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of the Regional Committee for Europe**

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Introduction

1. The Twenty-second Standing Committee of the Regional Committee for Europe (SCRC) held its third session in Copenhagen, Denmark, on 17 and 18 March 2015.

Opening by the Chairperson and the Regional Director

2. The Chairperson welcomed participants to the third session of the Twenty-second SCRC. She recalled that, in line with resolution EUR/RC63/R7,¹ the opening remarks of the Regional Director for Europe would be web streamed.

3. The Regional Director welcomed the members of the Twenty-second SCRC, Malta as Executive President of the 64th session of the Regional Committee for Europe (RC64), the Russian Federation as the link between the Executive Board and the Twenty-second SCRC, and Lithuania, which would host RC65, as an observer. The theme of RC65 would be promoting intersectoral action for health and well-being in the WHO European Region. Ahead of RC65, a mid-term review of the environment and health process would be held in Haifa, Israel, in April 2015 as a follow-up to the recent meeting of the European Environment and Health Ministerial Board in Madrid, Spain. The Regional Office was seeking offers to host the Sixth Ministerial Conference on Environment and Health. An expert workshop on collaboration with the education and social policy sectors to promote healthy choices would be held shortly in France. Another workshop, to be hosted by Germany in late April, would bring together Member States with a strategy for health and foreign policy to share their experiences and to prepare recommendations. The Regional Director thanked Member States for hosting these meetings. For the open session of the SCRC just before the Sixty-eighth World Health Assembly in May 2015, the Secretariat would prepare working documents on the basis of the web-based consultations with Member States on health systems strengthening, implementation of the WHO Framework Convention on Tobacco Control, the physical activity strategy and the new tuberculosis action plan, and first drafts of resolutions and decisions for RC65.

4. The Regional Director informed the SCRC about two important WHO governing body meetings in January 2015: the 21st session of the Programme, Budget and Administration Committee (PBAC) and the 136th session of the Executive Board, which proposed 15 resolutions and four decisions to be forwarded to the Health Assembly. She informed the SCRC of the special Executive Board session on the Ebola virus disease (EVD) and provided an update on the status of the EVD epidemic, including the rapid decrease and the subsequent plateau in the number of confirmed cases in recent weeks. The cases in Guinea and Sierra Leone were limited to specific geographical areas, and no new case had been reported in Liberia during the past three weeks. To date, the Regional Office had deployed 30 staff members (equivalent to more than 1000 staff days), and an additional 55 staff had volunteered. In accordance with the resolution adopted at the special Executive Board session, the Director-General had commissioned a panel of six independent experts to undertake an interim assessment of all aspects of the WHO response to the Ebola outbreak. In addition to the WHO-led assessment, there were other ongoing or planned external assessments, such as the evaluation of the United Nations system-wide response by the United Nations Secretary-General. A report was being prepared on the role of WHO in the United Nations Mission for Ebola Emergency Response (UNMEER). Resolution EBSS3.R1² on ending the Ebola outbreak also called for WHO reform in emergencies, addressing the changes required to increase the capacity of WHO's structures, human resources, planning and budgeting, finance, information management, communications

¹http://www.euro.who.int/__data/assets/pdf_file/0004/217741/63rs07e_Governance.pdf?ua=1

²http://apps.who.int/gb/ebwha/pdf_files/EBSS3/EBSS3_R1-en.pdf.

and accountability framework. In line with this, work is ongoing to define a global health emergency workforce. Furthermore, a proposal for a contingency fund for health emergencies, including its size, scope, sustainability, operations, financing and accountability, was being developed. The Global Policy Group meeting, to be held in Muscat, Oman, on 23–25 March, would discuss the resolution on Ebola and all other important strategic issues.

5. In the area of WHO reform, the PBAC working group on strategic budget space allocation will continue its work to determine a fair, equitable allocation of the US\$ 1 billion available for segment 1 of the global programme budget. Belgium and Finland are representing the European Region. The Executive Board had decided to initiate an intergovernmental process on WHO governance reform. A global working group had been formed, in which Estonia and the Russian Federation represent the European Region. The Regional Office had prepared a summary of good practices in the Region from the past five years as a contribution, which is accessible on the website.³ With regard to the framework of engagement with non-State actors, Member States had sent in substantial comments and an open-ended intergovernmental meeting would be held at the end of March. Other web-based technical consultations, including on intersectoral action for health and health equity and resolution WHA67.15 on addressing violence against women and girls, had been held or were under way. The Regional Director encouraged all Member States to contribute to those discussions.

