



**Report of the 65th session
of the WHO Regional Committee for Europe**

Vilnius, Lithuania, 14–17 September 2015

Keywords

REGIONAL HEALTH PLANNING
HEALTH POLICY
HEALTH PRIORITIES
RESOLUTIONS AND DECISIONS
WORLD HEALTH ORGANIZATION
EUROPE

EUR/RC65/REP

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Abbreviations

EHP	European Environment and Health Process
EU	European Union
FCTC	WHO Framework Convention on Tobacco Control
IHR	International Health Regulations
M/XDR-TB	multidrug-/extensively drug-resistant tuberculosis
MDGs	Millennium Development Goals
NCDs	noncommunicable diseases
NGOs	nongovernmental organizations
PB	programme budget
polio	poliomyelitis
SCRC	Standing Committee of the Regional Committee
SEEHN	South-eastern Europe Health Network
STIs	sexually transmitted infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund

Opening of the session

The 65th session of the WHO Regional Committee for Europe was held at LITEXPO in Vilnius, Lithuania, from 14 to 17 September 2015. Representatives of 53 countries of the WHO European Region took part. Also present were representatives of the Food and Agriculture Organization, the International Atomic Energy Agency, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund, the United Nations Development Programme, the United Nations Population Fund (UNFPA), the European Union (EU) and nongovernmental organizations (NGOs).

The first working meeting was opened by Dr Raymond Busuttil (Malta), outgoing Executive President.

Election of officers

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

Ms Rimantė Šalaševičiūtė (Lithuania)	President
Ms Taru Koivisto (Finland)	Executive President
Professor Benoît Vallet (France)	Deputy Executive President
Dr Mario Miklosi (Slovakia)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC65/2 Rev.2 and EUR/RC65/3 Rev.2)

The Regional Committee adopted the agenda and programme of work.

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 65th session addressing matters within the competence of the EU.

Address by the President of the Republic of Lithuania

Participants were welcomed by Mrs Dalia Grybauskaitė, President of the Republic of Lithuania, who said that the new challenges facing Europe could be overcome by cooperation directed towards a single target – a healthy human being. The top issues on the session's agenda were directly related to the quality of life and society's progress. WHO's encouragement to people to seek a healthy lifestyle, such as through the Physical activity strategy for the WHO European Region 2016–2025, and its call for politicians to adapt health care systems to the needs of society were very much to be welcomed.

Address by Her Royal Highness The Crown Princess of Denmark

Her Royal Highness Crown Princess Mary of Denmark, Patron of the WHO Regional Office for Europe, said that health and development were inextricably linked: better health was both an outcome of, and a prerequisite for, reducing poverty. How equitably health was distributed was a measure of progress across all aspects of development. Health was a benchmark for sustainable development. A paradigm shift was taking place towards a world where people created and maintained good health, rather than simply preventing and treating disease. The Regional Committee provided an ideal platform for looking to the future and new ways of working, notably intersectoral action for health, the main theme of the current session, which was a political choice and a shared responsibility.

She noted that over the previous 50 years, vaccines had saved millions of lives and had significantly reduced the disease burden on health systems and society. However, despite those positive developments, gaps in immunization continued to persist. The recent confirmation of cases of poliomyelitis (polio) in Ukraine and its reappearance in Tajikistan in 2010, as well as endemic transmission of measles, underlined how essential it was to maintain high vaccination coverage, high population immunity and high-quality surveillance. Through sustained political commitment and implementation of the required strategies by all countries, it would be possible to eliminate measles and rubella in the European Region.

The health of women and girls was also at the centre of sustainable development. Despite significant progress, gender inequalities persisted, however, and much more had to be done to address the global epidemic of domestic violence against women. The 4th Global Conference of Women Deliver, of which she was a patron, would be held in Copenhagen, Denmark, in May 2016. As one of the first large international conferences after the adoption of the 2030 Agenda for Sustainable Development, the event would provide an ideal platform to accelerate implementation of their common agenda on women's health.

Address by the WHO Regional Director for Europe

(EUR/RC65/5 Rev.1, EUR/RC65/R1, EUR/RC65/Inf.Doc./2)

The Regional Director said that the Regional Office continued to work towards "Better health for Europe: more equitable and sustainable". The previous year had seen numerous challenges, including the Ebola virus disease outbreak, deaths of children from measles and diphtheria, cases of polio in the European Region and a large influx of refugees and migrants. The Region had made good progress on key Health 2020 indicators and the differences among countries in life expectancy and health outcomes were shrinking, but there was still an 11-year gap between the countries with the highest and lowest life expectancy. The Region had also reduced premature mortality from cardiovascular diseases and made headway in reducing health risk behaviours, but people in Europe still smoked and drank more than anywhere else in the world and were among the most obese. That showed that Health 2020 worked, but there were still many challenges ahead.

The proportion of countries with national health policies aligned with Health 2020 had almost doubled from 2010 to 2013, and more decision-makers were formulating coherent and interconnected government policies with a strong intersectoral component. Health 2020 supported sound political decision-making for health and its key strategic directions remained

more relevant than ever before. Current investment in public health was not sufficient, although the economic case for investment in health was strong. Such investment not only improved health outcomes but also generated economic, social and environmental benefits. The health sector must highlight those benefits and call on governments to invest in health. It must also work in partnership with other sectors, especially those responsible for social and fiscal policies.

Health was also a precondition for development and poverty alleviation and an indicator and outcome of progress towards a sustainable society. World leaders would soon gather at the United Nations to adopt the post-2015 agenda for sustainable development, which aimed to end poverty by 2030. Among the 17 sustainable development goals, the one for health was central and was fully aligned with Health 2020. However, all the sustainable development goals would influence health because they all addressed determinants of health. Focusing solely on the health goal would be a missed opportunity to put into practice the whole-of-government and whole-of-society approaches to which Member States had subscribed through Health 2020. The Regional Office would support Member States in translating the new development agenda into national development plans with health at their core.

Intersectoral action, the major theme of the current session, was essential for policy coherence and provided the basis for accountability in health. The European Region had much experience with intersectoral action on, for example, environment and health through a well-structured political process, establishing links to national implementation. Intersectoral work on social determinants of health and on foreign policy and development cooperation had also been initiated. She looked forward to learning more about Member States' experience during the panel discussion on promoting intersectoral and interagency action for health and well-being.

In order to help foster the change in mindset and build the capacities needed for health ministries to take leadership in intersectoral processes, the Regional Office was supporting the establishment of intersectoral committees in countries and had developed sectoral and thematic policy briefs. Large-scale consultative processes would help to promote intersectoral work across the European Region through dialogue, sharing of experiences and common actions among countries, institutions and sectors. Those processes should focus initially on the education, finance and social sectors in order to promote attention to social determinants of health and health literacy.

The Regional Office was also working intensively on the development and implementation of national health policies aligned with Health 2020. Networks had become a more powerful platform for sharing practical experience in that regard, as demonstrated by the successes achieved by the South-eastern Europe Health Network (SEEHN) and the Small Countries Initiative. The Healthy Cities and Regions for Health networks helped to support subnational implementation of Health 2020 and strengthen local leadership for intersectoral action.

The European Region had made much progress in combating some communicable diseases. It was poised to eliminate malaria by the end of 2015, with no locally acquired cases so far in 2015, but continued vigilance would be essential to prevent reintroduction. There had been significant progress in the fight against tuberculosis: the incidence of tuberculosis had declined faster in Europe than in any other WHO region, but more effort was needed to end the tuberculosis epidemic by 2035 and to eliminate the disease by 2050. The proposed

tuberculosis action plan for 2016–2020 was expected to prevent or cure millions of cases and save over 3 million lives.

Less progress had been made in the area of HIV/AIDS, with a staggering 80% rise in new cases of HIV infection from 2004 to 2014, an alarming situation that called for concerted action and the implementation of evidence-based policies in order to put the European Region on course to end the epidemic by 2030. Viral hepatitis remained unaddressed, leading to some 400 deaths a day. Although treatments were available for hepatitis B and C, they remained unaffordable for most countries. The Region therefore needed to take a comprehensive approach, using available tools and focusing on prevention.

Vaccine-preventable diseases continued to burden the European Region. The return of polio had been a stark reminder of the need to maintain high immunization coverage and surveillance. Member States had committed themselves to eliminating measles and rubella by 2015, and while many were on track to do so, lack of political commitment in some countries was hindering achievement of the goal in the Region as a whole. The Regional Director urged Member States to honour the commitment they had made under the European Vaccine Action Plan 2015–2020 to eliminate measles and rubella.

Significant advances were observed in implementing the action plan for the prevention and control of noncommunicable diseases (NCDs) and reducing avoidable deaths from such diseases. Decreases in behavioural risk factors, including alcohol and tobacco use, had contributed to those reductions, but Europe remained the region with the highest overall rate of adult smoking, and greater effort was needed to eliminate illicit trade in tobacco products. She congratulated the countries that had become parties to the illicit trade protocol to the WHO Framework Convention on Tobacco Control (WHO FCTC) and urged others to follow suit. The Regional Committee would discuss the proposed roadmap for tobacco control, setting an ambitious goal of full implementation of the WHO FCTC, and the physical activity strategy, which complemented the European Food and Nutrition Action Plan 2015–2020, adopted the previous year. Noting that the Regional Office had developed a package of 15 essential interventions to tackle NCDs, she also called on Member States to increase attention to the management of NCDs and re-examine their programmes for early detection and screening. Some Member States had raised concerns about neglect and abuse of adults with intellectual disabilities who lived in institutions, and she had initiated a review on the issue and would propose a way forward.

Progress was being made in improving women's health but wide inequities between and within countries remained. Effective perinatal care had reduced maternal deaths, and it was now time to focus on pre-existing medical conditions, such as diabetes and cardiovascular disease, that were exacerbated by pregnancy. More also needed to be done with regard to sexual and reproductive health and rights. The WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020, to be held in Minsk, Belarus, on 21–22 October 2015, would be the first event linking the sustainable development goals with Health 2020 and focusing on maternal and child health and reproductive health and rights.

The European Region's work to strengthen health systems and public health capacity was guided by the Tallinn Charter: Health Systems for Health and Wealth and aimed to improve health outcomes, ensuring financial protection, responsiveness and efficiency. Transforming health services to match 21st-century needs would be the major strategic direction of the new vision for health systems strengthening during the coming five years. Coordinated, integrated

health-service delivery and people-centred care were the way forward. The Regional Office was preparing an action-oriented framework for that purpose to be presented to the 66th session of the Regional Committee in 2016. It was also accelerating support to countries for the achievement of universal health coverage.

Collective investments in health information, evidence and research as the basis for policy-making were paying off. Under the European Health Information Initiative, work had continued on the development of information on health and well-being, with a focus on indicators. A new health information web portal on the Regional Office for Europe's website was widely used by policy-makers and would soon allow simultaneous analysis of indicators across all of the Regional Office's databases. Several health information networks were enhancing countries' capacity to compile and use evidence for policy-making.

The Regional Director and the Regional Office remained fully committed to WHO reform and, in particular, to its work in outbreaks and emergencies with health and humanitarian consequences, in the wake of the Ebola virus disease outbreak. The Regional Office was taking an integrated, multisectoral, all-hazards approach to preparedness for both humanitarian and public health emergencies. Risk communication was an integral element of that approach. The Regional Office had also revised its emergency procedures and had launched a new initiative to improve laboratory capacity to detect and respond to diseases and outbreaks, which was an important component of core capacity under the International Health Regulations (IHR) (2005).¹

With the increasing influx of refugees and migrants into many European countries, the issue of migration and health was a growing concern. Countries should implement public health policies that gave migrants access to a broad range of health services, including those for prevention and care, which would also benefit their citizens. The common association of migration with importation of infectious diseases was not evidence-based and a statement to that effect had been posted on the Regional Office for Europe's website. The Regional Office was actively supporting countries in developing policies on migrant health.

WHO was leading the health cluster response to the conflict in the Syrian Arab Republic and the humanitarian crisis in Ukraine, assessing health needs and facilitating delivery of humanitarian assistance to populations in need.

The Regional Office continued to work with Member States, tailoring support to their priorities, needs and circumstances. Its efforts had been enhanced by the establishment of several new geographically dispersed offices in 2015 and by a network of national counterparts, which had improved the flow of knowledge and information. Country offices had been empowered through the delegation of more authority and responsibility. Partnerships with civil society organizations had also been strengthened. The European Region continued on a solid financial footing, with more flexible funds distributed strategically. The regional implementation plan for the programme budget 2016–2017 would be the main instrument of corporate accountability in the Region. The Regional Office would continue to work with Member States and partners to achieve the goal of better health for all, with equity and sustainability.

¹ International Health Regulations (2005). Second edition. Geneva: World Health Organization; 2008 (<http://www.who.int/ihr/publications/9789241596664/en/>, accessed 16 November 2015).

In the ensuing discussion, representatives commended the report of the Regional Director and her leadership, as well as the work undertaken to address regional health priorities and implement Health 2020, the European policy framework for health and well-being. Broad support was also expressed for the choice of intersectoral and interagency action on health as a main theme of the current session.

A representative speaking on behalf of the EU and its member countries welcomed the final report on implementation of the Tallinn Charter and emphasized the need to subscribe fully to the new sustainable development goals, with specific reference to their 13 health-related targets, and to pursue cooperation among all stakeholders in responding to health issues resulting from the mass influx of migrants and refugees into Europe. He highlighted the importance of diet and physical activity in the prevention and control of NCDs. Sustained action was needed to curb the HIV/AIDS epidemic and eliminate tuberculosis and hepatitis. There should be increased commitment to immunization, including through implementation of the European Vaccine Action Plan 2015–2020. The WHO Global Action Plan on Antimicrobial Resistance should be implemented through a focus on the “One Health” approach. The performance of WHO’s response structure in health emergencies such as the Ebola virus disease outbreak had underscored the need to improve global health security through investment in preparedness, planning and ensuring linkages with health systems strengthening and through accelerated implementation of the IHR (2005) and country ownership in that regard.

A representative speaking on behalf of the SEEHN and its member countries welcomed the final report and commended the success of the Regional Office in delivering an ambitious programme of work related to Health 2020, the policy framework for the European Region, and beyond. One issue identified as being of great importance was health information as a means to strengthen accountability of policy-makers by addressing the complexities of population health within the constraints of available resources. The establishment of the European Health Information Initiative was held in high regard and the SEEHN recognized its added value as a tool for better intersectoral coordination within the stronger governance and leadership for health by ministries of health. The importance of effective communication and governance in improving population health was also highlighted.

Widely endorsing those comments, numerous speakers provided examples of actions taken and progress achieved in their countries as a result of the exemplary support by WHO for implementation of the policies described in the Regional Director’s report. Emphasis was also placed on the need for commitment to a common vision and strategy for enabling adaptation in the face of financial and economic challenges to new global situations created by, inter alia, climate change and migration; the positive impact of the European Health Information Initiative, the Evidence-informed Policy Network and collaboration with the WHO Global Health Observatory data repository; the importance of people-centred health care; and the invaluable assistance received through the Small Countries Initiative.

Additional points for consideration raised by individual speakers concerned the need to increase private sector involvement in health actions; to ensure that WHO collaborating centres were proposed by Member States and that all important decisions entailing obligations for WHO and its Member States were taken by governing bodies; and to clarify procedures and set deadlines for the nomination of candidates for intergovernmental processes on the basis of transparency and equality with a view to securing the best possible experts. The challenge of ensuring an effective, coherent and integrated approach to attainment of the new

sustainable development goals and the development of a shared approach to funding the vital work of the WHO Consultative Expert Working Group on Research and Development: Financing and Coordination were also raised as concerns.

On behalf of his country, the representative of Hungary extended an invitation to host the 67th session of the Regional Committee in 2017, which had been sent to the Regional Director in writing, following a decree by the Government of Hungary.

The United Nations Secretary-General's Special Envoy for HIV/AIDS in Eastern Europe and Central Asia commended the steadfast commitment of the Regional Director and WHO staff to the prevention and control of HIV/AIDS, tuberculosis, multidrug-resistant tuberculosis and viral hepatitis, particularly in eastern Ukraine, where the highest-ever number of new HIV/AIDS cases were being reported and where undiagnosed infections and the poorest global access to prevention and treatment, in particular for vulnerable groups, posed major difficulties. Given the tools available as a result of scientific advances, the necessary political commitment and financial resources must be directed towards measures for ending the HIV/AIDS epidemic.

Echoing those remarks, the Director, UNAIDS Regional Support Team for Eastern Europe and Central Asia, drew attention to the universal consensus and ambition of the new HIV/AIDS target that would be embodied in the sustainable development goals; namely, that of ending the disease by 2030. All Member States and partners must join the efforts of UNAIDS to bring the epidemic in eastern Europe and central Asia under control. In this context, he paid tribute to Lithuania for removing its restrictions on the entry and stay of persons living with HIV/AIDS, in accordance with the commitment of all States Members of the United Nations to take that step by the end of 2015. UNAIDS and its 11 cosponsors, including WHO, remained unequivocally committed to realizing the goal of ending the HIV/AIDS epidemic across the European Region.

The Regional Director, UNFPA Regional Office for Eastern Europe and Central Asia, acknowledged the successful collaboration with the Regional Office for Europe in strengthening health systems response to gender-based violence, scaling up comprehensive sexuality education and enhancing evidence-based public health policy development. In addition to the commitment to continuing collaboration on key priorities for the future, urgent action was required to optimize the capacity of European health sectors to cope with the implications of the rising numbers of migrants and refugees, including those relating to the emergency reproductive health needs of displaced women. Close collaboration among European stakeholders was also necessary to address matters such as the impact of internal migration, population ageing and access by youth to vital health education and services.

The Regional Director, thanking Member States for their support, said that the Regional Office would appreciate their guidance concerning its envisaged role in the comprehensive response needed to address the new humanitarian crisis arising in the European Region as a result of the large-scale influxes of refugees and migrants. A meeting could be convened before the end of 2015 to discuss the health impact of the migration crisis from two perspectives: protecting the health of migrants and refugees arriving in the European Region, and protecting the health of local populations.

Responding to the points raised for consideration, the Regional Director noted that, in the context of its regular discussions on improving WHO's emergency preparedness and response

capacity, the Global Policy Group had this as a regular issue on its agenda to advise the Director-General on the emergency reform; she was also convinced that a discussion on the implementation of the new post-2015 sustainable development goals would take place in the Global Policy Group following the adoption of the 2030 Agenda for Sustainable Development. A discussion was already envisaged after the Regional Committee to further improve the coherence within the Regional Office in relation to the sustainable development goals and Health 2020; she also reiterated that these two were closely aligned. Experience gained from the implementation of Health 2020, particularly through whole-of-government, whole-of-society and health-in-all-policies efforts to address the determinants of health, would provide lessons learned and experience gained that could be useful for the implementation of the sustainable development goals. Efforts to increase private funding of health systems must be accompanied by strong regulation and stewardship, in particular to protect vulnerable populations and to prevent potential increases in health inequities. With regard to the selection of national experts, the Regional Office worked in direct cooperation with national counterparts and national technical focal points, who were nominated by their respective governments. For intergovernmental processes established at the global level, however, there was no clear system in place for the nomination of experts, which often occurred at short notice. The issue would therefore be taken up with the Standing Committee of the Regional Committee for Europe (SCRC). Procedures for the nomination of WHO collaborating centres were clear and had always included consultation with governments. Work was also under way to discuss and agree on the conditions under which the outcome documents from ministerial conferences would be brought forward to the governing bodies for endorsement. That issue had also been discussed by the Twenty-second SCRC, and the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020 in Minsk, Belarus, in October 2015 would be a pilot in that regard. She concurred with the need for a shared approach to funding the work of the WHO Consultative Expert Working Group and underscored the efforts to address the needs of vulnerable groups living with HIV/AIDS and those of refugees and migrants. Lastly, she thanked the representative of Hungary for the offer to host the 67th session of the Regional Committee.

The Committee adopted resolution EUR/RC65/R1.

Partnerships for health in the WHO European Region

The Regional Director underscored the importance of partnerships for better health for Europe and in attaining the new sustainable development goals, where health played a central role. The 2030 Agenda for Sustainable Development should be used to facilitate the transition of Member States from the support provided by international financing mechanisms and development aid to domestic funding. Countries could raise funds for health by tapping into new sources and improving cost efficiency. Investment in health must be more strategic and the health gains made through efforts to attain the Millennium Development Goals (MDGs) must be sustained. The Regional Office was committed to supporting the efforts of Member States to implement the 2030 Agenda; Health 2020 constituted a strong foundation in that regard by providing a framework for action across governments, sectors and society.

The Executive Director, the Global Fund to Fight AIDS, Tuberculosis and Malaria, said that the Global Fund was a partnership mechanism designed and governed by countries. It remained firmly engaged in the European Region. HIV and multi- and extensively-drug

resistant tuberculosis (M/XDR-TB) remained a high burden in the Region, and the Global Fund provided a considerable proportion of antiretroviral therapy and M/XDR-TB treatment. The transition to domestic funding required long-term planning and programmatic sustainability. Innovative approaches were being considered to ensure smooth transitions, including through the engagement of civil society and professional health institutions, as well as by strengthening partnerships with ministries of health.

The Deputy Chief Executive Officer, GAVI Alliance, said that efforts to attain the MDGs had resulted in considerable progress in the reduction of child mortality, including through the broadening of immunization coverage. Challenges with regard to vaccine-preventable diseases in the European Region would, however, deepen as countries opened their doors to the influx of refugees and migrants. Political commitment and enhanced investment in advocacy to overcome vaccine hesitancy were therefore crucial. The GAVI Alliance placed a high premium on sustainability and intergenerational equity, with country ownership at the centre of its support model. In the coming five years, five countries in the WHO European Region were due to transition from GAVI support; their governments must assume responsibility for sustaining immunization programmes. GAVI would take measures to assist those countries after the transition. The European Vaccine Action Plan 2015–2020 could have a positive impact, and signalled an unprecedented level of political commitment that could serve as an example to the rest of the world.

During a panel discussion moderated by Professor Martin McKee, the Senior Adviser of the National Board of Health and Welfare of Sweden emphasized the importance of an intersectoral approach to attain the new sustainable development goals: although there was only one goal specifically on health, many of the others related to the social determinants of health. Health 2020 had a key role to play in that regard. The Minister of Health, Republic of Moldova, and the General Director, National Centre for Disease Control and Public Health of Georgia, described their countries' experiences in preparing for the transition from donor funding to sustainability. In the Republic of Moldova, the support received from the Global Fund had been a useful tool for the Ministry of Health in its negotiations to secure budget allocations from the Ministry of Finance. Over time, the return on that investment in terms of improved population health had meant that sustainable domestic funding for tuberculosis and HIV treatment programmes would remain a priority. The Government of Georgia had recently doubled its health budget and a medium-term financial framework had been concluded with the Ministry of Finance to ensure a sustainable transition. It was hoped that after financial contributions from donors such as the Global Fund and the GAVI Alliance had ended, the technical assistance coordinated by WHO would continue.

Considering the question of whether budget allocations could be more easily obtained from ministries of finance by emphasizing the impact of health investment on the attainment of all the sustainable development goals, panellists agreed on the importance of a cross-sectoral approach. Health 2020 could be a useful tool in that regard. Adequate data systems were needed to gather evidence on the impact of health interventions, which could scale up investment in health, and data should be presented in such a way as to attract the attention of non-statisticians. Equity was a complex issue, since certain health issues, in particular HIV and tuberculosis, were associated with social stigma.

A representative of the International Federation of Medical Students' Associations said that health was a political choice, which required sustainable investment and resilient health

systems. He asked what could be done to engage civil society and empower the public to develop the resilience needed to face unpredictable health challenges in the future.

Panellists emphasized the need to address not only the supply side of investment in health, but also the demand side by empowering communities to hold health systems accountable. In so doing, health-seeking behaviour would become stronger and expectations would increase. A patient-centred approach could be achieved by promoting health in all policies, strengthening partnerships and communication to ensure a results-based approach, believing in people and not returning to a culture of victim blame. Social audits must be conducted and their results taken into account.

