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Second session

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Report of the second session

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Introduction

1. The Seventeenth Standing Committee of the WHO Regional Committee for Europe (SCRC) held its second session in Ohrid, the former Yugoslav Republic of Macedonia, on 9 and 10 November 2009. Apologies for absence owing to illness were received from Dr Boban Mugosa (Montenegro), while Lithuania was represented by its alternate member, Mr Viktoras Meizis.

2. Reporting on recent events at the WHO Regional Office for Europe, the Regional Director had the sad duty of informing the Standing Committee of the recent death of Dr Gudjon Magnusson, former Director, Division of Health Programmes. With regard to the H1N1 (2009) pandemic, Regional Office staff had formed the core of a multidisciplinary team sent to assist the Ministry of Health of Ukraine in handling the recent outbreak there. The subjects discussed at a recent meeting of the Director-General of WHO with regional directors and heads of WHO's country offices had confirmed the whole Organization's preoccupation with health systems and migration of the health workforce, while the country offices in the Republic of Moldova and Tajikistan had been singled out as models of good practice. Within the Regional Office, extensive training of staff was being undertaken before the launch of the Organization's global management system (GSM) in the European Region on 1 January 2010.

3. The report of the Seventeenth SCRC's first session (Copenhagen, 17 September 2009) was adopted without amendment.

Follow-up to the fifty-ninth session of the Regional Committee: review of SCRC and Secretariat actions

4. The Deputy Regional Director noted that a working paper had been distributed identifying those areas in the resolutions adopted and discussions held at the fifty-ninth session of the WHO Regional Committee for Europe (RC59) where follow-up action was required. Discussion at the current session of the SCRC could therefore focus on three more substantial items.

Governance of health in the WHO European Region

5. The Director, Division of Administration and Finance recalled that the Sixteenth SCRC had taken up the subject of health governance and that a preliminary discussion had been held at RC59. The Seventeenth SCRC would continue to work on the topic, with the involvement of the Regional Director designate, and the question would therefore be part of a wide-ranging informal discussion with her the following day. Broadly speaking, there were two aspects to the subject: an internal one, looking at the respective roles of the SCRC and the Regional Committee, their relations with the Executive Board and the World Health Assembly, the interaction between the Regional Office for Europe and WHO headquarters, etc. An external part would look over the current "scene" of international health in the European Region of WHO, which was a crowded one characterized by a multiplicity of players with overlapping mandates. As requested by the Seventeenth SCRC at its first session, a working paper had therefore been prepared by the Secretariat giving a list of agreements between WHO or its Regional Office for Europe and other international organizations. The SCRC member from Switzerland acting with the mandate received from the SCRC, had circulated an "input paper" for the discussion the following day, proposing a process for addressing that complex issue over the year ahead.

6. The SCRC also identified two dimensions to the topic of governance as applied to the European Region: broader questions related to relations between the Regional Office and WHO headquarters and, more particularly, the Office and the European Union (EU); and more limited issues, such as the mandate of the SCRC or the use of subregional groupings when nominating countries for membership of the Executive Board. The latter more limited category might be seen as including the arrangement

whereby those Member States in the WHO European Region that were permanent members of the United Nations Security Council served as members of the Executive Board for three out of every six years. The countries concerned had been informed at RC59 that the SCRC was intending to review that arrangement, known as "semi-permanency", as part of its consideration of the whole topic of governance, and under the terms of resolution EUR/RC53/R1 the Standing Committee was to report its findings to RC60 in 2010.

7. Given the very close interface between internal and external questions, the Standing Committee agreed to continue its discussion of the topic with the Regional Director designate the following day. Particular areas to be discussed were ideas about how to come forward with specific proposals to RC60, about where it could make recommendations concerning the process to be followed to take up certain issues in the future, and about topics that could be described, but not directly addressed by RC60. Given the fact that the Lisbon Treaty was shortly to come into force, relations with the EU were suggested as a suitable subject for process recommendations.

8. The Standing Committee also agreed to establish a working group on the question of governance, composed of its Chairperson, the adviser to the member from Sweden and the member from Lithuania, and chaired by the member from Switzerland. Based on the outcome of the discussion the following day, the working group would agree on its terms of reference and circulate them to members of the Standing Committee for approval by the end of November 2009. Further working groups could be set up, if required, to consider specific aspects of the question of governance.

Code of practice on the international recruitment of health personnel

9. The Director, Division of Country Health Systems informed the SCRC that, as requested by representatives attending RC59, a consultation would be held at WHO headquarters on 8 December 2009, before the subject was taken up by the Executive Board at its 126th session (EB126) in January 2010. The scope and purpose of that consultation were being defined. A preliminary version of the revised draft code of practice had recently been received from WHO headquarters, for internal use only; it was expected that a finalized version of the draft code, together with a compilation of summaries of discussions on the subject held at WHO regional committee sessions in September 2009, would be made available to participants in the consultation.

10. The SCRC commended the Regional Director on having invited his counterpart from the African Region to take part in the discussions at RC59: that was a good practice, which gave added value and should be continued. It noted that the United Nations Development Programme had recently issued its Human Development Report 2009, entitled *Overcoming barriers: human mobility and development* (http://hdr.undp.org/en/).

11. The Standing Committee recognized that the purpose of the consultation in December 2009 was to gain a better understanding of the divergences of views (if any) within the Region, rather than to reach agreement on a consensus position to be adopted by the Region as a whole. It suggested that EU member countries might wish to hold a coordination meeting just before the consultation. To that end, WHO headquarters should be urged to release the revised draft code of practice as soon as possible, and in any event no later than 1 December 2009, to allow time for it to be reviewed at national level. The question of health workforce migration necessarily involved a large number of ministries (foreign affairs, education, labour, employment, etc.), so an extensive process of consultation would be needed both before and after EB126. Lastly, the SCRC noted that the decision whether or not to accept a code of practice would be made by the World Health Assembly, not the Executive Board, and further meetings with and between countries could be organized, if necessary, between January and May 2010.

