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## **Report of the third session**

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## Opening of the session

1. The Twenty-third Standing Committee of the Regional Committee for Europe (SCRC) held its third session at UN City in Copenhagen, Denmark, on 9–10 March 2016. The Chairperson welcomed members and other participants and noted that the report of the second session of the Twenty-third SCRC, which had taken place in Paris, France, on 26–27 November 2015, had been circulated and approved electronically.
2. The provisional agenda (document EUR/SC23(3)/2) and provisional programme (document EUR/SC23(3)/3) of the session were adopted.
3. In her opening address, which was webstreamed, in line with Annex 4 of resolution EUR/RC63/R7, the WHO Regional Director for Europe gave an overview of the work of the Regional Office since the Twenty-third SCRC's second session in November 2015. Implementation of the 2030 Agenda for Sustainable Development had been a prominent item on the agenda of the 138th session of the Executive Board in January 2016, with emphasis on policy coherence and intersectoral and interagency collaboration. Health should be integrated into national development agendas. Member States in the WHO European Region were already well positioned to jumpstart the implementation of the health-related Sustainable Development Goals, due in part to the work already achieved on Health 2020 priorities. Heads of WHO country offices both globally and in the European Region had discussed how to best support countries with the implementation and agreed to include the Sustainable Development Goals in the planning for future bienniums. An internal mapping exercise had been launched to identify links and gaps in work on the Sustainable Development Goals at regional and country levels, focusing on the “what” and the “how” of WHO's work. During the retreat for regional directors of United Nations agencies and organizations in the European Region on the 2030 Agenda, emphasis was given to the importance of working as “one UN”. The regional directors recognized the central role of health in the Sustainable Development Goals, Goal 3 specifically, and as targets for many other goals, and had therefore decided to establish an issue-based coalition on health in the European Region, which would be led by the WHO Regional Office for Europe and for which the terms of reference were being finalized.
4. Substantial work had been done on WHO's emergency reform, guided by the report and recommendations of the Ebola Interim Assessment Panel, the Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies, and external reports, as well as the WHO Executive Board, and most recently, the report of the United Nations Secretary-General's High-Level Panel. 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 programme with one workforce, one budget, one set of rules and processes, one set of performance benchmarks, and one clear line of authority. The utmost effort would be made so that the new programme would be comprehensive, addressing all hazards flexibly, rapidly and responsibly, working in synergy with other WHO programmes and partners to address the full cycle of emergency preparedness, response and recovery; it would encourage the full participation and integration of all partners. The process for the selection of the Executive Director for the programme was under way, and an oversight body would be established to oversee the programme.

5. Following the advice of the IHR Emergency Committee on the Zika virus and observed increase in neurological disorders and neonatal malformations, the WHO Director-General had declared that the recent cluster of microcephaly and neurological disorders in Latin America and the Caribbean constituted a public health emergency of international concern. While no local transmission of the Zika virus had been recorded in Europe, the *Aedes* mosquito was present in the European Region and its activity would likely increase during spring and summer months. An incident management system had been established in the Regional Office, and the situation was being closely monitored with partners, in particular the European Commission and the European Centre for Disease Prevention and Control, including through assessments of Member States' capacities for surveillance, diagnosis, integrated vector management and emergency risk communication. The Regional Office was committed to supporting Member States in the implementation of comprehensive vector control measures, facilitating shipment of samples to WHO collaborating centre laboratories, delivering diagnostic tools for local testing, and risk communication.

6. The Regional Office, jointly with Monaco, had organized a side event on health as central to climate change action at the Conference of the Parties to the United Nations Framework Convention on Climate Change, in Paris, France, in December 2015, which was opened by His Highness Prince Albert II, who had focused on the impact of climate change on health: the burden of communicable and noncommunicable diseases, malnutrition and food security.

7. The host agreement for the WHO European Office for Investment for Health and Development in Venice, Italy, had been ratified. Constructive discussions had been held with the Russian Federation regarding the geographically dispersed office on noncommunicable diseases (NCDs), as well as on broader collaboration on the Sustainable Development Goals, and on the Regional Office's support for the new HIV strategy in the Russian Federation. A biennial collaborative agreement (BCA) with the Russian Federation had been concluded. BCAs had also been concluded with Montenegro and Romania. Belarus had held an event in October 2015 marking the 70th anniversary of the United Nations, at which the Regional Director had signed the implementation plan for the new United Nations Development Assistance Framework for Belarus. Discussions were ongoing with authorities in Hungary in preparation for the 67th session of the Regional Committee for Europe to be held in Budapest in September 2017.

8. One member of the Twenty-third SCRC requested further information on preparations for the emergency reform in general, and on the Regional Office's role in particular.

9. The Regional Director said that the Regional Office was being represented in the emergency reform process by the Director, Division of Communicable Diseases and Health Security, along with the WHO representatives from Turkey and Ukraine. The GPG held teleconferences every two weeks to receive updates on the Zika virus outbreak and to contribute to the emergency reform, reviewing the work under way. Arrangements for the reform were close to being finalized; health attachés in Geneva, Switzerland, would be briefed, and a final report would be submitted to the Sixty-ninth World Health Assembly in May 2016. The GPG was committed to implementing the reform as requested and agreed by Member States.