6. Activities at the regional level included the opening of the geographically dispersed office for primary health care in Almaty, Kazakhstan. The 12th Senior Officials Meeting of WHO and the European Commission, held in February, discussed the Ebola outbreak, health security, antimicrobial resistance, access to medicines and in-country and region-wide cooperation. Work on the roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control (FCTC) had continued, with a regional consultation in Moscow, Russian Federation. Europe had become the global leader in the standardized packaging movement, following the courageous decision of Australia in 2012. Ireland had become the second country in the world and the first in Europe to adopt such legislation. Several other Member States were moving forward on standardized packaging. At the request of France, the Regional Director was approaching Member States to lend political support to its work in the same area. Turkmenistan, in support of the implementation of the Ashgabat Declaration, had allocated US\$ 2.4 million over three years for tobacco control in the Region.

7. The Chairperson, stating that the web streaming had now closed, outlined the programme (document EUR/SC22(3)/3 Rev.2) of the session. The agenda (document EUR/SC22(3)/2 Rev.2) and programme of the third session of the Twenty-second SCRC were adopted.

Feedback from the 136th session of the Executive Board

8. The Regional Director, reporting on the special session of the Executive Board and the session of the PBAC, said that the discussion on strategic budget space allocation had been difficult because of the political implications. The original working group had thus been expanded to include two Member States from each region. With regard to global governance reform, she urged Member States to submit information on good practices within the Region to a dedicated space on the website. The Global Policy Group, which would meet the following week, would discuss the EVD response, the emergency response framework, health in the post-2015 development agenda, antimicrobial resistance, accountability and climate change and health. It would also discuss managerial issues, the proposed programme budget, including strategic budget space allocation, and the role of non-State actors in the work of WHO.

³ <http://apps.who.int/gb/mscp/mscp.html>

9. One member reported that the global working group on strategic budget space allocation had met briefly through a teleconference. Member States had been invited to send indicators for consideration by the group; those in the European Region had focused mainly on the process. Another member reported that the global working group on governance reform had agreed on its working methods and had begun to identify gaps and to attempt to determine why previous proposals had not been accepted.

10. The Director, Division of Administration and Finance, reiterated that no agreement had been reached in the Executive Board on strategic budget space allocation. He commented that the members of the group represented the mandates of their respective regions. The main point of discussion had been which weighting method should be used for calculating population size in the calculations. No agreement on an allocation method for segment 1 had been reached, and the Global Policy Group was asked to take a joint decision. With regard to the programme budget 2016–2017, there were three options: zero growth, growth with a correction for inflation, or allowing some inflation and some increase in certain programme areas. The Secretariat was asked for more evidence for each option. Regarding rotation and mobility of internationally recruited staff, there had been overwhelming support within the Executive Board. Such measures would first be introduced on a voluntary basis and would become mandatory after two to three years.

11. The Executive Manager, Strategic Partnerships and Resource Mobilization, said that the discussion at the Executive Board on the role of non-State actors in WHO's work had been lively, with diverse opinions, and no consensus had been reached. Member States had been asked to submit comments on a "framework of engagement with non-State actors" prepared by the WHO Secretariat. Many comments had been received, including on whether engagement in the work of WHO should be restricted or proactive; whether risk should be avoided or managed; and whether the PBAC provided adequate oversight or Member States should become involved in due diligence with regard to determining conflicts of interest. There were different proposals received on defining what constituted the private sector; on the level of transparency for due diligence, with publication of declared conflicts of interest on the WHO website; on the register of all non-State actors; and on the types of engagement and secondments from non-State actors to WHO.

12. In the ensuing discussion, members commented that the private sector, especially when defined broadly, as some had suggested in the consultation, contributed more than 50% of WHO's budget. The Organization would be unable to function without that income. When the working group's next report was presented, a clear explanation of WHO's financing should be given, including the implications of refusing funds from the private sector. The Member States in the European Region had supported the initial report that had been presented to the Executive Board; they should now ensure a common, coordinated approach and should reach out to Member States in other regions. One member commented that it would be impossible to eliminate risk; instead, it should be managed and mitigated.

13. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, reviewed technical agenda topics of the Executive Board relevant to the European Region. The outcome of the special session of the Executive Board on EVD was important, as the outbreak had possible implications for the response of Member States to emergency situations. The backbone of response was a country's core capacity for implementing the International Health Regulations (IHR); thus, health systems strengthening remained essential. With regard to preparedness for immediate needs in an emergency, WHO readiness for large-scale, sustained emergencies would be built up at all levels, and existing networks such as the Global Outbreak Alert and Response Network, Foreign Medical Teams from countries and other United Nations agencies would form the basis for the global health emergency workforce. The size, scope, sustainability and accountability of a contingency fund, including possible

sources of funding, would be presented to the Sixty-eighth World Health Assembly in May 2015. The lessons learned and the full consequences of the outbreak were to be assessed by several independent panels.

