



**World Health  
Organization**

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REGIONAL OFFICE FOR **Europe**

# Report of the 68th session of the WHO Regional Committee for Europe

**Rome, Italy, 17–20 September 2018**

### *Keywords*

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

EUR/RC68/REP

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## Abbreviations

AMR	antimicrobial resistance
EACHR	European Advisory Committee on Health Research
ECDC	European Centre for Disease Prevention and Control
EHII	European Health Information Initiative
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
GPW 13	Thirteenth General Programme of Work 2019–2023
IHR	International Health Regulations
ILO	International Labour Organization
IOM	International Organization for Migration
JMF	joint monitoring framework
MDR-TB	multidrug-resistant tuberculosis
NCDs	noncommunicable diseases
OECD	Organisation for Economic Co-operation and Development
SCRC	Standing Committee of the Regional Committee
SDG	Sustainable Development Goal
SEEHN	South-eastern Europe Health Network
TB	tuberculosis
TNCO	tar, nicotine and carbon monoxide
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNECE	United Nations Economic Commission for Europe
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNSDG	United Nations Sustainable Development Group
WHA	World Health Assembly
WHO	World Health Organization

## Opening of the session

The 68th session of the WHO Regional Committee for Europe was held at the Auditorium della Tecnica in Rome, Italy, from 17 to 20 September 2018. Representatives of the 53 countries in the WHO European Region took part. Also present were representatives of the Food and Agriculture Organization of the United Nations (FAO), the International Labour Organization (ILO), the International Organization for Migration (IOM), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Economic Commission for Europe (UNECE), the United Nations Population Fund (UNFPA), the European Union (EU), the Organisation for Economic Co-operation and Development (OECD), and non-State actors (Annex 3).

The first working meeting was opened by Ms Katalin Novák (Hungary), outgoing President of the 67th session of the Regional Committee.

In a festive musical opening, the Giuseppe Verdi di Roma Choir, conducted by Maestro Giovanni Cernicchiaro, sang works by Verdi: “Il brindisi” from *La Traviata*, “La vergine degli angeli” from *La Forza del Destino*, the “Coro dei gitani” from *Il Trovatore* and “Va Pensiero” from *Nabucco*.

The WHO Regional Director for Europe thanked the Government of Italy for hosting the session and welcomed participants. She outlined the many important topics on the agenda and thanked Member States for their active participation and support in preparing the agenda items and for their continued support to WHO and its work in the Region.

The WHO Director-General also thanked the Prime Minister and Government of Italy and recalled the adoption by the World Health Assembly in May 2018 of the Organization's Thirteenth General Programme of Work 2019–2023 (GPW 13), together with its “triple billion” goal of having 1 billion more people benefiting from universal health coverage, 1 billion more people better protected from health emergencies, and 1 billion more people enjoying better health and well-being. He commended the call by the heads of State of Germany, Ghana and Norway for WHO to guide the elaboration of one joint global action plan for the attainment of Sustainable Development Goal (SDG) 3, on healthy lives and well-being for all.

## Election of officers

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

- |  |                            |
|--|----------------------------|
| • Dr Armando Bartolazzi (Italy)          | President                  |
| • Professor Amiran Gamkrelidze (Georgia) | Executive President        |
| • Mr Ioannis Baskozos (Greece)           | Deputy Executive President |
| • Ms. Outi Kuivasniemi (Finland)         | Rapporteur                 |

## **Adoption of the agenda and programme**

*(EUR/RC68/2 Rev.1, EUR/RC68/2 Rev.1 Add.1 Rev.1, EUR/RC68/3 Rev.2)*

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

The Regional Committee agreed to invite the delegation of the EU to attend and participate without vote in the meetings of any subcommittees, drafting groups and other subdivisions taking place during the 68th session addressing matters within the competence of the EU.

## **Address by the Prime Minister of Italy**

The Prime Minister of Italy, speaking on behalf of the Government, extended a welcome to all participants. The 68th session of the Regional Committee came at an opportune time as the country celebrated the 40th anniversary of the birth of its national health system. The Italian model was rooted in the Constitution, article 32 of which read “The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent”. Health care, including diagnosis, treatment and rehabilitation, was accordingly provided to all people, regardless of their economic situation.

He was convinced that universal health coverage was a major priority for the whole world. All citizens must be able to exercise their right to health care. Governments needed to work very hard to ensure that people had equal access to quality care and essential services. His Government’s priority was to preserve the national health system and ensure full coverage, thereby protecting the health status of the country. It was carrying out studies to identify the best measures to take in order to attain that goal. In addition, it had taken up the challenge of ageing by drawing up a national five-year plan for the prevention and control of chronic and noncommunicable diseases (NCDs).

He paid tribute to the dedication and skills of the country’s health professionals and affirmed that merit and transparency were at the centre of government policy, with the aim of reversing the “brain drain” and attracting specialists back to Italy.

To counter inequality, families needed support in gaining access to health care. His Government was accordingly working to bridge gaps in access to health care, while taking up the challenge of ensuring the sustainability of health expenditure. Furthermore, the Government was launching measures (such as the introduction of a “citizens’ income”) to fight poverty and social marginalization. In addition, it was taking steps to enhance emergency preparedness, thereby reinforcing its standing as a reference point for excellence in health care.

He urged participants to translate the decisions they would take at the session into action that would allow citizens to exercise their right to health care, which was a major pillar of the well-being of society.

## **Address by the Minister of Health of Italy**

The Minister of Health of Italy addressed the Regional Committee, noting that the cuts in public health expenditure that her country had been obliged to undertake made it difficult to maintain long-term health interventions or address the inequalities that existed both between



and within regions and cities. It was difficult for young people to get into medical school, even though there was a serious shortage of health-care professionals. The barriers to access to health care included long waiting lists for initial diagnosis and specialist treatment. Her Government was preparing an emergency decree to help patients avoid catastrophic expenditure on health care.

## **Keynote speech by Her Royal Highness The Crown Princess of Denmark**

Her Royal Highness The Crown Princess Mary of Denmark delivered a keynote speech (Annex 4).

## **Address by the WHO Regional Director for Europe**

*(EUR/RC68/5 Rev.1, EUR/RC68/8(K), EUR/RC68/Inf.Doc./5, EUR/RC68/Conf.Doc./1 Rev.1)*

The Regional Director addressed the Regional Committee (Annex 5).

In the discussion that followed, representatives commended the strategic directions and the support provided by the Regional Director and the Regional Office, particularly acknowledging the leadership of the Regional Director in moving towards better health in Europe in an inclusive manner, in full partnership with Member States. They acknowledged the leading role of the Regional Office in promoting advances in health care globally, and welcomed its continued emphasis on the promotion of health throughout the life course and activities to combat tobacco and alcohol use, violence and injuries. Other aspects of the Regional Office's work singled out for particular mention were: support for strengthening of national health systems; support in emergency situations; and the emphasis on health inequalities both between and within societies and support for vulnerable groups. They welcomed the political commitment shown by Member States in the outcome statements of two recent major conferences: the high-level meetings, Health Systems Respond to NCDs: Experience in the European Region (Sitges, Spain, 16–18 April 2018) and Health Systems for Prosperity and Solidarity: Leaving No One Behind (Tallinn, Estonia, 13–14 June 2018). The small countries made a joint statement in which they advocated for the inclusion of a fourth 'I' in the Tallinn Charter for "Information", which should in fact be the "first I". At the 22nd International AIDS Conference (Amsterdam, Netherlands, 23–27 July 2018), participants had reaffirmed their commitment to addressing the HIV/AIDS epidemic in close collaboration with civil society. Representatives looked forward to similar positive results from the high-level meetings of the United Nations General Assembly on the fight to end tuberculosis (TB) and on NCDs, scheduled for 26 and 27 September 2018, respectively, as well as the forthcoming Global Conference on Primary Health Care (Astana, Kazakhstan, 25–26 October 2018). The outcomes of all those events would feed into the high-level meeting of the General Assembly on universal health coverage, scheduled for 2019. One representative offered to share his country's experiences of implementing universal health coverage in a lower-middle-income country.

Representatives expressed concern at the persistence of high premature mortality rates and high levels of health inequalities both between and within countries of the Region. Other topics of concern were the high level of tobacco use, harmful use of alcohol and rapidly increasing childhood obesity, antimicrobial resistance, low vaccination coverage and the

current outbreaks of measles and other vaccine-preventable diseases in the Region. Areas suggested for further work by the Regional Office included support for the creation and dissemination of innovative digital health technologies; support for retraining of health professionals; and the need to address all determinants, including commercial determinants of health. One representative drew attention to the danger of undue influence by the tobacco industry on the measurement of tar and nicotine in tobacco products through the industry's membership of the relevant technical committee of the International Organization for Standardization (ISO). Other participants reminded the Committee of the ongoing challenges faced by countries dealing with large influxes of migrants.

Representatives welcomed the publication of the *European health report 2018* and the preparation of the strategy on men's health, as well as the Regional Office's work to promote partnerships, the collection and dissemination of health data and the practical implementation of research findings. One representative called on the Regional Office to continue to facilitate the selection of indicators to measure social and behavioural determinants of health and to promote health literacy. The Regional Office's support for country efforts to strengthen health systems was particularly appreciated, since it also contributed to Member States' achievement of universal health coverage and their SDG targets. Representatives warmly acknowledged the valuable contribution of WHO country offices and the geographically dispersed offices (GDOs). One representative, speaking on behalf of the EU and its Member States, noted the positive impact of the Action Plan on the Increased Use of Evidence, Health Information and Research, and the fact that the European Health Information Initiative (EHII) and the health information networks of the European Region are regarded as best practice for the generation and use of interdisciplinary and cross-departmental sources of evidence, not least at the global level. The joint monitoring framework promised to be an effective instrument for minimizing the international reporting obligations of Member States in the Region, which would be important in the timely achievement of the Sustainable Development Goals (SDGs). The efforts by the Regional Office to develop a strategy on big data in order to support evidence-informed health policy decision-making was important too, and should take into account the work initiated by the OECD in that area.

The visits conducted so far had increased Member States' awareness of the Regional Office's work at country level, in line with the emphasis on country focus in GPW 13. More country visits should be arranged for European members of the WHO Executive Board and members of the Standing Committee of the Regional Committee (SCRC). Representatives commended the positive working atmosphere of the Regional Office and the interdivisional work, supported by the framework provided by various initiatives under the transformation agenda including the Respectful Workplace initiative. The proposed joint monitoring framework was welcomed as a way of relieving some of the reporting burden on Member States.

The representative speaking on behalf of the EU and its Member States welcomed and expressed support for the measures taken to accelerate the implementation of the International Health Regulations (IHR) (2005) in the European Region.

Several queries were raised concerning the level of detail in the programme budget for 2020–2021 and the budget envelope proposed for the Regional Office for Europe, which did not have the same level of increase as that proposed for other regions. Member States also queried the proposed increase being applied only to the country component of the budget and requested that this be reviewed, noting that different regions would need to implement different business models. The proposed 12% increase to the global budget was felt to be

unrealistic. Representatives regretted the delay in the publication of the proposed programme budget 2020–2021, and called for a timetable and more detail, including budget figures, for the next programme budget to be provided in good time, along with the relevant documentation to facilitate discussions at the Regional Committees.

Representatives speaking on behalf of the EU and its Member States, the Small Countries Health Information Network and the South-eastern Europe Health Network (SEEHN) reported on their organizations' collaboration with the Regional Office. A representative of UNAIDS said that the WHO Regional Office for Europe was at the forefront of the global response to the epidemic. Nevertheless, despite many years of good progress, many Member States worldwide were losing ground in their efforts to achieve global targets for antiretroviral treatment. The long-term aim was to put all HIV-positive persons on treatment as soon as they were diagnosed, expand the use of post-exposure prophylaxis and eliminate discrimination in health-care settings against persons with HIV. A representative of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) said that HIV and harm-reduction services had been scaled up, especially in the east of the Region, but that rates of new infection and coinfection were rising alarmingly. A representative of the International Federation of Red Cross and Red Crescent Societies described the organization's work at community level to respond to natural and human-made disasters and their aftermath, including the recent influxes of migrants into Europe.

The Regional Director, responding to the points raised, commended the political commitment to health shown by Member States and their efforts to translate that commitment into action. The work of the Regional Office since the previous session of the Regional Committee had focused on health systems, particularly the health system response to NCDs – a new approach that would make a valuable contribution to the discussion at the General Assembly the following week and the Global Conference on Primary Health Care in Kazakhstan in October, where Member States would celebrate the 40th anniversary of the Declaration of Alma-Ata. She welcomed the positive response to the country visits by Executive Board representatives and SCRC members; a further visit, to Kyrgyzstan, would take place shortly.

The proposed programme budget had been finalized at a very late stage, following the adoption of GPW 13 by the World Health Assembly in May. The new approach required both bottom-up planning, taking into account the needs expressed by Member States, and top-down planning to include global and regional public goods to address the priorities set by the Health Assembly. The large increase in the budget allocated to other WHO regions compared with the European Region was largely due to the transition of polio functions, and the associated resources, to the base segment of the programme budget, particularly in the African and South-East Asia regions. The remaining increase for all WHO regions including the European Region, and particularly for country level, is due to application of strategic budget space allocation principles. The Regional Office would continue to focus on the priorities identified by representatives, including HIV infection and AIDS, TB, vector-borne diseases, NCDs, mental health and health information systems.

The Committee adopted resolution EUR/RC68/R1.

## **Address by the WHO Director-General**

The Director-General addressed the Regional Committee (Annex 6).

In the ensuing discussion, members of the Regional Committee expressed support for the bold and ambitious agenda set forth in GPW 13 and welcomed the Director-General's firm mission to transform WHO into a stronger and more effective organization that could lead the way towards the achievement of the SDGs.

One representative, speaking on behalf of the EU and its Member States, noted the new focus on data and metrics in GPW 13 and reiterated the experience of the European Region in evidence-led policy making as facilitated by the EHII mechanisms; there was an expectation that the joint monitoring framework would play a vital role in simplifying reporting and would serve as an example of good practice in efforts to achieve the 2030 Agenda for Sustainable Development at global level. The 40th anniversary of the Alma-Ata Declaration would be a decisive moment in designing the future of primary health care and health for all, but that goal would not be reached unless there was political commitment to universal health coverage.

Expressing appreciation for the Director-General's strong emphasis on health as a human right, one member acknowledged his strong support for sexual and reproductive health and rights as an essential part of universal health coverage. The importance of addressing gender as a determinant of health, among others, was highlighted. Participants extended their gratitude to WHO for its support, identifying the prevention and management of NCDs, primary health care development, the creation of attractive working conditions and safe work places for the upscaling and retention of the health workforce, and access to quality health care as critical issues. It was noted that addressing inequalities in the prevention and management of NCDs must be a priority. Political commitment to universal health coverage was deemed strong across Member States and seen as a key tool to address the challenges.

There was strong support for safeguarding WHO's normative functions. Members referred to the Organization's comprehensive mandate and widespread global legitimacy, and highlighted the need for adequate resources to be allocated for the performance of core functions. There was agreement that WHO's role as a global coordinating and convening agency, its capacity to respond to health emergencies, and its role as an evidence-based advocate for public health needed to be strengthened further. Some members cautioned against transforming WHO into an implementing agency.

The proposed alignment of WHO's work with country needs was deemed useful, but some concern was expressed that a shift of resources could undermine WHO's normative work. Several representatives called for a thorough and transparent discussion about the role and functions of country offices, as a means to identify ways to enhance the effectiveness of WHO's work at country level. Additional resource allocation might not be the only way: the potential of priority setting, change of working methods and capacity-building at the regional level should be explored. Clarification was sought about the precise functions of country offices and other characteristics that typically applied to them. A request was made for the Director-General to present that information to the Executive Board at its 144th session. Without it, the governing bodies would be unable to assess country offices' resource needs. It was noted that the process of strengthening WHO's country presence should be taken forward under the oversight of the governing bodies and aligned with wider United Nations reform. The country visits conducted by members of the SCRC subgroup on countries at the centre were deemed useful.

Some criticism was voiced concerning the insufficient detail provided in the high-level programme budget for the biennium 2020–2021 about the projections and calculations made.

While there was certainly value in directing the attention of Member States mainly to strategically relevant information, without information on budget envelopes and shifts in emphasis between programmes, an informed discussion on priorities would be difficult. One member requested additional information about the foundation of the projections with regard to polio funds, in particular the apparent assumption that all current polio funds would remain available and become flexible, and of the presumed growth in the base budget.

Drawing attention to the time already elapsed since the adoption of the 2030 Agenda for Sustainable Development, participants called for accelerated action to implement the health-related goals set forth in the document. The fragmentation of the global health architecture was seen as a crucial challenge and the important coordinating role of WHO in the implementation of SDG 3 was highlighted. The representative speaking on behalf of the EU and its Member States expressed support for the efforts to increase WHO's role in the global health architecture and said that there was an expectation that, with reference to the transformation agenda, the Secretariat would fully involve WHO's governing bodies to ensure their oversight and guidance in that process. One representative, referring to a letter addressed to the Director-General in which the heads of State of Germany, Ghana and Norway had called for the development of a global action plan for healthy lives and well-being for all under WHO guidance, noted with appreciation that the Director-General expected to present the plan at the forthcoming World Health Summit, on 14–16 October 2018 in Berlin, Germany.

The Regional Director for Eastern Europe and Central Asia, UNFPA, commended the efforts of the WHO European Region to promote a more equitable approach to health and the Regional Office's commitment to broad-based partnerships. Her agency's collaboration with the Regional Office to support Member States in the promotion of sexual and reproductive health and rights was bearing fruit: many Member States had implemented sexual and reproductive health action plans and were progressing steadily towards universal coverage. Sexual and reproductive health was an essential component of overall health and access to relevant services at the primary care level was crucial. The 25th anniversary of the International Conference on Population and Development, to be held on 1 and 2 October 2018 in Geneva, Switzerland, would provide an opportunity to reflect on global progress made in ensuring rights and choices for all.

The Director-General thanked the Regional Committee for its constructive comments. It was important to keep abreast of WHO's work on the ground, and the country visits conducted in the European Region had yielded visible benefits. Inspired by that experience, WHO headquarters had followed suit and started to organize visits by Executive Board members to countries in other regions. It was useful to identify best practices at the different levels of the Organization and learn from each other.

Responding to the comments concerning the proposed programme budget, he recalled the fast-track adoption of GPW 13 and the ensuing implications for the content of the document. In addition, departure from previous practice meant that programmatic areas were no longer reflected separately, but instead had been integrated on the basis of WHO's strategic priorities – universal health coverage, health emergencies and healthier populations. Doing so would enable breaking out of silos, promoting cross-departmental collaboration and moving away from a fragmented approach towards a seamless, united WHO that focused on outcomes and impact.

In order to allay concerns expressed by some members that increased resource allocation for country offices might undermine WHO's normative functions, he assured the Regional Committee that the Organization's normative work remained core and would be further

strengthened. In line with GPW 13, WHO must be relevant to all Member States. There was no perfect health system and WHO's normative role was crucial to improving health infrastructures in all countries, regardless of their level of development. With regard to concerns about transforming WHO into an implementing agency, he said that its operational functions accounted for less than 15% of overall activities. In addition, those operations were largely restricted to emergency settings and fragile countries whose health systems had collapsed.

Health must be seen through a human rights lens. At the same time, keeping people healthy had added value as it contributed to prosperity and development and would thus form the basis for attaining all of the SDGs. The leadership shown by those countries in the European Region that had long made a political choice for universal health coverage was inspiring. The Region should be an advocate for universal health coverage elsewhere.

## **Matters arising from resolutions and decisions of the World Health Assembly and the Executive Board**

*(EUR/RC68/6)*

The European member of the Executive Board designated to attend sessions of the Standing Committee as an observer reported that the Seventy-first World Health Assembly had adopted 16 resolutions and 16 decisions in technical areas of importance to the European Region. He gave details of the following resolutions and decision, which were not otherwise scheduled to be discussed by the Regional Committee during the session.

In category 1 (Communicable diseases), the Health Assembly had adopted resolution WHA71.3 on the high-level meeting of the United Nations General Assembly on ending tuberculosis, which was due to take place the following week. It had further adopted resolution WHA71.16 on containment of polioviruses.

In category 2 (Noncommunicable diseases), resolution WHA71.6 dealt with the WHO global action plan on physical activity, inspired by the Physical activity strategy for the WHO European Region 2016–2025. Resolution WHA71.14 on rheumatic fever and rheumatic heart disease did not correspond to any specific action plan in the European Region, but the two diseases were covered by many resolutions and action plans adopted in recent years. The issues raised in resolution WHA71.9 on infant and young child feeding were covered by the European food and nutrition action plan 2015–2020. The World Health Assembly had also adopted resolution WHA71.2 on preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018.

In category 4 (Health systems), the Health Assembly had adopted resolution WHA71.8 on improving access to assistive technology. The Regional Office was documenting existing intercountry collaboration to increase access to medicines and health technologies: it could expand that work to cover assistive technologies by adding expertise as required.

In category 5 (Preparedness, surveillance and response), decision WHA71(11) on the Pandemic Influenza Preparedness Framework would allow the Regional Office to continue its work in the five recipient countries in the European Region, thereby increasing country ownership and sustainability and strengthening the regional influence and network.

## **Draft WHO global strategy on health, environment and climate change**

*(EUR/RC68/Inf.Doc./7)*

One representative, speaking on behalf of the EU and its Member States, noted that there were potential health cobenefits to be gained from climate change mitigation and adaptation activities, using a cross-cutting and preventive approach and promoting action aimed at healthier societies. The Regional Office had reviewed the evidence related to environmentally sustainable health systems and had elaborated a strategic document intended to create a health sector that was better than climate-neutral. Failure to act would be more expensive than taking appropriate action against pollution and climate change. The EU looked forward to working with WHO on the draft comprehensive global strategy on health, environment and climate change and on the preparations for the First Global Conference on Air Pollution and Health (Geneva, 30 October –1 November 2018).

Another representative asked how the role of the European Environment and Health Task Force might change if governance of climate change activities was transferred to the regional level.

The Director, Policy and Governance for Health and Well-being, responding to the points raised, said that the European Environment and Health Process, of which the Task Force was the governing body, was a strong policy platform that could provide a good model for the future global strategy. She drew attention to the European Health Information Gateway,<sup>1</sup> which gave access to a large volume of documentation, tools and other information in English and Russian on climate change adaptation, resilience and mitigation and many other topics.

## **Development of the road map on access to medicines and vaccines**

*(EUR/RC68/Inf.Doc./8)*

One representative, speaking on behalf of the EU and its Member States, said that all the activities in the proposed global road map were aligned with WHO's mandate and Member States should not seek to micromanage them. However, a calendar showing key deliverables and milestones should be drawn up for the following five years, so that the discussion at the Health Assembly each year could focus on a specific topic. The road map should be focused on the same key deliverables and milestones.

Another representative welcomed the broad approach taken in the preparation of the road map, in view of the concerns about research and development and intellectual property expressed by some Member States. Demand-side factors, such as patient behaviour and health literacy, and diagnostics, should also be included.

Statements were made by representatives of the International Federation of Pharmaceutical Manufacturers' Associations and Knowledge Ecology International. A written statement was submitted by Thalassaemia International Federation.

The Director, Health Systems and Public Health, responding to the points raised, said that 61 Member States from all regions had submitted comments on the draft road map, particularly related to emergency preparedness, fair pricing policies and intellectual property. The European Region could boast a number of valuable initiatives in the area of medicines pricing, including the Valletta Group and the BeNeLuxA collaboration.

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<sup>1</sup> See <https://gateway.euro.who.int/en/>.

## **Development of a draft global action plan on the health of refugees and migrants**

*(EUR/RC68/Inf.Doc./9)*

One representative, speaking on behalf of the EU and its Member States, said that tackling the causes and consequences of the recent large-scale movements of people into Europe was the shared responsibility of all stakeholders. The EU welcomed the Framework of priorities and guiding principles to promote the health of refugees and migrants, drawn up by WHO in 2017, and supported the inclusive consultation process for the draft global action plan on the health of refugees and migrants, due to be submitted to the World Health Assembly in 2019.