WHO reform: progress and implications for the European Region

(EUR/RC65/15)

The Regional Director presented an overview of progress on WHO reform and its implications for the European Region in five key areas: strategic budget space allocation; the framework of engagement with non-State actors; reform implementation, with emphasis on governance reform; strengthening of the WHO accountability framework; and global staff mobility as part of human resources reform. With regard to strategic budget space allocation, she recalled that, after long and difficult negotiations, the Executive Board at its 137th session had reached consensus with regard to budget segment 1, technical cooperation at country level, and a broad agreement had been reached during the Board's 136th session on general principles to be applied to segments 2, 3 and 4. As a result, the Regional Office's share of segment 1 would increase gradually from 5% to 6.4% over the coming three bienniums.

Resolution WHA68.9 outlined the next steps on the difficult issue of WHO engagement with non-State actors, which had been discussed repeatedly – and inconclusively – over four years. Good progress had been made during the open-ended intergovernmental meeting in July 2015 and informal meetings were currently taking place with a view to reaching agreement on various matters. The next intergovernmental meeting was scheduled for 7–10 December 2015. It was hoped that final agreement could be reached during the Sixty-ninth World Health Assembly in 2016. The Regional Office partnership strategy would be reviewed after agreement was reached at the global level.

Governance reform remained a priority for the European Region and several regional initiatives had helped to inform the reform process at the global level. In relation to accountability and compliance, she emphasized that the Regional Office had always had zero tolerance for non-compliance and had a robust internal control framework. Regarding staff mobility, the Ebola virus disease outbreak had highlighted the difficulties of managing rapid deployment of staff. While it was important to strengthen capacity to react quickly to emergencies and implement the new mobility policy, it was also necessary to maintain continuity and preserve technical expertise in key areas in order to remain relevant to the needs of the European countries. It was therefore important to further develop the governance structure and implementation plan, and to pilot the new policy.

A member of the Standing Committee recalled that the Twenty-second SCRC had set up a specific subgroup on governance, which had largely continued the work of the subgroup set up during the Twenty-first SCRC in relation to five topics. First, it had instructed the Secretariat to request Member States to provide a letter of intent when nominating candidates

for the Executive Board or the Standing Committee. It had also further reviewed the tool developed by the Twenty-first SCRC for the evaluation of nominations. Secondly, it had proposed amendments to the Rules of Procedure of the Regional Committee for Europe for nomination of the Regional Director following the recommendations of the 64th session of the Regional Committee in 2014. Thirdly, it had decided that a comprehensive review of the involvement of NGOs in future Regional Committee sessions should await the outcome of global negotiations on the framework of engagement with non-State actors. Fourthly, it had begun work on a procedure for developing conference declarations and outcome documents. It was hoped that the procedure could be submitted for approval by the Regional Committee in 2016. Lastly, the subgroup had considered how to structure WHO action plans, strategies and other types of policy papers. As that issue concerned the Organization as a whole, it was hoped that it would also be taken up by the working group on global governance reform.

In the ensuing discussion, a representative speaking on behalf of the EU and its member countries affirmed that the European Region's progress on governance reform could serve as an example to WHO as a whole, and welcomed the Regional Office's approach to safeguard the continuity of its work as result of its participation in the global mobility scheme. Other representatives echoed those sentiments, emphasizing that staff mobility must not lead to a loss in core competencies and that it must be well managed and perceived as fair by the staff affected. The need for greater investment in human resources at WHO headquarters was highlighted, as was the need for adequate financial support from Member States in order to enable WHO to perform properly. With regard to governance reform, the challenges presented by lengthy governing body agendas were acknowledged, and it was suggested that a code of conduct for Member States might help to alleviate the problem. Greater participation by Member States in the open sessions of the SCRC could also enhance the effectiveness of deliberations.

Representatives welcomed the Regional Office's efforts to increase alignment, transparency and accountability across the three levels of WHO. The regional plan for implementation of the 2016–2017 programme budget – which aligned regional priorities with those agreed at the global level – was cited as a good example of those efforts. The Regional Office's attention to the health implications of the current refugee crisis was also applauded.

One representative recalled the importance of the Secretariat's feasibility report on the framework of engagement for non-State actors, including on the impact of the framework on the work of the Regional Office and the country offices.

The Assistant Director-General, General Management, agreed that mobility must be well managed and any loss of core competency avoided. To that end, the mobility scheme would be introduced gradually and on a voluntary basis in the first three years, and would be adjusted on the basis of lessons learned during the implementation process. He also added that, thanks to the 8% increase in programme budget 2016–2017, it would be possible to strengthen the human resources departments in the regions as well as at headquarters.

Accountability and compliance

(EUR/RC65/15)

The Assistant Director-General, General Management, said that accountability and compliance had long been a key priority for the whole Organization, and it was fully

committed to zero tolerance of non-compliance. Recent initiatives in that field included the introduction of administrative and programmatic reviews of country offices. The programme budget was a core tool for ensuring accountability, and efforts were being made to improve the links between it and assessment of the performance of individual staff. The Assistant Director-General further explained that the Organization had three lines of defence for ensuring compliance: key staff such as managers of budget centres; headquarters and regional administrations, including compliance units; and independent audit and oversight mechanisms, including the Independent Expert Oversight Advisory Committee. Reporting and monitoring tools included a WHO management dashboard. A roadmap on compliance would be developed within 12 months, focusing on five areas: direct financial contributions, agreements for performance of work, donor reporting, performance management, and fixed assets management. Updated information on measures to strengthen accountability and compliance would be submitted to the Programme, Budget and Administration Committee of the Executive Board in January 2016 and to the Executive Board and the Sixty-ninth World Health Assembly in May 2016.

The Director, Administration and Finance, reported that the Organization's Office of Internal Oversight Services had audited seven country offices of the European Region in the previous three years and found that no management and control processes were unsatisfactory. The recent audit had determined that the overall controls of the Regional Office to mitigate key risks were satisfactory and were operating effectively. External auditors had also assessed the Regional Office and five country offices in 2011 and 2013; all recommendations from 2011 had been closed, and only six recommendations from 2013 were pending. Key systemic issues identified through those audits had included insufficient competitive selection for procurement of services; no externalization of back-up files; anomalies in the recruitment of project personnel in country offices; and shortcomings in the management of fixed assets. Remedial action taken included the development of guidelines and procedures, and the introduction of pre-checks on procurement and of mechanisms for clearance of recruitment.

In its most recent audit reports, the Office of Internal Oversight Services had also pointed out a number of good practices that could be shared with other regional offices, such as the monthly reports submitted to the Executive Management Committee at the Regional Office for Europe on the achievement of results, budgeting, resources, the situation with regard to financing of salaries, and compliance. The designation of focal points in each technical unit and country office was having a positive impact as a channel for systemic feedback of information. The SCRC was regularly informed of the European Region's financial situation and the implementation of its programme budget, as well as other important administrative and managerial issues, through extensive oversight reports to facilitate full accountability and compliance and enable the WHO governing bodies in carrying out their oversight function.

Initiatives would be taken to further strengthen controls. Performance appraisal would be linked to compliance targets; a new responsibility matrix would be rolled out for country offices and the Regional Office; administrative capacity in countries would be strengthened; and Regional Office staff would work closely with the Office of Compliance, Risk Management and Ethics on implementing the risk register. Coordination with the Organization's Global Service Centre, WHO headquarters and other regional compliance units would be strengthened, in order to ensure a harmonized approach, and future audit recommendations would be submitted to the Regional Committee for review as a standing agenda item.

A representative speaking on behalf of the EU and its member countries welcomed the assertion of zero tolerance of non-compliance, as well as the details of some of the actions being taken in the European Region to address the issue. He also welcomed the investment in WHO's audit and evaluation functions and the work done on implementing audit recommendations. Another representative agreed that it was vital to take concerns raised about non-compliance seriously, in particular to make sure that resources were effectively and properly used. More detailed information on the initiatives, such as when they were taken and what effect they were having, would be appreciated. The oversight reports to the SCRC were not only a valuable tool for driving transparency and compliance but also a move towards shared responsibility. The proposal to discuss the implementation of audit recommendations at future Regional Committee sessions was welcomed, as were plans to link compliance with performance.

The Director-General thanked representatives of Member States for their expression of concern and guidance with regard to accountability and compliance.

Overview of global governance reform

(EUR/RC65/15)

The representative of Estonia, speaking as the regional coordinator on behalf of the European Region's members of the working group on global governance reform (Estonia and the Russian Federation), said that the working group was engaged in two major areas; namely, on methods of work of WHO's governing bodies and on the alignment of governance at the three levels of the Organization. Analysis papers were currently being prepared by working group members, who would hold their next meeting in Geneva the following week. That would feed into the second open meeting of Member States in November 2015. The aim was to reach consensus on some immediate steps forward that could be agreed at the 138th session of the Executive Board in January 2016.

The informal discussion by Member States held on Sunday afternoon prior to the opening of the 65th session of the Regional Committee testified to the fact that the issue of governance reform was of the highest importance for the European Region and was proof of the Region's readiness to proceed with implementation of proposals put forward by Member States, reflecting their ownership of the process and of WHO itself.

Many representatives welcomed the efforts being made by the working group. The issues of alignment and agenda-setting were crucial in building a strong Organization for the future, with coherence across its three levels. While welcoming the global governance reform process, one representative noted that WHO's internal structure and communication mechanisms were crucial. The three-level structure represented both a challenge and an opportunity. WHO's elected regional directors could clearly exercise more political influence than their counterparts in other organizations of the United Nations system. The main objective was to prevent a lack of coordination among the various levels. The position of the Director-General vis-à-vis the regional structures should be strengthened and clarified; for instance, through the introduction of an accountability compact between the Director-General and the regional directors. There was a need to demonstrate that WHO was willing and able to carry out structural reform.

The Director-General recalled that the Joint Inspection Unit's 2012 review of management, administration and decentralization in WHO had underlined the importance of alignment of the three levels of the Organization. While the regional directors submitted an annual letter to the Director-General describing how they were executing their responsibilities, lessons could be learned from the model used by the United Nations Secretary-General, with a view to turning that letter into an accountability compact.

WHO's work in outbreaks and emergencies with health and humanitarian consequences

(EUR/RC65/15)

The Director, Communicable Diseases, Health Security and Environment, noting that the Ebola virus disease outbreak had highlighted the urgent need to strengthen WHO's capacity to prepare for and respond to future large-scale outbreaks and emergencies, outlined the steps being taken at the request of Member States at global governing body meetings and in response to the report of the Ebola Interim Assessment Panel. The process was being overseen by the Director-General, supported by the advisory group led by Dr David Nabarro, and a project management team. The Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response was also contributing.

In addition, a comprehensive internal consultation process was under way at the three levels of the Organization with the participation of the Global Policy Group, the Deputy Director-General and the Assistant Directors-General in relevant areas, the six regional offices, the chair of the advisory group and Member States. The intended outcome of the reform process was a unified WHO programme for health and humanitarian emergencies with clear performance metrics, a global health emergency workforce, a new business process that would facilitate a rapid and effective response, a contingency fund and accelerated research and development activities. The programme would be underpinned by a strong operational support platform that was able to support WHO's interventions at all three levels in humanitarian crises and disease outbreaks. The programme would also act in coordination with other agencies of the United Nations system, other intergovernmental organizations and civil society partners.

The work of the advisory group and the project management team was expected to conclude at the end of 2015, and a proposal would be submitted to the Executive Board in January 2016.

In the discussion that followed, a representative voiced concern that the emergency response reform process was not progressing quickly enough for a proposal to be submitted to the Executive Board in January 2016. Another representative pointed out that other evaluations, in addition to the report of the Interim Assessment Panel, were under way and that their results should be taken into account before any definitive conclusions were drawn. Noting that reliance on external organizations to assess what should be done in the field had delayed WHO's response; he highlighted the need for the Organization to develop its own assessment capacity and coordinate incoming support. It was also crucial to strengthen health systems, without which it would be impossible to tackle future health emergencies. Support was expressed for the introduction of an independent monitoring and evaluation of States' implementation of the IHR (2005). Clarification was requested of the place and role of the regions in the new unified structure and of how the new World Bank pandemic emergency

financing facility would relate to the WHO contingency fund to support WHO's emergency response capacity.

Responding to representatives' comments, the Director-General acknowledged the need to unify the outbreak and humanitarian areas of WHO's work, making use of the resulting synergies. A whole-organization approach had been adopted for assessing the scope and health risks of an emergency, with the regional and global levels "backstopping" country offices as required for response and outbreak management. Such an approach, in the context of a unified programme, also ensured the appropriate use of resources throughout the Organization. The importance of a country's core capacity to implement the IHR (2005) and its ability to deliver primary health care should be underlined and could be addressed by putting in place the right type of health system both to prevent outbreaks and to tackle multiple health issues. The World Bank's financing facility was still under discussion, but it would play a complementary role to WHO's contingency fund.

The Regional Director expressed the hope that the European Region would be able to pilot a scheme for the external evaluation of countries' ability to meet the core capacity requirements under the IHR (2005).

Address by the WHO Director-General

The Director-General recalled that the MDGs had demonstrated the power of international solidarity focused on reducing poverty and saving lives. The United Nations General Assembly was expected to finalize the new agenda for sustainable development. The success in attainment of the health-related MDGs was now driving an even more ambitious agenda, where the new sustainable development goals would also seek to address the new challenges in a much-changed world, including the current refugee crisis. She concurred with the views expressed by the Regional Director's statement concerning the health needs of refugees and migrants, adding that the current threats to health, ranging from the burden of chronic NCDs on health systems to the consequences of climate change, were larger and more complex than in 2000. The forthcoming Conference of the Parties to the United Nations Framework Convention on Climate Change was thus set to provide an exceptional opportunity for preventing the next generation from inheriting a ruined planet. In the area of tackling the growing antimicrobial resistance crisis, the leadership by governments of Member States in the European Region was much appreciated.

The multitude of challenges ahead must not be underestimated, particularly as the root causes of those challenges lay outside the traditional domain of public health and of sovereign nations. The World Bank data showed that, in 2011, more than 60% of the world's 175 largest economic entities were companies; the new distribution of power raised a critical question for health in the sustainable development era. In a world of radically increased interdependence and globalized marketing, all threats were transboundary ones. Health ministers must continue to insist on coherent government policies based on medical and scientific evidence.

In that context, the Physical activity strategy for the WHO European Region 2016–2025 would yield multiple benefits as a preventive tool for addressing the Region's obesity epidemic. It must be critically supplemented, however, by addressing the many factors identified as responsible for the prevalence of childhood obesity, as identified by the WHO

Commission on Ending Childhood Obesity, which singled out the globalized marketing of unhealthy foods and beverages as the pervasive driving force.

The WHO European Region had always been a pioneer, with many of its “firsts” providing the foundation for responses to new health challenges in the era of sustainable development and underscoring the importance of intersectoral action, as well as the commitment to equity and solidarity as the Region’s defining values. The European Region was the first to look at lifestyle-related diseases, ways of changing human behaviours and social determinants of health. It was also the first to recognize environmental hazards and, through the Tallinn Charter, to formulate convincing economic arguments for investing in health systems. The European Region brought phrases like “health in all policies” and “whole-of-government approach” into the health policy vocabulary. Health 2020 now drew on those achievements.

The Region’s other assets had also been amply illustrated through its prompt contributions to dealing with the Ebola virus disease outbreak. The outbreak, while not yet over, was very close to being so, and WHO leadership during the outbreak differed from the narrative presented in most media reports. The lessons learned had fed into the WHO reforms under way to strengthen WHO leadership in future outbreaks and other health emergencies. WHO’s achievement in the fight against the Ebola virus, such as trials of new vaccines, prequalified diagnostic tests and networks of laboratories, were made possible by the wide-ranging support that it had received from countries and partners. It was a true show of leadership that had created the conditions for multiple responders to work to their full advantage in future epidemics and pandemics.

In outlining the challenges to the delivery of health care and medical supplies in the non-government-controlled areas of his country, the Minister of Health of Ukraine emphasized the urgent need to scale up humanitarian action in those areas in order to immunize children against polio and avoid deaths from tuberculosis and HIV/AIDS. He praised the WHO Country Office and field offices in Ukraine for their timely and meaningful response to the humanitarian crisis and for their assistance with health system reforms, which served as a model for WHO in-country activities elsewhere.

The representative of Turkey stated that reforms in the area of response to health emergencies offered a unique opportunity to strengthen preparedness and response capacities for the future, in which context his country was set to assist by financing a geographically dispersed office on humanitarian and health emergencies. One representative, noting that global health policy featured high on the political agenda as a result of the Ebola virus disease outbreak, underscored the integral role of health systems strengthening in global health security and the difficult and wide-reaching structural reforms needed for enabling WHO to address the new challenges of the century. Another reflected on the need to learn from that outbreak in order to implement crucial changes by strengthening health systems, improving the IHR (2005) and reforming the Organization’s emergency capacities. Those actions could also be usefully linked to the sustainable development goals, with WHO playing a major role in the transition phase and in the evidence-based monitoring of progress.

Responding to those comments, the Director-General said that the outbreak of polio in Ukraine was a consequence of the challenging situation of insecurity described by that Minister of Health. An immunization programme should therefore be commenced in the very near future with full WHO commitment as a mark of WHO’s continuing support for Ukraine. Effective humanitarian responses were indeed vital in health emergencies but should not be

substituted for political solutions. Constructive criticism was welcome insofar as much work remained to be done to transform WHO into an Organization fit for purpose and in line with the expectations of its Member States, which must nonetheless be realistic. Priorities should therefore be established by focusing on WHO's strengths and capacities to deliver on requests and recommendations within the limits of its financial and other resources. Concerning implementation of the new sustainable development goals, WHO would certainly provide advice to countries. Stressing that underperformance on promises undermined confidence, she urged Member States to seize the opportunity available to them to keep their promises to WHO.

World No Tobacco Day Award

The Director-General and the Regional Director presented a World No Tobacco Day award to Mr Ilir Beqaj, Minister of Health of Albania, in recognition of his accomplishments in tobacco control and his outstanding leadership and commitment to strengthening implementation of the WHO FCTC.

Report of the Twenty-second Standing Committee of the WHO Regional Committee for Europe

(EUR/RC65/4 Rev.1, EUR/RC65/4 Rev.1 Add.1, EUR/RC65/R2)

The Chairperson of the Twenty-second Standing Committee of the Regional Committee for Europe reported that the Twenty-second SCRC had held five sessions and four teleconferences during the year. At its first session, the member from France had been elected as Vice-Chairperson, and the member from the Russian Federation, one of the European Member States on the Executive Board, had agreed to ensure the link between the Board and the Standing Committee.

In addition to supporting the Regional Office's response to the Ebola virus disease outbreak, preparation of the 65th session of the Regional Committee had been the key element in the Twenty-second Standing Committee's work. The SCRC had given advice to the Regional Director on the agenda and programme of the session, paying special attention to the time available to allow proper discussion of agenda items. It had welcomed the overall theme of intersectoral action as a key element of Health 2020 and recommended that the Regional Director should organize high-level meetings with representatives of Member States from different sectors. It had also carefully considered alignment with the agendas of the Organization's global governing bodies, especially on governance reform, and had proposed that an informal meeting of Member States on that topic should be held prior to the session.

At the Twenty-second SCRC's first session, two subgroups had been created, on implementation of Health 2020 and on governance reform. The Health 2020 subgroup had met twice and focused on two issues: the importance of increased availability of comparative data to assess the impacts of Health 2020 implementation; and promoting intersectoral collaboration, including national examples of good practice and the need to bridge gaps in collaboration in certain areas. The governance subgroup had met three times and held two teleconferences, continuing the work of the previous SCRC in that area. It had considered: the nomination procedure for membership of the Executive Board and the Standing Committee,

including introduction of the practice of submitting a letter of intent; the proposals of the Regional Evaluation Group concerning Rule 47 of the Rules of Procedure of the Regional Committee; the involvement of NGOs in Regional Committee sessions; the process of preparing WHO European Region conference declarations; and definitions of technical documents such as strategies, policies and action plans.

The SCRC had also exercised its oversight function in relation to budgetary and financial management. It had reviewed and discussed implementation of programme budget 2014–2015 and was informed of the action taken to reduce administrative costs and thus increase technical capacity. It had been pleased to learn that compliance and risk management had been strengthened. With regard to programme budget 2016–2017, the Standing Committee had reviewed the regional implementation plan, which it regarded as an excellent tool for ensuring accountability.

As in previous years, the Standing Committee had also discussed the nominations for membership of the Executive Board and the SCRC. The number and high quality of nominations received testified to Member States' strong commitment to and interest in participating in the work of the Organization's governing bodies, and the submission of letters of intent had provided valuable information. Member States were urged to continue that level of engagement in coming years.

The representative of one Member State, while welcoming the open session of the SCRC held in Geneva on the day before the opening of the World Health Assembly, noted that the timing of that session posed a practical problem for delegations in terms of preparation, since they had to review two extensive sets of documentation. He therefore proposed that a written consultation with European Member States on drafts of Regional Committee working documents and resolutions should be conducted, to run for one month after the end of the World Health Assembly.

The Regional Director noted that the Twenty-second Standing Committee had agreed to extend the deadline for Member States to comment on draft resolutions following the open session, but that not all countries had been aware of that extension. At its fifth session two days earlier, the Twenty-second SCRC had recommended that the proposal should be implemented in 2016, with experience reported back to the Regional Committee.

The Committee adopted resolution EUR/RC65/R2.

The European health report 2015: Targets and beyond – reaching new frontiers in evidence

As an introduction to *The European health report 2015: Targets and beyond – reaching new frontiers in evidence*,² a film that highlighted its main features was shown. The report charted progress towards the six targets of Health 2020. An assessment of the available data revealed that the European Region as a whole was on track to achieve the targets, but progress at the country level had been uneven and inequities remained to be overcome. The report

² The European health report 2015: Targets and beyond – reaching new frontiers in evidence. Copenhagen: WHO Regional Office for Europe; 2015 (<http://www.euro.who.int/en/publications/abstracts/european-health-report-2015-the-targets-and-beyond-reaching-new-frontiers-in-evidence>, accessed 16 November 2015).

emphasized that health was not only the absence of disease; it also noted that describing and measuring health and well-being in a culturally diverse Region was difficult. WHO had therefore launched an initiative to explore the cultural context of health and how cultural beliefs and practices might contribute to or hinder the improvement of health.

The Director, Division of Information, Evidence, Research and Innovation, recalled that the European health report was a flagship publication of the Regional Office, released every three years. The 2015 report broke ground by exploring the kind of evidence that would be needed to measure the new concepts enshrined in Health 2020 and health in the 21st century, including the information required to monitor the enhancement of well-being, which had been added as a target in 2013, with both subjective and objective indicators. Data on well-being could be difficult to compare and interpret, particularly where subjective experience was influenced by culture, and WHO had therefore embarked on a new stream of work that considered the cultural context of health and well-being. An international expert group convened in that connection had put forward a definition of culture and recommended systematic investigation of cultural contexts through a multisectoral and multidisciplinary approach.

The European health report revealed that many countries of the Region had aligned their national policies with Health 2020 and had set national targets. Data from 2013 indicated that 67% of European Member States had policies that addressed social determinants of health and inequalities. The report also highlighted the need to tackle health information challenges in order to ensure regular reporting of high-quality information at the country level. The single health information system for Europe envisaged as a goal under the European Health Information Initiative would help to strengthen data collection at the country level, reduce reporting burden by Member States and thereby enhance the measurement of progress in the Region.

The report would be made available in several formats, including, for the first time, an application for smart mobile phones, through which the Regional Office would welcome feedback and suggestions for improvement from Member States.

In the ensuing discussion, it was noted that the European health report was a true flagship as well as a further milestone, and the report's alignment with Health 2020 made it useful for developing, reviewing and updating policies across sectors that had an impact on health and well-being. The steps taken to enhance monitoring of health inequalities and of cultural determinants of health were welcomed. The availability of high-quality information was viewed as critical to the identification of health inequalities and to a better understanding of health and well-being. The representative of Lithuania reported that her country had recently joined the European Health Information Initiative and encouraged other countries to do the same.

The Director, Division of Information, Evidence, Research and Innovation, welcomed the recognition of the impact of cultural factors on health. The new WHO work stream would explore that relationship further over the coming years with the aim of eventually being able to measure cultural determinants of health. She looked forward to contributions to that effort from experts of Member States. She welcomed Lithuania's decision to join the European Health Information Initiative. She also explained that consideration was being given to the establishment of a health information network for small countries under the umbrella of the Small Countries Initiative. Among other objectives, the Initiative was intended to harmonize

health information across the European Region and reduce the reporting burden on Member States.