14. The outcome document of the second international conference on nutrition⁴ would be considered for endorsement at the Health Assembly in May. On the follow-up to the 2014 High-level meeting of the United Nations General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, there was no consensus on the proposal to introduce process indicators and many Member States emphasized that the global monitoring framework serves that purpose. No consensus had been reached on the resolution concerning air pollution; all Member States taking the floor acknowledged the global burden and requested that the discussions continue until the upcoming Health Assembly. Antimicrobial resistance was recognized as a global public health threat and the relevant action plan was being revised by a technical advisory group in line with comments from the Executive Board. A draft resolution on poliomyelitis was to be submitted to the Health Assembly, with emphasis on the continuing appearance of cases in Pakistan. Executive Board members had commented that reports from Member States were not an objective means of assessing their core capacity for implementing the IHR, and that a better way should be found. The resolution on malaria, which included actions towards elimination, was broadly supported. With regard to the agenda item on emergency and essential surgical care and anaesthesia, Member States from the WHO African Region had requested that ketamine remains on the list.

15. In response to a query about how the proposed contingency fund would be taken into account in the programme budget 2016–2017, the Regional Director said that the issue would be taken up by the Global Policy Group. The roles of the WHO regional and country offices in response to the EVD epidemic would be included in the interim assessment. In response to the comment that the post-2015 development agenda should include emergencies and public health threats, instituting universal health coverage and strengthening health systems and preparedness, she welcomed the comments and stated that intergovernmental negotiations on the outcome document had already started.

Reports by the chairpersons of the subgroups to the SCRC

16. The chairperson of the subgroup on implementation of Health 2020 said that each Member State undertook implementation at its own level and from its own standpoint. Involvement of the social and education sectors was essential and the subgroup had welcomed the Secretariat document on intersectoral action. They suggested that it could be improved by the inclusion of: a definition of “intersectoral action”; national examples, such as from the Healthy Cities initiative; political as well as social determinants, people empowerment, health literacy and the role of the citizen; and the role of industry, transparency and conflicts of interest. In order that intersectoral work be included on the agenda of RC65, explanations should be given of the breadth of the proposed platforms, the objectives and the sectors that would participate. The subgroup considered that the draft resolution could contextualize the global approach in the European Region, provide concrete justification for Member States in taking the work forward and acknowledge the existing legacy of intersectoral work in the Region.

17. The Director, Division of Policy and Governance for Health and Well-being, said that the document had been further revised in the light of discussions the previous day.

⁴ <http://www.fao.org/3/a-ml542e.pdf>

18. The Director, Division of Information, Evidence, Research and Innovation, said that evidence and information were the basis for implementing Health 2020. As requested by the SCRC, a roadmap for evidence-informed policy-making (EIP) would be presented at a technical briefing at RC65. Several tools had been developed, including a “starter kit” for countries to implement the EIP approach. Work was under way on means of measuring the cultural determinants of health in the context of well-being and Health 2020. The Regional Office was launching a bilingual English-Russian journal on public health policy, which would present its second issue on the special theme of intersectoral work at RC65.

19. The Regional Director said that progress on governance and intersectoral issues was critically important. Systematic intersectoral collaboration had been well established for health, the environment and transport. Progress had been made in intersectoral collaboration for health and foreign policy, with a link to sustainable development. However, gaps were still present in collaboration on other areas, such as cultural and healthy choices and social determinants. Further collaboration was needed at the regional level; emphasis would be on the educational and social sectors. RC65 would address the gaps in intersectoral collaboration in general, the ways and means to fill these gaps and indicate the sectors where collaboration required strengthening, such as the education, social and financial sectors. The Regional Office would support health ministers in reaching out to other sectors.

20. Several members reported that expert meetings on intersectoral collaboration were to be held in their countries in the near future.

21. The chairperson of the SCRC subgroup on governance said that they had discussed the input of the SCRC to the next meeting on the role of non-State actors, the structuring of the discussion on risk management and building coalitions of like-minded regions. The participation of nongovernmental organizations in Regional Committee meetings had improved in recent years; further steps in this regard would have to await the outcome of the engagement with non-State actors process. The subgroup had also discussed the amendments to Rule 47 of the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe, made available at the meeting. The subgroup recommended adoption of the amendments. On conference declarations, the subgroup identified two types – ministerial and high-level conference declarations, which have different weights. Both were important, and the subgroup welcomed the criteria for bringing conference declarations to governing body meetings, but expressed concern about the specifics; it also agreed that the SCRC should be involved in advising on the consultative process required and in discussing whether the declarations should be taken forward in a Regional Committee resolution. The subgroup had further agreed that its chairperson would continue working on criteria and would present a revised version at the next meeting. The subgroup had also discussed the development of templates for action plans, frameworks, roadmaps and strategies as well as the necessity for a hierarchy of technical documents between the global and regional levels. It agreed that a clear criteria and a transparent hierarchy would facilitate review by Member States and improve the quality of guidance. The Regional Director pointed out that the issue would require an Organization-wide response and proposed to ask Estonia to raise it at the global working group on governance reform. It had agreed to continue the stepwise work, starting with definitions for the most common types of technical documents.

