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Report of the Twenty-third Standing Committee of the Regional Committee for Europe

This document is a consolidated report on the work done by the Twenty-third Standing Committee of the Regional Committee for Europe (SCRC) at the four regular sessions held to date during its 2015–2016 work year.

The report of the Twenty-third SCRC's fifth and final session (to be held at the WHO Regional Office for Europe in Copenhagen, Denmark, on 11 September 2016, before the opening of the 66th session of the WHO Regional Committee for Europe) will be submitted to the Regional Committee as an addendum to this document.

The full report of each SCRC session is available on the Regional Office's website (http://www.euro.who.int/en/about-us/governance/standing-committee/twenty-third-standing-committee-of-the-regional-committee-2015-2016).

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Introduction

1. The Twenty-third Standing Committee of the WHO Regional Committee for Europe (SCRC)[1] has held four regular sessions to date:

- Vilnius, Lithuania, 13 September 2015;
- Paris, France, 26–27 November 2015;
- WHO Regional Office for Europe, Copenhagen, Denmark, 9–10 March 2016;
- WHO headquarters, Geneva, Switzerland, 21–22 May 2016.

2. In addition to the regular sessions mentioned above, the Twenty-third Standing Committee planned three teleconferences to deliberate pressing matters in a timely way. During a teleconference in April 2016, SCRC members discussed the handling of nominations for WHO governing bodies and committees and agreed to extend the deadline for nominations to the Standing Committee for Group A Member States and to the European Environment and Health Ministerial Board (EHMB) for all Member States. In July 2016, SCRC members discussed the issue of nominations for membership of the EHMB received by the second extended deadline and the best way to proceed. The Standing Committee also addressed issues pertaining to the preparations for the 66th session of the Regional Committee for Europe (RC66) in September 2016, including the role of SCRC focal points. An outcome of the teleconference included identifying tasks for the future SCRC subgroup on governance, such as the organization of technical consultations. The focus of the third and final teleconference in August 2016 was scheduled to address last-minute changes and amendments to the RC66 provisional programme.

3. In accordance with Rule 9 of the SCRC's Rules of Procedure, Professor Benoît Vallet (France), as Deputy Executive President of the WHO Regional Committee for Europe at its 65th session, is ex officio Chairperson of the Twenty-third SCRC. At its first session, Ms Dagmar Reitenbach (Germany) was elected Vice-Chairperson of the Twenty-third SCRC. The member of the WHO Executive Board from Sweden agreed to act as the link between the Executive Board and the SCRC in 2015–2016.

Reflections on the 65th session of the WHO Regional Committee for Europe

4. At the first session of the Twenty-third SCRC, members exchanged initial reflections on the 65th session of the Regional Committee for Europe (RC65). They welcomed the proposal to have a written consultation with Member States on draft resolutions to be considered by the Regional Committee for a period of one month following the SCRC session held in conjunction with the World Health Assembly in May. The Regional Director said that the Secretariat would make an internal evaluation of the panel discussions at RC65 and prepare a paper for consideration by the Twenty-third Standing Committee. A paper setting out possible solutions to how the Regional

[1] See Annex 1 for a full list of members, alternates and advisers to the Twenty-third Standing Committee of the Regional Committee for Europe 2015–2016.

Committee adopted reports of its sessions would also be presented to the SCRC at a subsequent session.

5. Evaluating RC65 at its second session in November 2015, the Twenty-third SCRC agreed that panel discussions needed to be limited in number and should be shorter and more engaging. The informal side meetings had been valuable, as they had facilitated the exchange of views and creative discussions on particular items. Efforts should be made to schedule that type of meeting the day before the opening of the session. The Standing Committee supported the introduction of a period of web-based consultation on draft resolutions prior to the Regional Committee session and the electronic adoption of the report of Regional Committee after the session.

SCRC subgroups

Subgroup on governance

6. The Twenty-third SCRC agreed at its first session that its subgroup on governance would continue its work, chaired by Dr Ivi Normet (Estonia) and composed of the members from Finland, France, Germany and Latvia. The member from Italy agreed to replace the outgoing member from Israel on that subgroup.

7. At the Twenty-third SCRC's second session, the chairperson of the subgroup outlined the key areas of unfinished work that it would undertake: reviewing the procedures for nominating national experts and standardizing the formats for policy papers throughout headquarters and the regions.

8. At the third session, the chairperson of the subgroup said that it had agreed that the nomination of experts to global and regional working groups and advisory committees should continue to be done through the network of WHO national counterparts. It recommended that the tool for evaluating candidates for nomination to WHO bodies and committees should be reviewed after the end of the current round of nominations. The subgroup welcomed the useful guidelines on the format for policy documents produced by the Secretariat. The subgroup had also discussed the work of the global working group on WHO governance reform.

Subgroup on implementation of the International Health Regulations (2005)

9. At its second session, the Twenty-third SCRC decided that the subgroup on implementation of the International Health Regulations (2005) (IHR) would be chaired by Professor Benoît Vallet (France) and composed of members from Finland, Georgia, Italy and Portugal. It agreed to add to the terms of reference of the subgroup the need to work on the IHR evaluation and monitoring framework, including an independent assessment tool.

10. At the third session, the chairperson of the subgroup said that it had agreed that the revised IHR monitoring and evaluation framework should be taken as a full package and that independent external evaluations, after action reviews, and simulation exercises

should complement annual reporting on IHR core capacities. A set of criteria should be established for the selection of experts for inclusion on a roster. Liaison with other organizations and partners was particularly important. It would be useful to share the experiences of those involved in IHR assessments through a regional meeting every two or three years, at which a review could also be made of the emergency work carried out by WHO, including work on alerts and grade 1 emergencies.