Update on pandemic (H1N1) 2009 and access to pandemic vaccine

12. The acting Director, Division of Health Programmes reported on the current situation with regard to pandemic (H1N1) 2009. As of 6 November 2009, more than 480 000 cases and 6000 deaths had been reported in nearly 200 countries and territories throughout the world, with nearly 80 000 laboratory-confirmed cases in 49 countries and 326 deaths in 28 countries in the WHO European Region. However, those figures were significant underestimates, since many countries had moved to clinical confirmation and laboratory testing only for cases with severe illness or high-risk conditions. The winter influenza season had started unusually early in the WHO European Region, with evidence of increasing and active transmission of pandemic influenza virus across northern and eastern Europe (including Ukraine and Belarus).

13. In Ukraine, as of 9 November 2009 there had been more than 900 000 cases of influenza-like illness (ILI) and over 65 000 cases of acute respiratory infection (ARI) and pneumonia. More than 43 000 people had been hospitalized, 2300 of whom had required intensive care and 50 of whom were on mechanical ventilation; 155 deaths from ARI had been reported. Preliminary reports indicated that the rapidly evolving situation in the country was mainly related to pandemic (H1N1) 2009 influenza, although other causes of respiratory illnesses could not be totally ruled out. A multidisciplinary team of nine experts from WHO, the European Centre for Disease Prevention and Control (ECDC), and CDC Atlanta, and experts from Member States had been deployed to the country at the request of the Ministry of Health to assist the national health authorities. The assessment team was due to meet the President and Prime Minister that day, to receive political commitment and support for priority actions.

14. To date, most human cases of new influenza A (H1N1) virus infection had had uncomplicated illness of limited duration. Globally, between 1% and 10% of patients with clinical illness required hospitalization; of those, from 10% to 25% required admission to an intensive care unit (ICU) and from 2% to 9% had a fatal outcome. Pregnant women seemed to be at least ten times more likely to have severe outcomes than the general population. WHO guidance on clinical management included basing initial treatment decisions on features of clinical presentation and epidemiological data, rather than waiting for laboratory confirmation, and giving prompt treatment with antiviral drugs, in combination with other supportive care measures, to patients in at-risk groups with uncomplicated illness due to influenza virus infection and to all patients with severe or progressive clinical illness. Appropriate infection control measures (standard plus droplet protection) should be adhered to at all times, with additional protection whenever aerosol-generating procedures were carried out.

15. Owing to the limited supply of vaccines in the early stages of the pandemic, the recommendations made by WHO's Strategic Advisory Group of Experts (SAGE) on Immunization in July 2009 were still applicable. Health care workers should be immunized as a first priority, to protect the essential health infrastructure. A step-wise approach to vaccinate particular groups might then be considered, with priority given (depending on country-specific conditions) to pregnant women, those aged above six months with one of several chronic medical conditions, healthy young adults of 15 to 49 years of age, healthy children, healthy adults of 50 to 64 years of age, and healthy adults of 65 years and above.

16. Public health considerations had also led to the following recent (October 2009) recommendations from SAGE:

- use of a single dose of vaccine in adults and adolescents from 10 years of age, provided such use was consistent with regulatory authority indications;
- where vaccine supplies were limited, provision of one dose of vaccine to as many children as possible, where priority had been assigned to that group by national authorities;
- provided no specific contraindication had been identified by the regulatory authority, use of any licensed pandemic vaccine to protect pregnant women; and

– possibility of co-administration of seasonal and pandemic vaccines, provided both were inactivated or one was inactivated and the other was live attenuated.

17. In the WHO European Region, the population in countries with advanced purchase agreements (APAs) with vaccine manufacturers or with planned domestic production could be as high as 700 million. Of the remaining countries, eight (with a total population of over 100 million) were eligible for support from the Global Alliance for Vaccines and Immunisation (GAVI) and would rely on access to the WHO stockpile of H1N1 vaccine donated by manufacturers. Some middle-income countries, with neither APAs in place nor domestic production, had been able to procure vaccine through direct contact with manufacturers and negotiations with other countries. In addition, the Regional Office was working with UNICEF Supply Division on pooled procurement. To date, some 17 countries in the Region had commenced vaccination, with 8 more due to begin in November 2009.

18. Post-marketing surveillance was considered to be the key to ongoing monitoring of the safety of monovalent pandemic vaccines. WHO headquarters was coordinating active surveillance for Guillain-Barré syndrome, and the major global regulatory authorities were providing weekly summaries that were forwarded to SAGE and the WHO Global Advisory Committee on Vaccine Safety. To date, most reactions reported had been mild and of short duration. Concerns about safety (including the use of adjuvant vaccines) had been mainly expressed outside the scientific context, and active anti-vaccine campaigns were under way in several areas of the world. Effective communication responses were urgently needed, both for the scientific community and for the general population.

19. The SCRC member from Ukraine paid tribute to the prompt response provided by the Regional Office and the objective evaluation made by the assessment team. She also thanked those Member States that had rendered humanitarian assistance to her country but expressed concern at the steps taken by a neighbouring country, apparently on behalf of the whole EU, to close its borders with Ukraine. The member from Sweden, the country currently holding the presidency of the EU, noted that those steps had not been supported by other EU member countries during a recent meeting of its Health Security Committee, and the country concerned had been asked to provide an explanation of its actions. Similarly, the Swedish Ministry of Foreign Affairs was seeking an explanation, while the Regional Office had in vain sought clarification from its National Focal Point for the International Health Regulations (2005) (IHR).