22. The Executive Manager, Strategic Partnerships and Resource Mobilization, said that the SCRC should approve the proposed modifications to Rule 47 of the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe in order that a decision could be prepared for the open session of the SCRC before the World Health Assembly. The amendments were approved.

Provisional agenda and provisional programme of the 65th session of the Regional Committee for Europe, including discussion on subitems under WHO reform and matters arising

23. The Regional Director introduced the draft provisional agenda (document EUR/SC22(3)/9) and the draft provisional programme (document EUR/SC22(3)/10) of RC65. She said that the item on WHO reform would include the programme budget 2016–2017, strategic budget space allocation, rotation and mobility of staff and the role of non-State actors. Reflecting the theme of RC65, there would be three sessions on promoting intersectoral action for health and well-being: one focused on health and foreign policy, one on health, education and social policy and the third on environment and health. There would be a technical briefing on women's health, which would be a substantive item at RC66 in 2016.

24. In response to comments from members, she said that the convening power of WHO allowed it to hold conferences that brought together the health, education and social sectors, which would be a challenge for some countries. The partnership with the European Union would be relaunched with a new memorandum of understanding and new roadmaps. Greater attention could be paid to nursing and midwifery only when the necessary resources became available; at that time, it could be considered as a substantive item in the programme of the Regional Committee meetings. The timeframe for discussion of progress on combating multidrug- and extensively drug-resistant tuberculosis and the tuberculosis action plan for the WHO European Region 2016–2020 should be extended.

Preparations for RC65

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

25. The Director, Division of Policy and Governance for Health and Well-being, introducing the item (document EUR/SC22(3)/11), recalled that intersectoral governance was a key strategic objective in Health 2020. Much could be learned from the broad experience of European Member States in intersectoral action and initiatives that could not be accomplished by one sector alone. The first step was to identify existing capacity, gaps and opportunities and the practices, tools, instruments, mechanisms and platforms for action. It would be important to institutionalize and ensure the sustainability of intersectoral processes. Health was a political choice and the links with foreign policy and the social, environmental, cultural and industrial determinants and relevant sectors were opportunities for improving health. Crucial sectors were social policy and education; school was the entry point for learning to lead a healthy life and educational inequalities could lead to health inequity. A strategic framework for action was being prepared, with concrete priorities, tools for implementation and lessons to be learned from experience. The working document being prepared for the fourth session of the Twenty-second SCRC would also contain sectoral briefs and a draft resolution that would ensure political and operational legitimacy at the national, regional and global levels, explore strategic partnerships with priority sectors and reinforce regional guidance to take this agenda forward.

26. One member commented that health was not a priority of governments; if an interministerial committee existed, the means should be found to ensure that it was used. If WHO were to have the mandate to approach heads of Government, the situation could improve, since it was they who gave targets to ministers. As the current view was that the economy took precedence over all other areas of government, evidence should be provided not only for what the economy could do for health but also for what health could do for the economy. A structure should be proposed for collecting evidence to support intersectoral collaboration. New legislation could include a requirement for a health impact assessment. The draft resolution

should have a clear strategic focus and should stress the importance of health information, which was essential for prevention. One member recalled that intersectoral collaboration was not an end in itself but rather a means for building coalitions on a common interest. Another member questioned the need for another resolution on Health 2020 and expressed the opinion that the document was much too ambitious as proposed.

27. The Director, Division of Policy and Governance for Health and Well-being, replied that the sectoral briefs would describe win–win situations based on convincing evidence. A mandate to obtain a presidential or prime-ministerial commitment would facilitate intersectoral collaboration, such as in parliamentary committees, and would add a strategic or policy element to technical discussions. In response to remarks by several members, he assured them that the document would be no longer than 10 pages and would include examples of mechanisms, best practices and cost–effective, sustainable approaches.

28. The Regional Director, responding to queries about whether yet another resolution on intersectoral collaboration was needed, said that the previous resolution had not addressed governance or whole-of-government, whole-of-society approaches. Once the text was finalized, the Committee could determine whether a resolution or a decision would be more suitable.

