Director, Division of Information, Evidence, Research and Innovation, said that in early 2015, the Regional Office would launch a new bilingual public health policy journal, to which Member States could submit articles on policy implementation. The publication would be published in English and Russian and would be a substantial platform for case studies. A special issue on intersectoral policies would be published prior to RC65 and Member States would be requested to submit articles for that edition, in order to share experiences from all over the Region.

18. The Director, Division of Policy and Governance for Health and Well-being, said that in most countries, health sectors were already engaging with other sectors. That willingness to cooperate should be harnessed to strengthen whole-of-government approaches to implementing Health 2020. The working document for RC65 would not be a progress report per se but would describe measures to promote intersectoral collaboration in the Region, many of which had not yet been reported. A truly intersectoral approach could not be achieved by telling other sectors what to do but, rather, by trying to understand their needs. Given the broad scope of Health 2020, collaboration with most sectors would be required. Priorities for cooperation would, however, be needed. The involvement of ministers and high-level representatives from other sectors would be highly beneficial to the Regional Committee's work. Consideration would be given to how to encourage their participation. The SCRC's comments would be used to revise the structure of the working document and the draft resolution to take account of experiences in the Region and to look at how to build on those experiences in future. France is currently considering the possibility of hosting a meeting to share information in that regard prior to the World Health Assembly in 2015. The discussions would feed into the documents to be submitted to the Regional Committee. The proposed structure of the discussions at RC65 could be revisited. The ministerial day would be used to report back on the EHP and the Health and Foreign Policy Process, tying them in with Health 2020 under a general theme of intersectoral collaboration.

19. The Regional Director added that the policy briefs could be used from both a sectoral and a thematic perspective: they provided guidance on which sectors to approach when addressing a particular topic and which topics to address when approaching a particular sector. The working document for the Regional Committee's consideration was intended to justify the reasoning behind adopting an intersectoral approach, explain how to create a win-win situation for all involved, guide the health sector in its interaction with others and explain why it would be beneficial to other sectors to align their approach to Health 2020. Health ministers had a lead role to play in that regard, particularly through advocacy and capacity-building, as well as by establishing an information base and reaching out to prime ministers. The use of evidence as an entry point for intersectoral collaboration was crucial. The European Health Report would be

useful in that regard, as would the study on the economics of public health and health promotion, conducted by the Organisation for Economic Co-operation and Development and the European Observatory on Health Systems and Policies. Further consideration should be given to how to achieve intersectoral collaboration in countries with devolved governments. The resolution would encourage Member States to take multisectoral approaches, in particular with sectors with which collaboration had not been sufficiently promoted.

Migration and health

20. The Director, Division of Policy and Governance for Health and Well-being, said that the issue of migrants and health was relevant to all countries. Many migrants faced stigma and were labelled as a threat to public health. Providing health care for them was a matter of human rights. The relationship between migration and health was sensitive and the Regional Committee should take it up as a formal item on its agenda. The Regional Office was planning a two-year roadmap, including a subregional dialogue to feed into preparations and analyse the situation on the ground. The SCRC should consider whether to include the topic in some form on the RC65 agenda before taking it up as a formal agenda item at RC66.

21. The SCRC agreed that a discussion on migration and health should be included on the agenda for RC66. Problems of large-scale migration in the Region, in particular in the Mediterranean Member States, meant that health systems in receiving countries must be strengthened. Preparations for the Regional Committee's discussion on the issue should take account of Member States' experiences. The Regional Committee should discuss only the health status of migrants and not their migration status, which is not within the WHO mandate. Emphasis should be placed on the various approaches required to meet the needs of different types of migrants and to address the immediate health requirements of large influxes of migrants upon arrival, as well as the longer-term provision of health care for migrants who remained in host countries. Migration and health was another issue that required an intersectoral approach, not just an isolated response from the health sector.

22. The Director, Division of Information, Evidence, Research and Innovation, said that the Regional Office had commissioned a series of Health Evidence Network evidence reviews on major areas of health care, including public health provisions, access to health care and quality of services and measuring the impact on migrants. That evidence would underpin discussions and would be available to Member States prior to the Regional Committee's session.

23. The Director, Division of Policy and Governance for Health and Well-being, agreed that types of migration and the status of migrants must be taken into account when planning health responses. Health care for migrants must be handled with care, since the right to health could be in conflict with other legal issues related to migration. The financial implications of migration must also be taken into account. A preliminary discussion could be held at RC65.

24. The SCRC agreed to hold a preliminary discussion in the form of a ministerial lunch at RC65, before conducting consultations with Member States to prepare the documentation for a formal discussion at RC66.

Priorities for health systems strengthening in the European Region 2015–2020: putting people first

25. The Programme Manager, Acting Director, Division of Health Systems and Public Health, said that the endorsement of Health 2020 had underscored the importance of people-centred health systems. The question was how to put that vision into practice and overcome challenges to ensure universal health coverage. Three possible strategic directions had been identified for health systems: establishing an operational framework to achieving people-centredness, responsiveness and accountability; transforming the provision of health services;

and ensuring universal health coverage through financial sustainability and accessibility of services to prevent people being impoverished by the cost of health care. Achieving those goals required: a competent workforce; efficient medicines and technologies that allowed for innovative solutions to health challenges; and greater health intelligence. In preparing the document for RC65, the Regional Office was gathering information from various sources, including a questionnaire on the implementation of the Tallinn Charter[5] sent to all Member States and the outcome of a meeting of experts in Barcelona, Spain, to consider priorities. The core group of Member States overseeing the report on the implementation of the Tallinn Charter would also provide guidance.

26. The SCRC commended the Regional Office's efforts to promote health systems strengthening and welcomed, in particular, the recent meeting in Barcelona. The health systems performance assessment was a very useful tool to demonstrate transparency and accountability, address the sustainability of financing, identify gaps in health systems performance and make decisions. Efforts should be made to encourage a broader understanding of the concept of universal health coverage, encompassing health promotion, prevention, rehabilitation and health systems financing. The European Region had a lead role to play in that regard.

27. The Programme Manager, Acting Director, Division of Health Systems and Public Health, agreed that the health systems performance assessment was an important means of measuring responsiveness and accountability and of assessing transparency, and welcomed the support expressed for broadening the understanding of universal health coverage.