## **Reports by chairpersons of the SCRC subgroups**

### ***Subgroup on governance***

10. The chairperson of the subgroup on governance, Dr Ivi Normet (Estonia), said that the subgroup had reviewed the handbook on the use of the tool for evaluating candidates for nomination to WHO bodies and committees. The subgroup recommended that the tool 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 long list of document types had been divided into four categories; SCRC feedback on those categories would be welcome.

11. The subgroup 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 national counterparts. For nomination within the Region, this had proven very useful. The main problems in relation to nomination at the global level stemmed from different nomination procedures, short timelines and lack of transparency with regard to the membership of the various advisory bodies. The subgroup had also discussed the work of the global working group on WHO governance reform and had noted that the Executive Board had not reached a conclusion on that item on its agenda, and had therefore set up an open-ended meeting for Member States to continue discussions, during which the representative of Estonia would raise the issues of unified policy documents and the nomination of experts.

### ***Subgroup on migration and health***

12. Dr Raniero Guerra (Italy), chairperson of the subgroup on migration and health, explained that the subgroup had focused its discussions on the public health aspects of migration, in order to contribute to the preparations of the draft Strategy and action plan for refugee and migrant health in the WHO European Region 2016–2022 (document EUR/23(3)/13) for submission, with an accompanying draft resolution, to the WHO Regional Committee for Europe at its 66th session (RC66). The draft document focused on several aspects of migration and health: human rights; gender responsiveness; health in all policies; solidarity; universal health coverage; and people-centred health systems.

13. Given the increasing complexity of the migration situation in the European Region, coordination between initiatives at both global and regional levels was particularly important, as were technical support and clear lines of action. The WHO European Region was in a unique position to liaise with the Eastern Mediterranean and African regions, and to encourage Member States to take evidence-based actions in addressing this diverse community and avoiding discrimination. Steps should be taken to enhance WHO support for efforts by Member States to strengthen their health systems to fill technical and skills-based gaps, as well as social gaps, and to increase positive attention on the issue by political decision-makers and the public. To that end, the subgroup supported the generation of a policy paper to assist Member States in responding to public health needs resulting from migration.

14. A request was made to include Finland in the list of members of the subgroup.

15. A member of the Twenty-third SCRC commended the work of the subgroup and emphasized the importance of measures to address migrants' health from both short- and long-term perspectives. Lessons should be learned from previous migration flows, and should extend through the full continuum of care. The draft strategy and action plan for refugee and migrant health should be aligned with the draft European action plan for human-rights based sexual and reproductive health 2017–2020 (document EUR/SC23(3)/9) and should make reference to the sexual and reproductive health and rights of migrants.

16. The Regional Director thanked the Italian authorities for hosting the high-level meeting on refugee and migrant health that had been held in Rome, Italy, in November 2015 and agreed that cooperation with other WHO regions was vital. In that regard, close collaboration with the Regional Office for the Eastern Mediterranean was planned. The Executive Board had held constructive discussions on migration and health, agreeing that WHO should strengthen its work on this important topic, and that the programme on migration and health would be strengthened. The political sensitivity of migration issues should not be underestimated and a thorough consultation on the draft strategy and action plan was therefore essential. Efforts would be made to further distinguish between short-, medium- and long-term requirements, and to align the draft strategy and action plan with the draft European action plan on human-rights based sexual and reproductive health.

### ***Subgroup on accelerating implementation of the International Health Regulations (IHR) (2005)***

17. The subgroup on accelerating implementation of IHR (2005), chaired by Professor Benoît Vallet (France), informed the Twenty-third SCRC that the subgroup had met twice (in a teleconference and face to face) and had also been briefed on global processes in relation to the IHR (2005). The subgroup agreed that health security is a global public good and that the implementation of IHR (2005) is therefore the mutual responsibility of every country. Strengthening the leadership and capacity of WHO is an important component in improving global governance of health security. The revised IHR monitoring and evaluation framework should be taken as a full package, and independent, external evaluations, carried out after action reviews and simulation exercises, should complement the annual reporting on IHR core capacities. Regarding the roster of experts, the subgroup had agreed that a set of criteria should be established for the selection of experts and that transparency was crucial. There should be at least 200 experts from a variety of sectors. Guidelines and training programmes should be put in place for the experts in the roster, and also for national technical focal points.

18. The subgroup also discussed the value of assessments carried out after action reviews and simulation exercises, stressing their importance in identifying gaps, and asked WHO to provide further guidance.

19. Liaison with other organizations and partners was particularly important to ensure a “one health” approach. Implementation gaps brought to light by assessments should be identified, analysed and followed up by national actions. It would be particularly useful to share the experiences of those involved in IHR assessments through a regional meeting every two or three years, which could also be an opportunity for a briefing about the evaluation of IHR implementation, and for Member States to be updated on

alerts, including their alignment with IHR rules, and to consider whether any gaps in that regard could be identified and filled.

20. The Regional Director emphasized the cyclical nature of evaluations: the recommendations of the external evaluations should be followed up and should then feed into the following round of evaluations. External validation of evaluations was particularly important. She agreed that simulation exercises had proven useful and should become standard practice. The roster of experts must indeed be multisectoral. She also agreed that a regional meeting to review the use of IHR and core capacities every two or three years could be beneficial and would enable external evaluations to be reviewed and follow-up to recommendations assessed. Such meetings could also provide an opportunity to review emergency work being carried out by WHO, including work on alerts and grade 1 emergencies, which was not well recognized by Member States.