20. Members of the Standing Committee welcomed the presentation and called for it (and the supporting briefing note) to be made available both in hard copy and electronically. They underlined the importance for planning purposes of the epidemiological and hospitalization data provided by WHO: in some of their countries, hospitalization rates were proving to be far lower than the 1–10% figure quoted, with concomitant over-purchasing of ventilators, while the guidance on administering immediate treatment with antivirals to those in risk groups (rather than to all patients with ILI) was questionable, given that 20–40% of patients with severe disease had no underlying condition. In response, the acting Director, Division of Health Programmes explained that the figures given portrayed data compiled from various countries at the global level, showing a wide range between countries; WHO was engaging with countries on an individual basis to offer guidance on the best examples to use and help with carrying out specific risk–benefit analyses.

21. Concern was expressed about the timing of delivery of vaccines from manufacturers or their release from WHO's stockpile. Equally, the SCRC echoed the Regional Director's concern about some physicians advising against immunization. While some members believed that WHO should offer Member States further advice on how to increase vaccine acceptance and uptake (or reiterate SAGE's recommendations at regional level), others were of the opinion that increasing awareness of the seriousness of the pandemic would change that situation. The need for pharmacovigilance was stressed: it was important to obtain properly aggregated data from countries that had started vaccination on which vaccines had been used, which groups had been vaccinated and which complications had been encountered. Such data, which so far revealed fewer adverse effects than expected, could go some way to overcoming physician resistance to vaccination.

22. Lastly, with the aim of strengthening coordination between WHO and ECDC, the Regional Office was working on technical arrangements to ensure that countries' reports to the EuroFlu web site (http://www.euroflu.org/index.php) were forwarded to both organizations, thereby avoiding double reporting.

Provisional agenda of the sixtieth session of the Regional Committee

23. The Regional Director noted that a number of items had to be included on the agenda of RC60, either because they were part of an Organization-wide process (such as the proposed programme budget 2012–2013) or in response to commitments made at previous RC sessions (e.g. governance, or reporting back on implementation of the Second European Action Plan for Food and Nutrition Policy). The SCRC could suggest other technical and policy items for consideration at the session, based on topics that would be taken up in the *World health report* in years to come, subjects that were important at global level or items on the agenda of future sessions of the Executive Board. Decisions in that connection could be taken at the SCRC's next session in March 2010, in consultation with the new Regional Director.

24. The SCRC noted that in the recent past the Regional Committee had not discussed the proposed programme budget in specifically regional terms. It therefore suggested that RC60 could consider the proposed programme budget 2012–2013 under two subheadings, one dealing with the Regional Committee's views on the global budget as a whole, and the other outlining which areas should be regarded as specific regional priorities, within overall global constraints.

25. In preparation for the discussion at its next session, the Standing Committee asked the Secretariat to compile an overview of subjects taken up as technical or policy items on the agenda of Regional Committee sessions or as topics of technical discussions over the previous six years, and to present that information in the form of a matrix with the 13 strategic objectives in the Organization's Medium-term strategic plan. That would enable the SCRC to identify areas that needed further consideration by the Regional Committee. In addition, it would be useful to have a list of topics on which the reporting back to the Regional Committee was mandatory, under the provisions of resolutions it had previously adopted.

26. The SCRC also pointed out that the topics of pandemic (H1N1) 2009 and the Fifth Ministerial Conference on Environment and Health (Parma, March 2010) would need to be included on the agenda of RC60: the former for obvious reasons, and the latter because the declaration that was due to be adopted at the Conference would require endorsement by the Regional Committee.

Membership of WHO bodies and committees

27. The Standing Committee was informed that two seats for the European Region on the Executive Board would become vacant in 2011, and nominations would therefore need to be made at RC60, while three seats on the SCRC would be up for election in 2010.

28. The SCRC agreed that the procedure and traditions governing the nomination of countries for membership of the Executive Board and their election to other bodies should not be changed in the period leading up to RC60, pending completion of its work on governance (see above, paragraphs 5–8). The Regional Director's letter inviting Member States to submit candidatures (to be sent out in January 2010) should make that position clear and should clarify that the subregional groupings specified in resolution EUR/RC53/R1 applied only to candidatures for the Executive Board.

Issues to be taken up with European members of the Executive Board in January 2010 and collaboration with its Programme, Budget and Administration Committee

29. The Deputy Regional Director noted that a number of items on the provisional agenda of EB126 were of direct relevance to the European Region or had been recently discussed by the Regional Committee. Such subjects included the Millennium Development Goals, health workforce migration, noncommunicable diseases, alcohol and the safety of blood products. While the item on sharing of influenza viruses and access to vaccines and other benefits related to the repercussions of the H5N1 avian influenza epidemic, the Intergovernmental Meeting on Pandemic Influenza Preparedness (PIP) in October 2009 had agreed that the situation with the pandemic (H1N1) 2009 should also be considered under that item.

30. The SCRC was also informed that, in response to the strong concern expressed by Member States at the 2008 session of the Programme, Budget and Administration Committee (PBAC) about the uneven and excessive carry-over of unspent funds from one biennium to the next, the Secretariat was preparing a paper outlining ways of overcoming that problem. The initial proposed actions could be discussed at a global meeting of deputy regional directors/directors of programme management and WHO headquarters staff later in the week; the proposed action points would then be discussed at the PBAC at its session before EB126.

31. The Regional Director confirmed that the traditional meeting with European members of the Executive Board and representatives of other Member States attending the EB session, together with the Chairperson of the SCRC, would be organized on the day before the opening of EB126. At that meeting, participants' attention could be drawn in particular to the EB126 provisional agenda item on the draft global code of practice concerning the international recruitment of health personnel.

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

32. In line with established practice, the incoming Regional Director would make suggestions for filling elective posts at the Sixty-third World Health Assembly.