Health 2020: promoting intersectoral and interagency action for health and well-being in the WHO European Region

(EUR/RC65/11, EUR/RC65/16, EUR/RC65/R1)

The Regional Director stated that health challenges in the WHO European Region, particularly the burden of NCDs and the health inequalities that existed within and between countries, could not be tackled without addressing upstream root causes determined by sectors other than health. Health 2020 was an essential tool for identifying key areas for cross-sectoral action, including education, labour, migration, and social, economic and fiscal policy.

Applying an intersectoral approach to address the determinants of health and well-being was a political choice. It required commitment and a willingness to seek solutions in complex circumstances and to negotiate sensitive challenges, such as differences in bureaucratic systems, distribution of resources and, in some cases, conflicts of interest. In that regard, Health 2020 provided useful guidance for intersectoral action for health, health in all policies, applying a whole-of-government approach and governance for health. The adoption of the 2030 Agenda for Sustainable Development, which was aligned with Health 2020, was an occasion to highlight the critical importance of an integrated approach.

Health 2020 had prioritized the social determinants of health; as a next step, the focus would be on social policy issues, such as employment, education, housing, decent income, and retirement with dignity. Many of the social determinants of health could be addressed at the local level and required cooperation within local governments. The Healthy Cities and Regions for Health networks had therefore played an important role in Health 2020 implementation. Health literacy was also an important priority to address.

Intersectoral action had a global dimension. Health was becoming increasingly prominent in foreign policy and more visible on the global political agenda. Intersectoral cooperation at all levels was therefore crucial. The WHO European Region had shown considerable global health leadership in recent years by ensuring that health was high on the Group of Seven agenda and given due consideration in security responses to challenges such as the Ebola virus disease outbreak and the unprecedented influx of refugees and migrants into the Region.

The European Region was particularly experienced with regard to intersectoral cooperation. One example in that regard was the European Environment and Health Process (EHP) – the intersectoral governance mechanism in the European Region for the past 26 years. Around one fifth of deaths and one quarter of the disease burden in the European Region could be attributed to environmental factors, which were determined by political decisions. The EHP and its ministerial conferences had been central to progress, but had also brought to light interesting and useful lessons.

The EHP was particularly valuable as a means of supporting Member States' implementation of their domestic agendas. It constituted a mechanism for monitoring and reporting, which increased political accountability and stimulated action at the national level. It was also a tool for disseminating new scientific and normative guidance.

A mid-term review of progress towards meeting the targets set at the Fifth Ministerial Conference on Environment and Health in 2010 had highlighted the need to strengthen joint efforts and focus on key issues such as air pollution, chemical safety, climate change and universal access to safe drinking water and sanitation. Good governance was essential to ensure adaptability to rapidly changing circumstances. The WHO European Centre for Environment and Health in Bonn, Germany, played a significant supportive role, working in close collaboration with the international scientific community across a broad range of disciplines.

Lessons learned from the EHP should be used to shape future cooperation between the health sector and other areas. Such cooperation must address politically relevant topics, maintain credibility and ensure that targets were set to link domestic agendas to international commitments. The political momentum of both Health 2020 and the adoption of the 2030 Agenda for Sustainable Development could be used to promote intersectoral collaboration to optimize the impact of health on sustainable development. Examples of best practices in Member States were being collected and would be shared.

The Regional Director proposed that new regional processes should be explored to identify mechanisms for the engagement of interested Member States to promote intersectoral work across the European Region and to foster dialogue, the sharing of experience and joint action among countries. The initial focus should be on cooperation with the education, finance and social sectors.

The Vice-Chairperson of the SCRC said that considerable progress had been made in Health 2020 implementation over the past year. The SCRC commended the Regional Office's efforts to increase the availability of comparative data to assess Health 2020 implementation and disseminate information about progress made. The Regional Office's focus on intersectoral cooperation was welcomed, in particular its efforts to draw from the lessons learned through the EHP with regard to coordinating the political and technical aspects of cooperation. The role of health ministers in raising awareness and promoting political consistency should be enhanced.

In the discussion that followed, speakers welcomed the reports on Health 2020 implementation and the EHP, and expressed support for intersectoral action; many cited examples of intersectoral collaboration with the education and environment sectors. The discussion revealed a growing awareness that population health involves more than the health sector alone; an intersectoral bridge is needed to narrow the gap by developing cross-cutting government policies that effectively impact on the social and economic factors affecting health. The proposed decision to promote intersectoral action was welcomed and supported.

One representative, speaking on behalf of the 10 Member States participating in the SEEHN, said that SEEHN participants were committed to a whole-of-government approach and had adopted SEE 2020, a subregional strategy on jobs and prosperity that was aligned with Health 2020 and acknowledged an intersectoral approach to health as an essential contributor to inclusive growth. SEEHN participants not only were committed to implementing Health 2020 at the national level, but also acknowledged the importance of cooperation at the subregional level to promote and protect health among countries, particularly in view of the current refugee and migration crisis in the European Region.

Many speakers expressed their governments' commitment to intersectoral approaches, health in all policies and a whole-of-government approach aligned with Health 2020; implementation of Health 2020 and the 2030 Agenda for Sustainable Development constituted a unique opportunity to promote intersectoral cooperation. One representative underscored the importance of intersectoral cooperation at the international level, since many global development challenges were cross-border issues. In that regard, several representatives drew attention to the need for an integrated approach to migration and health, particularly given the current migration and refugee crisis in the European Region. The Regional Office had a key leadership role with respect to cooperation at the international level. Member States shared their experiences of implementing cross-sectoral and health-in-all-policies approaches, highlighting best practices. One speaker described how the health authorities and those dealing with recreation, catering and urban planning in one municipality in his country had successfully worked together to halve childhood obesity rates. In several Member States, national development plans had been adopted in line with Health 2020, which required an integrated approach to ensure successful implementation. The post-2015 development agenda would provide further inspiration in that regard, since it would require integrated and coherent cross-sectoral approaches.

Speakers identified a number of factors mentioned that promote or favour intersectoral collaboration. Networks such as the SEEHN and the Small Countries Initiative were seen as supportive processes. A number of speakers proposed that the existence of a plan, policy or concept paper would serve to lay the foundation and provide the mandate for intersectoral collaboration. One speaker mentioned the facilitation by a supportive finance ministry and international financial institutions. Speakers expressed the need for a forum where they could share expertise and exchange information about lessons learned in general and among countries with similar contexts, as well as the need for capacity-building on intersectoral collaboration at different levels and supporting tools, including for monitoring.

The EHP was acknowledged as a good example of intersectoral cooperation, and lessons learned from the mid-term review could serve to shape future initiatives to address major health challenges that could not be tackled by the health sector alone. Environmental issues had a critical impact on health, and cooperation between the two sectors was therefore invaluable. Guidance provided by the WHO European Centre for Environment and Health in Bonn, Germany, was particularly important. Many speakers gave examples of efforts to promote cooperation between the environment and health sectors at the national level, including through initiatives to improve air quality, water and sanitation, and to promote renewable energy. Several representatives underscored the acute threat to health posed by climate change: rising temperatures were resulting in increased cases of malaria, chikungunya and dengue in the Region, and heatwaves were having serious health repercussions for vulnerable populations.

Speakers said that in order to ensure that the EHP remained relevant as a technical tool and to encourage the engagement of Member States, it should be more focused in scope, perhaps limited to two or three technical areas. Consideration should be given to streamlining its governance structure and fostering a clear sense of ownership among stakeholders. Speakers hoped that the role of the health sector would be acknowledged in the outcome document of the forthcoming Conference of the Parties to the United Nations Framework Convention on Climate Change, due to take place from 30 November to 11 December 2015. In general, the discussion indicated that the EHP was the model to emulate for intersectoral collaboration due to the successful engagement of multiple sectors. However, it was pointed out that the EHP

should not attempt to address all aspects of environment and health relevant at the global scale. Speakers also felt that the environment and health declaration should be further refined.

A video message was transmitted from the Executive Director, United Nations Environment Programme (UNEP), who acknowledged the positive partnership between UNEP and WHO, in particular through the EHP, and expressed support for WHO's leadership role in the implementation of the 2030 Agenda for Sustainable Development. Efforts were being made to identify linkages and complementarities in the work of WHO and UNEP, which could be harnessed for the benefit of people and the planet.

The Regional Director, UNFPA Regional Office for Eastern Europe and Central Asia, said that the adoption of the 2030 Agenda for Sustainable Development was an occasion to celebrate achievements with respect to meeting the MDGs, while acknowledging that challenges persisted, in particular with regard to reducing inequalities and ensuring universal access to sexual and reproductive health. The WHO European Region, comprising predominantly middle-income countries, could achieve results with relatively modest investment if health literacy could be improved. Social inequalities engendered health inequalities, and the health divide was an impediment to sustainable development. UNFPA was committed to strengthening interagency cooperation to advance the health and well-being for all in the European Region, in close collaboration with WHO.

Social determinants and health, and health literacy: links and coherence between health, education and social policy, and health in sustainable development and foreign policy

(EUR/RC65/16)

Panel discussion

In a panel debate moderated by Professor Ilona Kickbusch on the topic of health, foreign policy and development, the Minister of State for Security Policy and International Cooperation at the Hungarian Ministry of Foreign Affairs and Trade said that human well-being was the basis of prosperity and vice versa. In terms of health care, it was a matter of striking the difficult balance between the medically possible and the economically acceptable, which his country was striving to achieve in its own health system and in the health systems in countries where it had built hospitals. Close cooperation among ministries dealing with foreign affairs, development and finance was vital in that context, as was work with the private sector and civil society.

Agreeing with that view, the Ambassador for Global Health and Head of the International Affairs Department at the Swiss Federal Office of Public Health said that her work in implementing the Swiss foreign policy on health was greatly assisted by the experiences and contacts she had accumulated over time. The collaboration, coordination and consultation needed to drive forward that policy required, however, much patience and stamina. Given the lack of any "one-size-fits-all" solution, opportunities to exchange views and experiences in the interest of developing relevant best practices were always welcome.

The Adviser at the Global Health Division of the German Federal Ministry of Health outlined the process involved in his country's adoption of a concept paper on its role in global public

health matters. The paper had been useful in advising the German Chancellor concerning the three issues now placed on the global health agenda of the Group of Seven countries, namely, the Ebola virus disease, antimicrobial resistance and neglected diseases. Cooperation among ministries and ties with permanent missions were crucial to addressing global health issues, as was the appointment of appropriately informed diplomats.

The Director-General of Health of the French Ministry for Social Affairs, Health and Women's Rights said that diplomacy was increasingly related to health in today's globalized world, where a national approach was inadequate for dealing with pandemics and the more problematic communicable diseases. Indeed, diplomats were often assigned in preference to health professionals as global ambassadors for addressing key health issues.

The Minister of Health and Social Security, National Insurance, Family and Economic Planning of San Marino added that the Ebola crisis had highlighted the importance of taking different local customs into account in the process of providing health assistance to countries.

Summing up the debate, Professor Kickbusch highlighted the increasing role of representations and other organizations in health-related negotiations, as in the case of those relating to the new sustainable development goals. Relevant alliances and partnerships were often built through diplomacy, moreover, bringing together different actors, many of whom believed that WHO had a role to play in taking forward the agenda on health and foreign policy.

The second panel discussion, moderated by Dr Walter Ricciardi, focused on social determinants and health, and health literacy: links and coherence between health, education and social policy. A video featuring Professor Sir Michael Marmot was shown, in which he presented data illustrating the impact of social, economic and political factors on health and health inequalities. For example, data from EU countries indicated that the variation in life expectancy at age 25 was much greater among individuals with lower education levels than among those with more education. Data also showed that inequalities in cognitive development among young children were affected by multiple health and social risk factors. Such inequalities in early childhood often then translated into disadvantages that affected people throughout their lives. Sir Michael also pointed out that health inequities served as a measure of how well societies were doing and urged all countries to do more to address social determinants of health and reduce health inequalities.

The Director, Policy and Governance for Health and Well-being, made some practical suggestions for implementing intersectoral action and persuading colleagues in other sectors of the benefits of such action, noting that WHO was developing a variety of tools and materials to facilitate communication with other sectors and to support countries in promoting intersectoral action. He emphasized the importance of pragmatic and well-presented messages that made a strong business case, highlighted the dividends to be derived from working together and underscored the costs of inaction. It was also important to understand the language of other sectors and be open to learning from their approaches, define common goals and targets, and involve local governments, without which action on social determinants of health could not be effective.

In the panel discussion, several panellists drew attention to the role that the education sector could play in instilling healthy habits and thus promoting health and preventing disease. Moreover, equal access to education could help to reduce social inequalities that led to health

inequalities. The Minister of Education and Higher Education of Andorra pointed out that the education sector could also have indirect positive effects on health. Schools in Andorra, for example, were promoting the use of renewable energy sources as a means of combating climate change, which in the long term was expected to lead to better health. The Director General of Health, Ministry for Social Affairs, Health and Women's Rights of France, reported that various ministries in his country had reached agreement on an intersectoral approach to health education and promotion. Other panellists also cited examples of successful collaboration between the education sector and other sectors, such as environment and agriculture, to promote healthy behaviours and good nutrition.

The Minister of Health and Social Security, National Insurance, Family and Economic Planning of San Marino noted that his country was leading the Small Countries Initiative and stressed that small countries, with their strategic flexibility, strong social cohesion and ability to adapt, could be leaders of intersectoral action. His country had a tradition of intersectoral collaboration and joint decision-making, of which its new national health plan was a tangible result. The definition of clear roles had been key to success in that endeavour. It had also been important to strive for a long-term vision, while also being mindful of the need to produce visible benefits in the short term in order to garner political support. Noting the challenges that demographic and epidemiological transition posed for his country, the Director-General for Health of Portugal emphasized the importance of clear definitions of concepts such as premature mortality in order to be clear about the goals being pursued, facilitate monitoring of progress and produce comparable data.

The Director General of the National Board of Health and Welfare of Sweden said that his country's public health policy had a clear equity perspective and sought to address social determinants of health. It had served as a guide for intersectoral action at both the national and local levels. In the city of Malmö, for example, city planners, applying a health perspective to their work, had devised a strategy for eliminating barriers that were dividing poor and unhealthy populations from more affluent, healthier groups.

The State Secretary at the Ministry of Health of Slovakia described a project in his country in which members of the Roma community had been recruited to serve as "health assistants". The project had helped to raise vaccination rates, increase participation in preventive screening for various diseases and promote health, and within 10 to 15 years health in the Roma community was expected to be better than in the general population. In contrast, a previous Roma health project carried out by public health authorities had failed, which highlighted the importance of understanding local customs.

The First Deputy Minister of Finance of Belarus suggested that the role of the finance sector in intersectoral action for health might be overestimated. The sector's main concern was whether there was strong political support at all levels of government and society for health initiatives. Ensuring such support was especially important in times of constrained resources and tight budgets. Performance-based budgeting, clear identification of goals with measurable indicators, and effective monitoring and evaluation were also key in order to enable finance officials to determine what measures were most effective in achieving health goals and were therefore deserving of support.

The Minister of Education and Higher Education of Andorra observed that finance ministers generally considered education a worthwhile investment, which was another advantage of collaboration between the health and education sectors. Panellists also noted the need to be

clear about the benefits for other sectors of working together to improve health and emphasized the importance of ascertaining and communicating to other sectors how social determinants such as poor housing affected health and well-being and encouraging evidence-based decision-making in social sectors.

Concluding the discussion, Dr Ricciardi said that the European Region must avoid a “perfect storm” resulting from the convergence of phenomena such as demographic and epidemiological transition and growing social and economic inequality. Failure to take action would have huge costs.

General debate on intersectoral work, the decision and the panel discussion

In the ensuing general debate, representatives of Member States agreed that policy-makers in other sectors had to take account of all the many factors that affected people’s health. The deterioration in the quality of life brought about by austerity measures must be countered in a holistic way, and the problems faced by migrants and refugees called for action by multiple stakeholders from both the state and civil society. Collaboration between ministries of health, education, sports and social services on public health issues such as physical activity and healthy nutrition was of crucial importance, but agreeing common goals with ministries of economy and finance might be more difficult. Intersectoral action required a radical reorientation of health services and health personnel. Priorities included raising awareness about health among officials from other sectors, ensuring that people had the tools and resources to adopt healthy lifestyles, and ensuring the interconnectivity of information technology systems to facilitate collaborative intersectoral policy-making. Several representatives reported that their countries were adopting public health legislation or health promotion strategies that provided for sustainable mechanisms of intersectoral cooperation at different levels of their territory.

WHO and the Federal Ministry of Health of Germany were thanked for organizing a meeting in Berlin in April 2015 to share national experiences in the area of cross-sectoral cooperation in health and foreign policy. Different models could be adopted to incorporate health into foreign and development policy, but in all cases the aim should be to include health goals in such policy and to strive for their attainment. The post-2015 development agenda and accompanying sustainable development goals were very ambitious, but they afforded the opportunity to achieve significant improvements in global health outcomes through the involvement of other sectors. One target under the health-related sustainable development goals, for example, was to reduce premature mortality from NCDs by one third by 2030. To reach that target, sustainable financing would be required, and one representative welcomed the new global framework for financing sustainable development, adopted at the Third International Conference on Financing for Development, held in Addis Ababa, Ethiopia, on 13–16 July 2015.

The Director, Policy and Governance for Health and Well-being, presented the WHO European Healthy Cities Network as a striking example of nearly 30 years of intersectoral innovation. Preconditions for its success included strong and sustained political commitment by mayors and city councils (a “whole-of-local-government” approach), capacities and mechanisms (such as intersectoral committees) for change management, intersectoral city health development plans, and platforms for engaging a wide spectrum of civil society and

public stakeholders. Progress on all aspects of Healthy Cities work was regularly monitored and evaluated.

Statements were made by representatives of EuroHealthNet, the Framework Convention Alliance for Tobacco Control, who also spoke on behalf of the NCD Alliance, and the International Federation of Medical Students' Associations, the latter speaking also on behalf of the International Alliance of Patients' Organizations, Medicus Mundi International, World Federation of Occupational Therapists and World Organization of Family Doctors. Written statements were submitted by the International Association for Child and Adolescent Psychiatry and Allied Professions, Medicus Mundi International and World Federation of Occupational Therapists.

The Regional Director observed that the number of countries with multisectoral policies and coordinating mechanisms had doubled in one year, and that a full report and a menu of actions would be presented to the 66th session of the Regional Committee in 2016. Meetings would be organized across the European Region to promote intersectoral work. The Sixth Ministerial Conference on Environment and Health, scheduled to be held in 2017, would offer a unique opportunity to renew the Region's commitment to the EHP, review its governance structure and focus its priorities. She appreciated the exchange of views at the ministerial lunches during the session on migration and health, an issue that had made headlines across Europe. She cited the Public Health Aspects of Migration in Europe project, funded by Italy, as the action framework to address the issue, and confirmed that the Regional Office would organize a conference hosted by Italy before the end of the year to review the health and public health implications of migration, discuss and agree on policy issues and approaches, as well as key messages, and determine the scope of activities to be undertaken jointly by the Regional Office and Member States in an area of work where a multisectoral approach was relevant.

The Committee adopted decision EUR/RC65(1).

Physical activity strategy for the WHO European Region 2016–2025

(EUR/RC65/9, EUR/RC65/9 Add.1 Rev.1, EUR/RC65/R3)

The Programme Manager, Nutrition, Physical Activity and Obesity, said that physical inactivity was a major risk factor for NCDs and a significant cause of premature mortality. In the WHO European Region, one third of adults were not sufficiently active, and 70% of adolescents did not meet WHO physical activity recommendations. Urgent action was therefore required. The Physical activity strategy for the WHO European Region 2016–2025 aimed to inspire governments and stakeholders to work towards increasing physical activity for all by generating enabling environments, ensuring equal opportunities and removing barriers. Its guiding principles included reducing inequalities, promoting a life-course approach, empowering people and communities, promoting integrated, multisectoral, sustainable and partnership-based approaches, ensuring adaptability of physical activity programmes and using evidence-based strategies.

Five priority areas had been identified: leadership and coordination; child and adolescent development; physical activity for all adults as part of daily life; physical activity among older people; and monitoring, surveillance, evaluation and research. A set of country fact sheets had been drafted detailing the successes and experiences of Member States with regard to scaling

up physical activity and reducing sedentary behaviours, which would be published with a view to sharing experiences and best practices.

A representative of the SCRC said that the Standing Committee welcomed the strategy, which was inspired by Health 2020 and could be used to stimulate coordinated multisectoral approaches while providing leadership through strategic advice for Member States. The transparent, comprehensive consultative process for drawing up and revising the strategy had included input from a wide range of stakeholders at all levels. The SCRC considered the strategy to be an important, high quality document and encouraged the Regional Committee to endorse it and adopt the accompanying draft resolution.

In the ensuing discussion, Member States expressed their unequivocal support for the physical activity strategy and the draft resolution. The strategy should be implemented hand-in-hand with the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020, the Global Action Plan for the Prevention and Control of NCDs 2013–2020 and the WHO European Charter on Counteracting Obesity. Physical inactivity was one of the primary modifiable risk factors associated with NCDs, and was linked to high rates of obesity. Chronic diseases associated with overweight and obesity, such as diabetes, cardiovascular diseases and some cancers, were on the rise owing to the growing tendency towards a sedentary lifestyle. The strategy was therefore particularly relevant and timely.

Many speakers welcomed the comprehensive nature of the strategy, which contained clear guidelines, was relevant to all target groups and provided an excellent basis for the development of policies at the national level. Its recommendations were broad-based and applicable to all Member States in the European Region. Speakers underscored the importance of ensuring equal opportunities for physical activity for all, without discrimination, and drew attention to the need to apply a life-course approach, with a special focus on vulnerable groups, such as children, adolescents and the elderly.

Intersectoral cooperation, led by the health sector, was the key to reaching the strategy's full potential. Physical activity must be promoted in schools and at work, through transport policy and recreation. One speaker gave an example of how the Ministry of Health in collaboration with the Ministry of Education in her country had approved a programme of 10-minute exercises, which it had incorporated into the national school curriculum so that teachers could promote physical activity for children in an enjoyable manner. Education had a particularly important role to play in fostering behavioural change and cultivating good practices from a young age. The use of contemporary technology should be optimized to promote physical activity and reduce sedentary behaviours among target audiences. Given the ageing population in the European Region, steps must also be taken to promote physical activity among the elderly. The beneficial effects of physical activity should be monitored and evidence used to support awareness-raising efforts.

Several speakers described their national strategies for physical activity, which, although drafted before the European strategy, reflected its spirit. Others expressed their intention to use the European strategy as a model on which to base new policies and strategies at the country level. Examples of experiences and best practices were shared; these included the prescription for physical activity by physicians and the subsidization of fitness club membership fees for patients, expansion of cycle lanes in urban areas and city bicycle schemes to encourage physical activity as a form of daily transport, and the introduction of

mandatory daily physical education in schools. It was hoped that the country fact sheets for sharing best practices would be available soon.

A statement was made by a representative of the World Federation of Occupational Therapists.

The Programme Manager, Nutrition, Physical Activity and Obesity, thanked Member States for their support and welcomed their acknowledgment of the lead role of the health sector in promoting physical activity and of the importance of technology in monitoring, evaluation and awareness-raising. Diet and exercise were closely linked and must be addressed together in order to overcome challenges such as childhood obesity. The examples of successful measures to reduce sedentary behaviour and increase physical activity demonstrated the innovative approaches being used by Member States across the European Region. WHO stood ready to support Member States in their implementation of the strategy and efforts to overcome the challenges that they faced.

The Committee adopted resolution EUR/RC65/R3.

Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025: making tobacco a thing of the past

(EUR/RC65/10, EUR/RC65/10 Add.1 Rev.1, EUR/RC65/R4)

The Programme Manager, Tobacco Control, stated that despite a downward trend in tobacco consumption in the WHO European Region since 2000, tobacco use among women in Europe remained the highest in any WHO region. None of the Member States in the Region were on track to meet the WHO voluntary target of a 30% relative reduction in the prevalence of current tobacco use in persons aged 15 years or over by 2025. Tobacco control efforts – and efforts to implement the WHO FCTC in particular – must therefore be accelerated. Member States had expressed their commitment in that regard through the adoption of the Ashgabat Declaration on the Prevention and Control of Noncommunicable Diseases in the Context of Health 2020.