11. At the fourth session, the chairperson reported that the subgroup had held a teleconference on 2 May 2016, at which it had considered a report on alert and rapid response operations in the WHO European Region and the report of the Review Committee on the Role of the International Health Regulations (IHR) in the Ebola Outbreak and Response.[2] The subgroup had expressed support for the new Joint External Evaluation mechanism established as part of the Global Health Security Agenda. Lastly, the subgroup had reviewed the outcomes of the High-level Conference on Global Health Security held in Lyon, France, on 22–23 March 2016.

Subgroup on migration and health

12. At its second session, the Twenty-third SCRC established a subgroup on migration and health, to be chaired by Dr Raniero Guerra (Italy) and composed of members from Estonia, Portugal and Romania; a web-based consultation would be held to find additional members to serve in the subgroup.

13. At the third session, the chairperson of the subgroup reported that it had focused its discussions on the public health aspects of migration, in order to contribute to the preparation of the draft strategy and action plan on refugee and migrant health in the WHO European Region 2016–2022. One member of the SCRC called for that strategy and action plan to be aligned with the regional action plan for sexual and reproductive health. The Regional Director noted that at its 138th session the Executive Board had held constructive discussions on migration and health, agreeing that WHO should step up its work on that important topic and that the programme on migration and health would be strengthened.

14. At the fourth session, the chairperson reported that the subgroup had met in Copenhagen, Denmark, in March 2016 to refine the draft regional strategy and action plan. That document focused on protecting migrants' health and advocated for the right of migrants to access health services in an inclusive and proactive fashion. Two major political initiatives had been taken since the third session: an agreement had been reached between the European Union and the Government of Turkey to end irregular migration from Turkey to the European Union; and the "migration compact" proposed by the Government of Italy had been favourably received at the First Italy-Africa Ministerial Conference (Rome, Italy, 18 May 2016). A technical briefing on migration and health was scheduled for 27 May 2016, at the end of the Sixty-ninth World Health Assembly.

[2] World Health Assembly document A69/21.

Preparation for the 66th session of the WHO Regional Committee for Europe

Draft provisional agenda and programme

15. At its first session, the Twenty-third SCRC recommended that migration and health should be discussed during RC66 on a day when ministers would be expected to be present. One member suggested that hepatitis in general, and hepatitis virus B and C in particular, could be added to the subitem on HIV/AIDS. Another member endorsed the proposal that a regional action plan on evidence-informed policy-making should be discussed at RC66.

16. At the second session, the Regional Director presented the provisional agenda and programme of RC66. The first day of the Regional Committee session would include the presentation of her report on the work carried out by the Regional Office since RC65, followed by a general debate, and of the report of the Twenty-third SCRC, as well as discussions on partnerships for health globally and in the European Region, and WHO reform. The second day would be devoted to policy-related items of interest to ministers. Technical items would be discussed on the third day, which would also include elections and nominations. The final day would cover the remaining technical items, the proposed programme budget (PB) 2018–2019, matters arising from resolutions and decisions of the global governing bodies, and progress reports. One member of the Standing Committee suggested that the programme should allow more time to engage with ministers on substantive items, for instance by moving the discussion on partnerships to either the third or the final day.

17. At the third session, the Regional Director noted that some adjustments had been made to the programme of RC66: the item on WHO reform would also include WHO's work in outbreaks and emergencies, and discussions under the item on the midterm progress report on Health 2020 implementation should also link both to the progress report on the European Action Plan for Strengthening Public Health Capacities and Services (including essential public health operations) and to the Minsk Declaration on the Life-course Approach in the Context of Health 2020. The Regional Director also presented a proposed timeline of activity from the end of RC66 until the deadline for electronic approval of the report of the session. Responding to a request from members of the Standing Committee, the Regional Director said that a technical briefing could be organized on the subject of access to new high-priced medicines. Plans would be made to hold informal discussions the day before the opening of RC66, on topics to be decided after the Sixty-ninth World Health Assembly.

Rolling agenda for sessions of the WHO Regional Committee for Europe

18. At the Twenty-third SCRC's third session, the Regional Director presented a document setting out the standard items that appeared on the Regional Committee agenda every year, followed by the items that needed to be reported on at any given session, including progress reports, and the policy and technical matters and administrative and financial matters foreseen for inclusion on the agenda of future sessions. The Twenty-third SCRC expressed appreciation for the preparation of the

rolling agenda and suggested that the initiative could also be taken up at the global level, where it could help to improve the prioritization of agenda items.

19. At its fourth session, the Twenty-third SCRC welcomed the suggestion to leave action plans open-ended and allow the Secretariat to bring the need for renewal to Member States' attention whenever appropriate. It noted that it would be timely to hold discussions on a sustainable health workforce and on access to cost-effective medicines and technologies at RC67.

Action by the Regional Committee	**Review and adopt the Provisional agenda** (EUR/RC66/2) **and Provisional programme** (EUR/RC66/3) **of RC66.**

Health in the 2030 Agenda for Sustainable Development and its relation to Health 2020

20. At its second session, the Director, Division of Communicable Diseases, Health Security and Environment, and Special Representative of the Regional Director on Sustainable Development Goals informed the Twenty-third SCRC that the Regional Office planned to develop a technical paper, roadmap or action plan to localize the 2030 Agenda for Sustainable Development at the country level and to emphasize its alignment with Health 2020. The Standing Committee welcomed the proposed process, which would be of the utmost importance in helping Member States to develop appropriate national action plans. There was general agreement that it was too early to consider a regional action plan, particularly given that the indicators for the Sustainable Development Goals (SDGs) would not be finalized until March 2016. Developing a technical paper would be most appropriate; a roadmap should also be developed, possibly following RC66.

21. At the fourth session, the Director, Division of Policy and Governance for Health and Well-being, accordingly presented the draft of a paper for RC66 entitled "Towards a roadmap to implement the 2030 Agenda for Sustainable Development in the WHO European Region". Members of the Standing Committee welcomed the breadth of the regional paper but suggested that specific issues might be taken up in the roadmap, such as explaining more clearly the case for investing in health and taking account of new treatments and the shift in medical paradigms. Concern was expressed at the large number of indicators proposed for measuring progress towards the SDGs.