The Framework was referenced both in national responses to the challenges associated with mass migration flows and in the widely differing opinions about the proposed global compact on refugees and global compact for safe, orderly and regular migration. WHO should continue its close collaboration with IOM, as well as its work with the EU to establish guidance for good practices in respect of specific groups of migrants, such as children or elderly people. Robust evidence, good surveillance systems and more disaggregated data were required in order to develop informed policies and enhance high-quality health service delivery by competent health professionals. In addition, accurate communication and public information would help to eliminate discrimination, stigmatization and barriers to health care. Migrants should be included in decisions about services intended for them, in the interests of integration.

Another representative noted that migration was an issue that extended far beyond Europe. Intersectoral and international collaboration and exchanges of good practice would be required to meet the health needs of migrants throughout the world.

The Assistant Director-General for Strategic Initiatives, WHO headquarters, said that the European experience of finding the best humanitarian, legal and technical solutions, accumulating knowledge and achieving consensus and dialogue had made a valuable contribution to the preparation of the global compact for migration. The new United Nations Migration Network, which had replaced the Global Migration Group, would hold a framing conference in Geneva in October 2018 to determine its terms of reference, with IOM acting as its secretariat. The global compact for migration would be formally adopted in Morocco in December 2018. All those developments would contribute to the final draft of the global action plan, which would be submitted to the Executive Board in January 2019 and the World Health Assembly in May 2019. The global action plan sought to establish uniform standards for information systems, a minimum quality and range of services in all countries and equitable access to medicines, vaccines and treatments. It also sought to protect the basic human rights of the migrant community, including those people, especially in transit countries, who had fallen through the gaps in the existing systems, and to support Member States in the development and costing of their own national action plans and in the establishment of strong communication strategies based on facts.

## **Report of the Twenty-fifth Standing Committee of the Regional Committee for Europe**

*(EUR/RC68/4 Rev.4, EUR/RC68/4 Rev.4 Add.1, EUR/RC68/Conf.Doc./2 Rev.4)*

The Chairperson of the Twenty-fifth SCRC reported that since the 67th session of the Regional Committee, the Standing Committee's work had been conducted in five sessions and one



teleconference. At its first session, the SCRC had elected officers and initiated the preparations for RC68, taking account of lessons learned from RC67. While the comprehensive consultations to prepare the documentation for RC67 had been welcome, the Standing Committee had recommended that a more staggered approach should be taken in future to avoid overburdening Member States.

Subgroups had been set up on governance, vector control and countries at the centre. The subgroup on governance had assisted in the preparation of documents on WHO reform for submission to the Regional Committee. The subgroup on vector control had contributed to the report on implementation of the Regional Framework for Surveillance and Control of Invasive Mosquito Vectors and Re-emerging Vector-borne Diseases 2014–2020: lessons learned and the way forward, and had discussed the need to strengthen prevention and control capacity in all Member States in the WHO European Region. It had suggested that the scope of the Regional Framework should be open to expansion, as and when necessary, to address the threat of other vector-borne diseases in the Region. The subgroup on countries at the centre had conducted visits to WHO country offices to familiarize members of the SCRC and Executive Board with WHO's work at country level and increase their understanding of the strategic role of the country offices.

The Standing Committee had reviewed all working documents and draft resolutions and decisions for submission to RC68. It had welcomed the outcome of the high-level meetings held over the course of the year. It had been informed about ongoing work in respect of the joint monitoring framework for reporting on Health 2020, the SDGs and the Global Action Plan for the Prevention and Control of NCDs, on which it had advocated for robust online consultations. The Secretariat had briefed the SCRC on the most recent edition of the *European health report*, and the Standing Committee had supported the proposal to establish a high-level task force for big data. Members of the SCRC had also expressed support for the vision for advancing public health in the WHO European Region in line with Health 2020, the SDGs and GPW 13. On implementation of the European Vaccine Action Plan, the Standing Committee had welcomed the progress made, while expressing concerns regarding stagnating immunization coverage and measles outbreaks.

The Standing Committee had considered the credentials of non-State actors applying to attend the 68th session of the Regional Committee, in line with the provisions of the Framework of Engagement with Non-State Actors. It had also reviewed reports on budgetary and financial issues during its three substantive meetings. Regarding the implementation of the Programme budget 2018–2019, funding remained below projections and the Regional Office was working to mobilize more resources. Lastly, it had considered nominations to positions on WHO bodies and committees, and had established a proposed shortlist of candidates, which had been distributed among heads of delegations to RC68, in preparation for the forthcoming elections.

The Regional Committee adopted resolution EUR/RC68/R2.

## **Launch of the European health report 2018**

The Director, Information, Evidence, Research and Innovation said that the purpose of the *European health report 2018* was to assess the status of health and well-being in the WHO European Region and to measure progress made in the implementation of Health 2020, the European policy for health and well-being. The report also expanded on new directions and new forms of evidence, which could be mainstreamed to facilitate a more accurate description of the

health and well-being of the European people using qualitative approaches, including narratives. Referring to the fragmentation of health information and health systems, the report called for a standardized, harmonized and integrated health information system for the Region.

The key messages were clear: health and well-being in the European Region was steadily improving and the implementation of Health 2020 had catalysed much of that progress. Life expectancy was increasing for men and women in all countries and regional gaps in life expectancy were shrinking. However, the gender mortality gap remained much higher than 50 years previously and male life expectancy was lower than decades earlier. Childhood overweight and obesity levels were high and increasing: in some countries 40% of boys were overweight or obese. Tobacco use in young children was also higher than in the past and alcohol consumption in the Region remained the highest in the world. While health expenditure as a proportion of gross domestic product remained stable, there were vast differences between countries. At the same time, the fact that a growing number of countries were aligning their national policies with Health 2020 or adopting new strategies in line with the framework was reason for pride.

Health and well-being could not be assessed in numbers alone. New concepts enshrined in Health 2020 such as community resilience, the life-course approach and community empowerment needed to be incorporated. Measuring and describing them would enable a more holistic view of people's health and well-being and bring new insight. Quantitative and qualitative information needed to be mainstreamed and made available to all stakeholders. In order to ensure that Member States were not burdened with new reporting obligations, assessments would be conducted using routine data. The outstanding task of establishing an integrated health information system for the Region must be tackled. It would enable the pooling of data in one system which would, in turn, report to a single regional mechanism. EHII was a suitable platform to move such a project forward and she encouraged all Member States to join.

In response to a statement made by the representative of the International Association for Hospice and Palliative Care, the Director, Information, Evidence, Research and Innovation said that age-disaggregated data and the notion of palliative care were highly relevant. However, given the *European health report's* limited scope on the one hand, and the wealth of pertinent information on the other, choices had to be made. The European Health Information Gateway was broader in scope and thus a useful resource.

## **Implementation of the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy framework for health and well-being, and review of the joint monitoring framework**

(*EUR/RC68/8(M)*, *EUR/RC68/10 Rev.1*, *EUR/RC68/Conf.Doc./6 Rev.1*)

The Prime Minister of Albania said that despite the limited resources at its disposal, his country, like many others in the Region, had made considerable progress in health. However, progress remained uneven. More needed to be done to ensure that the benefits of progress were shared by all. Albania had integrated the 2030 Agenda for Sustainable Development with EU integration, as both processes were mutually reinforcing. A multi-stakeholder, high-level interministerial committee on SDGs had been appointed to oversee SDG implementation. It comprised representatives from key government institutions, business, civil society, academia and

international organizations. Parliament had unanimously adopted a resolution committing to SDG promotion, implementation and monitoring.

He said that achieving universal health coverage was one of the top priorities. For example, 600 000 uninsured citizens had recently been granted access to health care, and free annual health checks for people aged 35–70 years and family doctor visits had been introduced. Other positive developments included: establishment of smoke-free public places; abolition of the 10% value added tax on medication; and new policies on medicines, public health, palliative care and food security. Out-of-pocket payments for health care needed to be further reduced to 35%. Some 80 new clinics were being built to increase access to health care and more were planned. Still, underfunding, capacity gaps and uneven access to health services continued to pose challenges that could not be remedied with money alone. Human dignity should be not a privilege, but a key concern for all governments.

A short video was shown, as part of the “Voices of the Region” series, in which the Prime Minister of Iceland relayed the way in which she integrated the SDGs into her personal life and policy-making. Describing how her own experiences had influenced her values and priorities as a politician, she said that SDGs must be made a whole-of-society, whole-of-government issue. In Iceland, the Government was taking the lead, setting examples and creating a link between policy-making at the highest level and the relevance of SDGs to people’s daily lives.

The Director, Policy and Governance for Health and Well-being said that progress towards achieving the health-related targets of the 2030 Agenda remained uneven and, if business continued as usual, some of them would not be met. Alcohol and tobacco consumption, obesity and violence against women and children, among others, continued to obstruct progress. The European roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy framework for health and well-being (the roadmap) was aligned with GPW 13 and provided a unique opportunity to accelerate progress. It calls for strengthening universal health coverage, primary health care, public health, tackling the social, economic, environmental, cultural and commercial determinants of health, acting in partnership, and engaging in local implementation.

An analysis of 20 voluntary national reviews from the Region submitted to the United Nations High-level Political Forum on Sustainable Development had revealed that governance for SDGs, indicator setting and multi-partner cooperation had improved. Health was increasingly recognized at the highest level of government. While universal health coverage and equity were mentioned frequently, references to healthy settings, determinants of health, health literacy, financing and investment were less common. More needed to be done to bring the health dimension of sustainable development, the health cobenefits of action taken in other sectors, and the environmental benefits of health sector action into the limelight. The roadmap offered an opportunity for collective action. The Regional Office had developed a technical SDG resource package and assisted Member States in revising their national health policies to include SDGs. WHO also engaged in policy dialogue at country level and provided technical support. The Issue-based Coalition on Health coordinated a range of activities, including a United Nations common position on ending HIV, TB and viral hepatitis through intersectoral collaboration (2018).

In addition, the integration of the SDG roadmap strategic directions into the Copenhagen Consensus of Mayors, the SEEHN cooperation strategy, and the Small Countries Initiative, was highlighted.

In 2019, Member States would be requested to report on their implementation of the roadmap. The Regional Office intended to streamline reporting around progress made towards achieving health-related targets, national implementation and regional developments. Given the growing number of initiatives, Member States would require more support to develop roadmaps for SDG implementation, identify financing mechanisms and train their workforce on SDGs. The Regional Office would work with partners to share knowledge, mainstream health in all SDGs and identify accelerators for progress.

The Director, Information, Evidence, Research and Innovation said that there was a high level of alignment of indicators and overlap across the reporting frameworks on Health 2020, NCDs and the SDGs. In order to reduce the reporting burden and avoid duplication, the Regional Office, with support from a multi-country expert group, had set out to develop a joint monitoring framework based on a set of 41 indicators identified by the group, which covered all relevant areas of public health. When asked to provide feedback on the proposed framework earlier in 2018, Member States had expressed broad support. The Regional Office would collect information using a standard template and report on the results through the WHO European Health Information Gateway. Member States were free to report fully to all three frameworks; in order to avoid duplication, indicators on which they had already reported through the joint monitoring framework would be removed from the reporting forms of the other frameworks. The joint monitoring framework was the result of much debate, expert input and extensive consultations with all stakeholders; if adopted, it would be the first of its kind within WHO.

The ensuing panel discussion was moderated by the President of the European Public Health Association. The Deputy Prime Minister and Minister of Health, Malta, the Parliamentary State Secretary to the Federal Minister for Health, Germany, the Minister of Health, Armenia, the Minister of State for Health Care, Hungary, the Minister of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, Georgia, the State Secretary, Ministry of Health, Romania, and the Minister of Health, Belarus, participated as panellists.

The Deputy Prime Minister and Minister of Health, Malta said that achievement of the SDGs required political commitment, implementation and monitoring. Although development work certainly predated the adoption of the 2030 Agenda, the SDGs provided a structure and measurable targets. In that context, the joint monitoring framework was an excellent tool to ensure that States did not spend more time on monitoring and reporting than on implementation. Political commitment was a vital ingredient for progress. In order to bring on board ministers from all sectors, they needed to be convinced that health-related actions yielded positive results for their own sector. It might thus be useful to prepare a presentation explaining the cross-cutting benefits of health-related action to sectors other than health.

The Parliamentary State Secretary to the Federal Minister for Health, Germany said that the implementation of the European roadmap was a step in the right direction. Given the time that had already elapsed since the adoption of the 2030 Agenda, accelerated action was needed. SDG 3 was linked to most other SDGs and coordination was crucial to avoid duplication or gaps. The heads of State of Germany, Ghana and Norway had therefore requested the WHO Director-General to develop an action plan on the implementation of SDG 3, in cooperation with other relevant actors and agencies. The first draft of the plan would be presented at the 10th World Health Summit, to be held in Berlin, Germany, on 14–16 October 2018. Seeking such broad international cooperation to develop a global action plan was certainly a challenge,

but it was also an opportunity for WHO to position itself as the lead agency in the implementation of SDG 3. Her Government would support that ambitious task, both at the national level and through international cooperation.

The Minister of Health, Armenia, said that his Government had commenced nationalization of the SDGs, including through the launch of the Armenia Development Strategy 2030, in 2017. He provided an overview of his country's efforts, achievements and challenges with regard to SDG implementation and explained that particular attention was given to disease prevention, primary health care, quality services, specialized inpatient medical care for vulnerable groups, maternal and child health, sexual and reproductive health and adolescent health. Another priority was capacity building and professional development for health-care workers and the introduction of health insurance to enhance the financial stability of the health system. Progress in all those areas could not be achieved by the health sector alone. Cross-sectoral cooperation was needed to facilitate the allocation of resources and ensure their efficient use at the service delivery level. Government taxation and revenue collection, sound planning and financial management, anti-corruption measures and universal social protection were important ingredients, as was WHO support.

The Minister of State for Health Care, Hungary, said that Hungary had its own SDG strategy and had submitted a national voluntary review on implementation to the United Nations High-level Political Forum on Sustainable Development. SDG-related policy priorities included family empowerment, economic growth, employment innovation and access to clean water and sanitation. The structure of the Ministry of Human Capacity allowed for useful cross-sectoral collaboration. Prevention, primary health care services and action on lifestyle-related factors were crucial to improving population health. Special emphasis was placed on equity and a policy dialogue had been held, with WHO support, on the equity aspects of public policies on employment, housing and access to health services. A high-level intersectoral task force on health equity had been set up to ensure coherence across initiatives such as income tax cuts, access to health services for vulnerable groups, in-class physical activity and people-centred care, among others. WHO's support for those efforts had been highly valuable.

The Minister of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia said that the main asset of the SDGs was the setting of clear indicators and the pooling of a wide range of factors into one measurable goal. In Georgia, universal access to health care had been used as a vehicle to drive progress in all areas of health. The transition to universal health coverage had been a tremendous challenge and had only been possible with WHO support. Improving primary health care had also been made a priority. The availability of medicines for chronic diseases at the primary care level was one of the biggest challenges in that regard. Given the complexity of health-related issues, the SDGs served as useful guidance and a tool to assess progress. International cooperation was crucial to tackle the challenges.

The State Secretary, Ministry of Health, Romania, said that good governance, respect for the rule of law and human rights were important prerequisites for achieving health-related goals. The country was investing heavily in building or refurbishing community-based integrated medical centres, outpatient clinics and regional hospitals in different parts of the country, using both domestic and European Commission funds. Health services were being restructured, capacity-building activities were conducted, and guidelines and protocols had been developed to ensure quality and coherence in medical practice. Medical and social services had been integrated to ensure access to free health care for vulnerable groups.

Outstanding challenges included vaccination coverage, access to mental health services, health financing and retention of the health workforce. In order to progress towards attainment of the SDGs, intersectoral cooperation, better monitoring and evaluation of health interventions and evidence-based policy planning were crucial.

The Minister of Health, Belarus, said that granting access to health care to all citizens had been one of his country's main achievements. Current efforts focused on improving health financing and primary care, including through private-public partnerships and investment in health technology. The Government had appointed a national coordinator on SDG implementation, established a council for sustainable development, and agreed on a set of national indicators for monitoring progress. A roadmap had been developed that defined platforms for SDG implementation: transition to inclusive growth and universal access to health care; future generations; gender equality; and innovation. The joint monitoring framework would be an excellent tool to help Member States prepare their reports.

In the ensuing discussion, the members of the Regional Committee expressed unanimous support for the roadmap, the joint monitoring framework and the draft decision under consideration. They extended their appreciation to the Regional Office, the expert group and other contributors for their efforts to reduce the reporting burden on Member States. Commitment to implementing the 2030 Agenda was strong and cooperation was seen as an important tool. Universal health coverage, primary health care and health care financing, among others, were mentioned as crucial building blocks. Member States commended the Regional Director for the establishment of EHII, and the Visegrad countries called in a joint statement on all Member States to join EHII. They also called for the WHO Regional Office for Europe to begin a second phase of Health 2020 indicator development.

Reference was made to the need for Member States to come together and analyse complex issues in new ways in order to identify the best way forward. Participants drew attention to the importance of breaking down silos, encouraging experts at all levels to cooperate towards common goals and taking a whole-of-government approach to SDG implementation. Vertical coherence across different levels of government was seen as critical. Drawing attention to the 2030 Agenda's focus on people, one participant noted the importance of bringing the SDGs from the global political sphere into people's daily lives. Small countries had a comparative advantage in that respect, as smaller populations were more easily engaged with the political life of their country. Representatives pointed out that country-specific circumstances should be better reflected. Several speakers reported on action taken at the national level to monitor progress in SDG implementation to date. One country had conducted an analysis, matching national statistics to SDG goals with a view to developing national indicators to complement global tools. Others had produced reports on the way in which the implementation of the 2030 Agenda was enhancing the health and well-being of their populations, in order to assess progress towards SDG attainment.

Effective monitoring was seen as a key element to evaluate best buys and relevant policies. Comparing a country's performance with others, or with its own earlier performance, could be an important driver for improvement. The joint monitoring framework was considered to be important for Region-wide comparable reporting and should be replicated at global level. It provided a clear structure for measuring progress and would facilitate the prioritization of data collection and monitoring, help harmonize reporting, and prevent duplication. One participant noted the benefits of obtaining data from a wide variety of academic disciplines. Another pointed out the importance of a holistic approach to reporting. It was suggested that the joint

monitoring framework might serve as an inspiration for measuring outcomes under GPW 13. There was agreement on the value of cooperation on health information. Integrated health information systems such as EHII were considered to be crucial for harmonizing health information, increasing the availability and usability of data, and facilitating evidence-based policy-making. To be effective, information systems must be equity sensitive and bring together the most relevant data systems, technologies, tools and stakeholders at the subnational, national and regional levels. The Initiative was an exemplary mechanism to be emulated at the global level.

Attention was drawn to the difficulty of general reporting on indicators in situations where progress was uneven. Measuring equity and progress among hard-to-reach population groups was also challenging. Analysing, understanding and explaining the results was considered crucial for identifying gaps and designing effective policies. Several representatives referred to the need to take indicator development to the next stage. An in-depth analysis of existing indicators would be useful to identify possible gaps in coherence. Existing indicators might benefit from further development, taking account of developments and progress made with regard to accessibility and collection of data, in order to facilitate further unification of approaches to universal health coverage. It was suggested that the expert group might reconvene to assess the data collected and define the set of indicators further, in cooperation with Member States. Several references were made to the need to assess health literacy, and to understand and measure cultural determinants of health. One representative proposed that, given the considerable differences between the countries in the Region, indicators related to life satisfaction and household income, for example, should be reported for individual countries, rather than for the Region as a whole. Another representative called for improvements to the reporting procedure to facilitate internal coordination, documentation and consultation on responses to data collections and surveys.

A statement was made by the representative of the International Federation of Medical Students' Associations (speaking also on behalf of the European Medical Students' Association, the European Forum for Primary Care, the Centre for Regional Policy Research and Cooperation "Studiorum" and the International Society of Physical and Rehabilitation Medicine).

The Director, Information, Evidence, Research and Innovation thanked the members of the Regional Committee for their strong support for the work conducted on health information over the past years. It was gratifying to note that the tools developed were producing the desired outcomes for Member States. The time had come to move to the next stage of indicator development. EHII provided a useful platform in that regard, and members' stimulating comments, including the reference to health literacy as a core element, would be taken into account.

The Regional Director said that the 2030 Agenda and the commitment to the SDGs had created a unique momentum for public health. The implementation of the roadmap with its strategic directions and enablers would further accelerate development. The discussion showed that there were multiple pathways to implementing the SDGs, depending on national circumstances and priorities, and she thanked Member States for their commitment. There was currently an unprecedented opportunity to advance universal health coverage and strengthen health governance by implementing the SDGs across sectors and addressing all determinants of health.

The Committee adopted decision EUR/RC68(1).

## **Advancing public health in the WHO European Region for sustainable development**

*(EUR/RC68/17, EUR/RC68/17 Add.1, EUR/RC68/Conf.Doc./10 Rev.1)*

Introducing the item, the Regional Director said that in recent decades the European Region had been a champion of public health, but it was a dynamic concept that needed to be continuously adapted to the changing knowledge and policy environment and the emerging challenges faced by Member States. With the adoption of the 2030 Agenda for Sustainable Development and GPW 13, it was timely to bring all the components of public health together under one unifying vision. Public health was more than health care: it was a societal function, involving everyone, everywhere, across all sectors and levels of government; it was a coordination mechanism for intersectoral action; and it was an expert function. Above all, health was a political choice.

The multiple challenges across the life course (such as measles, migration and ageing populations) threatened sustainable development and were interlinked. Fulfilling the shared vision of health and well-being for all required recognizing the benefits of working across sectoral boundaries. In order to move forward, investments in public health must be significantly increased, and the misperception of health as a cost must be corrected; in fact, health was wealth. There was plenty of evidence that investment in public health and primary prevention delivered great value for money. The cost of inaction was significant: the direct and indirect costs of a high disease burden in countries could consume up to 15–20% of gross domestic product.

The 10-point action plan proposed for endorsement by the Regional Committee called for strong political leadership and accountability for health, supported by solid and transparent governance mechanisms across all levels of government. It advocated the institutionalization of multisectoral cooperation and effective engagement with all relevant sectors, civil society, local actors and stakeholders. Existing institutional frameworks should be critically reviewed, and more resources should be allocated to strengthen the capacities of public health actors, both within and outside the health system, to generate evidence, health data, information, tools and methods. A transparent accountability system would need to be put in place, to measure efficiency and effectiveness through relevant indicators.

The plan also called for the development of a new fit-for-purpose public health workforce, empowered to act effectively in complex environments, to produce evidence to support decisions, to communicate with policy-makers and the public, and to monitor the results of their work. Social and welfare provision should generate the necessary investments to promote knowledge and health literacy, while appropriate physical, societal and commercial environments would facilitate healthy choices.

The Adviser to the Minister of Health of Qatar and Member of the Scientific Committee on Health, Environmental and Emerging Risks of the European Commission, moderated a panel debate with five panellists: the Director, Department for Wellbeing and Services, Ministry of Social Affairs and Health, Finland; the Head, Division for Health Promotion and Prevention of Noncommunicable Diseases, Ministry of Health, Slovenia; the Regional Team Leader, HIV, Health and Development, Istanbul Regional Hub, United Nations Development Programme (UNDP); the Executive Director, European Public Health Association; and the Senior Fellow, Global Health Programme, Graduate Institute of International and Development Studies, Geneva, Switzerland.



One panellist described how the Health in All Policies approach was implemented in her country, underpinned by legislation and led by multisectoral teams in municipalities, who were responsible for monitoring the health and well-being of all population groups and drawing up annual and four-year reports that were included in the planning cycle. Efforts were being made to scale up that approach to the national and international levels.

