



**Report of the sixty-third session
of the WHO Regional Committee for Europe**

Çeşme Izmir, Turkey, 16–19 September 2013

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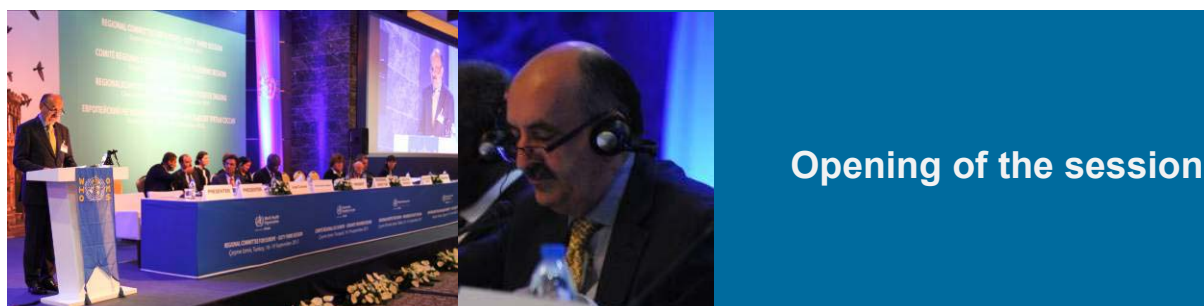
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The sixty-third session of the WHO Regional Committee for Europe was held at the Sheraton Çeşme Hotel in Çeşme Izmir, Turkey, from 16 to 19 September 2013. Representatives of 51 countries of the Region took part. Also present were representatives of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

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

Election of officers

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

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

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

Message from the Director-General

The Deputy Director-General, conveying a message from the Director-General, thanked the Government of Turkey for hosting the Regional Committee’s session. Health issues were prominent on the international agenda. The programme for the current session was packed with major health issues, on which the European Region would provide leadership for others. Historically, the European

Region had been visionary: it had been ahead of the rest of the world by at least two decades in calling for lifestyle changes to tackle the spread of noncommunicable diseases (NCDs), and had pioneered the practice and promotion of universal health coverage (UHC).

Of particular significance during the present session would be the launch of the *Review of social determinants and the health divide in the WHO European Region: final report* and the consideration of the European Mental Health Action Plan. Mental health care was a question of human dignity, which was especially relevant in the current climate of economic uncertainty. The regional framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases 2014–2020 was another important item on the Regional Committee's agenda; those vectors were threatening to introduce diseases such as dengue into the European Region. The Region could not be isolated from the problems of the rest of the world. Climate change was a factor in that regard, contributing to the changing landscape of communicable diseases. It was an indictment that measles and rubella continued to exist in the Region. Paying tribute to the Regional Director for her leadership and foresight, to the staff of the Regional Office for their hard work and to Member States for their support, he wished the Regional Committee a fruitful and productive session.

Adoption of the agenda and programme of work

(EUR/RC63/2 Rev.2 and EUR/RC63/3 Rev.2)

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

Other matters

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

Address by the WHO Regional Director for Europe

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



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

Health 2020 was a European initiative, closely aligned with WHO reform. The Regional Office was using national and international platforms to spread awareness of both the framework and the evidence on which it was based. The two Health 2020 documents (EUR/RC62/R8 and EUR/RC62/R9), approved by the Regional Committee at its sixty-second session, had been published in the four

official languages of the European Region, and the *Review of social determinants and the health divide in the WHO European Region: final report* would be launched at the current session. Other works issued had included a new study on governance for health in the 21st century, *The European health report 2012: charting the way to well-being* and the study on the economic case for public health action conducted jointly with the Organisation for Economic Co-operation and Development (OECD).

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

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

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

In addition, the Regional Office and its partners were implementing action plans on public health threats and pursuing or maintaining disease elimination. Activities had included establishing an antimicrobial resistance (AMR) surveillance network for non-EU countries, to complement the EU system, with the National Institute for Public Health and the Environment in the Netherlands and the European Society of Clinical Microbiology and Infectious Diseases; and expanding European Antibiotic Awareness Day, with the European Centre for Disease Prevention and Control (ECDC) and support from the Patron of the Regional Office, Crown Princess Mary of Denmark. With support from the EC, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and ECDC, Regional Office staff had made 71 country visits and conducted 9 in-depth programme reviews to promote a health systems approach to multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB). The

Regional Office was working to eliminate both mother-to-child HIV transmission and congenital syphilis in Europe, with the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF and UNFPA; and would hold a consultation on the use of antiretroviral drugs in October 2013. With outbreaks imperilling the achievement of measles and rubella elimination by 2015, the Regional Office had developed a package of accelerated action and a call for stronger commitment. Israel's detection of and response to the importation of wild poliovirus into the environment, supported by the Regional Office, showed both the high quality of its surveillance and response and the need for vigilance by all European countries. She pledged WHO's full support for countries' immunization and surveillance work and proposed a regional action plan, in line with the WHO Global Vaccine Action Plan 2011–2020 and Health 2020. Finally, while Europe could be the first WHO region to eliminate malaria, the Regional Office was proposing a regional framework for action – developed with Member States, ECDC and the European Mosquito Control Association (EMCA) – on the growing problem of re-emerging vector-borne diseases.

In the third priority area, strengthening people-centred health systems and public health capacity and emergency preparedness, surveillance and response, the Regional Office had intensified its support for UHC. In 2013, it would hold meetings in Estonia to discuss implementation of the Tallinn Charter and determine future strengthening of health systems, and in Kazakhstan to celebrate the thirty-fifth anniversary of the Declaration of Alma-Ata and discuss integration of essential public health operations into PHC. The Regional Office had supported policy decisions to reduce the adverse health effects of the economic crisis at a conference hosted by Norway, had promoted dialogue between the health and finance sectors with OECD, and had offered training to build policy-makers' capacities, such as the Barcelona Course on Health Financing. It had supported comprehensive health system reforms in Greece, with EU funding, as well as in Cyprus, Ireland and Portugal. Further, the Regional Office was supporting countries to prepare for and cope with health emergencies; upgrading and testing its new emergency operations centre; supporting countries such as Azerbaijan, the Russian Federation and Slovenia in their preparations for the health consequences of mass gatherings; and helping Turkey deal with an influx of refugees from the Syrian Arab Republic. At a meeting in Luxembourg it had assessed implementation of the International Health Regulations (2005) (IHR) and proposed criteria for granting extensions to the 2014 deadline for developing core capacities.

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

The Regional Director concluded her address with an overview of major managerial and governance developments in WHO, noting that the Regional Office had moved to the new UN City in April 2013. She commended the unprecedented engagement of Member States and the contributions and collaboration of staff at the three levels of WHO, which had resulted in significant progress in WHO reform. Guidance from the Regional Committee and the Standing Committee of the Regional Committee (SCRC) was ensuring coherence and better governance in the European Region; the Regional Committee would discuss further SCRC proposals on governance issues. The Twelfth General Programme of Work (GPW12) and the Programme budget (PB) 2014–2015 gave the

Regional Office a vision and a plan of action. The lessons learnt from the 2012–2013 “contract” had contributed to the global process, and Health 2020 would guide transformation of the programme budget into European operational planning. Having co-chaired the WHO task force on resource mobilization and management, she hoped that the Financing Dialogue would ensure a fully funded programme budget. She described measures taken to reduce costs in the Regional Office without affecting delivery of commitments to Member States. The Regional Office continued to extend its partnerships, including strengthening cooperation with the EU, its institutions and holders of the Presidency of the Council of the European Union, and signing a framework for action with UNFPA and UNICEF.

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

A representative speaking on behalf of the EU and its member countries called for concerted action on implementing Health 2020 according to countries’ needs and capacities and supported the Regional Office’s focus on NCDs and their risk factors, strengthening health systems and WHO reform. The proposed European Mental Health Action Plan, accelerated action on measles and rubella, and the regional framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases 2014–2020 were welcome new initiatives. The Secretariat was asked to include the financial and administrative implications with draft resolutions, keep the number of resolutions to a minimum and implement current initiatives before proposing new ones. The EU and its member countries would take part in the forthcoming informal consultation on the Executive Board agenda item on the health and well-being of lesbian, gay, bisexual, transgender and intersex people and would welcome other countries’ views.

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

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

A representative speaking on behalf of the 10 Member States participating in the South-eastern Europe Health Network (SEEHN) said that the Regional Office had supported those countries' efforts to improve the financial sustainability of their health systems by conducting analyses to build the evidence base, disseminating evidence and ideas with policy responses and providing technical assistance. SEEHN had proved to be an excellent vehicle for health diplomacy; the Regional Office supported it by providing innovative tools for SEEHN Member States to strengthen their capacities in that area and allocating a coordination officer. Such work led to cross-fertilization between WHO and SEEHN countries. The latter would report on their work to implement Health 2020, the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 and Regional Committee decisions at SEEHN's fourth ministerial forum.

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

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

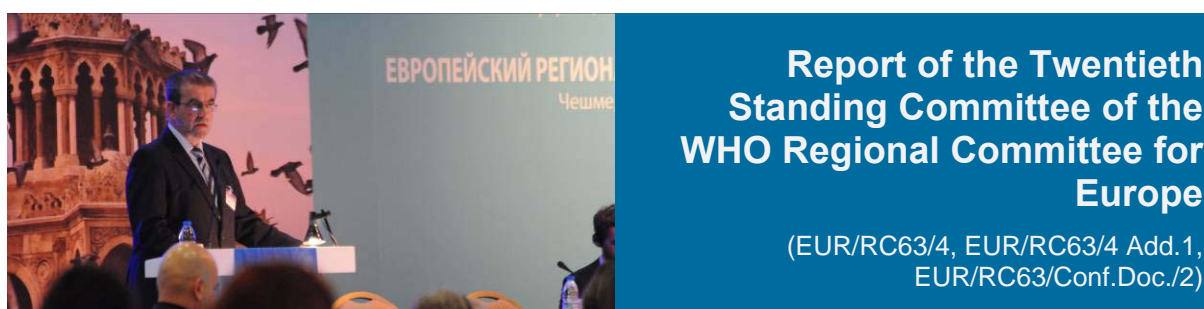
A representative of the Global Fund described its activities in the European Region, noting that eastern Europe and central Asia's unique TB and HIV situation required a specific, bold response. The Global Fund invested in highest-impact interventions and vulnerable populations based on the action plans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

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

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

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

The Committee adopted resolution EUR/RC63/R2.



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

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

Agreeing with the Regional Director that the current session of the Regional Committee should focus on reviewing the implementation of previously adopted policies, strategies and action plans, the SCRC had discussed progress reports to be presented to the Regional Committee and the review of the European Environment and Health Process (EHP). It had also been informed about the outcomes of recent high-level and ministerial meetings. Guidance had been given to the Secretariat on the two new issues on the Regional Committee's agenda: the European Mental Health Action Plan and the regional

framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases 2014–2020.

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

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

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

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

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

The Committee adopted resolution EUR/RC63/R1.

WHO reform

(EUR/RC63/15, EUR/RC63/19, EUR/RC63/20,
EUR/RC63/21, EUR/RC63/21 Corr.1,
EUR/RC63/Inf.Doc/3, EUR/RC63/Inf.Doc/4)



Overview of the impact of the WHO reform on the Regional Office for Europe

The Regional Director recalled that in May 2013 the Sixty-sixth World Health Assembly had approved both the Organization's GPW12 and PB 2014–2015. The programmatic reform that had

marked their preparation and adoption testified to the corporate spirit of the Organization, involving all six regions together with WHO headquarters. It had been driven by Member States, with European countries heavily involved in providing guidance to the Secretariat.

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

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

With regard to governance reform, the Regional Office hosted a partnership with the European Observatory on Health Systems and Policies, as called for by the policy on WHO’s engagement with global health partnerships and hosting arrangements (World Health Assembly resolution WHA63.10). It chaired the WHO steering committee on relations with the EU and had agreed joint road maps with the EC; its annual workplans were harmonized with those of the ECDC; and it was strengthening its partnerships with a number of intergovernmental organizations. A European strategy on partnerships would be elaborated once the comprehensive operational framework for WHO’s engagement with non-State actors had been elaborated at global level.

Further work on reform of internal governance had been done by the Twentieth SCRC, following up on the decisions taken by the Regional Committee at its sixtieth session (resolution EUR/RC60/R3). The Standing Committee’s recommendations on, inter alia, the process for nominating members of the Executive Board and the SCRC, submitting amendments to draft resolutions and ensuring the transparency of SCRC proceedings, as well as the draft Code of Conduct for the Nomination of the Regional Director of the European Region of the World Health Organization, would be considered later in the session.

Managerial reform efforts had been concentrated on securing the predictability, transparency and flexibility of future WHO financing. The Financing Dialogue with potential donors had been initiated: comments on that mechanism by regional committees would provide structured input into the second

dialogue, to be held in November 2013, and the lessons learnt would be reviewed by the Executive Board and the World Health Assembly in 2014.

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

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

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

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

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

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

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

Representatives commended the detailed information provided by the Regional Director and the Director, Administration and Finance. They believed that the reform process was making WHO more effective, transparent, accountable and financially consistent, and they congratulated the Member States and the Secretariat on the progress achieved to date. Nonetheless, reforming the way in which

WHO planned its work, obtained its finances and distributed resources within the Organization remained a key challenge. In particular, the uneven distribution of resources among SOs was problematic; WHO must not end up in a situation where it was unable to carry out tasks that were vital to the Member States.

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

The resource mobilization efforts being made by the Organization were welcomed. In particular, support was expressed for the key positions adopted during the Financing Dialogue: aligning resources with national priorities, increasing transparency and accountability through the establishment of a web portal and extending the donor base. It was important to ensure, however, that WHO reform did not impose a heavy burden on Member States and did not lead to an increase in their assessed contributions.

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

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

Process for developing the programme budget 2016–2017

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

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

- such costing should include both direct costs for outputs and indirect costs, including for administration.

Between January and June 2014, consultations would be held with Member States to define their priorities; those would then be reviewed in the context of regional and global priorities; and the budget would be finalized with costing of outputs and deliverables. PB 2016–2017 would be further discussed by the Executive Board and the World Health Assembly, allowing further input from Member States.

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

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

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

One representative said that while it was understood that PB 2014–2015 was a transitional one, proposals for a programme of work for the 2016–2017 biennium should be presented at the Regional Committee's sixty-fourth session as the basis for discussion, in order to guarantee the foreseen bottom-up approach in budgetary planning. He called for a detailed regional budget proposal to be made at the sixty-fifth session, based on the assumption that it would be fully funded, costed on the basis of the results chain and include clear deliverables and outputs. The Secretariat's deliverables and their indicators should be separated from joint outcomes to be achieved by WHO in collaboration with Member States. Discussion should begin at an early stage on action to be taken with regard to priorities that had not received adequate funding during the biennium.

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

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

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

Outcome of the first Financing Dialogue

The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters, said that the Financing Dialogue had been designed to ensure a match between WHO's agreed deliverables and the resources required to finance them. During a meeting in June 2013, Member States had made commitments to certain characteristics of financing that were important to WHO, including aligning funding to the programme budget, increasing the predictability and flexibility of funding and broadening the range of contributors. Operational planning since that meeting was well under way, a prototype web portal was being set up and bilateral meetings were being held with Member States that had expressed interest. Countries in the BRICS (Brazil, Russian Federation, India, China and South Africa) group and Gulf states were also being approached. A meeting to be held in November 2013 would allow contributors to express their financing commitments or intentions, and would indicate areas that were still underfunded; solutions to any underfunding could then be discussed. The meeting would require information on PB 2014–2015, which would be placed on the web portal, and on the distribution of voluntary contributions for 2014–2015 by category, programme and major office, which would require substantial input from Member States and other contributors. The next steps were for Member States to confirm bilateral meetings with the Secretariat and to encourage attendance at the meeting of senior representatives from development agencies and ministries of foreign affairs.

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

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



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

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

The Review of social determinants and the health divide in the WHO European Region: final report provided evidence that inequalities in health could be reduced. Although there were still discrepancies in, for instance, life expectancy within the Region, the causes were now known, and it had been shown that they could be reduced by universal access to high-quality health care and linkage to social policies. The practical implications of implementation of the recommendations of the review would be discussed in 2014. The publication was being introduced at the current session of the Regional Committee. It would be officially launched in London in late October 2013. A further important publication was *Implementing a Health 2020 vision: governance for health in the 21st century*. Governance was closely linked to social determinants of health, and new forms were needed. Although countries might use different approaches, they would remain united in purpose while maintaining their particularities.

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

The Director, Division of Policy and Governance for Health and Well-being reiterated that Health 2020 had been crafted as a strategy for action and innovation in national health policies, providing practical solutions to public health challenges that were based on evidence and information. It could also be used to compare policies and strategies among countries. Processes and mechanisms to

engage other sectors in health-in-all-policies (HiAP), whole-of-government and whole-of-society approaches were described as a means of developing health and resilience and empowering communities. The evidence base legitimized action, thereby providing a basis for political commitment, and made the case for the moral and economic aspects of health. Links had been forged between Health 2020 and every aspect of the work of the Regional Office, and cross-sectoral teams were working in countries. The implementation package contained tools, guides and services for communication and advocacy to involve other sectors; it would be important to develop use of social media in that respect.

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

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

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

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

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

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

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

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

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

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

Nevertheless, intersectoral approaches to tackling health determinants, like those involving the whole of government or requiring the incorporation of HiAP, were feasible only if a country already had a strong health sector. It was necessary to find ways of making health a key factor on the development agenda. One promising avenue had been to incorporate health in regional (subnational) development plans, in one case using the national Healthy Cities Network for that purpose. Representatives

recommended that the Regional Office provide countries with more opportunities to share such experience and exchange best practices of Health 2020 implementation. One cooperation platform was being provided through a five-year project for countries with a population of less than 1 million.

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

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

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

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

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



Health 2020 monitoring framework, including indicators

(EUR/RC63/8, EUR/RC63/Conf.Doc./7)

The Director, Information, Evidence, Research and Innovation recalled that when the Regional Committee had adopted the Health 2020 policy framework the previous year, it had also adopted “a set of regional goals ... and the appropriate indicators for the European Region” (resolution EUR/RC62/R4). Building on the work done by a working group of the SCRC, an expert group

(including representatives of the EC and OECD) had met at the Regional Office in February 2013 and had proposed a set of quantified targets and a shortlist of 20 indicators. Following their review by the Standing Committee, a written country consultation on the indicators had been conducted in April 2013. Thirty Member States had responded to the consultation, expressing overwhelming support for the core and additional indicators. Many excellent and detailed comments had been made on their operationalization and further elaboration. The Standing Committee, at its May 2013 session, had subsequently agreed on the revised indicators and the accompanying draft resolution to be submitted to the Regional Committee.

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

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

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

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

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

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

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

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

The Committee adopted resolution EUR/RC63/R3.



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

The Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 adopted at the Ministerial Conference held in July 2013 covered five priority areas:

- create healthy food and drink environments and encourage physical activity for all population groups;
- promote the health gains of a healthy diet throughout the life-course, especially for the most vulnerable;
- reinforce health systems to promote health and to provide services for NCDs;
- support surveillance, monitoring, evaluation and research of the population’s nutritional status and behaviours;

- strengthen governance, alliances and networks and empower communities to engage in health promotion and prevention efforts.