Action by the Regional Committee	**Review "Towards a roadmap to implement the 2030 Agenda for Sustainable Development in the WHO European Region"** (EUR/RC66/17)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./13) **and its financial implications** (EUR/RC66/17 Add.1)**.**

Midterm progress report on Health 2020 implementation 2012–2016

22. At its second session, the Director a.i., Division of Policy and Governance for Health and Well-being, presented to the Twenty-third SCRC the proposed outline for the midterm progress report on Health 2020 implementation, which, in accordance with resolution EUR/RC62/R4, was due to be submitted to RC66. It would provide an overview of the actions taken by Member States to date in implementing Health 2020 and of the work done by the Regional Office to support Member States in the implementation process.

23. At the Twenty-third SCRC's third session, the Director, Division of Policy and Governance for Health and Well-being, presented the draft midterm progress report. The number of countries in the European Region with national policies aligned to Health 2020 had increased, and the Regional Office's support had been key to enhancing intersectoral collaboration and strengthening health information systems, particularly since disaggregated health data collection remained a challenge. All strategies and action plans emanating from the Regional Office, and the outcome documents of all high-level meetings, were in line with Health 2020. The Regional Office was working with partners to promote Health 2020 and to enhance the evidence base. A high-level conference on intersectoral action, scheduled to take place in Paris, France, on 11–12 July 2016, would give rise to an outcome document for eventual adoption by the Regional Committee.

24. The Twenty-third SCRC welcomed the midterm progress report and particularly commended the information on country experiences. Analysis of the kinds of policies needed to narrow implementation gaps, and the identification of which sectors should be involved, would be useful not only to implement Health 2020 more efficiently but also to pave the way for the post-2020 period. The Paris conference could look at information both on the costs of multisectoral activities and on the savings that could ultimately be made by other sectors investing in health.

25. The Regional Director recommended that four separate proposals should be submitted for consideration by RC66: a draft decision by which the Regional Committee would take note of the midterm progress report on Health 2020; a draft resolution on the adoption of the Minsk Declaration (see below, paragraphs 29–31); a draft resolution on the outcome of the Paris conference; and a further draft resolution requesting the Regional Director to present her vision for Health 2020 implementation from 2017 to 2020.

26. At its fourth session, the Twenty-third SCRC reviewed an updated version of the draft midterm progress report, which gave further details of the support provided by the Regional Office for health policy development and of intersectoral action for health. Members of the Standing Committee noted that the planned activities described in paragraph 27 of the progress report were couched in general terms, and they recommended that permanent structures or processes should be an essential part of the European "architecture" for implementing intersectoral action.

Action by the Regional Committee	**Review the** "M**idterm progress report on Health 2020 implementation 2012–2016"** (EUR/RC66/16)**.**

Midterm progress report on implementation of the European Action Plan for Strengthening Public Health Capacities and Services

27. At the Twenty-third SCRC's second session, one member noted that essential public health functions did not receive sufficient attention within WHO at global level. At RC65, there had been agreement to submit a draft resolution to the Executive Board to be considered under the agenda item on the SDGs and to be linked to discussions on universal health coverage. Member States in the European Region that held seats on the Executive Board were urged to participate in finalizing the draft resolution.[3]

28. At the third session, the Director, Division of Health Systems and Public Health, presented the draft midterm progress report on implementation of the European Action Plan for Strengthening Public Health Capacities and Services. The results of three independent studies that had been commissioned would be available at the end of May 2016; the draft report under consideration should therefore be regarded as containing preliminary results and conclusions. One member of the SCRC called for public health services to be properly costed, with the aim of having at least 5% of a country's health budget allocated to public health. The "New directions in public health" initiative that had been launched by the Regional Director should be included in the rolling agenda of the Regional Committee.

Action by the Regional Committee	**Review the** "M**idterm progress report on implementation of the European Action Plan for Strengthening Public Health Capacities and Services"** (EUR/RC66/19)**.**

Minsk Declaration: the Life-course Approach in the Context of Health 2020

29. At its second session, the Twenty-third SCRC recommended that the Declaration adopted by the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020, (Minsk, Belarus, 21–22 October 2015) should be included on the agenda of RC66 as part of the midterm progress report on Health 2020 implementation.

30. At its third session, the Twenty-third SCRC agreed that the Minsk Declaration should be submitted, along with a background document and a draft resolution, to RC66 for adoption.

[3] Subsequently adopted by the Executive Board at its 138th session as resolution EB138/R5 and recommended for adoption by the Sixty-ninth World Health Assembly.

31. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, presented the draft resolution for RC66 on the Minsk Declaration to the Twenty-third SCRC at its fourth session. One member suggested that the Declaration should be appended to the draft resolution for RC66 and that operative paragraph 2(b) should be deleted.

Action by the Regional Committee	**Consider the draft resolution on the Minsk Declaration** (EUR/RC66/Conf.Doc./12) **and its financial implications** (EUR/RC66/22)**.**

Action plan for the prevention and control of noncommunicable diseases in the WHO European Region

32. At its second session, the Twenty-third Standing Committee was informed that the new regional action plan for the prevention and control of noncommunicable diseases (NCDS) would refer to the nine targets in the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020,[4] while taking into account the new targets under SDG 3. The SCRC agreed that the new European action plan should highlight the alignment of targets under the SDGs, Health 2020 and the Global Action Plan, with their different end dates. Several members called for a stronger link with primary health care and for enhanced training on prevention, as well as closer links between WHO and the major professional associations that researched chronic diseases.

33. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, presented the draft of the new European action plan to the Twenty-third SCRC at its third session, drawing attention to the key aspects that had been amended since the second session. While there was still a focus on the four major NCDs (cardiovascular disease, diabetes, cancer and chronic respiratory disease), efforts had been made to link to and formulate appropriate actions in other areas, such as musculoskeletal disorders, vaccinations, oral health and air quality. A final progress report on implementation of the 2012–2016 regional NCD action plan would be presented to RC66.