Date and place of meetings of the Seventeenth SCRC

33. The Seventeenth SCRC agreed to hold its third session at the WHO Regional Office in Copenhagen on 1 and 2 March 2010.

Other matters

34. While agreeing to have a general discussion at a later date on the advantages and drawbacks of meeting in locations that were difficult of access, the Standing Committee accepted with gratitude the invitation by the Government of Andorra to hold one of its sessions in 2010–2011 in that country.

35. Addressing the Standing Committee for the last time, the Regional Director paid tribute to the support and guidance that he had received from the SCRC throughout his two terms of office. He believed that it was very important for the Regional Office to continue to act as the champion of the horizontal approach, based on health systems and delivery of services to countries, that had permeated the whole Organization in recent years, that the spirit of solidarity and unity between diverse Member States and the WHO European Region would continue to be a core value underpinning work, and he hoped that the staff would continue to be selected and evaluated solely on the basis of their professional qualities.

36. The United Nations and its specialized agencies had the huge advantage of being able to lay claim to a position of neutrality, on the basis of "one country, one vote", and he was concerned that the formation of regional blocs (such as the EU) might endanger that position. The European Region of WHO was unique in that it brought together very disparate countries (a feature that he had constantly sought to strengthen), and he was very proud that its integrity had been maintained during his mandate.

37. The Executive President of RC59, attending the session as an observer, expressed his appreciation of the forthright and challenging honesty that the Regional Director (and his deputy) had always displayed. He could rightly take pride in his achievements and in the stamp that he had set on the Regional Office.

Informal brainstorming meeting

38. The second day of the session had been set aside for an informal brainstorming meeting with the Regional Director designate to discuss, among other things, preparatory activities for her assumption of office on 1 February 2010.

39. The Chairperson of the SCRC welcomed the Regional Director designate to the special session and, on behalf of the SCRC, congratulated her on her nomination by the Regional Committee to the post of Regional Director. The Regional Director designate thanked the SCRC and said that she was humbled and honoured by the trust and confidence of the Member States and that she would do her best to fulfil their expectations.

Agenda

40. As it was an informal session, no formal agenda had been prepared. The Chairperson and Regional Director designate proposed that she would start by outlining her vision of how best to tackle the priorities and challenges facing the Region and the Regional Office. She would also inform the SCRC about the "transition process" (which included briefing visits to the WHO Regional Office for Europe) and the proposed steps for as early as possible a start to implementation and realization of that vision. The Regional Director designate pointed out that to her the SCRC was crucial to that process, both before 1 February 2010 and more formally thereafter. She was therefore looking forward to the "brain storming session" and, most importantly, to the SCRC's advice, guidance and thoughts at that formative stage.

41. Since governance issues figured in both her vision and the SCRC's already agreed plan of work, it was decided that the Chairperson of the SCRC Working Group on Governance would (after the Regional Director designate's presentation) outline the workplan of the Working Group, having added those governance-related issues raised by the Regional Director designate. That would result in one consolidated list of governance issues, identifying those that would be tackled by the SCRC Working Group and those that would be covered initially through the transition process until 1 February 2010. The SCRC agreed to the proposal, especially as it would ensure that all issues were captured and subsequently, after 1 February 2010, taken forward as part of the formal SCRC process.

Priorities and challenges facing the WHO European Region and the Regional Office

42. The Regional Director designate started by reaffirming that the WHO Regional Office for Europe was currently as important as it ever had been, but that it had to adapt itself to the changing European environment in order to remain strong and competitive, add value and maintain its leading edge. The justification for adaptation lay in the significant changes in public health-related issues that

had taken place in recent decades (e.g. increasing social inequalities with their impacts on health; the economic crisis; climate change; the epidemic of noncommunicable diseases (NCD), and a competitive environment with many new players in Europe). The Regional Office had to adapt and respond to these changes as it had done in the early 1990s.

43. It was not "business as usual" for public health, and the Regional Office urgently had to rethink its role; renew its vision and leadership; clarify further its identity among other players; develop new partnerships and renew old ones; and find new ways of working, managing and responding to the challenges that public health faced at all levels, including by utilizing and building on the tremendous capacity in Europe.

44. In defining her vision for the future, the Regional Director designate mentioned that she had drawn upon the WHO Constitution as a starting point. The driving force behind her vision was for the Regional Office to be a leader in Europe in health policy and public health, and a centre of public health excellence. That required a strong evidence-based organization; one with good technical programmes and high-calibre staff known for their professional excellence; and one that was relevant to the whole Region, uniting, integrating and acting as a bridge between different parts while promoting solidarity and equity for health. It also required a place that kept ahead of developments, innovated, inspired and helped Member States by identifying and leading the way on public health issues, while being accountable for decisions taken by the Regional Committee and the World Health Assembly and, with Member States, helping to turn them into action.

45. The Regional Office needed to work in close partnership with WHO headquarters and other WHO regions, European Union (EU) institutions and other traditional and new players, developing, nurturing and strengthening its wide and extended network to advocate and support implementation through joint actions when needed. Above all the Regional Office must provide a positive work environment that inspired and empowered staff.

46. The Regional Director designate then presented the way forward for giving effect to each of the main elements in her vision. Key to strengthening the Regional Office's leadership role in health policy and public health in Europe would be the renewal of the European health policy as a common European vision of Member States and other partners. The most important internal governance issues related to ensuring that the Regional Committee attracted more policy-makers at the highest level to attend and that the role of the SCRC was broadened and strengthened, perhaps following the model of the relationship between the Executive Board and the World Health Assembly. Those and the other issues raised had been singled out by both the Regional Committee and the SCRC as being important in the years ahead and would also be discussed later in the meeting, alongside the planned work of the SCRC Working Group on Governance.

