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of the Regional Committee for Europe
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Introduction

1. The Twenty-first Standing Committee of the Regional Committee for Europe (SCRC) held its second session at the Grand Excelsior Hotel, Floriana, Malta, on 16 and 17 December 2013.

Opening by the Chairperson and the Regional Director

2. The Chairperson of Twenty-first SCRC opened the meeting.

3. Zsuzsanna Jakab, WHO Regional Director for Europe, announced that her opening statement was being video-streamed, so that Member States not represented on the Standing Committee could hear it. She encouraged them, in advance of the next session of the Twenty-first SCRC, to send specific questions they would like to be addressed in her introduction at that session. In her address, she recalled the constructive outcomes of the 63rd session of the WHO Regional Committee for Europe (RC63) in Izmir, Turkey, and the outcomes of the five high-level conferences that had been held in conjunction with the implementation of Health 2020. She noted that the main topics proposed for the 64th session of the WHO Regional Committee for Europe (RC64) would be discussed with the SCRC and would include: a report on progress made on Health 2020 implementation; a European strategy for children and adolescents; a regional vaccine action plan; a European action plan on food and nutrition; a health information strategy; a country strategy; and a partnership strategy.

4. Three major events had been held since RC63. The first had been a high-level meeting in Tallinn, Estonia, on the fifth anniversary of the Tallinn Charter, at which progress in strengthening people-centred health systems, reducing inequalities and increasing transparency and accountability, and the way forward on health systems strengthening beyond 2015 had been discussed. The second had been the 35th anniversary of the Declaration of Alma-Ata, held in Almaty, Kazakhstan, at which consensus had been achieved on advancing the vision, values and principles of the Declaration of Alma-Ata, while adapting them to changed conditions. The third had been a ministerial conference on noncommunicable diseases (NCDs) in Ashgabat, Turkmenistan, at which a commitment had been made to accelerate full implementation of the WHO Framework Convention on Tobacco Control.

5. Other activities had included joint meetings with the European Commission and the European Centre for Disease Prevention and Control (ECDC) to address measles, rubella and polio; the launch of the review of social determinants of the health divide; the post-2015 development agenda; strengthening the Greek health system through a contribution agreement co-funded by Greece and European Union (EU) Structural Funds; the Regional Director's special project on (multidrug resistant) tuberculosis; preventing violence against women; and two training courses. The second financing dialogue, with the objectives of attaining 70% predictable financing at the start of the 2014–2015 biennium, improving alignment of resources in the approved programme budget (PB), increasing flexibility in financing, extending the donor base and increasing transparency, had been held. The Regional Director had presented a new, coordinated resource mobilization strategy on behalf of the WHO Global Policy Group (GPG).

Report of the first session of the Twenty-first Standing Committee of the Regional Committee

6. The report of the first session of the Twenty-first SCRC (Izmir, Turkey, 19 September 2013) had been distributed and adopted electronically.

Follow-up to the 63rd session of the Regional Committee: evaluation and review of actions by the SCRC and the Secretariat

7. The Regional Director, referring to document EUR/RC63/SC(2)/9, recalled that Turkey had agreed to host RC63 at short notice. She stressed that care must be taken to ensure that countries offering to host sessions of the Regional Committee are fully aware of the financial implications of hosting the RC and, after evaluating these costs, would be requested to confirm this in writing. Only after receiving written confirmation would the offer be put forward in a resolution to the RC. The Regional Director indicated that draft resolutions and the annotated agenda for RC64 would be made available before the May meeting of the SCRC, which is open to all Member States. The involvement of members of the SCRC as focal points had been useful; she suggested that the focal points for specific technical items be announced well in advance of the May session, so delegates could consult with them. In order to ensure that ministerial lunches were effective, the topics should be carefully selected and ministers should be briefed both orally and in writing. The Regional Director welcomed the active involvement of the health attachés and felt that the early briefing given for the Permanent Missions to the United Nations Office at Geneva had been helpful.

8. The Regional Director highlighted two specific points that require further attention. Member States requested clarification on the shortlisting of nominations for representatives to serve on the Executive Board, the SCRC and as officers of the RC. The involvement of nongovernmental organizations (NGOs) was still not optimal and ways were being sought to ensure that they were heard. The SCRC subgroup on governance will be asked to support the Secretariat in bringing these issues forward.

9. Members commented that the agenda of Regional Committee sessions did not accommodate input from NGOs. One member suggested that a meeting be held with civil society organizations in the margins of the session and that their interventions during the session be limited to three per item.

10. It was generally agreed that the involvement of ministers could be improved. Prepared statements, which were sometimes irrelevant to the topic being discussed, should be discouraged. Ministers should be given specific topics to discuss well in advance of the ministerial lunches and panel discussions and should be briefed by the Secretariat.

11. It was pointed out that not all Member States have designated health attachés in the Permanent Missions in Geneva; some cover various topics and not only health, which might result in uneven participation.

12. The Regional Director thanked members for their valid comments and looks forward to further discussions on theses issues, particularly on the engagement of NGOs and the participation of ministers. She added that the involvement of health attachés could be improved through the provision of clear briefings, but this could not replace collaboration with governments.