34. The Twenty-third SCRC welcomed the draft of the new European action plan. Particular appreciation was expressed for the mapping of the interventions under the draft action plan to the NCD-related goals and targets set within the global monitoring framework, Health 2020 and the SDGs. Several suggestions were made for areas in which the draft action plan could be further modified: increased physical activity should be promoted in all settings, obesity should be considered as a disease in its own right, and mental health should feature more explicitly as an area for action. In response, the Secretariat explained that a decision had been made not to include sections on specific conditions in the draft action plan, but rather to look at cross-cutting risk factors and preventive measures that affected those conditions.

35. At its fourth session, the Twenty-third SCRC was informed that the new European action plan had been the subject of a comprehensive consultation process involving

[4] World Health Assembly resolution WHA66.10.

Member States and leading NCD experts. Rather than addressing issues such as mental health and nutrition directly, the NCD action plan would serve as a hub by making cross-references to specific action plans and strategies on those issues. The SCRC welcomed the efforts to incorporate the many suggestions made through the consultation process. The list of targets was particularly useful. A repository of best practices, accessible to Member States, would be very valuable. One member of the Standing Committee proposed a number of amendments to the operative paragraphs of the accompanying draft resolution.

Action by the Regional Committee	**Review the "Action plan for the prevention and control of noncommunicable diseases in the WHO European Region"** (EUR/RC66/11)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./7) **and its financial implications** (EUR/RC66/11 Add.1)**.**

Action plan for the health sector response to HIV in the WHO European Region

36. At its second session, the Twenty-third SCRC was informed that recent surveillance data showed that there had been more than 142 000 newly diagnosed HIV infections in the European Region in 2014, the highest since reporting had started in the 1980s. That increase was being driven by the higher rate of new diagnoses in the eastern part of the European Region. Treatment was not increasing fast enough to keep pace with new infections. The new European action plan accordingly set out a number of ambitious goals and would be aligned with the five strategic directions of the draft global health sector strategy on HIV, 2016–2021.[5]

37. The Twenty-third SCRC welcomed the action plan and its relation to the global health sector strategy and its strategic directions, but expressed some concern that the targets were too ambitious to be achievable. Other issues needed to be more clearly addressed, such as the decreased awareness of HIV/AIDS among young people; a low rate of testing, especially among high-risk populations; and coinfections. The Director, Division of Communicable Diseases, Health Security and Environment, acknowledged the diversity across the European Region and explained that the Region would be divided into three geographical areas – western, central and eastern Europe – which would follow different strategic approaches according to their specific epidemiological situations. She took note of the comments about the targets being overambitious and said that there needed to be a broad consensus on how to align the regional action plan with global strategies and targets while ensuring that it was suitable for the diverse conditions in the Region.

38. At its fourth session, members of the Twenty-third SCRC recognized that the new regional action plan had been significantly improved since the draft presented at the second session, and they welcomed the inclusion of coinfections and comorbidities. One

[5] World Health Assembly document A69/31.

member believed that the target of a 75% reduction in new infections was unrealistic for low-prevalence countries. The definition of "key populations at higher risk", as given in the draft global health sector strategy on HIV/AIDS, should be used. The regional action plan should take account of different settings (schools, streets, prisons, etc.) and advocate a comprehensive system of primary prevention. One member of the Standing Committee proposed a number of amendments to the draft resolution.

Action by the Regional Committee	**Review the** "**Action plan for the health sector response to HIV in the WHO European Region"** (EUR/RC66/9)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./5) **and its financial implications** (EUR/RC66/9 Add.1)**.**

Action plan for the health sector response to viral hepatitis in the WHO European Region

39. In a Regional Office consultation in June 2015 on the WHO global health sector strategy on viral hepatitis, 85% of respondents had considered that a European action plan on viral hepatitis was necessary in order to implement the global strategy, and 57% had thought that such an action plan should be developed as soon as possible.

40. At its second session the Twenty-third SCRC said that tackling viral hepatitis was a high priority in the European Region. There were some concerns that the target set out in the draft European action plan of reducing new cases of infection by 30% might be too ambitious. Further consideration needed to be given to what should be prioritized in the action plan. All reporting should be aligned with global reporting requirements, and the action plan should cover issues of epidemiology and access to treatment. There should also be consideration of how to prevent the risk of reinfection among high-risk groups. The action plan should emphasize the effectiveness of vaccination and complement other action plans on communicable diseases, such as HIV/AIDS, and on sexual and reproductive health.

41. At its fourth session, the Twenty-third SCRC welcomed the draft action plan, which was the first of its kind in the WHO European Region. Members who came from countries with a significant hepatitis burden drew attention to the high cost of medicines; others expressed concern that the targets in the action plan, in particular those on incidence reduction and the vaccination of newborns, would be impossible to meet in countries where the burden of viral hepatitis was already extremely low. Prevention of retransmission was the key to ensuring sustainable results.

Action by the Regional Committee	**Review the** "**Action plan for the health sector response to viral hepatitis in the WHO European Region"** (EUR/RC66/10)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./6) **and its financial implications** (EUR/RC66/10 Add.1)**.**

Strategy and action plan on refugee and migrant health in the WHO European Region

42. At the Twenty-third SCRC's second session the Director a.i. and the Coordinator, Division of Policy and Governance for Health and Well-being, jointly presented the key dimensions and guiding principles of a future regional strategy and action plan on refugee and migrant health, which would build on the outcomes of the High-level Meeting on Refugee and Migrant Health, (Rome, Italy, 23–24 November 2015) and the experience of the WHO Public Health Aspects of Migration in Europe (PHAME) project that had been established in 2012.