### **Provisional agenda and provisional programme of the 66th session of the Regional Committee for Europe (RC66)**

21. The Regional Director presented the provisional agenda (document EUR/SC23(3)/5 Rev.1) and provisional programme (document EUR/SC23(3)/6) for RC66. Some adjustments had been made to the programme since the second session of the Twenty-third SCRC, such as the suggestion to take advantage of the presence of ministers on the first two days of the session to discuss substantive policy items. She noted in particular that the item on WHO reform would also include WHO's work in outbreaks and emergencies and that discussions under the item on the midterm progress report on Health 2020 implementation should also link to both the progress report on the European Action Plan for Strengthening Public Health Capacities and Services and the Minsk Declaration. Although five topics had already been suggested as the focus for the technical briefings, the agenda would only support one technical briefing per day, so a decision should be taken as to which of the proposed topics would not be included. Referring to the previous agreement by the Twenty-third SCRC that the approval of the report of the session of the Regional Committee should be removed from the agenda in favour of a post-session electronic approval procedure, the Regional Director presented a proposed timeline of activity from the end of RC66 until the deadline for approval of the report of the session.

22. Several Standing Committee members expressed concerns about the heavy agenda and whether there would be adequate time for all discussions, and cautioned that consideration should be given to the capacity of Member States to implement the high number of action plans and strategies being presented. One member welcomed the topic of high-price medicines for a ministerial lunch. One member proposed that consideration should be given to deferring some items to the following year and focusing only on those items that were deemed to be of highest priority at RC66. Others suggested additional topics for discussion in technical briefings or ministerial lunches, including dementia and preparations for the 9th Global Conference on Health Promotion: Health Promotion in the Sustainable Development Goals, co-organized by WHO and the People's Republic of China, which would take place in Shanghai on 21–24 November 2016. The essential public health operations for delivering public health services should be included in the agenda, given their link to the 2030 Agenda for

Sustainable Development. One member said that it would be useful to have an informal event the day before the opening of RC66, as in previous years, on topical issues that might not be on the formal agenda.

23. The Regional Director welcomed the comments and said that although the agenda was heavy, it could be fully accommodated if the proposed timings were respected. Discussions on health promotion would cover the preparations for the 9th Global Conference on Health Promotion and refer to other relevant conferences. She also agreed that dementia was an important issue and proposed waiting until the outcome of the discussions on dementia at the Sixty-ninth World Health Assembly to consider how to include it on the RC66 agenda. Regarding the inclusion of high-cost medicines as a topic for ministerial discussion, it would be better to cover the topic in a technical briefing, with a view to adding it to the formal agenda at RC67. She agreed that it was time to revisit the European Action Plan for Strengthening Public Health Capacities and the essential public health operations, taking into consideration new developments such as Health 2020 and the Sustainable Development Goals. She suggested a two-step approach, beginning with a review of the essential public health operations and then placing a formal item on the agenda of the Regional Committee to review how public health was conceptualized in the light of Health 2020 and the Sustainable Development Goals. The informal discussions held prior to the opening of Regional Committee sessions in the past had indeed been valuable and plans should be made to hold a similar informal event ahead of RC66. Topics for discussion at that briefing should be decided after the Sixty-ninth World Health Assembly in May 2016. Finally, she proposed that the partnership session could focus on “one health” and could involve partners such as the European Union, the Food and Agriculture Organization of the United Nations and the International Organisation of Employers.

24. The Regional Director subsequently outlined items for future Regional Committee sessions (document EUR/SC23(3)/15) and information on hosting a Regional Committee session outside Copenhagen (document EUR/SC23(3)/Inf.Doc./1). The rolling agenda of items for future Regional Committee sessions set out the standard items that appeared on the 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. In relation to hosting a Regional Committee session outside Copenhagen, she outlined the criteria and conditions required for a session, and the need to ensure transparency and to assist Member States’ in their considerations when deciding whether to host a meeting. All Regional Committee sessions were governed by a host agreement, which delineated how tasks and costs were to be shared between the Regional Office and the host country. Broadly, the Regional Office was responsible for administration and content of the session, while the host country was responsible for logistics, including the provision of the venue, accommodation for participants, equipment and services.

25. 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 ease the increasingly heavy and unsustainable World Health Assembly and Executive Board agendas, and improve the prioritization of agenda items. Responding to comments, the Executive Manager, Strategic Partnerships and Resource Mobilization, said that the open-ended intergovernmental meeting on governance



reform had recently recommended that the WHO Director-General develop a six-year forward-looking planning schedule of expected agenda items, which broadly amounted to a rolling agenda at the global level. The Regional Director added that the document would be elaborated further and presented again at the fourth session of the Standing Committee. The Twenty-third SCRC would be asked to consider the proposed agenda for RC67 in order to assist with preparations for the 67th session of the Regional Committee in 2017.