Terms of reference of SCRC subgroups

Subgroup on implementation of Health 2020

13. The Chairperson, speaking on behalf of the subgroup on implementation of Health 2020, said that its terms of reference should ensure that partnerships were formed with educational establishments and that liaison was maintained with other SCRC subgroups, especially the subgroup on allocation of flexible resources; reporting mechanisms should be specified. The draft terms of reference for the subgroup were presented and agreed as follows.

14. To regularly review developments and progress on the implementation of Health 2020 and to develop proposals which would be presented and further discussed with the SCRC:

- on how to develop and enrich the Health 2020 implementation package with tools and good practice from the Region;
- on strategies and events across the Region that would broaden awareness on implementing the recommendations of the European review of social determinants and the health divide;
- on integrated interventions to implement the main strategic and policy pillars of Health 2020, including whole-of-government approaches and action to address the social determinants of health and action to strengthen public health services and capacity;
- on additional activities and timelines required to finalize the public health concept for Europe in the context of Health 2020, building on the basis of recent experiences in public health;
- on the best ways to disseminate country experiences in national health policies aligned with Health 2020;
- on strategies and tactics to use in events related to other sectors, subnational levels of government and other stakeholders, including international and national civil society organizations;
- on the ongoing work on Health 2020 indicators;
- on progress relating to the implementation of Health 2020 and on the monitoring of indicators and targets; and
- on the alignment and integration of the work of the Regional Office with Health 2020, and the dissemination of information at Regional Committee sessions and other regional, national and subnational events.

15. The Director, Division of Policy and Governance for Health and Well-being, suggested that the terms remain broad and that priorities be selected each year. The subgroup would report to the SCRC. At the first meeting of the subgroup, the following priority issues of special importance were identified: implementing multisectoral action; implementing national health policies; strengthening public health through the Health 2020 framework; promoting training of multidisciplinary health workers in Health 2020; and streamlining integrated monitoring and reporting on all aspects of Health 2020.

16. Members commented that training should be ensured not only for public health professionals, but also for professors and students of public health, with intercountry exchanges. Furthermore, capacity should be increased by establishing permanent national structures. One representative stated that the subgroup could reflect on challenges and opportunities of implementation of Health 2020 at the national level.

17. The remit of the subgroup should be limited in time. It was clear that the role of the subgroup was not to advise the Regional Office on technical issues, but to report to the SCRC on specific issues that could arise in the implementation of Health 2020 and on the means of mobilizing populations to implement the strategy. The Regional Director recalled that the subgroup is limited to the Twenty-first SCRC and should have clear objectives that would be reported to this body. If further work is needed, the next SCRC should clarify new terms of reference and establish a subgroup. It was decided that, in 2014, the subgroup would concentrate on the topic of engaging other sectors and civil society to promote whole-of-government and society and health-in-all-policies approaches.

18. The terms of reference of the subgroup were approved.

Subgroup on allocation of flexible resources

19. The Chairperson of the subgroup said its remit was to ensure continuous, stable allocation of funding for implementation of the General Programme of Work. Although establishment of a global working group to prepare a new strategic resource allocation method had been postponed, the Twentieth SCRC at its fourth session had decided to establish a subgroup to provide regional input on rules for sharing the budget by level and category. The main tasks of the subgroup are to:

- review current and past trends in income and expenditures of the Regional Office over the past bienniums, its business model, the impact of this model on resource allocation and systemic financial challenges;
- review the problem of "pockets of poverty" at both global and regional levels and identify measures to mediate and/or correct the problem;
- based on its review, identify potential resource allocation principles and mechanisms that could be applied globally;
- review the way in which the results were channelled through the SCRC to Member States or regional groups and then at the global level, which would be difficult;
- review the progress of the global planning process for 2016–2017, focusing on the role of the Regional Committee in the planning/approval cycle; and
- report regularly on these reviews to the SCRC, which would inform Member States, and report recommendations to the SCRC for inclusion in its report to RC64.

20. The terms of reference of the subgroup were approved.

Subgroup on governance

21. The Chairperson of the subgroup said that its terms of reference had been updated following discussions during RC63. They were to:

- consider options for formulating future resolutions, assessing their strategic value, their relations to the Health 2020 strategy and relevant global strategies, their financial and administrative implications and reporting requirements and timelines;
- consider the necessity, scope and appropriate ways and means of closer involvement of Member States in the work of the Regional Office and the SCRC, including through their permanent missions;
- consider options for improving the nominations procedure, including shortlists of nominations for leadership positions, members of expert groups and committees and

officers of governing bodies, for greater transparency and harmonious distribution among subregional groupings;

- consider methods to improve Member States' preparations for Regional Committee sessions and to enhance the participation of non-state actors in the sessions, taking into account the ongoing global discussion; and
- propose to the SCRC any other issues relevant to governance that might arise.

22. The terms of reference of the subgroup were approved.

23. The Chairperson said that much of the work of the subgroups would be conducted by teleconference and various types of Internet communication in order to reduce costs.