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

29. The Director, Division of Health Systems and Public Health, introducing document EUR/SC22(3)/7, said that it described the proposed strategic focus of work on health systems strengthening in the context of Health 2020. It was based on continuing discussions and collaboration with Member States and the outcome of the high-level meeting to mark the five-year anniversary of the signing of the Tallinn Charter. The values that drove health systems strengthening resulted in their transformation from reactive to proactive systems based on the continuum of care, in the move towards universal health coverage. The change would involve increasing health intelligence, ensuring equitable access to cost–effective medicines and technology and increasing the health workforce, all of which would require financial resilience. Health systems must be responsive to change and innovation. WHO support to Member States would be in systematizing translation of evidence into knowledge; creating platforms to facilitate learning; providing tailored technical assistance and advisory services; organizing political dialogue with broad stakeholder participation; and providing targeted capacity-building opportunities. A number of consultations would be held before RC65. The strategic priorities had been agreed by the seven Member States that were guiding the final report on implementation of the Tallinn Charter.

30. Member States welcomed the document as focused and timely, in line with the needs of Member States to strengthen health systems. Several members commented that the term “health intelligence” should be changed to “health information” in conformity with resolution WHA60.27, on strengthening of health information systems, and with the text of the document under discussion. In addition, the use of the term “enabler” in connection with health information contradicted the resolution, which identified health information as a “foundation” for and an “integral part” of health information systems. Moreover, relevant examples should be added to the existing bullet points listed, in particular the Evidence-informed Policy Network. Relevant aspects of health information, such as data harmonization, standardization and quality improvement, were not mentioned and should be included. A revision of the section incorporating those comments was requested. Several members asked for a glossary of terms such as “long-term care” and “community care” for better understanding of the concepts. Modern techniques should be used to provide health information to enable people to look after their own health. One member reported that Russian-speaking Member States had exchanged their wide experience and best practices in health systems strengthening, which could be shared

with other Member States. In the absence of sufficient financial resources, the means must be found to make health systems more efficient, and the paper should also focus on that aspect. Political commitment was essential to ensure equality in health care. One member asked that the introductory section, “My ideal health system”, be clearly designated as quotes from potential health system users and not specific recommendations of the document itself.

31. The Director, Division of Health Systems and Public Health, replied that the term “intelligence” had been used to express “health policy analysis”; however, he would work closely with the Division of Information, Evidence, Research and Innovation to revise the document. The revised document would also emphasize patient empowerment and a population-based perspective of primary health care, with long-term social services. A glossary on health systems strengthening had already been prepared by WHO headquarters, available on its website.⁵ It was suggested to go along with the same glossary for consistency.

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

32. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, speaking on document EUR/SC22(3)/6, said that the proposed strategy addressed the call in the Vienna Declaration on Nutrition and Noncommunicable Diseases for a strategy on physical activity for the European Region. A number of consultations and meetings had been held to finalize the document. There was clear evidence that physical inactivity increased the burden of diseases such as cardiovascular disease and diabetes. There was also evidence for effective intersectoral approaches to increase physical activity, including initiatives taken by local governments, such as cycling tracks. The vision of the strategy was the promotion of physical activity leading to longer lives for people of all ages and socioeconomic groups. It involved a life-course approach, from pregnancy through school settings and the working environment.

33. Members welcomed the proposed strategy. It was suggested that countries could consider reimbursing the cost of physical activity in order to create equal opportunities for an active life style; another member commented that such reimbursement should not be made from the health budget, and people should be encouraged to take part in low-cost physical activities outdoors. Basic sets of core indicators could be prepared for specific target groups, as the needs of people of different ages, gender and ability differed. The strategy should also include the promotion of physical activity for people with disabilities, including children, in addition to improving access. Physical activity should be included in health care processes. One member commented that the term “fitness” should be avoided, as it had commercial connotations.

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

34. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, introducing document EUR/SC22(3)/5, reminded the Committee that the European Region had the highest prevalence of tobacco smoking among adults in the world. The Ashgabat Declaration on the prevention and control of noncommunicable diseases in the context of Health 2020 described the vision of a tobacco-free Europe. That vision had been amended to one of a Europe free from the harms of tobacco. The document presented the regional programme for tobacco control, which would be implemented in cooperation with the WHO

⁵ Health systems strengthening glossary. In: WHO/Health systems [website]. Geneva: World Health Organization; 2015 (http://www.who.int/healthsystems/hss_glossary/en/).