## **Outcome of the WHO European Ministerial Conference on the Life-Course Approach in the Context of Health 2020**

26. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, said that the Ministerial Conference on the Life-Course Approach in the Context of Health 2020 had redefined the understanding of the life-course approach as a strategic area of Health 2020, and had divided it into three key features: early action, which includes early childhood development, foetal programming and attention to the origins of adult health and disease; timely action, which relates to the important social transitions in life that also have significant health implications; and joint action, which builds on the intersectorality of Health 2020 to address the determinants of health for different large cohorts of the population. The outcome document – the Minsk Declaration – would be submitted, along with a background document and a draft resolution, to RC66 for adoption. As further follow up, preparations were being made to draft an authoritative document by the end of 2017, summarizing the scientific foundations and policy implications of the three areas of work under the life-course approach, which would subsequently be submitted to the Regional Committee for adoption.

27. The Twenty-third SCRC agreed to include the outcome of the Ministerial Conference on the Life-course Approach under the item on Health 2020 implementation on the agenda for RC66.

### ***Technical agenda items for RC66***

#### **Midterm progress report on Health 2020 implementation 2012–2016**

28. The Director, Division of Policy and Governance for Health and Well-being, presented the draft midterm progress report on Health 2020 implementation 2012–2016 (document EUR/SC23(3)/12), which would be presented to RC66 in accordance with resolution EUR/RC62/R4. Data and information had been collected from all divisions in the Regional Office and compiled by the Division of Policy and Governance for Health and Well-being. In addition to the midterm progress report, the Minsk Declaration would be submitted to RC66, along with a presentation on implementation of the European Action Plan for Strengthening Public Health Capacities and Services as an essential implementation pillar of Health 2020. The progress report described the Regional Office's efforts to support Member States with health policy development, updating the evidence base, developing international partnerships, and updating their Health 2020 targets, indicators and monitoring. Despite good progress, the European

health report 2015<sup>1</sup> showed that inequities remain within and between countries with respect to life expectancy, infant mortality, and social determinants of health such as primary school enrolment and unemployment rates. 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.

29. 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 in numerous forums and conferences, and to enhance the evidence base. A study to gather evidence on the health impact of air pollution in Europe had been conducted, and an extensive evidence review had taken place ahead of the Ministerial Conference on the Life-Course Approach. The European health report, the European Health Information Gateway, the European Health Statistics mobile application, and *Public Health Panorama* – the new journal of the WHO Regional Office for Europe – were reflections of the success of Health 2020 monitoring and information. A high-level conference on intersectoral action was being organized, to be hosted by France, to bring together representatives of the health, education and social sectors in the European Region to consider how intersectoral efforts could be strengthened and used to improve health and well-being and improve social outcomes. The conference, scheduled to take place in Paris on 11–12 July 2016, would give rise to an outcome document for eventual adoption by the Regional Committee.

30. The Twenty-third SCRC welcomed the midterm progress report and particularly commended the information on country experiences, which served as valuable practical examples of implementation. Members wished to know what priority actions needed to be taken to ensure that the Health 2020 agenda would be implemented effectively by 2020. Analysis of the kinds of policies needed to narrow implementation gaps, and 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. Clarification was requested on how many documents would be submitted to RC66 under the agenda item on Health 2020 implementation. It would also be useful to know how many tools and strategies for intersectoral action would be developed and what measures were being taken to avoid duplication or overlap, either between those tools and strategies, or with the contents of the *Health in All Policies: Training Manual*.<sup>2</sup>

31. With regard to the promotion of intersectoral activities, the Paris conference could include information both on the costs of multisectoral activities and on the savings that could ultimately be incurred by other sectors investing in health. Ageing should be underscored in efforts to promote an intersectoral approach, since the elderly would depend not only on the health sector, but also on the social sector for welfare and care. More information on positive experiences of Member States with regard to environment

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<sup>1</sup> The European health report 2015: targets and beyond – reaching new frontiers in evidence. Copenhagen; WHO Regional Office for Europe; 2015 (<http://www.euro.who.int/en/data-and-evidence/european-health-report>).

<sup>2</sup> Health in all policies: training manual. Geneva: World Health Organization; 2015 ([http://who.int/social\\_determinants/publications/health-policies-manual/en/](http://who.int/social_determinants/publications/health-policies-manual/en/)).

and health would be welcome, given the impact of climate change on mortality, and in particular on the rise in the prevalence of mosquito vectors and the real possibility of the spread of vector-borne diseases in the European Region. The Healthy Cities Network could play an important role in highlighting the responsibility at the municipal level to prepare to face such threats, and WHO had a coordinating role to play at the regional, national and subnational levels.

32. The Director, Division of Policy and Governance for Health and Well-being, thanked the Twenty-third SCRC for its support and welcomed the comments and suggestions presented. She agreed that more specific priority areas of action should be identified for reducing health inequities. A report on targets, indicators and monitoring was required in the context of the Health 2020 progress report, while other reporting mechanisms also existed in the Regional Office, such as the European health report and other relevant publications. Tools, instruments and committees for intersectoral work should be viewed as a package. Efforts would be made to clarify how those elements linked together. She also agreed on the importance of more evidence and information on the economic benefits of intersectoral work. The suggestion to include more information on environment and health was welcome and consideration was being given on how to define new leadership and new areas of activity for the Healthy Cities Network.

33. The Regional Director recommended that four separate proposals 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; 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. Priority issues would be to promote policy coherence through Health 2020 and the 2030 Agenda for Sustainable Development, using intersectoral collaboration, Health in All Policies, whole-of-government and whole-of-society approaches, and to consider how income, employment and education policies could promote health benefits. Information on the economic benefits of health promotion should be used to send clear signals to policy-makers.