24. The Regional Director noted that Latvia had asked to withdraw from the subgroup on allocation of flexible resources, whereas Bulgaria was invited to join the subgroup on implementation of Health 2020 and the Republic of Moldova was to join the subgroup on allocation of flexible resources. The subgroups would meet in January 2014 during the weekend before the 134th session of the Executive Board and in March 2014, the day before the third session of the Twenty-first SCRC.

Provisional agenda of the 64th session of the Regional Committee

25. The Regional Director, introducing documents EUR/RC63/SC(2)/13 and EUR/RC63/SC(2)/14, said that the outcome of the meeting held on the occasion of the 35th anniversary of the Declaration of Alma-Ata in Almaty, Kazakhstan, would be added to item 5(b) depending on whether or not this matter was considered at the World Health Assembly. Primary health care was particularly relevant for the European Region.

26. The SCRC made an initial review of the topics for inclusion in the provisional agenda of RC64 and, in particular, the distribution of topics throughout the week and the time allocated for each. One member commented that there had been too many high-level conferences in 2013, all of which had resulted in declarations and required follow up by the Regional Committee. It was suggested to have a technical briefing on the outcome of the Tallinn conference (Health systems for health and wealth in the context of Health 2020, 17–18 October 2013) rather than a special session. The SCRC felt that there were too many new "strategies" proposed. It was suggested to define clearly and establish a hierarchy among "policy frameworks, "action plans" and "strategies." Members requested more time for the reform discussion, for the elections and nominations, and for the agenda item on investing in children's future.

27. The Regional Director, replying to comments, said that discussions at the Executive Board and the World Health Assembly on the WHO reform would broadly define the time needed for these topics at RC64. She reminded that Tuesday was the ministerial day. The large number of high-level conferences held in 2013 was related to implementation of Health 2020; in 2014 there might perhaps be one high-level conference on public health in the second half of the year. Regarding the hierarchy of policy documents, she proposed that a paper be prepared for the next session of the SCRC; the topic might also be discussed by the subgroup on governance. The presentation of the partnership strategy had already been requested by RC60, but was delayed to align with the WHO reform. The country strategy had been requested by RC62 and should be in line with the global strategy currently being developed and which will be presented to the GPG in March 2014.

28. The Chairperson of the SCRC requested members to reflect on their interest in being focal points for any of the RC64 agenda items before the SCRC meeting in March.

Implementing Health 2020: 2012–2014

29. The Director, Division of Policy and Governance for Health and Well-being, introduced document EUR/RC63/SC(2)/5, which proposed a structure for the progress report to RC64 on implementation of Health 2020.

30. Members commented that the report should mainly reflect implementation, as the infrastructure was now in place. It should include the responses of the Secretariat to country requests for improving intersectoral and health systems governance. It should demonstrate correct appropriation of the strategy by Member States and show how it would affect the organization of the Regional Office and allocation of resources. The report should indicate how progress in implementation was evaluated, such as meeting targets and indicators. One member noted that targets for well-being were missing.

31. One member emphasized the importance of sustainable support to countries for strengthening institutional capacity; particularly, making decision-makers accountable and adopting legally binding instruments. Concrete examples of interventions for raising awareness should be given. Care should be taken to ensure that Health 2020 was recognized as covering not only health promotion but the entire health system, including prevention and care.

32. The Director, Division of Policy and Governance for Health and Well-being, said that most requests for support to implement Health 2020 had come from countries with biennial collaborative agreements with the Regional Office. Indicators and targets for evaluating progress were still being refined and illustrative examples of good practice were being collected, including case studies. With regard to capacity-building, the Regional Office provided tools and experience from elsewhere, whereas countries prepared their own more permanent measures. In response to a query regarding the qualifications of the proposed pool of accredited policy consultants, he said that they would be high-level policy consultants with international profiles, expertise and experience identified by the Regional Office; suggestions from the SCRC would be welcome. About 45 candidates had been identified, who would be trained in all aspects of Health 2020. The operation of the Regional Office had undergone major changes in order to align it with Health 2020. In response to a query regarding networks of small Member States, he said that such a grouping could be beneficial in that they could develop a common platform for implementing Health 2020.

33. The Regional Director added that strategic planning for the next biennium was based closely on Health 2020. She underlined the importance of building the capacity of the public health workforce and of other health professionals in organizational structures and legislative issues to ensure the perennity of government commitment. The Regional Office provided support to those countries that requested it; it would welcome suggestions on ways of reaching other Member States.

34. The Director, Division of Information, Evidence, Research and Innovation, said that a joint meeting of experts on targets and indicators for health and well-being in Health 2020 had been convened by the Regional Office in February 2013. The group had identified life satisfaction as the core indicator of subjective well-being. Much of the information on which the group's conclusions were based was derived from surveys conducted in the EU in 2010. Efforts were being made to update the information and to extend it to non-EU Member States.