FCTC Secretariat. The programme was based on technical consultations to determine the gaps in tobacco control in the Region, with the financial support of Turkmenistan and the Russian Federation. A revised draft of the roadmap had been sent to Member States, and their comments would be incorporated in a final draft to be prepared for the fourth session of the Twenty-second SCRC. The main changes had been in the title of the document, further alignment with Health 2020 and greater emphasis on the WHO FCTC. The document only provided options for Member States, since some were not signatories to the Convention. The document focused on the specific needs and gaps of European Member States and on actions that would have the greatest impact, specifically in achieving the time-bound targets of the WHO FCTC. There should be a balanced approach, focusing on the regulation guidelines for smokeless tobacco products agreed at the sixth Conference of the Parties to the WHO FCTC, rather than electronic nicotine delivery systems, whose effectiveness in smoking cessation was under review. A recommendation had been made to link the roadmap to the achievement of the Millennium Development Goals and the post-2015 sustainable development goals. The self-assessment checklist (document EUR/SC22(3)/misc.1) contained indicators that were closely aligned with those of the global reporting mechanism for the WHO FCTC; they were not additional indicators, and the document did not represent an alternative reporting mechanism.

35. One member commented that the effects of cigarette smoking on climate change were mentioned only briefly; evidence for this association should be provided. Electronic nicotine delivery systems should not be ignored, as they were promoted by the tobacco industry and might lead to a new addiction problem in the near future. The Regional Office should compile the scientific evidence on the risks associated with their use. They agreed that the checklist should be considered as a tool and not a reporting system. Members suggested that additional columns be added to the checklist, for “partial” compliance and “not applicable”. One member mentioned that the roadmap must be aligned with the European Union policy. A glossary of terms was requested. A regional action plan was essential in view of the cross-border traffic in tobacco products. The European Region should serve as an example for other regions. One member asked for explicit inclusion of smokeless tobacco products such as snus in the roadmap and the checklist.

36. The Director, Division of Policy and Governance for Health and Well-being, said that the vision of a tobacco-free future had caught widespread attention and leadership in tobacco control should come from all levels of government.

37. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, replied that discussion of electronic nicotine delivery systems could not go beyond that of the sixth Conference of the Parties, which had been extensively negotiated by all 180 Parties to the WHO FCTC. He agreed that it would be useful to compile the available evidence on the use of such devices. Further involvement of cities in tobacco control might be brought about within the Healthy Cities programme.

38. The Regional Director said that, although she agreed that the plan should be aligned with European Union policy, the relevant European directive was less comprehensive than the WHO FCTC. The European Region was indeed leading the way in aspects of tobacco control such as plain packaging, which had been introduced in Ireland and was being considered in Finland, France, Turkey and the United Kingdom. She remarked that only six countries throughout the world had ratified the Protocol to Eliminate Illicit Trade in Tobacco Products. More emphasis should be placed on fiscal policies and intersectoral collaboration. In answer to a comment by one member, she said that while the roadmap sought to be comprehensive, it could be adapted to the requirements of each country through biennial collaborative agreements.

Address by a representative of the WHO Regional Office for Europe's Staff Association

39. A representative of the Regional Office for Europe Staff Association said that the Association and the management of the Regional Office were on opposite – not opposing – sides, with the same aspirations and goals but different perspectives. Collaboration had always been excellent. In the past year, a cooperation agreement had been signed by the Regional Director and the President of the Staff Association, which formally established and laid the ground work for continued positive cooperation to create a productive, forward-looking, successful, positive workplace. The agreement was the first of its kind in WHO, and other regions would use it as a model for similar agreements. The priorities addressed by the Staff Association in 2014 had been work–life balance and teleworking, the internal justice system and mobility.

40. Teleworking was linked to high job satisfaction, as staff working from home were shielded from office distractions and sometimes unnecessary meetings. A basic agreement had been reached on the occasional use of teleworking, but implementation of the policy should be monitored. The current internal justice system was overly bureaucratic, with inadequate safeguards; a charge of harassment, for example, could take six to eight years to be settled. WHO headquarters had recommended greater awareness and prevention, and the Regional Director had instituted a focal point for reporting mobbing, harassment or bullying. The Staff Association would continue to work towards strengthening and improving the internal justice system. The Association considered that the draft geographical mobility policy of the Organization failed to guarantee protection of staff rights. Mobility must be a career opportunity that allowed for promotion and provided all the necessary support for relocated staff members and their families; the impact of the policy on gender balance at different grades and the diversity of staff assigned to duty stations at which discrimination persisted must be considered. The requirement for specific expertise in some locations should be taken into account and the budget must be adequate to ensure that there was no detrimental effect on WHO's work and programmes. Member States were advised to follow the evolution of the policy closely, to ensure that the Organization attracted and retained the best staff. He thanked the SCRC for the valuable opportunity to address members. The Staff Association recognized that the work it did would not be possible without the continued support and cooperation of the SCRC.

41. One member expressed appreciation for the work of the staff in advancing reform.

42. The Regional Director emphasized the excellent relations between the management and the Staff Association. She would support occasional teleworking as long as it improved programme delivery; the situation would have to be monitored. With regard to the internal justice system, the Global Policy Group was considering how to shorten the process. The staff mobility policy was to be tested on a voluntary basis for two to three years, which would give time to prepare an action plan and a governance mechanism; the policy would then become compulsory.