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

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

In the ensuing discussion, representatives wholeheartedly thanked the Government of Austria for hosting the Ministerial Conference and expressed their support for the Vienna Declaration, noting that it represented a very relevant, timely and strategic milestone. They described some of the actions their countries were already taking to promote a healthy diet and reduce obesity, especially among children and adolescents, and to promote physical activity, two areas that should be taken forward in parallel. Preventive measures could only be effective if they addressed as many risk factors as possible in a complex manner. That was why reducing nutritional risk factors for childhood obesity required coordinated action. High-level government commitment and multisectoral cooperation was crucial. One speaker drew attention in particular to the potential benefit to be derived from promoting physical activity and suggested that WHO collaborating centres could make a significant contribution to such work. The SEEHN Regional Health Development Centre for NCDs also had a role to play in increasing countries’ capacity to implement agreed national and European commitments to reducing NCDs.

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

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

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

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



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

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

High-level meeting on health systems in times of global economic crisis – an update of the situation in the European Region

(Oslo, Norway, 17–18 April 2013)

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



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

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

In the ensuing discussion, all speakers thanked the Government of Norway and the Regional Office for holding the high-level meeting and welcomed the adoption of the Oslo outcome document. Representatives also thanked the Regional Office and the Observatory for providing evidence and other support to countries facing the challenge of sustaining or even improving their health systems' performance during the current economic crisis. Speakers drew important lessons from the 10 recommendations in the outcome document and from their own achievements in sustaining and protecting their health systems and people's health.

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

Drawing on the outcome document and their experience, representatives reaffirmed that resilient health systems were better able to weather crises and reduce their negative effects on health. As well as threats, crises offered opportunities to make structural reforms of health systems and to explore new

ways to generate resources, such as fiscal measures to control the use of tobacco and alcohol. Countries needed to take short-, medium- and long-term action to strengthen and protect health systems during crises, including balancing budgets and rationalizing services, but better resource management and allocation were not panaceas. Health systems also needed investment, and those that could prove their value in health and economic terms were more likely to secure sustainable financing.

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

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

In reply, the Director, Health Systems and Public Health thanked the Government of Norway and many other Member States for their strong call for the Regional Office to continue its leadership in health financing and the financial sustainability of health systems. Member States' most important message about the interplay of health and fiscal policies was that governments could choose where to allocate more or fewer funds, even within a restricted funding envelope. Priorities therefore mattered, and they could be influenced through good intersectoral dialogue, evidence and listening to the voice of the people. That message was in line with the Tallinn Charter and echoed the call of the 2009 high-level meeting for every minister to be a health minister. WHO would continue to advocate health as a fundamental right, based on the values of solidarity and equity enshrined in Health 2020.

The Committee adopted resolution EUR/RC63/R5.



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

(EUR/RC63/10)

The Executive President introduced the report of the EHMB, which presented the work carried out on the commitments undertaken at the Fifth Ministerial Conference on Environment and Health in Parma, Italy in 2010. The Board's work was closely related to Health 2020: the creation of resilient communities and supportive environments for health was one of the Health 2020 priority areas. Furthermore, through the EHP, WHO had pioneered the HiAP and whole-of-government approaches central to Health 2020. The EHP had led to the establishment of legally binding instruments on environment and health issues and had been instrumental in including the health dimension of climate

change on the agendas of ministries of health and environment. A new governance mechanism for the EHP had been in place since 2010; the EHTF and the EHMB represented all Member States and stakeholders and led implementation of the Parma Conference commitments.

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

In order for the EHP to remain relevant to both of its constituencies, steps should be taken to redefine the criteria underpinning the identification of its priorities. Mechanisms should also be developed to allow Member States to select and act on their own sets of priorities, in preparation for the next Ministerial Conference on Environment and Health in 2016. Priorities should be set in the context of the main international policy frameworks undertaken since the Parma Conference, and account should also be taken of the interdependence of economic, social and environmental objectives. Turning to the issue of governance of the EHP, he said that new institutional arrangements had been made to optimize effectiveness, including the establishment of an intersessional programme of work.

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

The Minister of Health of Serbia gave an overview of her Ministry's efforts to respond to the challenge of monitoring NCDs through cost-effective primary prevention, in line with the Parma Conference commitments. Joint action with the Ministry of Energy, Development and Environmental Protection had included two studies in the town of Zajača, the first on management of contaminated sites and the second to monitor lead exposure in children. A training workshop had been held on the elimination of asbestos-related diseases in southeast Europe. A national children's environment and health action plan had been drawn up, leading to a school survey project that aimed to improve indoor air quality in schools, ensure access to sanitation for children and promote physical activity. Air

quality plans had been drafted for four cities. Lastly, Serbia was implementing a project for sustainable urban transport in Belgrade and had expressed its interest in signing the Amsterdam Declaration of the Transport, Health and Environment Pan-European Programme.

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

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

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

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

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

The Deputy Director-General, Federal Ministry of Environment, Nature Protection and Nuclear Safety of Germany, speaking on the question of how governance and institutional mechanisms could be improved, said that an intersessional workplan was particularly important, with preparatory meetings for the EHTF. Member State input into how to shape EHP governance should be sought in future. Subregional meetings were being considered as a means of preparing for the upcoming midterm review. Host countries for the annual meetings of the EHTF were required. Efforts should be made to strengthen communication with Member States, so that those not represented on the EHMB were fully included in the EHP. Emphasis should be placed on the implementation of the Parma Conference commitments, which should not be compromised by efforts to address emerging issues. The monitoring indicators for implementation of the commitments should be revised and the EHP governance process as a whole should be streamlined.

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

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

The moderator said that the discussion had been an opportunity to reflect on the effectiveness of the institutional arrangements adopted in Parma, which aimed to bring a strong policy and political dimension to the HiAP process. Participation in and support to the EHP should not be seen as peripheral to the health agenda; it should be understood as an important means to address multiple

challenges. The burden of disease in the European Region was determined by how and where people lived and worked, what they ate and drank and the air they breathed. A large part of well-being was determined by surroundings. Thanking the participants for their contributions, he said that the discussion had underscored the EHP's relevance and value added to both the environment and health constituencies.



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

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

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

partnerships and coordinated action in affected areas. The SCRC recommended that the Regional Committee adopt the draft resolution.

In the discussion that followed, representatives agreed that the increasing threat of vector-borne diseases in the WHO European Region, which was being exacerbated by international trade and travel, required a coordinated response within and between countries. They therefore welcomed the development of the regional framework, and expressed their support for the draft resolution. Several participants expressed their commitment to tackling the reintroduction of invasive mosquito vectors and vector-borne diseases into the Region and shared their experiences and efforts in that regard. One representative drew attention to the successful public health response to a recent dengue epidemic in his country; a high level of preparedness had prevented any fatalities.

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

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

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

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

(EUR/RC63/12)



The Director, Communicable Diseases, Health Security and Environment, recalled that progress towards meeting the 2015 target for elimination of measles and rubella in the Region was under threat. While major progress had been made against measles until 2009, in the absence of a high immunization coverage rate, pockets of unvaccinated populations remained and new outbreaks had occurred, especially in the western part of the Region. Therefore, the Regional Office had decided to strengthen certain country activities. Although elimination of rubella had appeared to be within reach in 2011, the disease had reappeared suddenly in parts of eastern Europe in 2012 and 2013. Neither disease was benign and both could result in complications or death, even though they were vaccine-

preventable. More and more cases of measles were being seen in adolescents and young adults who had not been vaccinated as infants.

The criteria for verifying elimination of both diseases in the Region were: vaccine coverage of at least 95% and the absence of endemic cases in all Member States for at least three years. Progress must be documented with high-quality data on surveillance and immunization coverage sent to WHO; however, not all countries had established a national verification committee or sent annual reports to the Organization. The package for accelerated action for elimination of measles and rubella in the Region had six components: vaccination and immunization system strengthening; surveillance; outbreak preparedness and response; communications, information and advocacy; resource mobilization and partnerships; and verification of measles and rubella elimination. Cross-border and interregional coordination would be strengthened, particularly with the WHO Eastern Mediterranean Region.

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

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

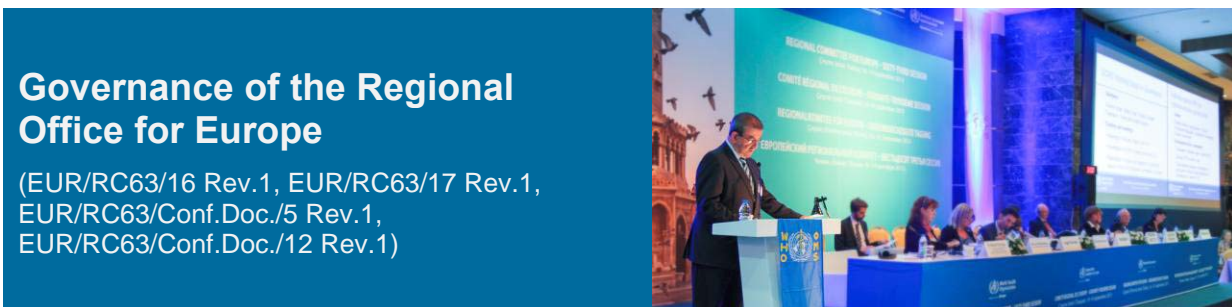
A representative speaking on behalf of the member countries of the EU raised the possibility that the 2015 target for elimination of measles and rubella be extended and asked the Secretariat to propose options at the sixty-fourth session of the Regional Committee. Large outbreaks of measles represented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

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

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

A statement was made on behalf of the GAVI Alliance.

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



Governance of the Regional Office for Europe

(EUR/RC63/16 Rev.1, EUR/RC63/17 Rev.1,
EUR/RC63/Conf.Doc./5 Rev.1,
EUR/RC63/Conf.Doc./12 Rev.1)

Amendments to the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe

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

At the outset, the working group had been tasked with reviewing six areas of governance:

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

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

Two further issues had been added in March 2013:

- election of members to the EHMB
- Code of Conduct for the Nomination of the Regional Director of the European Region of the World Health Organization.

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

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

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

Another speaker thanked the SCRC for its work and for taking into account comments made by Member States at a late stage. She called for the financial implications of measures proposed in draft resolutions to be quantified, and for multilingualism to be scrupulously respected. She asked whether the credentials committee would consist of one representative from each subgroup of countries as used for nominations to the Executive Board and the SCRC. Lastly, she called for paragraph IV.4 in section B of the Code of Conduct for the Nomination of the Regional Director of the European Region of the World Health Organization (as contained in Annex 6 to the draft resolution) to be amended to read: "The Regional Director may suggest that the Director-General consider applying Staff Rule 650

concerning special leave to staff members who have been proposed for the post of Regional Director”, since the current wording was not in line with the Staff Rule cited.

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

In response, the Chairperson, SCRC working group on governance, endorsed the proposals to facilitate common medium- and long-term planning, to make specific draft documents available to Member States at their request, and to circulate overviews of vacant seats with the call for nominations. He explained that the proposed composition of the credentials committee was not linked to the subregional groupings of countries.

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

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

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

Review of the status of resolutions adopted by the Regional Committee during the past ten years (2003–2012) and recommendations for sunseting and reporting requirements

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

The working paper under consideration contained a review of the 46 resolutions, in their entirety, adopted by the Regional Committee between 2003 and 2012, presented according to the categories

used in GPW12. New reporting requirements had been defined for 28 of the resolutions and sunsetting had been proposed for the remaining 18.

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

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

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

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

Elections and nominations

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

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

Executive Board

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

Standing Committee of the Regional Committee

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

European Environment and Health Ministerial Board

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

Regional Evaluation Group

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

The Committee adopted resolution EUR/RC63/R9.



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

The Regional Director reported that excellent progress had been made with existing partners. She elaborated on implementation of joint road maps with the EC, ongoing collaboration with the Global

Fund, including joint missions and greater use of WHO norms by the Global Fund. She also described joint work with the OECD on indicators, common information systems for health, and meetings with the Senior Budget Officials network. Good coordination and synergy among United Nations agencies was essential for reaching common goals, and to work more effectively and efficiently, including through the Regional Coordination Mechanism (RCM) and the Regional United Nations Development Group (UNDG) Teams, to which she was committed. The Inter-agency and Expert Group on MDG Indicators had issued reports on progress towards meeting the MDGs and on the United Nations post-2015 development process, as well as a number of advocacy and issue briefs. Many WHO country offices were members of United Nations Country Teams (UNCTs), working on United Nations Development Assistance Frameworks (UNDAFs). Under the auspices of the UNDG, United Nations agencies were collaborating through a regional working group on Roma, and WHO was working with other agencies to include Roma issues in work on MDGs 4 and 5.

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

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

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

The framework for action with UNFPA and UNICEF would consolidate their efforts to achieve equity, enhance the capacity of public health systems to focus on and be responsive to people, particularly in early childhood, through integration of care systems. UNICEF was therefore pleased to

be signing the framework that would allow each agency to capitalize on the comparative advantages of all. UNICEF was committed to translating the framework into operational plans, with regular communication and periodic reviews.

The UNFPA Regional Director said that the joint action framework was being signed at an important time for the health and development agenda. It would contribute to ensuring social equity, with better alignment of the contributions of United Nations agencies and their member states. The scientific information underpinning Health 2020 and UNFPA's review of achievements in the programme of action of the International Conference on Population and Development showed that societies could prosper under conditions of slow or no population growth and with population ageing if they adapted their institutions and invested equitably in education, health and employment opportunities. The inequalities that existed in the Region, particularly as they affected young people, would require strong political leadership and engagement of a broad range of stakeholders.

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

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

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

Geographically dispersed offices: business cases and progress reports

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



Primary health care

The Director, Health Systems and Public Health, recalled the historic Declaration on PHC signed in Alma-Ata, Kazakhstan in 1978, which had called for more social justice, more grassroots involvement and greater investment in human health. PHC had been one of the pillars of Health 2020. The workplan of the Health Service Delivery Programme of the Division of Health Systems and Public

Health covered strengthening the coordination and integration of people-centred health services, ensuring high-quality systems and the performance of health providers, enhancing management and leadership and strengthening care settings; however, the Programme had inadequate human resources to cover all those areas. The proposed GDO would support the gathering of information on PHC, develop technical skills, increase the capacity of Member States and the Regional Office and engage in partnerships. The work of the GDO would be fully aligned with that of the Regional Office. The offer made by Kazakhstan met all the essential requirements for hosting a GDO, including sustainable funding. The host government had specified that the premises would be in Almaty and confirmed the privileges and immunities of GDO staff. If the Regional Committee approved the offer, the announcement of the office could coincide with the 35th anniversary of the Alma-Ata Declaration on PHC. He thanked the Government of Kazakhstan for its generous, timely proposal.

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

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

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

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

The Committee adopted decision EUR/RC63(1).

Preparedness for humanitarian and health emergencies

The Director, Communicable Diseases, Health Security and Environment described the many humanitarian and health emergencies that had occurred in the Region between 1990 and 2012. Similar situations had been seen in other WHO regions, which had led the World Health Assembly to request Member States to strengthen all-hazards health emergency and disaster risk management. Furthermore, the new WHO Emergency Response Framework (ERF) defined a greater role for regional offices in improving national preparedness for public health emergencies. The capacity of the Regional Office had been limited in that regard, and therefore had to be expanded. Consultations with the SCRC had led to a change in the name of the proposed GDO from “humanitarian crises” to “humanitarian and health emergencies” to better reflect the scope of the Office’s work. The activities of the GDO would be fully integrated into the Regional Office’s work on health security and would be coordinated with that at headquarters and, as needed, country offices. It would undertake assessment

of health systems for emergency preparedness, facilitate training of human resources, provide support for hospital emergency preparedness, support preparedness in mass gatherings and organize national and regional exercises to test emergency preparedness. The GDO would also constitute surge capacity if WHO required further resources in response to humanitarian or health emergencies.

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

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

A member of the SCRC said that the SCRC fully supported the business case and offer from Turkey.

The Committee adopted decision EUR/RC63(2).

Noncommunicable diseases

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

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

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

Health systems strengthening

The Head, ad interim, Barcelona Office for Health Systems Strengthening presented the work of the Barcelona Office, which had been operating since 1999 under a five-year renewable agreement with the Regional Autonomous Government of Catalonia. The Office and its workplan were fully

integrated into the Regional Office. In 2007, the Office's main sphere of activity had changed from integrated health service delivery to health financing. The Office had a strong country support programme and demand from Member States was increasing. The Barcelona Office conducted two flagship courses each year, one on health systems strengthening with a focus on NCDs and the other on health financing policy with a focus on UHC. The Office was fully funded by the host and attracted additional donor funding. The Office was due to relocate to the Hospital Sant Pau UNESCO heritage site with a number of other United Nations agencies.

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

Environment and health

The Acting Head, WHO European Centre for Environment and Health said that the Centre was the largest of the existing GDOs. It had been established in 1990 as the key European technical institution for environment and health. Since the end of 2011, after the closure of the Rome office, environment and health activities had been consolidated in Bonn, Germany, and the previous 10-year agreement had been replaced by one ensuring indefinite support. The contribution of the German Government represented about 40% of the Regional Office's budget for environment and health, aligned with the WHO biannual programme budget cycle. Since 2010, it had been financed entirely by voluntary contributions. After the closure of the Rome office, overall administrative and operational costs had been significantly decreased, with a shift of funds to technical areas, and it was now a centre of excellence providing scientific information that was used as a basis for legislation and policies. The Centre was fully integrated into the Regional Office structure and provided a wide spectrum of expertise as a basis for policy-making and raising awareness about issues of public health concern. The Centre also supported Member States in achieving national priorities in environment and health in line with the Parma Declaration, including the health and economic impacts of climate change, and conducted numerous capacity-building activities.

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

Investment for health and development

The Head, WHO European Office for Investment for Health and Development in Venice said that the Office had two main functions: monitoring, review and systemization of evidence on the social and economic determinants of health, and provision of services to and cooperation with Member States to act on that evidence. The Office had opened in December 2003 under a 10-year host agreement; the renewal agreement for the period 2013–2017 had been signed and was awaiting ratification. The Office was an integral part of the Regional Office. Its achievements could be grouped into three areas:

scientific products, consisting of over 60 publications; technical assistance, especially training in conducting country-wide assessments, with a steady increase in requests; and follow-up of Regional Committee and World Health Assembly resolutions and global commitments, such as Regional Committee resolution EUR/RC62/R4 on Health 2020 and World Health Assembly resolution WHA62.14 on reducing health inequities through action on the social determinants of health. The budget of the Office was provided through an agreement with the Italian Government and had been predictable for 10 years. Like other GDOs, the Office contributed much valuable work. As the social determinants of health were a key element of Health 2020, he foresaw an increase in the number of requests for technical assistance, most of which would be for medium- or long-term support. The Regional Office would have difficulty in meeting those requests if the GDOs did not exist.