35. The Director, Division of Health Systems and Public Health, described two major ongoing initiatives on strengthening in-country capacities: the working group, led by the

Association of Schools of Public Health in the European Region, on the future of the public health workforce (as part of the European Action Plan for Strengthening Public Health Services and Capacity); and the transformation and scaling up of health workers training and education within Health 2020, bringing together health, science and education to better prepare health workers of the future.

A health information strategy for Europe

36. The Director, Division of Information, Evidence, Research and Innovation, introduced the concept note contained in document EUR/RC63/SC(2)/5 describing the proposed strategy. A strategy was necessary in order to meet the extensive reporting requirements of Health 2020 and to harmonize the reporting of health information to multiple agencies. Member States had differential capacity to collect and use health information, and resources for that activity were limited in the current economic situation. Resolution WHA60.27 gave the Regional Office a clear mandate to strengthen health information systems. The strategy document would contain background information including the areas covered and definitions, the purpose and content, the roles of the Regional Office and Member States, institutional, legal, technical and budgetary elements, budgetary conditions and partnerships. The main areas covered would be data collection, analysis and interpretation of data, and evidence-informed policy-making. The SCRC was invited to identify any missing elements and to advise whether the strategy should be more prescriptive, whether it should be accompanied by or followed by a concrete action plan, and whether targets should be set, with monitoring and evaluation. A broad consultation with Member States would be initiated for further input.

37. One member commented that neither a “strategy” nor an “action plan” should be required, as the core mission of the Division of Information, Evidence, Research and Innovation was to provide relevant information on health systems performance to Member States. The document should simply provide information on how the Division fulfilled its role.

38. Members generally considered that the document should be prescriptive rather than descriptive and should include outcomes of health promotion. All definitions should be harmonized with those of Eurostat, the Organisation for Economic Co-operation and Development (OECD) and other international organizations. The goal of the document should be to ensure the necessary information for implementation of Health 2020, with harmonization to make certain that every country collected the required data in a standard format. The need for an integrated concept of health promotion and health care services was also raised. The system should include guidance for turning data into policy and also guidance on the statistical analysis of data. As countries’ requirements for information differed, the system must be inclusive of all the data required. Information on best practice and e-health would also be useful.

39. The Director, Division of Information, Evidence, Research and Innovation, replied that the full document would contain many of the topics raised. Work was under way to harmonize standards, definitions and indicators; 20 indicators had been identified, which could be harmonized. A major challenge was to harmonize reporting in Member States that were not members of the EU.

40. The Regional Director suggested that the type of document should be decided at the next session of the SCRC. Collaboration would be extended to other partners, including the Council of the Commonwealth of Independent States.

Health systems for health and wealth in the context of Health 2020: high-level meeting on the fifth anniversary of the Tallinn Charter

41. The Director, Division of Health Systems and Public Health, introduced document EUR/RC63/SC(2)/12. He said that, in times of financial crisis, Member States required means for simultaneously performing acute crisis management for cutting costs (generic medicines, disinvestment, etc.), while taking the opportunity to pursue transformational changes in health systems, including primary health care and public health strengthening for better NCD and communicable disease prevention and control and universal health coverage.

42. Members generally agreed to the establishment of a core group to help the Division monitor progress in implementing the commitments of the Tallinn Charter and prepare for the final Tallinn report in 2015, although one member suggested that existing focal points could be used instead. One member commented that health systems strengthening was part of WHO reform and wondered whether this still necessitated a resolution.

43. One member proposed that the follow-up to the Tallinn Charter serve as an operational framework for reaching the MDGs and for the post-2015 strategy. He noted that measuring progress in the achievement of universal health coverage still needs to be worked out, but committed full support.

44. The Director, Division of Health Systems and Public Health, said that an operational approach to universal health coverage is being developed for the Region in line with the global action plan. The pillars are health financing, the establishment of baselines and people-centred access to quality health services.

45. The Regional Director said that the topic would be addressed only in a technical briefing at RC64 but would be an agenda item at RC65. As five-year reporting on progress was obligatory; a new resolution would be required within Health 2020 for the way forward on health systems strengthening from 2015 to 2020.

Investing in children: better health throughout the life-course: a European strategy for child and adolescent health and an action plan with a focus on preventing child maltreatment

46. The Director, Division of Noncommunicable Diseases and Life-course, introduced document EUR/RC63/SC(2)/8, which presented a strategy that would renew the previous one for child and adolescent health. He said that there were wide differences in infant mortality rates in the Region and within countries. The period of early childhood was particularly important for later health and a life-course approach was being proposed, which included aspects such as use of tobacco and drugs and obesity. The three proposed strategic areas were more operational than in the previous plan. The strategy included a focus on child maltreatment because surveys and reviews had shown that 18 million children had been abused by their eighteenth birthday. The strategy would therefore be presented jointly with a short action plan on the prevention of child maltreatment. The SCRC was invited to comment on the proposal including linkages to the MDGs and whether it should be included as an agenda item at RC64.