28. The Regional Director said that the health systems performance assessment was an Office-wide exercise that would be conducted in accordance with Health 2020. The complex nature of universal health coverage must be reflected in the post-2015 development agenda and the correct terminology should be used at all times. Efforts must go beyond curative interventions to encompass promotion and prevention. Although most Member States in the European Region had universal health coverage in principle, in practice 16 million people were impoverished by out-of-pocket payments for health care.

Final report on the implementation of the Tallinn Charter on health systems for health and wealth

29. The Programme Manager, Acting Director, Division of Health Systems and Public Health, said that, in preparing the final report on the implementation of the Tallinn Charter, a questionnaire had been circulated to all Member States in the European Region and interviews had been held with experts and colleagues from the Regional Office. Information contained in previous Tallinn Charter implementation reports and a review of information from partner institutions would also be used to compile the final report. Data analysis and consolidation of the information available would take place in January 2015 and a draft report would be circulated among Member States for review. A core group of eight Member States would oversee the drafting process. The seven values enshrined in the Tallinn Charter would be evaluated against the four functions of health systems, in order to formulate recommendations. The draft report would be reviewed by experts and submitted to RC65.

[5] The Tallinn Charter: Health Systems for Health and Wealth. WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth", Tallinn, Estonia, 25–27 June 2008 (http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf?ua=1, accessed 23 December 2014).

30. One member said that the format of the questionnaire sent to Member States on the implementation of the Tallinn Charter had been confusing, since it had not been in line with that of previous questionnaires.

Proposed physical activity strategy for the WHO European Region 2016–2025

31. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course said that since the WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020 in Vienna, Austria, on 4–5 July 2013, the Regional Office had been working to draft a new strategy on physical activity, which had been the subject of several technical consultations. The draft strategy would be further reviewed following a meeting of experts and a political consultation in January and February 2015, respectively, and would be presented to the SCRC at its third session in March 2015. The strategy would apply a Health 2020 lens to physical activity, focusing in particular on intersectoral cooperation, since physical activity could not be promoted by the health sector alone. A priority area for the Regional Office would be to gather and analyse disaggregated data in order to assess how the health impacts of physical activity and the lack thereof were distributed across the Region and society.

32. The SCRC expressed support for the draft strategy, which was balanced and applicable to all levels of society, and welcomed the focus on a multisectoral approach. Public-private partnerships must be in line with the framework on engagement with non-State actors and care must be taken to prevent conflicts of interest, such as with the tobacco industry and some food producers. Care should be taken to ensure that the document gives a balanced view of different types of physical activity. One member cautioned that the recommendation for national health-care services to prescribe physical activity and reimburse the costs incurred could be problematic. Low-cost outdoor activities should be promoted instead. The strategy should also address physical activity for persons with disabilities and should include specific indicators for monitoring implementation and progress. More evidence-based information would be useful for raising public awareness about the importance of physical activity and to show that physical activity did not only mean sport but also included activities such as walking and gardening, among others. The detrimental effects of spending long periods of time in front of computer and television screens should also be mentioned. Specific reference should be made not only to children, adolescents and the elderly but also to adults in order to ensure that the strategy covered the whole life-course. An explicit reference to the correlation between a lack of exercise and obesity would also be pertinent.

33. The Director, Division of Noncommunicable Diseases and Promoting Health, through the Life-course, said that further work would be done to ensure that all elements of physical activity were equally represented in the strategy. References to public-private cooperation would be consistent with the framework for engagement with non-State actors, would exclude the tobacco industry and would avoid providing food companies with advertising opportunities. All stages of the life-course would be accounted for. Specific indicators on progress could be prepared and submitted to the SCRC for discussion at its next session. Much work had been done on the economic impact of active transport, which could be included in the strategy. He agreed that the recommendation on reimbursement could be either toned down or linked to information on cost-effectiveness.

Women’s health

34. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, said that over the past 10 years, life expectancy for women in the WHO European Region had increased by three years, partly as a result of fewer deaths in childbirth. Nevertheless, extreme inequities remained. The Regional Office intended to address women’s

health in two phases. First, a report on inequalities in women's health in Europe would be prepared. It was expected to highlight the considerable inequalities in sexual and reproductive health, in particular violence against women, sex selection at birth, female genital mutilation, gender gaps in access to care, and unequal access to contraception and sexuality education. The report would have three sections: characteristics – on demography, sex selection at birth and life expectancy; health determinants – on access to resources and participation in public life, women's employment, income and social protection; and health influences – on conditions such as cardiovascular disease and diabetes, which presented different outcomes for women than for men, as well as breast and cervical cancer; and HIV and tuberculosis (TB) among women. A chapter on sexual and reproductive health that would form the basis for a future strategy and action plan would also be included. The report would be published in time for RC65 and would be discussed at the WHO European Ministerial Conference on Life-course Approaches in the Context of Health 2020 in Minsk, Belarus, in October 2015. The second phase would be to draft a sexual and reproductive health strategy and action plan for the European Region, for adoption at RC66.

35. The SCRC welcomed the report on women's health and the approach to bringing women's health and sexual and reproductive health to the attention of the Regional Committee. The Regional Office's efforts were in line with measures being taken at the national level in several Member States. The report should be practical and its findings based on existing data rather than increasing the reporting burden on Member States. In some countries in the European Region fertility problems were increasing as women waited until later in life to have children. That issue could also be addressed in the strategy on reproductive health. Member States would welcome guidance on reducing inequalities in women's health.

36. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, said that the Regional Office's initial focus would be to ensure that a life-course approach to women's health was included in all of its future action plans and strategies. Examples of the work being carried out in Member States, case studies and collaboration would be welcome. The report would be drafted on the basis of existing data and would provide guidelines and templates for analysis at the national level. The 2014–2015 biennium was a landmark for women's health issues, marking the 20th anniversary of the Beijing Declaration and Platform for Action[6] and the transition between major global mandates, such as the Millennium Development Goals (MDGs) and the post-2015 development agenda. A wide range of resources would therefore be available for the Regional Office to draw on. Consideration could also be given to fertility issues and the use of the technologies for medically assisted reproduction.