47. All the 35 WHO offices in Europe need to operate as integral elements of the Regional Office as a networked organization, with clearly defined roles and identities that together were part of a strengthened and strongly integrated Office. There should be an appropriate balance and blend of centralization and decentralization, with the Regional Office as a strong hub with all the core policy functions. The Regional Office should not rely only on its own staff in Copenhagen and its network of WHO offices; it should also use the extensive wealth of Member States' institutions, experts and networks in Europe; "networking the existing networks".

48. Partnerships were crucial in the new European environment, which had grown very much more competitive in the past 10 years. One of the key partners was the EU, many of whose institutions were actively engaged in health and health-related matters for an increasing number of mutual Member States. She intended to develop a "strategic partnership for health for Europe" together with the EU, for the benefit of all the 53 WHO Member States in the European Region, and that initial discussions had already started. Other WHO partners and partnerships, both traditional and new, would be assessed to clarify roles, responsibilities, priorities of work, linkages and interrelations to avoid duplication, ensure synergy and maximize returns for Member States.

49. Europe had an important role to play in supporting and contributing to global developments, including tackling the impact of globalization on health and collaborating with other WHO regions. Those issues, which were also part of the area entrusted to the SCRC Working Group and should be taken forward as part of its remit, would be discussed later in the meeting.

50. The diversity of the Region was both its beauty and its strength, but that provided a challenge for the Regional Office to be relevant for all its Member States. The Regional Office was in a unique position to play an important role in acting as a bridge and ensuring and facilitating international cooperation through the exchange of expertise, know-how and best practices (identifying what works and what does not). Intercountry work in joint partnerships was also an excellent way of building capacity and learning, especially when countries with similar needs were grouped such as in the Balkans and the Commonwealth of Independent States. Every biennium, the Regional Office negotiated specific bilateral technical programmes with those countries most in need in the Region, and those should be strengthened. Some countries in that group were probably now less in need, however, and the situation needed to be reviewed. The Regional Office could also support and facilitate bilateral partnerships between Member States – they had great potential for effective use of bilateral links and knowledge, while demonstrating solidarity. All countries played the above roles and the Regional Office's assistance in such efforts could be explored, while discussing support to specific countries, starting with the Russian Federation and Turkey. EU countries also needed the support of the Regional Office, but perhaps more to encourage advocacy, serve as inspiration and promote the exchange of best practices, rather than in the form of physical support; of course their help to and solidarity with the rest of the Region was as imperative as it was for non-EU countries.

51. The last key element of the vision presented was the main priorities for the work of the Regional Office. Priorities should be evidence-based, reflecting the main disease burden of the Region and the underlying causes and determinants, in order to improve people's health. Five main overriding priority areas included prevention of noncommunicable diseases (NCD) and health promotion (covering for example social determinants, alcohol, smoking, nutrition/obesity and exercise, encompassed in an action plan to follow up the integrated NCD strategy presented to the Regional Committee at its fifty-seventh session – RC57 – in Belgrade); communicable diseases (working in partnership with EU and ECDC for all of Europe); health systems (strengthening primary health care, the quality of care, public health functions, training, human resources for health and financing, as part of an action plan to implement the Tallinn Charter: Health Systems for Health and Wealth, with health policy advisers based in countries tackling major health reforms, where successful sectorwide approaches could also be promoted); information, evidence and communication, which would remain the basis for public health work; and finally in the area of environment and health and climate change, where the way ahead would need to be set out after the Copenhagen and Parma conferences and brought to the Regional Committee. There were of course other issues and priorities, such as the elderly, drug abuse, public health training, and internal office management priorities such as staffing, the budgetary situation and the working environment. Those issues would be tackled starting in February 2010, when Regional Director designate took office and would have a better insight into the current situation.

52. In closing, she gave a brief outline of the process and way forward during and after the transition. She saw the SCRC, during the transition period, as the only official and formal body giving advice to the Regional Director designate and reaffirmed that would never be by-passed. However, given and the urgent need for consensus, a broader informal consultation on those issues would take place in January 2010, which she hoped would better inform the work and help to ensure consensus at RC60 in September 2010.

53. That informal consultation would feed into the SCRC discussions at every stage, starting with its next formal session in March 2010. Feedback from members of the SCRC individually and collectively would also be welcome electronically at any time, especially if there was not enough time at the present meeting to discuss all the issues. Briefing visits to the Regional Office were continuing, and that she had every intention of building on and strengthening the good work that she saw in the Office.

54. There would be a first discussion of the outline of a paper on the issues raised by her vision at the SCRC session in March 2010. That paper would subsequently be presented to RC60 in Moscow in September 2010, so that there was a clear mandate for the way forward (with the main milestones) for the coming five years.

General discussion

55. There was universal, comprehensive and enthusiastic support from all SCRC members for the vision for the next five years that the Regional Director designate had presented.

56. It was commended for its balance in being both significant and extensive, broad yet specific, and visionary but practical. It was fresh, demanding, promising and important, in that it gave a picture of today's Europe and a vision for the future. In their view, the vision identified, outlined and clarified all the steps required for the Regional Office to develop and earn leadership in public health in Europe. The many fresh ideas, along with the renewal of the European health policy, were universally supported and applauded.

57. Each SCRC member also mentioned and highlighted many of the individual aspects of the vision. Specifically, the SCRC drew attention to the importance of the Regional Office for all countries of the Region (including EU countries); the need to make the Regional Committee attractive for policy-makers; the importance of NCDs, health promotion, tobacco and alcohol, and health care systems; the need to strengthen country offices and the Regional Office's overall capacity with technical staff of high calibre (both of which would help to enhance the image and reputation of the Regional Office); and the importance of collaboration through partnerships with other organizations active in the health sector in Europe. A special mention was made of the continued importance of communicable diseases, given current events (avian influenza and influenza A (H1N1)): that was and had always been an area where ministries of health as well as governments looked to WHO for authoritative evidence, norms, guidelines, leadership and support.