34. The Director, Division of Information, Evidence, Research and Innovation, added that monitoring and evaluation comprised five elements:

- (a) the European health report gave a comprehensive overview of all targets, indicators and progress every three years;
- (b) information on progress in relation to policy indicators was issued every two years, which included information on policy alignment with Health 2020 and target-setting at the national level;
- (c) an annual summary of the core health indicators was published, showing progress by country for each indicator;
- (d) the European Health Information Gateway and the mobile application showed progress by country, updated every six to 12 months, for each target and indicator; and
- (e) country profiles are in the process of being published, which will give in-depth analyses of progress towards Health 2020 implementation at the country level.

## **Strategy and action plan for refugee and migrant health in the WHO European Region 2016–2022**

35. The Director, Division of Policy and Governance for Health and Well-being, said that refugee and migrant health was a key priority for the Regional Office for Europe and a prime example of an area that could only be addressed through intersectoral action; the health sector needed to work with all other government and nongovernmental sectors to ensure that migration and health policies were coherently aligned. The draft European strategy and action plan for refugee and migrant health had been formulated taking into account Health 2020 and the 2030 Agenda for Sustainable Development, and strongly emphasized the need for a human rights-based, equity-driven, gender-sensitive approach. The subgroup on migration and health had met twice since the Twenty-third SCRC's second session in November 2015 and had proposed valuable revisions to the draft document, which were outlined by the Coordinator, Policy and Governance for Health and Well-being. Further consultations were planned with representatives of the Eastern Mediterranean and African regions of WHO, other United Nations agencies and Member States of the European Region. The revised draft would be presented for consideration at the fourth session of the Twenty-third SCRC in May 2016, after which further consultations would be held with Member States to discuss the draft resolution that would be submitted for consideration by RC66.

36. The Twenty-third SCRC welcomed the draft strategy and action plan for refugee and migrant health, which it deemed important and timely. Several members raised the issue of the definitions of the terms "migrant" and "refugee" used in the document and suggested that it could be useful to consult with the European Commission to ensure consistency in the terminology used, since discussions on those definitions had been held at the European Union level with due consideration for the particular sensitivities relating to the use of those terms. The draft strategy and action plan should take into account that the health needs of migrants and refugees are different. Further, the definitions should take account of the different needs of different migrant groups. Several speakers agreed 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. Negative media coverage, such as portraying migrants as spreaders of disease, further marginalized migrants and impeded access to the health services they required. One member underscored the fragile and dynamic nature of the situation. Even that day there had been reports of various borders and routes through Europe having been closed. The draft strategy and action plan must take into account such events and their implications on the situation and on the needs of the migrants and refugees.

37. The Coordinator, Vulnerability and Health, requested Standing Committee members to submit any proposed amendments to the draft strategy and action plan in writing for the sake of accuracy and transparency. The issue raised about which definitions would be used in the document was a delicate one and the Regional Office would work with other key partners and international organizations to ensure that the choice of terminology would be well reasoned and acceptable to all.

## **Strategy on women's health in the WHO European Region 2017–2021**

38. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, presented the draft strategy on women's health in the WHO European Region 2017–2021 (document EUR/SC23(3)/8), which had been revised to take into account the comments and suggestions made at the Standing Committee's second session. 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. Much of the action required under the first three areas was intersectoral by nature, while the fourth area focused on what was required from the health sector. Health systems should not narrow their focus to women's health needs as mothers, but rather should address the full spectrum of women's health, recognizing the need for gender-appropriate treatment and the fact that some conditions presented differently in women than in men and therefore ran the risk of going undiagnosed or untreated. The draft strategy constituted a template for national action and would guide decision-making. It should also be taken into account by anyone drafting policy documents for the Regional Committee to ensure that all technical issues included adequate consideration of women's health. Consultations on the draft strategy were still under way and the feedback received from Member States thus far had been positive.

39. In the ensuing discussion, members of the Twenty-third SCRC expressed their support for the draft strategy, which filled a gap in WHO policy documents, and illustrated why gender disaggregated health data and gender-specific indicators were so important. It would serve as welcome guidance for drafting policies and action plans at the national level. Some further refinements could be made to the draft strategy, 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, in particular with regard to pregnant women's right to physiological childbirth, since excessive use of caesarean sections constituted a threat to women's health in some Member States in the European Region. Some SCRC members also welcomed the possibility of a strategy on men's health in the future.

40. The Technical Officer, Equity, Social Determinants, Gender and Rights, welcomed the support that the Twenty-third SCRC had expressed regarding the current draft of the strategy and requested that members submit their comments and proposed amendments in writing to ensure they could be taken into account accurately in the revised version of the text. She agreed that it would be useful to cluster the proposed activities. Issues relating specifically to women's sexual and reproductive health would be expanded on in the draft European action plan for human rights-based sexual and reproductive health in the WHO European Region 2017–2021 (document EUR/SC23(4)/9). Those and the other issues mentioned, such as vulnerability to multiple discrimination, would be incorporated into the draft strategy on women's health as further evidence of the barriers that women faced, and of their need for better

health literacy and information to inform their decisions about their health and the services they needed.