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

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

European Mental Health Action Plan 2014–2020

(EUR/RC63/11, EUR/RC63/Conf.Doc./8)



The Director, Noncommunicable Diseases and Life-course, introducing the European Mental Health Action Plan, said that neuropsychiatric conditions had a considerable impact on the burden of disease in the WHO European Region. That situation was exacerbated by the fact that the social and welfare services in place to protect mental health were currently at risk as a result of the economic climate. At

the same time, mental health disorders, such as alcohol use and suicide, were prone to increase during times of economic crisis. Wise action from the health and social sectors was needed to mitigate the impacts of economic crisis. Despite the long-term commitment to mental health in Europe and the advanced nature of many national health services in the Region, a large proportion of people with mental health conditions remained untreated and the lack of access to evidence-based services was an indictment.

Measures to address mental health required a complex combination of positive factors to improve resilience and protect and promote mental health, taking account of the interaction between mental health and physical conditions such as NCDs. The Action Plan, which aimed to present a model for mental health throughout the life-course, contained seven objectives and had been clearly mapped to the components of Health 2020. It had been drafted through a series of comprehensive and inclusive consultations and was intended to offer a positive side to mental health promotion, through a human rights-based approach. Planning for the coming biennium incorporated the Plan's key actions under categories 2 and 3 of GPW12. Recalling the Mental Health Declaration for Europe adopted in 2005 in Helsinki, Finland, he said that there was no health without mental health. All areas of concern for the Regional Committee had either their origin or their destination in mental well-being, thus underscoring the importance of mental health and the common responsibility to promote it.

A member of the SCRC said that while the WHO Comprehensive Mental Health Action Plan 2013–2020 primarily targeted the needs of low- and middle-income countries, many of which had rudimentary mental health services, the comparatively advanced level of service development and relatively high resources in European Member States required specific objectives and actions, to ensure that mental health care in the Region met the needs and expectations of the people. The European Mental Health Action Plan had undergone several changes during the consultation process, taking account of input from a wide range of interested and dedicated parties. The SCRC welcomed the Action Plan and the accompanying draft resolution.

In the ensuing discussion, representatives expressed their strong support for the European Mental Health Action Plan and commended the inclusive spirit in which it had been drafted. Agreeing on the importance of prevention, particularly given the links between mental health disorders and NCDs, Member States expressed their commitment to implement people-centred interventions and promote public awareness of mental health issues. Two representatives proposed amendments to the Action Plan, to include definitions of “vulnerable” and “disadvantaged” groups and revise two of the proposed actions. Representatives shared their experiences of efforts to improve prevention and treatment of mental health disorders and agreed that the Action Plan would, henceforth, have an important role to play in guiding policies at national level.

Statements were submitted by Alzheimer International, the International Association for Child and Adolescent Psychiatry and Allied Professions, the International Federation of Medical Students' Associations and the World Federation of Occupational Therapists.

The Director, Noncommunicable Diseases and Life-course thanked Member States for their support and welcomed the proposed amendments, which would improve the clarity of the Action Plan. He commended, in particular, the efforts being made to include NCDs in integrated mental health care approaches.

The Committee adopted resolution EUR/RC63/R10, as amended.

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

(EUR/RC63/6, EUR/RC63/Inf.Doc./9, EUR/RC63/Inf.Doc./10, EUR/RC63/Inf.Doc./12)

The European member of the Executive Board designated to attend sessions of the SCRC as an observer reported that the Sixty-sixth World Health Assembly had adopted resolutions and decisions in technical areas of importance to the WHO European Region. He briefly described the implications for the Region of seven resolutions – on universal eye health (resolution WHA66.4), implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children (resolution WHA66.7), the comprehensive mental health action plan 2013–2020 (resolution WHA66.8), disability (resolution WHA66.9), neglected tropical diseases (resolution WHA66.12), transforming health workforce education in support of universal health coverage (resolution WHA66.23) and eHealth standardization and interoperability (resolution WHA66.24) – and one decision on substandard/spurious/false-labelled/falsified/counterfeit medical products (decision WHA66(10)). Regional committees had been requested to discuss five issues in detail.

Follow-up to the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases

The Director, Noncommunicable Diseases and Life-course said that the WHO Secretariat was seeking feedback from Member States on a proposed global mechanism to coordinate the work of multiple actors, as outlined in the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and as requested in World Health Assembly resolution WHA66.10 on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. The global coordination mechanism (GCM) was needed to ensure effective action while safeguarding against conflicts of interest. WHO had invited Member States to comment on a detailed discussion document, which had been posted on the WHO headquarters web site, and through the regional committees. The Secretariat would include all the feedback received in a report for the formal meeting with Member States to be held in November 2013.

In the ensuing discussion, speakers welcomed the proposal of a GCM in general, calling for it to have a lean structure, be led by WHO and report to its governing bodies. They offered preliminary views on its functions and agreed on the importance of safeguarding WHO and public health from conflicts of interest.

A representative speaking on behalf of the EU and its Member States said that the Sixty-sixth World Health Assembly's decisions were testament to WHO's global leadership in the response to NCDs; exercising that leadership, however, required more horizontal cooperation and possibly the reallocation of funds within WHO. The EU would contribute constructively to discussions on the proposed indicators for the Global Action Plan and on GCM's functions, which should be fully aligned with the Plan. Further, coherence between work on NCDs and on mental health should be guaranteed. To avoid duplication of effort, consideration should be given to what new aspects GCM would add to the work of the Secretariat and the United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases, and how their various tasks would be divided. The EU proposed a time-limited mandate for GCM with a mid-term review by WHO governing bodies. A debate on engagement with non-State actors through GCM needed to be fully aligned with the principles to be agreed in the WHO reform process. Further discussion on establishing a system of formal commitments by such actors should ensure the engagement of NGOs. Further, the EU welcomed the policy orientation of the proposed indicators for the Global Action Plan, repeated the World Health Assembly's emphasis on the need for them not to increase the reporting burden on Member States and hoped they would help streamline future reporting.

Other speakers envisaged information sharing and coordination as GCM's main functions and wondered about the functions and even the necessity of its proposed working groups. GCM's terms of reference should be fully aligned with those of the Interagency Task Force. A broad discussion of GCM's functions would be welcome.

As to the proposed indicators for the Global Action Plan, it was suggested that some of those indicators might be more informative if, rather than monitoring just the adoption of policies; they also considered those policies' effects on the social determinants of health. Although WHO's work against NCDs was valuable, national-level action and monitoring were the key to success. As some countries lacked monitoring capacity, support in that regard could be provided by European public health institutes.

Statements were submitted on behalf of the European Heart Network, World Heart Foundation, NCD Alliance and International Alliance of Patients' Organizations.

Health in the United Nations post-2015 Development Agenda

The Deputy Director, Communicable Diseases, Health Security and Environment described to the Regional Committee the process of determining the United Nations' development agenda after the deadline for achieving the MDGs. The Secretary-General had conducted an inclusive consultative process to create a single, comprehensive development agenda. That process would culminate in a summit of heads of state or government in 2015, to adopt a new framework with sustainable development at its core and, ideally, a limited number of goals. Health should be on the agenda, with an emphasis on maximizing health at all ages, with UHC as either a means or as an end in itself. The WHO Regional Office for Europe would maintain its strategy and support Member States; since ministries for foreign affairs were to be involved in the negotiations at the United Nations, health ministries needed to maintain good communications with them in order to lobby for health as a priority.

In the ensuing discussion, speakers welcomed the chance to participate in formulating the message that the WHO governing bodies would contribute to the United Nations deliberations on the post-2015 development agenda, although several also stressed the importance of continued work to achieve the health-related MDGs. It was agreed that health should be a priority, with a focus on maximizing health for all throughout the life-course and UHC as both a means to that end and an end in itself. UHC should be clearly defined as comprising not only access to services but also the social protection of health; it was essential to the integrated approach and government- and society-wide action, including on social determinants, required to improve health. It was also suggested that the new development framework address NCDs and the right to sexual and reproductive health services, especially for young people, emphasize human rights as a guide to implementation, and take account of demographic change and shared responsibility.

WHO was urged to review the guidance for Member States in World Health Assembly resolution WHA63.22 on human organ and tissue transplantation in order to submit a new resolution to the World Health Assembly in 2015 or 2016, with a view to the United Nations' ultimately developing an initiative on the illegal trade in organs and tissue, which was linked to human trafficking.

A statement was made on behalf of the Framework Convention Alliance and one was submitted on behalf of the International Alliance of Patients' Organizations.

International Health Regulations (2005)

The Director, Communicable Diseases, Health Security and Environment recalled that the IHR (2005) included a requirement for States Parties to have core capacity in surveillance and response and at points of entry. The first deadline for doing so had been reached in June 2012, whereupon a two-year extension had been possible and automatic, on the basis of a justified need and an implementation plan. Twenty-one countries in the European Region had obtained such an extension.

Since the end of that first extension would be reached in June 2014, criteria were being developed for the Director-General to grant a further extension. A proposal had been made to further consult State Parties at the 2013 sessions of WHO's regional committees. The Secretariat at WHO headquarters would collate the feedback provided at those sessions and would use it to update the proposal to be submitted to the Executive Board in January 2014. With the Executive Board's endorsement, the IHR Review Committee would be convened to advise the Director-General on each country's request for extension.

The Secretariat was proposing the following criteria or procedures.

- A State Party must make a formal written request to the Director-General at least four months before the target date of 15 June 2014.
- The request must include a statement explaining the exceptional circumstances that have prevented the development and maintenance of IHR capacities.
- The request must be accompanied by a new implementation plan.

In the ensuing discussion, one representative said that the IHR were a remarkable achievement for the improvement of global health security and the fact that the European Region had the lowest number of requests for extension was commendable. Nevertheless, developing and maintaining core capacities,

especially at points of entry, were crucial to control a large number of emerging and re-emerging communicable diseases and other health threats. All countries were urged to build up their core capacities by offering the necessary training and to integrate IHR into their national legislation and activities and the Regional Office was asked to continue to provide guidance and support for IHR implementation. The establishment of the new GDO on preparedness for humanitarian and health emergencies should result in a welcome increase in the Regional Office's capacity in the area of the IHR.

Another representative reported good experience with conducting regular simulation exercises. A third speaker called for WHO's continued advocacy of IHR at global and regional levels, in collaboration with the International Civil Aviation Organization, the International Maritime Organization and others, with the aim of incorporating IHR measures and provisions into international standard operating procedures for points of entry and international transport.

One representative believed that the criteria for IHR extensions beyond 2014 should be more stringent (perhaps based on the annual questionnaire sent to Member States) and asked the Regional Director to clarify how she intended to ensure that Member States were adequately consulted about them. The chronic lack of resources for IHR implementation, both in the Member States and within WHO, was a matter of concern.

In reply, the Regional Director said that a web-based written consultation would be initiated; Member States would be asked to send in their comments, if any, on the IHR criteria within two weeks of the closure of the Regional Committee's session. The draft regional report would be shared with Member States, in the interests of transparency, before being submitted to the Director-General.

Global Vaccine Action Plan

The Deputy Director, Communicable Diseases, Health Security and Environment said that the objectives of the new Polio Eradication and Endgame Strategic Plan 2013–2018 were to detect and interrupt all poliovirus transmission by 2014; to strengthen immunization systems and withdraw oral polio vaccine by 2016; to contain poliovirus and certify the interruption of transmission by 2018; and to engage in "legacy planning". Changes to polio immunization in routine schedules would include the introduction of at least one dose of inactivated polio vaccine and the removal of the type 2 component from oral polio vaccine; only 11 European Member States were currently using oral polio vaccine.

World Health Assembly resolution WHA65.17 urged Member States to report to regional committees on progress made towards reaching immunization targets. A framework for monitoring, evaluation and accountability had been presented to the Sixty-sixth World Health Assembly in May 2013 (document A66/19). That framework provided for annual reporting using a joint WHO/UNICEF reporting form and involvement of the European Technical Advisory Group of Experts on Immunization. The European Region had generally strong immunization programmes, with high national coverage, although there were gaps at subnational level, and some marginalized populations and anti-vaccination sentiments.

Building on the Global Vaccine Action Plan, the Regional Office proposed to produce an updated regional plan that would be harmonized with the Health 2020 policy, respond to regional and national

needs, and contain tailored regional targets. Following consultations with Member States, the draft regional vaccine action plan could be presented to the Regional Committee in 2014.

Consultative Expert Working Group on Research and Development: financing and coordination

The Director, Information, Evidence, Research and Innovation reported that, following an open-ended meeting of Member States in November 2012, the World Health Assembly had adopted resolution WHA66.22 on follow-up of the report of the Consultative Expert Working Group on Research and Development: financing and coordination. In that resolution, it had requested the Director-General to establish a global health research and development observatory within WHO's Secretariat and to facilitate, through regional consultations and broad engagement of relevant stakeholders, the implementation of a few health research and development demonstration projects to address identified gaps that disproportionately affected developing countries, particularly the poor, and for which immediate action could be taken. Regional directors were asked to propose experts to work with the Consultative Expert Working Group: a number of members of the European Advisory Committee on Health Research were being proposed and one nomination that had been received from a Member State had been transmitted to the Director-General; other nominations would be welcomed.

In the ensuing discussion, the representative of one country said that the establishment of a global health observatory was an essential prerequisite for WHO to set health research priorities on an independent basis. That was why his country had committed itself to contributing to its funding. Pilot projects would make it possible to test various coordination and financing mechanisms that had been validated by the Working Group. He asked the Secretariat to clarify how it intended to communicate the results of the web-based consultation on the selection of demonstration projects.

Another speaker said that the specific follow-up measures as agreed at the World Health Assembly were important steps towards strengthening research and development on health problems and diseases that disproportionately affected developing countries. Some of those diseases were also important public health concerns in the European Region. He encouraged other Member States to participate actively in the ongoing consultation being coordinated by the Secretariat.

In response, the Director, Information, Evidence, Research and Innovation thanked France for its excellent proposal and said that all projects proposed, including any from nongovernmental organizations, would be forwarded to WHO headquarters; the main criterion for forwarding such a submission would be the completion of the application template in its entirety. Rather than apply different selection criteria among the regions of WHO, the Regional Office for Europe opted to have all submissions scrutinized by the global expert group in December 2013.



The Executive President asked representatives to comment on the progress reports on topics in Category 1, Communicable diseases, on implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-resistant Tuberculosis in the WHO European Region 2011–2015 (EUR/RC61/R7) and in Category 5, Preparedness, surveillance and response, on implementation of the International Health Regulations (2005) in the WHO European Region (EUR/RC59/R5) and implementation of the European strategic action plan on antibiotic resistance (EUR/RC61/R6).

Representatives welcomed the TB action plan. One of the greatest challenges would be to increase the detection rate of MDR-TB from the current 38% of cases. Establishment of the Green Light Committee and of the European TB Laboratory Initiative to improve diagnosis in 18 high-prevalence countries were also welcomed. Special attention should be paid to the care of TB patients with concurrent problems of alcohol and drug abuse, as simultaneous treatment of those conditions was key to preventing treatment failure.

With regard to antibiotic resistance, one representative speaking on behalf of eight countries commended the work done by WHO, including setting up a global task force involving all regions and the Central Asian and Eastern European Surveillance of Antimicrobial Resistance (CAESAR) initiative. To address overuse and misuse of antibiotics, those countries called for control of over-the-counter sales, elimination of their use as growth promoters and prudent use in the veterinary sector. Furthermore, new incentives and business models were needed for investment in research and development of new antibiotics. The problem called for political commitment and a global multisectoral response and representatives urged WHO and Member States to intensify their activities. Another representative indicated that greater momentum could be achieved by use of a coherent, integrated, “one health” approach that included agriculture and fisheries, the food chain and the wider environment, including sanitation. Good prevention and control of infection should be the norm, with rapid diagnosis of infections and administration of appropriate treatment, and surveillance systems to identify new or changing resistance.

Statements were made on behalf of the TB Europe Coalition/Global Health Advocates and the European Respiratory Society.

The Director, Communicable Diseases, Health Security and Environment said that the Regional Office had made progress in combating drug resistance in the context of both TB and other microbes. An operational link had been forged with the Division of Health Systems and Public Health to work jointly on strengthening health systems. In the current emergency situation of growing drug resistance, the Secretariat had intensified its global and regional partnerships to implement the regional plan of action.

The Senior Adviser on Antimicrobial Resistance agreed with representatives that the visibility of AMR should be increased and cited the Global AMR Task Force that had been set up. The Regional Office had aligned its surveillance mechanism with those of the ECDC in order to establish comparability between countries and trends in the Region. He welcomed the comments on over-the-counter sales of antibiotics, which would be the topic of the next “awareness day” in 2014. In response to the comment concerning use of a “one health” approach, he underscored the importance of collaboration with FAO, World Organisation for Animal Health and other organizations.

The Director, Health Systems and Public Health said that the work of national TB managers had increased care coverage from 63% to 96%. He assured the Committee that TB patients were being involved in all aspects of planning and at international conferences. He concurred that inadequate attention was being paid to concurrent infection with HIV and TB bacteria, although some programmes were being implemented in penitentiary services and among intravenous drug users. Estonia had pioneered simultaneous treatment of TB and alcohol dependence.

The Executive President asked representatives to comment on the progress reports on topics in categories 2 and 3 on tobacco control, implementation of the second WHO European Action Plan for Food and Nutrition Policy, the action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 and progress towards attaining the health-related MDGs.

With respect to progress towards attaining the health-related MDGs, several representatives commented on the high rates of HIV infection in some parts of the Region. Many of those affected belonged to groups in socially vulnerable situations, such as people who injected drugs, men who had sex with men, and migrants. Close attention must be paid to human rights in plans for early detection of infection and legislation on HIV testing. Hepatitis C was another infection that was a major cause of death among drug users and that problem should also be addressed. The Global Fund was a major source of financing for strategies to reduce HIV infection, which should be evidence-based in order to overcome political reticence. Civil society organizations were essential for spreading knowledge and awareness, especially in countries with “top-down” governments, and could help to reduce stigmatization of and discrimination against people with HIV infection and drug users.

With respect to tobacco control, one representative described a successful strategy for reducing the prevalence of tobacco use among young people by more than 50% and offered to share it with other countries. Another representative described the legislative framework that had been adopted in her country, which was expected to reduce the prevalence of smoking by 10%.

Statements were delivered on behalf of the World Association of Societies of Pathology and Laboratory Medicine, the International Spinal Cord Society and the International Federation of Business and Professional Women.

The Director, Noncommunicable Diseases and Life-course thanked the representatives for the excellent examples of measures taken to reduce tobacco use, which in one case had been strongly opposed by the tobacco industry. He hoped that the forthcoming meeting in Ashgabat, Turkmenistan, would set up a vision for a smoke-free Europe.

The Deputy Director, Communicable Diseases, Health Security and Environment said that despite the action plan to halt the epidemic of HIV/AIDS, there was still a large treatment gap. She welcomed the reports of representatives on use of evidence-based policies with respect for human rights. Hepatitis C was indeed a hidden disease that imposed a heavy burden in the Region; more capacity and resources would be required to address that problem. In order to accelerate achievement of the MDGs, more work should be done in collaboration with other international bodies, such as UNAIDS and the Global Fund.

Confirmation of dates and places of future sessions of the WHO Regional Committee for Europe

EUR/RC63/Conf.Doc./3

The Committee adopted resolution EUR/RC63/R11 by which it confirmed that it would hold its sixty-fourth session in Copenhagen from 15 to 18 September 2014. It also decided that its sixty-fifth session would be held in Vilnius, Lithuania from 14 to 17 September 2015 and that its sixty-sixth session would be held in Copenhagen from 12 to 15 September 2016.