47. Members commented that the proposed interventions and surveys should cover children of all ages and that the strategy should include prevention of suicide, health literacy, social determinants, interdisciplinary services and marginalization leading to mental health problems. It was essential that children and families be empowered to participate in the development and not serve simply as study subjects. Strategic area 1 should analyse the situation and propose actions. Strategic area 2 should include vulnerable groups and the role of the environment in which children developed, such as the well-being of parents. Early detection of problems and

rapid intervention were important. For the prevention of maltreatment, awareness should be raised among all people working with children and adolescents; hospital staff should be trained to recognize all possible signs of maltreatment and not only head trauma. One member asked for clarification about the "return on investment" with regard to health promotion that was mentioned in the strategy.

48. One member commented that the topic was certainly part of the MDGs. The strategy could serve as a model for collaboration among sectors in transferring responsibility for health to those affected. Another member said that designing a strategy for both children and adolescents was difficult, as their problems were not the same. Adolescents should be empowered to look after their health, for example, through peer groups. The whole of society should be involved in formulating policy, including families and social, sports and cultural centres.

49. One member asked for a report on the outcomes of the previous strategy and also requested that goals for the new strategy be formulated.

50. The Director, Division of Noncommunicable Diseases and Life-course, agreed that an intersectoral approach was required. He would propose a number of goals for the strategy at the next session of the SCRC. The issue of maltreatment had been chosen because it was well documented; in order that it does not overshadow the strategy, he proposed that it be presented separately as an illustration of the practical implications of implementation of the strategy. In answer to a query regarding a possible overlap with the work of the United Nations Children's Fund (UNICEF), he said that the United Nations, civil society and other stakeholder activities would be included in the strategy.

51. One member said that if reducing maltreatment was used as an example of improving infant, child and adolescent health, two sets of indicators would be required: one with respect to maltreatment and the other to determine which activities were effective and could be applied to other areas.

Regional vaccine action plan 2014–2020 to address immunization challenges in the WHO European Region

52. The Director, Division of Communicable Diseases, Health Security and Environment, summarized document EUR/RC63/SC(2)/10, with its five strategic objectives.

53. Members commented that current trends in opposition to vaccination in the Region were not conducive to the introduction of new vaccines, as stated under strategic objective 2. One member questioned whether it was the role of WHO to introduce new vaccines or whether it was to provide evidence for decision-makers. The introduction of new vaccines had financial implications for national programmes and cost–benefit analyses should be considered in the decision-making process. A real problem was reaching specific hard to reach groups that were insufficiently covered by vaccination; as the level of immunization in the Region was generally high although some groups did not recognize the value of vaccination. One member pointed out that national vaccination schedules differed from country to country in the Region. The strategy should make clear reference to vulnerable groups like migrants and the steps to be taken by national programmes. One member suggested that cooperation be established with ECDC for planning and reporting. Another said that adverse events following immunization monitoring should be strengthened to follow up any side-effects of vaccines, perhaps with the involvement of general practitioners.

54. More information was needed about the perception of the risk of vaccination in society and also among health professionals. Communication about the benefits of vaccination should

be improved and health professionals, including nurses and midwives, should be better trained in vaccinology. One member commented that referring to vaccination as a "right" may place an obligation on Member States, which could have financial implications.

55. The Director, Division of Communicable Diseases, Health Security and Environment, replied that comments of SCRC will be taken on board in the next version of the document and more emphasis will be given to reaching hard to reach populations and addressing anti-vaccination groups. He emphasized that cost–benefit analyses were conducted for all new vaccines at the global level and the decision-making process for introduction of a new vaccine involves a policy dialogue, taking into account the national context.

Partnerships for health in the European Region

56. The Executive Manager, Strategic Partnerships and Resource Mobilization, summarized document EUR/RC63/SC(2)/7.

57. One member said that greater use should be made of well-established bodies such as the Council of the Commonwealth of Independent States, while changes to the structure of the Eurasian Economic Community should be taken into account. Others stressed that the outline of the document should be fully aligned with the global discussion on partners. It would be important not to pre-empt the discussion of the Executive Board on the role of non-state actors and it therefore needs to be clarified whether this should be presented to RC64 or to RC65. The contribution of each partner to public health should be the main criterion for partnership.

58. The Executive Manager, Strategic Partnerships and Resource Mobilization, said that the objective of the report to RC64 would be to describe existing relationships with partners and NGOs. The Regional Director proposed that work continue on the document and that it be discussed further during the SCRC in March.

A country strategy for the WHO Regional Office for Europe

59. The Executive Manager, Country Relations and Corporate Communications, introduced document EUR/RC63/SC(2)/11, reminding members of the requests made to the Regional Director in resolution EUR/RC62/R7. A global country strategy was being developed, with the involvement of the Regional Office, which was closely aligning the WHO European country strategy to the global one. She asked for comments on the concept note being presented, whether the structure of the proposed strategy was acceptable and how and if it should be taken forward to the Regional Committee even though the global strategy was not yet completed.