### **European action plan for human-rights based sexual and reproductive health 2017–2021**

41. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, introduced the draft European action plan on human rights-based sexual and reproductive health 2017–2021 (document EUR/SC23(3)/9), which 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. WHO was committed to providing technical support to Member States for the implementation of the draft action plan, and for the development of monitoring frameworks.

42. 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 the reference to rights be removed from the title of the document, while another had requested that all references to rights be removed throughout the document. The Secretariat felt that such an amendment would reduce the impact of the document considerably. Another issue of contention was the reference to "safe abortion", which although accepted and agreed terminology in some documents had been deemed an oxymoron, with the argument that surgical procedures could never be 100% safe. Some further objections to the document related to sexuality education, which one Member State considered should be entirely at the discretion of each Member State. The call to bridge the gap between demand for and access to contraception in the European Region was also considered problematic, particularly when referring to adolescents and their needs for information and access to technologies.

43. The Secretariat was in communication with each of the Member States that had expressed objections to the text, and was preparing a table of each of the issues raised – and the solutions found – with the aim of reducing the list of unresolved issues. In the event that some of those issues had not been resolved by the time of its fourth session, the Twenty-third SCRC might wish to consider a mechanism for intervention or direct discussion with the Member States concerned, with a view to reaching an acceptable consensus. Every effort would be made to resolve the issues in time to submit the draft action plan to RC66 for adoption.

44. Members of the Twenty-third SCRC expressed their overwhelming support for the draft action plan, which was timely and ambitious. While they understood the need to accommodate the concerns of all Member States, the content of the document should not be weakened, and the draft should be finalized for submission to RC66. The document was well structured, fully aligned with Health 2020, and presented the key interventions needed to promote and protect sexual and reproductive health and rights. While some members said they could accept the removal of the reference to rights in the title of the document in a spirit of compromise, others felt that such an amendment would be detrimental to the spirit and letter of the draft action plan. One said that "human rights-based" should be replaced by "sexual and reproductive health and rights".

45. 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. "Safe abortion" was agreed terminology and nothing would be gained by re-opening a discussion on that issue. In any case, not all abortions were surgical. Support was expressed for the proposed process for negotiating with those Member States that had objections to the text, with a view to seeking as many solutions as possible while optimizing the potential of the draft action plan. Increased emphasis on sexual health literacy, sexual disorders, sexually transmitted infections, and the important role of nongovernmental actors – including the church – would be welcome. Some members suggested specific textual amendments, which they agreed to submit in writing.

46. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, welcomed the strong expressions of support from the Twenty-third SCRC, which gave the Regional Office negotiating strength when addressing individual objections. The Regional Office would continue with bilateral negotiations in an effort to reduce the number of contentious issues. The Director was optimistic that a draft action plan with the full support of all Member States in the European Region would be ready in time for the fourth session of the Standing Committee in May 2016.

47. The Regional Director said it was clear that the Standing Committee wished to see the draft action plan adopted and she reiterated that every effort would be made to build consensus in time for RC66, and to ensure the adoption of a regional action plan that was founded on the Beijing Declaration and Platform for Action and in line with the 2030 Agenda for Sustainable Development.

### **Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016–2025**

48. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, presented the draft Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016–2025 (document EUR/SC23(3)/10), drawing attention to the key aspects that had been amended since the Twenty-third SCRC's second session. While there was still a core 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. The structure of the draft action plan had not changed: it dealt first with priority action areas, then priority interventions at the population and individual levels. The title of the section "supporting interventions" would be amended in response to feedback that the issues raised in that section were not secondary to the other actions described, as that title suggested. The draft action plan would follow on from the Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases, which was due to come to an end in September 2016; a progress report on the implementation of that Action Plan would be presented to RC66. The new action plan would build on previous mandates and on the considerable work undertaken by the Division of Noncommunicable Diseases and Promoting Health through the Life-course in collaboration with other divisions in the Regional Office, including Health Systems and Public Health, and Information, Evidence, Research and Innovation.

49. Positive feedback on the draft action plan had already been received from national NCD programme directors and managers, Member State representatives and WHO collaborating centres. Support had been expressed in particular for the way in which the interventions had been mapped according to how they contributed to achieving Health 2020 targets, the WHO global monitoring framework targets and the Sustainable Development Goals. The draft action plan would be a tool for Member States to assess how their national NCD programmes linked with global targets. A number of suggestions had been proposed for further enhancing or expanding sections of the draft action plan or for including new content. However, the current document was already twice as long as recommended, and while some leeway might be afforded to its length, the next draft would need to be significantly shorter.

50. The Twenty-third SCRC welcomed the draft action plan, which would be a useful tool for Member States. 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 Sustainable Development Goals. Concern was expressed that the vision of the draft action plan – for a “Europe free of preventable noncommunicable disease” – was unrealistic. Several suggestions were made for areas in which the draft action plan could be further modified and improved to make it more action-oriented or to give greater prominence to particular issues or conditions. Physical activity in particular could benefit from further development in the document and should not be presented only in terms of disease prevention but as health promotion as well. The goal to promote increased physical activity was currently too narrow; the focus should not be on doing so only through health systems but more generally in all settings, such as schools and workplaces, and among all population groups. Obesity should be considered as a disease in its own right and not just as a risk factor for other conditions. Mental health should feature more explicitly as an area for action, and further improvements could be made to the sections on product reformulation, nutrition and reducing fats, sugars and salt.