Governance matters

Future sessions of the SCRC

43. The Technical Officer, Regional Governance, introducing document EUR/SC22(3)/8, recalled that the SCRC at its second session had asked the Secretariat to find a way of reducing the number of face-to-face meetings in order to limit the workload and costs. Some aspects of SCRC sessions were defined in the Rules of Procedure; furthermore, the Secretariat required eight to ten weeks to prepare documents, for administrative and logistic tasks and for additional

consultations with Member States. Those activities, with the timing of global meetings, defined the planning of SCRC meetings. It was proposed that the first session of each SCRC be moved to the morning of the day after the Regional Committee meeting, although the four new members of the SCRC would have been elected only two days previously and would not have had time to consider the documents. For this reason, a web-based forum could be created on which SCRC members could continue discussions, which would be included in the report of the meeting. The proposal for the second session was that it be virtual and paper-less and be held one month earlier than currently. It would consist of two 3-hour meetings and a password-protected forum open for two further days allowing members to raise questions, comments, amendments and proposals. Potential problems to be overcome were adaptation to the 5-hour difference in time zones in the Region, and providing interpretation. Two technical solutions were proposed: a call-in teleconference or use of web-based technology. The drawbacks to teleconferencing were the telephone costs and the time required for simultaneous interpretation in each non-English-speaking country. The main drawback to the second option was the technology for two-way web-streaming with interpretation, which was being developed but was as yet only theoretical and would be expensive. It was proposed that the third, fourth and fifth sessions remain unchanged, except for providing more time at the fourth session before the World Health Assembly in Geneva.

44. Members spoke unanimously against a virtual paper-less second session. Although the Slavic Economic Union, which also had a problem of time zones, held its meetings by teleconference with good connections, the meetings lasted less than three hours and documents were sent ahead of time. It would be difficult to ensure accountability and oversight if no documents were available. Members also disagreed with holding the first session on the day after the Regional Committee meeting, as travel arrangements of newly elected SCRC members would have to be changed: they could not be foreseen. One member said that her country had strict rules about the types of computer programs and equipment that could be used by government officials. Many members commented that the social interaction of members during SCRC sessions was sometimes more important than the exchanges during the sessions. Furthermore, members were away from their offices and could therefore concentrate on the issues being discussed. Teleconferences were useful for discussing specific issues but would not be suitable for a full meeting. France offered to host the second session of the Twenty-third SCRC in Paris.

45. The Regional Director welcomed members' appreciation of the ambiance of the face-to-face SCRC meetings. She understood, as an outcome of the discussion, that the timing of SCRC meetings would remain the same for the present, allowing the Secretariat time to prepare the necessary documents.

Duration of existing action plans

46. The Executive Manager, Strategic Partnerships and Resource Mobilization, said that the existing action plans had been reviewed to determine whether the reporting obligations were feasible and whether the plans should be renewed for RC70 in 2020. Eight action plans would be completed by 2020, five would require reporting in that year and the remaining three in 2021, when reports on implementation of Health 2020 would also be required. It was proposed to agree on some overall principles on reporting. Regional action plans could be aligned with global action plans one year after their adoption by the Health Assembly. If there was no global action plan on an issue, a regional plan could be formulated, with an open ending date but regular reporting, which would be considered as a full agenda item by the Regional Committee every six years.

47. Several members commented that the "sunsetting" exercise had been undertaken to stop open-ended reporting. They proposed that each action plan be reviewed separately. One member

asked for an explanation of the hierarchy of “action plans”, “roadmaps”, “strategies” and “frameworks” with regard to priority. Action plans should be revised or updated when they reached their completion date. With regard to reporting, the Region should not be obliged to adhere to the global pattern.

48. It was agreed that the SCRC subgroup on governance would further review the action plans and their alignment with global plans.

Update on financial and budgetary matters

49. The Director, Division of Administration and Finance, reported that projected contributions for the 2014–2015 programme budget would come to US\$ 245 million, which represented 4% more than the current allocated budget ceilings (these would subsequently be increased to US\$ 247 million). At present, the Regional Office had available funding of US\$ 203 million. The proportion of the allocated programme budget that was funded by voluntary contributions had reached 50% by December 2014 because the second tranche of corporate funding had been received from headquarters. The distribution of corporate funds had become more transparent and predictable, being largely based on the financial requirements of all major offices. Although overall funding was good, “pockets of poverty” remained: categories 2 and 3 had received funding for only approximately 70% of the budget ceiling approved by the Health Assembly. The next tranche of corporate funds could be used to partially make up the deficit in those categories. Implementation of the programme budget was still low, partly because all funds had not yet become available. The number of staff had been reduced, mainly through a voluntary separation scheme, and the cost of salaries had fallen by 20% over the previous biennium – a greater decrease than in any other major WHO office. The reductions had been made primarily in programme support and administrative functions in order to allow for increases in the Regional Office’s technical capacity.