60. Members commented that the strategy must be relevant to all 53 Member States and thus adaptable to a variety of health systems. The role of the Regional Office was to give policy advice and technical support to implement Health 2020 and to increase countries' public health capacity. WHO reform foresaw the strengthening of country offices and that aspect should be the subject of a concept note, with mention that such offices could be closed when no longer required. Another important area was the role of collaborating centres. The strengths and weaknesses of country cooperation strategies should also be analysed.

61. Several members commented that the strategy was not advanced enough to be presented to RC64. One said that the experiences of the wide diversity of countries in the Region would be a useful addition to the global strategy. An analysis of creating a country presence, closing country offices when they were no longer required and upgrading and downgrading WHO's physical presence at country level should be undertaken. Countries with WHO offices could interact with those with monitoring systems and use the data to make policy decisions for

implementation of Health 2020. Country cooperation strategies could maintain the priorities of each country for three to six years despite changing governments.

62. The Executive Manager, Country Relations and Corporate Communications, emphasized the importance of the concept of "one WHO" at global, regional and national levels. A WHO country presence helped to maintain the priorities of countries and external stakeholders through changing governments. The country cooperation strategies would be led by WHO representatives and heads of country offices. In the absence of a country office, national counterparts could take the lead. WHO representatives would be trained in establishing country cooperation strategies, which would exist with every country of the Region that requested one by 2016. Criteria for opening and closing country offices would be developed as part of the global country strategy and subsequently incorporated into the European strategy.

63. The Regional Director added that country offices are set up and their mandates defined on the basis of bilateral decisions. Countries without country offices could rely on the Regional Office and the geographically dispersed offices for support. Of the 29 existing country offices in the Region, seven are large and have adequate technical capacity; nevertheless, she would be reluctant to abolish the smaller offices as the countries find them to be useful. They are not particularly expensive to run as they are staffed by national professional officers. The Regional Director further clarified that during the GPG meeting in March the global country strategy would be discussed as part of the agreed WHO reform.

Food and nutrition action plan 2014–2020

64. The Director, Division of Noncommunicable Diseases and Life-course, introducing document EUR/RC63/SC(2)/18, said that the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 had set forth ground-breaking principles, which could form the basis for the food and nutrition action plan. The issue of physical activity would be addressed in a separate plan, to be presented to RC65.

65. Members made several comments on terms used in the document and suggested that health promotion, conflicts of interest and scientific independence be added. They requested a list of concrete objectives, a timetable for implementation of the plan with an intersectoral approach, and targets and indicators. Care should be taken to avoid overlap with the existing action plan on NCDs. One member noted that the Executive Board would be discussing the sensitive topic of the involvement of industry; furthermore, a joint conference with the Food and Agriculture Organization to be held in 2015 would make recommendations regarding industry involvement, which should be considered carefully.

66. The Director, Division of Noncommunicable Diseases and Life-course, thanked members for their constructive comments, which would be incorporated into the document. Targets and indicators had already been set in both the regional and the global action plans on NCDs and in Health 2020 and links would be made with existing programmes. Several consultations were planned for revision of the document in preparation for RC64.

Report of the Secretariat on budget and financial issues

67. The Head, Programme and Resource Management, presented document EUR/RC63/SC(2)/15, with up-to-date figures and trends; highlights included:

- nearly full funding of the Regional Office budget with respect to the World Health Assembly-approved budget levels for 2012–2013; nevertheless, persistent "pockets of poverty" remained for certain programmes;

- 91% achievement of planned regional outcome results for 2012–2013; and
- 90% implementation of available funding for base programmes in 2012–2013.

68. The main changes in the global 2014–2015 budget were due to the new results chain set out in the Twelfth General Programme of Work and in PB 2014–2015, as well as the absence of Health Assembly approval for allocation of 2014–2015 assessed contributions. Instead, overall "budget envelopes" by category and major office had been approved.

69. The Director, Division of Administration and Finance, reported on the outcome of the financing dialogue in November 2013 with regard to funding the remaining 25% of the PB. Coordinated, targeted Organization-wide resource mobilization would be required throughout the 2014–2015 biennium. Although in theory the PB would be fully funded from assessed and flexible contributions, with some specified voluntary contributions, the reality was that the three main donors had indicated that they would continue to earmark funds in the near future; the Bill & Melinda Gates Foundation had stated that it would fund only "trusted" teams. The funding gap for 2014–2015 was US$ 107.2 million; US$ 15.5 million was expected in the core voluntary contributions account, leaving US$ 91.7 million to be raised within one year. There were also large differences in funding for strategic objectives; categories 1 and 2 being the least well funded, while those that depended heavily on corporate funds were categories 4, 5, 9 and 10. Malaria was expected to be better funded than in 2012–2013, while fewer resources were expected for influenza and vaccine-preventable diseases. PB 2016–2017 would be based on an approach devised by the global working group; bottom-up prioritization and costing, with discussion of priorities by the Regional Committee; a strengthened role of category networks; and lessons learnt from PB 2014–2015. Unresolved issues included: how the Regional Office would fill gaps; how Member States could drive bottom-up prioritization; the role of regional committees in planning, budgeting and setting priorities; lack of criteria for allocating corporate and voluntary funds centrally; and what to do about funds that exceeded the approved budget (for example, increase the PB ceiling, reallocate funds or refuse funds).