In another country, health promotion centres had been set up within primary health care centres to tackle the determinants of health (such as tobacco smoking and obesity), and outreach activities were being conducted with district nurses and social services, with the aims of tackling risk factors and reducing inequalities. The initiative had been described in a good practice brief published in connection with the WHO high-level meeting in Sitges.

The institutional mechanism for country-level “domestication” of the SDGs, initiated by UNDP, necessitated extensive interministerial cooperation. Large United Nations programmes, including Global Environment Facility projects, contributed to the global public health good, while issue-based coalitions (such as the one on health, led by WHO) ensured mutual accountability for joint action by various organizations. The informal Interagency Task Team on Sustainable Procurement in the Health Sector was a further example of the implementation of a cooperative approach at global level.

In the area of research, one panellist called for continued investment in collaborative research. There was a need to build up researchers’ skills in translating knowledge into practice and to facilitate dialogue between researchers and policy-makers. Equally, the skills and expertise of people in other sectors needed to be strengthened so that they had knowledge of public health, and health literacy, especially of politicians, should be fostered.

Another panellist observed that public health was always at the crossroads of power and politics. The evidence base must therefore include not only health gain or economic gain, but also political gain. Stakeholder analysis and mutual gain negotiations were valuable approaches in efforts to include health in all policies. Health diplomacy was the ability to negotiate for health in the face of other interests, notably those related to the commercial determinants of health. Nutrition and obesity were identified as one area where a multisectoral approach was essential to counter those powerful commercial determinants. As had been shown with the tobacco sector, divestment was a powerful strategy for bringing about changes that benefited public health.

In the ensuing discussion, representatives welcomed the proposed action plan and reiterated that modern public health was about tackling strong vested interests, empowering people so that they could make healthy choices and recognizing that health was a political choice. Numerous Member States had recently drafted national public health strategies and action plans, established national public health councils and were engaging in public health reforms. More funding for public health could be secured through efficiency gains in the rest of the health system. Health and well-being were not only the final outcomes but also the enablers and determinants of the SDGs.

The Regional Director for Eastern Europe and Central Asia, UNFPA said that comprehensive, people-centred public health approaches were essential in order to address inequalities. Investing in public health was critical for every country, regardless of income status. It was hoped that the upcoming Global Conference marking the 40th anniversary of the Declaration of Alma-Ata would result in a renewed commitment by Member States to invest more, and achieve more. UNFPA was committed, together with its partners, to deliver on its three

transformative goals by 2030: zero maternal deaths, zero unmet need for family planning, and zero gender-based violence and harmful practices.

Statements were made by representatives of Wemos (speaking also on behalf of the Council of Occupational Therapists for European Countries, the European Forum for Primary Care, Health Care without Harm, Medicus Mundi International, the Centre for Regional Policy Research and Cooperation “Studiorum”, the World Federation of Occupational Therapists and the World Organization of Family Doctors) and the International Federation of Medical Students’ Associations (speaking also on behalf of EuroHealthNet, Health Care without Harm, EuroCare, Medicus Mundi International and Wemos). Written statements were submitted by the European Forum of National Nursing and Midwifery Associations, the International Federation of Medical Students’ Associations and IOGT International. A joint written statement was submitted by the Association of Schools of Public Health in the European Region, European Public Health Association, the Association for Medical Education in Europe, the European Federation of Associations of Dietitians, the European Forum for Primary Care, the European Forum of National Nursing and Midwifery Associations, the European Medical Students’ Association, the European Public Health Alliance, the International Alliance of Patients’ Organizations, the International Association for Hospice and Palliative Care, the International Pharmaceutical Students’ Federation, the International Union of Toxicology, Public Services International, the Centre for Regional Policy Research and Cooperation “Studiorum”, and the World Federation of Occupational Therapists/Council of Occupational Therapists in European Countries.

The Committee adopted resolution EUR/RC68/R6.

## **Can people afford to pay for health care? New evidence on financial protection in Europe**

*(EUR/RC68/11, EUR/RC68/Inf.Doc./1)*

The Head, WHO Barcelona Office for Health Systems Strengthening, introduced a new regional study on financial protection in Europe, which was the result of five years’ work by over 50 national and international experts and covered 25 countries. The study filled a gap in evidence and relevance by providing estimates of financial hardship attributable to out-of-pocket payments for health care, using a new methodology that is relevant for all Member States of the European Region. For the first time, it had been possible to go beyond averages and show the distributional impact of financial hardship based on country-level analysis. The study identified common gaps in coverage, the main drivers of financial hardship and the most successful coverage policies based on context-specific analysis of the 25 countries in the study. Earlier research had shown that, optimally, out-of-pocket payments should not exceed 15% of total spending on health: the new study showed that it was equally important to introduce policies to enhance financial protection especially for the most vulnerable groups in each society.

The Senior Health Financing Specialist, WHO Barcelona Office for Health Systems Strengthening, said that the study used data from household budget surveys regularly conducted in most Member States to monitor “catastrophic” out-of-pocket payments (amounting to over 40% of the household’s capacity to pay) and “impoverishing” out-of-pocket payments (where the household was previously above the poverty line but was pushed below it by its spending on health care or where the household was already below the poverty line and became even poorer). The evidence showed that some households in every country became impoverished

after out-of-pocket payments. Across countries, the incidence of catastrophic out-of-pocket payments ranged from 1% to 15% of households. The poorest households were most likely to experience catastrophic spending on health. Catastrophic spending was mainly attributable to outpatient medicines in countries with weaker financial protection and to dental care in countries with stronger financial protection. In most countries, catastrophic spending among the poorest households was primarily attributable to outpatient medicines.

The incidence of catastrophic spending on health was generally found to rise as the out-of-pocket share of total spending on health rose, but policies were also likely to influence the extent of financial hardship in a country – for example, gaps in any of the three dimensions of coverage (population coverage, service coverage and user charges) – underlining the importance of context-specific policy analysis.

Gaps in population coverage arise when entitlement to publicly financed health care is based on employment or payment of contributions and countries lack effective mechanisms to enforce participation. In European countries, the most common gaps in service coverage were dental care for adults and outpatient medicines. Gaps in service coverage may result in financial hardship for richer households but lead to unmet need for poorer households. Carefully re-designing copayment policies would help to reduce financial hardship. At present, many States provided free access to primary care but imposed copayments for outpatient medicines, even though medicines were an essential part of treatment in primary care. A strong copayment policy was characterized by three features: exemptions from payment for people on low incomes and for people who are regular users of health care (for example, people with one or more chronic conditions) or who may be vulnerable in other ways (for example, children and older people); an annual cap on the total amount of copayments; and replacing percentage copayments with a fixed, but low, copayment irrespective of the actual cost of the medicine (ensuring both affordability and predictability of expenditure).

The Professor, Health Policy and Management, Trinity College Dublin, Ireland, described the importance of financial protection in moving towards universal health coverage and linked it to the three dimensions of coverage. Universal health coverage implied that all people should be entitled to use publicly financed health services – there was no good case for excluding some people from coverage. Ideally, people should not have to pay any user charges (copayments) because these shift the burden of financing health care to poorer people, may lead to unmet need and do not enhance efficiency. However, service coverage should not extend to health services that were not good value.

Due to strong evidence showing that user charges were not useful for guiding people's choice of treatment (since they discouraged the use of both optimal and less useful services and medicines), the only purpose of user charges was to raise revenue for the health system. If States continued to impose user charges, they should design their copayment policies in such a way that they raised funds while doing the least possible harm, as demonstrated by the new study – namely, low, fixed copayments with an annual cap on all copayments and exemptions for poor people and other vulnerable people. The evidence was clear and could be applied in all Member States of the Region.

Representatives welcomed the study, particularly its use of new metrics. They stressed the importance – but also the sometimes challenging nature – of attempting to improve financial protection for hard-to-reach groups, and drew attention to the continuing health challenges facing migrants. One noted that the issue of policies to reduce pharmaceutical prices was being addressed by mechanisms such as the Valletta Group. Another said that social care for

older people and those with chronic conditions was a further cause of serious financial hardship. Representatives shared details of their national financial protection mechanisms: in Lithuania, under a new pharmaceuticals policy, the Government had reduced the rate of value added tax for some medicines; it was also planning to cap copayments and had been promoting the use of generic and biosimilar medicines where appropriate.

Statements welcoming the study and noting the importance of the issues it covered were made by representatives of the International Federation of Medical Students' Associations and Public Services International. Written statements were submitted by EuroHealthNet and the Standing Committee of European Doctors.

The Director, Health Systems and Public Health, thanked the Member States that had contributed their data to the study. The next step was to support countries as they began to implement the policy recommendations it contained.

### **Report on the WHO high-level meeting, Health Systems Respond to NCDs: Experience in the European Region (Sitges, Spain, 16–18 April 2018)**

*(EUR/RC68/19, EUR/RC68/Inf.Doc./3)*

**and**

### **Report on the WHO high-level meeting, Health Systems for Prosperity and Solidarity: Leaving No One Behind (Tallinn, Estonia, 13–14 June 2018)**

*(EUR/RC68/Inf.Doc./6, EUR/RC68/Conf.Doc./8 Rev.1, EUR/RC68/19 Add.1)*

The Director, Health Systems and Public Health and the Director, Noncommunicable Diseases and Promoting Health through the Life-course introduced the discussion on the high-level meetings held in Sitges and Tallinn, noting that they were significant milestones on the road to universal health coverage and that their outcome statements should be taken forward to the Third United Nations High-level Meeting on Non-communicable Diseases, to be held in New York, United States of America, on 27 September 2018. Building on those outcomes, consideration could also be given to promoting the health system response to mental health and air pollution.

A slide show was presented, giving highlights of the Sitges meeting.

The Senior Health Economist, WHO Barcelona Office for Health Systems Strengthening said that the premise behind the Sitges meeting had been that making a greater impact on NCD outcomes required scaling up the NCD best buys more aggressively, which in turn required a comprehensive and aligned health system response. The policy recommendations presented at the meeting had been based on six years of work, including country assessments with policy dialogues and follow-up, good practice briefs, annual training courses and consultative meetings. The key policy messages that had been derived had been debated in Sitges by 250 participants from 40 Member States in the Region and had been captured in a synthesis report and compendium of good practices that would be launched during the current Regional Committee session.

Health systems needed to transform and adapt to the “wicked problem” that NCDs posed through a complex web of interrelated causal determinants. They were doing so through a number of approaches or “cornerstones”. Intersectoral public policies and fiscal policies required sustainable governance structures with appropriate skills and resources. Three enabling factors were essential: first, public health education must be transformed; secondly, far greater investments must be made into health promotion and disease prevention; and thirdly, new financing mechanisms for intersectoral action must be adopted.

People and their carers were the front line workers for NCDs; primary health care was thus becoming the nexus, connecting different services that had previously been compartmentalized. Larger multidisciplinary primary care teams were needed, so the skill mix had to be rethought, tasks shifted, cost-effective medicines included in benefits packages, and appropriate financial incentives put in place. While universal policies constituted the backbone of the health system response, one size did not fit all: targeted approaches must be identified in order to enhance health equity. Health systems played a key role in reducing health inequalities by combining universal with targeted policies.

The WHO European Region could present a success story in the area of reduction of premature mortality from NCDs and managing chronic conditions. Even more dramatic reductions could be achieved by “leapfrogging” or adopting current best practices, changing track quickly and engaging in large-scale qualitative change. Exploiting opportunities for leapfrogging required paying attention not only to the “what” but also to the “how” of health system transformation, and managing the political economy of change. The Regional Office stood ready to continue to work with all Member States and demonstrate that leapfrogging was possible.

A slide show was presented, giving highlights of the Tallinn meeting.

The Senior Adviser for Policy and Strategy said that the meeting, which had been generously hosted by the Government of Estonia and technically supported by the European Observatory on Health Systems and Policies, had been organized to celebrate the 10th anniversary of the signing of the Tallinn Charter. Bringing together around 240 participants from 40 countries and many partners, it had set out policy directions for the future under the headings of “Include”, “Invest” and “Innovate”, all of which reflected the Tallinn Charter values of solidarity, equity and participation.

The first theme dealt with access to services, coverage and financial protection. It lay at the heart of universal health coverage, was a priority under GPW 13 and was central to attaining SDG 3. It was about ensuring that health systems reached and served everyone without causing financial hardship. Participants during the meeting had reaffirmed the Tallinn Charter call that no one should become poor due to ill health. It generated consensus to enhance solidarity in order to scale up universal health coverage and confirmed the need to revisit and strengthen financial protection in the European Region.

The second theme stood for sustained investment in health systems for better outcomes. Across the region there was better awareness today that the health system was a driver not just of individual and population health but also of wealth and economic growth. Participants in the meeting had turned to making the business case for investing in health systems and getting serious about investing in public health, and discussing means to demonstrate that health sector investments could work towards economic and fiscal objectives.

The third theme emphasized that innovations – whether in systems, services or technologies – could result in more effective and integrated ways of delivering on health system values and objectives. However, scaling up innovations was complex and context specific, and innovations of any type might widen inequalities. Appropriate policy regulation and governance mechanisms were therefore vital, to ensure that the benefits of innovation were widely distributed and shared.

The representative of Estonia, speaking on behalf of the Nordic and Baltic countries (Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden) said that the outcome statement from the Sitges meeting fitted very well with that from the Tallinn meeting and would be valuable input into the Third High-level Meeting on Non-communicable Diseases and the Global Conference on Primary Health Care (Astana, Kazakhstan, 25–26 October 2018). Strengthening health systems was closely linked to the achievement of universal health coverage, but work to that end should be balanced with moves to address environmental risk factors, such as air pollution, and to support healthy choices and lifestyles. The harmful use of alcohol was one of the four most common modifiable and preventable risk factors for major NCDs. The year 2020 would mark the tenth anniversary of the global strategy in that area and the expiry of the current European action plan. Preparations for commemorating the anniversary should include discussion of the challenges still faced and planning of actions for the future in the Region. The topic of NCDs should be more strategically placed on the agenda of the forthcoming session of the Executive Board.

The representative of Switzerland recalled that her Government and that of Afghanistan had organized a side event at the Seventy-first World Health Assembly, at which a call to action for universal health coverage in emergencies had been proposed. Building on that initiative, the President of Switzerland would host an event on that topic during the Third High-Level Meeting the following week. In addition, Switzerland would host the first General Meeting of the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases on 5 and 6 November 2018.

Another representative recalled his country's lengthy experience of a statutory health insurance system, embedded in a social market economy and giving expression to solidarity. Health services were the largest employer in many countries and thus a pillar of economic development, welfare and social cohesion. However, health systems had to continue to take up new challenges, so as to ensure that they were financially sustainable and that no one was left behind.

Statements were made by representatives of the Northern Dimension Partnership in Public Health and Social Well-Being, the Standing Committee of European Doctors, Wemos (speaking also on behalf of the Council of Occupational Therapists for European Countries, the European Public Health Association, the European Public Services Union, the International Association for Hospice and Palliative Care, the International Federation of Medical Students' Associations, Medicus Mundi International, Public Services International, the Centre for Regional Policy and Research Cooperation "Studiorum", the World Federation of Occupational Therapists, the World Federation for Medical Education and the World Organization of Family Doctors) and the World Heart Federation (speaking also on behalf of the European Heart Network). A joint written statement was submitted by Medicus Mundi International and Wemos.

Participants commended the organization of the Tallinn meeting by WHO and reiterated their commitment to the values expressed in the Tallinn Charter. One speaker reported on the

adoption of a national action plan inspired by the three themes of the meeting, while another described the measures being taken, with WHO support, to bring about improvements in four strategic areas (including the hospital sector and health financing) and to integrate primary health care and public health. One representative noted that her country would co-chair the first United Nations High-Level Meeting on Universal Health Coverage, to be held in New York in September 2019, and pledged to ensure that the outcome statements of the Sitges and Tallinn meetings would inform the preparations for that event.

Another representative called on the Regional Office Secretariat to compile a list of all the initiatives, models, platforms and tools that were currently being implemented, from which Member States could select the most appropriate instruments for carrying out their high-priority measures. Particular importance was attached to translating that material into local languages.

Statements were made by the representatives of the Standing Committee of European Doctors and EuroHealthNet.

One representative, speaking on behalf of the EU and its Member States, proposed that the third and fourth lines of operative paragraph 3(d)<sup>2</sup> of the draft resolution contained in document EUR/RC68/Conf.Doc./8 Rev.1 should be amended to read: "... recognizing that excessive out-of-pocket payments for outpatient services and medicines can be a significant source of financial hardship ...".

The Committee adopted resolution EUR/RC68/R3.

## **Action plan to improve public health preparedness and response in the WHO European Region**

*(EUR/RC68/14, EUR/RC68/14 Add.1, EUR/RC68/Conf.Doc./5 Rev.1, EUR/RC68/Conf.Doc./5 Rev.2)*

A short video was shown as part of the "Voices of the Region" series. The Director, Health Emergencies and Communicable Diseases said that the draft action plan to improve public health preparedness and response in the WHO European Region, 2018–2023 built on the guidance for accelerating implementation of the IHR (2005) and increasing laboratory capacity, approved by the Regional Committee at its 67th session, and on the five-year global strategic plan to improve public health preparedness and response, 2018–2023, that had been welcomed with appreciation by the Seventy-first World Health Assembly in May 2018. Its aim was to prevent or minimize the impact of health emergencies throughout the Region.

The Coordinator, Health Emergencies, described the process of drafting the action plan, beginning with a high-level meeting in Munich, Germany in February 2018 and continuing with an online consultation to which 36 Member States and other stakeholders had responded. The SCRC had also discussed the draft in detail. The comments received included a call for the text to be aligned with EU and other subregional mechanisms. One Member State had submitted detailed comments and recommendations.

The three strategic pillars of the draft action plan were: to build, strengthen and maintain the core capacities of States Parties to the IHR (2005); to strengthen event management and compliance with IHR requirements; and to measure progress and promote accountability,

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<sup>2</sup> Operative paragraph 3(e) of the adopted resolution.

including compulsory annual reports to the World Health Assembly and voluntary qualitative and quantitative assessments.

Building on the global strategic plan to improve public health preparedness and response, 2018–2023, the action plan recognized the interdependence of health emergency preparedness, health systems strengthening and the essential public health functions; it adhered to the framework and principles of the IHR (2005) and strived to contribute to the achievement of the commitment in the SDGs to leave no one behind, through the promotion of universal health coverage, and complied with existing international health policy frameworks. The action plan also recognized the fundamental importance of country ownership that focused on a needs-based approach to capacity development and drew, where possible, on domestic sources of funding in order to ensure sustainability. All preparedness and response strategies and actions undertaken by States Parties should be based on national risks, hazards and vulnerabilities and should involve relevant national and, where applicable, intersectoral collaboration. It emphasized the leadership role of WHO in guiding stakeholders to support countries in capacity development and coordinate the provision of assistance during an emergency in line with the IHR (2005); it prioritized WHO support to priority countries in the WHO European Region, and was based on the importance of an all-hazard, as well as One Health approach, focusing on all phases of the emergency management cycle and acknowledging existing subregional frameworks.

Many Member States welcomed the draft action plan and accompanying draft resolution and called for their immediate adoption. They singled out for particular praise the intersectoral approach adopted in the draft action plan and the training for national focal points provided by the International Health Regulations Coordination Department, based at the WHO office in Lyon, France. They further stressed the indivisibility of the four elements of IHR monitoring and evaluation – annual reporting to the World Health Assembly (an obligation under the IHR (2005)), joint external evaluations, after-action reviews and simulation exercises. One said, however, that limited resources would oblige it to focus on its mandatory annual report to the Health Assembly rather than on a joint external evaluation.

A statement was made by a representative of the International Federation of Medical Students Associations. Written statements were submitted by the Association for Medical Education in Europe and the International Association for Hospice and Palliative Care.

The Director, Health Emergencies and Communicable Diseases, responding to the points raised, stressed that the draft action plan was a product of the joint efforts of the Regional Office, Member States and other stakeholders, and had been drawn up in an inclusive and transparent process. The Regional Office would lead the implementation of the action plan in order to meet the needs expressed by Member States. The only binding obligation was the annual report to the Health Assembly under the IHR (2005); all other mechanisms were voluntary and intended to build national capacity. The Regional Office understood the concerns expressed by some Member States and would ensure that the action plan was implemented sensitively.

One Member State submitted detailed amendments to the draft resolution. It preferred the word “welcome” rather than “adopt” in the draft resolution for a number of reasons: the draft action plan provided for measures to be conducted by the Regional Office and unspecified “key partners”, without specifying that those measures must first be requested by the State concerned; the consultation process did not fully address some countries’ concerns about monitoring and evaluation, particularly the tools for and financing of joint external evaluations



and the proposed formal endorsement of the latter in the action plan even though other, voluntary, mechanisms were available; finally, the proposed monitoring framework with indicators for each technical area of the strategic pillars should likewise be thoroughly discussed by all Member States, particularly since the draft action plan included some initiatives which were not in the interests of all. The self-assessment mechanism provided for in the IHR (2005) required further work in a forum in which all Member States could participate.

A representative of the EU said that the EU Member States did not wish to accept any wording which did not explicitly state that the Regional Committee had formally adopted the action plan. Activities under IHR (2005) were part of the core business of WHO. The draft resolution, as currently worded, gave a strong mandate to the Regional Office and sent a firm political message to the wider world.

Following further discussion in an informal working group, consensus was reached on an amended version of the draft resolution, which the Committee adopted as resolution EUR/RC68/R7.

## **Strategy on the health and well-being of men in the WHO European Region**

*(EUR/RC68/12, EUR/RC68/12 Add.1, EUR/RC68/Conf.Doc./7 Rev.1)*

A short video was shown as part of the “Voices of the Region” series, in which an Irish livestock farmer described having a health scare and the care he had received for a heart condition. His experiences had given his friends and acquaintances the necessary encouragement to also attend health checks. Owing to stereotypical notions of masculinity, men often felt a sense of weakness and embarrassment when discussing fears about their health, and thus often did not seek help until it was too late. While men must take responsibility for their health, health care professionals should also reach out to them, offering support and encouragement.

The Director, Noncommunicable Diseases and Promoting Health through the Life-course, informed the Regional Committee that it was the first time in the history of WHO that a governing body was discussing a strategy on the health and well-being of men. The European Region was a good place to start such an initiative. As with the Strategy on Women’s Health and Well-being in the WHO European Region discussed by the Regional Committee two years previously, the preparation of the Strategy on the Health and Well-being of Men had been led by the Division of Noncommunicable Diseases and Promoting Health through the Life-course and the Division of Policy and Governance for Health and Well-being, and had received considerable support from all other divisions in the Regional Office, including GDOs, as well as from experts and civil society. Implementation of the strategy, the aim of which was to reduce premature deaths from NCDs and achieve gender equality in health using a life-course approach, would need strong support. Given the groundbreaking nature of the Strategy, its implementation was a particularly great responsibility to bear. The guidance and support of Member States would therefore be particularly important.

The Programme Manager for Gender and Human Rights said that the Strategy on the Health and Well-being of Men in the WHO European Region connected several agendas that were at the heart of WHO’s work, such as Health 2020 and the 2030 Agenda, and particularly SDGs 3, 5 and 10. It complemented the Strategy on Women’s Health and Well-being adopted by the

Regional Committee in 2016. Although the health of men in the European Region had improved over the years, too many men were still dying young in Europe from NCDs and injuries. The differences were large across the Region, with almost 17 years difference in life expectancy between men living in different countries. It was not news that many of these deaths were due to men's higher-risk behaviours and less use of services than women, so using a gender approach to accelerate progress on preventing those premature deaths was one of the main drivers behind the Strategy.