37. The SCRC agreed that discussions on women's health at RC65 should take the form of a technical briefing.

Roadmap of actions to fully comply with the WHO Framework Convention on Tobacco Control in Europe (2015–2020)

38. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, said that despite the broad ratification of the WHO Framework Convention on

[6] Beijing Declaration and Platform for Action. The Fourth World Conference on Women, Beijing, China, 4–15 September 1995 (http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf, accessed 23 December 2014).

Tobacco Control[7] (FCTC), there was still a lack of implementation in the European Region, which had the highest level of tobacco consumption globally. To ensure that the roadmap was in line with its workplan, the Regional Office was working closely with the FCTC Secretariat and with a senior advisory group comprising representatives of civil society, Member States and experts. There had been discussions on five focus areas:

- improving surveillance;
- supporting Member States in their implementation of the FCTC and their efforts to overcome the challenges posed by the tobacco industry, and to encourage declarations of intent to become tobacco-free;
- legislating with regard to electronic cigarettes, which gave rise to considerable debate and for which evidence was still lacking;
- "denormalizing" tobacco by overriding industry propaganda on short-term economic gain and employment, and underscoring the economic impact of long-term population ill-health, as well as exposing the links between the industry and governments; and
- enhancing partnerships with ministries of finance, trade and agriculture to reduce tobacco consumption.

39. The advisory group had suggested that surveillance and monitoring should be cross-cutting and that priority areas for action – such as tobacco use among women, taxation, pricing and affordability, trade agreements and the implementation of the tobacco products directive in the European Union – should be identified.

40. The SCRC expressed support for the roadmap and particularly welcomed the discussion on electronic cigarettes, which was controversial pending evidence on whether they could be considered a medicinal tool to help people stop smoking or whether they were simply an innovation of the tobacco industry to keep people addicted to nicotine. All other alternatives to cigarettes should be included in that discussion. The roadmap would be a useful tool to assist States Parties in their implementation of the FCTC. That said, it contained a great deal of information. A simple checklist of actions required to implement each article of the FCTC would be helpful and could perhaps be annexed to the roadmap. Tobacco consumption among young people could be addressed specifically as a priority area and data on passive smoking could also be used to "denormalize" tobacco. Civil society should be engaged to change attitudes at the societal level, which would encourage governments and parliaments to adopt legislation. Trade agreements were a particularly problematic issue.

41. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course agreed that a checklist of cost-effective interventions for FCTC implementation would be useful. Trade agreements were the cause of considerable concern, particularly in the eastern part of the Region, posing a substantial barrier to effective action on the pricing of tobacco products. More evidence on electronic cigarettes was required and all alternative products would be included in the roadmap. Cost-effectiveness analysis of tobacco reduction was particularly important: with appropriate taxation, tobacco control would pay for itself. Finland's declaration of intent to become a tobacco-free nation should serve as an example to other countries.

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[7] WHO Framework Convention of Tobacco Control. Geneva: World Health Organization; 2003, updated reprint 2004, 2005 (http://whqlibdoc.who.int/publications/2003/9241591013.pdf?ua=1, accessed 23 December 2014).

European health report 2015: new frontiers in evidence – reaching beyond targets

42. The Director, Division of Information, Evidence, Research and Innovation, introducing the European health report 2015, said that the report, which would be divided into three chapters, had three main goals:

- to take stock of regional progress towards meeting the Health 2020 targets and indicators;
- to highlight the importance of the cultural determinants of health and well-being; and
- to explore new frontiers in evidence and information.

43. The report would be a scorecard for the European Region and would be underpinned by the Health 2020 monitoring framework. Interesting trends in evidence, including a narrowing of the inequality in injury mortality between men and women in the region, were already coming to light. An assessment of the cultural determinants of well-being would be particularly interesting given the broad cultural diversity of the European Region. No extra reporting would be required from Member States. An expert group has been established to look into the impact of culture on health and health care as a barrier to the achievement of the highest standard of health worldwide. Over time, consideration would also be given to the political and other determinants of health. Evidence would be assessed from a multidisciplinary viewpoint. A meeting of experts is scheduled for January 2015 to take stock of existing evidence and consider what was meant by "culture" in the context of health. With regard to new frontiers, consideration would be given to defining concepts and indicators for new Health 2020 elements, such as "community resilience", "empowerment" and "people-centredness". Health 2020 had been an important catalyst for new work in evidence and that trend should continue. The draft report would be submitted for peer review to the European Advisory Committee on Health Research (EACHR) in spring 2015 and the final report would be published in English and Russian in time for RC65. The executive summary of the report would also be available at RC65 in all four official languages of the Region.

44. The SCRC welcomed the European health report, in particular the consideration of the cultural determinants of health. Cultural issues, which were often sensitive and therefore required careful attention, could have a significant impact on health, well-being and life satisfaction. Caution should be exercised to ensure that the cultural determinants of health were clearly defined and that the adoption of new approaches did not detract from the original impetus behind Health 2020: the social determinants of health and the health divide. The gaps should be identified and steps taken to bridge them. Rather than adding more types of determinants – cultural, political and social – consideration could simply be given to determinants of health as a whole.

45. The Director, Division of Information, Evidence, Research and Innovation, thanked the SCRC for its support and said that the report would not only illustrate success stories with respect to the implementation of Health 2020, but it would also identify gaps in monitoring and suggest how to address them. She agreed that clear definitions of determinants must be used. The participation of an SCRC representative at the meeting of experts in January 2015 would be appreciated, as it would provide the governing bodies' perspective.

46. The Regional Director added that it would also be useful to invite a member of the SCRC to serve as a link with EACHR.

Enhancing evidence-informed policy-making in the WHO European Region

47. The Director, Division of Information, Evidence, Research and Innovation, said that wide gaps between evidence and policy persisted in the European Region. It is the express mandate of the Regional Office to assist in bridging those gaps. In that regard, the recently established

European Health Information Initiative provided evidence in multiple formats to meet policy-makers' needs, promoted effective policies in support of Health 2020 and facilitated the institutionalization of evidence-informed policy-making by establishing national advisory bodies. EACHR had formed a subcommittee on evidence-informed policy-making and had requested the Regional Director to draft a regional action plan, to be approved by the Regional Committee. Five major evidence-informed policy gaps had been identified in the Region and the Secretariat had been requested to provide guidance on how to address them. Four options for addressing the gaps had been drawn up:

- business as usual;
- consolidate and strengthen evidence-informed policy-making within the Secretariat;
- develop a roadmap for accelerated action; or
- develop a regional action plan, to be submitted to the Regional Committee for approval.