70. Members commented that overfunding should be addressed case by case. One member suggested a return to the situation in which most of the Organization's resources were from assessed contributions, so that WHO could plan on the basis of analyses of global health trends and retain staff with knowledge and experience. Reducing staff numbers was not a solution. Good relations with partners were nevertheless essential, so that they clearly understood countries' core activities and agreed to fund them. Another commented that assessed contributions had remained at the same level for many years, as inflation indexes did not apply; however, suggestions to raise them would meet with stiff resistance. It would appear that the financing dialogue instead of increasing the level of flexible funds had had the opposite effect.

71. A further problem was that earmarked funds did not contribute to personnel costs and donors had not welcomed the introduction of a post occupancy charge. Members deplored the lack of commitment to provide voluntary contributions from middle-income countries and those with emerging economies. An effort should be made to communicate the added value of WHO as compared with other actors on the global health scene. The activities of geographically dispersed offices should not be additional to those of the Regional Office, but should replace those that the Secretariat was unable to do; therefore, ceilings should not be raised or funds transferred for those activities. Member States with country offices should assume as much financial responsibility for them as possible. One member commented that one role of the subgroup on allocation of flexible resources was to find solutions for filling funding gaps.

72. The Director, Division of Administration and Finance, thanked members for their concrete suggestions and comments, which should also be raised at the global level. The current situation was directly linked to Member States' decision to dispense with partnerships in the PB. Increasing the "trustworthiness" of recipients of funds would be a long-term effort.

73. The Head, Programme and Resource Management, added that many voluntary contributions made in the past had been linked to strong personal relationships, which had instilled confidence that the team was reliable. Interactions between technical staff and donors must be coordinated. Although it would appear that the financing dialogue had had the opposite effect from that intended, the situation was evolving in the right direction.

74. One member proposed that the Director-General be asked to ensure as much flexibility in funding as possible in the transition period of 2014–2015, as the approved PB would not meet the Region's priorities. If bottom-up priority setting was maintained, there would be less need for flexibility. He asked for a report on the number of activities, with their budgets, that had been introduced after approval of the previous approved budget, and the percentage of unforeseen needs that had been accommodated, in order to make provision for new needs in the 2014–2015 PB.

75. The Regional Director said that the GPG had set strategic criteria for allocating the outstanding 20% of assessed contributions, with operational planning based on certain assumptions. That would result in a further US$ 13 million in resources. Multiannual agreements had made it possible to ensure 85% of the PB for the coming two years, with increased transparency on the identity of donors. Fund raising at WHO now had a corporate spirit and did not rely on individual efforts. Recognition of technical teams as credible would depend on global networks of programme managers and technical staff. The principles of fund raising should be presented to Member States at a governing body meeting, focusing on means to avoid voluntary contributions of highly earmarked funds with no salary component. The results of the financing dialogue would become apparent only after several bienniums. The Director-General could make it a success only if the funds raised were distributed regularly through a bottom-up approach, planned by country offices and focal points. Nevertheless, the top-down role of regional committees must be clarified. Overfunding at country level, for example, for geographically dispersed offices, was a problem since the Organization would not be able to influence policy if it could not accept funds, and private organizations could step in.

76. The Head, Programme and Resource Management, said that ceilings had been raised by US$ 39 million during the 2012–2013 biennium, representing 18% of the Regional Office's budget. The funds had been used mainly for emergencies, polio and partnerships.

Membership of WHO bodies and committees

77. The SCRC was informed that the customary nominations or elections for membership of the following WHO bodies and committees would take place at RC64:

- Executive Board: four seats, with one vacancy in group A, one in group B (France, a semi-permanent member, was expected to nominate one candidate) and one in group C;
- Standing Committee of the Regional Committee for Europe: four seats, with one in group A, two in group B and one in group C;
- Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases: one vacancy; and
- Special Programme of Research, Development and Research Training in Human Reproduction: one vacancy.

Other matters

Health in the post-2015 development agenda

78. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, and Special Representative of the Regional Director on Millennium Development Goals and Governance, briefed members on progress made in ensuring the place of health in the development agenda after 2015, the target date for achievement of the MDGs. In June 2012, the United Nations Secretary-General had convened a high-level panel of "eminent persons" from civil society, the private sector and governments, which had prepared a report, *A new global partnership: eradicate poverty and transform economies through sustainable development*, that covered health within "inclusive social development". Subsequently, the United Nations Development Group had led a "global conversation" on the post-2015 agenda, which had also included health as one of the thematic topics. Between September 2012 and March 2013, WHO and UNICEF had led a broad consultation on health throughout the world. The outcome of the report, *Health in the post-2015 agenda: report of the global thematic consultation on health*, had been presented to the Sixty-sixth World Health Assembly. In parallel, the United Nations Secretary-General had established a "sustainable development solutions network" designed to convene academics throughout the world to seek practical solutions to sustainable development. The report, *An action agenda for sustainable development*, had been published in June 2013. Lastly, countries attending the United Nations conference on sustainable development in Rio de Janeiro, Brazil, in June 2012 had agreed to establish an open working group, comprising 30 members nominated from the five United Nations regional groups, to prepare a set of goals for sustainable development, to be presented to the Sixty-ninth United Nations General Assembly in September 2014. In order to coordinate the various initiatives, the Secretary-General had nominated a special adviser, who was an ex officio member of the high-level panel. Her work with regard to health was supported directly by WHO.