Other matters

A representative of the International Confederation of Midwives made a statement also on behalf of the European Respiratory Society, International Alliance of Patients' Organizations, International Council of Nurses, International Diabetes Federations, International Society of Physical and Rehabilitation Medicine, International Spinal Cord Society, TB Europe Coalition, World Association of Societies of Pathology and Laboratory Medicine and World Federation of Occupational Therapists.

Closure of the session

A representative of Switzerland said that the Regional Committee's session had been conducted in a spirit that emulated the calm and tranquillity of its Aegean coastal setting. It had afforded an opportunity to assess the considerable progress made in several areas as well as to undertake new commitments. The adoption of the European Mental Health Action plan was particularly welcome. She congratulated all concerned on a very successful session.

Resolutions and decisions

EUR/RC63/R1. Report of the Twentieth Standing Committee of the Regional Committee

The Regional Committee,

Having reviewed the report of the Twentieth Standing Committee of the Regional Committee (documents EUR/RC63/4 and EUR/RC63/4 Add.1);

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

EUR/RC63/R2. Interim Report of the Regional Director on the work of WHO in the European Region 2012–2013

The Regional Committee,

Having reviewed the Regional Director's interim report on the work of WHO in the European Region in 2012–2013 (document EUR/RC63/5) and the related information document on the financial situation of the WHO Regional Office for Europe (document EUR/RC63/Inf.Doc./4);

1. THANKS the Regional Director for the report;
2. EXPRESSES its appreciation of the work done by the Regional Office in the biennium 2012–2013;
3. REQUESTS the Regional Director to take into account and reflect the suggestions made during the discussion at the sixty-third session when developing the Organization's programmes and carrying out the work of the Regional Office.

EUR/RC63/R3. Indicators for Health 2020 targets

The Regional Committee,

Having considered document EUR/RC63/8 on the indicators proposed for the six overarching goals of the European policy framework for health and well-being, Health 2020, following consultation with Member States;

Recalling resolution EUR/RC62/R4 adopted by the Regional Committee at its sixty-second session, which set out Health 2020 as “a framework to accelerate the attainment of better and more equitable health and well-being for all, [...] together with a set of regional goals [...] and the appropriate indicators for the European Region”;

Building on the legacy and experience of the European Region with the values, principles, targets and indicators of Health for All, HEALTH21 and declarations adopted at ministerial conferences on environment and health;

Mindful of the ongoing WHO reform and its implications for strong alignment between global and regional policies, including the Global Monitoring Framework on Noncommunicable Diseases;

Taking into account the findings and recommendations of *The European health report 2012: charting the way to well-being*¹, undertaken to inform Health 2020 target- and indicator setting, as well as the *Report on social determinants of health and the health divide in the WHO European Region*² and recognizing the need to further develop the Health 2020 monitoring system and ensure its alignment with the adopted Health 2020 policy;

Aware of the key leadership and initiation role of the health sector in the collection, analysis and interpretation of health and allied information;

Acknowledging the work of the Regional Office to avoid double reporting and prevent an increase in the reporting burden on Member States;

¹ *The European health report 2012: charting the way to well-being*. Copenhagen, WHO Regional Office for Europe, 2013 (<http://www.euro.who.int/en/what-we-do/data-and-evidence/european-health-report-2012>; accessed 6 May 2013).

² *Report on social determinants of health and the health divide in the WHO European Region*, Executive summary. Copenhagen, WHO Regional Office for Europe, 2012 (<http://www.euro.who.int/en/who-we-are/governance/regional-committee-for-europe/sixty-second-session/documentation/background-documents/report-on-social-determinants-of-health-and-the-health-divide-in-the-who-european-region.-executive-summary>; accessed 6 May 2013).

Aware of the ongoing cooperation with international partners in order to work towards a single integrated health information system in Europe, to the benefit of Member States and all other relevant stakeholders and without pre-empting the final outcome.

1. ADOPTS the core indicators proposed for Health 2020 as indicators to be used by the WHO Regional Office for Europe to monitor regional progress with the six adopted goals for Health 2020;
2. AGREES that further work is to be conducted on the development of objective well-being indicators as outlined in document EUR/RC63/8;
3. AGREES that the WHO Regional Office for Europe implements the proposed monitoring framework as outlined in Annex 1 of document EUR/RC63/8 to collect, analyse and regularly publish the indicators in its regular publications;
4. URGES Member States:
 - (a) while taking into account their existing monitoring capacity and obligations and avoiding any unnecessary increases in reporting burden, to report on additional indicators for Health 2020 as proposed in Annex 1 of document EUR/RC63/8, where available;
 - (b) to contribute to health information systems and data-gathering activities in European countries in order to assess the core indicators as outlined in Annex 1 of document EUR/RC63/8;
 - (c) to take into account the regional Health 2020 policy framework in international health activities within the European Region;
5. REQUESTS the Regional Director:
 - (a) to report on progress towards meeting the Health 2020 regional targets, together with routine progress reports on Health 2020;
 - (b) to work towards achieving harmonization of data requirements, with other relevant international bodies, taking into account their work in this area;
 - (c) to lead further work to explore means of measuring and setting targets for health and well-being, fully involving Member States, and to continue with the work of the expert group on indicators for Health 2020 to finalize the development of objective well-being indicators, taking into account social determinants of health and health equity, and report on these results to the Regional Committee, at its sixty-fourth session;
 - (d) to communicate the regional Health 2020 targets and indicators in relevant international fora and actively disseminate the results and appropriate information materials;
 - (e) to update continuously the evidence- and knowledge bases on health information, using all appropriate communication tools;
 - (f) to report on Health 2020 indicators and progress in harmonizing data requirements to the Regional Committee.

EUR/RC63/R4. Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020

The Regional Committee,

Acknowledging the burden of disease related to poor nutrition, unhealthy diet and physical inactivity in the European Region;

Reaffirming its resolution EUR/RC56/R2, by which it adopted the European Strategy for the Prevention and Control of Noncommunicable Diseases as a strategic framework for action by Member States in the European Region to implement their country policies and engage in international cooperation;

Recalling its resolution EUR/RC57/R4 by which it adopted the Second European Action Plan for Food and Nutrition Policy (2007–2012);

Reaffirming the endorsement of the European Charter on Counteracting Obesity adopted in 2006;

Recalling World Health Assembly resolution WHA66.10 that endorsed the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020;

Recognizing World Health Assembly resolution WHA63.23, calling for increased political commitment to prevent and reduce malnutrition in all its forms, to strengthen implementation of the Global Strategy for Infant and Young Child Feeding and to scale up nutrition interventions;

Taking into account the new European policy framework for health and well-being – Health 2020;

Acknowledging document EUR/RC63/18 containing the progress report on nutrition, physical activity and obesity in the WHO European Region;

Having considered the outcome of the WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020 – the Vienna Declaration – adopted in Vienna, Austria in July 2013;

1. ENDORSES the Vienna Declaration;
2. CALLS UPON Member States:³
 - (a) to consider the policy options presented in the Vienna Declaration as a significant contribution for building or strengthening national policies on nutrition and physical activity;

³ And regional economic integration organizations, where applicable

- (b) to promote an evidence-based approach that includes all levels of government and engages all stakeholders;
 - (c) to ensure appropriate governance for implementation of actions towards the prevention of conditions related to poor nutrition and physical inactivity and to build intersectoral alliances and networks and foster citizen empowerment;
 - (d) to promote, engaging relevant stakeholders as appropriate, access and affordability to healthy nutrition and physical activity as a means to reduce inequalities;
 - (e) to strengthen national capacity for health systems to respond to nutrition and physical activity related health issues;
3. REQUESTS the Regional Director:
- (a) to develop, in close collaboration with Member States¹ and fully taking into account ongoing initiatives and regional and global plans and strategies, a European action plan on food and nutrition to be presented to the Regional Committee at its sixty-fourth session and a physical activity strategy, to be presented at its sixty-fifth session;
 - (b) to pursue the aims of the Vienna Declaration and promote its support.

EUR/RC63/R5. Health systems in times of global economic crisis: an update of the situation in the WHO European Region

The Regional Committee,

Conscious of the continuing financial and economic crisis in the WHO European Region and its effects on human health;

Aware that, since the onset of the global financial and economic crisis in 2008, unemployment has increased sharply and government finances have deteriorated in many countries;

Also recognizing that not all Member States in the WHO European Region have been affected, or have not been affected to the same degree, by the financial and economic crisis;

Recognizing that the tight fiscal context and high unemployment are likely to continue in the near future, and that it is therefore critical to take stock of the latest evidence and draw lessons in order to inform future policy responses that mitigate the negative impact on population health and protect the health gains made in recent decades;

Recalling resolution EUR/RC59/R3, which took note of the recommendations for action agreed at the meeting held in Oslo, Norway in April 2009, and which urged Member States to ensure that their health systems continued to protect those most in need;

Bearing in mind the European policy framework for health and well-being, Health 2020, that it adopted in 2012;⁴

Having considered *The European health report 2012: charting the way to well-being*⁵ and the *Report on social determinants of health and the health divide in the WHO European Region*⁶,

1. COMMENDS the WHO Regional Office for Europe on its technical leadership in response to the financial and economic crisis, including developing analytical frameworks to review government policies in response to the crisis, synthesizing evidence of the impact on health and health system performance, holding policy dialogue and knowledge brokerage events, conducting training courses and providing direct technical assistance;
2. EXPRESSES its gratitude to the Government of Norway for generously hosting a high-level meeting to review the impact of the economic crisis on health and health systems in the WHO European Region (Oslo, 17 and 18 April 2013);
3. ENDORSES the policy lessons and recommendations set out in the outcome document of the high-level meeting (EUR/RC63/13);
4. URGES Member States⁷ to take account of and, as appropriate, act on these lessons when shaping their responses to the continuing financial and economic crisis;
5. REQUESTS the Regional Director:
 - (a) to continue to provide Member States with tools and support for policy analysis, development, implementation and evaluation;
 - (b) to cooperate closely to that end with partners such as the European Observatory on Health Systems and Policies, the Organisation for Economic Co-operation and Development, the European Commission, the International Monetary Fund and the World Bank.

⁴ Resolution EUR/RC62/R4

⁵ *The European health report 2012: charting the way to well-being*. Copenhagen, WHO Regional Office for Europe, 2013 (<http://www.euro.who.int/en/what-we-do/data-and-evidence/european-health-report-2012>, accessed 6 May 2013).

⁶ *Report on social determinants of health and the health divide in the WHO European Region*, Executive summary. Copenhagen, WHO Regional Office for Europe, 2012 (<http://www.euro.who.int/en/who-we-are/governance/regional-committee-for-europe/sixty-second-session/documentation/background-documents/report-on-social-determinants-of-health-and-the-health-divide-in-the-who-european-region.-executive-summary>, accessed 6 May 2013).

⁷ And regional economic integration organizations, where applicable

EUR/RC63/R6. Regional framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases 2014–2020

The Regional Committee,

Taking note of the global spread of *Aedes albopictus*, *Ae. aegypti* and *Culex* mosquito species, which are effective vectors of potentially severe diseases such as dengue, chikungunya and West Nile fevers;

Recognizing a worrying trend in the increase of the geographic distribution of the population of *Ae. albopictus*, *Ae. aegypti* and *Culex* mosquito species and the number of reported indigenous cases and outbreaks of dengue, chikungunya and West Nile fevers in the WHO European Region over the past decade;

1. SUPPORTS the Regional Framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases;
2. CALLS on Members States⁸ at greater risk to use the Regional Framework as guidance for the development of national action plans;
3. REQUESTS the Regional Director;
 - (a) to further develop partnerships and coordinate disease risk assessment and vector control in the WHO European Region;
 - (b) to report to the Regional Committee at its sixty-eighth session on the progress made in countries using the Regional Framework.

EUR/RC63/R7. Governance of the WHO Regional Office for Europe

The Regional Committee,

Recalling resolution EUR/RC60/R3 which, inter alia, requested the Standing Committee of the Regional Committee (SCRC) to initiate a cycle of comprehensive reviews of governance in the WHO European Region and report back to the Regional Committee on lessons learned in this regard at such intervals as the SCRC itself deems appropriate;

Noting that the Twentieth SCRC decided at its second session in November 2012 to establish an ad hoc working group on governance with a mandate to review experience over the past two years in the implementation of the above-mentioned resolution;

Further noting that the SCRC has endorsed fully the recommendations of the above-mentioned working group regarding the method of work and amendments to the Rules of Procedure of the

⁸ And regional economic integration organizations, where applicable

Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe;

Having itself considered those recommendations, as contained in the report of the Regional Director on this subject (document EUR/RC63/16 Rev.1);

1. CONFIRMS that the selection of Member States in the European Region to submit candidatures for membership of the Executive Board and the SCRC shall be made in accordance with:
 - (a) the subregional groupings of countries confirmed by resolution EUR/RC60/R3, and as contained in Annex 1 to the present resolution;
 - (b) the periodicity for permanent members of the United Nations Security Council set forth in resolution EUR/RC60/R3; and
 - (c) the criteria for experience and areas of competence confirmed by resolution EUR/RC60/R3, and as contained in Annex 2 to the present resolution;
2. DECIDES that the selection of Member States in the European Region to submit candidatures for membership of the Executive Board and the SCRC shall follow the long-term schedules of representation outlined in Annex 3 to this resolution;
3. DECIDES exceptionally that the term of office for two out of the four members of the European Environment and Health Ministerial Board (EHMB) elected at the sixty-third session of the WHO Regional Committee for Europe will be for three years (from 1 January 2014 to 31 December 2016), while the remaining two members will serve for the standard term of 2 years (from 1 January 2014 to 31 December 2015) ;
4. ENDORSES the recommendations relating to (a) transparency of SCRC proceedings and (b) communications between SCRC members and Member States in the European Region, contained in Annex 4 to this resolution;
5. FURTHER DECIDES that names and titles of the SCRC members will be posted on the public web site of the Regional Office and that their contact details will be posted on the password-protected web site;
6. ADOPTS the amendments to the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe contained in Annex 5 to this resolution, to be effective from the end of this session;
7. ADOPTS the Code of Conduct for the Nomination of the Regional Director of the European Region of the World Health Organization, contained in Annex 6 to this resolution;
8. CALLS UPON Member States to implement and abide by the Code of Conduct, make it widely known and easily accessible, and bring it to the attention of persons they wish to propose for the post of Regional Director in future nomination processes;
9. DECIDES that the Code of Conduct will become effective at the end of this session of the Regional Committee;

10. REQUESTS the Regional Director to support the implementation of the Code of Conduct, as envisaged in the Code;

11. FURTHER REQUESTS the Regional Director to impress upon the Secretariat of the Regional Office the importance of complying with the obligations laid out in the Staff Regulations and Staff Rules with regard to the conduct to be observed during the process of nomination of the Regional Director, as provided in the section of the Code of Conduct on internal candidates.

Annex 1. Subregional grouping of Member States

Group A: (17 Member States)

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

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

Group B: (17 Member States)

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

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

Group C: (19 Member States)

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

From this group there would at all times be four members on the Standing Committee and three seats on the Executive Board.

Annex 2. Criteria for the selection of candidates for membership of the WHO Executive Board and the Standing Committee of the WHO Regional Committee for Europe

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

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

- (a) a current position in health administration in his/her country (or a position held in the recent past) close to the political decision-making level;
- (b) experience of working with international organizations, WHO or other United Nations organizations;

- (c) the ability to collaborate, coordinate and communicate within the country and between countries;
- (d) experience of coordinating high-level political and/or technical programmes, nationally (interregional, interministerial) or internationally (bilateral or intercountry);
- (e) availability and commitment; and
- (f) gender (female applicants are encouraged).

Annex 3. A. Schedule of European membership to the Executive Board

Table 1: Annual overview of vacant seats per subregional grouping – by year of nomination

Nomination Year	Group A	Group B	Group C
2013	United Kingdom	No vacant seat	Russian Federation
2014	1 vacant seat	France 1 vacant seat	1 vacant seat
2015	1 vacant seat	No vacant seat	1 vacant seat
2016	No vacant seat	1 vacant seat	1 vacant seat
2017	United Kingdom 1 vacant seat	No vacant seat	1 vacant seat
2018	No vacant seat	1 vacant seat	1 vacant seat
2019	1 vacant seat	No vacant seat	Russian Federation
2020	1 vacant seat	France 1 vacant seat	1 vacant seat
2021	1 vacant seat	No vacant seat	1 vacant seat
2022	No vacant seat	1 vacant seat	1 vacant seat
2023	United Kingdom 1 vacant seat	1 vacant seat	1 vacant seat

The nomination year indicates the year when Member States are requested to nominate candidates and the Regional Committee will consider these nominations at its annual session, usually held in September. The nomination year is one year prior to the actual year of commencement of the term as an Executive Board member.

B. Schedule of membership to the Standing Committee

Table 2. Annual overview of vacant seats per subregional grouping – by year of nomination

Nomination Year	Group A	Group B	Group C
2013	2 vacant seats	1 vacant seat	1 vacant seat
2014	1 vacant seat	2 vacant seats	1 vacant seat
2015	1 vacant seat	1 vacant seat	2 vacant seats
2016	2 vacant seats	1 vacant seat	1 vacant seat
2017	1 vacant seat	2 vacant seats	1 vacant seat
2018	1 vacant seat	1 vacant seat	2 vacant seats
2019	2 vacant seats	1 vacant seat	1 vacant seat
2020	1 vacant seat	2 vacant seats	1 vacant seat
2021	1 vacant seat	1 vacant seat	2 vacant seats
2022	2 vacant seats	1 vacant seat	1 vacant seat
2023	1 vacant seat	2 vacant seats	1 vacant seat

The nomination year indicates the year in which Member States are requested to nominate candidates and the Regional Committee will consider these nominations at its annual session, usually held in September. The selected candidates will take office immediately after that session of the Regional Committee.

Annex 4. Transparency of SCRC proceedings and communications between SCRC members and Member States in the European Region

The agenda of each SCRC meeting and a list of the documents to be discussed will be published on the password-protected web site well ahead of the meeting and, in the case of the May meeting of the Standing Committee, the draft documents will be made available to all Member States at the same time they are made available to members of the Standing Committee.

Member States can send questions and/or proposals to the Regional Director through the password-protected web site. Those issues will be addressed in the Regional Director's opening statement, which will be transmitted by video streaming.

Members of the SCRC will agree to be focal points for specific technical items and resolutions. The decision as to which members are nominated as focal points will be taken during the spring meeting of the SCRC, recorded in the minutes of the meeting and made available to all Member States, thus allowing them to contact their SCRC focal point from the open SCRC meeting in May until the Regional Committee's session in September.

The officers of the SCRC – the Chair and Vice-Chair – shall work closely together with subregional organizations of Member States such as the European Union, the South-eastern Europe Health Network, the Commonwealth of Independent States and the Eurasian Economic Community, especially in preparation for the Regional Committee. Members of the SCRC whose countries are members of these subregional organizations are encouraged to keep them informed about the SCRC's work.

Annex 5. Proposed amendments to the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe

Part 1: Rules of Procedure of the Regional Committee for Europe

Rule 14.2.10

h) to examine credentials of delegates of Members, by establishing a subdivision of three members, and report thereon to the Regional Committee.