The SCRC's guidance was sought on how to proceed.

48. The SCRC underscored the importance of health information and evidence and agreed that Member States should take measures to bridge the gaps identified. Evidence-informed policy-making was difficult to achieve in practice, often because policies were formulated and decisions taken at times of uncertainty or as a compromise. On that basis, it was perhaps too early to move forward with an action plan or framework. The SCRC therefore agreed that, for the time being, the third option – a roadmap for accelerated action – would be the most reasonable approach. There would still be the possibility to develop an action plan or framework at a later date. The roadmap should support Member States and provide a platform for cooperation and the exchange of experiences and best practices, particularly since countries used different methods to inform policy-making. The Director, Division of Information, Evidence, Research and Innovation, said that the SCRC's guidance would be taken forward. The roadmap would indeed be a mechanism to support Member States and ensure that the institutionalization of evidence was achieved naturally. A representative of the SCRC would be invited to attend the meeting of experts in January 2015, which will address the formulation of such a roadmap, to serve as a link with the governing bodies. Work on the roadmap would be a strongly consultative process.

49. The Regional Director emphasized that closer links were needed between the SCRC and EACHR. While she agreed that the roadmap was the most appropriate course of action at this point in time, she hoped that it would lead to the drafting of an action plan for the region. In support of this initiative, an internal review of evidence-informed approaches within the Secretariat should be undertaken. She also strongly supported the view that the Secretariat should execute the second option.

50. The SCRC agreed that evidence-informed policy-making should be the topic of a technical briefing at RC65, with a view to a substantive agenda item at a future session of the Regional Committee. The technical briefing could include preliminary discussions on the process of drawing up a roadmap, as well as considerations for eventually developing an action plan.

Final report on implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-resistant Tuberculosis in the WHO European Region 2011–2015 and European action plan for tuberculosis prevention and control 2016–2020

51. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, said that the implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-resistant Tuberculosis in the WHO European Region

2011–2015 had been a priority in the Region. Most of the milestones for the seven areas of action had been achieved. The Regional Office has been working closely with Member States, as well as in partnership with the European Centre for Disease Prevention and Control and the Global Fund to Fight AIDS, Tuberculosis and Malaria. At the outset, 18 high priority countries, where 85% of TB cases had been reported, had been the focus of activity in the Region and the incidence rates in those countries had decreased substantially. However, there was still a considerable disparity between the highest and lowest national incidence rates in the Region and multidrug-resistant tuberculosis (MDR-TB) was still on the rise. The increase in registered cases was partly due to improved diagnostics. Major progress was being made in case detection and treatment coverage, having increased to 95%. However, the treatment success rates were still lower than expected. The new action plan for 2016–2020 would be in line with the global Stop TB strategy and Health 2020, and would be applicable to the whole Region. The draft action plan would be developed through a comprehensive consultation process with input from a technical advisory group, WHO programme managers, Member States and the SCRC.

52. The SCRC welcomed the report and efforts to develop a European action plan. Greater emphasis on integrated care and comorbidities would be appreciated; in particular, approaches to treatment for people with alcohol or drug dependence and policy actions, including HIV and TB prevention, care and treatment. Social support for TB patients with addiction problems and those in detention was of critical importance. The action plan should also take into account transboundary risks related to extensively drug-resistant tuberculosis. TB should also be a focus during discussions on migration and health. The action plan should underscore the importance of lifelong learning for health care professionals. Several representatives thanked the Regional Office for supporting efforts to address TB in their countries, where the disease remained a major public health issue and disproportionately affected the disadvantaged. In that regard, the action plan should also address the social determinants of TB. Outpatient care was often unsuccessful owing to difficulties in keeping track of patients. Intersectoral action on TB would contribute to better control. Civil society also had a role to play. It could therefore be beneficial to consider how the services provided by nongovernmental organizations (NGOs) could be integrated into national action plans. Much could be learnt about the training of primary health care professionals and TB specialists if countries would share their experiences.

53. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, said that many lessons had been drawn from implementing the Consolidated Action Plan, particularly with regard to comorbidities and coinfections. She welcomed support for making the new action plan relevant to the whole Region and agreed that high-risk groups, including migrants, should be targeted and that health systems strengthening had a significant role to play and that NGOs and patient groups had been fully engaged in the consultative process.

Environment and health in the European Region: reflections on implementation since the fifth ministerial conference and future directions

54. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, said that 2015 was an important year for the EHP, since the high-level midterm review would be prepared in the second quarter of the year and preparations for the Sixth Ministerial Conference on Environment and Health in 2017 would be under way. A document on the implementation of the Parma Declaration on Environment and Health[8] was being

[8] Parma Declaration on Environment and Health. Fifth Ministerial Conference on Environment and Health: “Protecting children’s health in a changing environment”, Parma, Italy, 10–12 March 2010 (http://www.euro.who.int/__data/assets/pdf_file/0011/78608/E93618.pdf?ua=1http://www.euro.who.int/__data/assets/pdf_file/0011/78608/E93618.pdf?ua=1, accessed 23 December 2014).

prepared for RC65. It would review achievements and challenges, the main political processes and strategic partnerships, and future priorities as identified by the European Environment and Health Ministerial Board (EHMB) and the European Environment and Health Task Force (EHTF). A panel discussion, which would include members of the EHMB and EHTF, would be held at RC65. It might be beneficial to invite representatives of the environment sector and other stakeholders to participate in that discussion. The documents for the midterm review, which include a paper on governing the EHP – "Lessons learned and the way forward", had been prepared. The chairperson's summary of the midterm review would be presented to the EHMB and EHTF; the main elements of the review would also be reported to the Regional Committee.