43. SCRC members underscored the need for strengthening the availability of data on the public health aspects of migration, disaggregating data and identifying health needs according to the migration routes taken and the public health profile of the country of origin. The strategy and action plan should address the different health needs pertaining to refugee and migrant populations. Minimum standards for individual health assessment of refugees and migrants were needed. The SCRC also raised the issue of addressing societal attitudes to migrants and refugees. The strategy and action plan therefore needed to be grounded on an objective, indisputable evidence base that could not be refuted or manipulated. Other necessary measures included the training of health personnel, effective communication strategies, and intersectoral and interagency coordination. The SCRC was informed that discussions were taking place with the WHO Regional Offices for the Eastern Mediterranean and for Africa; it was crucial that migration was seen as a global issue, not just a European phenomenon.

44. At its third session, the Twenty-third SCRC was informed that the draft European strategy and action plan on refugee and migrant health had been formulated. Further consultations were planned with representatives of the WHO Regional Offices for the Eastern Mediterranean and Africa, other United Nations bodies and Member States of the European Region. The Twenty-third SCRC welcomed the draft strategy and action plan. Members advised that the document should refer to the need for effective communication strategies for migrant groups and for the general public. Public awareness should be raised about the health needs of migrants and refugees, and steps must be taken to allay fears and false perceptions. The Regional Office should work with other key partners and international organizations to ensure that the choice of terminology (in particular, definitions of the terms "migrants" and "refugees") were well reasoned and acceptable to all.

45. At its fourth session, the Twenty-third SCRC was informed that the amendments to the draft made since its previous session had enhanced the references to human rights and emphasized the importance of cooperation between countries of origin, transit and destination with regard to data gathering and the sharing of health information. A set of five new indicators had been distributed, and a biennial questionnaire was being prepared in consultation with Member States. The SCRC commended the revised draft; the fact that the document included both a long-term policy perspective and an approach to address the immediate crisis was particularly welcome.

46. Responding to concerns expressed by one observer with regard to the scope of the proposed actions, since no distinction was made between documented and undocumented migrants and their eligibility to receive health services, the Coordinator,

Public Health and Migration noted that a "disclaimer" excluding undocumented migrants would be contrary to the principles of human rights and inclusion. The Regional Director said that a maximum of two weeks could be allocated to further consultation on the indicators and the final version of the document.

Action by the Regional Committee	**Review the "Strategy and action plan on refugee and migrant health for the WHO European Region"** (EUR/RC66/8)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./4) **and its financial implications** (EUR/RC66/8 Add.1)**.**

Strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery

47. At the Twenty-third SCRC's second session, the Director, Division of Health Systems and Public Health, recalled that RC65 had endorsed, in resolution EUR/RC65/R5, the two priorities for health systems strengthening up to 2020. The first of those priorities, transforming health services delivery to meet health challenges in the 21st century, would be taken forward under the European framework for action, in alignment with the work of WHO headquarters on integrated health services delivery, which would be presented for consideration at the Sixty-ninth World Health Assembly.[6]

48. The SCRC generally welcomed the proposed outline of the European framework for action. It should be underpinned by clear goals, and greater emphasis should be placed on the role of health policy-makers and managers. The framework for action would also have implications for the training of health workers, where it was important to engage nongovernmental organizations. Funding was an important issue; much more needed to be allocated to prevention and to enhancing quality and safety, and regulated public–private partnerships should be recognized.

49. The draft European framework for action was presented to the Twenty-third SCRC at its third session. The framework captured the minimum areas for action required for transforming services delivery. Those "domains" – people, services and systems – were each underpinned by a change management component, itself divided into key actions, strategies and tools, including information on country experiences.

50. The SCRC agreed that the proposed process of consultation on the draft European framework for action was acceptable and made suggestions for further improvement of the document. Better links could be made with primary health care, and greater emphasis could be placed on the need to invest in disease prevention and health promotion, as well as to stress the importance of eHealth. The high cost of new drugs and procurement should be properly reflected in the framework, since that supported the case for investing in prevention.

[6] Executive Board resolution EB138.R2 and World Health Assembly document A69/39.

51. At its fourth session, the Twenty-third SCRC was informed about three parallel consultations that had been held with Member States. Repeated calls had been made for the addition of diabetes and dementia to priority health needs, and for further emphasis to be placed on workforce development. There had been acknowledgement of the importance of governance and the regionalization of services. Respondents had also called for the clarification of country-specific goals.

52. Members of the Standing Committee appreciated the extremely important work being done on integrated health services delivery. In view of the diversity of national and subnational health systems in the Region, it would be difficult to define a specific target for inclusion in the draft resolution for submission to RC66.

Action by the Regional Committee	**Review "Strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery"** (EUR/RC66/15)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./11) **and its financial implications** (EUR/RC66/15 Add.1)**.**

Strategy on women's health and well-being in the WHO European Region

53. At the Twenty-third SCRC's second session, the Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, said that the Regional Office had been working for more than a year on developing a strategy on women's health. The rationale for the strategy was that, while women had a mortality advantage in the Region in that they lived longer than men, they were disadvantaged in a number of other ways. Despite their longer life expectancy, their later years were not necessarily healthy. They also faced many challenges outside the health sector that nevertheless could have an impact on their health. One key finding had been that women were significantly less prevalent in clinical trials. The proposed key areas of the strategy would accordingly be to enhance equity in norms, in access to and provision of services and in health research.

54. The Standing Committee recognized that when data were disaggregated by gender, they raised issues that had been ignored in the past. In addition to gender-sensitive data collection, it was crucial to ensure gender-sensitive planning and budgeting in order to make sure that the issues that had been raised were effectively addressed.

55. At its third session, the Twenty-third SCRC was informed that the strategy had been revised to take into account the comments and suggestions made. The draft strategy presented four key areas for strategic action: strengthening governance for women's health and well-being; eliminating discriminatory norms, values and practices that affected women's health and well-being; tackling the impact of gender and social, economic, cultural and environmental determinants; and improving health system responses. Consultations on the draft strategy were still under way.