Gender equality was both a goal and an accelerator of the SDGs and engaging men in gender equality was the other main driver of the Strategy. Shared responsibility for sexual and reproductive health, prevention of violence against women and sharing paid and unpaid care were key strategies aiming at gender equality. Women shouldered a disproportional share of care responsibilities in every country in the Region. Shifting that imbalance would have benefits for women and men; when men cared for others, they were better equipped to take care of themselves and had less need for formal and informal care.

The report on the health and well-being of men informed the recommendations of the Strategy and highlighted some aspects of men's health. It also looked at the health impact of the links between biology, gender and the other social determinants of health during different stages of life and the way in which traditional gender norms and notions of masculinity affected health-seeking behaviour and created gender bias in health service provision.

The Strategy took an asset-based, participatory approach, building on positive experiences. Its agenda was transformative, as it involved cultural and societal change. Each of the priority areas (strengthening governance of men's health, making gender equality a priority, making health systems gender responsive, improving health promotion and building a strong evidence base) stressed the need to adopt a life-course approach to men's health, identifying three key transitions in men's lives that present challenges but also opportunities for action: adolescence, fatherhood and retirement.

It was proposed that its monitoring framework would align with the joint monitoring framework to avoid duplication and make best use of Member States' resources. The draft resolution also proposed combining the monitoring of the Strategy and reporting to the Regional Committee with the monitoring of and reporting on the women's health strategy, since the actions implementing these strategies would be carried out within the overall agenda of gender equality.

The ensuing panel discussion on the Strategy on the Health and Well-being of Men in the WHO European Region was moderated by the Director, Policy and Governance for Health and Well-being. The Healthy Workplaces Project Lead, Ireland, the Deputy Director-General of Health, Portugal, and a Senior Analyst, Swedish Gender Equality Agency, Sweden, participated as panellists.

The Healthy Workplaces Project Lead, Ireland, said that Ireland's National Men's Health Policy 2008–2013 took account of the gender and social determinants of health. Its success was a result of strong leadership at the governmental level, expert advice for implementation, strong reporting mechanisms, capacity-building, research, awareness-raising and advocacy. The policy was evidence-driven and subject to ongoing evaluation. In a context of dwindling resources, cooperation with civil society partners and academia had been vital. The presence of a cohort who were enthusiastic about men's health and worked together for a common agenda had been crucial. In order to promote a whole-of-government approach, the second

action plan for implementation of the policy had been aligned with the Healthy Ireland Framework for Improved Health and Well-being adopted in 2013. The resulting integration of men's health into national policy-making had been the key to success. The European Strategy gave a clear mandate for action at the regional level. It would create greater visibility for health and gender and an opportunity to share practices, work together, build the evidence base and keep the issue on the agenda.

The Deputy Director-General of Health, Portugal, said that NCDs were the single most important cause of mortality in his country and any action to reduce exposure had benefits for society as a whole, including men. Given the complexity of reasons underlying the gender mortality gap, the involvement of non-health sectors, civil society and the population was crucial. The two main aspects that needed to be addressed were: notions of masculinity that caused high-risk behaviour in men, and men's interaction with the health care system. Men needed to be made aware of health risks, health needs and the availability of treatment. Engagement with the health sector from an early age would be useful in that regard. At the same time, health care providers' awareness of gender as a determinant of health needed to be increased. The European Strategy, like other WHO instruments, lent momentum, a stronger evidence base and additional arguments to national efforts.

The Senior Analyst, Swedish Gender Equality Agency, Sweden, said that gender equality had long been on his country's agenda and public policy promoted men's engagement in fatherhood and unpaid care. Social policies such as subsidized childcare had also been important. Evidence showed that men who occupied a caring role in their family were less likely to expose themselves to certain risks, engaged in better health behaviour, helped change societal perceptions of masculinity and were less likely to die young. Conversely, premature mortality was particularly high among divorced men who lacked access to social networks and did not keep in touch with children from previous relationships. There was also a proven link between notions of masculinity and mental health, as mental illness in men was often underdiagnosed and left untreated. The Swedish Association of Local Authorities and Regions had conducted awareness campaigns and workshops and issued publications aimed at changing masculinity norms, creating social support networks, developing new role models and lowering thresholds for seeking help. The Swedish Gender Equality Agency established in early 2018 had lent additional support to the inclusion of men's health in gender-sensitive health policies. The European Strategy could help sustain existing efforts for gender equality and address emerging challenges arising from growing socioeconomic and sociocultural gaps that led to a resurgence of traditional gender norms.

In the ensuing discussion, participants expressed broad support for the Strategy, which was perceived as an important milestone on the road to gender responsive health policy in the Region. It was also seen as highly relevant to the implementation of the 2030 Agenda and to enabling targeted health promotion for men and women. Citing a plethora of gender-related health problems in men, participants drew attention to the need to take account also of the cultural, socioeconomic and environmental determinants of health. One member noted that, given the complex interplay of factors, it was difficult to assess the relative effectiveness of any given measure. Representatives highlighted the need for a comprehensive, whole-of-society approach to men's and women's health. Although health needs of men could be addressed in a way that also benefited women and children, they should also be recognized in their own right.

Promoting men's engagement in paid and unpaid care, parenting and prevention of violence as set forth in the Strategy was commended. While understanding the biological differences between men and women for medical purposes was important, gender disparities in health outcomes were largely influenced by values, norms and traditions. By acknowledging the vulnerability of men and their role as agents of change, the Strategy could provide useful guidance for further action at all levels. One member described her country's approach to health from a gender perspective, both in general and specifically, and drew attention to the need for gender-specific health research and reporting. The importance of prioritizing culture change was noted. One member pointed out that the focus on men's health should not divert resources from women's health needs. Men's health outcomes were often related to personal choices and cultural habits, while women's health was frequently determined by broader societal conditions. Both needed comprehensive approaches and might best be addressed under a broader umbrella of gender-sensitive health. The proposed joint reporting on the Strategies for men's and women's health to the Regional Committee received broad support. Linking men's and women's health would provide a solid basis for gender-sensitive health policy-making of the future.

The Regional Director for Eastern Europe and Central Asia, UNFPA expressed support for the Strategy, which built on strong evidence and expertise. The impact of gender norms and notions of masculinity on men's health had been widely recognized and documented and the gender dimension of the Strategy was critical. Meeting the sexual and reproductive health needs of men was crucial for advancing the health of families, communities and societies. The comprehensive analysis of key determinants of the sexual and reproductive health of men, as well as the challenges and priorities, contained in the document was thus highly relevant. The valuable recommendations for impact-oriented action provided in the Strategy would not only advance the health and well-being of men, but also accelerate the implementation of the SDG agenda in the Region. Her organization stood ready to continue its cooperation with WHO and Member States in the implementation of the Strategy.

Statements were made by the representatives of the International Federation of Medical Students' Association (also speaking on behalf of the Alliance for Health Promotion, the European Forum of Primary Health Care, Medicus Mundi International, Wemos and the Centre for Regional Policy Research and Cooperation "Studiorum") and the International Association for Hospice and Palliative Care.

The Committee adopted resolution EUR/RC68/R4.

## **Implementation of the Regional Framework for Surveillance and Control of Invasive Mosquito Vectors and Re-emerging Vector-borne Diseases 2014–2020: lessons learned and the way forward**

*(EUR/RC68/16)*

The Director, Health Emergencies and Communicable Diseases, introducing the subject, indicated that work to implement the Regional Framework for Surveillance and Control of Invasive Mosquito Vectors and Re-emerging Vector-borne Diseases 2014–2020 was particularly important given the establishment and spread of *Aedes* mosquitoes and the increasing introduction of vector-borne diseases to the European Region. The Regional Office's resources for implementing the Framework were limited, however, and it therefore relied on critical support from four Member States in particular. While the Framework

focused on two vector-borne diseases – chikungunya and dengue – other vector-borne diseases, such as Lyme borreliosis and West Nile fever, were also a cause for concern, particularly in the southern part of the WHO European Region. She underscored the importance that the Regional Office placed on cooperation with partners, including the European Centre for Disease Prevention and Control (ECDC), the European Mosquito Control Association and VectorNet.

The Coordinator, Communicable Diseases, said that, while the number of cases of dengue and chikungunya imported into the European Region had increased, the data did not show the whole picture as the majority of cases had few or no symptoms and were therefore not identified or reported. An outbreak of West Nile fever was taking place in southern Europe and 64 deaths had been reported in the Region thus far. The vectors of these diseases already existed in many countries in the Region but there were data gaps that needed to be filled. The Regional Office had used the Zika virus disease outbreak as an opportunity to assess the capacity of Member States to contain transmission of Zika virus at an early stage. In terms of integrated vector management only 23 Member States reported having both entomological surveillance and vector management plans in place. With regard to the clinical surveillance of vector-borne diseases, 33 countries reported having surveillance for vector-borne diseases and rash and fever in place. Efforts were being made to support countries in capacity building, training and vector identification. Communication and awareness-raising materials were being produced for use by Member States. Strong political commitment would be the key to preventing wider outbreaks; human and financial resources must be allocated to vector control, and strong surveillance, monitoring and evaluation were crucial. Vigilance among health care workers and awareness of all symptoms were also essential. Intersectoral approaches were needed, local communities must be mobilized, and cross-border collaboration must be strengthened. WHO is fully committed to continuing its support to Member States. The SCRC subgroup on vector control, welcoming the strategic approach to integrated global vector control, considered as next steps the following three options: (1) developing, in accordance with resolution WHA70.16, a regional plan on vector control; (2) expanding the scope of the existing Regional Framework to include other vector-borne diseases of concern; and (3) accelerating implementation of the Regional Framework and addressing other vector-borne diseases of concern on the basis of a disease-specific and subregional approach. The SCRC concluded with the proposal to further accelerate implementation of the Regional Framework and address other vector-borne diseases of concern on the basis of a disease-specific and subregional approach.

The Chairperson, SCRC subgroup on vector control, said that, in view of concerns about the increasing transmission of vector-borne diseases and the pressure on health systems in the WHO European Region for various reasons including climate change, the SCRC had established a subgroup on vector control. Chikungunya and dengue had been transmitted locally in southern European countries, with *Aedes albopictus* mosquitoes present in Europe. At the same time, there was a risk of *Aedes aegypti* re-introduction in Europe. West Nile virus had been established in parts of the Region, with large numbers of cases recorded. Malaria was also present, proving that previously eliminated diseases could re-emerge. Efforts must therefore be made to strengthen public health systems by employing more epidemiologists, entomologists and public health professionals to respond to this public health threat. National preparedness and response plans were essential. Political commitment at the highest level was needed to ensure long-term funding and capacity-building. Effective and sustainable vector surveillance and control was also crucial, supported by appropriate legislation. Other stakeholders, such as environmental agencies, should also be involved in vector-control measures. Further research

was needed to understand the epidemiology of the pathogens of concern, to identify predictive indicators and establish effective vector-control methods. Communication campaigns to raise public awareness were essential, and travellers' health advice should also be improved to minimize the importation of vector-borne diseases. The SCRC subgroup would continue its work to study the situation and issue recommendations for the further implementation of the Regional Framework.

In the discussion that followed, representatives of Member States welcomed the report and expressed their concerns regarding the rise in vectors and the increasing threat of several vector-borne diseases in the European Region. Describing their experiences with vector control at the national level, they underscored the critical need for a multisectoral approach, in particular through close cooperation with the climate, animal health, agriculture and transport sectors. Member States must share information, particularly surveillance data, since vector-borne diseases were a transnational threat. Health-care workers must be trained to identify potential cases of vector-borne diseases, especially those with low manifestation of symptoms. Further work should take place in parallel along with an increase in the scale of fundamental and applied research. Inclusion of Congo-Crimean haemorrhagic fever into the scope of the Regional Framework was proposed.

A statement was made by a representative of the International Federation of Medical Students' Associations.

The Director, Health Emergencies and Communicable Diseases, thanked participants for their acknowledgement of the increasing threat of vector-borne diseases and the links to climate change. Intersectoral action would be crucial in meeting the threats of re-emerging vectors. Vector control was a neglected area of preparedness, with limited human and financial resources, which must be strengthened. Increased attention should also be paid to surveillance. Regarding information sharing, cross-border data exchanges, both within the European Region and with countries in the Eastern Mediterranean Region, must be strengthened. While all suggestions for broadening the scope of vector control were welcome, resources for implementing the Framework remained scarce.

## **Vaccine-preventable diseases and immunization: realizing the full potential of the European Vaccine Action Plan 2015–2020**

*(EUR/RC68/9)*

A short video was shown as part of the "Voices of the Region" series, in which a German mother of a three-year-old daughter, with a baby on the way, described her experiences of encountering vaccine hesitancy among other mothers of young children. She expressed particular concern regarding the threat that unvaccinated children posed when coming into contact with infants and other young children who could not be vaccinated. She emphasized the importance of 95% immunization coverage to achieve herd immunity and thereby protect all children against communicable diseases, irrespective of their immunization status.

The Director, Health Emergencies and Communicable Diseases reported on progress made towards the goals of the European Vaccine Action Plan 2015–2020. According to an independent midterm review, as of the end of 2017, the European Region was on track to meet three of the Plan's six goals: maintaining polio-free status; making evidence-based decisions on new vaccines; and achieving financial sustainability of immunization

programmes. Given the implementation of the Action plan for the health sector response to viral hepatitis in the WHO European Region (2017), it was likely that the goal to control hepatitis B infection was also on track.

Despite the progress made, gaps in national and subnational immunization coverage were causing considerable challenges. The number of cases of measles in the Region had increased dramatically compared to 2016: around 23 000 cases had been recorded in 2017, while some 41 000 had been recorded in the first six months of 2018. The increase in measles cases and recorded deaths was both unacceptable and preventable. Inadequate coverage was due to vaccine shortages and impediments to access to new vaccines in some countries. Vaccine hesitancy also constituted a serious problem, which required analysis at the local level and tailored solutions. Health care professionals had a key role to play in that regard, and good quality immunization data were critical to inform decision-making at the local level.

The Chairperson, European Technical Advisory Group of Experts on Immunization, said that over recent decades, tireless immunization efforts had reduced the occurrence of some childhood diseases to the extent that young medical professionals might not recognize them. Such success could give rise to complacency regarding vaccination. A resulting drop in immunization could bring back forgotten diseases. A case in point, the significant rise in measles cases in the European Region, illustrated gaps in vaccine uptake and years of underachievement. Immunization did not just protect those who were vaccinated but also those around them. Concerted efforts to protect populations by delivering effective universal vaccine programmes were essential to protect against the harms of misinformation, misunderstanding and complacency.

In the discussion that followed, all speakers welcomed the report and expressed concern regarding the significant and rapid increase in measles cases in the European Region. Pledging their commitment to vaccination as an essential public health intervention, and in particular to meeting the goals set in the European Vaccine Action Plan, participants shared measures taken at national level to enhance vaccination coverage. In many Member States, national action plans were being implemented. While efforts were being made to ensure that vaccine costs were met by governments, some middle-income countries faced challenges in introducing new vaccines and wished to seek solutions to procurement challenges, such as through joint procurement arrangements. WHO support might be needed in this regard and in addressing other issues in middle-income countries.

While in some countries vaccination was a requirement for children's enrolment in preschool and primary school facilities, and was therefore de facto obligatory, in others vaccination of children remained at the discretion of parents and guardians. Vaccine hesitancy and the increasing traction of the anti-vaccine movement were particularly worrying. Every effort must be made to engage the media in advocacy efforts and build trust in immunization, in order to reverse the spread of measles and meet the targets of the European Vaccine Action Plan. Particular attention should be paid to broadening vaccination coverage to encompass hard-to-reach communities, such as the Roma and populations living in border areas, conflict-affected areas or disputed territories. Surveillance and data use should also be strengthened to inform and optimize interventions. Representatives thanked the Regional Office for its invaluable support of their efforts.

A representative of an observer State cautioned that endemic transmission of measles has been re-established in one Member State in the Region of the Americas, which served to

demonstrate the fragility of measles elimination and the vulnerability of health systems. High population immunization rates were a crucial aspect of preparedness.

Statements were made by representatives of the World Organization of Family Doctors (also on behalf of the World Federation of Occupational Therapists, the European Forum for Primary Care, the Council of Occupational Therapists for the European Countries, the Centre for Regional Policy Research and Cooperation “Studiorum” and Medicus Mundi International), the International Federation of Medical Students’ Associations (also on behalf of the European Medical Students’ Association and the European Forum for Primary Care), the European Public Health Association, the Standing Committee of European Doctors and the International Pharmaceutical Students’ Federation. A joint written statement was submitted by the European Public Health Association and the European Forum of National Nursing and Midwifery Associations.

The Director, Health Emergencies and Communicable Diseases thanked all participants for the strong reaffirmation of their commitment to immunization and for sharing their experiences. She agreed that communication and awareness-raising would be key to countering the anti-vaccination movement and overcoming vaccine hesitancy. WHO remained committed to working with Member States in that regard and had developed various materials and tools for use at the local level. Data monitoring would be an important area of focus for the Regional Office and would be central to identifying immunization gaps and targeting interventions to meet the needs of vulnerable groups, including hard-to-reach populations and migrants. The challenges posed by global vaccine supply and procurement persisted; the Regional Office would continue its efforts to overcome those challenges, including through the development of a roadmap on joint procurement as part of the wider middle-income country immunization roadmap. The European Technical Advisory Group of Experts provided valuable guidance for defining WHO strategies and policies, which had been subsequently reflected in activities at national level. Immunization would remain a priority for the Regional Office, and close cooperation with all partners, including ECDC and Centers for Disease Control and Prevention, would continue.

## **Countries at the centre: the strategic role of country offices in the WHO European Region**

*(EUR/RC68/Inf.Doc./4 Rev.1)*

A video was shown, as part of the “Voices of the Region” series, on the strategic role of country offices in the WHO European Region, showing the work of country offices in various contexts and describing the experiences of members of the SCRC and European members of the Executive Board who had visited country offices in Georgia, Slovenia, Russian Federation and Turkey. The visitors had also been afforded an opportunity to engage with representatives of government institutions, civil society and partner agencies, and to learn about the way in which WHO’s collaboration with national partners helped make a difference to people on the ground. The insights gained from such visits could inform decisions taken in WHO governing bodies on resource allocation for country work.

The Director, Country Support and Communication said that considerable progress had been made in WHO’s country work over the past decade. Health 2020, WHO reform and more recently GPW 13 and the transformation agenda had improved the way WHO worked in and with countries. The shift from nationally- to internationally-led country offices was nearly



complete and country cooperation strategies had been rolled out in some Member States that did not have country offices. The mandate given by GPW 13 to strengthen country work underpinned the drive towards outcome-based, fit-for-purpose offices. However, most European country offices were small and the Regional Office's capacities to assist in policy dialogue and deliver strategic support, technical assistance and coordinated services to all Member States were limited. The European model was based on the provision of strategic direction and technical support from the Regional Office as guided by global policy and backstopped, if and as necessary, by WHO headquarters. However, in order to be well prepared for GPW 13 and the new programme budget, the Regional Office was exploring creative and cost-effective ways of providing more support to countries without unduly expanding the staffing within country offices. That included, among others, placing international staff for multi-country support where they could be readily mobilized when needed on a more regular basis.

Positive health outcomes at country level were the result of a trusting relationship between Member States and the Regional Office and synergies developed over time. WHO's participation in United Nations country teams had also played an important role and positioned the Organization as a central member of the United Nations family. At the regional level, WHO's work had helped elevate health as a critical component of the SDGs. WHO had been fully engaged in United Nations reform and strengthened its collaboration with all United Nations agencies at all levels. However, it was important that, as United Nations reform was implemented, WHO would ensure that its mandate as a specialized health agency was preserved.

Overall, country visits had provided valuable insight into the work of WHO as coordinated by country offices, which served as platforms for all three levels of WHO to come together and work with national counterparts and partners in a coordinated manner. The visits had also afforded some insight into human and financial resource needs and provided an opportunity for host countries to showcase major achievements for health.

The Chairperson of the SCRC subgroup on countries at the centre extended her gratitude to the Regional Director, the Division of Country Support and Communication, WHO representatives, country office staff and host governments, among others, for their invaluable contributions to the visits conducted by members of the SCRC and European members of the Executive Board. It had been inspiring to see how decisions taken by WHO governing bodies were put into practice on the ground. The leadership and coordinating role of country offices and the extent of their involvement with and knowledge of national institutions, civil society, partners and other actors had been particularly impressive. Country office staff had readily responded to even the most difficult questions posed by the visitors. Although country offices were a model of efficiency, there were limitations and investment in staff would be necessary in some cases. The participation of national staff was a key component of an office's ability to take account of country context. Those specific needs should be reflected in GPW 13. Considering the large number of dedicated people engaged in health work at country level, attainment of the SDGs was feasible.

In the ensuing discussion, participants expressed broad support for country visits, which were seen as a valuable tool for enhancing Member States' understanding of WHO's work at country level. They agreed that the practice should be maintained, expanded to a greater number of countries and exported to other regions. In addition to providing useful insights, the visits could serve to convey Member States' appreciation of their work to country office

staff, whose activities were one of the pillars of WHO's work. One representative commended the usefulness of country visits for host countries, as they served to raise awareness and enhance the visibility of health among a broad range of actors. Face-to-face engagement with WHO representatives at governing body meetings was also seen as a valuable tool. Several speakers referred to their countries' positive experiences with the WHO representative system. It was suggested that an evaluation of the WHO representative system, to look at issues such as language barriers to communication with local experts, might be useful.

With regard to the information contained in the report, a deeper analysis of challenges faced by country offices was deemed desirable. Given the increasing focus on country work under GPW 13, participants felt that the specific role and features of country offices should be well established and communicated in order to facilitate a better understanding of resource needs. Transparency and accountability for results achieved and resources used were considered fundamental. WHO country offices in the European Region were smaller and received fewer resources from the global budget than country offices in other regions. Although there were good reasons for this, the Region faced considerable health challenges and it was thus surprising to note that the high-level programme budget provided for 10% increases in all but the European Region. It would be useful to discuss those differences and the underlying reasons for them. A request was made for the preparation of a document on country offices' core functions, staffing, resources, relationship with authorities and collaboration with other United Nations agencies for submission to the Executive Board at its 144th session so as to enable the governing bodies to provide strategic guidance, in particular with regard to the proposed programme budget for 2020–2021. Participants encouraged the Regional Director to take that initiative forward to the global level. It was also suggested that the impact of United Nations reform on WHO's work in countries be discussed, as the concrete implications were unclear. Clear guidelines were needed on the way in which reform should be implemented.

GDOs carried out important work, which benefited not only the Region as a whole, but also the host country. The assistance provided by country offices in drafting and implementing national strategies, and in delivering direct assistance, was mentioned. Efforts to strengthen country offices and further discussion about the most effective way to do so were welcomed. Attention was drawn to the value of taking country-specific circumstances into account. The long-standing, valuable support the Regional Office had provided to the Member States in SEEHN was mentioned as a good example of fruitful collaboration. Intercountry cooperation at the regional level was perceived as creating unique opportunities for the Organization as a whole. Lastly, the Regional Committee was informed about the recent opening of a new country office in Athens, Greece, which would help intensify and build on existing relations with the Regional Office.

The Director, Country Support and Communication, said that the request for a clearer analysis of the challenges faced at country level would be taken on board. Regarding solutions that were tailor-made to country needs, she said that currently discussions were being held within the Regional Office, together with WHO representatives, on the implications of GPW 13 and ways in which WHO could become more fit for purpose while ensuring that the strategic direction of work led by the Regional Office was maintained. She welcomed recognition of the important role played by GDOs in supporting country work in cooperation with the country office, and thanked SEEHN Member States for their ongoing trust and good cooperation with WHO. She explained that the Regional Office was exploring options for further (human and financial) resource allocation to the country offices through various regional and global meetings of WHO representatives, as well as the impact of United Nations

reform on WHO country work. The presence of WHO representatives at governing body meetings allowed this discussion to take place directly with Member States. Extending her gratitude to host countries and WHO representatives for their valuable contributions to country visits, she said that the practice would be maintained.