The Roadmap currently before the Regional Committee had been designed to support Member States in their efforts. It had been prepared in a comprehensive, consultative drafting process, with guidance from Member States and the WHO FCTC Secretariat. The Roadmap was inspired by, and was in line with, the policy decisions of the Conference of the Parties to the WHO FCTC, and was underpinned by the close relationship between the Regional Office and the WHO FCTC Secretariat. It set the ambitious goal of full FCTC implementation, which would contribute to the WHO voluntary targets of a 25% reduction in premature mortality from NCDs and a 30% relative reduction in the prevalence of current tobacco use in people aged 15 years or over by 2025. Actions such as enacting smoke free legislation, especially in children’s environments, enforcing comprehensive bans on all tobacco advertising, promotion and sponsorship, and increasing public awareness to prevent young people from starting to use tobacco would help achieve that goal. It would be implemented through a “one WHO” approach, to make achieving the voluntary 2025 target a reality.

A member of the SCRC underscored the importance of tobacco control as the primary entry point for achieving the voluntary target of a 25% relative reduction in premature mortality

from NCDs by 2025, as agreed by the World Health Assembly. Implementation of the WHO FCTC was therefore crucial. The Roadmap presented a welcome vision of a European Region free from tobacco-related morbidity, mortality and addiction. The SCRC had contributed to the drafting process with a focus on optimizing the Roadmap's added value. He expressed the SCRC's full support for the Roadmap and the draft resolution.

The Head, WHO FCTC Secretariat, said that 2015 marked 10 years since the entry into force of the WHO FCTC. During those 10 years, considerable progress had been made. Europeans had campaigned against the evils of tobacco since it had first been brought to European shores from the Americas, but despite their hard-line approach, tobacco use still prevailed throughout Europe some 400 years later. That battle must be fought again and obstacles to tobacco control must be overcome. She called on all stakeholders to do their duty to the public, taking effective actions through the Roadmap.

Of the 53 Member States in the WHO European Region, 50 were parties to the WHO FCTC. Broad disparities in the retail price of cigarettes still prevailed across the Region, however, and greater tobacco control efforts were needed, such as comprehensive smoking bans in all public places; large health warnings on tobacco packaging; prohibition of indirect advertising, promotion and sponsorship; and help for consumers to give up tobacco use. Although European Member States had been quick to introduce such measures, early successes in a few countries had not spread across the continent.

The 2030 Agenda for Sustainable Development would provide the necessary impetus to address the challenge of tobacco use, and full implementation of the WHO FCTC would accelerate anti-tobacco initiatives and the attainment of the voluntary target of a 30% relative reduction in tobacco use among people aged 15 years or over by 2025. Yet a formidable opponent to the anti-tobacco movement still remained: the tobacco industry. The introduction of new tobacco products, such as e-cigarettes, was potentially increasing addiction rates. Interference by the tobacco industry constituted the greatest threat to WHO FCTC implementation.

The tobacco industry had also tried to obstruct efforts to implement the Protocol to Eliminate Illicit Trade in Tobacco Products. The trade in illicit tobacco accounted for an estimated 10% of the global tobacco market. To date, nine States had ratified the Protocol; a further 31 ratifications were needed for it to enter into force.

WHO, international partners and civil society therefore had a duty to work together with the WHO FCTC Secretariat to continue the fight and continuously remind legislators and other key players of the need for action. The WHO FCTC, its Protocol and the new Roadmap offered the route to a better future, but would have value only if they inspired effective action. The WHO FCTC Secretariat stood ready to work with WHO to support tobacco control efforts in the WHO European Region.

In the ensuing discussion, representatives thanked the Regional Office for its work in developing the inspiring Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the European Region 2012–2025: making tobacco a thing of the past, for which wholehearted support was expressed. The Roadmap was commended not only as a policy-making guide but also as a tool for promoting the attainment of goals relating to sustainable development and the prevention and control of

noncommunicable diseases. Thanks were further expressed to the Regional Director for the dedicated support provided to countries in their tobacco control efforts.

Numerous representatives emphasized the priority afforded in their national health agendas to tobacco control policies, describing legislative, strategic and other actions envisaged or already taken to implement the provisions of the WHO FCTC through the introduction of various price and tax measures, non-price measures, measures relating to protection from exposure to tobacco smoke, packaging and labelling of tobacco products, and tobacco advertising, promotion and sponsorship, in addition to demand reduction measures concerning tobacco dependence and cessation. Others further described measures taken to reduce the supply of tobacco by targeting the illicit trade in tobacco products and sales of tobacco products to and by minors. Many reported encouraging outcomes achieved as a result of the measures described. They anticipated yet further success in their endeavours to reduce the prevalence of tobacco use, which also encompassed efforts to reshape social norms concerning tobacco consumption. One speaker underlined the need for clear WHO guidance concerning the use of smokeless and electronic versions of tobacco or cigarette-like products.

With respect to strengthening implementation of the WHO FCTC, broad emphasis was placed on the need for strong political commitment, intersectoral action and support, and cooperation and coordination among countries, which the Regional Office was ideally placed to promote. The engagement of civil society and the advocacy role of NGOs in particular were also singled out as instrumental to promoting the success of tobacco control activities. In short, joint efforts were deemed key to achieving both the long-term vision of a European Region free of tobacco-related morbidity, mortality and addiction and the target of the relative reduction in the prevalence of current tobacco use in persons aged 15 years or over by 2025.

Member States in the European Region that had not yet signed and ratified the Protocol to Eliminate Illicit Trade in Tobacco Products were encouraged to do so, with similar encouragement directed at the three countries not having yet acceded to the WHO FCTC. The Ashgabat Declaration on the Prevention and Control of Noncommunicable Diseases in the Context of Health 2020 was also cited as an important instrument in the fight to achieve the tobacco control vital to attaining the global goal of reducing by one quarter premature mortality from such diseases by 2025.

A representative speaking on behalf of the EU and its member countries drew attention to the new EU Tobacco Products Directive regulating the manufacture, presentation and sale of tobacco and related products in the European Union, the aim of which was to minimize the number of approaches to those matters. Continuing collaboration among the Regional Office, the WHO FCTC Secretariat and Member States in the European Region must be pursued in tackling the single most preventable cause of death and disease and the leading contributor to health inequalities in Europe.

Another representative speaking on behalf of Finland, France, Hungary, Iceland, Norway and the United Kingdom stated that, on the basis of the scientific evidence concerning the public health and related benefits of standardized packaging of tobacco products, those countries had decided to follow the Australian lead with respect to such packaging. They were furthermore committed to fulfilling their obligations under the WHO FCTC to protect public health policy-making from the vested interests of the tobacco industry and to working together to defend their tobacco control laws against legal challenges. They were also ready to share their expertise and knowledge on tobacco control and to promote standardized packaging.

Statements were made by representatives of the Standing Committee of European Doctors and the Framework Convention Alliance.

The Programme Manager, Tobacco Control, expressed appreciation to Member States for their support of and trust in the work of the Regional Office and for sharing their experiences and lessons learned in the field of tobacco control, to which intersectoral action and, indeed, partnership with NGOs was key. The Regional Office was in turn committed to supporting countries in their efforts and stood ready to facilitate contacts among them to that end.

The Director, Noncommunicable Diseases and Promoting Health through the Life-course, said that adoption of the Roadmap to strengthen WHO FCTC implementation, the Physical activity strategy and the related draft resolutions would mark the completion of the five-year project to develop a mandate for work relating to the prevention and control of NCDs in the European Region. Member States had clear guidance available to them for the implementation of effective evidence-based actions in that domain. It was also in their interest to ratify the Protocol to Eliminate Illicit Trade in Tobacco Products.

The Head of the WHO FCTC Secretariat said that her organization was at the disposal of all parties to the WHO FCTC and appealed to all non-party Member States to accede to the Convention in order to strengthen its implementation. Ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products was also important for that same reason. Multisectoral cooperation and efforts to underscore the merits of the WHO FCTC in international forums would promote a consistent approach to the fulfilment of the Convention's obligations with a view to constructing a better world.

The Regional Committee adopted resolution EUR/RC65/R6.

Elections and nominations

(EUR/RC65/7, EUR/RC65/7 Add.1 Rev.1, EUR/RC65/7 Add.2)

Executive Board

The Committee decided that the Netherlands and Turkey would put forward their candidatures to the Sixty-ninth World Health Assembly in May 2016 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee selected Georgia, Iceland, Italy and Tajikistan for membership of the SCRC for a three-year term of office from September 2015 to September 2018.

Environment and Health Ministerial Board

The Committee selected the ministers of health of Belarus and Uzbekistan for membership of the Environment and Health Ministerial Board for a two-year term of office from 1 January 2016.

Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness

(EUR/RC65/13, EUR/RC65/13 Add.1, EUR/RC65/R5)

The Director, Health Systems and Public Health, said that the subheading of the document under consideration, “walking the talk on people centredness”, reflected the importance of ensuring that health systems in the European Region met people’s needs as indicated at the high-level meeting held in Tallinn, Estonia, in 2013 to commemorate the fifth anniversary of the signing of the Tallinn Charter: Health Systems for Health and Wealth. A people-centred approach meant not only listening to people’s voices, but truly empowering them and engaging them as co-producers of their own health. It also meant improving health systems and achieving better and more equitable health, particularly for the most vulnerable.

Health systems strengthening had long been a priority for WHO Member States. Outlining the major commitments undertaken in the European Region with regard to health systems strengthening since the adoption of the Declaration of Alma-Ata in 1978, he said that overwhelming evidence had accumulated to show that health systems with strong primary health care were more efficient and responsive than those without, yielding better health outcomes and reducing inequalities. Health systems in the European Region faced considerable pressure owing to the significant burden of communicable and noncommunicable diseases, health security threats and disabilities. However, due to a range of innovations, they mostly remained resilient and responsive to those challenges. That notwithstanding, fundamental issues, such as the impact of an ageing population on health systems, were still to be addressed. The question of whether an existing health system would be sustainable would ultimately depend on whether the benefit package could be financed from the existing revenue base.

To determine its strategic priorities for health systems strengthening for the coming five years, the Regional Office had engaged in a Member State-driven, inclusive, participatory process, led by a core group of Member States, with input from external experts. Surveys had been conducted to assess Member States’ progress towards meeting their commitments under the Tallinn Charter, and consultations had been held with country offices and Member States. Lastly, a peer review had been conducted by external experts.

People-centred health systems reflected the values of solidarity and equity, leaving no one behind, minimizing social exclusion and promoting financial protection. Key priorities for ensuring people-centredness were transforming services delivery and moving towards universal health coverage. Those priorities could be achieved only with a competent health workforce, innovation in medicines and technology, and robust health information. Change management and innovation were crucial.

Responding to health needs in the 21st century required a transition towards a health system with strong primary health care that delivered comprehensive, integrated and people-centred services, with public health as the key pillar. Health information was also a fundamental resource at all levels of the health system and had a significant role in enhancing decision-making to steer the health system in the direction of better health outcomes and people-centredness. The Regional Office would continue to work closely with key partners, and stood ready to support Member States through the provision of technical assistance, analysis and policy dialogue, and capacity-building.

A member of the SCRC said that the Standing Committee welcomed the Member State-driven process to link the final report on the implementation of the Tallinn Charter with key challenges, issues and priorities for strategic health systems strengthening for the coming five years. The Tallinn Charter continued to provide the vision and guidance needed by Member States to build sustainable and resilient health systems, centred on people's needs. The transition to people-centred health systems was essential to obtain better health outcomes, reduce health expenditure and stimulate behaviour change to address the double burden of communicable and noncommunicable diseases. Further progress required whole-of-government and whole-of-society approaches, a high-quality workforce, medicines and technology, and health information. The SCRC welcomed the alignment of the working document with the WHO Global Strategy on People-centred and Integrated Health Services and the WHO global strategy on human resources for health: workforce 2030.

The numerous representatives who participated in the ensuing discussion wholeheartedly endorsed the approach to health systems strengthening based on the values of solidarity and equity, as well as the two strategic priorities of transforming health services and moving towards universal health coverage, and the three essential foundations of health systems: the health workforce; medicines and other technologies; and health information.

Many speakers emphasized that a people-centred approach was a bold yet necessary one, taking forward the values that had been endorsed in the Tallinn Charter. Such an approach was also recognized as essential for implementing the European health policy framework, Health 2020. It entailed empowering people in terms of health literacy, making the health care transaction a partnership between equally informed and interested parties. On the other hand, one speaker noted that people-centredness should not minimize the role of society and the community in the health system.

Solidarity and equity were clearly singled out as values that should underpin countries' responses to the challenges posed also by migration. Strong and resilient health systems would be able to absorb current and future waves of migrants and provide them with sustainable, high-quality health services. One speaker pointed to the need to evaluate the public health response to the migrant crisis and countries' capacity to ensure an appropriate, safe and people-centred response.

Many representatives described the steps already taken in their countries to transform health services, the first strategic priority. They included strengthening the role of primary care services, creating a single-payer system, introducing results-based payment schemes, and institutionalizing the function of strengthening population health, for linking health services with other sectors and the public and for health promotion. Nonetheless, one of the main challenges was to ensure that health systems were comprehensive and provided a collective response to people's needs and expectations. Speakers proposed a number of steps that could be taken, such as striking the appropriate balance between inpatient and outpatient systems, promoting home-based care and community welfare, bringing together surveillance of and response to communicable and noncommunicable diseases, as well as health promotion, moving from vertical programmes towards wider health system approaches, tackling financial constraints and ensuring sustainable financing.

The drive to achieve efficiency gains was seen as a good way of transforming health services. One speaker reported that health systems performance assessment had been a valuable tool and urged the Regional Office to continue with this work. Speaking on behalf of countries

that were members of the SEEHN, one representative recalled that the Network had supported self-assessment of essential public health operations in a majority of member countries between 2006 and 2010.

Another speaker regretted the lack of mention of essential public health functions in the document under consideration and proposed that the European Region could consider a joint resolution on public health, to be submitted to the Executive Board in 2016 under an existing agenda item.

The representative of one country reported that the launch of a government programme on universal health coverage, made possible by a substantial increase in public funding for the health system, had shown that tangible benefits for the population could be provided very quickly when the government as a whole was committed to making health care more accessible and affordable. Another speaker noted the recent introduction of a third-party payer system, and one representative considered that mandatory health insurance formed the basis of universal health coverage. Access to high-quality health services could be adversely affected by financial crises and economic stagnation but an economic case could be made for risk containment and preventive measures.

NCDs were considered to be the most challenging issue threatening the sustainability of universal health coverage. One speaker suggested that universal health coverage could be seen as the most important leadership priority in the Organization's Twelfth General Programme of Work, while another urged WHO to promote universal health coverage at the international level in the context of the post-2015 development agenda and the sustainable development goals.

With regard to the first foundation, enhancing the health workforce, one representative noted a shortage of doctors and nurses in his country as a result of high rates of emigration and suggested that ways to improve retention could include strengthening health systems, improving the skills mix and ensuring that education systems were more quickly adaptable to emerging demands. Another speaker advocated redefining the roles, competences and professional relations of health personnel, moving towards a multiprofessional approach. One representative reported that his country was working closely with the European Commission on the Action Plan for the EU Health Workforce, while another reported on activities aimed at establishing an observatory on human resources for health.

On cost-effective medicines and technology, one speaker noted that the availability of new medicines at high cost could have an adverse impact on equity and the financial sustainability of a health system. There was a need for careful health technology assessment, in terms of therapeutic advantage and added value compared to existing products. An integrated approach was needed in order to strike a balance between innovation and affordability of pharmaceuticals. WHO was called on to provide leadership in adopting strategic procurement mechanisms.

Many speakers commended the Regional Office on the establishment of the European Health Information Initiative, which all countries in the European Region were urged to join, as well as the introduction of a data web portal and a health statistics application. Similarly, they welcomed the work done by the Regional Office on generating evidence for policy-making through the Evidence-informed Policy Network. The representative of one country reported on hosting the Autumn School on Health Information and Evidence for Policy. Another

speaker advocated promoting the multisectoral involvement of other sectors, NGOs, academic and research communities and the private sector in work on the third foundation, health information. There was scope to improve people's health literacy, as well as the availability of data and the monitoring of policy impact.

It was suggested that the Regional Office and WHO country offices could support Member States in a number of ways, such as by facilitating the exchange of experiences, generating new evidence on financial protection, giving advice on country self-assessments, organizing high-level seminars and flagship courses, monitoring financial protection and identifying ways of enhancing efficiency. The area of health systems strengthening should integrate all relevant WHO activities and programmes, and the Secretariat should better communicate how such horizontal collaboration was promoted. It was expected that the geographically dispersed office on primary health care, once it was fully operational, would play a catalysing role in making a reality of people-centred health systems.

A statement was made by the International Federation of Medical Students' Associations on behalf of the European civil society coalition Health Workers for All and All for Health Workers, the European Midwives Association, the European Public Health Alliance, Medicus Mundi International, the International Alliance of Patients' Organizations, the International Confederation of Midwives, the International Council of Nurses, the World Federation of Occupational Therapists and the World Organization of Family Doctors. Other statements were made by Alzheimer's Disease International, the European Forum for Primary Care, the European Patients Forum, the International Network of Health Promoting Hospital and Health Services and the World Federation of Societies of Anaesthesiologists. Written statements were submitted by the International Alliance of Patients' Organizations, the International Association for Child and Adolescent Psychiatry and Allied Professions, the International Confederation of Midwives, the International Council of Nurses and the International Federation of Medical Students' Association.

The Director, Health Systems and Public Health, thanked Member States and partners for a very proactive approach throughout the year-long consultation process. In reply to one speaker, he clarified that the first strategic priority, transforming health services, covered the full continuum of care, including essential public health functions. The next step for the Regional Office would be to assemble evidence on how to advise policy-makers and manage the transition to people-centred health systems.

The Regional Director informed representatives that the Regional Office would continue to work to respond to migration and health within the context of World Health Assembly resolution WHA61.17 on health of migrants and Health 2020 and would also continue its work to support Member States in assessing the health system capacity required to respond to the challenges. She said that she intended to organize a conference on the subject before the end of the year to review public health and health systems, agreeing on a common approach. In response to a statement, she confirmed – as the Director-General had also stated in her address – that the IHR (2005) would be integrated with the work on health systems. She also affirmed that essential public health functions were fully integrated in the health systems strengthening approach at the Regional Office. In response to one delegate, the Regional Director reported that following some discussions at the fifth session of the Twenty-second SCRC, the Director-General had been approached with regard to the proposal to submit a draft resolution to the Executive Board on population-based public health under an existing agenda item from the European Region, and both the Director-General and she welcomed that

proposal as part of goal 3 of the sustainable development goals with a link to universal health coverage.

The Committee adopted resolution EUR/RC65/R5.

Final report on implementation of the Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015 and consideration of the proposed Tuberculosis action plan for the WHO European Region 2016–2020

(EUR/RC65/17 Rev.1, EUR/RC65/17 Add.1 Rev.2, EUR/RC65/R6)

A video that highlighted achievements under the Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015 was shown. It also underscored key challenges to be addressed under the proposed new action plan.

The Regional Director's Special Representative for Multidrug-/Extensively Drug-resistant Tuberculosis said that, since the adoption of the Consolidated action plan in 2011, tuberculosis prevention and control activities had been scaled up, incidence of the disease had fallen significantly and treatment coverage had increased. The Regional Office for Europe had supported countries in addressing health system-related barriers in tuberculosis prevention and control and had produced a compendium of best practices.

The Programme Manager ad interim, Tuberculosis and Multidrug-resistant Tuberculosis, reported that 1 million tuberculosis patients had been cured, 200 000 multidrug-resistant cases had been averted and 2.6 million lives and US\$ 11 billion had been saved as a result of the Consolidated action plan. Although the incidence of tuberculosis had been declining by 6% per year – a faster rate than in any other WHO region – several key challenges remained, including continued transmission of multidrug-resistant tuberculosis, growing drug resistance and HIV–tuberculosis comorbidity.

The proposed Tuberculosis action plan for the WHO European Region 2016–2020 had been developed through a region-wide consultation process involving Member States, technical and funding agencies, civil society organizations and communities. In line with the global End TB Strategy, the regional action plan comprised three pillars: integrated, patient-centred care and prevention; bold policies and supportive systems; and intensified research and innovation. Its vision, goal and targets were also aligned with those of the global strategy, although some of the regional targets were more ambitious than the global ones. The regional action plan would emphasize scale-up of rapid diagnosis, expansion of patient-centred care models, shorter and more effective treatment regimens, preventive therapy, research for new tools and an intersectoral approach to address inequities. By the action plan's end date in 2020, it was expected that 3.1 million lives would have been saved, 1.4 million patients cured, 1.7 million new cases prevented and US\$ 48 billion saved.

A member of the Twenty-second Standing Committee reported that the SCRC had reviewed the draft regional action plan and suggested that greater emphasis should be placed on integrated care and comorbidities, social support for tuberculosis patients with addiction problems and those in detention, and the importance of incorporating tuberculosis into

discussions on migration and health. The Standing Committee had welcomed the Region-wide consultation, which would ensure stakeholder ownership of the action plan. Implementation of the plan would help to sustain and scale up efforts to strengthen health systems and address social determinants of health. The SCRC therefore endorsed the regional action plan and supported adoption of the draft resolution.

A representative speaking on behalf of the EU and its member countries said that tangible results had been achieved under the Consolidated action plan 2011–2015 with regard to improvements in diagnosis and treatment and reduction of the incidence of tuberculosis. Those successes had contributed to the achievement of target 6C of the MDGs. Persistent challenges remained, however, particularly the ongoing transmission of M/XDR-TB, increasing drug resistance and low treatment success rates. Multisectoral approaches, integrated care and closer coordination with social services were important for tuberculosis prevention and care, especially for patients with comorbidities. The Global Fund to Fight AIDS, Tuberculosis and Malaria had played an important role in fighting tuberculosis in the European Region, but it was time for countries to assume full responsibility for a sustainable national response funded primarily from domestic resources.

In the current context of increasing global mobility, tuberculosis was a serious cross-border health issue that required collaboration between countries for rapid detection of cases and treatment of patients. The EU decision No 1082/2013/EU on serious cross-border threats to health was an important tool for member countries' response to the disease. She encouraged the Regional Office to continue working with the European Centre for Disease Prevention and Control, particularly on surveillance and reporting. She also welcomed the proposed Tuberculosis action plan for the WHO European Region 2016–2020, which was a key policy document providing support and guidance for regional tuberculosis prevention and control efforts and for the implementation of the global End TB Strategy.

Other representatives also voiced support for the proposed action plan, applauding in particular its emphasis on evidence-based and cost-effective diagnosis and treatment models and on political commitment, leadership and governance and adequate resourcing of tuberculosis programmes. Numerous representatives described their countries' prevention and control activities and offered to share their experiences and best practices with others.

Ensuring universal access to effective and affordable prevention, diagnosis and treatment was considered crucial to the success of efforts to end tuberculosis in the European Region. Access for highly vulnerable populations, including poor, migrant and incarcerated groups and persons with HIV, was especially important. Access to new medicines for the treatment of M/XDR-TB was also critical. Multisectoral action and comprehensive, all-of-government and health-in-all-policies approaches were required in order to address social, economic and environmental determinants that contributed to the spread and persistence of the disease. Involvement of communities and civil society organizations was also necessary.

Many speakers stressed the need for cross-border collaboration in detecting cases and treating patients and contacts. A common European response was imperative, particularly in the current context of growing human mobility. Procedures for rapid screening of migrants on arrival should be devised and joint procedures for referral and cross-border management of suspected tuberculosis patients put in place. A shared standardized information system was also needed. The representative of Italy encouraged the Regional Office to incorporate the

issue of migrant health and cross-border tuberculosis care among migrant populations more explicitly into the draft action plan.

The representative of Slovakia noted that his country was taking steps to establish a new WHO collaborating centre on tuberculosis. The representative of Latvia drew attention to the Joint Riga Declaration on Tuberculosis and Its Multidrug Resistance, adopted in March 2015 by the ministers responsible for health of the EU member countries and the countries of the Eastern Partnership, who had committed to do their utmost to reach a 75% reduction in the number of tuberculosis deaths and a 50% reduction in tuberculosis incidence by 2025 in their respective countries.