58. All members, in one form or another, concluded that the vision presented had been elegant and comprehensive and was not just for 2010 but for the following five years. The SCRC decided to call it the "Ohrid Vision" and wished the Regional Director designate every success in its implementation. Recognizing that it was a very ambitious and demanding programme, the SCRC also specifically asked what they and the Member States could do to help.

59. The Regional Director designate thanked members of the SCRC for their enthusiastic and whole-hearted response and support and was delighted that it should be referred to as the Ohrid Vision. Their remarks had reminded her of an additional item for discussion, which was a request from the Director-General to revisit the subject of the Regional Search Group and voting during the Regional Committee session.

60. In response to the SCRC request to identify the main barriers to implementation that could be foreseen, the Regional Director designate pointed out that they all related to the availability of resources and the flexibility to redirect them in the early months of 2010. The initial briefing on the budget situation, the fact that the 2010–2011 plans for the Regional Office and country collaborative agreements had already been decided, and the implementation of the Organization's new global management system (GSM) in the European Region in 2010 all suggested that there was very limited flexibility. In addition, it was easier to raise funds for communicable diseases and NCDs than for health systems, and the timing of when voluntary contributions were made available was also very unpredictable. Similar issues applied to the availability and recruitment of staff. The priority was to select a strong senior management team (SMT) of directors who would support the Regional Director designate in implementing the Ohrid Vision by strategically leading, directing and managing its various components. As pointed out by the SCRC, high-quality technical staff would also need to be recruited. In order to make rapid progress, it was therefore essential that in the early years, when

flexibility was limited, Member States supported implementation of the Ohrid Vision through a combination of voluntary donations specifically for the SMT and secondment of technical staff.

61. The SCRC understood and was supportive of the request for voluntary donations to help implement the Ohrid Vision, and some agreed to look at the year-end financial situation in their countries and see whether resources were available. It was also suggested that WHO headquarters should be asked if GSM implementation could be delayed from January 2010, in order to make it easier to introduce the changes required to align the 2010–2011 budget on the new priorities.

Leadership role in Europe in health policy and public health

62. To the main question "Do you agree to have a renewed health policy for Europe?" the SCRC unanimously answered in the affirmative.

63. Although the suggested timeline of obtaining a mandate from RC60 in 2010 and developing the European policy by 2011 was considered ambitious, the SCRC agreed that this was a key element of the Vision and required urgent action. The idea of having discussion panels at RC60 in Moscow, at least on social determinants and inequalities and their impact on health, was endorsed. If possible, there could also be panel discussions on other health determinants and the impact of development challenges such as globalization.

Governance

64. The SCRC members had already agreed that it was very important to attract policy-makers to attend a decision-making segment of the annual session of the Regional Committee, especially as that would promote ownership. In the ensuing debate on how to do that, the SCRC recognized the problems involved (for example, EU affairs took up significant amounts of ministers' time) and made a number of suggestions. Those included linking the RC session with a ministerial conference, which was a good idea but the practicalities of back-to-back meetings needed to be explored, especially given that the next four sessions of the Regional Committee were to be held in different countries across the Region. Other suggestions included putting more "content" into the programmes of Regional Committee sessions (perhaps by strategic objective in the Organization's Medium-Term Strategic Plan), with resolutions that required real and tough negotiations (the process would need to be looked at).

65. The Ohrid Vision would offer an opportunity for political "buy-in" and signal that the Regional Office was at the forefront of development. That could be used to attract ministers to RC60 in Moscow. The challenge remained how to make most effective use of the short time that ministers would have at the Regional Committee session: perhaps the process followed by the EU could be a source of inspiration. For the EU Health Council meetings, the preparations and negotiations were extensive (cf. the suggestion above), and ministers came to make decisions. In the context of WHO, however, it was also critical for non-EU ministers to meet and discuss with EU ministers, as well as for the latter to show their solidarity. The Lisbon Treaty, with its effect on the EU's international coordination and external relations work, would also need to be considered in that connection.

66. The Regional Committee had asked the SCRC to review its mandate and come back with suggestions. The Regional Director designate's comments were therefore entirely relevant (e.g. consider an arrangement modelled on the relationship between the World Health Assembly and the Executive Board; give the SCRC more responsibility and decision-making powers; broaden participation, with full members and observers; appoint the chairperson only from inside the SCRC or, as before, also from those attending the relevant session of the Regional Committee); additional specific suggestions were to ensure transparency for those Member States that were not members of the SCRC in the year in question, and possibly to include a representative of the European Commission as an observer. The SCRC had set up a working group on governance, and it was agreed that its members would contribute to the debate. The Chairperson of the Working Group pointed out

that with such a vibrant vision, all countries (and especially the "large" ones) would need to be consulted. The overall objective must be to make the SCRC more efficient and effective, while ensuring that it was not marginalized.

The Regional Office as a networked organization

67. Members of the SCRC were unanimous in their view that all core functions should be located in Copenhagen, and that only supportive functions should be outsourced. They regarded this as a very important strategic decision which would help to resolve any vagueness about the geographically dispersed offices (GDOs), since they could and should be very important generators of knowledge. The SCRC also fully supported the suggested review of GDO's, building on the report prepared by Professor Silano in 2001 (document EUR/RC52/Inf.Doc./4).