79. In September 2013, the President of the United Nations General Assembly had hosted a special event to review progress made in meeting the MDGs and to discuss the way forward. World leaders had agreed to intensify action against poverty, hunger and disease and had called for a summit in September 2015 to adopt goals for activities after 2015. The United Nations Secretary-General had presented a report, *A life of dignity for all*, outlining his vision of the action needed to meet the MDGs and for the post-2015 sustainable development agenda. The goals should be universal, sustainable, achieve inclusive economic transformation, achieve peace and governance with a human rights-based approach, be based on a global partnership and ensure the presence of the right institutions and tools. The participants in the special event had noted the uneven achievement of the MDGs, especially with regard to reproductive health, HIV/AIDS, multidrug resistance and NCDs, including mental health.

80. In the European Region a United Nations interagency report was being prepared on post-2015; progress achieved; and a document on health was provided by WHO. A regional consultation on the post-2015 agenda had been held in Turkey, which had been attended by representatives of 40 Member States, NGOs and academia. The priorities identified were similar to those at global level, except that the EU had placed greater emphasis on universal health coverage. The participants had also recognized the importance of Health 2020 as the framework for health in the post-2015 development agenda.

81. In response to a query regarding the place of health in the post-2015 agenda, the Deputy Director, Division of Communicable Diseases, Health Security and Environment, and Special Representative of the Regional Director on Millennium Development Goals and Governance, said that health had a prominent role in current MDGs, with three of the eight goals related to health, and this prominent role should be maintained in the post-2015 era, with at least one goal

specific to health. The argument that health is essential to development and to the attainment of most of the other goals should be communicated more effectively.

82. The Director, Division of Information, Evidence, Research and Innovation, recalled that civil registration of births, adoptions, marriages, divorces and deaths was one of the targets of Member States and partners. The United Nations Economic and Social Commission for Asia and the Pacific would be holding a ministerial summit on that topic in November 2014, where the importance of registration should be raised.

Documents not discussed

83. The Regional Director noted that documents EUR/RC63/SC(2)/16, WHO reform: structure and issues to be presented to RC64, and EUR/RC63/SC(2)/17, on items for future Regional Committee meetings, had not been discussed.

National technical focal points

84. The Executive Manager, Country Relations and Corporate Communications, presented a new template listing the areas for which national technical focal points are required, in line with PB 2014–2015. The template also contained a list of responsibilities of these focal points. She asked for approval of the template by the SCRC in order that nominations could be requested from Member States.

85. Members commented that the proposed number of technical focal points – 38 for each of the 53 Member States – would appear to be unmanageable. Possible solutions would be to reduce the number of national technical focal points or to merge some programme areas. Governments must be responsible for nominating focal points. One member suggested that a protected website be set up so that focal points could communicate with each other. Another reported that in her country one person in the Ministry of Health was responsible for the work of all focal points in the country, with meetings every six months to report on progress.

86. The Executive Manager, Country Relations and Corporate Communications, replied that the list of national counterparts had been placed on the public website and the intention was to provide them with the names of all the focal points in their countries. The names and contact details of the focal points would be placed on a protected site and this would allow them to communicate with each other. The country team and technical divisions in the Regional Office would maintain the lists of focal points. The number of national focal points proposed reflected the areas identified by the technical divisions that required intensive cooperation with Member States. Programme managers had resisted the merging of responsibilities, which would have reduced the number of national focal points.

87. The Regional Director replied that the intention was to ensure better liaison with countries through the national counterparts and greater integration of work at the national level. A uniform number of focal points would help to ensure consistency across the Region. The Regional Director agreed that the lists may need further review and suggested that the template might be simplified through further streamlining of the areas requiring national focal points, particularly for countries without country offices.

Reporting on resolutions

88. One member noted that two resolutions of the Regional Committee required reports to RC64: resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region and resolution EUR/RC54/R3 on the European environment and health process. Resolution

EUR/RC55/R8 on strengthening health systems could be "sunset" as it had been superseded by EUR/RC62/R5 on the European action plan for strengthening public health capacities and services.

Nominations for Vice-President of the Sixty-seventh World Health Assembly

89. The Regional Director informed the members of the SCRC on the elective posts available for the European Region at the Sixty-seventh World Health Assembly and called for proposals for nominations for Vice-President of the Sixty-seventh World Health Assembly and for Chairperson for Committee A.

Closure of the session

90. It was announced that the third session of the Twenty-first SCRC would take place in Copenhagen on 19–20 March 2014. After the usual exchange of courtesies, the second session of the Twenty-first SCRC was closed.

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