56. Members of the Twenty-third SCRC expressed their support for the draft strategy, which would serve as welcome guidance for drafting policies and action plans at the national level. Some further refinements could be made, including by clustering the proposed activities. Several members suggested including the words "and well-being" after "health" in the title of the draft strategy, to bring it into line with Health 2020. More emphasis should be placed on the protection of women crossing borders, the health needs of pregnant migrants, and women's vulnerability to multiple discrimination. Greater reference should be made to health information.

57. At its fourth session, members of the Twenty-third SCRC expressed their satisfaction with the draft strategy, which had amended in light of comments made at the previous session. Violence against women should be addressed in greater detail in the strategy. Additional emphasis could also be placed on the prevention of environmental hazards, to protect unborn children.

Action by the Regional Committee	**Review the "Strategy on women's health and well-being in the WHO European Region"** (EUR/RC66/14)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./10) **and its financial implications** (EUR/RC66/14 Add.1)**.**

Action plan for sexual and reproductive health – towards achieving the 2030 Agenda for Sustainable Development in the WHO European Region

58. At the Twenty-third SCRC's second session, the Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, said that the Regional Office had been working for more than a year on developing an action plan for sexual and reproductive health. The action plan would be aimed at ensuring sexual health and well-being for all, regardless of gender or sexual orientation, and would be based on the life-course approach. It would focus on three areas: sexual health; reproductive health; and selected populations with special needs.

59. The Standing Committee recommended that the goals and objectives of the action plan should also address the sexual and reproductive health of cancer survivors; screening for women's cancers; infertility treatment, with reference to WHO global infertility guidelines; and the diagnosis, treatment and management of menopausal symptoms and sexual dysfunction. The action plan should include an analysis of the various legal rights and protections that women had in each country.

60. At its third session, the Twenty-third SCRC was informed that the draft action plan comprised three goals: informed decision-making; access to services; and addressing social determinants and inequities. Those goals were accompanied by proposed objectives and actions for WHO, governments and nongovernmental organizations. Despite extensive consultations, the draft action plan remained the subject of some controversy. WHO's mandate on issues such as sexual rights was being

questioned by some Member States: one Member State had requested that all references to rights be removed throughout the document.

61. Members of the Twenty-third SCRC expressed their overwhelming support for the draft action plan, which was timely and ambitious. The document was well structured, fully aligned with Health 2020, and presented the key interventions needed to promote and protect sexual and reproductive health. The draft action plan must be forward-looking and should reflect the interests of humanity, while respecting countries' integrity with regard to such sensitive issues. Increased emphasis on sexual health literacy, sexual disorders, sexually transmitted infections, and the important role of nongovernmental actors – including the church – would be welcome. Support was expressed for the proposed process for negotiating with those Member States that had objections to the text.

62. At its fourth session, members of the Twenty-third SCRC and one observer expressed their support for the revised draft action plan, which they hoped would be submitted to the Regional Committee without major amendment. Several observers, however, remained concerned about the reference to sexual rights and called for the draft to be brought into line with the 2030 Agenda for Sustainable Development, which referred to "sexual and reproductive health and reproductive rights". The Regional Director agreed that the Secretariat drafting process had reached its limit and that further negotiations should be undertaken by government representatives empowered to agree language.

Action by the Regional Committee	**Review the "Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind"** (EUR/RC66/13)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./9) **and its financial implications** (EUR/RC66/13 Add.1)**.**

Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region

63. At its second session, the Director, Division of Information, Evidence, Research and Innovation, informed the Twenty-third Standing Committee that in 2015 a roadmap had been formulated with the European Advisory Committee on Health Research (EACHR) and, following further discussions and a technical briefing at RC65, Member States had proposed that the roadmap be developed into an action plan. The action plan would include three key pillars: harmonizing health information across the Region and strengthening national health information systems; establishing and strengthening national health research systems; and enhancing knowledge translation. The Regional Office was conducting a mapping exercise of knowledge translation capacity in the Region to establish a baseline. The SCRC believed that the action plan was a welcome and much-needed tool for Member States: there was a wealth of information in the public health sphere, but no mechanism to translate that information into evidence-informed policy.

64. At the Twenty-third SCRC's third session the Director, Division of Information, Evidence, Research and Innovation, introduced the draft action plan, which was the first to focus specifically on evidence for policy-making. The draft plan comprised a vision and goal, guiding principles and four key action areas with expected results, deliverables, key indicators and proposed actions. It would be implemented over a five-year timeframe, and included strong elements for monitoring and evaluation. The European Health Information Initiative (which included partners such as the European Commission and the Organisation for Economic Co-operation and Development) would serve as an operational platform for implementing the action plan.

65. Members of the SCRC commended the draft action plan. Some suggestions were made to further enhance the document by defining the indicators in more detail, and by giving examples of the balance between the use of evidence and other contextual factors. The link between health information systems and eHealth should be strengthened; in that regard, adding health technology assessment as an element could be useful.

66. At its fourth session, the Twenty-third SCRC reviewed the revised draft of the regional action plan, which had been amended following an online consultation with Member States. A new guiding principle on health information governance had been added. The action plan had been made more comprehensive, by including the generation of research and incorporating health system performance. The key indicators in each of the four action areas had been made more specific. Further actions had been proposed for Member States and the Regional Office, and emphasis had been placed on collaboration with the European Commission. Members of the Standing Committee welcomed the incorporation of countries' comments and commended the revised draft of the action plan. They recommended that the key indicators in the plan should be precisely the same as those used by WHO in other contexts. The action plan should address the problem of what to do in case of weak or insufficient evidence. Emphasis should be placed on the need for links and interoperability between health and financial data sets.