68. The SCRC also agreed that the country offices should be reviewed in order to identify ways to further strengthen them and to find new modalities for those in EU countries. Some of the suggestions made included identifying the basic strategic functions of country offices; in EU countries, developing partnerships with the European Commission to share work and capacities; reviewing the need for more international staff as heads of offices; and making greater use of rotation and subregional arrangements. The SCRC also suggested making a review of the WHO collaborating centres in Europe and of their use for the technical work of the Regional Office, as well as developing "exit" strategies and criteria for all the above. The SCRC agreed that RC60 in 2010 should be approached to secure a mandate for the above work, with a suggested timeframe for reporting back to RC61 in 2011.

69. The importance and usefulness of networks had been demonstrated in Europe in the past, and the issue should be revisited to define what should be the role of the networks and who should be members. Again, a mandate could be obtained from RC60 in 2010, with work starting immediately

Partnerships

70. SCRC members agreed with the idea of developing a strategic partnership with the EU and welcomed the news that work had already started along those lines, as they agreed that the EU was not a threat but an opportunity. EU matters attracted the attention of non-EU Member States, so it was important to develop the partnership, clarifying the respective roles and mandates and sharing work and contributions as suggested in the Ohrid Vision. Like the Regional Director designate, they emphasized that the partnership should be for the benefit of all the 53 countries in the Region and developed with the involvement of both the European Commission (specifically its directorates-general for health and consumer policy, external relations, research, and enlargement), as well as with the presidencies of the European Council – some upcoming presidencies were already putting that topic on their agenda. The SCRC agreed that the European Parliament should also be engaged and that, where possible and sensible, joint ventures with the European Centre for Disease Prevention and Control (ECDC) should be initiated. The SCRC also suggested that the support of the Council should be enlisted and the new Lisbon Treaty and the EU health policy (which was currently with member countries for consultation) should be taken into account.

71. The SCRC emphasized the importance of the issue of partnerships, which should be managed in a framework of opportunity, and pointed out that it should not be compromised by doing it in the wrong way. They agreed that a step-wise approach was required, and that the topic should be brought to the March and June 2010 sessions of the SCRC and then presented to RC60 in Moscow. There was also agreement that the new European Commissioner for Health and Consumer Policy should be invited to RC60 in Moscow.

72. The SCRC agreed that rushed statements at sessions of the Regional Committee, for example by representatives of nongovernmental organizations (NGOs), were neither helpful nor productive. In taking a fresh look at existing partnerships, the relationship with the Council of Europe should also be considered. The idea of memoranda of understanding with key partners was one possibility, and a

special half-day meeting during a Regional Committee session devoted to partnerships could also be useful. That could be a coordination forum for all the key players, and not simply a "NGO forum". Work on that topic could start as soon as possible, with a mandate sought from RC60 in 2010.

73. The European Region had an important role to play in supporting and contributing to global developments. There were three possible dimensions: the impact of globalization and global issues on health in Europe; support from Europe to global developments; and Europe and the other WHO regions. Those aspects were covered in the paper presented by the Chairperson of the SCRC Working Group on Governance and would be further elaborated in that context.

Diversity of the WHO European Region

74. Members of the SCRC underlined the importance of WHO's work in the newly independent states (NIS) and Balkan countries and the need to further improve it, as well as to explore such improvements with the Russian Federation and Turkey. They agreed that efforts should be made to ensure that the Regional Office was also relevant to EU countries. They emphasized that, although the Regional Office's attention should remain focused on countries most in need, its relevance to the EU could be explored through, for example, the promotion of international and intercountry cooperation and the use of the European Observatory on Health Systems and Policies (with perhaps increased collaboration with the Organisation for Economic Co-operation and Development – OECD). All those issues should be brought to RC60 in 2010, in order to seek a mandate to undertake the necessary work, with the results being ready for presentation to RC61 in 2011.

Main priorities for the work of the Regional Office

75. In addition to the comments already made, the SCRC agreed to the priorities listed and every member fully agreed with putting NCD as the top priority, especially given that the comparative investment in that area had been so small. Mental health should also be put clearly on the agenda, especially given the ministerial conference on health promotion due to be held in Finland in 2013. A description of the work to be done should be presented to RC60 in 2010, in order to seek a mandate, with the NCD action plan developed for submission to RC61 in 2011, with the timing of political commitments on other issues in 2011–2012 to be further clarified. The SCRC also agreed that, following the Parma Conference, a discussion should take place at RC60 in 2010 to decide on the way forward in the area of environment and health.

76. The SCRC also supported the Regional Director designate's proposal to strengthen the technical programmes in the Office by streamlining management and making it leaner. They would welcome a first proposal at their March 2010 session, once the Regional Director designate had taken Office.

International health governance in the WHO European Region

77. The SCRC was reminded that RC59 had debated health governance issues without attempting to reach any conclusions and had expressed the hope that their discussions could help the SCRC, with the new Regional Director, to bring a paper forward for consideration by RC60 in 2010. The previous day, the SCRC had decided to set up an ad hoc working group on health governance in Europe composed of its members from Switzerland (Gaudenz Silberschmidt, Chairperson of the Working Group) the former Yugoslav Republic of Macedonia (Vladimir Lazarevik, Chairperson of the SCRC), Sweden (Fredrik Lennartsson) and Lithuania (Viktoras Meizis). The mandate of the working group began in November 2009 and would end with RC60 in September 2010, subject to any decision by the Regional Committee on further work.

78. The Chairperson of the SCRC Working Group had prepared and circulated for discussion an "input paper", which structured international health governance in Europe into five main areas and proposed a process for addressing the issues over the year ahead. Switzerland had been working on

some of those issues already (e.g. on a proposal for Committee C of the World Health Assembly to serve as a partnership forum) and experience had shown the need for documentation. If the SCRC agreed, Switzerland was ready to finance the work that needed to be done for the Working Group and the related transition process through the Graduate Institute for Development Studies in Geneva, who could prepare a background paper on the issues raised by the SCRC and provide a consultant to help the SCRC. In addition, the Graduate Institute could host the consultation meeting in January 2010, as proposed by Regional Director designate, to seek the views of a wider audience on the Ohrid Vision.