55. One member of the SCRC commended the Regional Office's leadership on environment and health and welcomed the newsletter, which was a useful tool for updating stakeholders on the environment and health process at the regional and global levels. He asked whether the midterm review report would address the economic impact of environmental risks to health and whether it would specifically address health risks to children posed by poor environmental conditions.

56. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, said that the economic impact of environmental risks to health would be addressed in a background document for the Regional Committee's consideration. She welcomed the proposal to include risks to children's health.

"Rolling" agenda of future Regional Committee meetings – alignment of reporting periods to bienniums

57. The Regional Director introduced the "rolling" agenda, which included standard agenda items, as well as the schedules for regular and periodic reporting, for future sessions of the Regional Committee until RC72 in 2022. The rolling agenda was a work in progress, since new items that often could not be foreseen in advance continually emerged from global governing bodies. The rolling agenda must therefore be updated regularly. An issue that had come to light when considering reporting schedules was that time-bound action plans often needed to be renewed after their deadline had expired. In future, it would perhaps therefore be advisable to draft action plans with a time frame of up to 10 years. The SCRC's guidance was sought on how to proceed with action plans that had not been fully implemented and required prolongation.

58. The SCRC welcomed the rolling agenda, which gave a long-term perspective and was a useful tool for Member States in terms of their preparations for future sessions of the Regional Committee. One member suggested that the Secretariat should prepare an overview of the action plans requiring renewal, with details on whether they would be redrafted or simply extended; the SCRC could consider the approach to take for each action plan on a case-by-case basis. In future, midterm reports on the implementation of action plans would be useful to judge whether they would require prolongation.

59. The Regional Director said that, with the SCRC's approval and in the interests of transparency, the Secretariat would present an overview of the rolling agenda for RC66 and RC67 to the open session of the SCRC in May 2015. She agreed that an overview of the status of action plans could be prepared in time for the SCRC's third session in March 2015, for a case-by-case discussion.

Terms of reference of the SCRC subgroups and reports of chairpersons

Subgroup on implementation of Health 2020

60. The chairperson of the SCRC subgroup on implementation of Health 2020 said that the subgroup's terms of reference had been reviewed and had remained unchanged, with one exception – the decision that subgroup members would support the promotion and implementation of Health 2020 at the request of the Secretariat. With the SCRC's approval, a sentence to that effect would be added to the terms of reference. The subgroup had met the previous day and had been attended by the Director, Division of Information, Evidence, Research and Innovation. Discussions had focused on the increased availability of comparative data to assess the impacts of Health 2020 implementation, supported through the WHO Autumn School on Health Information and Evidence for Policy-making, the various dissemination platforms to report progress, including a new public health journal to be published by the Regional Office, and a revitalization of the country profiles, "Highlights on health". Attention had also been given to promoting intersectoral collaboration: one of the subgroup's terms of reference and its theme for RC65.

61. The Director, Division of Policy and Governance for Health and Well-being, said that the subgroup had held productive discussions on the practical promotion and implementation of intersectoral action for Health 2020 and had discussed how to enhance intersessional feedback from the SCRC to the Secretariat on the content of working documents being drafted for RC65.

62. The Regional Director said that there was a great deal of interest in the ongoing work on Health 2020. The experiences of Member States with respect to Health 2020 implementation should be documented and the tools to support Health 2020 implementation should be reviewed and refined, as necessary.

63. The SCRC approved the revised terms of reference of the subgroup on implementation of Health 2020.

Subgroup on strategic resource allocation

64. The chairperson said that the SCRC had held three teleconferences to discuss its subgroups, but had postponed discussions on the future of the subgroup on strategic resource allocation. The Standing Committee should decide whether to:

- continue the work of the subgroup by way of open-ended teleconferences;
- hand the subgroup's work to the subgroup on governance; or
- take up the subgroup's work in the Standing Committee as a whole.

65. One member of the SCRC pointed out that the subgroup on governance already had a heavy schedule. The subgroup on strategic resource allocation had fulfilled its original mandate. If the subgroup was to be maintained, it would require a new mandate, which could not be set at the present time. The subgroup could become "dormant" and be re-established if and when its role and function could be precisely defined. Another member asked whether the Ebola virus disease outbreak would affect budget allocation.

66. The Regional Director said that strategic resource allocation was still under discussion in PBAC and its Working Group. So far, the Working Group had only discussed in depth segment 1 of the draft PB 2016–2017. The SCRC might decide that the subgroup had a role to play in the light of future PBAC decisions with regard to segments 2, 3 and 4. She therefore

agreed with the suggestion to leave the revision of its terms of reference pending. The Ebola virus disease outbreak would affect decisions in upcoming global governing body meetings, since it would result in increased demands to scale up preparedness. An increase in the budget ceiling for PB 2016–2017 would therefore be suggested and, if approved by the Executive Board, would be incorporated into the draft PB 2016–2017 before the World Health Assembly in May 2015.

67. The SCRC agreed to keep the subgroup "dormant" and postpone the review of the subgroup's terms of reference until its session in March 2015. The subgroup would be reconstituted if the SCRC deemed it necessary.

Subgroup on governance

68. The chairperson of the SCRC subgroup on governance said that a revised version of the subgroup's terms of reference had been submitted to the SCRC for its consideration. The subgroup advised that the working methods of the SCRC, including the frequency of the meetings, should be discussed regularly by the Standing Committee as a whole and should not be in the terms of reference. The tool for assessing candidatures to the Executive Board and the SCRC had been refined to include an explanation of the scoring procedure. The current format should be used from now on, with the possibility to make further revisions in due course in the light of experience and lessons learned. The letter sent to Member States inviting them to nominate candidates should include a request for a "manifesto" stating the relationship of the Member State with WHO, its commitment to WHO priorities at the global and regional levels, and the contribution that it would make as a member of the Executive Board or the SCRC. While the scores calculated for each candidate by using the tool would not be published, they would be made available to the Member State in question, upon request. Nominated countries would not participate in the scoring process or the deliberations. The subgroup had considered three suggestions made by the Regional Evaluation Group and had requested that the Secretariat propose appropriate action. It had also asked the Secretariat to draft a document detailing options for further improving NGO participation in sessions of the Regional Committee. The subgroup had also requested that the Secretariat develop guidelines to ensure a unified format for technical documents and that its chairperson, Estonia, develop options for bringing conference outcomes to the Regional Committee, jointly with the Secretariat.