The Regional Director said that it was encouraging to note Member States' support for engagement with WHO representatives during Regional Committee sessions. The Director-General had noted that regional practice with appreciation and had stated his intention to explore options for inviting WHO representatives to participate in meetings of the global governing bodies. Member States' support for WHO's work at country level and country visits was greatly appreciated. The suggestion to expand country visits, include other countries and export the practice to other regions, and to place WHO's country work on the agenda of the global governing bodies, would be given due consideration.

The European Region's business model was designed to accommodate a very large number of Member States with very few resources, taking an integrated approach to country work. The integrated model was more efficient and effective than building technical capacities in each country. GDOs played a crucial role in providing additional capacities and essential, issue-specific support. Despite that, capacities were insufficient to respond to all requests from Member States in a timely fashion. It was thus reasonable for Member States to expect further discussion on the reasons why the European Region received fewer funds from the programme budget than other regions, and to link the debate on country presence with deliberations on the programme budget in general. Options for tailoring country work to country- or region-specific priorities while keeping sight of the global context could also be discussed. The item would remain on the Regional Committee's agenda.

## **Proposed high-level programme budget 2020–2021 for Regional Committee consultations**

*(EUR/RC68/18)*

The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters, presented the principles underpinning the process for developing the proposed high-level programme budget 2020–2021, which was the first programme budget under GPW 13. Given the time frame for the approval of GPW 13 and the focus on bottom-up planning, the figures in the programme budget currently before the Regional Committee remained high-level, calculated on the basis of the strategic budget space allocation principles approved by member states. A detailed consultative process was underway with Member States to ensure that the finalized programme budget 2020–2021 would be driven by country priorities, in a bottom-up approach that would orient the work of the Organization at all three levels, including its normative function.

Prioritization would be based on outcomes, rather than programme areas, with resources concentrated at country level. Outputs had been developed, capturing the Secretariat's contribution to the outcomes and the achievement of the triple billion goal. A general understanding of the resources required to achieve the outputs at country level would be needed to cost the outcomes and the strategic priorities within the overall budget envelopes set by major offices. The draft programme budget would need to be prepared by mid-November 2018, in time for the Executive Board session in January 2019.

The base part of the global programme budget would increase by US\$ 469 million, as a consequence of the GPW 13 financial estimate, while the budget for the poliomyelitis eradication programme would decrease. More than half of the proposed base budget increase was thus related to sustaining core public health functions previously financed through the WHO polio programme, such as immunization and surveillance. The United Nations reform levy, through which the General Assembly of the United Nations had decided to strengthen the resident coordinator system in countries, would be financed through various means. As the details of the levy and the actual costs to WHO in that regard remained unknown, the worst-case scenario had been incorporated into the document presented to the Regional Committee.

Despite this increase in the overall budget, there would be no requests for an increase in assessed contributions. The Secretariat had committed to a US\$ 99 million efficiency and reallocation saving, which would be absorbed by WHO headquarters in order to preserve resources for country offices, whose share of the overall programme budget would increase from 38% to 42% in line with the GPW 13 country focus. It was hoped that the remainder of the overall budget increase could be met through voluntary contributions. Resource mobilization was being strengthened throughout the Organization as a key aspect of the transformation agenda. Although the programme budget as planned was ambitious, it was realistic; there were positive signs of new donors coming forward and the Organization was receiving more contributions earmarked at the higher level, which boded well for financing the proposed increase.

The Director, Programme Management, described the work done by the Regional Office to identify the European Region's bottom-up priorities for GPW 13 and the biennium 2020–2021, in consultation with WHO representatives and staff in countries with a country presence, and with national counterparts in countries with no WHO country office. Owing to the high-level cross-cutting nature of outcomes, “scopes” had been defined for each outcome to assist Member States in identifying priority thematic areas. A total of 35 Member States had defined their priorities. According to the information received thus far, universal health coverage appeared to be a common priority. Other priorities were promoting healthier populations, addressing health emergencies, and data and innovation.

Member States had been asked to rank outcomes as high, medium or low priority. Quality essential health services had been identified as the top priority outcome in most countries. Data collected on priorities would be analysed further, with country by country breakdowns, to assess which areas were deemed to be of highest priority. At the same time, the Secretariat was reviewing its cooperation with each country, assessing whether a country cooperation strategy or bilateral cooperative agreement was in place, and trying to anticipate the needs and requests of each Member State, also taking into consideration the global and regional public goods. The European business model had traditionally been based on the premise that the Region had a relatively small budget and a high number of Member States, and had therefore tended to keep the strongest technical capacity in the Regional Office, supported by GDOs in key priority areas, with relatively small country offices.

Under the renewed business model, every effort would be made to ensure the most effective delivery of results, making optimal use of the Regional Office's technical capacity, while also increasing technical capacity at country level. Consideration was being given to subregional cooperation, knowledge-sharing hubs and the coordination of integrated delivery to countries. In that regard, an increase of US\$ 60 to 80 million would be required in the European Region's budget envelope for the GPW 13 period. That increase would likely be incremental;

an increase of about US\$ 20 million for the next biennium, according to the strategic budget space allocation, would allow the Region to plan the expected delivery of its priorities.

Following the Regional Committee's discussions, the prioritization exercise would be completed, and country support planning would be rolled out to ensure that the programme budget 2020–2021 would be focused on country needs. The European budget would be developed for incorporation into the global consolidated proposed programme budget for the consideration of the Executive Board. Following the Executive Board's session in January 2019, any revisions would be included before the proposed programme budget was submitted to the World Health Assembly, after which operational planning for its implementation would begin.

In the discussion that followed, participants expressed concern regarding the ambitious increase in the global budget as presented and asked whether resource mobilization activities had resulted in a clear commitment to increase funds. The United Nations reform levy was expected to bring cost efficiencies at no expense to Member States. How would those efficiencies be achieved while increasing contributions to the resident coordinator programme?

The high-level format constituted a departure from the usual presentation of a proposed programme budget and revealed a disappointing lack of detail. The absence of precise information on the areas and activities on which funds would be spent made it difficult for Member States to provide substantial guidance. More information on the application of the strategic budget space allocation formula, and on how the European business model would be applied in conjunction with that formula, would be welcome. Clarification would also be appreciated on whether donors to the polio programme had indicated that they were willing to continue to provide funding for non-polio related activities.

Questions were raised as to why the Regional Office for Europe was the only regional office that would not receive a proportional increase in funding. Given the new operations model, a major shift of resources was foreseen from WHO headquarters to countries. That shift should be discussed thoroughly before being implemented. One representative, speaking on behalf of the European Union and its Member States, noted that given the major shift of resources from headquarters to countries foreseen in the budget, a new operating model would be needed in countries. The EU had frequently urged the Secretariat to bring the issue of WHO's role, function and operating model in countries to be debated in WHO's governing bodies at global level, and this should take place before major shifts were implemented. It would be interesting to know how country work would be increased in the many EU countries that did not have WHO country offices. Further information was also requested on how much information on country priorities remained outstanding, and on how flagship programme areas such as antimicrobial resistance and NCDs were reflected in the prioritization process. Participants particularly wished to know when the programme budget for 2020–2021 was expected to be fully funded, and how the increase in funding would be maintained into future bienniums.

The Director, Planning, Resource Coordination and Performance Monitoring, WHO headquarters, responding to the concerns raised, explained that fundamental timing challenges in preparing the programme budget needed to be overcome to allow time for the prioritization process. Currently, with only two months between the World Health Assembly and the start of the regional committees' schedule, time was limited, and the decision had therefore been taken to undertake consultations with Member States in time to prepare the bottom-up plan for the January session of the Executive Board, and to present high-level figures to the regional committees. A better solution must indeed be sought. It would be important to organize briefings and opportunities for discussion on the evolving draft prior to its

presentation to the Executive Board, to ensure that all Member States were well informed at all times.

While the United Nations reform levy would doubtless be cost neutral for the United Nations system as a whole, WHO would incur immediate, short-term costs. Member States had the right to know how much those costs would be and how they would be absorbed. The components of the overall increase in the programme budget had been assessed and a formula established for their distribution. Since half of the funds would come from current staffing and programmes related to poliomyelitis transition, those would not apply to the European Region. It was not the case that polio-related funds would be used for non-polio activities, but rather that essential public health functions previously under the aegis of the polio programme would need to be maintained in countries from which the programme was withdrawing. Those functions were essential and non-negotiable, and were therefore being included in the base programme. For country strengthening, the strategic budget space allocation formula for 2020–2021 had been applied. Flagship programmes would maintain their importance; while strategic priorities and outcomes were being broken down by output, flagship areas such as antimicrobial resistance and NCDs maintained their significance.

The increase in budget for the European Region, while perhaps not as much as Member States had expected, was sizeable. The increase was ambitious but the Organization must aim high. While mobilizing the funds would not be easy, the Secretariat was confident in its resource mobilization capacity and believed the ambitions to be realistic.

The Chef de Cabinet, Office of the Director-General added that GPW 13 was ambitious and transformation-centred. With that in mind, the programme budget should be built from country level upwards. Although timing issues for the preparation of such documents needed to be resolved, the country focus was the key to advancing health at the local level.

The Director, Programme Management, said that thus far 35 Member States in the European Region had finalized their priorities; 18 had yet to complete their prioritization. As soon as all Member States had reported, the information received would be analysed and reported back through the governing bodies. The European business model was not new: the Regional Office had long had mechanisms in place for working with individual countries, as well as various subregional networks to bring Member States together on areas of common interest. Consideration was being given to staffing arrangements and the distribution of technical expertise, including the possibility of establishing teams of technical experts to work across countries, which would have implications on how the regional budget envelope would be split up. Discussions were ongoing as to how the redistribution of funds from the polio programme would be organized, whether support and assets would be localized, and which functions would be resourced. Regarding cross-cutting issues such as antimicrobial resistance and NCDs, consideration was being given to an intercountry mode of work, which would bring multiple countries together to move the regional and global agendas forward. The Regional Office's budget for the period 2018–2019 was currently funded at 66%. Consideration was being given to how to ensure that the remaining outstanding funds would be delivered to the Region.

## Impact of WHO reform on the work of the WHO European Region

*(EUR/RC68/8(J), EUR/RC68/8(L), EUR/RC68/15)*

The Chef de Cabinet, Office of the Director-General updated participants on the intensive work done over the previous 12 months to begin transforming WHO into the organization that Member States wanted and the world needed. The goal of the transformation, as stated by the Director-General, was to make WHO a modern organization that worked seamlessly to make a measurable difference to people's health at country level. The transformation was grounded in the WHO Constitution, the SDGs and United Nations reform, and it drew on the lessons learned from work in WHO (and especially the Regional Office for Europe) in the previous decade. GPW 13, and in particular its triple billion goal, provided a clear purpose for the transformation and clearly articulated what the Organization was, what it would do, and how it would do it.

The process of transformation involved listening to Member States, staff and partners, and carrying out detailed process mapping and benchmarking with the support of global experts. The focus of attention would shift from outputs to results and impact. WHO headquarters should concentrate on its normative role, while the capacity of regional and country offices should be strengthened, in order to translate that normative work into country-level impact. Core administrative processes would be standardized, a culture of collaboration and high performance would be optimized, and the problem of earmarked, unpredictable and fragmented funding would be addressed.

By the end of 2018, it was expected that a full proposed programme budget 2020–2021 would have been drawn up using the Organization's new planning process; a number of other key business processes would have been enhanced or redesigned; work would be better aligned across the three levels of the Organization; and a new, WHO-wide external engagement model would be in place.

The Director, Programme Management said that in the European Region, the transformation built on "Better health for Europe" the programmatic manifesto of the then newly appointed Regional Director, which had been adopted by the Regional Committee in 2010 (resolution EUR/RC60/R2). Given its close compatibility with the global WHO transformation, "Better health for Europe" had been the Regional Office's springboard to the transformation agenda. The Regional Director was a member of the Global Policy Group, the regional transformation team was integrated into the global team, and senior staff (including WHO country representatives) were engaged in all work streams.

Key regional developments over the previous year had included the establishment of a regional coordination team and the appointment of senior technical officers and WHO representatives to all the workstreams of the transformation. The Regional Office had actively engaged with all Member States in the first planning exercise for the implementation of GPW 13. A retreat would be held for all European Region WHO representatives and heads of country offices after RC68 to discuss the transformation, with a focus on its implementation and implications at country level. Following up on the results of the global survey on organizational culture which had been carried out in October 2017, a European action plan would be developed by the end of 2018, aligned with current initiatives such as the Respectful Workplace initiative, and engaging relevant bodies such as the Staff Association. A European change network had also been established.

Through the SCRC and its successive working groups, the Region had been proactive in governance reform, focusing on: nomination procedures for membership of the Executive Board and SCRC; the procedure for nomination of the Regional Director; strengthened governance oversight by Member States; management of the agendas of sessions of the Region's governing bodies; management of resolutions and amendments; alignment of global and regional governance; and management of regional conferences.

In the ensuing discussion, participants welcomed the steps already taken to transform WHO following the adoption of GPW 13 and to ensure that it was a modern organization able to play a pivotal role in meeting future health challenges. The strong input by the Regional Director in the Global Policy Group was commended, as was the work done by the European Region and, in particular, the adoption of Health 2020, the European policy for health and well-being. Moves to develop action plans and working groups at the three levels of the Organization were welcomed.

Member States must be consulted on and involved in major decisions concerning the transformation plan, and notably in the further development of the proposed programme budget 2020–2021. The Organization's programme budgets should be based on realistic evaluation of Member States' resource mobilization capacities. It was a major challenge to place countries at the centre of WHO's work while sustaining its normative function. WHO's country presence should be strengthened through closer cooperation between WHO representatives and United Nations resident coordinators and better alignment with United Nations budget centres. The repercussions on WHO of reform of the United Nations system needed to be further discussed. WHO's central resource was its staff; employment practices should be in line with best practice (gender parity, teleworking, flexible working hours, etc.).

Emphasis was placed on the Executive Board's responsibility to carry forward governance reform, reducing the agendas of sessions of the Organization's governing bodies, adopting a more disciplined approach to resolutions, and ensuring alignment with United Nations reform initiatives. The SCRC could serve as a model in that regard.

Responding to the comments made, the Director-General affirmed that WHO reform was being undertaken with a purpose, namely to help attain the SDGs. The transformation needed to be aligned with United Nations reform; the "One UN Family" approach was essential for the people whom the Organization served. With regard to management tools, WHO had mapped existing processes and benchmarked with successful organizations, to match best performances. Various consulting companies had been brought in, and support had been secured from experts within and outside the Organization. Further consultations would be held with Member States to ensure their ownership of the transformation. On partnerships, WHO should move from a stance of risk aversion to risk management. The Framework for Engagement with Non-State Actors was intended to help manage conflicts of interest.

The Organization's normative functions only made sense when carried out at country level; there was accordingly a need to strengthen WHO's country offices. The aim was to create an agile and modern organization that was fit for purpose. The transformation of the Organization should bring deep changes to WHO's culture and mind set. Saving lives was the justification for that transformation.



## **Accreditation of regional non-State actors to the WHO Regional Committee for Europe**

*(EUR/RC68/13, EUR/RC68/Conf.Doc./9)*

The Committee approved the list of 19 regional non-State actors which had applied for accreditation to attend its meetings, in accordance with the procedure it had agreed at its 67th session.

A statement was made by a representative of the European Public Health Association on behalf of the 19 non-State actors in question, supported by a further 11 non-State actors in official relations with WHO. A statement was also made by a representative of the International Federation of Medical Students' Associations.

The Committee adopted decision EUR/RC68(2).

## **Progress reports**

### **Category 1 (Communicable diseases) and Category 5 (Preparedness, surveillance and response)**

*(EUR/RC68/8(A), EUR/RC68/8(I))*

Representatives expressed their appreciation for the Secretariat's effort and the concise, yet comprehensive midterm progress report on implementation of the Tuberculosis Action Plan for the WHO European Region. They drew attention to the serious threats posed to public health by TB and its drug-resistant forms; a number of Member States had provided additional funding to tackle them. The world was going through a critical period in the fight against TB, which continued to kill more people each year than any other communicable disease. The representative of an eastern European Member State reported that his country was among the top five in the world in terms of the prevalence of multidrug-resistant TB (MDR-TB). Speakers called for research and development efforts for innovative diagnostics and treatments to be continued and stepped up. The extensive political commitment to be expressed in the political declaration from the high-level meeting of the United Nations General Assembly on the fight to end TB would potentially save millions of lives, and representatives called for finalization and implementation of the multisectoral accountability framework.

The global action plan on antimicrobial resistance should be implemented at European level, in cooperation with the Food and Agriculture Organization of the United Nations and the World Organisation for Animal Health. Speakers commended the support provided by the Regional Office to Member States in developing national plans to tackle antimicrobial resistance but would appreciate an analysis of the outcomes of regional activities: a follow-up paper would be useful, with details of how the Regional Office would coordinate with the European Commission in order to avoid duplication.

Responding to the comments made, the Director, Programme Management, assured participants that the activities at European level were in line with the implementation of the global action plan. There was good collaboration between the regional offices of the international organizations, as well as with the European Commission and its technical agencies. WHO welcomed the suggestion to carry out an analysis of the outcome of regional

activities, in collaboration with the technical agencies of the European Commission, to ensure a region-wide overview.

A statement was made by a representative of the European Medical Students' Association. Written statements were submitted by the International Council of Nurses and the Standing Committee of European Doctors.

## **Category 2 (Noncommunicable diseases)**

*(EUR/RC68/8(B), EUR/RC68/8(C), EUR/RC68/8(D), EUR/RC68/8(E))*

Representatives welcomed the action taken by the Regional Office to promote physical activity among older people but called for more specific information on systematic activities and measures undertaken to implement the Physical activity strategy for the WHO European Region 2016–2025 during the reporting period. One speaker drew attention to the work done in that area and the support provided by the WHO European Office for the Prevention and Control of Noncommunicable Diseases in Moscow, Russian Federation, the WHO Country Office and the Ministry of Health of the Member State hosting that Office. The Global action plan on physical activity 2018–2030 was also welcomed. Another representative reported on the multisectoral approach that had been used to draw up national strategies, action plans and targets on physical activity, sport, cycling and walking, and called on the Regional Office to provide further support for effective coordination mechanisms.

One representative commended article 5.3 of the Framework Convention on Tobacco Control as an important element for tobacco policy but expressed serious concern about the method for measurement of tar, nicotine and carbon monoxide (TNCO) in cigarettes prescribed by ISO and used in the EU Tobacco Products Directive (2001/37/EC). Recent research showed that measurements obtained using the ISO method did not provide an accurate picture of the amount of TNCO that smokers actually inhaled. WHO was called on to take action in that regard.

Statements were made by representatives of the International Alliance of Patients' Organizations, the International Pharmaceutical Students' Federation, the World Federation of Societies of Anaesthesiologists and the International Association for Hospice and Palliative Care. Written statements were submitted by the Thalassaemia International Federation and jointly by the European Academy of Neurology, the European Stroke Organization, the World Federation of Neurology and the World Stroke Organization.

## **Category 3 (Promoting health through the life course)**

*(EUR/RC68/8(F), EUR/RC68/8(G))*

One representative expressed support for the European Child Maltreatment Prevention Action Plan 2015–2020 and described how her country's quality-setting body had been requested to develop guidelines for professionals working in that area. Another noted that his country had been a pathfinder in the Global Partnership to End Violence against Children and, in February 2018, had hosted the 2030 Agenda for Children: End Violence Solutions Summit, the main session of which had been devoted to INSPIRE, the seven strategies that together provided a framework for ending violence against children. A third recalled that her country had hosted the Nordic/Baltic Workshop on Child Maltreatment Prevention in June 2017 and, with technical assistance from WHO, was developing national guidelines on the health sector's role in that area.

Another speaker recalled the adoption of the Ostrava Declaration at the Sixth Ministerial Conference on Environment and Health and called on WHO to create a template for national portfolios for action and other standardized tools. In addition, it would be useful if WHO could establish an electronic discussion platform for exchange of views and communication with the Secretariat.

The representative of IOM expressed satisfaction that work in the health policy sector was well integrated in global migration discussions, including in the global compact for safe, regular and orderly migration that would be adopted by Member States in Marrakech, Morocco, in December 2018. The compact addressed the health needs of migrants, taking into consideration the relevant recommendations of the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants. IOM was piloting an initiative in six EU member countries to roll out an electronic personal health record system for mobile populations and had increased its training and capacity-building activities.

A statement was made by the International Association for Hospice and Palliative Care. A written statement was submitted by the World Heart Federation.

#### **Category 4 (Health systems)**

*(EUR/RC68/8(H))*

Written statements were submitted by the European Public Health Association and the Thalassaemia International Federation.

#### **Category 6 (Corporate services and enabling functions)**

One representative requested further information on the key systematic issues identified by internal and external audits. He also wished to know whether there were sufficient resources to carry out work on accountability, risk management and compliance, and asked for further details of the Respectful Workplace initiative.

The Director, Administration and Finance, said that she appreciated the comment and provided an update on the activities conducted with regard to the Respectful Workplace initiative, and mentioned that more details would be included in the next report.

#### **Cross-cutting**

The Director, Information, Evidence, Research and Innovation said that the comments made by participants throughout the session were testament to the increasing role of data in informing health policy. Every effort would be made to expand the health information gateway even further, in particular with the introduction of the joint monitoring framework. She looked forward to further collaboration with Member States in that regard.

## **Elections and nominations**

*(EUR/RC68/7, EUR/RC68/Inf.Doc./2, EUR/RC68/Conf.Doc./4)*

### **Executive Board**

The Committee decided that Austria and Tajikistan would put forward their candidatures to the Seventy-second World Health Assembly in May 2019 for subsequent election to the Executive Board.

### **Standing Committee of the Regional Committee**

The Committee selected Croatia, Poland, the Republic of Moldova and the Russian Federation for membership of the SCRC for a three-year term of office from September 2018 to September 2021.

### **Regional Evaluation Group**

The Committee adopted resolution EUR/RC68/R5, by which it elected Estonia, Germany, Kazakhstan, the Netherlands, Slovakia and Slovenia as members of the Regional Evaluation Group to make a preliminary evaluation of candidates for nomination as Regional Director.

### **Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases**

In accordance with paragraph 2.2.2 of the Memorandum of Understanding on the Special Programme for Research and Training in Tropical Diseases, the Regional Committee selected Georgia for membership of the Joint Coordinating Board of the Special Programme for a four-year period from 1 January 2019.

### **Confirmation of dates and places of regular sessions of the Regional Committee**

*(EUR/RC68/Conf.Doc./3 Rev.1)*

The Committee adopted resolution EUR/RC68/R8, by which it reconfirmed that its 69th session would be held in Copenhagen, Denmark, from 16 to 19 September 2019, and decided that the 70th session would be held in Tel Aviv, Israel, from 14 to 17 September 2020, and that the 71st session would be held in Copenhagen, Denmark, from 13 to 16 September 2021.

The representative of Israel said that her Government looked forward to welcoming the Committee in 2020.

### **Closure of the session**

The representative of one Member State, speaking on behalf of all those present, expressed deep appreciation to the Prime Minister and Government of Italy for hosting the session, to the Regional Director and staff of WHO and the Ministry of Health of Italy for a well prepared and well run meeting, to the officers of the session and the Regional Director for

guiding the Regional Committee with patience and wisdom, and to representatives of Member States, partner organizations and civil society for their participation.

The Healthy RC68 initiative was commended, as were the “activation sessions”, which had been held each afternoon. Thanks were expressed to the host country for the hospitality extended to participants and the memorable evening programmes that had been organized, with receptions held in breathtaking palaces in the eternal and irresistible city of Rome.