79. The Regional Director designate fully supported the proposals and thanked and commended the member from Switzerland for his generous offer, which fitted well with the SCRC work on governance and the mandate of its Working Group. The Working Group's tasks should encompass all the work that needed to be done on governance, work including that with the WHO Secretariat, and not only items which would be done by the Graduate Institute. It was important that in the following three weeks, there should be clarification of what would be done through the transition process (and on implementation of the Ohrid Vision) by the Working Group itself, the WHO secretariat and the Graduate Institute. It was even more important to be clear that the SCRC Working Group would be "the steering group" for all work on governance and the channel for reporting to the SCRC and thereafter to the Regional Committee.

80. Against that background, the Chairperson of the SCRC Working Group presented a table in which all governance-related issues and proposals, as put forward by the RC, the SCRC and the Regional Director designate, had been consolidated. Those had now been extended and grouped into six broad areas. It was proposed that the table should be a working document for the SCRC and its health governance working group, both to structure governance issues and to act as a checklist to ensure that no issues were missed. It should also help the process of drawing up background documents and proposals to be submitted to RC60 in September 2010, especially by identifying which issues were to be taken forward and by whom. The SCRC agreed that this was a good and useful way to handle all the complex issues related to health governance in Europe.

81. The SCRC then discussed each of the six broad areas one by one, as well as the detailed issues that were grouped under each of those broad areas. The SCRC's comments and suggestions were incorporated "on screen" by the Chairperson of the Working Group, who would circulate the final table immediately after the meeting.

82. On the broad areas, it was agreed that material in the first "block" should go into the Graduate Institute's background paper, to explain why work was being done on health governance and to raise awareness of its importance, also for Member States at national level. A specific request was made to include issues covering national capacity-building in both health governance and diplomacy. Policy coherence at national level was also important, and perhaps a draft Regional Committee resolution could be prepared inviting Member States to strengthen coordination.

83. There was extensive discussion of the second area, related to the strategic partnership with the EU. Many issues were added and the Regional Office Secretariat was asked to complete the analysis of existing partnerships, including formal ones. Member States also had specific relationships with agencies (such as OECD and the Council of Europe), which could influence their partnerships. The Russian Federation and Turkey could be approached and consulted bilaterally as part of the Regional Director designate's proposed initiative to strengthen the Regional Office's country work.

84. The next broad area that generated considerable debate was "Governance in the WHO European Region", covering the many internal and external SCRC- and Regional Committee-related issues. Issues surrounding membership of the Executive Board (and in particular the sensitive issues of subregional groupings when nominating countries and 'semi-permanency' of membership) were also the subject of extensive debate, continuing the discussions held by the Seventeenth SCRC at its second session.

85. The debate surrounding subregional groupings also potentially affected SCRC membership, and there was extensive discussion of the advantages and drawbacks of subregional groupings as such. The precise composition of subregional groups, and whether groupings were "political" or "representative", also affected the benefits and disadvantages.

86. It was pointed out that the three countries that enjoyed "semi-permanent" membership of the Executive Board had been informed at RC59 that the SCRC was intending to review the arrangement under the topic of governance; they had also been told that the SCRC would establish a working group to consider the matter in detail, and that they would be invited to submit their views to it (see the report of the first session of the Seventeenth SCRC).

87. The extensive debate highlighted the sensitivity of both issues and the importance of following the correct process to take this broad area to RC60. Perhaps the most important thing to emphasize was that the overall objective was to strengthen the SCRC (and the representativeness of all the regional governing bodies) and make it more effective, and not to marginalize it (which could happen through a restricted or nonrepresentative membership). If, for example, some countries had to be consulted in parallel because they were not members of the SCRC, that would weaken health governance in Europe.

88. In conclusion, it was agreed that the amended table would be structured in line with the comments made and then circulated to SCRC members for further review. At the same time, their comments would be sought on the priorities and timescales for implementation, indicating which issues were important and needed to be tackled now and which could wait and be covered later. The table would be shared with the Graduate Institute and remain as a working document and checklist for the Working Group and the SCRC.

Conclusions

89. The Regional Director designate thanked the SCRC for the stimulating discussions and the many suggestions that had been made, which she would incorporate into the next draft of the paper setting out the Ohrid Vision and the way forward. That draft would be presented and discussed at the January 2010 consultation that had been generously funded by Switzerland as part of the transition process and which would be hosted on the Regional Director designate's behalf by the Graduate Institute in the vicinity of Geneva. The consultation would be with a number of public health experts, representatives of some Member States (also taking the opportunity of their attendance at the Executive Board session) and some WHO headquarters staff. Feedback from that consultation would be presented to the SCRC at its next session in March 2010.

90. The terms of reference of the Working Group would be circulated for comments (including to the Regional Director designate) by the end of November 2009 and then finalized and submitted to the SCRC. There should be a clear delineation between the tasks carried out by the Graduate Institute and those done by the Regional Office Secretariat.

91. The Regional Director designate concluded by indicating that at present she expected that the agenda for RC60 would cover the Way forward, Governance, Partnership with the EU, Proposals for renewal of the European health policy, and obligatory items. As previously mentioned, the possibility of panel discussions would also be explored.

92. In closing the special one-day brainstorming meeting, the Chairman thanked the Regional Director designate for sharing her vision with the SCRC at that early stage. In turn, the Regional Director designate thanked the SCRC for its invitation and its very positive reaction to the "The Ohrid Vision" that she had outlined. Personally and on behalf of all the participants, she thanked the SCRC Chairman for hosting the very useful session in the wonderful location of Ohrid and for his hospitality and that of the Minister of Health and of the former Yugoslav Republic of Macedonia.