50. In response to a question about the influence of the exchange rate on the budget, he noted that the strength of the US dollar against the euro had reduced staff costs. The unpegging of the Swiss franc to the euro could have cost implications for staff costs at WHO headquarters. The hedging mechanism would protect the budget for the current biennium 2014–2015, but the programme budget for 2016–2017 would be affected.

Membership of WHO bodies and committees

51. The SCRC met in private session to discuss vacancies for election or nomination at RC65 and elective posts at the Sixty-eighth World Health Assembly.

Other matters

Update on the Ebola virus disease outbreak in West Africa

52. The Deputy Director, Division of Communicable Diseases, Health Security and Environment, said that the EVD epidemic was into its twelfth month, with a total of about 25 000 cases and an overall mortality rate of approximately 70%. There was a sharp drop in incidence once effective action, such as safe burials, treatment and care, had been taken. WHO was assessing preparedness in certain unaffected countries after determining their vulnerability to an outbreak of EVD. No new cases had been reported in Liberia in the past three weeks and the situation had stabilized in Sierra Leone. In Guinea, there continued to be resistance by some communities to the proposed interventions, and behaviour change was an issue of concern;

however, the epidemic was more localized than previously. There were clear command structures for supervision of field work, but difficulties remained owing to lack of funds. Thirty staff members had been deployed to West Africa by the Regional Office for a total of 1000 working days. While staff remaining in Copenhagen had performed their work, no increase in funding had been provided. The risk that EVD would spread to Europe was low, and most countries had robust health systems that were well prepared for such a threat, although two countries still lacked the capacity and there was room for strengthening capacity in at least half of the countries of the Region.

53. Responding to questions from members, she said that two vaccines had been tested in fast-track phase-3 trials and were now being assessed in the field both for safety and efficacy. More investment into research and development was required for the prevention, control and treatment of diseases that affect the poorest populations. She thanked all Member States for their support and for direct deployments of medicines and personnel during the epidemic. The “broader early recovery needs” of the countries that she had mentioned would include health systems strengthening. Gaps in IHR core capacities and health systems of the affected countries would be mapped and the countries would be supported appropriately. Investment in IHR core capacity would be increased in order to ensure preparedness for all emergencies, with appropriate processes for a faster response, standard operating procedures, logistics, information technology and infrastructure.

54. One member commented that medical evacuation of cases had been poorly organized; in that respect, WHO headquarters had become operational rather than simply coordinating activities. Another member commented that her country had put aside funds to support the activities of various international agencies, but no proposals had been received for their use. Better communication and a plan for using funding effectively should be discussed at the World Health Assembly. Coordination among sectors and countries was essential both for fund-raising and for emergency response. One member described the work of the Global Health Security Initiative, which coordinated action packages that included indicators to measure progress and country assessments to determine where projects were needed. Some of the conclusions that had already been reached were that collaboration was needed within governments and between WHO and other organizations. Furthermore, transmission of organisms from animals to humans should be studied carefully.

55. The Regional Director said that the Regional Office was supporting Member States in strengthening preparedness, capacity-building and implementation of the IHR. The rapid response capacity of each Member State would be assessed to determine their preparedness for such an event. The Office was working with the Global Health Security Initiative, UNMEER and many partners in Europe, with a link to the European directive on cross-border health threats. Simulation exercises had been carried out and more would be conducted, in cooperation with the European Commission. If a similar event occurred in Europe, the Regional Office would take the lead, after consultation with WHO headquarters; in the case of such a high-level event occurring in another region, the European Regional Office would offer capacity, as was the case with the Ebola outbreak where many staff had volunteered for deployment. She agreed that internal coordination could still be improved for a coordinated and rapid response.

Update on the upcoming forum in Turkmenistan

56. The Deputy Minister of Health and Medical Industry of Turkmenistan described an international health forum to be held in July 2015 on the 20th anniversary of her country’s national health programme. High-level guests had been invited to participate in five panel discussions: on the country’s achievements towards Health 2020, the role of the WHO FCTC in the prevention of noncommunicable diseases, progress in achieving the Millennium

Development Goals, the benefits for health of Turkmenistan's foreign policy and neutral status and intersectoral action for health in line with Health 2020 and national programmes.

Closure of the session

57. After the usual exchange of courtesies, the third session of the Twenty-second SCRC was closed.

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