51. The Senior Technical Officer, Integrated Prevention and Control of Noncommunicable Diseases, thanked the members of the Twenty-third SCRC for their constructive comments, particularly with regard to the structure of the draft action plan. Efforts had been made to strike a balance between achieving a comprehensive, yet concise document, and as a result some issues had not been addressed in great detail. Steps would be taken to fill the gaps pointed out. The wording of the vision had been copied directly from the European Strategy on the Prevention and Control of Noncommunicable Diseases, which was considered the parent document to the new draft action plan. Consideration would need to be given to whether that vision could be redrafted, given that the Strategy remained in effect. Regarding musculoskeletal conditions, mental health issues and injuries, which were particularly relevant to disability and had a significant economic impact in the European Region, 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. The Secretariat would make every effort to follow up on feedback from Member States regarding the strengthening of certain sections of the draft action plan.

52. The Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, added that a wealth of new technology was available that could be used for the prevention of NCDs. He agreed that a follow-up meeting in 2018 could



be useful, particularly since there would be much to report on the implementation of the Ashgabat Declaration on the Prevention and Control of Noncommunicable Diseases in the Context of Health 2020 and on progress in the newly established geographically dispersed office on NCDs in the Russian Federation. There was some discrepancy with regard to statistics on obesity, since treatment and clinical interventions had reversed the cardiovascular mortality trend while obesity was continuing to rise in the European Region. If current obesity projections continued, the positive effects of those interventions and treatments could be at risk.

### **Strengthening people-centred health systems: a European framework for action on integrated health services delivery**

53. The Director, Division of Health Systems and Public Health, and the Programme Manager, Health Services Delivery, jointly presented the draft European framework for action on integrated health services delivery, with its focus on strengthening people-centred health systems (document EUR/SC23(3)/11). The document had been finalized based on input received from the Twenty-third SCRC at its second session to ensure that it 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 and divided into key actions, strategies and tools, including information on country experiences. The draft framework for action made clear that everyone had a role to play in integrating health services delivery, including patients themselves. Further consultations on the draft framework for action would be held in the coming months, before the final version and accompanying resolution were presented for adoption by RC66 in September. The Twenty-third SCRC was asked to confirm whether the issues raised at the second session were adequately reflected in the current draft, to consider the alignment of the draft framework for action with other policies, such as the draft action plans on NCDs and women’s health, and to agree on the proposed consultation process.

54. The Twenty-third SCRC agreed that Members’ previous comments had been taken into account in the revised draft and that the proposed consultation process was acceptable. Suggestions were made for the further improvement of the draft framework, to which the Programme Manager, Health Services Delivery, responded confirming that a better link could be made with primary health care, and that greater emphasis could be placed on the need to invest in prevention and promotion as well as on the need to stress the importance of eHealth, especially as a means to reach rural or marginalized populations. Monitoring and evaluation requirements and the relevant indicators and targets would be presented to the Twenty-third SCRC at its fourth session in May. To ensure that the document was practical and valuable to those who would be using it, he agreed that it would be wise to make use of annexes and that, if necessary, there could be two documents: a shorter working document and a longer comprehensive version.

55. The Director, Division of Health Systems and Public Health, added that the high cost of new drugs and procurement was a priority, having been the subject of a recent report and had also been taken up by a working group on strategic procurement. He agreed that it was important to reflect the issue properly in the draft framework for action and that it supported the case for investing in prevention.

## **Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region 2016–2021**

56. The Director, Division of Information, Evidence, Research and Innovation, introduced the draft Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region 2016–2021 (document EUR/SC23(3)/7), which was the first action plan to focus specifically on evidence for policy-making in WHO. The draft action plan reflects the six core functions of WHO and was based on existing policies at the global and regional levels so as not to introduce a new process but rather to build on and synergize previously agreed principles. The European Health Information Initiative would serve as an operational platform for implementing the draft action plan. 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. One goal focused expressly on the use of multisectoral and interdisciplinary sources of evidence, in line with Health 2020, and would contribute to the reduction of inequalities and the improvement of health throughout the European Region. A midterm implementation review would be carried out.

57. The guiding principles of the draft action plan were that evidence must come first, local knowledge should be used for local decision-making, investment was required for innovation, and an intersectoral approach was crucial. While many elements were required to shape policy, evidence should be the primary consideration. Such an approach engendered trust and was an indicator of transparency. Countries had not been sufficiently encouraged to use their local evidence in decision-making, but as context was important, national health information systems should be strengthened to optimize the use of local information. Ownership of information at the national level could inform policy-making and was viewed as crucial to translate evidence into action. The four key action areas in the draft action plan were to strengthen national health information systems, establish and promote national health research systems, increase country capacities and mainstream the use of evidence to influence how policy was shaped. The key indicators in the draft action plan were not new; mostly they referred to information that had already been collected by Member States or that was being collected by the Regional Office. The Regional Office was undertaking key actions to support Member States, working with the resources it had at its disposal: its publications, journals, the Evidence-informed Policy Network (EVIPNet), the European Health Information Gateway, and statistics mobile application. A web-based consultation would be held on the draft action plan, which would be revised before being submitted to RC66 for adoption.