69. The Regional Director said that the introduction of the evaluation tool for candidatures to the Executive Board and the SCRC was a positive step. Following consultations with the Regional Office's legal counsel, she suggested that the term "manifesto" be replaced by "letter of intent". It was noted that discussions in the Secretariat and in the subgroup had reached the same conclusion – that the SCRC did not necessarily require five sessions per year. Consideration should be given to reducing the time set aside for future sessions of the SCRC.

70. The SCRC took note of the revised terms of reference, agreed to remove consideration of its working methods and replace "manifesto" with "letter of intent", and welcomed the Secretariat's efforts to draft papers on the remaining items on the subgroup's agenda.

Report of the Secretariat on budget and financial issues

71. The Head, Programme and Resource Management, Division of Administration and Finance, presented an overview of the financial situation of the Regional Office as of 6 November 2014. Category 1 (communicable diseases) was the best funded, at 82% of the allocated budget, whereas category 2 (NCDs) was the least funded, at 47%. Uneven funding persisted, particularly at the programme level, which meant that "pockets of poverty" existed alongside the need for a ceiling increase in some categories. Overall, the Regional Office for

Europe was the second lowest funded after the Regional Office for the Americas. Categories 2, 3, 4 and 6 in the Regional Office for Europe were the lowest funded among all major offices except for the Regional Office for the Americas.

72. Implementation of the allocated programme budget was slightly below the level that would be expected with linear implementation. This was expected to change over the course of the second year of the biennium. Implementation of available funds was at 57% and the lowest funded categories had the highest implementation rates in respect of available funds. The overall funding gap stood at US$ 83.5 million but that would be reduced to US$ 39.5 million if projected voluntary contributions were received. If projected corporate funds were received, the gap would be reduced to US$ 9.5 million. Salaries accounted for 54% of total spending to date. The current salary gap stood at US$ 47 million. Overall, the Regional Office was seeing the results of the sustainability plan that had begun in the 2012–2013 biennium, with a reduction in staff costs of around 10%, a reduced salary gap and increased technical staff capacity in priority areas.

73. With regard to the draft PB 2016–2017, the Regional Committee's comments and suggestions were being incorporated into the revised version, to be considered at the 136th session of the Executive Board and the twenty-first meeting of PBAC in January 2015. The Regional Office had also provided an additional budget for consideration, including the financial implications of the resolutions on antimicrobial resistance and hepatitis.

74. One member of the SCRC said that despite efforts to align the programme and budget, funding discrepancies persisted. She wished to know how the Secretariat planned to approach donors to try to rectify that situation. It would be interesting to know whether any trends in funding, such as the surge in funding to respond to the Ebola virus disease outbreak, had impacted other areas or whether that response had been financed by additional funding. She asked whether the Director-General had used her prerogative to shift funding between categories and between regions. She enquired about the Secretariat's plan to propose an increased budget for 2016–2017. While the reasons for that plan were understandable, it went against the zero growth decision taken by Member States. Lastly, she wished to know whether measures were being taken into account for the budget implications of World Health Assembly resolutions. Another member asked about programmes that were overfunded, such as the TB programme. She wondered whether the Director-General had decided to raise the budget ceiling for the TB programme and, if so, whether the existing programme staff would be able to manage the workload.

75. The Head, Programme and Resource Management, Division of Administration and Finance, said that despite progress at the global level, alignment of funding to programme budget ceilings remained a challenge in the European Region, particularly since some programme areas were more popular with donors than others. Most of the funding for the Ebola crisis response had been programmed; there had been no diversion of funds at the regional level in the European Region. Under the Director-General's delegated authority to make budget shifts, de facto shifts had occurred. For PB 2016–2017, the Regional Office had submitted a zero-growth option and an option with 9% growth, taking account of the results of the bottom-up planning process, which were not consistent with zero growth. The issue of how to incorporate the financial implications of resolutions approved by the World Health Assembly had been the subject of considerable discussion. While the Regional Office had incorporated the programme budget implications of resolutions at the regional level into its proposal for PB 2016–2017, measures at the global level were not visible as yet. With regard to the TB programme, efforts had been made to offset the extra funds against other programmes in the same category. Given the high amount of funding, however, a request had been made to increase the budget ceiling for that programme. A decision on that request had not yet been

taken. Donors wished to see their funding implemented but the Regional Office could not programme the funds unless the budget ceiling was available.

76. The Executive Manager, Strategic Partnerships and Resource Mobilization, said that to date, the financing dialogue had looked at enhancing predictability, improving alignment between the programme budget and resources, reducing vulnerability and increasing transparency. While the predictability of funding had increased for the current biennium, funding for the European Region would remain vulnerable in future bienniums. In addition to differences in alignment between the global and regional levels, there were also variations in shortfalls. While there was an increase in flexible funding in the form of global core voluntary contributions coming from some Member States, earmarked funding for specific programmes and countries continued to be the dominant funding mechanism. With regard to the Ebola virus disease crisis response, WHO was relying heavily on a few major donors. While 80% of the Regional Office's voluntary contributions came from 12 donors, Member States that had not traditionally been WHO donors were beginning to contribute.

77. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, said that in line with a request from Member States, a decision had been taken to focus the Regional Office's work on standard-setting and guidance. However, the Regional Office received continuous requests from Member States and partners to support operational activities in countries. Should the Director-General agree to increase the budget ceiling for the TB programme, the Regional Office had the capacity to handle the workload.