Rule 22 bis

Formal proposals by Member States in the form of resolutions or decisions, relating to items of the provisional agenda, shall be introduced in writing and transmitted to the Regional Director at least seven days prior to the opening of the first day of the session of the Regional Committee provided the relevant documentation is published three weeks prior to the commencement of that session. The Regional Committee may, if it deems it appropriate, consider formal proposals which have been introduced by Member States of the Region after the above-referenced deadline.

Proposals for substantive amendments of such formal proposals shall normally be introduced in writing and handed to the Regional Director, prior to the closure of the first day of the session of the Regional Committee. The Regional Director shall circulate copies of such amendments to the delegations no later than the opening of the second day of the session. No such amendments shall be

discussed or put to the vote at any meeting of the Regional Committee unless copies of them have been circulated to all delegations at least 24 hours previously. The President may, however, permit the discussion and consideration of amendments, even though they have not been circulated in accordance with this timeline.

Rule 22 ter

Formal proposals by the Secretariat in the form of resolutions or decisions, relating to items of the provisional agenda shall be sent by the Regional Director to the Member States, and to the organizations referred to in Rule 2 invited to be represented, at least six weeks before the commencement of the session.

Proposals for substantive amendments of such formal proposals shall normally be introduced in writing and handed to the Regional Director at least 24 hours prior to the opening of the first day of the session of the Regional Committee. The Regional Director shall circulate copies of such amendments to the delegations no later than the opening of the first day of the session. No such amendments shall be discussed or put to the vote at any meeting of the Regional Committee unless copies of them have been circulated to all delegations at least 24 hours previously. The President may, however, permit the discussion and consideration of amendments, even though they have not been circulated in accordance with this timeline.

Rule 22 quater

In furtherance of the fair and efficient conduct of business of the session of the Regional Committee, formal proposals for resolutions, decisions or substantive amendments thereof may require prior consultation on the way forward with the Officers of the Regional Committee and the Regional Director, if the Regional Committee so decides. The Regional Committee may, furthermore, decide to establish a subcommittee to consider and elaborate on such matters.

Rule 47

47.4 Any Member of the Region may propose the name or names of one or more persons, each of whom has indicated willingness to act as Regional Director, submitting with each proposal particulars of the person's qualification and experience. Member States shall be mindful of the Code of Conduct adopted by the Regional Committee and shall bring it to the attention of such persons. Such proposals shall be sent to the Director-General ... (*paragraph continues as in the current Rules of Procedure*).

Part 2: Rules of Procedure of the Standing Committee of the Regional Committee for Europe**Rule 3**

Except for the meeting to be held in May every year prior to the World Health Assembly in which all Members⁹ from the Region will be invited to participate without the right to vote, the meetings of the

⁹ And regional economic integration organizations, where applicable

Standing Committee shall be private unless the Standing Committee decides otherwise. However, having in mind ... (*paragraph continues as in the current Rules of Procedure*).

Annex 6. Code of Conduct for the Nomination of the Regional Director of the European Region of the World Health Organization

This Code of Conduct (Code) aims to promote an open, fair, equitable and transparent process for the nomination of the Regional Director of the European Region of the World Health Organization (WHO). In seeking to improve the overall process, this Code addresses a number of areas, including the submission of proposals and the conduct of electoral campaigns by Member States and candidates.

The Code is a political understanding reached by the Member States of the European Region (Member States). It recommends desirable behaviour by Member States and candidates with regard to the nomination of the Regional Director to increase the fairness, openness and transparency of the process and thus its legitimacy, as well as the legitimacy and acceptance of its outcome. As such, the Code is not legally binding, but Member States and candidates are expected to honour its contents.

The Code builds on, and reinforces, the provisions pertaining to nomination of Regional Director for the European Region as set out in Rule 47 of the Rules of Procedure of the Regional Committee for Europe.

A. General requirements

I. Basic principles

1. The whole nomination process, as well as electoral campaign activities related to it, should be guided both by the provisions of Rule 47 of the Rules of Procedure and by the following principles that further the legitimacy of the process and of its result:

- fairness
- equity
- transparency
- good faith
- dignity, mutual respect and moderation
- non-discrimination
- merit.

II. Authority of the Regional Committee and its Rules of Procedure

1. Member States accept the authority of the Regional Committee for Europe (Regional Committee) to conduct the nomination of the Regional Director in accordance with Rule 47 of its Rules of Procedure and the relevant resolutions of the Regional Committee.

2. Member States that propose persons for the post of Regional Director have the right to promote their candidature. The same applies to candidates with regard to their own candidature. In the exercise of that right, Member States and candidates should abide by all rules governing the nomination of the Regional Director contained in Rule 47 of the Rules of Procedure of the Regional Committee as well as in relevant resolutions and decisions of the Regional Committee.

III. Responsibilities

1. It is the responsibility of Member States and candidates to observe and respect this Code.
2. Member States acknowledge that the process of nomination of the Regional Director should be fair, open, transparent, equitable and based on the merits of the individual candidates. They should make this Code publicly known and easily accessible.

B. Requirements concerning the different steps of the nomination process

I. Submission of proposals

1. When proposing the name of one or more persons for the post of Regional Director, Member States will be requested by the Director-General to submit the necessary particulars of each person's qualifications and experience in accordance with the criteria adopted by resolution EUR/RC40/R3, affirmed and supplemented by resolution EUR/RC47/R5.

II. Electoral campaign

1. This Code applies to electoral activities related to the nomination of the Regional Director whenever they take place until the nomination by the Regional Committee.
2. All Member States and candidates should encourage and promote communication and cooperation among one another during the entire nomination process. Member States and candidates should act in good faith bearing in mind the shared objectives of promoting equity, openness, transparency and fairness throughout the nomination process.
3. Member States and candidates should refer to one another with respect; no Member State or candidate should at any time disrupt or impede the campaign activities of other candidates. Nor should any Member State or any candidate make any oral or written statements or other representations that could be deemed slanderous or libellous.
4. All Member States and candidates should disclose their campaign activities (e.g. hosting of meetings, workshops, visits). Information disclosed will be posted on a dedicated page of the web site of the Regional Office.
5. Member States and candidates should refrain from improperly influencing the nomination process, by, for example, granting or accepting financial or other benefits as a quid pro quo for the support of a candidate, or by promising such benefits.
6. Member States and candidates should not make promises or commitments in favour of, or accept instructions from, any person or entity, public or private, when that could undermine, or be perceived as undermining, the integrity of the nomination process.
7. Member States that have proposed a candidate should facilitate meetings between their candidate and other Member States, if so requested. Wherever possible, meetings between candidates and Member States should be arranged on the occasion of conferences or other events involving Member States of the Region rather than through bilateral visits.
8. Member States nominating candidates for the post of Regional Director should consider disclosing grants or aid funding for the previous two years in order to ensure full transparency and mutual confidence among Member States.

9. Travel by candidates to Member States to promote their candidature should be limited in order to avoid excessive expenditure, which could lead to inequality among Member States and candidates.

In this connection, Member States and candidates should consider using as much as possible existing mechanisms (regional committees, Executive Board, World Health Assembly) for meetings and other promotional activities linked to the electoral campaign.

10. Electoral promotion or propaganda under the guise of technical meetings or similar events should be avoided.

11. After the Director-General has dispatched the names and particulars of candidates to Member States in accordance with the provisions of Rule 47.9 of the Rules of Procedure, he/she will open on the web site of WHO a password-protected question-and-answer web forum open to all European Member States and the candidates who request to participate in such a forum.

12. After the Director-General has dispatched the names and particulars of candidates to Member States, the Regional Office will post on its web site information on all candidates who so request including their curricula vitae and other particulars of their qualification and experience as received from Member States, as well as their contact information and the relevant rules and decision points pertaining to the nomination process as per Rule 47 of the Rules of Procedure. The web site will also provide links to individual web sites of candidates upon request. Each candidate is responsible for setting up and financing his/her own web site.

13. In addition to the above, the Regional Evaluation Group may, if it deems it desirable, make arrangements for candidates to give time-limited oral presentations to the meeting of European Member States convened jointly with the Standing Committee immediately prior to the opening of the World Health Assembly, as per Rule 47.8.

III. Nomination

1. The nomination of the Regional Director is conducted in private meetings of the Regional Committee in accordance with Rule 47.12 of the Rules of Procedure. Attendance at the private meetings is prescribed by the Director-General and limited to essential Secretariat staff besides Member States. Candidates should not attend those meetings even if they form part of the delegation of their country. The votes in the private meeting are conducted by secret ballot. The results of the ballots should not be disclosed by Member States.

2. Member States should abide strictly by Rule 47 of the Rules of Procedure and other applicable resolutions and respect the integrity, legitimacy and dignity of the proceedings. As such, they should avoid behaviours and actions, both inside and outside the conference room where the nomination takes place, which could be perceived as aiming at influencing its outcome.

3. Member States should respect the confidentiality of the proceedings and the secrecy of the votes. In particular, they should refrain from communicating or broadcasting the proceedings during the private meetings through electronic devices.

IV. Internal candidates

1. WHO staff members, including the incumbent Regional Director, who are proposed for the post of Regional Director are subject to the obligations contained in the WHO Staff Regulations and Rules, as well as to the guidance that may be issued from time to time by the Director-General.

2. WHO staff members who are proposed for the post of Regional Director must observe the highest standard of ethical conduct and strive to avoid any appearance of impropriety. WHO staff members must clearly separate their WHO functions from their candidacy and avoid any overlap, or perception of overlap, between campaign activities and their work for WHO. They also have to avoid any perception of conflict of interest.

3. WHO staff members are subject to the authority of the Regional Director and the Director-General, in accordance with the applicable regulations and rules, in case of allegations of breach of their duties with regard to their campaign activities.

4. The Regional Committee may suggest that the Director-General consider applying Staff Rule 650 concerning special leave to staff members who have been proposed for the post of Regional Director.

EUR/RC63/R8. Review of the status of resolutions adopted by the Regional Committee at previous sessions and recommendations for sunseting and reporting requirements

The Regional Committee,

Having reviewed document EUR/RC63/17 Rev.1 on the status of resolutions adopted by the Regional Committee during the past ten years (2003–2012) and recommendations for sunseting and reporting requirements;

Recalling Regional Committee resolution EUR/RC58/R5 on the review of the process of reporting back to the Regional Committee on resolutions adopted at previous sessions;

Noting that a number of resolutions have an open-ended requirement for reporting back to the Regional Committee;

1. ENDORSES the recommendations made in document EUR/RC63/17 Rev.1 for sunseting and reporting, that is to establish a practice of time-limited reporting, discontinue open-ended reporting, and to sunset the resolutions that have been superseded in their entirety by subsequent resolutions;

2. REQUESTS the Regional Director to continue the practice of defining the requirements for reporting on the implementation of resolutions, with a specific end date for reporting back to the Regional Committee.

EUR/RC63/R9. Appointment of a Regional Evaluation Group

The Regional Committee,

Pursuant to Rule 47 of its Rules of Procedure:

1. APPOINTS a Regional Evaluation Group composed of the following members and alternates:

Members:

Dr Daniel Reynders (Belgium)

Ms Outi Kuivasniemi (Finland)

Dr Svetlana Axelrod (Russian Federation)

Alternates:

Professor Maksut Kulzhanov (Kazakhstan)

Professor Vilius Grabauskas (Lithuania)

Mr Mykhailo Statkevych (Ukraine)

2. REQUESTS the Regional Evaluation Group to carry out its work taking into consideration the principles contained in the Code of Conduct and according to the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe and other criteria laid down in document EUR/RC63/Inf.Doc./2 with the aim of reporting on its work to the Regional Committee at its sixty-fourth session.

EUR/RC63/R10. The European Mental Health Action Plan

The Regional Committee,

Building on resolution EUR/RC55/R2 adopting the Mental Health Declaration signed in Helsinki in 2005, which supported the implementation of mental health policies aiming to achieve mental well-being and social inclusion;

Recognizing that the European Mental Health Action Plan proposes an approach that is interdependent and integrated with other WHO strategies and policies, such as Health 2020 – the European policy framework for health and well-being (resolution EUR/RC62/R4), the comprehensive mental health action plan 2013–2020 (resolution WHA66.8) and the European Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (resolution EUR/RC61/R3);

Recalling and emphasizing the importance of United Nations instruments, particularly the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities; and the obligations of States parties under these instruments, and encouraging Member States that have not yet become parties to them to consider applying their provisions, as appropriate;

Welcoming the involvement of Member States, user- and family representative groups, professional organizations and experts in the development of this Action Plan;

1. ENDORSES the European Mental Health Action Plan;
2. URGES Member States:¹⁰
 - (a) to improve the mental health and well-being of the entire population and reduce the burden of mental disorders, ensuring actions for promotion and prevention, and intervention on

¹⁰ And regional economic integration organizations, where applicable

the determinants of mental health, combining both universal and targeted measures, with a special focus on vulnerable groups;

(b) to respect the rights of people with mental health problems, promote their social inclusion and offer equitable opportunities to attain the highest quality of life, addressing stigma, discrimination and isolation;

(c) to strengthen or establish access to and appropriate use of safe, competent, affordable, effective and community-based mental health services;

3. CALLS on international, intergovernmental and nongovernmental organizations, including user- and family associations and professional associations, to support the implementation of the Action Plan;

4. REQUESTS the Regional Director:

(a) to provide technical support for the implementation of the Action Plan;

(b) to report back on progress by 2017.

EUR/RC63/R11. Date and place of regular sessions of the Regional Committee in 2014–2017

The Regional Committee,

Recalling its resolution EUR/RC62/R8 adopted at its sixty-second session;

1. RECONFIRMS that the sixty-fourth session shall be held in Copenhagen from 15 to 18 September 2014;

2. DECIDES that the sixty-fifth session shall be held in Vilnius, Lithuania from 14 to 17 September 2015;

3. DECIDES that the sixty-sixth session shall be held in Copenhagen, from 12 to 15 September 2016;

4. FURTHER DECIDES that the sixty-seventh session shall be held on dates and location to be decided.

EUR/RC63(1). Establishment of a new geographically dispersed office (GDO) for primary health care in Kazakhstan

The Regional Committee decides,

1. that the Secretariat has the mandate to establish, in Kazakhstan, a GDO in the area of primary health care, based on the business case and technical profile presented in documents EUR/RC63/22 Rev.1 and EUR/RC63/Inf.Doc./8;

2. to request the Secretariat to establish the GDO in full cooperation with the host country, taking into account the comments made and discussions held during the sixty-third session of the Regional Committee;
3. that regular progress reports will be presented to the Regional Committee every year as part of the Report of the Regional Director on the work of WHO in the European Region, and every five years as part of the report on the activities and evaluation of all GDOs.

EUR/RC63(2). Establishment of a new geographically dispersed office (GDO) for preparedness for humanitarian and health emergencies in Turkey

The Regional Committee decides,

1. to change the name of the GDO for humanitarian crises (EUR/RC62(2)) to GDO on preparedness for humanitarian and health emergencies;
2. that the Secretariat has the mandate to establish, in Turkey, a GDO for preparedness for humanitarian and health emergencies, based on the business case and technical profile presented in documents EUR/RC63/23 and EUR/RC63/Inf.Doc./11;
3. to request the Secretariat to establish the GDO in full cooperation with the host country, taking into account the comments made and discussions held during the sixty-third session of the Regional Committee;
4. that regular progress reports will be presented to the Regional Committee every year as part of the Report of the Regional Director on the work of WHO in the European Region, and every five years as part of the report on the activities and evaluation of all GDOs.

Annex 1. Agenda

1. Opening of the session

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

2. Addresses

- (a) Report of the Regional Director on the work of WHO in the European Region since RC62

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

- (a) Follow-up to the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases
- (b) Health on the United Nations post-2015 Development Agenda
- (c) International Health Regulations (2005)
- (d) Global Vaccine Action Plan
- (e) Consultative Expert Working Group on Research and Development: financing and coordination

4. Report of the Twentieth Standing Committee of the Regional Committee (SCRC)

5. Policy and technical topics

- (a) Health 2020
 - (i) Implementing Health 2020: progress and developments since RC62
 - (ii) *Report on social determinants of health and the health divide in the WHO European Region*
 - (iii) Health 2020 monitoring framework, including indicators
- (b) Regional Framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases
- (c) Report of the European Environment and Health Ministerial Board
- (d) European Mental Health Action Plan 2014–2020
- (e) Progress report on measles and rubella elimination and the package for accelerated action to achieve elimination by 2015
- (f) Partnerships
- (g) Outcomes of high-level conferences
 - (i) High-level meeting on health systems in times of global economic crisis – an update of the situation in the European Region, Oslo, Norway, 17–18 April 2013
 - (ii) Eighth Global Conference on Health Promotion: the Helsinki statement on Health in All Policies: a call for action; including Europe Day – Promoting Health in All Policies – experiences from the European Region, Helsinki, Finland, 10–14 June 2013
 - (iii) WHO European Ministerial Conference on nutrition and noncommunicable diseases in the context of Health 2020, Vienna, Austria, 4–5 July 2013

- (h) WHO reform – implications for the Regional Office for Europe
 - (i) Overview of the impact of the WHO reform on the Regional Office for Europe
 - (ii) Implementing the programme budget 2014–2015, including strategic resource allocation
 - (iii) Process to develop the programme budget 2016–2017
 - (iv) Outcome of the first Financing Dialogue
 - (v) Financial situation of the Regional Office
 - (i) Governance of the Regional Office for Europe, including
 - (i) Amendments to the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe
 - (ii) Review of the status of resolutions adopted by the Regional Committee over the past ten years (2003–2012), and recommendations for sunseting and reporting requirements
 - (j) Geographically dispersed offices (GDOs): business cases and progress reports
 - (k) Progress reports
 - (i) Category 1: Communicable diseases
 - Implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011–2015 (EUR/RC61/R7)
 - (ii) Category 2: Noncommunicable diseases
 - Tobacco control in the European Region
 - Implementation of the Second WHO European Action Plan for Food and Nutrition Policy 2007–2012 (EUR/RC57/R4 and EUR/RC58/R5)
 - Action Plan for the implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (EUR/RC61/R3)
 - (iii) Category 3: Promoting health through the life-course
 - Progress towards attaining the health-related Millennium Development Goals (EUR/RC57/R2)
 - (iv) Category 5: Preparedness, surveillance and response
 - Implementation of the International Health Regulations (2005) in the WHO European Region (EUR/RC59/R5)
 - Implementation of the European strategic action plan on antibiotic resistance (EUR/RC61/R6)
- 6. Private meeting: elections and nominations**
- 7. Confirmation of dates and places of regular sessions of the Regional Committee**
- 8. Other matters**
- 9. Approval of the report and closure of the session**

Technical briefings

- Preventing maltreatment and other adverse childhood experiences
- *Report on social determinants of health and the health divide in the WHO European Region*

- Implementing Health 2020: strengthening multisectoral responsibility for health in Turkey
- Introductory briefing on the WHO programme budget and financial issues

Ministerial lunches

- Social determinants of health and health governance – Report on social determinants of health and the health divide in the WHO European Region and its governance implications
- The rising threat of antimicrobial resistance to the public's health
- Implementation of the WHO Framework Convention on Tobacco Control in the WHO European Region