Statements were made on behalf of the International Federation of Red Cross and Red Crescent Societies, the TB Europe Coalition and the European Respiratory Society.

The Programme Manager ad interim, Tuberculosis and Multidrug-resistant Tuberculosis, welcoming the expressions of support for the draft action plan, said that, although the European Region had made good progress in combating tuberculosis, there was no room for complacency. The new action plan could be effective only if it was implemented. He had taken note of the comments regarding the need for greater emphasis on cross-border action. That aspect would be addressed in a more detailed version of the plan currently being developed. An existing electronic platform could facilitate communication between countries and help ensure continuity of care for patients who migrated across borders. He agreed on the need to work together to address gaps in tools for M/XDR-TB. At the same time, it would be essential to make rational use of new medicines in order to avoid risking further drug resistance. Destigmatizing tuberculosis was also important so that patients were not inhibited from seeking care. Various collaborating centres, including one in Azerbaijan on prevention and control of tuberculosis in prisons and one in Latvia that provided training in the management of multidrug-resistant tuberculosis, could be important resources to help countries scale up tuberculosis prevention and care.

The Regional Director's Special Representative for Multidrug-/Extensively Drug-resistant Tuberculosis commended the commitment and achievements of Member States. Much work remained to be done, however, to combat M/XDR-TB and eliminate tuberculosis in the European Region as a whole. The fight against tuberculosis must be linked to the reform of health systems and services and the strengthening of evidence-based and people-centred models of care.

The Director, Communicable Diseases, Health Security and Environment, affirming the need for concerted action, noted that the Region's progress towards ending tuberculosis as a public health problem demonstrated the central role of health systems in implementing actions that a disease programme alone could not undertake.

The Regional Director recalled that she had set up a special programme and appointed a special representative on tuberculosis in 2010, when the disease had constituted a real emergency for the Region. With the progress that had been made since then, the special programme was no longer needed. Its discontinuation, however, did not in any way mean that tuberculosis would cease to be a priority for the Regional Office. Indeed, it had already taken steps to strengthen the tuberculosis programme within the Division of Communicable Diseases, Health Security and Environment.

The Regional Committee adopted resolution EUR/RC65/R6.

Regional plan for implementation of programme budget 2016–2017

(EUR/RC65/14, EUR/RC65/Inf.Doc./1)

The Director, Administration and Finance, introducing the item, drew attention to the fact that document EUR/RC65/Inf.Doc./2 gave an overview of the implementation of programme budget (PB) 2014–2015 in the WHO European Region, while document EUR/RC65/Inf.Doc./1 presented the regional plan for implementation of PB 2016–2017 by category. His presentation would focus on the lessons learned from implementation of PB 2014–2015 and their links with PB 2016–2017.

The approved PB 2014–2015, amounting to US\$ 225 million, was currently funded to a level of 108%, while the allocated budget (US\$ 253 million) was 99% funded. New features of PB 2014–2015 were that it had been adopted in its entirety (that is, including both assessed and voluntary contributions) and that it had included the provision for a financing dialogue with donors. For the Regional Office for Europe, PB 2014–2015 had resulted in a 9% increase in its share of corporate resources compared to the previous biennium, giving greater flexibility, more even funding across categories and fewer “pockets of poverty”. Staff costs were 10% lower than in 2012–2013, with no salary gap.

Implementation of PB 2014–2015 was currently below expectations owing to the timing of resource availability, a stronger US dollar and lower expenditure on staff, as well as slow implementation from January to June 2014 as a result of the emergency response to the Ebola virus disease crisis. The Secretariat had drawn up and was carrying out an implementation plan, and the situation was improving.

There were close links between PB 2014–2015 and PB 2016–2017: there was not only continuity of priorities, although with fewer priorities in PB 2016–2017, but also continued programmatic and budgetary accountability of the Regional Office to Member States. The new “contract” detailed the European contribution to the global results chain and global indicators, in terms of outcomes (joint responsibility of Member States and the Secretariat) and outputs (responsibility of the Secretariat alone). The resulting PB was judged to be realistic, in that it was in line with both the allocated PB 2014–2015 and the funded PB 2014–2015.

In the discussion that followed, one representative welcomed the progress in the funding of PB 2014–2015 in terms of predictability, timeliness and sustainability. He pointed to the relatively large amount of PB 2016–2017 for category 6 (Corporate services/enabling functions): US\$ 60 million, an increase of US\$ 6 million compared to PB 2014–2015, representing 25% of the total programme budget. The resources allocated to category 3 (Promoting health through the life-course) could be regarded as an overall indicator of WHO’s success, since category 3 was directly linked with the sustainable development goals.

Another speaker, noting that at the end of March 2015 the allocated PB 2014–2015 for the Regional Office had been funded at 93%, wished to know the current percentage. Moreover, given the projected 9% or US\$ 20 million increase in PB 2016–2017 compared to the World Health Assembly-approved PB 2014–2015, he asked what impact that would have on staff planning. At the global level, WHO relied on a relatively small number of donors of voluntary

contributions; he wondered what the European Region's situation was in that regard and, furthermore, if the discussion about increasing Member States' assessed contributions was being followed up.

Another representative requested clarification of the statement in the regional plan for implementation of PB 2016–2017 that “a considerable portion of the Regional Office's country work [would] be delivered by technical staff based in Copenhagen”, especially for those countries without country offices.

Welcoming the more detailed costings and stronger links to performance-based management in PB 2016–2017, the representative of one country asked how confident the Secretariat was that the budget for the outbreak and crisis response segment had been set at the right level, and what plans it had to address “pockets of poverty” and politically challenging areas. With regard to PB 2014–2015, the lag in the rate of implementation had been attributed to knock-on effects of the response to the Ebola virus disease outbreak, but in retrospect it seemed that it had been due to more familiar causes, such as the lack of technical capacity at the country level and delayed receipt of resources from WHO headquarters. She asked what action the Secretariat had taken to tackle such factors, what implementation rate could be estimated for the end of the biennium, and what plans were in place to handle the shortfall that would exist at the start of the new biennium.

Another speaker asked how the 10% increase in allocated PB 2016–2017 as compared to the World Health Assembly-approved budget would affect funding and implementation in programme areas that to a large extent relied on flexible funds. He also wondered how the 5% limit on budget ceiling increases at the global category level would affect regional resource mobilization and implementation. He commended the increased transparency of PB 2016–2017, which improved alignment between the global and regional levels of WHO and strengthened the Regional Office's accountability for delivering on the priorities adopted by the World Health Assembly.

Answering the questions raised, the Director, Administration and Finance, explained that the Director-General had the authority to shift up to 5% of the approved programme budget between categories. The substantial increase to category 6 in PB 2016–2017 had been made in response to recommendations in the United Nations Joint Inspection Unit's 2012 review of management, administration and decentralization in WHO; all heads of country offices in countries outside the EU would henceforth be internationally recruited WHO representatives and administrative support at the country level would be strengthened. Experience from WHO's first financing dialogue justified earlier recruitment of staff in the future. The Director-General's proposal concerning an increase in assessed contributions was no longer under consideration. The Regional Office was endeavouring to monetize the delivery of country work by staff based in Copenhagen and other geographically dispersed offices. The budget for the outbreak and crisis response segment was indicative and could be increased or decreased in response to events. “Pockets of poverty” would be tackled through earlier recruitment of staff and allocation of flexible resources. Despite the impediments due to familiar causes, it was expected that an implementation rate of 90% would be achieved by the end of the current biennium. In order to start operations promptly at the beginning of the 2016–2017 biennium, the first tranche of funding would be allocated after the second financing dialogue in November or December 2015.

The Regional Director confirmed that the European Region's human resources plan for 2016–2017 would be finalized in October or November 2015. The Region's special business model of integrated regional and country work would be maintained but staffing at the country level would be strengthened with the appointment of internationally recruited heads and deputy heads of country offices in larger countries and of technical staff with generic capacity in public health, as well as some internationally recruited administrative staff. As was done in other regions, staff delivery of programme budget outputs would be linked to the Organization's performance management and development system. She also confirmed that the 90% implementation rate was feasible and every effort was being made in the Regional Office to achieve this.

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

(EUR/RC65/6)

The member of the Twenty-second Standing Committee acting as a link between the Executive Board and the SCRC briefly described the implications for the European Region with respect to resolutions and decisions adopted at the Sixty-eighth World Health Assembly.

In category 1 (Communicable diseases), resolution WHA68.2 concerning the global technical strategy and targets for malaria 2016–2030 was important in view of the elimination of malaria target in the European Region. In the case of resolution WHA68.6 concerning the global vaccine action plan, it would be necessary to further strengthen immunization programmes in the Region in order to address the ongoing problems relating to immunization, such as vaccine hesitancy, vaccine-preventable diseases, particularly measles and rubella outbreaks, and political commitment.

In category 2 (Noncommunicable diseases), resolution WHA68.19 concerning the outcome of the Second International Conference on Nutrition resonated with actions already under way in the European Region, which should direct particular attention to providing technical assistance for coordination with United Nations agencies and partners in developing an accountability framework.

In category 5 (Preparedness, surveillance and response), resolution WHA68.3 and decision WHA68(9) on poliomyelitis called for stopping wild poliovirus transmission and supporting the polio endgame strategy. This has significance for the European Region, notably in the light of the recent polio outbreak in Ukraine. Resolution WHA68.7 concerning the Global Action Plan on Antimicrobial Resistance, which is aligned with the European Strategic Action Plan on Antimicrobial Resistance, would help to accelerate the Region's ongoing development, particularly the establishment of national multisectoral mechanisms and surveillance networks.

Welcoming the efforts of the Regional Office to implement the Global Action Plan on Antimicrobial Resistance and the expansion of existing antimicrobial resistance surveillance networks, one speaker said that work should be focused on supporting the development, implementation and monitoring of national action plans and on strengthening multisectoral cooperation.

Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections

(EUR/RC65/Inf.Doc/3)

The Director, HIV/AIDS and Global Hepatitis Programme, said that substantial progress had been achieved towards finalizing the three separate but interlinked strategies on HIV, viral hepatitis and sexually transmitted infections (STIs), the aim being to end, by 2030, the AIDS epidemic and, likewise, to end the STI and viral hepatitis epidemics as major public health threats. Having cited positive examples of measures taken in some countries of the European Region towards achieving those aims, he outlined the five strategic directions underpinning the frameworks for action at the country, partner and WHO levels in the context of the three strategies; namely, information for focus and accountability; interventions for impact; delivering for quality and equity; financing for sustainability; and innovation for acceleration.

Targets had been set for 2030 with respect to HIV impact in the areas of prevention, treatment and reduction of HIV-related deaths and with respect to incidence and mortality in the case of viral hepatitis and to incidence and prevention in the case of STIs.

The Regional Committee was requested to consider the implications of the global health sector strategies for the European Region; how best to engage Member States, partners and relevant regional stakeholders in supporting the implementation of those strategies in the Region; and whether regional action plans were needed for a feasible and timely implementation of the strategies. He thanked Member States for their active engagement in the development of the strategies and for the input already provided through consultations.

One representative remarked on the size and speed of the response that would be needed to end AIDS by 2030 and, taking into account the worrying growth of the epidemic in the European Region among key populations at risk, particularly welcomed the recommendations relating to those populations contained in the report of the UNAIDS and Lancet Commission on the subject of defeating AIDS. WHO must continue its active engagement in the formulation of the solid monitoring framework essential for gathering evidence-based information and decision-making in the interest of ensuring access to services for persons living with AIDS and of combating stigmatization and discrimination.

Statements were made by representatives of the World Hepatitis Alliance and the AIDS Healthcare Foundation Europe.

In response to the comments made, the Director for HIV/AIDS and the Global Hepatitis Programme noted the similarity of the modes of transmission for the diseases covered by the three strategies, to which the key populations mentioned were especially vulnerable. The hope was that the strategies would assist the fight against stigmatization and discrimination, an area in which much remained to be done, and would be synchronized with work on health systems strengthening.

The Deputy Director, Communicable Diseases, Health Security and Environment, added that undiagnosed cases and late diagnosis of HIV/AIDS had a major impact on outcomes, as did the fact that not all receive appropriate treatment. The HIV treatment cascade served as a useful tool, while the European Action Plan for HIV/AIDS 2012–2015 had shown the way forward for evidence-based policies, which called for commitment and concerted efforts to reach out to vulnerable populations.

International Health Regulations, the assessment and monitoring of core capacities

(EUR/RC65/Inf.Doc/4)

The Coordinator of Support to IHR Capacity Assessment, Development and Maintenance, stressing the essential nature of IHR core capacity-building in the light of the importance of the IHR to global health security, said that the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation had concluded that the data obtained through the existing IHR monitoring framework provided limited information on the functionality of systems at the country level. The variety of approaches that it had subsequently recommended for shorter- and longer-term assessment of IHR core capacities included those of strengthening the self-assessment system, implementing in-depth reviews of significant disease outbreaks and, ultimately, combining self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts.

The principles developed for a post-2016 IHR monitoring scheme were described in document EUR/RC65/Inf.Doc/4 and would be further developed, together with tools and protocols, for approval by the Executive Board at its 138th session in January 2016. Once the tools and protocols had been finalized and pilot tested, the proposed IHR monitoring and evaluation framework would be submitted for approval at the Sixty-ninth World Health Assembly.

The Director, Communicable Diseases, Health Security and Environment, referring to the regional web-based consultation process, appealed to Member States to return their comments by the extended deadline of mid-October 2015 and to attend a related technical workshop to be held in late October. Overall, the Region's capacities were progressing, although data collection required improvement, and it had an active National IHR Focal Point network. Many governments, however, were unaware of the legally binding nature of the IHR or of the need to strengthen intersectoral action for implementation. Ten Member States had required extensions in 2014. Given the commitment of Member States and the Regional Office to the IHR issue, the European Region was well placed to lead new approaches in IHR monitoring and assessment.

A representative speaking on behalf of the EU and its member countries welcomed the proposals for enhancing IHR implementation and for carrying out the recommendations of the Review Committee, adding that the EU member countries were keen to participate in the development or piloting of standardized, transparent and reliable instruments for IHR assessment and also favoured real-time exercises at the regional level. Furthermore, the EU decision No 1082/2013/EU on serious cross-border threats to health would serve as an important tool for the coordination of preparedness. WHO regional offices must assist IHR implementation by encouraging the more function-oriented independent evaluations proposed, which, with the benefit of continuous guidance and support from WHO headquarters, would help countries to identify gaps and plan accordingly. The use of external experts could also be considered in the case of regional assessments. Member States looked forward to learning about the plans being developed by the Regional Director in the vital area of IHR assessment.

Numerous speakers endorsed those comments and urged continuing cooperation for strengthening IHR core capacities, including through the sharing of information and best practices. Cross-sectoral collaboration for effective disaster responses must likewise be developed at all levels, including across the United Nations system, through joint, regional

and global preparedness exercises. Health systems strengthening was also an essential component.

A representative of France drew attention to an international conference on IHR monitoring and reporting to be organized in Lyon, France, in March 2016, in collaboration with WHO and other partners, while a representative of Finland outlined the successful outcomes of the testing of a voluntary external country assessment model, based on peer review, which had been developed for obtaining an overview of preparedness capacities. Together with measurable targets, the baseline information obtained through such methods would assist the elaboration of country plans, in collaboration with WHO country offices and development partners. It was stressed that assessments conducted in the context of the Global Health Security Agenda were not intended to replace IHR reporting.

A representative of Italy highlighted the important role of IHR in health emergencies such as those prompted by the current migrant crisis, which would serve as a laboratory for testing IHR implementation and for monitoring core capacities. His country was fully committed to improving migrant health and thus stood ready to host the conference on migration and health proposed before the end of 2015. A representative of Switzerland said that his country stood ready likewise to support Member States in building their core capacities and called on WHO to develop and coordinate regional and global action plans to that end. In that context, external assessments would promote the standardization of capacities at both those levels. Switzerland encouraged Member States to participate in and contribute to the financing of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation. As part of its contribution to the Global Health Security Agenda, it had also developed a capacity-building programme for government experts in health crisis management.

A representative speaking on behalf of the countries of the SEEHN said that, with respect to migrants and health, gaps had been identified in the public health policies of those countries, which were therefore seeking to standardize relevant protocols and strengthen their coordination activities and health information systems in that domain. WHO input on the issue would be welcome, as would assistance from additional donors in the light of recent developments pertaining to migration.

The Coordinator of Support to IHR Capacity Assessment, Development and Maintenance thanked speakers for their comments, which interlinked well with efforts under way to move the issue collectively forward. The Regional Office welcomed the increase in multisectoral cooperation with all stakeholders on improving IHR implementation and acknowledged the important role of country networks and cross-border health initiatives in that connection. It also appreciated the good intentions demonstrated to enhance notification and reporting practices.

The Director, Communicable Diseases, Health Security and Environment, said that efforts were being made to strike a balance between peer review and other means of assessment and to encourage reporting. WHO was already working in cooperation with civil aviation bodies with regard to operations at ports of entry. He called on experienced Member States to lend their skills in setting up the preparedness exercises mentioned, adding that the Global Health Security Agenda also provided useful tools that should be further piloted in the Region.

The Regional Director said that it would be a pioneering step for the European Region to pilot test the tools and protocols currently in development. She thanked France for its organization of an international conference on IHR monitoring and reporting in March 2016 and of a further meeting on the subject in June 2016. She also thanked Italy for its offer to host an international conference on migrant health in 2015.

Global strategies on people-centred and integrated health services and on human resources for health

(EUR/RC65/Inf.Doc/5)

The Executive Director, Global Health Workforce Alliance at WHO headquarters, introduced the Global Strategy on Integrated, People-centred Health Services and the Global Strategy on Human Resources for Health: Workforce 2030, both of which had been drafted in an extensive, broad-based consultation process in which the European Region had played a significant role. The two strategies were part of a renewed approach to health systems strengthening, based on people-centred health and universal health coverage.

The Global Strategy on Integrated, People-centred Health Services had been drafted in line with the Tallinn Charter: Health Systems for Health and Wealth, with strategic goals for reconsidering models of care and the renewal of primary health care.

The Global Strategy on Human Resources for Health: Workforce 2030 had been developed over the past two years, taking into consideration the principles of obtaining quality health care when required. It had taken into account the WHO Global Code of Practice on the International Recruitment of Health Personnel and its implementation and the Joint Action of the European Union on Health Workforce Planning and Forecasting. The Global Strategy underscored the importance of data- and evidence-based policy and practice. The European Region was already a leader in health workforce information for the Code of Practice. The Strategy also centred on the recognition that the health and social care sectors represented an increasingly significant proportion of economic growth and jobs, and included references to essential public health operations, in particular with regard to health systems strengthening and preparedness.

Member States that had not submitted their reports on implementation of the Code of Practice on the International Recruitment of Health Personnel were urged to do so, since the information contained in those reports would be used to feed into the next iteration of the Global Strategy. Member States would be kept informed of feedback received on the draft document and the resulting revisions to the Global Strategy.

In the discussion that followed, Member States welcomed the progress made in drafting the two new strategies. Concerns were raised that the targets in the two strategies were not aligned: while the Global Strategy on Human Resources for Health: Workforce 2030 contained time-bound targets, the Global Strategy on Integrated, People-centred Health Services did not. A clear methodology for measuring progress would be required. An integrated and balanced set of indicators was needed for both strategies, developed from a universal health coverage perspective. One representative said that while her Government agreed that adequate resources should be allocated to train, develop and retain human resources for health, targets requiring that a certain percentage of gross domestic product should be allocated to health worker production, recruitment, deployment and retention were

too detailed. Resources would come from a variety of financial sources and budget lines and would be difficult to measure. She also questioned the target of allocating 25% of development assistance for health to human resources.

Other speakers added that greater consideration should be given to the profile of the future health workforce and how it would meet the changing needs of the population. A closer link should be made with the Code of Practice for the International Recruitment of Health Personnel. More emphasis should be placed on coordination with other organizations working on health information, such as the Organisation for Economic Co-operation and Development and Eurostat.

The Executive Director, Global Health Workforce Alliance at WHO headquarters, said that Member States' concerns with regard to the targets would be taken into account. Work was being done jointly with the World Bank to consider data on health accounts and estimate the indicative spend required to achieve universal health coverage. WHO already worked closely with the Organisation for Economic Co-operation and Development and Eurostat, and that cooperation would be strengthened. The target on development assistance contributions to health care employment was an existing target that had been sourced from a World Bank document on innovative financing.

Address by the European Commissioner for Health and Food Safety

The Regional Director, welcoming the European Commissioner for Health and Food Safety, said that since signing a joint declaration in 2010, the Regional Office and the European Commission had expanded their collaboration on a range of issues, including health security, antimicrobial resistance, data exchange, NCDs and the public health consequences of social and economic inequalities. Their cooperation had focused on avoiding overlaps in reporting and joining forces to support Member States more efficiently and had led to the development of an effective synergy in critical areas.

The Regional Director was pleased to announce that the Commissioner and she had signed a new joint declaration (document EUR/RC65/Inf.Doc./7), committing the Regional Office and the European Commission to cooperate in six priority areas: innovation and health; health security; modernizing and integrating the public health information system; health inequalities; health systems strengthening; and chronic diseases. The Ebola virus disease outbreak had underscored the importance of effective, efficient, resilient health systems and the need to ensure that Member States had the core capacities identified under the IHR (2005), without which true health security could not be achieved. The Regional Office and the Commission must join forces to that end.

They also had a common duty to ensure implementation of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. The European Commission had a key role to play in addressing social, economic and environmental determinants of health through intersectoral action and integrated policy measures. The 2030 Agenda on Sustainable Development was universal and relevant for all countries in the European Region; collaboration with the European Commission would also be crucial for implementation. Indeed, recent events had made it clear that poverty was not limited to a few countries and that developed and developing countries alike were confronted with the task of protecting their populations from

the negative effects of economic turbulence. Together, the Regional Office and the European Commission must ensure that NCDs, sexual and reproductive health and rights, universal health coverage and the unfinished agenda of the MDGs were addressed under the new sustainable development agenda. She was convinced that the new joint declaration would further strengthen the partnership between the Regional Office and the European Commission and would contribute to the achievement of better health for all in the European Region.

The European Commissioner, Health and Food Safety, said that he welcomed the opportunity for the European Commission and the Regional Office to renew and strengthen their cooperation to achieve their shared objective of better health in Europe. The European Commission, the Regional Office and countries in the European Region had all adopted a range of strategies and programmes to contribute to meeting that objective. Those strategies and programmes must be mutually supportive.

Many unacceptable disparities in health persisted across the European Region, which must be redressed through joint efforts to share information and experiences and initiatives to address shared concerns. Social and economic inequalities were deepening within and between countries to the detriment of social cohesion and economic development. Those gaps must be bridged. Urgent action was required to tackle the particularly high tobacco and alcohol consumption rates in Europe, which were significantly contributing to health services expenditures and the chronic disease burden in European society.

The time had come to renew and strengthen the principles and modalities of cooperation between the European Commission and the Regional Office for Europe: health issues were high on the international agenda. Globalization meant that vigilance must be increased to guard against the increased movement of communicable diseases: the reintroduction of poliomyelitis into Europe showed that international and intersectoral approaches were essential. Cooperation would mean better and more efficient delivery of health care to millions of people. The European Commission and WHO must therefore optimize their cooperation, in particular making use of the European Commission's cross-sectoral structure to emphasize the collective importance of people's health for the overall health of the economy.

Cooperation with regard to health information should be scaled up. The European Commission and WHO would work together to gather data, statistics and information, in a harmonized manner, in order to generate comparisons that could guide policy-making at the national level. Health indicators must be harmonized and enshrined in national and regional strategies, since those strategies could not be effectively implemented without comparative data.

Key areas had been identified, in which enhanced cooperation could be of particular benefit to citizens in the European Region: NCDs and the social determinants of health, including alcohol and tobacco use, and sedentary lifestyle; communicable diseases, with a focus on HIV/AIDS, tuberculosis, hepatitis, measles and rubella – concerted efforts must be made to counter the anti-vaccination movement and the misleading information that it disseminated; antimicrobial resistance; and health systems performance and strengthening.