## Resolutions

### **EUR/RC68/R1. Report of the Regional Director on the work of WHO in the European Region in 2016–2017**

The Regional Committee,

Having reviewed the Regional Director's report on the work of WHO in the European Region in 2016–2017<sup>1</sup> and the overview of implementation of the 2016–2017 programme budget;<sup>2</sup>

1. THANKS the Regional Director for these reports;
2. EXPRESSES its appreciation for the work done by the Regional Office in the 2016–2017 biennium;
3. REQUESTS the Regional Director to take into account and reflect the suggestions made during the discussions at the 68th session of the Regional Committee when developing the Organization's programmes and carrying out the work of the Regional Office.

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<sup>1</sup> Document EUR/RC68/5 Rev.1.

<sup>2</sup> Document EUR/RC68/Inf.Doc./5.

### **EUR/RC68/R2. Report of the Twenty-fifth Standing Committee of the Regional Committee**

The Regional Committee,

Having reviewed the report of the Twenty-fifth Standing Committee of the Regional Committee;<sup>1</sup>

1. THANKS the Chairperson and the members of the Standing Committee for their work on behalf of the Regional Committee;
2. INVITES the Standing Committee to pursue its work on the basis of the discussions held and resolutions and decisions adopted by the Regional Committee at its 68th session;
3. REQUESTS the Regional Director to take action, as appropriate, on the conclusions and proposals contained in the report of the Standing Committee, taking fully into account the proposals and suggestions made by the Regional Committee at its 68th session, as recorded in the report of the session.

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<sup>1</sup> Documents EUR/RC68/4 Rev.4 and EUR/RC68/4 Rev.4 Add.1.

## **EUR/RC68/R3. Reaffirming commitment to health systems strengthening for universal health coverage, better outcomes and reduced health inequalities**

The Regional Committee,

Recalling the adoption of Transforming our world: the 2030 Agenda for Sustainable Development,<sup>1</sup>

Recalling its resolution EUR/RC62/R4 by which it adopted Health 2020, the European policy framework for health and well-being, which supports action across government and society for health and well-being, with health systems strengthening as a central pillar embedded in a whole-of-government and intersectoral approach for better and more equitable health outcomes;

Recalling the commitments of the Ljubljana Charter on Reforming Health Care in Europe (1996) and the Tallinn Charter: Health Systems for Health and Wealth (2008);

Recalling resolution EUR/RC65/R5, welcoming Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness and resolution EUR/RC66/R11 on an action plan for the prevention and control of noncommunicable diseases in the WHO European Region;

Having considered the outcome statement of the WHO high-level regional meeting, Health Systems Respond to NCDs: Experience in the European Region, held in Sitges, Spain, in April 2018, on accelerating implementation of an equity-oriented, comprehensive and aligned health systems response to reduce the burden of noncommunicable diseases, aiming not only to reach but to exceed global targets;

Having considered the outcome statement of the WHO high-level regional meeting, Health Systems for Prosperity and Solidarity: Leaving No One Behind, held in Tallinn, Estonia, in June 2018, on the importance of inclusion, investment and innovation as essential engines of health system transformation for universal health coverage, better health outcomes and greater health equity;

Understanding that this resolution does not replace any previous Regional Committee resolutions;

1. TAKES NOTE, with appreciation, of the outcome statements of the two WHO high-level meetings on health systems held in Sitges, Spain, and Tallinn, Estonia;
2. EXPRESSES its continued commitment to the values of solidarity, equity, and participation enshrined in the Tallinn Charter and Health 2020 as foundations for health systems strengthening and its commitment to achieving universal health coverage and with particular reference to Sustainable Development Goal target 3.8: achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all;

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<sup>1</sup> United Nations General Assembly resolution 70/1.

3. URGES Member States:

- (a) to prioritize and to adequately resource a comprehensive and integrated health system response to address Europe's main sources of ill health;
- (b) to ensure a strong focus on equity, gender equality and solidarity in health systems strengthening to provide quality health care and improve outcomes for all people, especially those with greater health and socioeconomic needs, as well as the elderly with multiple chronic diseases balancing universal policies with contextualized and targeted approaches in all sectors of governance, and connecting global, national, regional and local responses to promote equitable health care;
- (c) to promote gender equal health systems through systematic gender mainstreaming, including sex-disaggregated data, data analysis and interventions;
- (d) to increase investment in health and to direct more sustainable financial resources to primary health care and public health to achieve universal health coverage, to seek and harness efficiency gains, and to strengthen capacities for a more effective fiscal dialogue;
- (e) to support systematic monitoring of financial protection and unmet need for health services, to support the assessment and equity impact of policy changes and to improve access and financial protection for everyone, recognizing that excessive out-of-pocket payments for outpatient services and medicines can be a significant source of financial hardship in many countries in the Region;
- (f) to prioritize sectoral and intersectoral public health action and primary health care with a focus on disease prevention and health promotion that is continuous, comprehensive, coordinated, community-oriented and people-centred, as the most efficient and equitable mechanisms for addressing the main disease burden in Europe, including the scale-up of the best buys for NCDs and to strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries as appropriate;
- (g) to invest in the health workforce, ensuring a skill mix and competencies fit for the future, and integrated service delivery models centred around people and their needs as well as taking advantage of digital solutions, and to promote management practices that ensure decent work including adequate compensation, meaningful opportunities to exercise the trained skills, for professional development and career progression;
- (h) to achieve integrated people-centred health services, putting the comprehensive needs of people and communities, not only diseases, at the centre of health systems, and empowering people to have a more active role in their own health (WHO Framework on integrated people-centred health services);
- (i) to support policy and research and harness innovations to ensure that health systems have up-to-date information systems, services and technologies to meet people's needs, and that health policy-making is transparent and is informed by the best available evidence;



4. REQUESTS the Regional Director:

- (a) to continue to provide leadership on health systems with a special focus on health promotion and disease prevention, primary health care and integrated care strengthening in collaboration with relevant partners, and advocate for adequate investments;
- (b) to support Member States, including by facilitating partnerships, in operationalizing equity-oriented and comprehensive health systems strengthening with universal access for improved health outcomes;
- (c) to continue to create opportunities for regional exchange and sharing of good practices on health promotion and disease prevention, inclusion, investment and innovation in health systems, to promote access to affordable, preventative and curative health care of good quality;
- (d) to channel the results of the two high-level regional meetings to the United Nations high-level meetings on noncommunicable diseases in 2018 and on universal health coverage in 2019;
- (e) to report to the Regional Committee on progress made in 2023.

#### **EUR/RC68/R4. Strategy on the health and well-being of men in the WHO European Region**

The Regional Committee,

Having reviewed the strategy on the health and well-being of men in the WHO European Region<sup>1</sup> and the evidence and priorities it puts forward on men's health and well-being throughout the life course;

Recalling resolution EUR/RC62/R4 on Health 2020 – the European policy framework for health and well-being, supporting action for more equitable health, and the transformative nature of the 2030 Agenda for Sustainable Development;

Recalling resolution WHA60.25 on the strategy for integrating gender analysis and actions into the work of WHO;

Recalling resolution WHA66.10, endorsing a global action plan for the prevention and control of noncommunicable diseases, and resolution EUR/RC66/R11 on an action plan for the prevention and control of noncommunicable diseases in the WHO European Region;

Recalling the Minsk Declaration on the Life-course Approach in the Context of Health 2020 and the commitments made in resolution EUR/RC66/R3;

Keeping in mind the Strategy on Women's Health and Well-being in the WHO European Region,<sup>2</sup> adopted by the Regional Committee in resolution EUR/RC66/R8;

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<sup>1</sup> Document EUR/RC68/12.

<sup>2</sup> Document EUR/RC66/14.

Recalling the Beijing Platform for Action, which acknowledges that gender equality is a goal for the whole of society, that men's engagement is essential for achieving this goal, and that gender equality is positive for men's and women's health;

Understanding that this resolution does not replace any existing Regional Committee resolutions;

1. ADOPTS the strategy on the health and well-being of men in the WHO European Region;
2. URGES Member States:<sup>3</sup>
  - (a) to use a gender approach in health policies and strategies to advance the physical and mental health and well-being of men at the local, subnational and national levels; and to promote gender equality policies that strengthen the participation of men alongside women in promotion and prevention activities;
  - (b) to prioritize interventions addressing gender and socioeconomic determinants with an impact on men's high exposure to health risk and poor health outcomes, taking a life-course approach;
  - (c) to improve health system capacity and responses to ensure that services are accessible to men across their life course, while facilitating men's engagement in their own health and the health of others;
  - (d) to strengthen the collection and disaggregation of data and gender analysis and research relevant to men's and women's health and well-being;
  - (e) to facilitate the development of intersectoral collaboration and platforms to tackle the impact of gender and social, economic, cultural and environmental determinants of men's and women's health and well-being;
3. REQUESTS the Regional Director:
  - (a) to support Member States in implementing the actions identified in the strategy on the health and well-being of men in the WHO European Region, alongside those identified in the Strategy on Women's Health and Well-being in the WHO European Region, including the development of tools and resources that support implementation;
  - (b) to continue to provide leadership on using a gender approach to improve men's health across their life course while supporting gender equality goals;
  - (c) to identify and facilitate the exchange of good practices and experiences among Member States on policies and actions that address men's health from a gender perspective;
  - (d) to pursue the objectives of the strategy in partnerships with international, intergovernmental and nongovernmental organizations working on gender and men's health and well-being;<sup>4</sup>

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<sup>3</sup> And regional economic integration organizations as appropriate.

<sup>4</sup> And regional economic integration organizations as appropriate.

- (e) to monitor progress towards improved men's health and well-being in the European Region on the basis of already existing monitoring and accountability systems;
- (f) to report to the Regional Committee in 2020 and 2023 jointly on progress made with regard to this resolution and resolution EUR/RC66/R8.

## **EUR/RC68/R5. Appointment of a Regional Evaluation Group**

The Regional Committee,

Pursuant to Rule 47 of its Rules of Procedure;

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

Dr Maris Jesse (Estonia)

Mr Thomas Ifland (Germany)

Dr Valikhan Isayevich Akhmetov (Kazakhstan)

Mr Herbert Barnard (Netherlands)

Dr Mário Mikloši (Slovakia)

Dr Vesna-Kerstin Petrič (Slovenia);

2. REQUESTS the Regional Evaluation Group to carry out its work taking into consideration the principles contained in the Code of Conduct for the Nomination of the Regional Director of the European Region of the World Health Organization and in compliance with the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe, and other criteria laid down in document EUR/RC68/Inf.Doc./2, with the aim of reporting on its work to the Regional Committee at its 69th session.

## **EUR/RC68/R6. Advancing public health for sustainable development in the WHO European Region**

The Regional Committee,

Recalling resolution EUR/RC62/R4, adopting Health 2020, the European policy framework for health and well-being, which supports action across government and society and provides a shared vision, set of principles and approach to health as a human right;

Recalling resolution EUR/RC62/R5, endorsing the European Action Plan for Strengthening Public Health Capacities and Services<sup>1</sup> as a necessary component of health improvement in the WHO European Region;

Recalling the adoption of Transforming our world: the 2030 Agenda for Sustainable Development,<sup>2</sup> which established the Sustainable Development Goals (SDGs), and the targets under SDG 3 and other targets tackling the broader determinants of health, and resolution

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<sup>1</sup> Document EUR/RC62/12 Rev.1.

<sup>2</sup> United Nations General Assembly resolution 70/1.

EUR/RC67/R3, adopting the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy framework for health and well-being;

Recalling World Health Assembly resolution WHA69.1 on Strengthening essential public health functions in support of the achievement of universal health coverage;

Committed to the implementation of WHO's Thirteenth General Programme of Work, 2019–2023,<sup>3</sup> achievement of which will greatly depend on a stronger public health capacity to effectively address the determinants of health across sectoral boundaries;

Commending the leading role and commitment of the WHO European Region's Member States in advancing the public health agenda for sustainable development;

Acknowledging that public health interventions can be cost-saving and that high returns for health and sustainable development can be achieved through investing in public health policies and actions across the Region that take into account specific national contexts, provide greater coherence across national policies with impact on public health, and mainstream public health across all policies and levels of government;

Having considered document EUR/RC68/17 on Advancing public health for sustainable development in the WHO European Region, and its values, principles and call for action;

1. ENDORSES document EUR/RC68/17 on Advancing public health for sustainable development in the WHO European Region, with its vision, ethical values, principles and framework for action;
2. URGES Member States,<sup>4</sup> as a contribution to the 2030 Agenda for Sustainable Development:
  - (a) to reaffirm their political commitment to providing leadership and efficient governance for the development of strong, well-resourced and fit-for-purpose public health systems, including the institutional bases and adequate human resources and capacities;
  - (b) to develop or strengthen coherent national public health strategies and policies, aligned with national policies for implementation of the SDGs, addressing the determinants of health across all policy sectors and inequalities in health, particularly in vulnerable groups, following gender-sensitive and participatory approaches;
  - (c) to review the institutional frameworks for public health action, and provide the necessary resources to strengthen the capacity building for public health professionals and other actors, within health systems and across other relevant sectors;

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<sup>3</sup> Document A71/4.

<sup>4</sup> And regional economic integration organizations, where applicable.

- (d) to establish or strengthen effective intersectoral mechanisms for addressing all health determinants, particularly the environmental, social, economic, cultural, commercial and behavioural determinants, across policy sectors and levels of government, including by exploring common interests across public policies, as well as common threats to a sustainable future;
  - (e) to establish or strengthen broad partnerships to effectively engage with all relevant sectors, civil society, local actors and stakeholders, including the general public where appropriate and the private sector, recognizing and addressing possible conflicts of interest, and empowering communities to take effective actions to protect and promote health;
  - (f) to ensure adequate investments in public health policies and interventions, with particular emphasis on evidence-informed and cost-effective public policy approaches;
  - (g) to support and strengthen institutional capacities for the generation of evidence, health data, information, tools and methods to support evidence-informed policy-making and decision-making, implementation and monitoring of results with a focus on translation from evidence to policy practice;
  - (h) to invest in training and continuous development of human resources for public health to create a fit-for-purpose health workforce with the necessary core public health capacities and further attributes (in areas such as policy, political and strategic analysis, capacity to undertake health and health equity impact assessment, political astuteness, and influencing and negotiating skills), both within health systems and across other relevant policy sectors;
  - (i) to empower people to make healthy decisions for themselves and their families, by ensuring access to knowledge, promoting health literacy, social values and resources, and providing health-conducive environments that facilitate healthy choices;
  - (j) to work in collaboration with international, intergovernmental and nongovernmental organizations, including United Nations agencies, user associations, family associations and professional associations, to support the implementation of this resolution
3. REQUESTS the Regional Director:
- (a) to continue providing leadership and advocacy for effective public health policies and strategies for health and well-being in the context of sustainable development;
  - (b) to continue advocating and supporting strong governance for public health within health systems and across sectoral policies to attain a high level of health protection in all policies, universal health coverage and sustainable development;
  - (c) to support national action, on request, through the provision of technical assistance and advice, the production of evidence, tools and guidelines, and the collection and dissemination of good practices;
  - (d) to continue engaging in cooperation with United Nations agencies and other organizations and relevant stakeholders, promoting intersectoral and interagency action for health and well-being through relevant intersectoral mechanisms and platforms;

- (e) to support national and local action by leveraging existing regional platforms and networks in order to share information and best practices and address issues of common interest through collaborations and partnerships;
- (f) to report on the implementation of this resolution to the Regional Committee in 2023, using existing regional monitoring mechanisms.

## **EUR/RC68/R7. Action plan to improve public health preparedness and response in the WHO European Region**

The Regional Committee,

Reaffirming the commitment of States Parties, as expressed in the adoption of the International Health Regulations (IHR) (2005), to develop, strengthen and maintain the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern;

Recalling World Health Assembly decision WHA69(14), in which the Director-General was requested to develop for consideration of the regional committees in 2016 a draft global implementation plan for the recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, including immediate planning to improve delivery of the IHR (2005);

Further recalling World Health Assembly decision WHA70(11), which noted the global implementation plan and requested the Director-General to develop a draft five-year global strategic plan in full consultation with Member States, including through the regional committees;

Building on World Health Assembly decision WHA71(15) that welcomed with appreciation the global strategic plan to improve public health preparedness and response;

Recalling Regional Committee resolution EUR/RC59/R5, in which Member States reaffirmed their commitment to the implementation of the IHR (2005) and the development and/or maintenance of the core capacities, and noting the progress made in implementing the Regulations, as specified in the progress reports submitted to the regional committees in 2013, 2015 and 2017;

Reconfirming that Member States of the WHO European Region agreed that the development of the regional action plan is to be aligned with the global strategic plan;

Recognizing that adequate protection against health threats requires high-level political and financial commitment to address the full cycle of emergency management, including prevention, preparedness, response and recovery, supported by multisectoral engagement, and as appropriate whole-of-society approaches and effective partnerships;

Recognizing the existence of regional legislation, instruments and measures to combat health threats and the importance of continued cooperation with regional economic integration organizations in this regard;

Having considered the draft action plan to improve public health preparedness and response in WHO European Region;<sup>1</sup>

1. WELCOMES with appreciation the action plan to improve public health preparedness and response in the WHO European Region;
2. URGES Member States:<sup>2</sup>
  - (a) to mobilize and sustain political and financial commitments to the development and strengthening of core capacities under the IHR (2005);
  - (b) to strengthen or maintain their capacities, including those of the national IHR focal points, to fulfil obligations and requirements under the Regulations to detect, assess, notify and report, and respond to public health risks and events with the potential for international spread in alignment with their obligations under regional economic integration organization frameworks;
  - (c) to commit to and take proactive multisectoral action in the implementation of the regional action plan, recognizing the importance of a multisectoral approach in improving preparedness for and response to emergencies;
  - (d) to identify and strengthen synergies between the health system and essential public health functions and IHR (2005) implementation;
  - (e) to undertake systematic and repeated assessments of national capacities in order to monitor progress, identify gaps and prioritize actions according to IHR;
3. REQUESTS the Regional Director:
  - (a) to provide upon request of Member States and being mindful of national as well as of regional economic integration organization legislation, instruments and measures in this regard, the technical support for the implementation of the regional action plan, including monitoring and assessment according to IHR (2005) and, when specified by a Member State, measures to build, maintain and strengthen core capacities under IHR (2005);
  - (b) to advocate for, engage and mobilize resources for the implementation of the regional action plan, including working with and through partnerships with relevant stakeholders, civil society and community organizations, in line with FENSA;
  - (c) to strengthen and maintain the functions and capacities of the Secretariat for event management, as outlined in the regional action plan;
  - (d) to facilitate the exchange of experience and best practices among States Parties, including the sharing of lessons learned in the implementation and application of the IHR (2005);
  - (e) to monitor and evaluate regional progress annually to enable rapid monitoring of progress towards the establishment of the IHR (2005) core capacities in the Region;
  - (f) to report on progress on the implementation of the regional action plan at the 71st session of the Regional Committee in 2021.

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<sup>1</sup> Document EUR/RC68/14.

<sup>2</sup> And, where applicable, regional economic integration organizations.

## **EUR/RC68/R8. Dates and places of regular sessions of the Regional Committee for Europe in 2019–2021**

The Regional Committee,

Recalling resolution EUR/RC67/R8 adopted at its 67th session;

1. RECONFIRMS that the 69th session shall be held in Copenhagen, Denmark, from 16 to 19 September 2019;
2. DECIDES that the 70th session shall be held in Tel Aviv, Israel, from 14 to 17 September 2020;
3. DECIDES that the 71st session shall be held in Copenhagen, Denmark, from 13 to 16 September 2021.

## **Decisions**

### **EUR/RC68(1). Joint monitoring framework in the context of the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being**

The Regional Committee,

Having considered document EUR/RC68/10 Rev.1, which contains the set of indicators proposed for the joint monitoring framework (JMF) for the Sustainable Development Goals (SDGs), Health 2020 and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, following consultation with Member States;

1. DECIDES to adopt the set of indicators proposed in document EUR/RC68/10 Rev.1 for the JMF for the SDGs, Health 2020 and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, which is based on the indicators already adopted for each of the three frameworks and is aligned with the Thirteenth General Programme of Work, and to report regularly to the WHO Regional Office for Europe on the indicators of the JMF;
2. AGREES that the WHO Regional Office for Europe should implement the proposed monitoring framework, as outlined in document EUR/RC68/10 Rev.1, by collecting, analysing and regularly publishing information on progress made on the common set of indicators in its regular publications.



## **EUR/RC68(2). Engagement with non-State actors: accreditation of regional non-State actors not in official relations with WHO to attend meetings of the WHO Regional Committee for Europe**

The Regional Committee,

Having examined the report on accreditation of regional non-State actors not in official relations with WHO to attend meetings of the WHO Regional Committee for Europe;<sup>1</sup>

DECIDES, in line with the Framework of Engagement with Non-State Actors,<sup>2</sup> to grant accreditation status to the following non-State actors:

- Alzheimer Europe
- Association for Medical Education in Europe
- Center for Health Policies and Studies (PAS Center)
- Centre for Regional Policy Research and Cooperation “Studiorum”
- Eurocare (European Alcohol Policy Alliance)
- EuroHealthNet
- European Association for the Study of the Liver
- European Cancer Organisation
- European Federation of Allergy and Airways Diseases Patients’ Associations
- European Federation of the Associations of Dietitians
- European Forum for Primary Care
- European Forum of Medical Associations
- European Forum of National Nursing and Midwifery Associations
- European Medical Students’ Association
- European Public Health Alliance
- European Public Health Association
- Health Care Without Harm
- Standing Committee of European Doctors
- Wemos.

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<sup>1</sup> Document EUR/RC68/13.

<sup>2</sup> As contained in the Annex to resolution WHA69.10 (2016).