Annex 2. List of Documents

Working documents

EUR/RC63/1	Provisional list of documents
EUR/RC63/2 Rev.2	Provisional agenda
EUR/RC63/2 Rev.2 Add.1	Provisional agenda (annotated)
EUR/RC63/3 Rev.2	Provisional programme
EUR/RC63/4	Report of the Twentieth Standing Committee of the WHO Regional Committee for Europe
EUR/RC63/4 Add.1	Twentieth Standing Committee of the WHO Regional Committee for Europe: report of the fifth session
EUR/RC63/5	The work of WHO in the European Region in 2012–2013: interim report of the Regional Director
EUR/RC63/6	Matters arising out of the resolutions and decisions of the Sixty-sixth World Health Assembly
EUR/RC63/7 Rev.1	Membership of WHO bodies and committees
EUR/RC63/7 Add.1	Membership of WHO bodies and committees
EUR/RC63/8	Health 2020 targets, indicators and monitoring framework (URL)
EUR/RC63/9	Regional Framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases
EUR/RC63/10	Report of the European Environment and Health Ministerial Board to the WHO Regional Committee for Europe and the United Nations Economic Commission for Europe Committee on Environmental Policy
EUR/RC63/11	The European Mental Health Action Plan
EUR/RC63/12	Progress report on measles and rubella elimination and the package for accelerated action to achieve elimination by 2015 (URL)
EUR/RC63/13	Outcome document for the high-level meeting on Health systems in times of global economic crisis: an update of the situation in the WHO European Region
EUR/RC63/14	Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020
EUR/RC63/15	WHO Reform: progress and implications for Europe
EUR/RC63/16 Rev.1	Governance reform in the WHO European Region
EUR/RC63/17 Rev.1	A review of the status of resolutions adopted by the Regional Committee during the past ten years (2003–2012), and recommendations for sunseting and reporting requirements
EUR/RC63/18	Progress reports
EUR/RC63/18 Corr.1	Progress reports
EUR/RC63/19	Report of the Launch of WHO's Financing Dialogue
EUR/RC63/20	Preparation of the proposed programme budget 2016–2017
EUR/RC63/21	Implementing the programme budget 2014–2015
EUR/RC63/21 Corr.1	Implementing the programme budget 2014–2015
EUR/RC63/22 Rev.1	Business case for the proposed geographically dispersed office on primary health care

EUR/RC63/23	Business case for the proposed geographically dispersed office for preparedness for humanitarian and health emergencies
EUR/RC63/23 Corr.1	Business case for the proposed geographically dispersed office for preparedness for humanitarian and health emergencies
Conference documents	
EUR/RC63/Conf.Doc./1 Rev.1	Interim Report of the Regional Director on the work of WHO in the European Region 2012–2013
EUR/RC63/Conf.Doc./2	Report of the Twentieth Standing Committee of the Regional Committee
EUR/RC63/Conf.Doc./3	Date and place of regular sessions of the Regional Committee in 2014–2017
EUR/RC63/Conf.Doc./4	Appointment of a Regional Evaluation Group
EUR/RC63/Conf.Doc./5 Rev.1	Governance of the WHO Regional Office for Europe
EUR/RC63/Conf.Doc./6	Regional Framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases
EUR/RC63/Conf.Doc./7	Indicators for Health 2020 targets
EUR/RC63/Conf.Doc./8	The European Mental Health Action Plan
EUR/RC63/Conf.Doc./9	Health systems in times of global economic crisis: an update of the situation in the WHO European Region
EUR/RC63/Conf.Doc./10 Rev.1	Vienna Declaration on nutrition and noncommunicable diseases in the context of Health 2020
EUR/RC63/Conf.Doc./11 Rev.1	Draft decision: Establishment of a new geographically dispersed office (GDO) for primary health care in Kazakhstan
EUR/RC63/Conf.Doc./12 Rev.1	Review of the status of resolutions adopted by the Regional Committee at previous sessions and recommendations for sunseting and reporting requirements
EUR/RC63/Conf.Doc./13	Draft decision: Establishment of a new geographically dispersed office (GDO) for preparedness for humanitarian and health emergencies in Turkey
Information documents	
EUR/RC63/Inf.Doc./1	Implementing Health 2020
EUR/RC63/Inf.Doc./2	Appointment of a regional evaluation group
EUR/RC63/Inf.Doc./3	Implementing the programme budget 2014–2015: supplementary information
EUR/RC63/Inf.Doc./4	Financial situation of the WHO Regional Office for Europe
EUR/RC63/Inf.Doc./5	Progress report on the WHO Barcelona Office for Health Systems Strengthening
EUR/RC63/Inf.Doc./6	Progress report on the WHO European Centre for Environment and Health, Bonn, Germany (WHO/ECEH)
EUR/RC63/Inf.Doc./6 Corr.1	Progress report on the WHO European Centre for Environment and Health, Bonn, Germany (WHO/ECEH)
EUR/RC63/Inf.Doc./7	Progress report on the WHO European Office for Investment for Health and Development, Venice, Italy (WHO/PCR-SDH)
EUR/RC63/Inf.Doc./8	WHO Regional Office for Europe Centre for Primary Health Care

EUR/RC63/Inf.Doc./9	Health on the United Nations post-2015 development agenda
EUR/RC63/Inf.Doc./10	Development of a limited set of action plan indicators to inform reporting on progress made in the implementation of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020
EUR/RC63/Inf.Doc./11	WHO Regional Office for Europe Centre for Preparedness for Humanitarian and Health Emergencies
EUR/RC63/Inf.Doc./12	Implementation of the International Health Regulations (2005)
EUR/RC63/Inf.Doc./13	The Global Vaccine Action Plan 2011–2020: monitoring progress and preparing a regional vaccine action plan
EUR/RC63/Inf.Doc./14	Draft background text on regional implications of the new polio strategic plan
EUR/RC63/Inf.Doc./15	Draft terms of reference for a global coordination mechanism for the prevention and control of noncommunicable diseases

Annex 3. List of representatives and other participants

I. Member States

Albania

Representative

H. E. Mr Genci Muçaj
Ambassador, Embassy of Albania in Turkey

Andorra

Representative

Ms Carme Pallarés
Director of Health Resources, Ministry of Health and Welfare

Austria

Representatives

Professor Pamela Rendi-Wagner
Director-General for Public Health, Chief Medical Officer, Federal Ministry of Health

Ms Petra Lehner
Adviser on nutrition, food, veterinary medicine and genetic engineering, Federal Ministry of Health

Alternate

Dr Verena Gregorich-Schega
Head, Department for International Coordination of Health Policy and the World Health Organization, Federal Ministry of Health

Advisers

Ms Aziza Haas
Department for International Coordination of Health Policy and the World Health Organization,
Federal Ministry of Health

Ms Ilana Ventura
Project Coordinator for the Director-General of Public Health

Azerbaijan

Representative

Mr Elsevar Aghayev
Deputy Minister of Health

Belarus

Representatives

Dr Vasily Zharko
Minister of Health

Mr Anatoly Grushkovsky
Head, Department for External Relations, Ministry of Health

Alternate

Mr Igor Belyi
Consul-General of Belarus in Istanbul

Adviser

Ms Tatyana Bogushevich
First Secretary, General Department for Multilateral Diplomacy, Ministry of Foreign Affairs

Belgium

Representatives

Mr Alex Lenaerts
Diplomatic Adviser, Minister's Office, Minister of Social Affairs and Public Health

Dr Daniel Reynders
Head, International Relations Service, FPS for Public Health, Food Chain Safety and the Environment

Alternates

Dr Paul Cartier
Minister Counsellor, Permanent Mission of Belgium to the United Nations Office and other international organizations in Geneva

Ms Stephanie Langerock
Attaché, International Relations, FPS for Public Health, Food Chain Safety and the Environment

Ms Marleen Van Dijk
Agency for Care and Health, Flemish Ministry of Welfare, Public Health and Family

Mr Loïc Ledent
External Relations Unit, General Operational Office for Local Administration, Social Action and Health, Public Service of Wallonia

Bulgaria

Representatives

Professor Chavdar Slavov
Deputy Minister of Health

Professor Petko Salchev
Director, Classification Systems Directorate, National Centre of Public Health and Analyses,
Ministry of Health

Alternates

Professor Mira Kojouharova
Deputy Director, National Centre for Infectious and Parasitic Diseases, Ministry of Health

Ms Elka Doncheva
Second Secretary, Human Rights Directorate, Ministry of Foreign Affairs

Croatia

Representatives

Ms Sibila Žabica
Minister's Adviser on European Affairs and International Cooperation, Ministry of Health

Dr Krunoslav Capak
Head, Department for Environment and Health, National Institute of Public Health

Cyprus

Representatives

Dr Petros Petridis
Minister of Health

Dr Olga Kalakouta
Chief Medical Officer, Ministry of Health

Alternate

Dr Demetris Efthymiou
Medical Officer, Ministry of Health

Czech Republic

Representative

Dr Jarmila Rážová
Director-General, Public Health Protection and Public Health Network Management, Ministry of Health

Alternates

Ms Martina Parízková
Officer, Ministry of Health

Ms Gita Vaščiková
Officer, Ministry of Health

Denmark

Representatives

Ms Hanne Findsen
Senior Adviser, Ministry of Health

Ms Marianne Kristensen
Senior Adviser, Danish Health and Medicines Authority

Alternate

Ms Gitte Lindgaard
Head of Section, Ministry of Health

Estonia

Representatives

Ms Ivi Normet
Deputy Secretary General, Health Policy, Ministry of Social Affairs

Ms Liis Roováli
Head, Department for Health Information and Analysis, Ministry of Social Affairs

Alternate

Dr Maris Jesse
Director, National Institute for Health Development

Finland

Representative

Ms Taru Koivisto
Director, Ministry of Social Affairs and Health

Alternates

Ms Outi Kuivasniemi
Ministerial Adviser, Ministry of Social Affairs and Health

Dr Eero Lahtinen
Counsellor, Permanent Mission of Finland to the United Nations Office and other international organizations in Geneva

Advisers

Mr Pasi Mustonen
Ministerial Adviser, Ministry of Social Affairs and Health

Dr Anni-Ritta Virolainen-Julkunen
Senior Medical Officer, Ministry of Social Affairs and Health

Dr Sakari Karvonen
Director, Ministry of Social Affairs and Health

France

Representative

Mr Cyril Cosme
Delegate, European and International Affairs, Ministry of Social Affairs and Health

Alternates

Ms Brigitte Arthur
Head, International Office for Health and Social Welfare, Delegation for European and International Affairs, Ministry of Social Affairs and Health

Ms Saran Branchi
Officer-in-Charge, Ministry of Foreign Affairs

Advisers

Mr Marc Boisnel
Health Adviser, Permanent Mission of France to the United Nations Office and other international organizations in Geneva

Ms Caroline Collin
Officer-in-Charge, International Affairs, Mission for European and International Affairs, Ministry of Social Affairs and Health

Ms Marie-Camille Lenormand
Officer-in-Charge, Delegation for European and International Affairs, Ministry of Social Affairs
and Health

Georgia

Representative

Ms Mariam Jashi
Deputy Minister of Labour, Health and Social Affairs

Germany

Representatives

Mr Udo Scholten
Director-General, European and International Health Policy, Federal Ministry of Health

Ms Dagmar Reitenbach
Head of Division, Global Health Policy, Federal Ministry of Health

Alternate

Ms Chariklia Balas
Deputy Head of Division, Global Health Policy, Federal Ministry of Health

Adviser

Mr Thomas Ifland
Adviser, Multilateral Cooperation in Public Health, Federal Ministry of Health

Greece

Representative

Ms Zoi Makri
Deputy Minister of Health

Alternate

Ms Athina Kyrlesi
Director-General of Public Health and Quality of Life, Ministry of Health

Adviser

Ms Krystallia Vougioklaki
Administrator, Ministry of Health

Hungary

Representatives

Dr Hanna Páva
Deputy Secretary of State, Ministry of Human Resources

Dr Árpád Mészáros
Deputy Head of Department, Ministry of Human Resources

Iceland

Representative

Ms Vilborg Ingólfssdóttir
Director-General, Department of Quality and Prevention, Ministry of Welfare

Alternate

Ms Dóra Guðrún Guðmundsdóttir
Head of Division, Department of Health Determinants, Ministry of Welfare

Ireland

Representatives

Dr Deirdre Mulholland
Deputy Chief Medical Officer, Department of Health

Ms Louise Kenny
Assistant Principal, International and Research Policy Division, Department of Health

Alternate

Ms Gabrielle Jacob
Assistant Principal, Workforce Planning, Agency Governance and Clinical Indemnity Unit,
Department of Health

Israel

Representatives

Professor Ronni Gamzu
Director-General, Ministry of Health

Professor Alex Leventhal
Director, Department of International Relations, Ministry of Health

Italy

Representative

Dr Giuseppe Ruocco
Director-General for Prevention, Ministry of Health

Alternates

Dr Francesco Cicogna
Senior Medical Officer, Directorate-General for European Union and International Relations,
Ministry of Health

Mr Alberto Bertoni
First Counsellor for Health, Permanent Mission of Italy to the United Nations Office and other
international organizations in Geneva

Kazakhstan

Representatives

Dr Salidat Kairbekova
Minister of Health

Dr Gulnara Kulkayeva
Deputy Director, Department of Medical Services, Ministry of Health

Alternate

Dr Maksut Kulzhanov
Deputy Director-General, National Centre for Health Development, Ministry of Health

Kyrgyzstan

Representative

Dr Abdimannap Muratov
Head, Department for Education, Culture and Sport

Latvia

Representatives

Dr Ingrida Circene
Minister of Health

Mr Rinalds Mucins
State Secretary, Ministry of Health

Alternates

Ms Agnese Rabovica
Director, Department of European Affairs and International Cooperation, Ministry of Health

Ms Liga Serna
Deputy Director, Department of European Affairs and International Cooperation, Ministry of Health

Dr Viesturs Silins
Director, Institute of Medical Postgraduate Education, University of Latvia

Lithuania

Representative

Mr Vytenis Povilas Andriukaitis
Minister of Health

Alternate

Dr Kęstutis Miškinis
Head, European Union Affairs and International Relations, Ministry of Health

Advisers

Professor Vilius Jonas Grabauskas
Chancellor, Medical Academy, Lithuanian University of Health Sciences

Ms Ona Davidonienė
Director, State Mental Health Centre

Ms Birutė Abraitienė
Minister Chancellor, Permanent Mission of the Republic of Lithuania to the United Nations Office and other international organizations in Geneva

Ms Simona Gailiūtė
Chief Specialist, European Union Affairs and International Relations, Ministry of Health

Ms Agnė Petravičiūtė
Expert, “Promoting Lithuania’s Networking in the European Union” project, Ministry of Foreign Affairs

Mr Mindaugas Štelemėkas
Junior Scientist, Institute of Health Sciences, Lithuanian University of Health Sciences

Luxembourg

Representatives

Mr Laurent Jomé
First Government Counsellor, Ministry of Health

Dr Robert Goerens
Chief Physician, Occupational Health Division, Health Directorate

Malta

Representative

Dr Ray Busuttill
Superintendent of Public Health, Ministry of Health

Alternate

Ms Karen Demicoli
Director, Policy Development, European Union and International Affairs, Ministry of Health

Monaco

Representatives

Ms Carole Lanteri
Ambassador, Permanent Representative, Permanent Mission of Monaco to the United Nations
Office and other international organizations in Geneva

Dr Anne Nègre
Director, Health and Social Work Directorate, Department of Social Affairs and Health

Montenegro

Representatives

Dr Mira Jovanovski Dašić
Deputy Minister of Health

Ms Nataša Terzić
Deputy Director, National Institute of Public Health

Netherlands

Representatives

Mr Herbert Barnard
Director, International Affairs, Ministry of Health, Welfare and Sport

Mr Gert-Jan Rietveld
Attaché for Health, Permanent Mission of the Netherlands to the United Nations Office and other international organizations in Geneva

Alternates

Ms Jacqueline Steenbergen
Senior Policy Adviser, Ministry of Health, Welfare and Sport

Ms Regine Aalders
Senior Policy Adviser, Ministry of Health, Welfare and Sport

Norway

Representative

Dr Bjørn Guldvog
Chief Medical Officer, Directorate of Health

Alternate

Mrs Hilde Caroline Sundrehagen
Deputy Director-General, Ministry of Health and Care Services

Advisers

Dr John-Arne Røttingen
Acting Deputy Director-General, Norwegian Institute of Public Health

Ms Tonje Margrethe Borch
Director, Directorate of Health

Mr Thor Erik Lindgren
Senior Adviser, Ministry of Health and Care Services

Mr Sverre Berg Lutnæs
Counsellor, Permanent Mission of Norway to the United Nations Office and other international organizations in Geneva

Mr Anders Lamark Tysse
Senior Adviser, Ministry of Health and Care Services

Mr Eivind Berg Weibust
Adviser, Directorate of Health

Poland

Representative

Ms Katarzyna Rutkowska
Deputy Director, International Cooperation Department, Ministry of Health

Alternates

Professor Mirosław Wysocki
Director, National Institute of Public Health, State Institute of Hygiene

Ms Justyna Tyburska-Malina
Senior Expert, International Organizations Unit, International Cooperation Department, Ministry of Health

Mr Wojciech Gwiazda
First Secretary, Permanent Mission of Poland to the United Nations Office and other international organizations in Geneva

Portugal

Representative

Mr Fernando Leal da Costa
Deputy Secretary of State, Assistant to the Minister of Health, Ministry of Health

Alternate

Mr Francisco George
Director-General for Health, Ministry of Health

Advisers

Professor José Pereira Miguel
President, Executive Board, “Doutor Ricardo Jorge” National Institute of Health

Mrs Eva Falcão
Director, International Relations Directorate, Directorate-General of Health, Ministry of Health

Republic of Moldova

Representative

Mr Andrei Usatîi
Minister of Health

Romania

Representative

Mr Francisk-Iulian Chiriac
Secretary of State, Ministry of Health

Alternate

Ms Roxana Rotocol
Head, European Union Affairs and International Relations, Ministry of Health

Russian Federation

Representative

Mr Sergey Muravyev
Director, Department of International Cooperation and Public Relations, Ministry of Health

Alternates

Dr Svetlana Axelrod
Deputy Director, Department of International Cooperation and Public Relations, Ministry of Health

Mr Pavel Esin
Chief Expert, Department of International Cooperation and Public Relations, Ministry of Health

Advisers

Professor Sergei Boitsov
Director, National Research Centre for Preventive Medicine, Ministry of Health

Ms Natalia Frolova
Head, Division for the surveillance of infectious and parasitic diseases, Federal Service for Surveillance on Consumer Rights Protection and Human Well-being

Ms Elena Lynova
Chief Expert, Department of International Cooperation and Public Relations, Ministry of Health

Mr Alexey Kulikov
Third Secretary, Permanent Mission of the Russian Federation to the United Nations Office and other international organizations in Geneva

Dr Albina Melnikova
Deputy Head of Division, Management of epidemiological supervision, Federal Service for Surveillance and Protection of Consumer Rights and Human Welfare

Ms Anastasia Smirnova
Deputy Director, International Cooperation Division, Federal Service for Surveillance on Consumer Rights Protection and Human Well-being