Under the new joint declaration, staff of the European Commission and the Regional Office for Europe would meet regularly to work towards common objectives. A workplan would be established for the coming year, which would include specific actions for cooperation and

clear deadlines. The systematic approach would mean that progress could be measured and the maximum possible health gains would be brought to all, throughout the European Region and beyond.

Welcoming the renewed expression of partnership between the Regional Office for Europe and the European Commission, speakers emphasized the important role of cooperation with respect to improving health information and health information systems. The European Commission's engagement in the European Health Information Initiative was particularly welcomed and should be strengthened. In that regard, WHO and European Commission indicators must be harmonized in order to facilitate the collection of reliable and comparable data; one Member State called on the European Commission to align its EU indicators with the Health 2020 indicators that have been adopted by all European Member States, including EU member countries. One speaker said she hoped that the renewed cooperation would also stimulate cooperation between the Regional Office and the European Centre for Disease Prevention and Control. Another added that renewed action to address alcohol consumption rates in the European Region was crucial.

Progress reports

Category 1: Communicable diseases

Multidrug- and extensively-drug resistant tuberculosis in the WHO European Region (resolution EUR/RC61/R7 – final report)

(EUR/RC65/12 Part A)

The Regional Committee took note of the progress report on Multidrug- and extensively-drug resistant tuberculosis in the WHO European Region.

Category 3: Promoting health through the life-course

The Millennium Development Goals in the WHO European Region (resolution EUR/RC57/R2; for reporting, see also resolution EURO/RC58/R5)

(EUR/RC65/12 Part B)

The Regional Committee took note of the progress report on the Millennium Development Goals in the WHO European Region.

The future of the European environment and health process (resolution EUR/RC60/R7)

(EUR/RC65/11, EUR/RC65/18)

The Regional Committee took note of the progress report on the future of the European environment and health process.

Category 4: Health systems

Behaviour change strategies and health: the role of health systems (resolution EUR/RC58/R8; see also resolutions EUR/RC58/R4, EUR/RC61/R3, EUR/RC62/R5)

(EUR/RC65/12 Part C)

The Regional Committee took note of the progress report on behaviour change strategies and health: the role of health systems.

Stewardship/governance of health systems in the WHO European Region (resolution EUR/RC58/R4)

(EUR/RC65/8, EUR/RC65/12 Part E)

A representative of one Member State thanked the Secretariat for its work on the final report on implementation of the Tallinn Charter: Health Systems for Health and Wealth. The Tallinn Charter had been a major contributor to solidarity, equity and participation in health systems across Europe. Health systems performance assessment was useful to identify gaps and improve health system efficiency and outcomes. Sustainable health systems financing remained an important challenge for many countries and the dual goals of reaching sustainability and reducing out-of-pocket expenses could be achieved only by increasing efficiency. Public health continues to be an integral part of the health system and an optimal health system focuses on both population and individual health services. Despite progress in health systems strengthening, there was still more to be done and the Tallinn Charter would remain relevant for many years to come.

The Director, Health Systems and Public Health, said that the preparation of the final report on implementation of the Tallinn Charter had been enriching and productive and had been an exercise in looking back at progress made, while also providing a view to the future to steer the movement towards people-centredness. He welcomed the progress made by Member States through their implementation of the Charter, which remained relevant and underpinned the European Region's Health 2020 policy framework.

Category 5: Preparedness, surveillance and response

Implementation of the International Health Regulations (2005) in the WHO European Region (resolution EUR/RC59/R5)

(EUR/RC65/12 Part D)

The Regional Committee took note of the progress report on implementation of the International Health Regulations (2005) in the WHO European Region.

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

(EUR/RC65/R7)

The Regional Committee adopted resolution EUR/RC65/R7, by which it confirmed that its 66th session would be held in Copenhagen, Denmark, from 12 to 15 September 2016, and decided that the 67th session would be held in Budapest, Hungary, from 11 to 14 September

2017, the 68th session would be held from 17 to 20 September 2018, in a location to be decided, and the 69th session would be held in Copenhagen, Denmark, on dates to be decided.

Closure of the session

A representative of one Member State, speaking on behalf of all those present, thanked the Government of Lithuania for hosting the 65th session of the Regional Committee in the beautiful, historic and welcoming city of Vilnius. The efficient organization of the proceedings, the good conduct of business, the engagement of civil society, and the Regional Director's leadership and close relations with the Director-General had all facilitated a productive session, in which key health issues had been discussed and tangible progress had been made to ensure better health for all in the WHO European Region.

Resolutions and decisions

EUR/RC65/R1. Interim report of the Regional Director on the work of WHO in the European Region 2014–2015

The Regional Committee,

Having reviewed the Regional Director's interim report on the work of WHO in the European Region in 2014–2015 (document EUR/RC65/5 Rev.1) and the overview of implementation of programme budget 2014–2015 (document EUR/RC65/Inf.Doc./2);

1. THANKS the Regional Director for the report;
2. EXPRESSES its appreciation of the work done by the Regional Office in the 2014–2015 biennium;
3. REQUESTS the Regional Director to take into account and reflect the suggestions made during the discussions at the 65th session of the Regional Committee when developing the Organization's programmes and carrying out the work of the Regional Office.

EUR/RC65/R2. Report of the Twenty-second Standing Committee of the Regional Committee for Europe

The Regional Committee,

Having reviewed the report of the Twenty-second Standing Committee of the Regional Committee for Europe (documents EUR/RC65/4 Rev.1 and EUR/RC65/4 Rev.1 Add.1);

1. THANKS the Chairperson and the members of the Standing Committee for their work on behalf of the Regional Committee;
2. ADOPTS the amendments to Part 1 of the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe contained in the Annex to this resolution;
3. INVITES the Standing Committee to pursue its work on the basis of the discussions held and resolutions adopted by the Regional Committee at its 65th session;
4. 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 65th session, as recorded in the report of the session.

**Annex. Proposed amendments to Part 1 of 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

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Rule 14

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14.2.2 The rules set forth below shall apply for determining the membership of the Standing Committee.

- (a) Not less than ~~eight~~ eight months before the date fixed for the opening of the next annual session of the Regional Committee, the Regional Director shall inform each Member State of the Region that he or she will receive nominations for membership on the Standing Committee. Nominations shall be made by Member States notifying the Regional Director six months before the date fixed for the opening of the Regional Committee session of their interest in having a representative on the Standing Committee. Member States shall submit with their nominations (1) curricula vitae, in a standard format, of the representatives they intend to appoint if elected to the Standing Committee, and (2) a letter of intent explaining the relationship of the Member State with WHO, its commitment to WHO priorities at the global and regional levels, and the contribution that it would make as a member of the Standing Committee. The Regional Director shall notify all Member States of the Region prior to the start of the World Health Assembly of the nominations so received and shall send to all Member States the curricula vitae of the intended representatives and the letters of intent.

....

Rule 47

....

47.1 At its session preceding the one at which a person is due to be nominated as Regional Director, the Regional Committee shall appoint a Regional Evaluation Group composed of ~~three~~ six members chosen from delegations of the Members attending the Regional Committee, based on equitable geographical representation, to make a preliminary evaluation of candidates for nomination in the light of the criteria specified by the Regional Committee and to perform related functions as set out in this Rule. ~~The Regional Committee shall also appoint three alternates to the Regional Evaluation Group.~~ Four members shall constitute a quorum for the Regional Evaluation Group to conduct its business.

47.2 The rules set forth below shall apply for determining the composition of the Regional Evaluation Group.

- (a) The selection of the members ~~and alternates~~ of the Regional Evaluation Group shall be carried out, *mutatis mutandis*, in accordance with the procedure set forth in Rule 14.2.2. In view of the Standing Committee's oversight role vis-à-vis the Regional

Office, ~~one~~ two members of the Regional Evaluation Group should normally be a persons having either recently served on the Standing Committee or currently representing ~~his or her~~ their countries on that Committee. In the event of an election being held pursuant to Rule 43, the allocation of seats for members ~~and then alternates~~ shall be made in accordance with the order in which members received the majority votes.

- (b) The members ~~and alternates~~ shall cease to serve on the Regional Evaluation Group if a candidate is presented by the Member on whose delegation they served at the Regional Committee when they were appointed. ~~Alternates appointed to the Regional Evaluation Group shall replace members when the latter are unable to complete their term for any reason.~~

47.3 Not less than eleven months before the date fixed for the opening of a session of the Regional Committee at which a person is due to be nominated as Regional Director, the Director-General shall inform each Member of the Region that he or she will receive proposals of names of candidates for nomination by the Regional Committee as Regional Director. Copies shall be sent to the Regional Office's list of official contacts, as well as to the Chairperson of the Regional Evaluation Group.

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 qualifications 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 so as to reach him or her not less than seven months before the date fixed for the opening of the session. This time limit may be extended by the President of the Regional Committee on the proposal of the Regional Evaluation Group. Any such extension shall be communicated by the Chairperson of the Regional Evaluation Group to the Director-General, who shall promptly inform the Member States of the Region.

47.5 A person holding office as Regional Director for the Region shall, if he or she is eligible and has so requested within the time limit referred to in Rule 47.3, be a candidate for nomination without being proposed under the preceding paragraph.

47.6 [Deleted]

47.7 Not later than two weeks after the expiration of the time limit referred to in Rule 47.4, the Director-General shall transmit a list of names and all particulars of candidates received to the Chairperson of the Regional Evaluation Group.

47.8 The Regional Evaluation Group ~~may, if it deems it desirable,~~ shall, unless it exceptionally decides otherwise, make arrangements for all candidates to give a time-limited oral presentation at a meeting to which all Member States of the Region are invited. This arrangement shall, in the interest of due process and transparency, apply in all cases, even when there is only one candidate. In order to give all Member States an equal opportunity to attend such a meeting, it would normally be convened jointly with the Standing Committee during the latter's session immediately prior to the opening of the World Health Assembly.

47.9 The Director-General shall, not less than six months before the date fixed for the opening of the session, cause copies of all proposals for nomination as Regional Director (with particulars of qualifications and experience) received by him or her within the period specified to be sent to each Member of the Region and shall indicate to each Member whether or not the person holding the office is a candidate for nomination. Copies shall be sent to the Regional Office's list of official contacts, as well as to the Chairperson of the Regional Evaluation Group.

47.9 bis Prior to the release of the evaluation report by the Regional Evaluation Group on all candidates provided in Rule 47.10 below, the person(s) who have been proposed for the post of Regional Director and/or the person holding office as Regional Director for the Region who has requested to be a candidate for nomination, as provided by Rule 47.5 above, shall be invited to undergo a medical examination, and to have a completed WHO medical examination form brought to the attention of the Director, Health and Medical Services, at WHO headquarters. The Director, Health and Medical Services, shall inform the Chairperson of the Regional Evaluation Group as to whether the person(s) who have been proposed for the post of Regional Director and/or the person holding office as Regional Director for the Region who has requested to be a candidate for nomination as provided by Rule 47.5 enjoy the good physical condition required of all staff members of the Organization and satisfy the criterion stipulated in paragraph 2(f) of resolution EUR/RC47/R5.

47.10 Not less than ten weeks before the date fixed for the opening of a session, the Chairperson of the Regional Evaluation Group shall send, under confidential cover, the evaluation report of the Evaluation Group on all candidates, and an unranked short-list of not more than five candidates who in its opinion most closely meet the criteria laid down, to the President, the Executive President and the Deputy Executive President of the Committee, to each Member State of the Region according to the Regional Office's list of official contacts, and to the Director-General.

47.11 In the event that the post of Regional Director unexpectedly falls vacant, the Director-General shall:

- (a) designate a person to act as Regional Director until the appointment of a new incumbent;
- (b) decide, in consultation with the President, whether a special session of the Regional Committee should be convened as set out in Rule 5.

47.12 The nomination of Regional Director shall take place at a private meeting of the Regional Committee, which will be attended only by representatives, alternates and advisers of Members of the Regional Committee and by essential members of the Secretariat as established by the Director-General. The Regional Committee shall make a selection by secret ballot from among the persons who are candidates under this Rule, in the following manner:

- (c) at each ballot, each representative entitled to vote shall write on his or her ballot paper the name of a single candidate chosen from those who are candidates under this Rule;
- (d) if a candidate obtains at any ballot the majority required under Rule 39, he or she shall be declared nominated;

- (e) if at a ballot no candidate obtains the required majority and one candidate obtains a lesser number of votes than any other candidate, he or she shall be eliminated and a further election ballot held;
- (f) if at any ballot no candidate obtains the required majority and two or more candidates obtain the same lesser number of votes than other candidates, the Regional Committee shall decide by ballot as to which of the candidates obtaining such lesser number of votes shall be eliminated and, such candidate having been eliminated, a further election ballot shall be held.

47.13 If the number of candidates is reduced to two, and if there is a tie between those two candidates after three further ballots, the names of both those candidates shall be forwarded for selection to the Executive Board.

47.14 The name of the person or persons so nominated shall be announced at a public meeting of the Regional Committee and submitted to the Executive Board.

47.15 ~~[Deleted] The Regional Committee may also inform the Executive Board of the name of another candidate considered suitable for the case where the person first nominated is not available.~~

47.16 The appointment of the Regional Director shall be for five years and he or she shall be eligible for reappointment once only.

EUR/RC65/R3. Physical activity strategy for the WHO European Region 2016–2025

The Regional Committee,

Having considered the Physical activity strategy for the WHO European Region 2016–2025 (document EUR/RC65/9);

Recalling resolution WHA57.17, endorsing the WHO Global Strategy on Diet, Physical Activity and Health;

Recalling resolution WHA66.10, endorsing the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020;

Recognizing the importance of tackling noncommunicable diseases within the policy priorities of Health 2020, the WHO European policy framework for health and well-being;

Noting resolution EUR/RC61/R3, concerning the Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 as a strategic framework for action by Member States in the European Region;

Noting resolution EUR/RC63/R4, endorsing the Vienna Declaration on Nutrition and Noncommunicable Diseases in the context of Health 2020;

Recalling the outcome documents of the Second International Conference on Nutrition;

1. ADOPTS the Physical activity strategy for the WHO European Region 2016–2025;
2. URGES Member States:³
 - (a) to apply the policy priorities options presented in the Physical activity strategy for the WHO European Region 2016–2025 in developing, implementing and evaluating national policies on health enhancing physical activity in a complementary way, as applicable, to existing regional initiatives and actions;
 - (b) to promote physical activity throughout the life-course and aiming to reduce inequalities using evidence-based policies at all levels by facilitating affordable, accessible opportunities for increased physical activities;
 - (c) to set up, if applicable, appropriate governance mechanisms for implementation of multisectoral actions, to promote health enhancing physical activity, to prevent conditions related to physical inactivity and sedentary behaviours;
 - (d) to build intersectoral alliances and networks, engaging relevant stakeholders and fostering citizen empowerment;
 - (e) to support action through regular monitoring, surveillance, evaluation and research;
3. REQUESTS the Regional Director:
 - (a) to support Member States in the implementation of the Physical activity strategy for the WHO European Region 2016–2025 in a way that is complementary to existing regional initiatives, avoiding overlap and duplication of effort;
 - (b) to pursue the aims of the Physical activity strategy for the WHO European Region 2016–2025 and the related aims of the Vienna Declaration, in partnership with international, intergovernmental organizations and non-State actors;
 - (c) to monitor and report to the Regional Committee at its 68th, 72nd and 75th sessions in 2018, 2022 and 2025, respectively, on the implementation of the Physical activity strategy for the WHO European Region 2016–2025 and to report on the mid-term evaluation of the strategy due in 2020.

³ And regional economic integration organizations, where applicable

EUR/RC65/R4. Roadmap of actions to strengthen the implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025

The Regional Committee,

Having considered the Roadmap of actions to strengthen the implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025: making tobacco a thing of the past (document EUR/RC65/10);

Noting that more than ten years have passed since the entry into force of the WHO Framework Convention on Tobacco Control on 27 February 2005;

Noting the decision of the sixth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control towards a stronger contribution by the Conference of the Parties to achieving the noncommunicable disease global target on reduction of tobacco use;⁴

Recalling the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, endorsed by resolution WHA66.10 and noting the global voluntary targets of a 25% relative reduction in the risk of premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases and a 30% relative reduction in the prevalence of current tobacco use in persons aged 15 years and over;

Recognizing the importance of tackling noncommunicable diseases within the policy priorities of Health 2020, the WHO European policy framework for health and well-being;⁵

Noting resolution EUR/RC61/R3, concerning the Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 as a strategic framework for action by Member States in the European Region;

Noting resolution EUR/RC64/R6, adopting Investing in Children: the European Child and Adolescent Health Strategy 2015–2020;

Noting resolution EUR/RC64/R4, endorsing the Ashgabat Declaration on the Prevention and Control of Noncommunicable Diseases in the Context of Health 2020;

1. **ADOPTS** the Roadmap of actions to strengthen the implementation of the WHO Framework Convention on Tobacco Control in the WHO European Region 2015–2025: making tobacco a thing of the past;

2. **URGES** Member States:⁶

⁴ Decision FCTC/COP6(16). Towards a stronger contribution of the Conference of the Parties to achieving the noncommunicable disease global target of reduction of tobacco use. Sixth session of the Conference of the Parties to WHO Framework Convention on Tobacco Control, 13–18 October 2014. Geneva: WHO Framework Convention on Tobacco Control; 2014 ([http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6\(16\)-en.pdf](http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6(16)-en.pdf), accessed 23 July 2015).

⁵ Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.euro.who.int/en/publications/abstracts/health-2020-a-european-policy-framework-and-strategy-for-the-21st-century>, accessed 23 July 2015).

- (a) to give due consideration to the recommendations presented in the Roadmap when developing, implementing and evaluating national evidence-based tobacco control policies in line with the WHO Framework Convention on Tobacco Control, its Guidelines and the Protocol to Eliminate Illicit Trade in Tobacco Products, and in accordance with national circumstances;
 - (b) to set up and reinforce, if applicable, appropriate governance mechanisms for implementation of multisectoral tobacco control policies;
 - (c) to build intersectoral alliances and networks, engaging relevant stakeholders and fostering citizen empowerment to achieve the targets of the Roadmap;
 - (d) to sustainably fund and strengthen national capacity to implement effective tobacco control programmes and measures;
3. CALLS ON international, intergovernmental and nongovernmental organizations to support the Roadmap and to work jointly with Member States, the Convention Secretariat and with the WHO Regional Office for Europe to strengthen national policies in tobacco control;
4. REQUESTS the Regional Director, in cooperation with the Head of the Convention Secretariat:
- (a) to support Member States, upon request, in the implementation of the Roadmap of actions to strengthen the implementation of the WHO Framework Convention on Tobacco Control in the WHO European Region 2015–2025;
 - (b) to pursue the aims of the Roadmap and the relevant aims contained in the Ashgabat Declaration, in partnership with international, intergovernmental and non-State actors;
 - (c) to monitor implementation and report on the implementation of the Roadmap based on the existing reporting requirements of the WHO Framework Convention on Tobacco Control to the Regional Committee at its 68th, 72nd and 75th sessions in 2018, 2022 and 2025, respectively.

EUR/RC65/R5. Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness

The Regional Committee,

Recalling resolution WHA60.27 on strengthening health information systems;

Recalling resolutions WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel and WHA64.7 on strengthening nursing and midwifery;

⁶ And regional economic integration organizations, where applicable

Recalling resolution WHA64.9 on sustainable health financing structures and universal coverage;

Recalling resolution WHA66.23 on transforming health workforce education in support of universal health coverage;

Recalling resolutions WHA67.20 on regulatory system strengthening for medical products, WHA67.21 on access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, WHA67.22 on access to essential medicines, and WHA67.23 on health intervention and technology assessment in support of universal health coverage;

Recalling the Ljubljana Charter on Reforming Health Care in Europe, adopted at the WHO European Conference on Health Care Reforms (Ljubljana, Slovenia, 18–19 June 1996);

Recalling resolution EUR/RC58/R4, by which it endorsed the Tallinn Charter: Health Systems for Health and Wealth, adopted at the WHO European Ministerial Conference on Health Systems (Tallinn, Estonia, 25–27 June 2008);

Bearing in mind that the WHO European policy framework for health and well-being, Health 2020, adopted in resolution EUR/RC62/R4 by the 62nd session of the Regional Committee in 2012, underscores the need for intersectoral action to achieve better and equitable health outcomes;

Recalling resolutions EUR/RC59/R3 and EUR/RC63/R5 on the policy lessons and recommendations of the impact of the economic crisis on health and health systems performance following the high-level meetings on health systems in times of global economic crisis (Oslo, Norway, 1–2 April 2009 and 17–18 April 2013);

Recalling resolution EUR/RC62/R5, by which it endorsed the European Action Plan for Strengthening Public Health Capacities and Services as a necessary component of health improvement in the WHO European Region;

Noting that moving towards universal health coverage requires policies that expand access to quality health services, including public health, safe medicines and competent workforce for all, and provide financial protection, especially against the risk of impoverishment as a result of paying out-of-pocket for care;

Having considered Priorities for health systems strengthening in the European Region 2015–2020: walking the talk on people centredness (document EUR/RC65/13) and the Final report on implementation of the Tallinn Charter – summary (document EUR/RC65/8);

1. WELCOMES the progress accomplished by Member States in the framework of the follow-up to the WHO European Ministerial Conference on Health Systems, in Tallinn, Estonia, on 25–27 June 2008;

2. EXPRESSES its renewed commitment to the values of solidarity, equity and participation as enshrined in the Ljubljana Charter, the Tallinn Charter and Health 2020, the WHO European policy framework, as foundations for health systems strengthening;

3. WELCOMES the strategic priorities of the WHO Regional Office for Europe in the area of health systems strengthening for 2015–2020;
4. CALLS ON Member States:⁷
 - (a) to transform health services to meet the health challenges of the 21st century moving towards a proactive, people-centred approach involving better coordination and delivery of health promotion, disease prevention, health care and condition management throughout the life-course aiming at improved quality and health outcomes and reduced health inequalities within a comprehensive continuum of individual- and population-based health services;
 - (b) to work towards achieving and sustaining universal health coverage for a Europe free of impoverishing out-of-pocket payments;
 - (c) to note that health systems strengthening activities also require appropriate policies for ensuring an adequate health workforce, ensuring equitable access to services and interventions, including population-level public health services, as well as to cost-effective medicines and technologies, and strengthening quality health information and health information systems as the key foundations to evaluate and further underpin them;
 - (d) to promote transparency and accountability for people-centred health systems strengthening, including through the promotion and use of health systems performance and other relevant information and evidence in decision-making, in order to better meet the needs of the people and attain health system goals, ensuring that robust health systems strategies, consistent with WHO and national values are linked to clear performance expectations;
 - (e) to facilitate and accelerate monitoring of the extent to which people are protected against financial risk when using health services, and to identify and implement policies to improve financial protection, especially for vulnerable groups of people;
5. REQUESTS the Regional Director:
 - (a) to continue providing leadership in the field of value-driven health systems strengthening in collaboration with partners;
 - (b) to support Member States in strengthening their health systems in line with the strategic priorities for the WHO Regional Office as set out in document EUR/RC65/13 and pursue the commitments of health systems strengthening agreed in the Tallinn Charter, in partnership with international, intergovernmental and non-State actors;
 - (c) to provide Member States with tools and support for activities described under OP4, in particular for monitoring financial protection and for policy analysis, development, implementation and evaluation;

⁷ And regional economic integration organizations, where applicable

- (d) to develop, taking into account the specific needs of the European Region and minimizing any additional costs, a framework for action to implement the WHO global strategy on people-centred and integrated health services to be adopted at the Sixty-ninth World Health Assembly, for submission to the Regional Committee at its 66th session in 2016;
- (e) to report on implementation of this resolution, focusing mainly on the extent of financial protection at the regional level and on policy options for improving financial protection to the Regional Committee at its 68th session in 2018; and
- (f) to provide a final report to the Regional Committee at its 71st session in 2021.