78. The Regional Director said that the resource mobilization unit in Geneva had been moved to the Office of the Director-General and a global resource mobilization team had been established. At its first meeting, the team had highlighted the need to look more systematically at "pockets of poverty" across the seven offices and across budget categories. In the European Region, several programme areas remained underfunded. At the recent GPG meeting, it had been decided that 20% of the regular budget and some core voluntary contributions would be directed to the Ebola crisis response. Much of the donor funding pledged to the Ebola response had not been received, although some of it may have come in the form of in-kind contributions or donations to the United Nations. In recent correspondence, the Director-General had agreed to a US$ 12-million increase to the Regional Office's budget ceiling for Categories 1, 4 and 5 at the regional level, including for the TB programme. With regard to the two options submitted by the Regional Office on PB 2016–2017, the GPG had agreed that the Director-General should submit a supplementary paper to the Executive Board detailing the following: (a) the impact of accommodating the increased allocation from bottom-up planning; (b) gauging Member States' opinions on a potential increase in the budget to accommodate a staff cost increase; and (c) the requirements with regard to the Ebola virus disease crisis response and increased preparedness. Depending on the reaction of Member States to that paper, a decision would be taken as to whether to revise the proposed PB 2016–2017.

Programme budget 2016–2017 regional implementation plan as a contract between the Regional Committee and the Regional Office

79. The Head, Programme and Resource Management, Division of Administration and Finance, said that all regional committees had contributed to the global process for drafting PB 2016–2017. One particular concern raised by Member States had been to have a clear picture of the Secretariat's responsibilities with regard to the results contained in the programme budget. A budget validation exercise had been conducted and the draft programme budget had been adjusted at the regional and global levels. The revised draft would be reviewed by PBAC and the Executive Board in January 2015.

80. Corresponding to the global PB 2016–2017, a regional implementation plan for PB 2016–2017, referred to as a "contract" between Member States of the European Region and the Secretariat, would be the main instrument of accountability at the corporate level in the Region. It would highlight issues of relevance for the Region, such as which outcomes or outputs in the global results chain were relevant to the Region and the regional contribution to each indicator. The plan would help Member States to understand the Regional Office's targets for the biennium. Examples of results that were jointly undertaken by the Secretariat and Member States and others that were the sole responsibility of the Secretariat were given. The final version of the global PB 2016–2017 would be required before the regional plan could be finalized for submission to the 65th session of the Regional Committee in September 2015.

81. The SCRC welcomed the proposal for the development of a regional implementation plan, which, when finalized in the light of the programme budget, would be an excellent tool for accountability.

82. The Head, Programme and Resource Management, Division of Administration and Finance, said that following discussions in the PBAC and Executive Board, the regional implementation plan could be developed, for submission in draft form to the SCRC at its session in May 2015.

Membership of WHO bodies and committees

83. The SCRC was informed that the customary nominations or elections for membership of the following WHO bodies and committees would take place at RC65:

- Executive Board 2 seats
- Standing Committee of the Regional Committee for Europe 4 seats
- European Environment and Health Ministerial Board 2 seats

Regional suggestions for elective posts at the Sixty-eighth World Health Assembly

84. The SCRC was informed that the European Region was required to submit candidatures for the posts of Vice-President of the World Health Assembly, Vice-Chairperson of Committee B of the World Health Assembly, Rapporteur of Committee A of the World Health Assembly, five members of the General Committee of the World Health Assembly and three members of the Committee on Credentials of the World Health Assembly.

Issues to be taken up with European members of the Executive Board in January 2015 and collaboration with the Programme, Budget and Administration Committee

85. The SCRC was informed that the Secretariat was preparing a document on the European Regional perspective on matters to be addressed by the Executive Board, which would be made available to Member States early in January 2015. Two issues of particular importance to the European Region would be strategic budget space allocation and staff rotation and mobility. On the latter, an internal review had been conducted by the Staff Association of the European Region at the Regional Office, which raised the issue of the mandatory nature of the mobility plan. Given the importance of aligning the interests of the Organization with the interests of its staff, efforts were being made to find a solution by introducing mobility on a voluntary basis, at least for the first three years.

86. The Head, Programme and Resource Management, Division of Administration and Finance, said that the PBAC Working Group on Strategic Budget Space Allocation had met at WHO headquarters in Geneva with representation from each region. It had decided that it would focus mainly on segment 1 of the draft PB 2016–2017, that is, technical cooperation to countries. There had been considerable discussion on identifying the parameters for segment 1 budget allocation across the regional offices of the Organization. The Working Group's second step had been to apply those agreed parameters and to assess their impact in terms of budget distribution to major offices, which had resulted in significant variances from the current budget distribution model. In a situation of zero growth, if an allocation to one region increased, the allocation to another must decrease accordingly. The results of the Working Group's deliberations would be submitted to the Executive Board and PBAC.

87. Members of the SCRC said that, in the past, negotiations on similar issues had taken around two years. While the outcome of the process would be highly political, its impact might be low, since, if limited to segment 1, it would apply only to one quarter of the total budget line, which was usually highly earmarked. Any increase in budget allocation to the European Region was likely to be slight. It was important not to enter into drawn-out intergovernmental negotiations.

88. The Head, Programme and Resource Management, Division of Administration and Finance, said that while segment 1 covered approximately a quarter of the budget, the new approach would be a significant departure from previous budget allocation models.

89. The Regional Director added that the process had been instituted by a decision of the World Health Assembly and an initiative of the Director-General. Member States in the Region must be united in their response. The European Region stood to gain from the procedure and the support of Member States was required to ensure success.

Briefing on the process for the post-2015 development agenda

90. The Special Representative of the Regional Director on MDGs and Governance, briefing the SCRC on the post-2015 development process, highlighted the key milestones of the process, including the finalization of the work of the United Nations Open Working Group on Sustainable Development Goals and the submission of its proposal on sustainable development goals to the United Nations General Assembly. The proposal included a set of 17 goals and 169 targets, with health being addressed in Goal 3, entitled "Ensure healthy lives and promote well-being for all at all ages". The health targets included the unfinished health MDGs, emerging global health priorities, universal health coverage and the broader determinants of ill-health. In accordance with General Assembly resolution 68/309,[9] the Open Working Group's proposal shall be the main basis for integrating the sustainable development goals into the post-2015 development agenda, while recognizing that other inputs, including the Secretary-General's synthesis report,[10] will also be considered.

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[9] United Nations General Assembly resolution 68/309 on the report of the Open Working Group on Sustainable Development Goals established pursuant to General Assembly resolution 66/288. Resolution adopted by the General Assembly on 10 September 2014. New York: United Nations; 2014 (A/RES/68/309; http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/68/309, accessed 23 December 2014).