Ms Anna Korotkova
Deputy Director, Federal Research Institute for Health Organization and Informatics, Ministry of Health

Dr Mark Tseshkovsky
Department Head, Federal Research Institute for Health Organization and Informatics, Ministry of Health

Dr Galina Maslennikova
Lead Researcher, National Research Centre for Preventive Medicine, Ministry of Health

San Marino

Representative

Dr Andrea Gualtieri
Director, Health Authority

Serbia

Representative

Professor Slavica Djukić-Dejanović
Minister of Health, Ministry of Health

Alternate

Ms Svetlana Vrga
Special Adviser for International Cooperation, Ministry of Health

Advisers

Ms Irena Žnidaršić-Trbojević
Interpreter, Ministry of Health

Mr Dragan Dejanovic
Ministry of Health

Mr Vukasin Raskovic
Ministry of Health

Slovakia

Representative

Professor Ivan Rovný
Chief Public Health Officer, Public Health Authority

Alternate

Ms Elena Jablonická
National Counterpart for overall strategic cooperation with WHO, Ministry of Health

Slovenia

Representative

Dr Vesna-Kerstin Petrič
Head, Division for Health Promotion and Prevention of Noncommunicable Diseases, Ministry of Health

Spain

Representative

Dr Mercedes Vinuesa Sebastián
Director-General, Public Health Quality and Innovation, Ministry of Health, Social Services and Equality

Alternates

Dr Karoline Fernández de la Hoz
Head of the Unit for International Technical Coordination, General Secretary for Health and Consumer Affairs, Ministry of Health, Social Services and Equality

Ms Isabel Sáiz Martínez-Acitores
Coordinator, Women's Health Observatory, Ministry of Health, Social Services and Equality

Advisers

Ms Isabel Ortega Crespo
Head of Section, Unit for International Technical Coordination, General Secretary for Health and Consumer Affairs, Ministry of Health, Social Services and Equality

Ms Esther Rodríguez Machado
Head of International Affairs Service, Deputy Directorate for International Relations, Ministry of Health, Social Services and Equality

Sweden

Representative

Dr Lars-Erik Holm
Director-General, Chief Medical Officer, National Board of Health and Welfare

Alternates

Ms Anna Halén
Counsellor, Health Affairs, Permanent Mission of Sweden to the United Nations Office and other international organizations in Geneva

Mr Bosse Pettersson
Senior Adviser, Public Health Policy, National Board of Health and Welfare

Ms Louise Andersson
Head of Section, Ministry of Health and Social Affairs

Adviser

Ms Ingvor Bjugård
Senior Officer, Swedish Association of Local Authorities and Regions

Switzerland

Representative

Ms Tania Dussey-Cavassini
Deputy Director, Ambassador, Head, International Affairs Division, Federal Office of Public Health

Alternate

Ms Muriel Peneveyre
Deputy Head, International Affairs Division, Federal Office of Public Health

Advisers

Mr Robert Thomson
Scientific Adviser, Federal Office of Public Health

Dr Leo Karrer
Diplomatic Officer, Permanent Mission of Switzerland to the United Nations Office and other international organizations in Geneva

Ms Noémie Charton
Diplomatic Officer, Sectoral Foreign Policies Division, Federal Department of Foreign Affairs

Tajikistan

Representative

Mr Salomuddin Isupov
Head, Department for Medical Education, Pharmaceuticals, Human Resources Policy and Science, Ministry of Health

Alternate

Dr Saida Jobirova
First Deputy Minister of Health

The former Yugoslav Republic of Macedonia

Representatives

Mr Nikola Todorov
Minister of Health, Ministry of Health

Mr Jovan Grpovski
State Counsellor, Ministry of Health

Alternate

Mr Angel Mitevski
Ministry of Health

Turkey

Representatives

Dr Mehmet Müezzinoğlu
Minister of Health

Professor Nihat Tosun
Under Secretary, Ministry of Health

Alternates

Mr Agah Kafkas
Deputy Minister of Health

Dr Ahmet Gülle
Counsellor, Ministry of Health

Dr Necdet Ünüvar
Deputy, Head of Health Commission, Grand National Assembly

Dr Cevdet Erdöl
Deputy, Grand National Assembly

Mr Mustafa Akçaba
Counsellor, Ministry of Health

Dr Hakki Yeşilyurt
Deputy Under Secretary, Ministry of Health

Mr Ö.Faruk Koçak
Mayor, City of Elazığ

Dr Hüseyin Çelik
Adviser to Minister of Health, Ministry of Health

Ms Şenay Özgülcü
Ministry of Health

Professor Sabahattin Aydin
Rector, Istanbul Medipol University

Professor Turan Buzgan
Chairman, Public Health Agency, Ministry of Health

Dr Öner Güner
General Director, Directorate-General of Foreign and European Union Relations, Ministry of Health

Professor Ali Coçkun
Director-General, Emergency Health Care, Ministry of Health

Professor Ali Ihsan Dokucu
President, Public Hospitals Agency, Ministry of Health

Mr Kamuran Özden
Director-General/Counsellor, Ministry of Health

Dr Mehmet Ali Torunoğlu
Deputy Chairman, Public Health Agency, Ministry of Health

Dr Bekir Keskinliç
Deputy Chairman, Public Health Agency, Ministry of Health

Professor Hasan Irmak
Deputy Chairman, Public Health Agency, Ministry of Health

Dr Yasin Akar
Counsellor, Ministry of Health

Ms Sevim Tezel Aydın
Counsellor, Ministry of Health

Dr Bahadır Sucaklı
Head of Department, Early Warning-Response and Field Epidemiology, Public Health Agency, Ministry of Health

Dr Ahmet Özlü
Head of Department, Contagious Diseases, Public Health Agency, Ministry of Health

Professor Sibel Örsel
Head, Department of Mental Health Programs, Public Health Agency, Ministry of Health

Ms Seher Musaonbaşıoğlu
Head of Tuberculosis Department, Public Health Agency, Ministry of Health

Dr Hasan Gökhan Öncül
Head of Department, Directorate of Strategy Development, Ministry of Health

Dr Banu Ayar
Head of Department, Directorate-General of Health Research, Ministry of Health

Dr Sema Zergerođlu
Head of Department, Directorate-General of Health Research, Ministry of Health

Dr Muzaffer Akkoca
Head of Department, Directorate-General of Emergency Health Services, Ministry of Health

Dr Selami Kılıç
Head of International Health Policies Department, Directorate-General of Foreign and European Union Relations, Ministry of Health

Dr Seyhan Ően
Head of Department for Relations with International Organizations, Directorate-General of Foreign and European Union Relations, Ministry of Health

Dr Murat ŐimŐek
Directorate-General Of Emergency Health Care, Ministry of Health

Dr Songül Dođan
Directorate-General of Health Research, Ministry of Health

Dr Seda Usubütün
Directorate-General of Foreign and European Union Relations, Ministry of Health

Dr Canan Yılmaz
Directorate-General of Foreign and European Union Relations, Ministry of Health

Mr Azmi Ekmen
European Union Expert, Directorate-General of Foreign and European Union Relations, Ministry of Health

Ms Asude Güler
Directorate-General of Foreign and European Union Relations, Ministry of Health

Dr Yusuf Irmak
Directorate-General of Foreign and European Union Relations, Ministry of Health

Mr Çetin Dođan Dikmen
Deputy European Union Expert, Directorate-General of Foreign and European Union Relations, Ministry of Health

Ms Sıdka Tekeli
Directorate-General for Emergency Health Care, Ministry of Health

Ms Özlem Kural
Counsellor, Permanent Mission of Turkey to the United Nations Office and other international organizations in Geneva

Turkmenistan

Representative

Dr Nurmhammet Amanepesov
Minister of Health and Medical Industry

Advisers

Dr Gylychnepes Annanepesov
Deputy General Director, International eye disease centre, Administration of International Medical Centres, Ministry of Health and Medical Industry

Mr Annakerim Annamuradov
Lead Specialist, State Sanitary-Epidemiological Service, Ministry of Health and Medical Industry

Ukraine

Representative

Dr Raisa Bogatyryova
Minister of Health, Ministry of Health

Mr Mykhailo Statkevych
Head, External Relations and European Integration, Ministry of Health

Alternate

Professor Mykola Prodanchuk
Director, L.I. Medved's Institute of Ecohygiene and Toxicology

Ms Natalya Nizova
Director, Ukrainian Centre for AIDS Prevention, Ministry of Health

Mr Oleksii Shulga
Head, Protocol, Ministry of Health

Ms Liudmyla Khariv
Assistant to the Minister

Mr Ruslan Deremedved
Consul, Economic Relations, Consulate General of Ukraine in Istanbul

United Kingdom of Great Britain and Northern Ireland

Representative

Professor Dame Sally Davies
Chief Medical Officer and Chief Scientific Adviser, Department of Health

Ms Kathryn Tyson
Director, International Health and Public Health Delivery, Department of Health

Alternate

Mr Matthew Harpur
Head, European Union and Multilateral Team, International Branch, Department of Health

Mr Mark Rush
Second Secretary, Global Health and Environment, Permanent Mission of the United Kingdom of Great Britain and Northern Ireland to the United Nations Office and other international organizations in Geneva

Adviser

Ms Nicky Shipton-Yates
Policy Manager, Global Health Policy Manager, Department of Health

Uzbekistan*Representative*

Dr Anvar Alimov
Minister of Health

Alternate

Dr Abdunumon Sidikov
Director, Department of International Relations, Ministry of Health

II. Observers from Member States of the Economic Commission for Europe*United States of America*

Dr Nils Daulaire
Assistant Secretary for Global Affairs, U.S. Representative to the WHO Executive Board, U.S. Department of Health and Human Services

Mr Colin McIff
Health Attaché, Permanent Mission of the United States of America to the United Nations Office and other international organizations in Geneva

III. Representatives of the United Nations and related organizations*Food and Agriculture Organization of the United Nations*

Mr Mustapha Sinaceur
Representative in Turkey and Sub-Regional Coordinator for Central Asia

International Atomic Energy Agency

Ms Marion Pinerros-Petersen
Cancer Control Specialist, Programme of Action for Cancer Therapy Programme

United Nations Children's Fund

Ms Marie-Pierre Poirier
Regional Director, Central and Eastern Europe and the Commonwealth of Independent States

Dr Octavian Bivol
Regional Advisor Health Systems and Policies

United Nations Economic Commission for Europe

Ms Brinda Wachs
Environmental Affairs Officer

United Nations Population Fund

Mr Werner Haug
Regional Director, Eastern Europe and Central Asia

Ms Marta Diavolova
Regional Programme Adviser

World Meteorological Organization

Mr Davut Öztürk
Deputy Regional Director, Izmir

IV. Representatives of other intergovernmental organizations

European Union

Dr Isabel De la Mata Barrango
Dr Canice Nolan
Ms Lourdes Chamorro
Dr Marc Sprenger
Dr Maarit Kokki

Council of Europe

Ms Mehri Gafar-Zada

V. Representatives of nongovernmental organizations in official relations with WHO

Alzheimer's Disease International

Mr Jean Georges
Mr Marc Wortmann

Framework Convention Alliance on Tobacco Control

Elif Dağlı

International Alliance of Patients' Organizations

Ms Jolanta Bilinska
Ms Neda Milevska Kostova

International Association for Child and Adolescent Psychiatry and Allied Professions

Dr Fusun Çetin Çuhadrođlu

International Bureau for Epilepsy

Mr Michael Alexa

International Confederation of Midwives

Ms Mary Higgins

International Council of Nurses

Dr Saadet Ülker

International Diabetes Federation

Professor Sehnaz Karadeniz

International Federation of Medical Students' Associations

Dr Miguel José Cabral de Pinho

Mr Christopher Schürmann

Mr Halit Onur Yapici

Mr Semih Kucukcankurtaran

Mr Thilo Rattay

Mr Hilmican Ulman

International Spinal Cord Society

Mr Sergio Aito

International Federation of Business and Professional Women

Dr Luisa Monini

International Society of Physical and Rehabilitation Medicine

Mr Boya Nugraha

Union for International Cancer Control

Professor Tezer Kutluk

World Association of Societies of Pathology and Laboratory Medicine

Dr Gamze Mocan Kuzey

World Federation of Acupuncture and Moxibustion Societies

Dr Rinaldo Rinaldi

World Federation of Chiropractic

Dr Mustafa H. Agaoglu

World Federation of Occupational Therapists

Dr Samantha Shann

World Medical Association

Ms Elif Keles
Dr Ahmet Murt

VI. Observers*Association of Schools of Public Health in the European Region*

Professor Anders Foldspang

Comité Permanent des Medecins Europeens

Ms Birgit Beger
Dr Katrin Fjeldsted

European Centre for Environment and Human Health

Mr George Morris

European Federation of Nurses Association

Ms Unni Hembre

European Forum for primary care

Dr Mehmet Akman

European Health Forum Gastein

Ms Dorli Kahr-Gottlieb

European Respiratory Society

Ms Maeve Barry

European Society of Cardiology

Ms Sophie O'Kelly

GAVI Alliance Secretariat

Mr Stephen Sosler
Ms Nilgun Aydogan
Mr Santiago Cornejo

Global Fund to fight AIDS, Tuberculosis and Malaria

Mr Nicolas Cantau

International Network of Health-Promoting Hospitals and Health Services

Mr Thor Bern Jensen

Municipality of Bucharest

Dr Tania Rădulescu

TB Europe Coalition

Mr Timur Abdullaev

Turkish Nurses Association

Hulya Ikumus
Güberen Kocornan

World Health Summit

Dr Mathias Bonk

Guests and Temporary Advisers

Professor Róza Ádány
Professor Mark Bellis
Professor Otto Cars
Professor Peter Goldblatt
Professor Ilona Kickbusch
Dr Mihály Kökény
Professor Sir Michael Marmot
Professor Martin McKee
Mr Alexander Nies
H. E. Mrs Sandra Roelofs
Dr Mirta Noemi Roses
Mr Mustafa Toprak
Mr Aziz Kocaoglu
Ms Inci Sezer Becel
Mr Şahin Aslan
Mr Ergüder Can
Mr Selim Tokmak

Annex 4. Address by the Regional Director

Mr President, your excellencies, ministers, delegates, partners, ladies and gentlemen,

It is with the greatest pleasure that I welcome you to the sixty-third session of the Regional Committee for Europe. It is a real honour and a privilege to be addressing you at a Regional Committee for the fourth time and I will present the major achievements and progress the last year has brought.

Before I continue, I would like to take a moment to thank each and every one of you. I am grateful for the spirit of cooperation in which we have worked together. There have been many changes for better health in our European Region in the last three years. It takes courage to change, and for that I applaud you.

In 2010, I proposed a five-year plan to improve health and to reduce inequalities in the European Region. Thanks to your support, the Regional Committee adopted it in 2010. We agreed to follow a roadmap with specific milestones, to enable the WHO Regional Office for Europe to respond to the changing environment and to further strengthen it as an evidence-based centre of health policy and public health excellence, which could better support the Region's diverse Member States.

During the past three years, we have worked together to define our policy directions and to develop and agree on a number of important strategies and action plans. Most importantly, you, the Regional Committee, endorsed Health 2020 as a policy framework for health and well-being. This was very timely also due to WHO reforms. As I promised, now our focus is on implementation and action, as a joint undertaking with Member States and partners to make a difference in health.

Three years after you endorsed my proposed plan, I am honoured to report that work is either completed or very well advanced in all areas. Where it is not yet completed, it is because we are awaiting the final outcome of the reform process.

Today, I will particularly focus on selected priority areas, providing you an overview of impact and early results.

Health 2020 is a European regional initiative, yet it is also closely aligned with the continuing WHO reform, and it was needed in the light of the global and regional challenges we all need to address in an integrated way.

It shows how action on the whole spectrum of health determinants leads to wider benefits for society, including social, community and economic benefits.

To recall, Health 2020 has two strategic objectives and four priority areas, which structure my presentation.

Since Health 2020 was adopted in Malta, it has been an exciting year of progress and developments. We have directed our energy and corporate efforts towards making it a reality. This has been a systematic exercise focused on spreading awareness across the Region on various national and

international platforms, and we have launched Health 2020 and its evidence-based studies at various high-profile events.

I am delighted that the two published documents are now available in all official languages to this Regional Committee. Further, we completed and expanded the core studies. I thank Professor Sir Michael Marmot, who so ably led the European review on the social determinants of health and health divide to its successful completion. We will launch the final report during this Regional Committee, and it will be the topic of discussion during the ministerial lunch today. We have also published a companion volume, on governance for health in the 21st century, a study led by Professor Ilona Kickbusch, which provides practical guidance and a wide range of participatory governance examples from across our Region and beyond. We plan to launch the joint WHO/Organisation for Economic Cooperation and Development (OECD) study on the economic case for public health action later in the year.

Already many countries across the Region have embarked on initiatives to develop national health policies in line with Health 2020. I am confident it will continue to be implemented according to your circumstances and needs, and will make a difference. We have supported you in adapting Health 2020 approaches, and I want to assure you that we will continue to give our fullest support in the future.

We are developing a package of tools and resources to assist Member States, as well as web-based information tools. It comprises nine interconnected components, which you will hear more about tomorrow.

We in the Regional Office applied the Health 2020 lens to all aspects of our work, integrating its strategic priorities in the operational planning process for 2014–2015. Meanwhile, we also strengthened our capacity to support the implementation of Health 2020, and I established the Division of Policy and Governance for Health and Well-being, which includes also the WHO European Office for Investment for Health and Development in Venice, Italy.

Given that so many factors affect health and that health affects so many areas of human life, progress can only come from whole-of-society and whole-of-government efforts. This is why everyone has a role to play in implementing Health 2020, from prime ministers to civil-society organizations and citizens. As indicated in the report on the social determinants of health, shortfalls in health result from society's social, economic, environmental and cultural situation and require a life-course approach.

As for our work on the social determinants of health, I would like to acknowledge the excellent work carried out by our WHO European Office for Investment for Health and Development, and thank the Government of Italy for supporting it.

In 2012, you agreed on six overarching targets and asked us to develop a monitoring system for Health 2020.

We have gone through an intensive consultative process. The full list of indicators will be presented to you tomorrow. Let me highlight that the Regional Office broke new ground by incorporating well-being in Health 2020. Now, to quantify a European target and relevant indicators on well-being, we started to develop a common concept and approach that would allow valid measurement and yield information useful in policy-making. All these are outlined in detail in *The European health report*

2012: *charting the way to well-being*, and I would like to thank Poland for hosting the launch of the report in March this year.

The Regional Office's efforts include a life-course approach with a focus on disease prevention, health promotion and the quality of care.

Since 1990, the maternal mortality ratio in the WHO European Region has decreased by 54%, to the lowest level in the world. Nevertheless, the highest risk of death from causes related to pregnancy and childbirth in Europe is more than 40 times the lowest; the risk depends on where women live and receive health care.

We focused on improvements in access to quality primary health care for pregnant women, mothers and newborn babies. I would like to thank the Russian Federation for its support in reaching these objectives, particularly in countries in eastern Europe and central Asia. Supporting countries in decreasing this inequity is among our priorities and, with strong commitment from ministries, we have already started to observe improvements in the quality of maternal care based on lessons learnt.