EUR/RC65/R6. Tuberculosis action plan for the WHO European Region 2016–2020

The Regional Committee,

Having considered the Tuberculosis action plan for the WHO European Region 2016–2020 (document EUR/RC65/17 Rev.1);

Recognizing the importance of tackling tuberculosis within the framework of Health 2020,⁸ the WHO European policy framework, to improve the health and well-being of populations and to reduce health inequalities;

Noting the commitment of the WHO European Region to respond urgently to the threat tuberculosis poses to public health and among those Member States that participated, through the Berlin Declaration on Tuberculosis, adopted by the WHO European Ministerial Forum – All Against Tuberculosis in 2007, and the Eastern Partnership Ministerial Conference on Tuberculosis and Multidrug-resistant Tuberculosis; and to end tuberculosis in the European Region through the Joint Riga Declaration on Tuberculosis and its Multidrug-resistance in 2015;

Recalling World Health Assembly resolution WHA62.15 on prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis (M/XDR-TB) as part of the transition to universal health coverage, and the 2009 Beijing “Call for Action” on tuberculosis control and patient care;

Recalling resolution EUR/RC61/R7, which adopted the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015 as a strategic framework for action by Member States in the European Region;

⁸ Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.euro.who.int/en/publications/abstracts/health-2020-a-european-policy-framework-and-strategy-for-the-21st-century>, accessed 23 July 2015).

Recalling resolutions EUR/RC61/R6 and WHA68.7 on antibiotic resistance as policies to prevent and mitigate antimicrobial resistance, which also contribute to the prevention and control of M/XDR-TB;

Acknowledging that most of the milestones for Member States, the Secretariat and partners to scale up a comprehensive response to prevent and control tuberculosis and M/XDR-TB under the Consolidated Action Plan have been achieved, including significant increases in case detection and treatment coverage, and that Millennium Development Goal 6 on reversing tuberculosis incidence has been reached;

Concerned that despite this progress, there is continuing primary transmission of MDR-TB and decreasing treatment success rates among M/XDR-TB patients in several Member States;

Concerned over an increasing prevalence of HIV among tuberculosis cases and a growing inequality highlighted by the divergent epidemiological picture of tuberculosis across the Region and within countries, particularly among vulnerable groups, and aware that tuberculosis and MDR-TB are also cross-border health threats due to increased mobility of the population;

Recognizing the need for increased political commitment to ensure efficient and evidence-based tuberculosis prevention and expanded access to new models of care, new drugs and tools, as well as social approaches and strategies for tuberculosis management in the context of health systems strengthening;

Noting that the post-2015 global End TB Strategy for ending the global tuberculosis epidemic by 2035, endorsed by resolution WHA67.1, calls for regional support in the implementation of the Strategy; and acknowledging alignment of the Tuberculosis action plan for the WHO European Region 2016–2020 with the global End TB Strategy;

Understanding that this resolution covers the period from 2016–2020 and thereby succeeds resolution EUR/RC61/R7, which endorsed the Consolidated Action Plan from 2011–2015;

1. ADOPTS the Tuberculosis action plan for the WHO European Region 2016–2020 and its targets;
2. URGES Member States:⁹
 - (a) to align, as appropriate, their national health strategies and/or national tuberculosis and M/XDR-TB response with the Tuberculosis action plan for the WHO European Region 2016–2020 and to closely monitor and evaluate implementation as outlined in the action plan;
 - (b) to facilitate equitable access to early diagnosis and effective treatment until completion for all forms of tuberculosis including rational and adequate use of new drugs;
 - (c) to identify and address health systems challenges related to the prevention and care of all forms of tuberculosis, particularly to integrate tuberculosis services into the

⁹ And regional economic integration organizations, where applicable

primary health care level and to scale-up patient-centred care initiatives and approaches and improve access to tuberculosis prevention and care for hard-to-reach and vulnerable populations;

(d) to address social determinants of tuberculosis, the prevention of insurmountable costs to patients and their households due to tuberculosis, and the provision of social support to patients, including multisectoral and civil society collaboration as appropriate;

(e) to adopt sustainable financial mechanisms and strengthen human resources capacity for tuberculosis prevention and care, particularly in countries with decreasing external funding, and to move from external financing to self-financing: working with all relevant actors, including ministries of health and finance, parliaments, intergovernmental and non-State actors, to secure the long-term sustainability of programmes, including services for hard-to-reach and vulnerable populations, from domestic resources;

3. REQUESTS the Regional Director:

(a) to support Member States in the implementation of the Tuberculosis action plan for the WHO European Region 2016–2020 by providing leadership, strategic direction and technical support to Member States, upon request;

(b) to continue working in partnership with international, intergovernmental and non-State actors;

(c) to monitor implementation and report to the Regional Committee at its 68th and 70th sessions in 2018 and 2020, respectively, on implementation of the Tuberculosis action plan for the WHO European Region 2016–2020.

EUR/RC65/R7. Date and place of regular sessions of the Regional Committee for Europe in 2016–2019

The Regional Committee,

Recalling its resolution EUR/RC64/R8 adopted at its 64th session;

1. RECONFIRMS that the 66th session shall be held in Copenhagen, Denmark, from 12 to 15 September 2016;

2. DECIDES that the 67th session shall be held in Budapest, Hungary, from 11 to 14 September 2017;

3. DECIDES that the 68th session shall be held from 17 to 20 September 2018, exact location to be decided;

4. FURTHER DECIDES that the 69th session shall be held in Copenhagen, Denmark, exact dates to be decided.

EUR/RC65(1). Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice

The Regional Committee,

1. WELCOMES and supports Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice (document EUR/RC65/16), which is at the heart of Health 2020, the WHO European policy framework, and which underscores the need to encourage the development of sustainable mechanisms that enable cooperation between sectors in order to achieve health, equity and well-being for the whole population through action on policy coherence and mechanisms for accountability, as well as synergy and coordination;

2. REQUESTS the Regional Director:

- (a) to initiate, in close collaboration with the Standing Committee of the Regional Committee, under the leadership of the Regional Committee, and in consultation with Member States, meetings across the European Region to promote intersectoral work that supports implementation of Health 2020, the WHO European policy framework; and
- (b) to report on the outcome of the mid-term evaluation of progress with regard to uptake and implementation of the Health 2020, the WHO European policy framework (resolution EUR/RC62/R4), to the Regional Committee at its 66th session in 2016.

Annex 1. Agenda

1. Opening of the session

- (a) Election of the President, the Executive President, the Deputy Executive President and the Rapporteur
- (b) Adoption of the provisional agenda and the provisional programme

2. Addresses

- (a) Address by the Regional Director and interim report on the work of WHO in the European Region since the 64th session of the Regional Committee for Europe (RC)
- (b) Address by the Director-General
- (c) Address by the European Commissioner for Health and Food Safety
- (d) Address by Her Royal Highness The Crown Princess of Denmark
- (e) Address by the President of the Republic of Lithuania

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

4. Report of the Twenty-second Standing Committee of the Regional Committee for Europe

5. Policy and technical topics

- (a) Promoting intersectoral and interagency action for health and well-being in the WHO European Region, including discussions on:
 - environment and health in the WHO European Region: progress, challenges and lessons learned;
 - health in sustainable development and foreign policy;
 - social determinants and health, and health literacy: links and coherence between health, education and social policy
- (b) The European Health Report 2015: Targets and beyond – reaching new frontiers in evidence
- (c) Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness
- (d) Physical activity strategy for the WHO European Region 2016–2025
- (e) Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025: making tobacco a thing of the past
- (f) Final report on implementation of the Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the

WHO European Region 2011–2015 and consideration of the proposed
Tuberculosis action plan for the WHO European Region 2016–2020

- (g) Partnerships for health in the WHO European Region
- (h) WHO reform: progress and implications for the Regional Office for Europe
 - WHO’s work in outbreaks and emergencies with health and humanitarian consequences
 - Overview of global governance reform
 - Accountability and compliance
- (i) Regional plan for implementation of programme budget 2016–2017
- (j) Progress reports

Category 1: Communicable diseases

- Multidrug- and extensively drug-resistant tuberculosis in the WHO European Region (resolution EUR/RC61/R7) – final report

Category 3: Promoting health through the life-course

- The Millennium Development Goals in the WHO European Region (resolution EUR/RC57/R2; see also resolution EUR/RC58/R5)
- The future of the European environment and health process (resolution EUR/RC60/R7)

Category 4: Health systems

- Behaviour change strategies and health: the role of health systems (resolution EUR/RC58/R8; see also resolutions EUR/RC58/R4, EUR/RC61/R3, EUR/RC62/R5)
- Stewardship/governance of health systems in the WHO European Region (resolution EUR/RC58/R4)

Category 5: Preparedness, surveillance and response

- Implementation of the International Health Regulations (2005) in the WHO European Region (resolution EUR/RC59/R5)

6. Private meeting: elections and nominations

- (a) Nomination of two members of the Executive Board
- (b) Election of four members of the Standing Committee of the Regional Committee
- (c) Election of two members of the European Environment and Health Ministerial Board

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

- Women's health in the WHO European Region
- Making progress towards a sustainable health workforce in the WHO European Region
- Evidence-informed policy-making in the WHO European Region
- Migration and health in the WHO European Region

Ministerial lunches

- Migration and health in the WHO European Region
- Health 2020 implementation: Lithuanian experience and achievements

Annex 2. List of documents

Working documents

EUR/RC65/1 Rev.2	Provisional list of documents
EUR/RC65/2 Rev.2	Provisional agenda
EUR/RC65/2 Rev.2 Add.1	Provisional agenda (annotated)
EUR/RC65/3 Rev.2	Provisional programme
EUR/RC65/4 Rev.1	Report of the Twenty-second Standing Committee of the Regional Committee for Europe
EUR/RC65/4 Rev.1 Add.1	Twenty-second Standing Committee of the Regional Committee for Europe: report of the fifth session
EUR/RC65/5 Rev.1	The work of WHO in the European Region in 2014–2015: interim report of the Regional Director
EUR/RC65/6	Matters arising from resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC65/7	Membership of WHO bodies and committees
EUR/RC65/7 Add.1 Rev.1	Membership of WHO bodies and committees
EUR/RC65/7 Add.2	Membership of WHO bodies and committees
EUR/RC65/8	Final report on implementation of the Tallinn Charter – summary
EUR/RC65/9	Physical activity strategy for the WHO European Region 2016–2025
EUR/RC65/9 Add.1 Rev.1	Financial and administrative implications for the Secretariat of the draft Regional Committee resolution on the Physical activity strategy for the WHO European Region 2016–2025
EUR/RC65/10	Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025: making tobacco a thing of the past
EUR/RC65/10 Add.1 Rev.1	Financial and administrative implications for the Secretariat of the draft Regional Committee resolution on Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025: making tobacco a thing of the past
EUR/RC65/11	Environment and health in the WHO European Region: progress, challenges and lessons learned
EUR/RC65/12	Progress reports
EUR/RC65/13	Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness

EUR/RC65/13 Add.1	Financial and administrative implications for the Secretariat of the draft Regional Committee resolution on Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness
EUR/RC65/14	Regional plan for implementation of programme budget 2016–2017 in the WHO European Region
EUR/RC65/15	WHO reform: progress and implications for the European Region
EUR/RC65/16	Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice
EUR/RC65/17 Rev.1	Tuberculosis action plan for the WHO European Region 2016–2020
EUR/RC65/17 Add.1 Rev.2	Financial and administrative implications for the Secretariat of the draft Regional Committee resolution on Tuberculosis action plan for the WHO European Region 2016–2020
EUR/RC65/18	Progress report on the European Environment and Health Process

Conference documents

EUR/RC65/Conf.Doc./1 Rev.1	Report of the Regional Director on the work of WHO in the European Region 2014–2015
EUR/RC65/Conf.Doc./2 Rev.1	Report of the Twenty-second Standing Committee of the Regional Committee for Europe
EUR/RC65/Conf.Doc./3 Rev.2	Date and place of regular sessions of the Regional Committee for Europe in 2016–2019
EUR/RC65/Conf.Doc./4 Rev.1	Physical activity strategy for the WHO European Region 2016–2025
EUR/RC65/Conf.Doc./5 Rev.2	Tuberculosis action plan for the WHO European Region 2016–2020
EUR/RC65/Conf.Doc./6 Rev.1	Roadmap of actions to strengthen the implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025: making tobacco a thing of the past
EUR/RC65/Conf.Doc./7 Rev.1	Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness
EUR/RC65/Conf.Doc./8 Rev.1	Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice

Information documents

- EUR/RC65/Inf.Doc./1 Regional plan for implementation of programme budget 2016–2017 by category in the WHO European Region
- EUR/RC65/Inf.Doc./2 Overview of implementation of programme budget 2014–2015 in the WHO European Region
- EUR/RC65/Inf.Doc./3 Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections (2016–2021)
- EUR/RC65/Inf.Doc./4 Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005)
- EUR/RC65/Inf.Doc./5 Global Strategy on Integrated, People-centred Health Services and Global Strategy on Human Resources for Health: Workforce 2030
- EUR/RC65/Inf.Doc./6 Public Health Aspects of Migration in Europe (PHAME): Project implementation 2012–2015
- EUR/RC65/Inf.Doc./7 The objectives, principles and modalities for continued cooperation between the European Commission and the WHO Regional Office for Europe

Annex 3. List of representatives and other participants

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Annex 4. Address by the Regional Director

Your Royal Highness, Madam Director-General, Mr Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Mr United Nations Special Envoy for HIV/AIDS in Eastern Europe and Central Asia,

Honourable ministers, Excellencies, colleagues, ladies and gentlemen,

Better health for Europe: more equitable and sustainable – that is what we agreed to work for.

Last year was challenging. We fought Ebola; we saw children dying from measles and diphtheria; now we face cases of poliomyelitis (polio) in the WHO European Region, and there is a large influx of refugees and migrants, with many people asking for help.

We made good progress in many areas but we must do more and we must do better in some.

On key Health 2020 indicators, such as life expectancy, Europeans are living longer and the differences between countries in health outcomes are shrinking: a clear sign that inequalities are declining and Health 2020 works. But the gap between the countries with the highest and lowest life expectancy is still 11 years.

The Region is on track towards reducing premature mortality due to the decline in cardiovascular diseases, and Europeans are reducing their health risk behaviours. But people in Europe still smoke and drink more than anywhere else in the world, and they are among the most obese.

More decision-makers are making coherent and interconnected government policies, with a strong intersectoral component, and are using Health 2020 as the way forward. From 2010 to 2013, the proportion of countries with national health policies aligned with Health 2020 almost doubled: from 38% to 70%. And I am proud of this.

This progress demonstrates what we can do if we are committed and work together but it also shows that we have many challenges ahead, confirming that the key strategic directions of Health 2020 remain more relevant than ever before.

All the determinants of health – social, economic and environmental challenges and demographic changes – affect both people's health and health systems. Migration, the ageing of the population and health-workforce mobility are only a few examples.

Only the governments that put health and well-being high on their social, economic and development agenda will be able to overcome these challenges. Health is a political choice.

In essence, Health 2020 supports making the right political choices for health. Our key role is to protect health as a universal value and to promote it as a social and political goal for governments and societies as a whole.

The economic case for investment in health is strong. Investing in health generates cost-effective health outcomes and economic, social and environmental benefits. The health

sector's call on government to invest in health will make this change happen. We need to deliver this message loudly.

For example, current evidence suggests that investment in reproductive, maternal and child health has a potential return of more than US\$ 20 for every dollar spent. The argument for investing in the best-buy interventions is equally clear for addressing noncommunicable diseases.

Tomorrow, we are proud to launch the study on the economics of prevention, one of the Health 2020 studies prepared by the Regional Office, the European Observatory on Health Systems and Policies and the Organization for Economic Co-operation and Development. I would like to thank the Government of Belgium for hosting the Observatory.

Current investments in health and public health are not sufficient. We need to invest more. It is alarming to see that, between 2007 and 2011, the health share of public spending fell in 24 countries in Europe. By tapping into new sources, improving efficiencies and giving priority to health, I am sure that all countries can find ways to raise sufficient funds for health.

But they cannot do this on their own, and need to work in partnership, especially with those responsible for social and fiscal policies.

Development is impossible without better health. Health is a precondition for alleviating poverty, as we heard from Her Royal Highness, and an indicator and outcome of progress towards a sustainable society.

This is an exciting year. Within 10 days, world leaders will gather at the United Nations summit to adopt the Agenda for Sustainable Development to end poverty by 2030. The Agenda has universal goals that will apply to every nation – not just to developing countries.

Among the 17 sustainable development goals, the one for health is central. It aims to “ensure healthy lives and promote well-being for all at all ages”. There is increasing acceptance that the new health goal must also aim to achieve universal health coverage in every community in every country of the world.

The formulation of the health goal is fully aligned with Health 2020. This was confirmed at the regional consultation for the post-2015 development agenda, where Health 2020 was defined as the regional framework for this new vision for health.

Focusing solely on the health goal would be a missed opportunity. All the sustainable development goals will influence health because they all address the determinants of health. The 2030 Agenda will link different dimensions of development – including health – to the environment, to prosperity and to all actions and policies that people need.

Now we have a historic political responsibility to pursue the integration of health and well-being into each and every goal. We have the opportunity to put into practice the whole-of-government and whole-of-society approaches to which we subscribed through Health 2020.

The new development agenda will need translation into national development plans, with health at their heart. We are fully committed to supporting you in implementing national development plans.

Health 2020 is key in this renewed policy environment, and the expectations we formed in 2011 are becoming a reality. All Member States have shown incredible enthusiasm in embracing the principles of Health 2020.

You are showing us that real improvements in health can be achieved if we work across government. Intersectoral action is essential for policy coherence and provides the basis for accountability in health. It is therefore the major theme of this Regional Committee.

Intersectoral action for health requires political commitment. It should focus on key public health priorities and upstream interventions by addressing the determinants of health and health equity, and strive for maximum impact by creating win-win partnerships.

Our Region has much experience with intersectoral action on, for example, the International Health Regulations, antimicrobial resistance and health-system financing, working with ministries of finance.

One concrete example is the European Environment and Health Process. With its 26 years of experience in intersectoral work, it has proved to be a good model.

It brings together different sectors on an equal footing, and the Environment and Health Ministerial Board illustrates the importance of a well-constructed political process. The European Environment and Health Task Force ensures accountability and establishes a link to national implementation.

Generously supported by the Government of Germany, our office in Bonn provides evidence and technical support to address environment and health challenges in our Region.

We are grateful to Israel for hosting the successful mid-term review meeting in Haifa. It provided clear direction towards the Sixth Ministerial Conference on Environment and Health, planned for 2017. I invite you all to actively engage in the preparations.

Health 2020 prioritizes the social determinants of health and health literacy. Social policies – ranging from employment and education to housing – must be a strategic priority. We discussed this at the meeting in Paris in April and the meeting of the Small Countries Initiative in Andorra in June.

Health has great significance in foreign policy processes and development cooperation. We discussed this in Berlin in April and at the International Health Forum in Ashgabat in July, and we will continue to support Member States in the year ahead. We look forward to learning from your experiences during the ministerial panel tomorrow.

Taking leadership in intersectoral processes requires a new mindset and capacities in health ministries. These processes are ongoing and are showing positive results. We are supporting the establishment of intersectoral committees in countries. We developed sectoral and thematic policy briefs to contribute to their agenda setting and successful outcomes.

European consultative processes to engage Member States that are interested in joining will help promote intersectoral work across the European Region in support of its national implementation. They will allow dialogue, sharing of experiences and common actions between countries, institutions and sectors. We suggest that they focus initially on education, finance and social sectors to promote social determinants and health literacy.

We worked intensively on the successful development and implementation of national health policies aligned with Health 2020. Networks became a more powerful platform for sharing practical experience with implementing Health 2020 among countries.

For example, the countries of the South-eastern Europe Health Network are committed to intergovernmental and intersectoral action, and agreed to further scale up implementation of Health 2020, which is in line with their South-east Europe 2020 strategy.

The Small Countries Initiative is another efficient network. Inspired by Health 2020, its members are committed to aligning their national health policies and implementing the Health 2020 vision, as shown by the San Marino Manifesto and the Andorra Statement.

I am honoured to have received the San Marino Order of Saint Agatha last month for improving health in San Marino and throughout the Region. This award is a clear recognition of the value of Health 2020 and the work of WHO.

Local leadership and intersectoral action are very important and can be innovative. The Healthy Cities and Regions for Health networks help to support subnational implementation of Health 2020 and sharing of good practices. We shall hear more about this tomorrow.

Thanks to the Government of Italy for supporting our office in Venice for investment in health and development, which contributes to our work in this important area.

Now let me move to communicable diseases. While the Region has made much progress, these diseases still challenge Europe's public health.

Over the past five years, the Region has made major progress in the fight against tuberculosis. Over 1 million tuberculosis patients were cured; about 200 000 cases of multidrug-resistant tuberculosis (MDR-TB) were averted; and more than 2.6 million lives were saved.

The incidence of tuberculosis dropped by 6% during each of the past five years: the fastest decline of all WHO regions. All patients detected with MDR-TB received treatment, compared to only 63% in 2011.

Extensive actions and initiatives taken in partnership, with your leadership and commitment, made this possible. You reiterated your commitment in the Riga Declaration at the first Eastern Partnership Conference in March. Thanks to the Latvian Presidency of the European Union (EU) for its leadership.

Yet this is not enough to end the tuberculosis epidemic by 2035 and eliminate the disease by 2050. Through the proposed European tuberculosis action plan, we estimate that more than 1.4 million tuberculosis patients will be cured, 1.7 million new cases will be prevented, and over 3 million lives and US\$ 48 billion will be saved. It will be presented on Wednesday, and I call for your continued commitment to make our dream of eliminating tuberculosis in our lifetime come true.

Unfortunately, progress towards HIV control is not as good. With 136 000 new infections, 2014 was the year with the highest number of new HIV cases – a staggering 80% increase since 2004.

Since 2010, I have repeatedly drawn your attention to this alarming situation, calling for concerted action. Evidence is available; we know what works. Only bold action in implementing evidence-based policies will get us on track to end the epidemic by 2030.

Viral hepatitis remains unaddressed throughout the Region, with 13 million people estimated to live with chronic hepatitis B and 15 million with chronic hepatitis C, leading to 400 deaths related to viral hepatitis a day.

Even though treatments are now available for hepatitis B and C, access and affordability remain a challenge for most countries. We must take a comprehensive approach to fight this silent killer, using available tools and focusing on prevention.

I look forward to your input to define how the Regional Office can support you in controlling these public health threats when we discuss the global health sector strategies on Thursday.

We are very close to a historic achievement: eliminating malaria by the end of 2015. As of today, there are no locally acquired malaria cases in the whole Region. Let me congratulate you all on your commitment and dedication, in partnership with all stakeholders.

The achievements are huge but the situation is fragile, and we must remain vigilant. I request all of you to maintain the highest political commitment. This will be the focus of a high-level consultation in Turkmenistan in February next year.

Vaccine-preventable diseases continue to burden our Region. The loss of a child from diphtheria, the deaths of children from measles complications, alongside thousands of cases of measles, represent solemn reminders of unfinished business. Accepting the status quo is not an option.

There is no stronger reminder of the need for vigilance than the return of polio. The report of two cases in Ukraine, on 28 August, is alarming, particularly given the large pockets of susceptible populations who could be exposed to this crippling, deadly disease.

We immediately deployed a rapid response team to start case investigation and risk assessment. We are supporting the Ministry of Health in preparing for three rounds of national supplementary immunization campaigns. Vaccine is being distributed in the country as we speak, and the first round of immunization will start this week.

I commend the Ukrainian authorities for their commitment to taking all necessary action for a rapid response. I also thank the Global Polio Eradication Initiative partners for their support. It is imperative that Ukraine and all European countries continue to mitigate the risks posed by polio by maintaining high immunization coverage and surveillance.

In adopting the European Vaccine Action Plan last year, you committed yourselves to eliminating measles and rubella by 2015. While many countries are on track to do this by the end of this year, the regional goal continues to elude us owing to the lack of steadfast political commitment in some countries. I need you, as leaders, to stand by your commitments to eliminate measles and rubella.

The tenth anniversary of European Immunization Week, celebrated throughout the Region in April, included some of the most interactive and high-profile efforts to promote immunization that we have seen to date.

I was honoured to visit Tajikistan with Her Royal Highness The Crown Princess of Denmark in October to advocate stronger immunization delivery and increased investment in maternal and child health services.

In the area of noncommunicable diseases, we continue to see significant advances in implementation of the action plan for the prevention and control of noncommunicable diseases.

We continue to see a decline in mortality from cardiovascular diseases in almost all countries. Declines in behavioural risk factors, including smoking, and biological risk factors, such as high blood pressure and serum cholesterol, contribute to these reductions.