## **Annex 1. Agenda**

### **1. Opening of the session**

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

### **2. Addresses**

- (a) Address by the Regional Director and report on the work of the Regional Office since the 67th session of the WHO Regional Committee for Europe
- (b) Address by the Director-General
- (c) Keynote speech by Her Royal Highness The Crown Princess of Denmark

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

### **4. Report of the Twenty-fifth Standing Committee of the Regional Committee for Europe**

### **5. Policy and technical topics**

- (a) Launch of the *European health report 2018*
- (b) Implementation of the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy framework for health and well-being, and review of the joint monitoring framework
- (c) Advancing public health in the WHO European Region for sustainable development
- (d) Can people afford to pay for health care? New evidence on financial protection in Europe
- (e) Report on the WHO high-level meeting, Health Systems Respond to NCDs: Experience in the European Region (Sitges, Spain, 16–18 April 2018)
- (f) Action plan to improve public health preparedness and response in the WHO European Region
- (g) Strategy on the health and well-being of men in the WHO European Region
- (h) Implementation of the Regional Framework for Surveillance and Control of Invasive Mosquito Vectors and Re-emerging Vector-borne Diseases 2014–2020: lessons learned and the way forward
- (i) Vaccine-preventable diseases and immunization: realizing the full potential of the European Vaccine Action Plan 2015–2020
- (j) Report on the WHO high-level meeting, Health Systems for Prosperity and Solidarity: Leaving No One Behind (Tallinn, Estonia, 13–14 June 2018)
- (k) Countries at the centre: the strategic role of country offices in the WHO European Region

- (l) Proposed high-level programme budget 2020–2021 for Regional Committee consultations
- (m) Impact of WHO reform on the work of the WHO European Region
- (n) Accreditation of regional non-State actors to the WHO Regional Committee for Europe
- (o) Progress reports

Category 1: Communicable diseases

- Tuberculosis Action Plan for the WHO European Region 2016–2020 (resolution EUR/RC65/R6)

Category 2: Noncommunicable diseases

- Physical Activity Strategy for the WHO European Region 2016–2025 (resolution EUR/RC65/R3)
- Roadmap of actions to strengthen the implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025 (resolution EUR/RC65/R4)
- Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region (resolution EUR/RC66/R11)

Category 3: Promoting health through the life course

- Investing in Children: the European Child and Adolescent Health Strategy 2015–2020 and the European Child Maltreatment Prevention Action Plan 2015–2020 (resolution EUR/RC64/R6)
- Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region (resolution EUR/RC66/R6)
- Implementation of the European Environment and Health Process (resolution EUR/RC67/R4)

Category 4: Health systems

- Action Plan to Strengthen the Use of Evidence, Information and Research for Policy-Making in the WHO European Region (resolution EUR/RC66/R12)

Category 5: Preparedness, surveillance and response

- Implementation of the European Strategic Action Plan on Antibiotic Resistance (resolution EUR/RC61/R6)

Category 6: Corporate services and enabling functions

- Audit and compliance
- Work of the geographically dispersed offices (decisions EUR/RC63(1) and EUR/RC63(2) and resolution EUR/RC54/R6)
- Governance of the WHO Regional Office for Europe (resolution EUR/RC60/R3)

Cross-cutting

- Implementation of Health 2020, including indicators (resolution EUR/RC63/R3)

**6. Private meeting: elections and nominations**

- (a) Nomination of two members of the Executive Board
- (b) Election of four members of the Standing Committee of the Regional Committee
- (c) Election of six members of the Regional Evaluation Group
- (d) Nomination of one member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

**7. Confirmation of dates and places of regular sessions of the Regional Committee**

**8. Closure of the session**

**Technical briefings**

- Measuring health literacy in the European Region
- Healthy people through environmentally sustainable urban transport: towards the fifth High-level Meeting on Transport, Health and Environment
- The impact of health systems on global sustainability: current situation and expectations
- The upcoming WHO European Health Equity Status Report Initiative

**Ministerial lunches**

- Migration and health (including a short briefing on: emergency medical teams in the WHO European Region)
- Innovations in health information systems

## Annex 2. List of documents

### Working documents

EUR/RC68/1 Rev.3	Provisional list of documents
EUR/RC68/2 Rev.1	Provisional agenda
EUR/RC68/2 Rev.1 Add.1 Rev.1	Provisional agenda (annotated)
EUR/RC68/3 Rev.2	Provisional programme
EUR/RC68/4 Rev.4	Report of the Twenty-fifth Standing Committee of the Regional Committee for Europe
EUR/RC68/4 Rev.4 Add.1	Report of the Twenty-fifth Standing Committee of the Regional Committee for Europe: report of the fifth session
EUR/RC68/5 Rev.1	Leaving no one behind: report of the Regional Director on the work of WHO in the European Region in 2016–2017
EUR/RC68/6	Matters arising from resolutions and decisions of the World Health Assembly and the Executive Board
EUR/RC68/7	Membership of WHO bodies and committees
EUR/RC68/8(A)	Progress report on implementation of the Tuberculosis Action Plan for the WHO European Region 2016–2020
EUR/RC68/8(B)	Progress report on implementation of the Physical Activity Strategy for the WHO European Region 2016–2025
EUR/RC68/8(C)	Progress report on the Roadmap of actions to strengthen the implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025
EUR/RC68/8(D)	Progress report on implementation of the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025
EUR/RC68/8(E)	Progress reports on Investing in Children: the European Child and Adolescent Health Strategy 2015–2020 and the European Child Maltreatment Prevention Action Plan 2015–2020
EUR/RC68/8(F)	Progress report on implementation of the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region
EUR/RC68/8(G)	Progress report on implementation of the European Environment and Health Process

## Working documents

EUR/RC68/8(H)	Progress report on implementation of the Action Plan to Strengthen the Use of Evidence, Information and Research for Policy-making in the WHO European Region
EUR/RC68/8(I)	Progress report on implementation of the European Strategic Action Plan on Antibiotic Resistance
EUR/RC68/8(J)	Report on accountability and compliance of the WHO Regional Office for Europe
EUR/RC68/8(K)	Progress report on the work of the geographically dispersed offices of the WHO Regional Office for Europe
EUR/RC68/8(L)	Governance of the WHO Regional Office for Europe
EUR/RC68/8(M)	Progress report on indicators for Health 2020 targets
EUR/RC68/9	Vaccine-preventable diseases and immunization: realizing the full potential of the European Vaccine Action Plan 2015–2020
EUR/RC68/10 Rev.1	Briefing note on the expert group deliberations and recommended common set of indicators for a joint monitoring framework
EUR/RC68/11	Can people afford to pay for health care? New evidence on financial protection in Europe
EUR/RC68/12	Strategy on the health and well-being of men in the WHO European Region
EUR/RC68/12 Add.1	Financial and administrative implications for the Secretariat of the draft Regional Committee resolution on the strategy on the health and well-being of men in the WHO European Region
EUR/RC68/13	Engagement with non-State actors: accreditation of regional non-State actors not in official relations with WHO to attend meetings of the WHO Regional Committee for Europe
EUR/RC68/14	Action plan to improve public health preparedness and response in the WHO European Region
EUR/RC68/14 Add.1	Financial and administrative implications for the Secretariat of the draft Regional Committee resolution on the action plan to improve public health preparedness and response in the WHO European Region
EUR/RC68/15	WHO reform: new strategic vision and transformation plan

### **Working documents**

EUR/RC68/16	Implementation of the Regional Framework for Surveillance and Control of Invasive Mosquito Vectors and Re-emerging Vector-borne Diseases 2014–2020: lessons learned and the way forward
EUR/RC68/17	Advancing public health for sustainable development in the WHO European Region
EUR/RC68/17 Add.1	Financial and administrative implications for the Secretariat of the draft Regional Committee resolution on advancing public health for sustainable development in the WHO European Region
EUR/RC68/18	Proposed high-level programme budget 2020–2021 for Regional Committee consultations
EUR/RC68/19	Reaffirming commitment to health systems strengthening for universal health coverage, better outcomes and reduced health inequalities
EUR/RC68/19 Add.1	Financial and administrative implications for the Secretariat of the draft Regional Committee resolution on reaffirming commitment to health systems strengthening for universal health coverage, better outcomes and reduced health inequalities

### **Draft resolutions and decisions**

EUR/RC68/Conf.Doc./1 Rev.1	Draft resolution on the report of the Regional Director on the work of WHO in the European Region in 2016–2017
EUR/RC68/Conf.Doc./2 Rev.4	Draft resolution on the report of the Twenty-fifth Standing Committee of the Regional Committee
EUR/RC68/Conf.Doc./3 Rev.1	Draft resolution on dates and places of regular sessions of the Regional Committee for Europe in 2019–2021
EUR/RC68/Conf.Doc./4	Draft resolution on appointment of a Regional Evaluation Group
EUR/RC68/Conf.Doc./5 Rev.1	Draft resolution on the action plan to improve public health preparedness and response in the WHO European Region
EUR/RC68/Conf.Doc./6 Rev.1	Draft decision on the joint monitoring framework in the context of the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being
EUR/RC68/Conf.Doc./7 Rev.1	Draft resolution on the strategy on the health and well-being of men in the WHO European Region

### **Draft resolutions and decisions**

- EUR/RC68/Conf.Doc./8 Rev.1 Draft resolution on reaffirming commitment to health systems strengthening for universal health coverage, better outcomes and reduced health inequalities
- EUR/RC68/Conf.Doc./9 Draft decision on engagement with non-State actors: accreditation of regional non-State actors not in official relations with WHO to attend meetings of the WHO Regional Committee for Europe
- EUR/RC68/Conf.Doc./10 Rev.1 Draft resolution on advancing public health for sustainable development in the WHO European Region

### **Information documents**

- EUR/RC68/Inf.Doc./1 Can people afford to pay for health care? New evidence on financial protection in Europe
- EUR/RC68/Inf.Doc./2 Appointment of a Regional Evaluation Group
- EUR/RC68/Inf.Doc./3 Outcome statement of the high-level regional meeting, Health Systems Respond to NCDs: Experience in the European Region, 16–18 April 2018, Sitges, Spain
- EUR/RC68/Inf.Doc./4 Rev.1 Countries at the centre: the strategic role of country offices in the WHO European Region
- EUR/RC68/Inf.Doc./5 End-of-biennium performance assessment: regional plan for implementation of the programme budget 2016–2017
- EUR/RC68/Inf.Doc./6 Outcome statement of the high-level regional meeting, Health Systems for Prosperity and Solidarity: Leaving No One Behind, 13–14 June 2018, Tallinn, Estonia
- EUR/RC68/Inf.Doc./7 Draft WHO global strategy on health, environment and climate change
- EUR/RC68/Inf.Doc./8 Development of the road map on access to medicines and vaccines
- EUR/RC68/Inf.Doc./9 Development of a draft global action plan on the health of refugees and migrants



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## **Annex 4. Keynote speech by Her Royal Highness The Crown Princess of Denmark**

Your Excellency Mr Prime Minister, Director-General, Regional Director, honorable ministers, distinguished guests, ladies and gentlemen,

It is indeed a pleasure to once again, at the beginning of this, the 68th session of the WHO Regional Committee for Europe, have the opportunity to address such a distinguished group of professionals; people who are dedicated to the achievement of good health and well-being for all, at all ages.

Regional Director, dear Zsuzsanna, thank you for the invitation to attend this important session. And thank you to our Italian hosts for their warm hospitality. I hope the incomparable city of Rome will serve as inspiration for us to join together in further shaping and strengthening Europe's agenda on health and well-being.

When we think about Italy and its people it is often synonymous with "La Dolce Vita", the sweet life. And it is this zest for life, the passionate wish to ensure that the people of Europe enjoy the healthiest, happiest lives possible, that brings us so fittingly to Rome. The agenda over the coming four days will offer opportunities to make progress on several important issues, issues that are important to all of us.

One of these issues is vaccination. Tremendous progress has been achieved in recent decades in advancing Europeans' health, education and living standards, and vaccines have played a fundamental part in this progress.

However, recently vaccination has become one of the most discussed issues in Europe, and last month the WHO European Office issued a news release that gave a strong warning to both policy-makers and the public about the increased risks from vaccine-preventable diseases.

"Measles cases hit record high in the European Region" ran the headline. This is unacceptable given that a safe and effective vaccine exists to avoid the 40,000-plus infections that were recorded in the first six months of 2018 alone. And it becomes intolerable when we learn that 37 people have now lost their lives as a consequence of a disease that can be avoided with just two shots of an available vaccine.

These trends are seriously jeopardizing the progress that has been made in our Region towards eliminating measles, as well as rubella. While more countries have interrupted the endemic spread of measles and rubella, we are seeing worrisome setbacks.

Why is this?

It is true that the majority of parents get their children vaccinated according to their national immunization schedules. But to prevent measles and other dangerous diseases from spreading, we know that very high coverage of 95% or more of the population is needed.

Reaching the optimal ‘herd immunity’ level has proven to be difficult in some countries, and in others coverage has even been falling in recent years. The reasons for not vaccinating are many and complex, and are all specific to individual countries and communities. For example, some countries have experienced vaccine stock-outs, some parents mistrust vaccines or have limited access to the health system, some find the local vaccination services inconvenient, and some parents do not realize how serious and even fatal these diseases can be. It is therefore essential that you, the health authorities, analyse and understand the barriers to vaccination and take measures to address these that fit your national context and your people.

It is very timely that midterm progress towards the goals of the European Vaccine Action Plan is under review at this Regional Committee. We are all together in this: I am confident that we will be able to identify the gaps to be filled, actions to be taken to protect each and every one of our children and to set our Region back on track towards finally eliminating these dreadful diseases. Immunization for all is an investment in the health and future of both children and adults and will contribute to achieving both health-related and other global targets set out by the Sustainable Development Goals.

The Global Goals provide a pathway or a framework for development and innovation. They provide a plan for people, prosperity and planet, that strives to leave no one behind. To have any chance of achieving the SDGs, it will require strong collaborative action in critical areas of public health. And tackling antimicrobial resistance is one of the most pressing areas of concern.

I have shown my support in the fight against AMR since 2012. I am convinced that this is one of the major threats of our time to the health of humans and animals and therefore, my support will continue in this case. AMR affects us all, therefore it is essential that this threat is communicated simply and widely, so that everyone has the necessary level of understanding and can act accordingly. It’s important that all relevant sectors of government, private industry and the public work together. We have the knowledge and know-how; there is no excuse **not** to act.

Europe will dedicate this year’s World Antibiotic Awareness Week to One Health. Some antimicrobials used to treat infectious diseases in animals may be the same or similar to those used for human beings. So, we need to address the rising threat of AMR from multiple perspectives. That is why this week will be dedicated to what is called; One Health.<sup>1</sup> And I also support this approach, as it is – after all – common sense.

As you know, over-use and misuse of antibiotics in both animals and humans is contributing to, even accelerating, the rising threat of antibiotic resistance. It is not enough to work towards responsible use of antibiotics in humans; it is also critical to stop any unnecessary use

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<sup>1</sup> One Health is an approach to designing and implementing programmes, policies, legislation and research in which multiple sectors communicate and work together to achieve better public health outcomes. The areas of work in which a One Health approach is particularly relevant include food safety, the control of zoonoses, and combatting antibiotic resistance <http://www.who.int/features/qa/one-health/en/>.

in rearing livestock for food. In order to reduce the chances that bacteria become resistant, we need to take a holistic approach.

Arising in humans, animals or in the environment, resistant bacteria can spread from one to the other, and from one country to another. AMR does not respect geographic or human–animal borders.

This means that efforts by just one sector cannot prevent or eliminate the problem. What we need is a bold step to a multisectoral approach. We need you, the health sector, to position AMR high at whole-of-government and at whole-of-society level and take common actions to address all risks and drivers that are intertwined in a complex web of human, animal and environmental interactions.

And we need to act across countries, simultaneously. Our Region has always been in the forefront of the fight against AMR. Being in this room together gives us a better chance to reach common solutions. I encourage each and every one of you to embrace the One Health approach and join forces with other sectors and bring together all levels of society to mark World Antibiotic Awareness Week 2018, together with WHO, the Food and Agriculture Organization and the World Organisation for Animal Health.

Ladies and gentlemen,

As I mentioned a moment ago, the WHO European Region is often at the forefront of health developments, and this year's agenda proves no exception. For the first time, this group will discuss a strategy for men's health. And here the very essence of the strategy is different. It seeks to improve men's health and well-being through gender responsive approaches, challenging traditional norms around masculinity and calling on us to rethink gender stereotypes and break down the barriers existing between programmes. Its vision is lifelong and intergenerational. Looking at the way in which we live our lives, and how health is interconnected with so many factors, is very much in the spirit of the 2030 Sustainable Development Agenda.

The strategy for men's health points to gender equality as a priority for men's health, and it highlights transitions in life as important opportunities to improve health for all. Think about one such transition – into fatherhood – that joyous, poignant moment many of us look back on tenderly when we became a parent. This time could present a golden opportunity for men to boost their child's, their partner's and their own physical and mental health. When fathers are involved in caring for their child from an early stage, there are health pay-offs. Studies show that “hands on” dads live longer, have fewer physical and mental health problems, are more productive at work, have fewer accidents and express more satisfaction with their lives.

A recent survey of over 1000 fathers in Denmark found that 78% thought more about their health after becoming a father. Over 50% drank less alcohol, and 43% of those who were smokers before, stopped smoking after the birth of their child. This is not only good news for their own health, but also for the health of their partners and children.

We must ensure that fathers can grasp this golden opportunity through involving them in antenatal classes, training health professionals to include partners to a much greater extent, allowing for paternity leave and increasing social acceptance of such leave, reflecting on our own attitudes and behaviours, and so on.

I have long been active in promoting the health of mothers and children. We cannot achieve real and sustainable improvements in maternal and child health without the engagement of men in caregiving and also in their own health.

The Regional Committee agenda is once again a busy one. I wish you stimulating, productive discussions, and robust, forward-looking decisions.

These days present a window of opportunity to stand strong and resolute together in our commitment to improving the health and well-being of every citizen in this richly diverse region.

Thank you.

## **Annex 5. Address by the WHO Regional Director for Europe**

Your Royal Highness The Crown Princess of Denmark, Director-General of WHO, Dr Tedros, Honourable Ministers and delegates and dear guests...

I warmly welcome you to this 68th session of the WHO Regional Committee for Europe.

These are exciting and challenging times. We have the commitment, the knowledge and the opportunity to transform health and achieve our goal of “better health for Europe; equitable and sustainable”. So far, with our implementation of the Sustainable Development Goals and Health 2020, we have achieved a lot. The SDGs, Health 2020 and the Thirteenth General Programme of Work are truly coherent and integrated. All three show clearly how health is positioned at the centre of development. This is our crucial message.

Health investment is the smartest investment – it pays off. Yet the environment has changed, and there is a state of political flux in which some long held common political and social assumptions have been shaken, and there are profound security anxieties and a prevailing sense of uncertainty. In this situation, more than ever, we must pursue our agreed values in health investments: the right to health, universality, solidarity, equity and fairness.

We need to achieve multisectoral policy responses, able to address all health determinants and health promotion through the life course. We must rise to the challenge of ageing populations and the increased burden of noncommunicable disease. We must respond to the continuing threat from communicable diseases and health emergencies; the exponential explosion of health technologies; and increasing public expectations. We must face ever-present financial pressures including constant cost pressures for the efficient use of resources, yet also achieve universal health coverage and good financial protection.

We also have important new opportunities. We must continue to be innovative and think differently, considering new scientific knowledge. We understand better the complexity of interactions between the human genome and the environment over the life course. We are well aware that these interactions are shaped by policies, opportunities and social norms created by society, like political, environmental and cultural contexts, that we can influence. There are huge opportunities arising from the use of digital technology and other innovations that help reduce inequities in access.

We know that mobilizing communities and increasing health literacy will lead to making the right choices. Working together, in stronger partnerships and with multi-stakeholder engagement, will pay off. And progress will depend upon securing the highest level of political commitment and increased resources for health as a smart investment.

Health is a political choice, and it is the one we urge you all to make.

After adoption of the SDG roadmap last year, many countries started developing national roadmaps and creating whole-of-government mechanisms at the highest level to drive the agenda forward. So far, 35 European Member States have reported on SDG implementation at the High-level Political Forum. You will hear more about this tomorrow. Also, a majority of countries now have a national health policy with defined targets and indicators aligned with Health 2020.

These are real achievements, presented now in our ground-breaking publication, the *European health report 2018*. The report also explains the alignment of indicators in a proposed “Joint Monitoring Framework” for the SDGs, Health 2020 and the Global Action Plan for the Prevention and Control of NCDs, as well as with GPW 13. The report presents exciting new work on the use of qualitative evidence, bringing to life Health 2020 concepts such as well-being, community empowerment and resilience, and the whole-of-society approach.

Now three snap-shots demonstrating the progress on health and well-being against these targets:

- Life expectancy at birth increased to 77.9 years in 2015.
- The maternal mortality rate decreased to 11 deaths per 100 000 live births in 2015.
- We are on track to achieve the Health 2020 target to reduce premature mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases by 1.5% annually.

Yet, ladies and gentlemen, there are still major inequities in health and well-being between and within countries. The difference between the countries with the highest and lowest life expectancy at birth is still more than 10 years. Despite the progress, tobacco use in the Region is not decreasing fast enough. We are still the Region with the highest alcohol consumption. Overweight and obesity are on upward trends which give cause for serious concerns. While by the end of 2017, 43 countries had eliminated or interrupted endemic measles transmission, persistent immunity gaps have resulted in a large number of outbreaks. We are absolutely not on track to meet our HIV targets and co-infections are increasing.

Making progress towards better health challenges us to work in transformative ways. We have to ensure policy coherence across different sectors at all levels, using inclusive and transparent governance mechanisms. National health and development policies are the principal mechanism here, and I urge Member States to review their existing policies against the SDG roadmap and the monitoring framework. To help Member States, we have developed a range of SDG instruments and tools, including national health policy reviews.

Our broad coalition of partnerships, networks and platforms plays a vital and excellent role in implementation. Here, I will mention some, although there are many others:

- the small countries initiative, with excellent recent meetings we had in Malta and Iceland;

- the WHO European Healthy Cities Network, with a very successful Summit of Mayors in Copenhagen;
- and the South-eastern Europe Health Network, with very productive meetings this year in Montenegro and Israel.

We look forward to another Healthy Cities meeting in Almaty in October and the 30th anniversary of Healthy Cities later this year in Belfast.

A majority of countries in the Region now have a policy or strategy to address the social determinants and health inequities, thanks to the European Region leading this work globally. However, there are still significant income inequalities across the Region with humanitarian, health and economic implications, which need collaborative responses across sectors. The Region has seen a considerable reduction in infant mortality; however, the variation between countries remains high. While the proportion of children not enrolled in primary school is falling, a large variation between countries is reported. A similar picture emerges for unemployment rates, which ranged from 0.5% to 26% in 2015. Later this year we will publish a health equity status report, providing transformative thinking with new evidence and policy directions to help reduce these gaps. I thank the Government of Italy and the Veneto Region for their continuing support to our Office for Investment for Health and Development in Venice.

Ladies and gentlemen, let me now turn to behavioural determinants.

There are many success stories in tobacco control; for example, eight European Member States now have plain packaging legislation for tobacco products and several are moving towards becoming “tobacco-free”, with a smoking prevalence of 5% or less. Yet, tobacco use in the Region is not reducing fast enough to meet the global targets. Tobacco products are still far too affordable in many countries. The Protocol to Eliminate Illicit Trade in Tobacco Products will enter into force on 25 September and the first Meeting of Parties will take place in October. Entry into force is a major milestone and I call upon all Member States to ratify the Protocol in order not to lose momentum. The war against tobacco has not ended – we need to step up the work against this most deadly risk factor.

Recent evidence confirms that, compared to 2010, alcohol consumption has decreased in the Region, and so have overall levels of alcohol-related mortality and morbidity. Despite these achievements, the European Region still has the highest adult alcohol consumption of all WHO regions. Pricing policies and restrictions on availability and marketing continue to represent a highly cost-effective intervention for alcohol prevention and control. In 2017 we developed various tools to assist Member States to assess the adoption of the recommended policy standards, and we are committed to the implementation of solutions.

The tripling of obesity prevalence in many countries compared to the 1980s and a major increase in overweight among children and adolescents are threatening the gains we are making in premature mortality in the Region. We continued to support the WHO European Childhood Obesity Surveillance Initiative and launched a new Health Evidence Network Synthesis Report, which creates momentum to act.



On physical activity, collaboration between WHO, Member States and the European Commission to promote health-enhancing physical activity throughout the Region led to several innovative projects.

All these behavioural determinants are closely linked to the social and environmental determinants, and therefore efforts should be made to align them in a coherent national policy framework for intersectoral action.

Despite improvements, environmental risks still cause one fifth of the burden of disease in the European Region. Following the Ostrava Ministerial Declaration last year, many Member States developed national portfolios for action on environment and health. The Environment and Health Task Force, with its new chairs and governance mechanism, plays a key role in the implementation of the Ostrava commitments across the Region. Looking to the future, we are working with Member States on the development of a new global strategy on environment and health, which will be presented to the WHA next year. I wish again to express my gratitude to the Government of Germany for their continuing generous support to the work of the WHO European Centre for Environment and Health in Bonn. The Bonn Centre is making important contributions to the global normative work, while leading the Ostrava Declaration implementation.

This year, the *European health report* captures the full range of health concerns, including the cultural context. This gives us a much richer understanding of the context to inform policy development and implementation, moving beyond quantitative to more qualitative information, and engaging local communities.

I now turn to the commercial determinants of health. It is clear that today's rise in noncommunicable diseases reflects a system which prioritizes economic and financial growth and advantage over better health. We need to address and prevent conflicts of interest, particularly those involving commercial interests. While we have no common interest with, for example, the tobacco and alcohol industries, I believe that we should do our best to convince the food and soft drinks industries to follow WHO standards and norms. While working with the private sector, appropriate governance mechanisms need to be enforced that affirm the primacy of public over private interests, which are within the principles of FENSA.