[10] The road to dignity by 2030: ending poverty, transforming all lives and protecting the planet. Synthesis report of the Secretary-General on the post-2015 sustainable development agenda. United Nations General Assembly document A/69/700, 4 December 2014 (http://www.un.org/ga/search/view_doc.asp?symbol=A%2F69%2F700&Lang=E, accessed 23 December 2014).

91. The Secretary-General's synthesis report will guide the negotiations for a new global agenda that is centred on people and the planet and underpinned by human rights. The synthesis report presented dignity, people, prosperity, the planet, justice and partnerships as an integrated set of "essential elements" aimed at providing conceptual guidance during discussions of the goals. Universal health-care coverage was mentioned in paragraph 70 of the report.

92. The final stage in the preparations for the post-2015 development agenda would involve open, inclusive and transparent consultations and intergovernmental negotiations that address outstanding issues related to the United Nations Summit for the adoption of the post-2015 development agenda. The outcome document to be prepared for adoption at the Summit in September 2015 would contain the following main components: an introductory declaration; the sustainable development goals, targets and indicators; means of implementation and a new global partnership; and a framework for monitoring and reviewing implementation. The means of implementation would be addressed mainly in separate consultations on financing for development. However, there were certain aspects that required attention within the post-2015 consultations. These could include issues such as technology facilitation and the shaping of an overall global partnership. Arrangements would be made to ensure close interaction between the post-2015 development agenda consultations and those on financing for development and the climate change negotiations in the context of the United Nations Framework Convention on Climate Change.[11]

93. The SCRC said that the process for the post-2015 development agenda was long and difficult. The brief reference to health in the Secretary-General's report was cause for concern. Health systems and health security were underrepresented in the new agenda. The Ebola virus disease outbreak should serve to illustrate the importance of strengthening health systems and the potential impact on the development of major epidemics. Specific indicators on NCDs should also be included. Following on from the success of the MDGs, it would be interesting to be able to assess the impact of the new goals by measuring their implementation.

94. The Special Representative of the Regional Director on MDGs and Governance agreed that the process had been difficult and complex. The MDGs had been a simple political and advocacy tool. It was now up to Member States, since the intergovernmental process was under way and Member States would decide whether the proposed new goals were acceptable or whether they should be revised. Measurable indicators should be agreed and baselines and targets defined. Member States should make every effort to ensure that health remained high on the post-2015 development agenda, particularly since the new agenda would also define the shaping of partnerships for development assistance in the future. All the documentation was now in place; it was time for Member States to consider the proposals and voice their positions.

Other matters

Update on the Ebola disease outbreak in West Africa

95. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, said that, to date, the Ebola virus disease outbreak had affected eight countries, with intense transmission in Guinea, Liberia and Sierra Leone. As of 8 December 2014, there had been 17 290 cases, including 6128 deaths. At that time, the disease had an overall mortality rate of 70%. Capital cities and large urban areas were most affected. It was the first complex

[11] United Nations Framework Convention on Climate Change. New York: United Nations; 1992 (http://unfccc.int/files/essential_background/background_publications_htmlpdf/application/pdf/conveng.pdf, accessed 23 December 2014).

Ebola outbreak and was spreading rapidly as a result of the lack of Ebola experience in the area, the lack of haemorrhagic symptoms usually typical of Ebola, extensive population mobility, the wide geographical distribution, slow diagnosis and the incomplete reporting of cases and contact tracing. The outbreak had fast become a global issue. Efforts were therefore being made to increase preparedness, particularly in high-risk areas. WHO had declared the situation a Grade 2 crisis according to the Emergency Response Framework and had deployed more than 400 staff to the response effort.

96. To control the spread of Ebola, it was essential to educate and engage local communities, enhance case management, in particular early isolation and care, improve contact tracing and ensure safe and dignified burials. Steps must be taken to stop residual chains of transmission. Despite stabilization efforts, major concerns remained with regard to the disease spreading internally in Guinea, Mali and Sierra Leone and a plateau in progress in Liberia. It was therefore critical that all planned Ebola treatment centres be set up as quickly as possible and that operational presence at the district level for case finding and contact tracing be scaled up.

97. The Regional Office was supporting the global response through staff deployments, assistance with medical evacuations to the European countries from affected countries, mapping preparedness and capacity in Member States of the WHO European Region, and engaging in strengthening the preparedness capacity and advocacy with Member States, working in close collaboration with the European Commission and other partners. A regional Ebola team had been established and weekly teleconferences on preparedness were being held with Member States. Technical assistance was being provided to Member States upon request and four country missions had been conducted. The European Region could assist by ensuring the full financing of critical response activities, providing field epidemiologists and surveillance capacity, enhancing the medical evacuation capacity, facilitating the movement and travel of those assisting in the response, and ensuring appropriate levels of preparedness.

Update on national counterparts

98. The Executive Manager, Country Relations and Corporate Communication, said that 90% of national counterparts and 80% of national technical focal points had been nominated. Of the eight Member States still to submit nominations for national counterparts, five had confirmed that they would do so in the near future. Responses were pending from three. The appointment of national technical focal points was more problematic than expected. The SCRC had requested that the Secretariat restrict the number of national technical focal points (NTFPs) to 12, in line with the categories of the programme budget. However, some Member States had submitted more names, as they had specific experts for certain public health issues, while other Member States did not have sufficient capacity for 12 focal points. Each Member State in that position was being dealt with on a case-by-case basis, which was taking time. To date, only 23 Member States had completed the list of 12 NTFPs in the right way. In the meantime, the current updated list of national counterparts and NTFPs that was on the external website was as up to date as possible and details of the nominees had been posted on the SCRC Sharefile. It was anticipated that the appointments would soon be completed. As a next step, the Secretariat was exploring the possibility of having a side meeting with the national counterparts at the World Health Assembly. It would also encourage Member States to include these individuals in their national delegations to the Regional Committee, thereby allowing an annual meeting of these counterparts to take place. The Regional Office was encouraging the national counterparts to hold country days once a year to bring together their NTFPs, while internally the Secretariat was also organizing country days to discuss and to plan country assistance and collaboration among the staff. National counterparts were invited to these meetings to share their ongoing work and to discuss future collaboration.

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