Equal access to quality child and adolescent health services and care also remains a priority. We intensified our efforts to improve quality of hospital care, particularly in central Asia. Shorter hospital stays, reduced unjustified hospitalizations, significant reductions in unnecessary injections and savings in hospital costs are some of the early results.

Our latest report from the Health Behaviour in School-aged Children (HBSC) study on social determinants of health and well-being among young people, has won an award in the 2013 British Medical Association Medical Book Competition.

We would like to give you a progress report on child and adolescent health, and present our proposals for a renewed commitment aligned with Health 2020 at the next Regional Committee session.

We have stepped up our work through the Healthy Cities network to exchange good practices and to provide guidance on policies for age-friendly environments. Following the European Year for Active Ageing and Solidarity between Generations in 2012, this work is now supported by a major project of the European Commission, which is an important milestone for implementing our strategy and action plan for healthy ageing in Europe.

Health 2020 focuses on a set of integrated strategies and interventions to address major health challenges across the European Region from both noncommunicable and communicable diseases. Let me start with the noncommunicable diseases (NCDs).

The 2013 World Health Assembly delivered on the promises of the past two years: we have a new WHO Global NCD Action Plan. And the global monitoring framework, developed under Norway's chairmanship last November, was unanimously endorsed. We can congratulate ourselves as a region on having played a leadership role in forging ahead with this global agenda.

We can also look forward with confidence. As you can see from this graph, in the last decade we have reversed the regional epidemic of circulatory diseases. They are now declining steadily in all parts of

the Region, and we should be able to report a dramatic fall in both east and west by the target dates of 2020 in Europe and 2025 globally.

Nevertheless, at current rates, in 2025, a person of central or eastern Europe will still have six times the risk of dying from heart disease or stroke as a person in the west.

For this reason, we have to intensify our efforts and do better. For example, on World Health Day 2013 we reminded the Region of the dangers of high blood pressure. We mapped countries' efforts to address hypertension and one of its root causes: salt intake. With the support of the Russian Federation, we have started a programme to strengthen action on NCDs in many countries, including supporting surveys and intersectoral policy development.

We developed a tool to assess barriers to and opportunities for NCD prevention and control in health systems and used it to make intensive assessments in Hungary, Kyrgyzstan, the Republic of Moldova, Turkey and Tajikistan. These experiences – as well as the implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases and the challenges Europe will face in the next decade – will be the main theme for the first European ministerial conference on NCDs. I would like to thank Turkmenistan for hosting the Conference in Ashgabat in December this year.

The European action plan to reduce the harmful use of alcohol provides the framework for effective policy actions. So far, 37 countries have national or subnational policies on alcohol and 10 more are developing them.

We surveyed alcohol consumption, harm and policy responses in all 53 Member States and published the Status report on alcohol and health in 35 European countries 2013. Adult per capita alcohol consumption has markedly decreased in the European Region as a whole over the past 20 years. In spite of the overall decline in consumption in western and central Europe, with the largest decline in southern Europe, the eastern part of the Region shows an upward trend.

We have seen tangible policy achievements in tobacco control. Tajikistan became a State Party to the WHO Framework Convention on Tobacco Control, which only three Member States in our region have yet to ratify. The Russian Federation adopted a strong tobacco-control law. Ukraine went smoke-free and banned tobacco advertising. Kazakhstan took leadership by adopting Europe's strongest pictorial health warnings. And Ireland started introducing standard packaging for tobacco products.

Policy action brings tangible results. Turkey registered a 13% reduction in adult smoking prevalence between 2008 and 2012, a rate that bodes well for the Region's achieving the global targets, if it is emulated in other countries.

The current discussions on the European Union (EU) Tobacco Products Directive have huge potential to strengthen European tobacco-control policies. WHO pledged technical and political support to the proposed Directive. But we must not rest on our achievements. The tobacco industry is escalating its actions and I urge all delegations here to stand strong against big tobacco.

We will discuss the implementation of the Framework Convention tomorrow, during the ministerial lunch, and I am pleased to welcome Dr Haik Nikogosian, Head of the Convention Secretariat.

We have made tremendous progress in nutrition and obesity in recent years.

You were very successful in establishing and scaling-up monitoring and surveillance systems critical to inform policies. Policy developments in countries were remarkable: 49 Member States developed or updated their national policies and several countries thoroughly evaluated them.

Nevertheless, the negative impact of unhealthy diets and physical inactivity, particularly childhood obesity, is high and still growing in countries in the European Region.

The WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020, hosted by the Government of Austria, was an enormous success: 48 Member States attended and approved the Vienna Declaration, a milestone in public health in Europe. You have agreed to take coordinated action to effectively tackle unhealthy diets, obesity, malnutrition and physical inactivity.

This Regional Committee will discuss the Vienna Declaration and its proposed actions in detail.

And now let me focus on unfinished business in communicable diseases.

With commitment from you, we made good progress in implementing the European strategic action plan on antibiotic resistance. A harmonized and coordinated surveillance network is needed to provide Region-specific information. Working with partners, we supported the monitoring of antibiotic use in 17 Member States outside the EU; 12 are ready to publish their data for the first time. Through partnership with the National Institute for Public Health and the Environment (RIVM) in the Netherlands and the European Society of Clinical Microbiology and Infectious Diseases (ESCMID), we established a new network for the surveillance of antimicrobial resistance (AMR) for all non-EU countries. These networks complement the excellent surveillance system for EU countries. We also supported countries in strengthening their intersectoral coordination and surveillance capacity.

Thanks to good collaboration with the European Centre for Disease Prevention and Control (ECDC), we helped expand European Antibiotic Awareness Day to non-EU countries in the Region. Here I would like to thank Her Royal Highness Crown Princess Mary of Denmark for her support.

Action to implement the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis [M/XDR-TB] in the WHO European Region started to bear fruit; you will find details in the progress report.

This was possible only through substantial support to countries provided with partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the European Commission and ECDC. In total, WHO staff conducted 71 country visits during the past 2 years, supporting 23 Member States and organizing 9 in-depth programme reviews. I discussed with you and many heads of state the importance of a health-system approach to TB control.

Countries increased their capacity to detect MDR-TB, so that more than half of estimated cases are now detected in our Region. And treatment enrolment increased to 96% in 2012. Nevertheless, the treatment success rate varies widely, from 18% to 80%. We are working with Member States and the Global Fund to address remaining gaps.

I encourage you to visit the compendium of best practices in the exhibition area.

In response to the rising number of people living with HIV in the Region, we are implementing the European Action Plan for HIV/AIDS.

In 2011, the number of people on antiretroviral treatment in the European Region increased to 600 000, but treatment is not yet keeping pace with the approximately 1.5 million HIV infections.

Two key initiatives will help further implement our commitments. WHO's new *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* offer a public health approach to scaling up treatment and containing transmission. We will organize a regional technical consultation in October; thanks to Turkey for hosting it.

We are also working towards elimination of both mother-to-child transmission of HIV and congenital syphilis in the Region, thanks to partnership with the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF and UNFPA.

Outbreaks of measles and rubella continued in 2012 and 2013 in various countries, and imperil the Region's goal of eliminating measles and rubella by 2015. This is the main reason for presenting you with a package of accelerated action and a call for stronger commitment to eliminating these diseases. I look forward to the discussion on this agenda item on Wednesday.

Now let me give you an update on sustaining the European Region's polio-free status, as called for by the Regional Committee in 2010. At its annual meeting in May, the European Regional Certification Commission identified the countries at risk for transmission following poliovirus importation and stressed the need for vigilance. The Commission had good reason. A large outbreak in 2010 threatened the Region's polio-free status, and the recent importation of wild poliovirus into the Region reminds us of the need to keep up our guard.

Israel has conducted systematic environmental surveillance over the past 25 years, and detected type 1 wild poliovirus earlier this year, closely related to the viruses isolated in Egypt and Pakistan. This indicates virus circulation in the environment in Israel. I want to underline that there have been no cases of paralytic poliomyelitis, thanks to the very high immunization coverage in Israel.

Indeed, gold-standard surveillance and reporting have enabled Israel to respond effectively by conducting supplementary immunization activities to interrupt transmission and prevent exportation and possible cases. We have worked with the national authorities since May this year to support their investigation and response. Introducing bivalent oral polio vaccine (OPV) and reaching close to 800 000 children since mid-August are tremendous achievements. I thank the Minister of Health, the Director-General for Health and the Prime Minister for taking action and personally engaging in the campaign.

The Certification Commission will meet next month to review the outcomes of Israel's action to interrupt transmission, and the risk to the Region's polio-free status.

High national and subnational immunization coverage, hand in hand with strong surveillance, is key to achieving disease-control targets. Political commitment is an absolute necessity, no longer an option.

We at WHO fully intend to do our part. We will consult you, during the matters-arising session on Thursday, on the formulation of a European regional vaccine action plan harmonized with the Global Vaccine Action Plan and aligned with Health 2020.

Let me briefly mention that European Immunization Week was again a success, with all 53 Member States participating.

Progress towards malaria elimination is good, with only 253 cases in 2012. The European Region could be the first WHO region to complete the elimination process.

Nevertheless, re-emerging vector-borne diseases, especially dengue and chikungunya fever, are of increasing concern in the Region. Mosquito vector activity is a growing problem, driven mostly by the globalization of travel and trade, urbanization and climate change. As requested by the 2012 Regional Committee, we developed a regional framework for action, in cooperation with you, ECDC and the European Mosquito Control Association (EMCA), to be discussed on Tuesday.

Improving public health and ensuring people-centred health systems – including human resources for health, health financing and enhanced governance – are all key focus areas of Health 2020. On health research, let me thank the European Advisory Committee on Health Research (EACHR) and Professor Tomris Turmen, its Chair, who is represented here by the Vice-Chair, Dr Laura Rosen, and the outgoing Chair, Professor Martin McKee, for supporting and coordinating research in international health.

Universal health coverage means that all people have access to the high-quality health services they need (including prevention, promotion, treatment and rehabilitation), while protecting them and their families from financial hardship. And it is relevant for the whole Region: countries affected by the economic crisis need to safeguard access to needed services. Political commitment to move towards universal health coverage is growing in countries in the eastern part of the Region.

Universal health coverage is among my priorities and I am committed to intensifying our support for achieving and sustaining it in the coming years.

Two important events related to strengthening health systems are coming up later this year.

Five years after its adoption, we will discuss the implementation of the Tallinn Charter at a high-level meeting in October; thanks to Estonia for hosting it. We will exchange inspiring examples of health-system strengthening and agree on future directions to fulfil our commitments in the context of Health 2020.

In addition, the thirty-fifth anniversary of the Declaration of Alma-Ata on Primary Health Care will be celebrated in November. We are working closely with Kazakhstan to prepare for a meeting at which we will describe the status of primary health care in the Region and the way forward to integrate the essential public health operations into it.

There is compelling evidence for going upstream and integrating disease prevention, health promotion and other essential public health functions, along with work on social determinants, into health systems, as requested by the 2012 Regional Committee.

We engaged intensively with Member States to support effective policy decisions that reduce the adverse effects of the economic crisis on health outcomes and equity. The WHO Barcelona Office for Health Systems Strengthening carries forward this work, and I thank them and I thank Spain for supporting it.

Four years after the first meeting on the topic, our work in this area culminated in the Oslo conference on health systems and the economic crisis in April, generously hosted by Norway. It brought together both the health and finance sectors, reaching agreement on an outcome document about which you will hear more on Tuesday. Let me underline that the participants emphasized that, even with restricted budgets, governments and health ministries have choices, and can focus on areas and services that encourage economic growth and reinforce equity.

In addition to our work to build evidence, we aim to strengthen policy-makers' capacities. All feedback from the participants shows that our annual Barcelona Course on Health Financing is excellent, and I encourage you to send representatives to attend it.

Further, we are receiving an increasing number of requests from Member States for support to comprehensive reforms. For example, the Greek Government is committed to pursuing health-system reform. As requested by the Government and the EU Task Force for Greece, WHO recently agreed to play an expanded normative and technical role in developing health-systems policy in Greece, with Greece.

I would also like to commend Cyprus, Ireland and Portugal for similar fruitful collaboration on health-system reforms, aiming to safeguard access to quality services and universal health coverage.

As the lead agency of the health cluster in humanitarian emergencies, we help countries prepare for and cope with emergencies and health crises.

We revised our emergency procedures, upgraded the emergency operations centre at our new premises in the new UN City, in line with the new global WHO Emergency Response Framework, and tested it in several simulations.

We are also supporting countries such as Azerbaijan, the Russian Federation and Slovenia in preparing for mass gatherings.

Another important area of health security is building core capacities to implement the International Health Regulations (IHR) through expert training and table-top exercises. In February 2013, in collaboration with the European Commission and with support from Germany and the United Kingdom, we held a meeting in Luxembourg, taking stock of the implementation process five years after IHR's entry into force. The progress report gives details and on Thursday we will seek your guidance on the criteria for extensions beyond the 2014 deadline for core capacities.

With the crisis in the Syrian Arab Republic triggering large-scale population displacement and a growing number of refugees in neighbouring countries, we coordinated a United Nations interagency health-needs-assessment mission in December 2012 to refugee camps in southern Turkey. It concluded that high-quality health services are provided to refugees in Turkey.

In close consultation with the Turkish authorities, we are scaling up our response capacity by establishing a WHO field presence in southern Turkey.

A systematic assessment of the health effects of a rapidly changing environment is essential and must be followed by action to ensure benefits to health.

Tomorrow you will hear a report on the work of the European Environment and Health Ministerial Board and Task Force.

Pioneering the health-in-all-policies approach, we are working through the European environment and health process with Member States and key partners, to provide evidence and support countries in implementing intersectoral approaches.

We scaled up technical support to countries to achieve their commitments under the Parma Declaration on Environment and Health, producing a number of new assessments and tools, and establishing new networks on chemical safety and economics. We are grateful to all the Member States and partners that generously support our work on environment and health, particularly to Germany for its continued support of the WHO European Centre for Environment and Health, in Bonn, and a project that advanced several countries' preparedness and capacities to address the health challenges posed by climate change.

Now, let me give you an overview of major developments in the Regional Office and WHO globally, focusing on the managerial and governance aspects of our work. We continued to improve our efficiency, seek sustainable funding, deepen and extend our partnerships, and strengthen communications.

In April 2013, we moved our head office in Copenhagen to the new UN City, along with all the United Nations agencies in Denmark. We are deeply grateful to the Danish Government for its generosity in providing excellent premises. We were honoured to have Her Majesty Queen Margrethe of Denmark and United Nations Secretary-General Ban Ki-moon inaugurate UN City.

WHO is reforming to be better equipped to address increasingly complex health challenges in the 21st century. Significant progress has been made in moving forward the reform agenda since I reported to you last year, mostly owing to the unprecedented engagement and active involvement of Member States. I am immensely grateful to you for contributing in so many different ways.

Let me take this opportunity to thank all staff in the Region for their contribution to the process and adapting to the changes required by reform. There has been thorough collaboration at all levels of WHO, with full leadership of the Director-General and engagement of all the regional directors in the Global Policy Group. I very much appreciated the opportunity to co-chair, with Dr Asamoah-Baah, the WHO task force on resource mobilization and management and take an active role in the financing dialogue.

WHO reform is clearly having an impact. The work of the Regional Committee and Standing Committee of the Regional Committee (SCRC) demonstrates that WHO is an organization of Member States that exercises its important functions primarily through Member States. With guidance from the Regional Committee and SCRC, we ensured greater coherence and better governance in the European

Region. The SCRC working group on governance addressed issues such as governing-body memberships, timely proposal of amendments to proposed resolutions and screening of credentials, which will be further discussed on Wednesday.

The World Health Assembly gave WHO a clear direction for the programmatic component of reform by approving the Twelfth General Programme of Work and the Programme Budget for 2014–2015. These give us a vision and a plan of action.

The Programme Budget has several new characteristics: a more realistic assessment of income and expenditure, a robust results chain and a clear description of the contribution of each level of WHO to the work. The concepts behind and lessons learnt from the European Region's 2012–2013 "contract", which I presented two years ago as "the strategic tool for accountability", were a major contribution to the global process.

During this Regional Committee session, I will present the implementation of the Programme Budget for 2014–2015 in the European Region, which is well advanced. Health 2020 guides the transformation of the Assembly-approved Programme Budget into European operational planning. We had a ten-day Office-wide retreat to ensure coherence, particularly in implementing Health 2020, and we consulted Member States to define the priorities of the biennial collaborative agreements. According to our business model, staff based at the head office will continue to provide technical support to our Member States.

But the Programme Budget still needs to be financed. Our first financing dialogue took place in June, a successful meeting with full support of Member States and partners. I look forward to working with you towards the second meeting in November. I have great hope that this innovative mechanism will ensure a fully funded programme budget, and end the financial uncertainty in delivering our workplans.

To ensure sustainability at the Regional Office, we took measures that would not affect the delivery of our commitments to Member States, including lowering staff costs (by reducing recruitment while preserving technical capacity and excellence), and reducing travel costs and spending on consultant services.

I promised the 2010 Regional Committee we would develop a partnership strategy for the European Region. While awaiting decisions on collaboration with non-state actors to deliver on this commitment, I am happy to report that we continue to work with a broad range of partners, engaging actively and deepening our collaboration more and more every year.

In the Regional Office, we strengthened collaboration with the EU and its institutions. Let me present a few highlights. We continued to work with and support the health priorities of countries holding the EU Presidency: Cyprus, Ireland and Lithuania. We welcomed a delegation from the EU Committee of the Regions to the Regional Office. We had a large number of important events and worked with the European Parliament. We discussed our joint roadmaps with the European Commission during the very successful meeting of senior officials held at WHO headquarters in June. These roadmaps have deepened our collaboration significantly.

We have increased the range and depth of work with partners such as United Nations agencies, the World Bank, OECD, global health partnerships (particularly the Global Fund and GAVI Alliance), subregional networks and civil-society organizations.

I am honoured to welcome regional directors of UNICEF and UNFPA. We three will sign a joint framework for action during the partnership session on Wednesday. It aims to support you in achieving the health-related Millennium Development Goals (MDGs) and address new challenges in the context of Health 2020 policies.

Apart from various regional events and conferences, there were many occasions during the year for bilateral discussions with Member States. I visited 18 countries and had the opportunity to meet with you and your presidents and prime ministers, promoting intersectoral approaches and ensuring that health is placed high on the governments' agendas.

It was an honour to welcome 13 health ministers and delegations to the Regional Office during the year. I value these visits, as they are very useful in guiding our work and choosing areas for future collaboration.

In addition we started developing country cooperation strategies (CCSs), signing the first CCS in the Region with Switzerland in May, along with the Director-General. We have started developing CCSs with Belgium, Cyprus, Greece, the Russian Federation and Turkey.

Subregional mechanisms remain an increasingly effective way to work with Member States. We are implementing activities with the South-east Europe Health Network (SEEHN) and subregional projects with countries in the Commonwealth of Independent States.

Ours is a complex and beautiful region, home to 900 million of the world's people and approximately 86 languages. Its diversity gives us a unique opportunity to draw on an incredibly wide range of expertise and experience.

We are at the forefront of progress in so many areas of public health. I am sure that, together with you, we can make it.

Thank you for your attention.