Action by the Regional Committee	**Review the "Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region"** (EUR/RC66/12)**.** **Consider the corresponding draft resolution** (EUR/RC66/Conf.Doc./8) **and its financial implications** (EUR/RC66/12 Add.1)**.**

Partnerships for health in the WHO European Region

67. At its second session, members of the Twenty-third SCRC were informed that it had been deemed sensible to put the development of a partnerships strategy at the regional level on hold until the draft framework of engagement with non-State actors had been discussed and finalized by the Executive Board and the World Health Assembly.

Budgetary and financial issues

Report of the Secretariat on budget and financial issues

68. The Director, Division of Administration and Finance, presented the report of the Secretariat on budget and financial issues (oversight function of the SCRC) to the Twenty-third SCRC at its third session. The approved PB 2014–2015 had been funded at 95%, with implementation at 89%. About 48% of the financial resources for the biennium had been fully or highly flexible funds and 52% had been highly specified voluntary contributions (VCs). Nine per cent more assessed contributions and core voluntary contributions account funds had been allocated to the Regional Office from the global level compared with previous bienniums, which had allowed for greater flexibility to fund previously underfunded and priority areas. The Twenty-third SCRC agreed that an end-of-biennium assessment should be on the agenda of RC66, but that the document should be the shorter of the two options proposed.

69. At its fourth session, the SCRC was informed that PB 2016–2017 for the European Region of US$ 246 million, as approved by the Sixty-eighth World Health Assembly, had been increased by approximately US$ 15 million (6%) in the outbreaks and crisis response (OCR) programme area of Category 5, for activities in Turkey and Ukraine, resulting in an allocated budget of approximately US$ 261 million. A timely start had been made with technical and financial implementation of PB 2016–2017. All biennial workplans had been operational on 1 January 2016. Projections for the receipt of VCs by the Regional Office were higher for 2016–2017 than for 2014–2015. Detailed analysis of funding by category for the European Region showed that Category 2 (noncommunicable diseases) was the highest funded (51%), while Category 5 base programmes (preparedness, surveillance and response) had the lowest funded percentage (31%) of the approved PB.

Proposed PB 2018–2019

70. The Twenty-third SCRC was informed at its fourth session that bottom-up priority-setting by countries had been finalized, outputs had been costed by heads of WHO country offices and regional technical programmes, and global programme area networks had been activated to review priorities, the result chain and indicators. A first full draft of the proposed PB 2018–2019 and the regional perspective on it would be presented to RC66.

Action by the Regional Committee	**Review the "Proposed programme budget 2018–2019"** (EUR/RC66/20) **and the regional perspective on it** (EUR/RC66/27)**.**

WHO reform: progress and implications for the European Region

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

71. At the Twenty-third SCRC's second session, the Regional Director reported that the Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies with

Health and Humanitarian Consequences had submitted its report to the Director-General. WHO was in the process of establishing a programme for emergency preparedness and response with clear responsibility, adequate capacity and strong lines of accountability and a command and control system.

72. At its third session, the SCRC was informed that, following the 138th session of the Executive Board in January 2016, the Global Policy Group (GPG) had issued a statement confirming its commitment to work urgently to achieve one unified Health Emergencies Programme with one workforce, one budget, one set of rules and processes, one set of performance benchmarks, and one clear line of authority. The process for selection of the Executive Director for the Programme was under way, and an oversight body would be established to oversee the Programme.

73. At the fourth session, the Regional Director reported that the transition toward that new arrangement had already started; an ambitious timetable was included in the documentation for the forthcoming Sixty-ninth World Health Assembly; and the Programme, Budget and Administration Committee of the Executive Board had recommended that the Health Assembly should consider approving an increase of US$ 160 million for PB 2016−2017.[7]

Membership of WHO bodies and committees

74. The Twenty-third SCRC was informed at its second session that nominations or elections for membership of the following WHO bodies and committees would take place at RC66:

- Executive Board (two vacancies);
- SCRC (four vacancies);
- European Environment and Health Ministerial Board (two vacancies).

75. In private meetings during its third and fourth sessions, the Twenty-third SCRC reviewed the vacancies on WHO bodies and committees and the candidatures received.

76. At the fourth session, the Chairperson reported that, despite an extension of the deadline and a repeated call for nominations, only one candidature for membership to the Standing Committee had been received from Group A countries to fill the two vacancies for that group, whereas three candidatures had been received from Group B countries for one vacancy. Following consultations with the WHO Legal Counsel, the Twenty-third Standing Committee had accordingly decided to exceptionally move one vacancy from Group A to Group B in 2016, and to counter balance the situation by reallocating one vacancy from Group B to Group A in 2017. With this proposed change the balance of subregional representation, in accordance with resolution EUR/RC63/R7 Annex 3.B, would be maintained (see Annex 2).

Action by the Regional Committee	**Review the report on "Membership of WHO bodies and committees"** (EUR/RC66/7,

[7] World Health Assembly documents A69/30 and A69/61.

EUR/RC66/7 Add.1 and EUR/RC66/7 Add.2).

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

77. At its third session, the President of the WHO Regional Office for Europe Staff Association (EURSA) briefed the Twenty-third SCRC on the Staff Association's grave concerns regarding the new global staff mobility scheme. The changes made to the Staff Regulations and Staff Rules in that connection meant that while staff could move laterally or be demoted, they could no longer request a post description review or a promotion. Furthermore, the financial sustainability of different positions across regions and offices was not clear, which meant that staff might only be given the option to move to a time-bound post or a shorter-term post with potentially less sustainable funding than the one to which they had been initially recruited. In the first volunteer round for jobs posted in the WHO mobility compendium, two-thirds of volunteers had been men. With the current implementation of the framework, the Staff Association questioned how talent would be retained.