The overall consumption of alcohol is falling by about 2% per year, and tobacco smoking among adults continues to decline. Nevertheless, ours remains the Region with the highest overall rate of adult smoking.

I am proud that our countries are taking global leadership in plain packaging for tobacco products. France, Ireland and the United Kingdom were pioneers and several other countries announced their intent to follow. Congratulations to the WHO Framework Convention on Tobacco Control (WHO FCTC) for a decade of action.

Since my last report, four additional countries in our Region have become parties to the Protocol to Eliminate Illicit Trade in Tobacco Products. I congratulate them and call on others to join.

On Wednesday, we will discuss the proposed roadmap for tobacco control, setting an ambitious goal of full implementation of the WHO FCTC. We are grateful to Turkmenistan for its pledge to support implementation of the roadmap in the coming years.

We will also discuss the physical activity strategy for the Region, which complements the action plan on food and nutrition adopted last year. Our achievements since then include attaining a membership of 30 countries participating in the Childhood Obesity Surveillance Initiative.

Member States have approached me to express concerns about the neglect and abuse of adults with intellectual disabilities who live in institutions. This challenge requires intersectoral action, and we cannot ignore this as a Region. I have initiated a review and will report back, presenting the way forward.

There is strong evidence that improved medical care is a strong contributor to declining illness and mortality from cardiovascular diseases. We will review this new evidence at an international conference in Saint Petersburg in November.

It is my special plea that Europe increase its attention to the management of noncommunicable diseases, while re-examining its programmes for early detection and screening. We developed a package of 15 essential interventions to tackle noncommunicable diseases, which is being implemented in 23 countries. All of these are core components of the package.

Our capacity to respond to noncommunicable diseases increased this year with the launch of the new geographically dispersed office (GDO) for noncommunicable diseases in Moscow. We are grateful to the Government of the Russian Federation for its support.

Many countries are applying the life-course approach in developing their national policies or improving collaboration between sectors, which is a key strategic direction of Health 2020.

The WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020, to be held in Minsk in October, will be the first event to link the sustainable development goals with Health 2020 and to focus on maternal and child health, as well as reproductive health and rights. I would like to thank Belarus for hosting this important event.

We are making progress in improving women's health but wide inequities between and within countries remain. The use of modern, effective methods of contraception is alarmingly low in many countries. Some countries have the highest abortion rates in the world.

Effective perinatal care resulted in the decrease in the major killer of mothers – severe obstetrical bleeding. Now is the time to focus on pre-existing medical conditions – such as diabetes, obesity, cardiovascular diseases and mental diseases – that are exacerbated by pregnancy.

More needs to be done on sexual and reproductive health and rights – an area we plan to bring to your attention in the future. We will outline the European women's health report, to be published in 2016, at the technical briefing today.

Our work to strengthen health systems and public health capacity aims to improve health outcomes in an equitable manner, ensuring financial protection, responsiveness and efficiency.

The Tallinn Charter: Health Systems for Health and Wealth guided this work, and we will present the final report on its implementation on Wednesday. This report fed directly into the new vision for health systems strengthening for the next five years.

Transforming health services to match the needs of the 21st century is the strategic priority of this new vision, which reaches out to the voice of the people. It will provide health leaders with an inclusive approach that harnesses feedback from citizens in designing health systems that are more responsive to their needs.

Coordinated, integrated health service delivery towards people-centred care is the way forward. We scaled up our efforts and are preparing an action-oriented framework that will be presented to the Regional Committee next year.

Taking forward the renewed vision of the Declaration of Alma-Ata and integration of the essential public health functions, we support countries in revising their delivery models for primary health care, with a focus on quality.

The inauguration of the GDO on primary health care, in Almaty in February, expanded our capacity. Thanks to the Government of Kazakhstan for its support.

The world health report estimates that, in 2010, 19 million people faced catastrophic payments in the Region and 7 million faced impoverishing expenditure. Universal health

coverage is central to addressing this challenge. We are working on updating these estimates and have accelerated our support to countries.

Annual training courses delivered by the Barcelona Office were a continuing success. Many senior officials from 33 Member States benefited from one of the two courses in 2015. Let me thank the Government of Spain for its continued support to the Barcelona Office for Health Systems Strengthening.

We are addressing health systems barriers for specific diseases and conditions, including communicable diseases and noncommunicable diseases. That work is then translated into policy decisions and actions. We are now broadening the focus to include environmentally sustainable health systems.

Our collective investments in health information, evidence and research, as the basis for policy-making, are paying off. Since its launch in 2012, the European Health Information Initiative has been the umbrella for all health information activities and I encourage you to join. Let me now highlight some of the Initiative's main achievements.

We continued to work on the development of information on health and well-being, with a focus on indicators. This year, we examined new evidence on cultural determinants, which will help us consider the impact of culture on health and well-being across the diverse European Region.

We supplied a wide range of information and analytical resources, including the new health information web portal. It is widely used by policy-makers, and soon will allow simultaneous analysis of indicators in all databases.

In addition to tools for health information strategies and national e-health strategies, we actively supported the conference on e-health held in Riga during eHealth Week in May.

We launched a new a bilingual journal, *Public Health Panorama*, to highlight successful examples in countries. We are launching the second issue, with a special theme of intersectoral policies, at this Regional Committee.

The annual Autumn School on Health Information and Evidence for Policy-making, hosted by Poland in October 2014, was a real success. As you requested, we organized an advanced workshop on health information and data assessment in Moscow in July 2015 to give more in-depth training.

The Central Asian Republics Health Information Network is a platform for improving health information systems. The Evidence-informed Policy Network Europe aims to build countries' capacity. We will discuss this at the technical briefing on Wednesday, when we present an accelerated roadmap for evidence-informed policies.

The Health Evidence Network provides syntheses of best available evidence for policy-makers. We launched two reports last year; three more, on migration and health, will be presented at the ministerial lunch today.

The recent Ebola outbreak in West Africa demonstrated that the international community is not sufficiently prepared to manage major health hazards. We contributed to the response by

deploying 25 staff on 36 missions from the Regional Office. We are grateful to all partners and Member States for their support for the response.

This is a defining moment for change. We have to ensure that the world is adequately prepared to effectively detect and respond whenever and wherever an emergency with health consequences strikes.

We are fully committed to taking all necessary action. This is clear in the statement issued in March by the Director-General and the six regional directors. We are moving ahead with the six areas of work outlined by the Director-General, and we will discuss progress and next steps later today.

At the Regional Office, we take an integrated, generic, all-hazards and multisectoral approach to preparedness for both humanitarian and public health emergencies. Risk communication is an integral element.

Back in 2010, I merged three areas of work – outbreak alert and response, the International Health Regulations (IHR) and country emergency preparedness – under a clear command and control system. We continuously screen signals of potential health threats. We revised our emergency procedures and the emergency operations centre in the Regional Office functions as the regional hub.

Compliance with IHR obligations is crucial for national and global health security. Many Member States have raised the need to supplement the self-assessment of core capacities with independent evaluations. Your input to the proposed global approach to IHR monitoring and evaluation is critical, and I look forward to the discussion on Thursday.

Better Labs for Better Health is a new initiative that we launched to improve laboratory capacity to detect and respond to diseases and outbreaks. It is an important component of IHR core capacity, and I ask Member States and all stakeholders to join the initiative to make it a success.

We will soon sign the host agreement with the Government of Turkey to establish the GDO in Istanbul for preparedness for humanitarian and health emergencies, which will increase regional and global capacity.

Let me now move to migration and health, which is high on the agenda across the Region. The situation is becoming more challenging, with the increasing influx of refugees and migrants to many European countries, calling for an urgent response to their health needs.

I issued a statement on our website, highlighting the public health implications, which are challenges for both the refugees and the receiving countries. The common association of migration with importation of infectious diseases is not evidence-based. Countries should implement policies that give migrants access to a broad range of health services, including those for prevention and care. This will also benefit the receiving countries' populations.

We continued to respond to increasing demand and provide support to affected countries, and delivered emergency kits to address refugees and migrants' health needs. We developed new research and evidence to support decision-makers in making policies on migrant health.

I want to thank the Government of Italy for its support in this area. The ministerial lunch today is dedicated to migration and health, and we look forward to receiving your guidance on how to take forward this important topic.

The conflict in the Syrian Arab Republic sent 2 million refugees into Turkey. We are working with the Government of Turkey, which has demonstrated an outstanding performance in managing the response to the refugee influx.

We are leading the health cluster to assist Syrian refugees in Turkey. We are contributing to the “whole of Syria approach”, following United Nations Security Council resolution 2165 (2014), in collaboration with the WHO Regional Office for the Eastern Mediterranean.

In response to the humanitarian crisis in Ukraine, which affects more than 5 million people, we are leading the health and nutrition cluster to coordinate the response to internally displaced persons and affected communities. The WHO teams in the United Nations field offices are facilitating the delivery of medical kits, supplies and medicines to treat hundreds of thousands of people.

The network of mobile emergency primary health care units and health impact specialists plays a crucial role in assessing health threats and delivering health services in difficult-to-reach areas.

It has been an exciting year for work on antimicrobial resistance, with the adoption of the global action plan. Europe is leading the way. Almost half of the Member States in Europe have an intersectoral coordination mechanism and national action plans.

The Central Asian and Eastern European Surveillance of Antimicrobial Resistance network, which now includes around 250 laboratories, is supplementing EU surveillance data. I am happy to inform you that the network published its first report last month.

The Antimicrobial Medicines Consumption network allows us to monitor the use of antimicrobials in 17 countries outside the EU, providing evidence from 45 Member States.

Building on the success of European Antibiotic Awareness Day, we are shaping a global campaign to launch World Antibiotic Awareness Week in November. This year, we hope that all 53 Member States will mark the Week.

We do all this work with you, Member States, and with partners to achieve our goal – better health for all: equitable and sustainable.

We worked with all Member States, tailoring support to their priorities, needs and circumstances. We now have a fully functional network of national counterparts, which streamlines all correspondence and improves the knowledge and information flow.

I had the privilege of visiting many countries, meeting with heads of state, prime ministers and ministers, advocating health and promoting intersectoral work.

With the Director-General, I was honoured to receive the Turkmenistan State award from His Excellency the President of Turkmenistan on behalf of WHO, in recognition of our collaboration over the past two decades. On behalf of the Organization, I was also honoured

to receive the Gold Medal of the Portuguese Minister of Health for distinguished services in Portuguese multisectoral health policy development.

We welcomed ministers and senior delegations to the Regional Office, and gave Member States a stronger voice through a new initiative: country days. They have proved to be valuable platforms for identifying priorities for our joint work.

To ensure that the Regional Office is a strong, evidence-based organization, relevant to the whole Region, we continued to increase our technical capacity. We empowered country offices by delegating more authority and responsibility to them. I thank all my staff for their dedication and hard work.

We invest in partnerships to increase policy coherence, improve health in our Region and serve Member States more efficiently. I am pleased that many of our partners, including civil society organizations, are here with us today.

This year, the partnership session, with the participation of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance, will focus on opportunities and challenges for a successful transition from international to domestic funding.

In our work as part of one United Nations, let me highlight one important element. We coordinate a regional United Nations thematic group on noncommunicable diseases and social determinants of health to support implementation of the United Nations political declaration on noncommunicable diseases and Health 2020. We are pleased that health and noncommunicable diseases are prominent in recently developed United Nations development assistance frameworks, and we look forward to their joint implementation.

And finally, WHO reform remains and will remain an important priority. Later today, we will discuss continuing reform initiatives on governance and we will present our work to strengthen accountability and transparency in the Regional Office. Let me emphasize two points very briefly here.

We continue the biennium on a solid financial foundation, with more flexible funds that are now distributed strategically. Thanks to you, Member States, and to the Director-General for making this happen.

The World Health Assembly's adoption of the programme budget for 2016–2017, with an 8% budget increase, was a historic moment, demonstrating the trust of Member States.

The regional implementation plan for the programme budget, which will be presented on Thursday, will be the main instrument of corporate accountability in the Region and the contract between you and me.

Your Excellencies, ladies and gentlemen,

We have great responsibility for the health and well-being of our populations. Next week, we will approve the 2030 Agenda for Sustainable Development. Let us make sure that we are ready, and we leave no one behind.

Thank you for your attention.

Annex 5. Address by the Director-General

Excellencies, honourable ministers, distinguished delegates, my dear colleague Zsuzsanna Jakab, ladies and gentlemen,

Let me first and foremost thank the Government of Lithuania for hosting the 65th session of the Regional Committee.

The world has changed dramatically since the start of this century, when the Millennium Development Goals became the focus of international efforts to reduce human misery.

At that time, human misery was thought to have a discrete set of principal causes, like poverty, hunger, poor water and sanitation, several infectious diseases and lack of essential care during childhood, pregnancy and childbirth.

The results of that focus, and all the energy, resources and innovations it unleashed – millions of lives were saved – exceeded the wildest dreams of many. It demonstrated the power of solidarity and brought out the best in human nature.

I was personally not optimistic about the prospects of reaching Goals 4 and 5, until the Every Woman Every Child strategy kicked in, with spectacular results. Some of the strongest supporters of that strategy are here in this room. I thank you for your commitment to the strategy, as well as Secretary-General Ban Ki-moon for his unwavering support.

I see no signs that the momentum for better health, driven by commitment to the Millennium Development Goals, is beginning to slow. On the contrary, one of the best signs of the success of the health-related Goals comes from the fact that Member States are approving new strategies and plans of action with even more ambitious goals. These include ending the HIV and tuberculosis epidemics, eliminating malaria from a large number of countries and ending preventable maternal, newborn and childhood diseases and deaths.

Later this month, the United Nations General Assembly is expected to finalize the new agenda for sustainable development. The agenda currently has 17 goals, including one for health, and 169 targets. The factors that now govern the well-being of the human condition, and of the planet that sustains it, are no longer so discrete. That agenda will try to reshape a very different world.

More and more, we are seeing the worst in human nature: international terrorism, senseless mass shootings, bombings in markets and places of worship, ancient and priceless archaeological sites reduced to rubble and seemingly endless armed conflicts that have contributed to the worst refugee crisis since the end of the Second World War.

Your Regional Director has issued a statement on the health needs of refugees and migrants. I fully agree with her views. I am sure that this subject – migration and health – will continue to be debated in WHO.

Since the start of this century, newer threats to health have gained prominence. Like the other problems that cloud humanity's prospects for a sustainable future, these newer threats to health are much bigger and more complex than the problems that dominated the health agenda 15 years ago.

Chronic noncommunicable diseases have overtaken infectious diseases as the biggest killers worldwide. Few of the world's health systems were built to manage chronic, if not life-long, conditions. Even fewer doctors were trained to prevent them. And even fewer governments can afford to treat them.

For example, every new cancer drug approved in 2014 by the US Food and Drug Administration cost more than US\$ 120 000 per patient per year. Many of these treatments extend life by only a few months.

The climate is changing. WHO estimates of mortality from air pollution, the single most important environmental hazard in this Region, have finally given health a place in debates about the consequences of climate change.

Worldwide, this past July was the hottest month since at least 1880, when scientists began keeping records. This year's thousands of deaths associated with heatwaves in India and Pakistan provide further headline evidence of the health effects of extreme weather events.

In December, Paris will host the twenty-first session of the Conference of the Parties to the United Nations Framework Convention on Climate Change. Many regard this Conference as our best chance ever to prevent the next generation from inheriting a ruined planet.

Medicine is losing more and more mainstay antimicrobials as pathogens develop resistance. Superbugs haunt hospitals and intensive care units, also here in Europe. Gonorrhoea is now resistant to multiple classes of drugs.

An epidemic of multidrug-resistant typhoid fever is rolling across parts of Africa and Asia. In Europe, as elsewhere, only around half of all cases of multidrug-resistant tuberculosis can be successfully cured.

I appreciate the leadership of governments represented in this room in tackling the antimicrobial-resistance crisis with an appropriate sense of urgency, alert to the need for innovation. Through the European Commission, this Region is also addressing the need for research and development incentives to develop replacements for products that fail.

Do not underestimate the challenges that lie ahead. Protecting our children from the marketing of unhealthy foods and beverages is harder than protecting our children from vaccine-preventable diseases. Persuading countries to reduce greenhouse gas emissions is harder than digging wells or building latrines. Getting industrialized food producers to reduce their massive use of antibiotics is harder than getting companies to donate medicines for leprosy or river blindness.

All of these newer efforts face fierce opposition from powerful economic operators and their equally powerful lobbies. Economic power readily translates into political power.

These newer threats do not neatly fit the biomedical model that has historically guided public health responses. Their root causes lie outside the traditional domain of public health.

They are also beyond the traditional domain of sovereign nations accustomed to governing what happens in their territories. In a world of radically increased interdependence, all are transboundary threats.

The globalized marketing of unhealthy products respects no borders. By definition, a changing climate affects the entire planet. As sharply illustrated by malaria, tuberculosis, and bacteria carrying the famous NDM-1 enzyme, drug-resistant pathogens travel well internationally.

Many of the risk factors for noncommunicable diseases arise from the behaviours of multinational corporations. In the interest of prevention, ministers of health, notoriously underfunded, are now challenged to change corporate behaviours. You have a tough job.

World Bank data show that, in 2011, more than 60% of the world's 175 largest economic entities were companies, not countries. Data also show that this concentration of power is rapidly growing.

The new distribution of power raises an absolutely critical question for health in the sustainable development era. Who really governs the policies that shape our health? Is it democratically elected officials acting in the public interest? Is it multinational corporations acting in their own interest? Or is it both: that is, governments making policies that are heavily influenced by corporate lobbies?

I urge you, as ministers of health, to continue your insistence on coherent government policies. Ministers of health look at the medical and scientific evidence. But ministers of finance and trade often listen to other voices.

Strengthening implementation of the WHO Framework Convention on Tobacco Control is on your agenda. Countries wishing to protect their citizens through larger pictorial warnings on packages or by introducing plain packaging are being intimidated by tobacco companies, and have to deal with the fear and the reality of lengthy and costly litigation.

Mechanisms for settling investor-State disputes are being used to sue governments for tobacco legislation that hurts industry profits. To date, let me report to you, Australia has spent nearly AUS\$ 50 million defending its right, as a country, to introduce plain packaging.

We need to watch all of this very closely. What is at stake here is nothing less than the sovereign right of a nation to enact legislation that protects its citizens from harm.

On the positive side, there may very well be a limit to how far corporate behaviours can push the tolerance of the public and the press. Last month, The New York Times ran a front-page story exposing how one soda giant is funding scientists to shift the blame for obesity away from sugary drinks.

As the newly launched Global Energy Balance Network argues, the real cause of obesity is the lack of physical activity. The Network is funded, incidentally, by the soda company. The group cites "strong evidence" that the key to preventing weight gain is not reducing calorie intake, but "maintaining an active lifestyle and eating more calories". The so-called strong evidence cited is actually two studies funded by the soda company.

You will be discussing a physical activity strategy for Europe covering the next 10 years. As noted in the strategy, exercise has multiple benefits that go well beyond preventing weight gain.

You are wise to add such a strategy to your arsenal of preventive tools. As noted, in 47 countries, representing 87% of the Region's population, more than 50% of adults are overweight or obese. In several countries, the rate is close to 70% of the adult population.

But physical activity alone will not be sufficient to curb this Region's obesity epidemic. As the WHO Commission on Ending Childhood Obesity reported earlier this year, "Addressing the obesogenic environment is not enough, but no approach that fails to address this environment can be successful."

The Commission identified many factors that help explain why the prevalence of childhood obesity is increasing in all countries. But it singled out one particularly pervasive driving force: the globalized marketing of unhealthy foods and beverages. In fact, the Commissioners described the evidence of its impact on childhood obesity as "unequivocal".

This example raises a critical question. Can science be bought to give industry's tactics a respectable veneer, to confound the evidence, confuse the public and reduce its concerns?

Does health advice derive from the evidence or can its content be shaped by the biggest bidder? The tobacco industry certainly used this tactic successfully for a number of years. But let us hope the world has changed.

The launch of the Global Energy Balance Network unleashed a firestorm of criticism in the print and social media. We will need to have the weight of public opinion, sometimes even outrage, on our side as we struggle to help people make the right lifestyle choices.

For WHO, Europe has always been a pioneering Region. Many of your "firsts" provide the foundation for responding to new health challenges in the era of sustainable development. As stated in one of your documents, "No health issue today can be adequately dealt with without an intersectoral response".

You were the first to look at lifestyle-related diseases, the first to explore ways of changing human behaviours and the first to address the social determinants of health. Early on, this Region recognized environmental hazards as an upstream cause of ill health and began to tackle them in a systematic way. With the landmark Tallinn Charter, European Member States were among the first to formulate convincing economic arguments for investing in health systems.

This Region brought phrases such as Health in All Policies and a whole-of-government approach into the health policy vocabulary. Health 2020, to which many of you refer, draws on these achievements. They are shaping many of your health policies and strategies. They underscore the commitment to equity and solidarity as the Region's defining values.

And you have other assets. The first mobile laboratory deployed to Guinea at the start of the Ebola outbreak came from this Region. Your countries contributed health professionals, logisticians, engineers, managers, vehicles, supplies, military personnel and quite a lot of money.

Nongovernmental organizations and charities based in your countries provided the bulk of clinical care, comfort and compassion. Officials in this Region helped solve the challenge of medical evacuation, which deterred so many countries from sending medical teams.

The outbreak is not yet over, but we are very close. We are in a phase where we can track the last chains of transmission, and break them. To get to this phase, WHO deployed more than 1000 staff to 68 field sites in the three countries. Many of them are short-term staff recruited from African countries.

As the pace of the response slows and the facts begin to come in, the picture of WHO leadership during the outbreak differs markedly from the narrative in most media reports. At an Ebola workshop organized by the United States Institute of Medicine earlier this month, WHO was described as “a convenient scapegoat during the outbreak”. And it went on to say, it was so easy to slap WHO around.

As the head of this agency, I need to take a stand. Doing so is all the more important as some of our achievements support Organization-wide reforms under way to strengthen WHO leadership during future outbreaks and other health emergencies.

Already during the outbreak, WHO staff from all regions and headquarters dealing with outbreaks and humanitarian crises worked together. This collaboration helps provide proof of concept for the single new programme that I announced at the World Health Assembly last May.

Managerial responses were too slow at the start but we found a way to streamline administrative procedures and speed things up. The managerial lessons we learned will feed into the design of the programme’s expedited recruitment and deployment procedures, which will be separate from the rest of WHO.

Prior to the outbreak in West Africa, Ebola was a rare disease. All responders had trouble finding sufficient numbers of experienced clinicians and epidemiologists. Many agencies and organizations, in their great desire to help, took on roles that went well beyond their mandates and previous experience. Those with no experience in the clinical management of Ebola took several months to become operational.

No internationally agreed procedures were in place for coordinating the activities of the multiple response teams that eventually arrived. To reduce some of the chaos of uncoordinated and sometimes inappropriate aid, WHO made an inventory of the qualification and skills of foreign medical teams and developed a register. Again, this work will feed into plans for establishing a global health emergency workforce.

On that subject, I would like to thank the European Commission for your discussion with WHO to develop a European emergency corps. I will work with you to ensure it feeds into the global health emergency workforce.

WHO used two networks to deploy 32 laboratories to the three countries and Nigeria. With these partners, we developed the logistics of specimen transportation needed to ensure that every district, county and prefecture in the three countries had access to laboratory services within 24 hours. By the last quarter of 2014, the speed and quality of testing approached that seen in wealthy countries. This is equity and solidarity at their best.

The world is on the verge of having a safe and effective vaccine. At the request of the Government of Sierra Leone, the WHO clinical trial of the new vaccine, which has been

running in Guinea, has been extended to include this second country. Being able to vaccinate close contacts of confirmed cases gives us another ring of protection.

We have pre-qualified four rapid point-of-care diagnostic tests. We are developing a blueprint for research and development, with generic clinical trial protocols and arrangements for fast-track regulatory approval, to expedite the development of new medical products during the next emergency.

All of these achievements were made possible by the unprecedented support of many countries and the unprecedented collaboration of multiple partners, coordinated by WHO. As just one example, laboratory support involved collaboration with 19 institutions in two networks.

Like all other responders, we were slow at the start but we made quick course corrections. These changes that I have just described created conditions that made it possible for multiple responders, national and international, to work to their full advantage in future epidemics and pandemics. This is leadership.

I thank you for your attention.