Facing today's health challenges and dealing with all determinants require a strong and transformed public health for the 21st century. This is a public good, and a shared social and political responsibility, not only of health, but of all sectors. It is also an indicator of success for the government as a whole and is an investment in the economic development of countries. This is where strong and high-level political commitment and leadership are required, which are not present in every country. Public health across the Region needs to be strengthened with good legislation, governance, institutional structures and a competent workforce. I am personally committed to strengthening public health further in the Region. I therefore commissioned a broad consultation process, engaging external experts, and we will be presenting our vision for advancing public health on Wednesday.

The review of implementation of the European strategy for refugee and migrant health indicates that there has been notable progress, which forms the core of the forthcoming European migrant health report. Now we are contributing to the establishment of a global action plan on the health of refugees and migrants for consideration by the WHA in 2019. We have also contributed to ensuring that health is a key component of the United Nations Global Compact for Safe, Orderly and Regular Migration and the Global Compact on Refugees. I offer my thanks to the Government of Italy and the Regional Health Council of Sicily for their support to the second Summer School on Refugee and Migrant Health that will take place in Sicily this month.

I turn now to noncommunicable diseases, where Europe can present a major success story in the reduction of premature mortality from NCDs, since we see a fast decline everywhere in the Region and among both sexes. With this rate of decline, we estimate that achievement of target 3.4 of the SDGs will take place earlier than 2030. As the Regional Director, I was proud to present these results at the WHO Global Conference on NCDs in Montevideo last year, when we also launched our report, “Monitoring NCD commitments in Europe”. This report demonstrated that cost-effective NCD interventions are not implemented in many Member States. We cannot just sit back and enjoy our successes; we need to accelerate our interventions. We know what to do! But we are not doing enough! Otherwise it will take two decades for countries with higher mortality to catch up with those with lower mortality.

There are equality gaps due to different socioeconomic means, environmental exposures, and access to social policies and benefits. There are also pockets of avoidable high mortality among men under 70 years – with significant social and economic implications. We must accelerate improvements in NCD outcomes by strengthening the equity orientation of health system policies – to leave no one behind and to break the harmful cycles of health inequalities.

We were all inspired by the successful and comprehensive health system transformation efforts in Europe to respond to NCDs that were shared at the high-level meeting in Sitges in April this year. There, we agreed on the required building blocks and actions to be taken, as well as on the need for leapfrogging. We know that we must strengthen health systems to achieve better NCD outcomes. There is a need for ambitious transformation in how we deliver public health, primary care and specialist services, with a sharpened focus on outcomes, coordination, continuity and comprehensiveness. I believe this to be a groundbreaking initiative from the WHO European Region in connection with the third UN high-level meeting on NCDs in New York next week. I hope that your countries will be represented at the highest level at this historic event.

All these will be discussed tomorrow, and on Wednesday we will launch our new report, *Health systems respond to NCDs*, which describes efforts to act in unison with all countries to beat NCDs. On Wednesday we will also discuss the Strategy on health and well-being on men that contributes to this effort through a gender approach. I express my deepest gratitude to the Russian Federation for their generous support to the Office for the Prevention and Control of NCDs in Moscow.

Ladies and gentlemen, strong health systems are a prerequisite for advancing universal health coverage and achieving sustainable development. Many high-level events this year underlined the importance of strong, people-centred and agile health systems. We celebrated the 10th anniversary of the Tallinn Charter – thanks to Estonia for hosting this high-level meeting in Tallinn in June. At the meeting, we reaffirmed our commitments towards solidarity, equity and participation. We agreed that strong health systems have to be inclusive, leaving no one behind, and that no one should become poor as a result of ill-health. We also considered how health system innovations can be harnessed to better meet people's needs. Our health systems should not be passive in the face of changing economic, political, social and health challenges, but instead be able to prepare for and adapt to the future.

In Tallinn, we presented the results of a regional study on financial protection, producing up-to-date estimates of the incidence of impoverishing levels of out-of-pocket payments. We use a new approach suited to high- and middle-income countries in this study and also present actionable policy recommendations which are being implemented in several countries. While some Member States are progressing well, we still have a long way to go to achieve that no one becomes poor as a result of ill health. Among the 25 countries in the regional study, the share of households impoverished or further impoverished due to out-of-pocket payments ranges between 0.3% and 9%. The study suggests that it is possible to avoid poverty due to ill health through a combination of reducing out-of-pocket expenditure to 15% of the total spending on health and strengthening pro-poor coverage policies.

We also engaged in dialogue between health and fiscal decision-makers to make the case for public investment in health systems, and public health in particular. We will be discussing all these tomorrow.

Another important meeting this year will be held in Astana in October on the occasion of the 40th anniversary of the Alma-Ata conference on primary health care. I request your governments to participate at the highest level possible. The meeting will commemorate the 1978 Alma-Ata Declaration, plan for the forthcoming Global Conference on Primary Health Care, and aim to renew the political commitment to developing people-centred primary health care. It will also provide the foundation for the United Nations high-level meeting on universal health coverage to be held in New York next year. In this context, I am pleased to announce the launch of the WHO Task Force on the Economics of Primary Health Care, which met for the first time two weeks ago, generously hosted by the Danish Health Authority. I thank the Government of Kazakhstan for their support to the WHO European Centre for Primary Health Care in Almaty.

We continued the series of courses on strengthening health systems for improved TB prevention and care, and included representatives from health and finance ministries, and national health insurance funds. The annual WHO Barcelona course on health financing for universal health coverage will be delivered in October. I offer my thanks to the Government of Spain and the Regional Government of Catalonia for their continued support to the WHO Barcelona Office for Health Systems Strengthening. We also continued the Summer School

on Pharmaceutical Pricing and Reimbursement Policies together with the Collaborating Centre in the Austrian Public Health Institute.

Access to affordable, effective, quality medicines is another major component of universal health coverage and is of great concern in many Member States. Improving access requires multidimensional interventions, with comprehensive national policies, together with supportive legal and regulatory frameworks and efficient supply chains. It is encouraging to see several cross-border country collaboration projects seeking better negotiating powers and alignment of prices and costs. As global external financial instruments are not available any more to most countries in the Region, efficient transitioning to domestic financing and supply management is crucial. We will support national planning for this transition.

The analysis and dissemination of health information has become ever more sophisticated. This is evident in many of our initiatives, like the European Health Information Gateway, the peer-reviewed journal *Public Health Panorama* and our Health Evidence Network reports. In our two annual flagship courses, including the Autumn School on Health Information for Policy, we continue to build capacity in countries to collect, assess and use evidence for policy. We are now establishing a new curriculum for the second phase of the Autumn School and its Advanced Course.

The Evidence-Informed Policy Network, which is now active in 21 countries, is helping to strengthen country capacity to develop health policies through evidence for policy briefs and policy dialogues in countries.

This year, we launched the European Health Research Network in Bulgaria to support the development of health research systems in countries. The European Advisory Committee on Health Research continued its crucial role in the formulation of policies for the development of health research. This year the EACHR recommended that WHO establish a European high-level task force for big data and develop a strategy, which we are now pursuing.

All these activities are coordinated and guided by the European Health Information Initiative, which now has 39 members, from countries as well as international partners such as the EC and the OECD. Under this initiative, we now have eight health information networks, which form the basis for evidence and information for health policy.

Ladies and gentlemen, I turn now to communicable diseases. The good news is that we have been able to keep our malaria- and polio-free status and we plan to certify malaria elimination this year. Building upon the Ashgabat commitments, malaria interventions like surveillance, vector control, and intersectoral and cross-border collaboration, contribute to the prevention and control of other vector-borne diseases, which are worryingly on the increase in the Region. We will be discussing this on Thursday.

Progress regarding measles and rubella elimination is mixed. In spite of success in interrupting endemic measles or rubella transmission in 43 Member States, large measles

outbreaks, especially in western European countries, with deaths and complications, are unacceptable in the presence of effective and affordable vaccines.

We are working closely with the affected countries, and many have taken steps to strengthen immunization, including through legislative frameworks, to contain outbreaks. We have to place the highest political commitment on immunization in order to achieve the goals established in the European Vaccine Action Plan and avoid disease outbreaks. The midterm report provides valuable findings on ensuring equitable access to affordable and effective vaccines. We will discuss this in detail tomorrow. I urge all Member States to extend the benefits of vaccination equitably across the life course to all individuals in the Region.

Let me acknowledge the commitment of south-eastern European ministers to accelerating actions towards immunization in Montenegro this year. Our Patron, Her Royal Highness The Crown Princess of Denmark, as in previous years, was with us on the occasion of European Immunization Week and we are grateful for her continuous support.

We have good news regarding tuberculosis control. We are the Region with the fastest decline in TB incidence and we also observe a significant decline in mortality. Thanks to your efforts and in collaboration with partners, MDR-TB case detection has more than doubled and treatment success has slowly but steadily continued improving. These achievements were made possible through strengthening the health system response with implementation of people-centred models of care. Despite the progress, the Region still has the highest rate of MDR-TB in the world, with one out of five people with MDR-TB living in our Region. There is an increase in HIV coinfection, to 12%, and every eighth TB patient is now co-infected with HIV. Now is the time to accelerate our efforts. Based on the ministerial meeting in Moscow last year, the UN high-level meeting on TB in New York next week will be a unique opportunity to renew our commitments to Ending TB by 2030.

Regarding HIV, the challenges are substantial, and one fifth of all people living with HIV in the Region still do not know their status. In 2017, 82% of all new HIV infections were from eastern Europe and central Asia, where only one third of people living with HIV were receiving antiretroviral therapy. The highest political commitment and bolder actions are required for HIV prevention and care, particularly among the key populations. At a policy dialogue in July this year in Amsterdam, we agreed with the ministers of health of eastern Europe and central Asia that the time to accelerate our efforts is now and that we cannot afford to do “business as usual”. We have to scale up implementation of evidence-based interventions and take urgent collective actions to curb the HIV epidemic. We are working towards a road map with country-specific action in all affected countries. I would like to thank the Government of the Netherlands and UNAIDS for co-hosting that important meeting, back to back with the 22nd Global AIDS Conference.

Another challenge is viral hepatitis, which leads to at least 60% of liver cancers and which requires accelerated actions and commitment. We will continue to support you in strengthening surveillance and laboratory capacities and updating treatment guidelines,

thereby ensuring that everyone living with viral hepatitis has access to safe, affordable and effective prevention, care and treatment services.

The global effort to address antimicrobial resistance continues with unwavering determination, and Europe continues to lead the way. I am pleased that 34 countries in our Region have developed multisectoral national action plans and we are supporting the remaining countries to finalize theirs, as well as with implementation. As the picture of antimicrobial consumption and the resistance patterns of our Region becomes more complete through the work of our dedicated surveillance networks, we will focus on policy interventions that reduce overuse of antimicrobials, as well as on infection prevention and control, especially in health care settings. Here again, I would like to acknowledge the valuable support provided by Her Royal Highness The Crown Princess of Denmark in raising awareness of AMR whenever possible.

Ladies and gentlemen, preparedness and response to health emergencies continue to be a priority, with a major focus on detecting early warning signals and helping countries get prepared. Taking a step forward, the draft regional action plan to improve public health preparedness focuses on the interdependence of health emergency preparedness, health systems strengthening and the essential public health functions, towards universal health coverage. We will discuss this on Wednesday.

In health emergency response operations, let me commend Turkey for providing universal access to culturally sensitive, people-centred, quality health services for the 3.5 million Syrian refugees in Turkey. Training of the Syrian health workforce and engaging them within the Turkish health system is an example of social inclusion and adaptation, which at the same time provides universal health services to all refugees by their fellow health personnel. This flagship model will be presented on Wednesday.

Working for and with countries is at the core of WHO's mandate and it has been my highest priority since I became the Regional Director. We have been delighted to welcome ministers and high-level officials from many countries to the Regional Office. Within WHO reform, the focus has been on strengthening WHO leadership at the country level. We have been empowering country staff and upgrading them to become international WHO representatives. We have continued to strengthen our country offices and have recently opened a new WHO office in Greece. This aims to better support countries to achieve the highest possible impact in their health-related policies and actions. Thanks also for warmly receiving me during my visits to many countries across the Region. I am extremely grateful for the many high-level discussions on health with presidents, prime ministers, ministers and high-level national officials. I am pleased that the visits of Standing Committee members to countries was the opportunity to demonstrate WHO's work at country level. You will hear more about this later this week.

Partnership is one of the priority areas of the Director-General's transformation agenda. I have been personally committed to strengthening partnerships over the last eight years across the Region, which culminated in a partnership strategy last year. Collaboration with UN agencies at

the regional level in a broad range of areas has been exemplary, as was the case with the UN issue-based coalition on the health-related SDGs that WHO is leading. I want to thank Cihan Sultanoglu, the Chair of the regional UNDG team, who is leaving this position, for her outstanding leadership during the past six years. I have been requested to act as interim UNSDG Chair in Europe and central Asia until the new appointment is made, which I accepted as a great honour. This function will give us further insights into UN reform and it will help WHO to position itself in its implementation, while keeping our normative work intact. We have been actively preparing for the UN reform process throughout the three levels of the Organization and we will also be aligned with its implementation.

WHO has worked extensively with the European Union on health, including in the fields of humanitarian and development aid. We held a successful meeting of Senior Officials of the EU and WHO, involving HQ and all regions, to discuss our future work, including work in research and development and on the environment. We have collaborated strongly with current and past EU presidencies in taking forward many high-priority health topics.

The last example I would like to share with you is our collaboration with non-State actors. The agenda item on Thursday will be a major milestone, when we will be officially accrediting 19 NSAs for the first time, on the basis of reviews and recommendations by the SCRC. This procedure is fully in line with FENSA.

Director-General, we are working together to make WHO fit to implement GPW 13 and enhance its impact in countries to deliver the “triple billion” goal. Under your leadership, and that of the Global Policy Group, we see important efforts across the three levels of WHO to define and align our common values, culture and operating models and processes. Here in the Regional Office we are ready, committed and well equipped to respond to this challenge. We are implementing the comprehensive transformation process, building upon our “Better health for Europe” initiative of 2010, which addresses the same strategic dimensions of WHO reform.

Our Regional Office business model enables us to be highly efficient and effective within a relatively small budget envelope, providing a broad range of support to Member States, from policy and strategic advice to technical assistance. I am pleased that the effectiveness of the Regional Office’s risk management and internal control processes were successfully validated by recent internal audits. This makes us proud and at the same time more committed to sustaining and enhancing accountability and transparency in delivering results. I would like to thank my team in all offices across the Region, for their hard work, dedication and commitment in delivering high quality results in a most efficient and effective manner.

Ladies and gentlemen, we should be proud of the tremendous results we have collectively achieved. Yet, to make more progress and close the gaps we need a stronger political commitment to health and well-being as an integral component of sustainable development. This commitment needs strong actions by all relevant sectors and stakeholders. It should impact parliamentary decision-making and build policy coherence across different sectors at all levels.

WHO is committed to taking the lead and engaging with governments and with all partners to ensure that health is placed firmly on political agendas. WHO is committed to streamlining the way we do business, to work efficiently for the highest impact. The SDGs, Health 2020, and our renewed public health vision lead the way, and GPW 13 gives us the means and tools to succeed.

We share a vision: to build a world where everyone realizes their right to a healthy and prosperous life. To reach this vision, all of us – politicians, decision-makers, professionals and people in all walks of life – need to pledge their commitment.

I ask you for that commitment!



## **Annex 6. Address by the WHO Director-General**

Dr Zsuzsanna Jakab, WHO Regional Director for Europe,

Excellencies, honourable delegates, colleagues and friends,

As I said this morning, it's a great honour to be here in the Eternal City. You have a busy week ahead of you, with several important matters to discuss and resolutions to pass.

There are many encouraging signs of progress in this region in relation to each of the “triple billion” targets. As I said this morning, Europe has some of the world's most advanced health systems, the highest rates of service coverage, and the lowest rates of catastrophic spending. In many ways, many European countries are a model of health equality for the rest of the world.

And yet we know there is a lot of inequality in Europe between east and west, between north and south, between rich and poor, between citizens and migrants. The most established health systems face challenges of financial sustainability. Although Europeans enjoy the world's lowest rates of catastrophic health spending, even in Europe there are people who experience financial hardship because of out-of-pocket health spending. That means more people in this region are being forced to make difficult choices between health and other basic needs.

Tomorrow my colleagues from the Regional Office will be presenting new evidence about financial protection in Europe. You are aware of these issues. And you are working to address them. The meeting in Tallinn in June emphasised that inclusion, investment and innovation are the essential building blocks of the health systems of the future. And the meeting in Sitges in April this year brought an important focus to building health systems to address the burden of noncommunicable diseases.

The resolution before you this week is a powerful statement that universal health coverage is a journey, not a destination. No country and no region can ever afford to rest. There are always new challenges to overcome. There are always gaps in service coverage to fill. There are always people being left behind. The resolution calls on you to design health systems that are uniquely tailored to the challenges you face; it calls on you to emphasise equity, with a special focus on the poorest and most vulnerable; it calls on you to increase your investments in health, and to seek efficiency gains to ensure you get the most health for the money; it calls on you to keep a close eye on out-of-pocket spending, especially for medicines; it calls on you to prioritize primary health care, with a focus on health promotion and disease prevention; it calls on you to invest in health workers; and it calls on you to invest in research and innovation so that your health systems keep pace with shifting needs and expectations, and are based on the best evidence. I echo each of these calls.

Investing in health is not only the right thing to do, it's the smart thing to do. It's an investment not just in healthier populations, but in more prosperous and stable societies. It's an investment in the future – but it's also an investment in the now.

Next month we will gather again in Astana to celebrate the 40th anniversary of the Alma-Ata Declaration. I thank my sister Zsuzsanna and my brother Yelzhan Birtanov, the health minister of Kazakhstan, for their leadership in bringing this important event to fruition. But we are not simply looking back on the past 40 years; we're looking forward. We're looking forward to societies and governments that prioritize, promote, and protect people's health; to people and communities empowered and engaged in determining their own health; to sustainable health care that is available, accessible and affordable for everyone, everywhere; and to quality health care that serves people with compassion, respect, and dignity. This is what primary health care means. This is what health for all looks like.

I'm pleased to see that alongside the resolution on universal health coverage, you are also considering a resolution on public health for sustainable development. This is very encouraging. It recognizes that to build the healthier, more prosperous societies we all want, health systems cannot simply treat the sick. That is like fighting a fire with a garden hose. We must protect the healthy, by addressing the root causes of ill-health: the social, economic, commercial and environmental factors that are the reasons people end up in our hospitals. We must make it easier for people to choose the healthy option. Encouragingly, the European region is on track to meet the SDG target for a one-third reduction in premature mortality from noncommunicable diseases by 2030.

But there is much work to do. Data published just this week by the International Agency for Research on Cancer shows that Europe is home to 23% of the world's cancer cases and 20% of cancer deaths, even though it accounts for just 9% of the world's population. Although lung cancer is falling among men, it is rising among women, particularly in northern and western Europe.

But in other areas, Europe is leading the way. There are many lessons in this region from which the rest of the world can learn. Just this year, Ireland and the United Kingdom introduced taxes on sugar-sweetened drinks, and Norway increased its levy. Many of your countries are also leaders on plain packaging and tobacco taxation.

But although tobacco taxation is higher in this region than many others, there has been little progress in recent years. Less than half of your countries tax tobacco at the recommended level. This is an easy win, both for reducing tobacco use, and for generating revenues for your health systems.

Alcohol consumption is higher in Europe than anywhere else in the world. But it is encouraging to see many of your countries taking measures to reduce harmful alcohol use – through taxation, labelling, marketing regulations and more. Keep going.

Indoor air pollution is not the problem in Europe that it is in Asia, and yet more than half a million people die prematurely every year because of outdoor air pollution.

These are just some of the successes you have had, and the challenges you are facing. I know there are many more. Addressing these and other risks pays huge dividends. It keeps people

out of hospitals and in their communities, working, learning, innovating and contributing to society.

Many of the risks I have described affect men. Which is why the strategy on the health and well-being of men is so important. It provides a much-needed complement to the strategy on women's health adopted two years ago. Men have unique health needs that require a unique health response. Men can also suffer from health inequities and discrimination based on their age, race, class, ethnicity, sexual orientation and gender identity, among others. The strategy and its five priority areas cover a wide range of actions that all countries can take to address those needs. It includes health policies that address key risks for men's health including alcohol, tobacco, road injuries and mental health; addressing gender norms that contribute to health risks for men and women; engaging men in preventing violence; addressing men's unmet needs for sexual and reproductive health; empowering men to play their part in promoting and protecting the health of women; and engaging men as users of health services in designing systems that are uniquely adapted to their needs.

All of the measures you are considering this week require investments. Nothing comes for free. But it's critical that countries see them as investments, and not costs. They are investments in a healthier Europe. They're investments in a fairer Europe. And they're investments in a safer Europe.

You will get tired of hearing me say that health systems and health security are two sides of the same coin. But I will keep saying it because it is a fundamental truth. I will keep saying it until vulnerable people are no longer left exposed to outbreaks by the weakness of their health systems. The two most recent Ebola outbreaks in the Democratic Republic of the Congo show that we have come a long way. The changes we have made to make our emergency operations more agile and responsive are working. Together with our partners, we are saving lives.

But we can always do more. Last week we held the first meeting of the Global Preparedness Monitoring Board in Geneva. This is a new mechanism put together by WHO and the World Bank to monitor the world's readiness for outbreaks and other health emergencies. Its job is to identify gaps in the world's defences, and to keep all of us accountable for filling those gaps. We are only as strong as the weakest link. The world is as vulnerable as its most fragile health system. Europe may not face regular Ebola outbreaks, but you do face other weaknesses that pose major threats to the region's people.

Declining vaccination rates are allowing measles to make a comeback in Europe. The region is on track for the most measles cases in a decade. You must address this outbreak with the same urgency as you would any other. Its effect is the same – lives lost to a preventable disease. Vaccines are the cornerstone of health and well-being. I urge you this week to commit to fully implementing the European Vaccine Action Plan.

Ladies and gentlemen, in the coming weeks and months, you will be hearing more about how WHO is transforming to put countries at the centre of everything we do. But the clearest example is our Programme Budget for 2020 and 2021. The budget has been developed based

on country priorities. Its focus is on strengthening the capacity of our country offices to deliver impact. As you will hear, we are proposing an almost 30% increase in technical capacity for country offices, while the headquarters budget will stay flat. This is what it means to put countries first. This is part of our commitment to leaving no one behind. The good news is that the 2018-19 budget is already more than 90% financed. We're grateful to all Member States for this vote of confidence.

I also want to emphasise that WHO's transformation is linked closely with the wider UN reforms. Both the GPW and the new UN Resident Coordinator system will take effect as of 1 January next year. This is a great opportunity for us to become more effective – to deliver as one. We must all break out of our silos and work together with colleagues from across government and across the UN family. That is exactly what the Sustainable Development Goals demand of us.

In closing, I leave you with three challenges:

First, I urge you to rise to the challenge you are setting yourselves on universal health coverage. Take ownership for ensuring that the people of this region are set free from catastrophic health spending. Celebrate your successes, learn from your mistakes, and share those lessons with the region and the world.

Second, I urge you to work with your colleagues across government to promote and protect health, as well as treating disease. The causes of ill-health are complex and dynamic – so must be our response. Create cleaner environments, build safer roads, and do not be afraid to stand up against powerful industries that profit from harming health.

Third, I urge you to fight declining vaccination rates head-on. Do not allow this problem to become worse than it already is. Lives are at stake. I recognize that this is a complex problem. I recognize that there is no silver bullet. But if you can't address these issues, who can? You are the people who have been charged with protecting the health of your people. You have resources at your disposal and science on your side.

Thank you to all of you for your commitment and dedication. Thank you for everything you do every day to promote health, keep the world safe, and serve the vulnerable.

Thank you so much, and see you in Astana!

Vielen dank. Merci beaucoup. Spasiba. Grazie mille!

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## **The WHO Regional Office for Europe**

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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