78. Efficient and effective governance would be the key to the success of the mobility policy. Staff should be confident that they had at their disposal a mechanism to seek answers, clarifications, assistance and internal justice if necessary. Such a mechanism did not exist. Staff representatives had only been granted observer status in the Global Mobility Committee meeting, thus receiving the message from top WHO management that staff could be seen, but not heard. The implications of a weak governance mechanism had a direct impact on staff motivation. The President of the Staff Association encouraged Member States to keep a critical eye on the implementation of the mobility framework.

79. Members of the Twenty-third SCRC welcomed the statement by the President of the Staff Association and agreed that the mobility framework should be used to strengthen the Organization. It was useful for Member States to hear the Staff Association's views and concerns, which would serve as crucial background to discussions in upcoming governing bodies' sessions. The Regional Director agreed that a robust governance mechanism had not been formulated yet but was essential and pledged to continue to work with the Staff Association to that end.

Annex 1. Members, alternates and advisers to the Twenty-third Standing Committee of the Regional Committee for Europe 2015–2016

Members, alternates and advisers

Belarus
Dr Vasily Zharko
Minister of Health
Ministry of Health

Adviser
Mr Anatoli Hrushkousky
Head, Foreign Relations Department
Ministry of Health

Adviser
Dr Marina Sachek
Director, Republican scientific and practical center for Medical Technologies, Computer Systems, Administration and Management of Health

Estonia
Dr Ivi Normet
Deputy Secretary General on Health
Health Policy Department
Ministry of Social Affairs

Adviser
Dr Liis Rooväli
Head
Department of Health Information and Analysis
Ministry of Social Affairs

Adviser
Mr Jürgen Ojalo
Chief Specialist
Health System Development Department
Ministry of Social Affairs

Adviser
Ms Kaija Lukka
Adviser
Health System Development Department
Ministry of Social Affairs

Adviser
Mr Taavo Lumiste
Third Secretary, Permanent Mission of the Republic of Estonia to the United Nations Office and other international organizations in Geneva

Members, alternates and advisers

Finland[8]
Ms Taru Koivisto
Director
Department for Promotion of Welfare and Health
Ministry of Social Affairs and Health

Alternate
Ms Outi Kuivasniemi
Ministerial Adviser
Ministry of Social Affairs and Health

France
Professor Benoît Vallet
Director General of Health
Ministry of Social Affairs and Health

Alternate
Ms Amélie Schmitt
Head of European and International Affairs
Directorate General for Health
Ministry of Social Affairs and Health

Adviser
Ms Emmanuelle Jouy
International Officer
Delegation for European and International Affairs
Ministry of Social Affairs and Health

Adviser
Ms Katell Daniault
Delegation for European and International Affairs
Ministry of Social Affairs and Health

Adviser
Mr Patrick Kluczynski
Head of International Affairs Office, Health Branch
Delegation for European and International Affairs
Ministry of Social Affairs and Health

Georgia
Dr Amiran Gamkrelidze
General Director
National Center for Disease Control and Public Health

Alternate
Mr Luka Sartania
First Secretary
Embassy of Georgia in Denmark

[8] Ms Taru Koivisto, the Chairperson of the Twenty-second Standing Committee of the Regional Committee for Europe, is an ex officio member.

Members, alternates and advisers

Germany
Ms Dagmar Reitenbach
Head, Division of Global Health
Federal Ministry of Health

Adviser
Mr Björn Kümmel
Desk Officer and Deputy Head, Division of Global Health
Federal Ministry of Health

Iceland
Dr Sveinn Magnússon
Director General, Department of Health Care Services
Ministry of Welfare

Italy
Dr Raniero Guerra
Director General for Health Prevention
Ministry of Health

Alternate
Dr Francesco Cicogna
Director, Office III
Directorate General for European and International Relations
Ministry of Health

Latvia
Ms Agnese Raboviča
Director, Department of European Affairs and International Cooperation
Ministry of Health

Alternate
Ms Līga Šerna
Deputy Director, Department of European Affairs and International Cooperation
Ministry of Health

Portugal
Dr Francisco George
Director-General of Health
Ministry of Health

Alternate
Ms Eva Sofia Moço Falcão
Director
Directorate of International Relations
Directorate-General of Health

Romania
Professor Alexandru Rafila
Adviser to the Minister
Ministry of Health

Members, alternates and advisers

Sweden[9]
Ms Olivia Wigzell
Director General
National Board of Health and Welfare

Alternate
Mr Bosse Pettersson
Senior Public Health Policy Adviser
National Board of Health and Welfare

Tajikistan
Dr Salomudin Yusufi
Head, Department of Medical and Pharmaceutical
Education, Human Resources and Science
Ministry of Health and Social Protection

Adviser
Dr Lola Bobohojieva
First Deputy Minister of Health and Social
Protection
Ministry of Health and Social Protection

Adviser
Dr Rano Rahimova
Head, International Relations
Ministry of Health and Social Protection

Turkmenistan
Dr Leyli Shamuradova
Deputy Minister and Chief Medical Officer
Ministry of Health and Medical Industry
Head, State Sanitary and Epidemiological Service

Adviser
Mrs Bahargul Agayeva
Head, Information and Statistics Department
Ministry of Health and Medical Industry

[9] Sweden serves as the link between the Executive Board and the Standing Committee of the Regional Committee for Europe.

Annex 2. Vacancies for membership to the Standing Committee of the Regional Committee for Europe 2016–2018

Nomination year	Group A	Group B	Group C
2016 (original)	2	1	1
2016 (proposal)	1	2	1
2017 (original)	1	2	1
2017 (proposal)	1 + 1 = 2	2 – 1 = 1	1
2018 (original)	1	1	2

Group A: Belgium, Czech Republic, Denmark, Estonia, Finland, Germany, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Slovakia, Sweden, United Kingdom of Great Britain and Northern Ireland.
Group B: Andorra, Austria, Bulgaria, Croatia, Cyprus, France, Greece, Hungary, Italy, Malta, Monaco, Portugal, Romania, San Marino, Slovenia, Spain, Switzerland.
Group C: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Israel, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, Uzbekistan.

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