58. Members of the Twenty-third SCRC commended the draft action plan, which would serve as excellent guidance for Member States on the use of evidence in policy-making and health systems reform at the national level, particularly given current economic constraints, which meant that streamlined decision-making was crucial if health systems were to remain robust and responsive. 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 in decision-making. Consideration should be given to the use of the term “information”, which could mean different things in different languages or contexts. The link between

health information systems and eHealth should be strengthened, and in that regard, adding health technology assessment as an element could be useful. Further information on the Regional Office's joint work with respect to data and evidence gathering with partners such as the Organisation for Economic Co-operation and Development (OECD) would be appreciated.

59. The Director, Division of Information, Evidence, Research and Innovation, and the Unit Leader, Evidence and Intelligence for Policy-making, expressed their appreciation for the Twenty-third SCRC's support and comments, which would be taken into account in the revision of the draft document. Good country examples existed to show that the results of action plans and strategies had enhanced policy-making, which could be included in more detail in the draft action plan. At WHO, the use of the term "information" (not to be confused with "communication") had been defined by the European Health Information Initiative; those definitions could be annexed to the text, for the sake of clarity. Health technology assessment was indeed an important part of evidence for policy-making. While the amount of information to be collected might seem overwhelming, no Member State in the European Region was starting from scratch; a lot of health information was already available or was being collected. Exchanges of experience, such as those achieved through EVIPNet, would be very valuable. The European Health Information Initiative, which included partners such as the European Commission and the OECD, was a key operational platform for the draft action plan, and as such, those partners were very much involved in the draft plan itself. WHO has enhanced its joint data collection with Eurostat and the OECD in recent years. Further consultations on the draft action plan would be conducted with Member States, and a revised text would be submitted to the fourth session of the Twenty-third SCRC.

### **Address by a representative of the Staff Association of the European Region of the World Health Organization**

60. The President of the Staff Association of the European Region of the World Health Organization briefed the Twenty-third SCRC on the Staff Association's grave concerns regarding the new global staff mobility scheme, which had recently come into force and was impacting on all aspects of WHO's work at all levels of the Organization, and in particular on staff engagement and motivation. The overall purpose of the mobility framework was to develop a multiskilled, flexible and mobile workforce, and enable the Organization to place its most qualified and experienced staff members wherever they were needed in the world. The Staff Association agreed that a global mechanism for staff rotation could be positive – and could have a positive impact on global health – but only if it was well designed, with an effective governance mechanism, and was used to motivate staff to excel in their areas of expertise and in their careers.

61. The global mobility framework had been placed under pillar 2 of the revised WHO human resources strategy, entitled "retaining talent". In order to retain talent, staff must believe in the mission of the Organization and know how they contributed to it, and they must trust that when they invested in the noble aims of the Organization, the Organization was likewise investing in them, in particular through career development. It was therefore ironic that in preparation for the introduction of the mobility

framework, all references to promotion had been removed from the WHO Staff Regulations and Staff Rules. Those changes to the Staff Regulations and Staff Rules 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. Although WHO had worked hard to achieve a gender-balanced workforce, the experience of mobility schemes in other international organizations had shown that enforced mobility was inherently discriminatory against women. Indeed, 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.

62. 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. The first meeting of the Global Mobility Committee would be held in the coming weeks. Despite an agreement with the Global Staff Management Council that staff representatives would be entitled to full participation in the Global Mobility Committee meeting, they had only been granted observer status, thus receiving the message from top WHO management that staff could be seen, but not heard. The organization of the Committee meeting remained entirely opaque. The implications of a weak governance mechanism had a direct impact on staff motivation. When considering the mobility scheme, Member States and the Organization must consider what staff profile they wished to develop. The Staff Association wanted staff mobility to be as positive and effective as possible, and firmly believed that all of the concerns raised could be addressed and resolved, given the opportunity and the will. The Director-General had stated on many occasions that WHO would be nothing without its staff. The President of the Staff Association encouraged Member States to maintain a critical eye on the implementation of the mobility framework, and to ensure that it was implemented in such a way as to enable WHO staff members to fulfil their mandates to the best of their abilities.

63. Members of the Twenty-third SCRC welcomed the statement from 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.

64. The Regional Director responded by thanking the Staff Association for its work in 2015, and for the open and frank relationship it maintained with the management of the Regional Office. The Regional Office was committed to a modern mobility policy to serve the interests of the Organization, and had provided the highest number of positions of any office in the current mobility compendium. She 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. Mobility must not endanger WHO's technical capacity, and should be viewed in a context of career progression, including promotion. A balance must be struck between maintaining members of staff who had context-specific knowledge for particular geographic locations, and optimizing

the use of technical expertise, as well as balancing experience and institutional knowledge with new, fresh ideas.

65. Financial sustainability was a key issue for the whole Organization, and efforts had been made, through the financing dialogue, to ensure a better match between the programme budget, staffing needs and available funding. Particular progress in that regard had been made in the Regional Office, and any gaps in the funding of staff positions were taken very seriously. In the event of posts being abolished owing to a lack of funds, every effort had been made to reassign as many affected staff as possible. Budget holders had a considerable responsibility to match recruitment with funding availability.

## **Oversight report on the work of the WHO European Region**

66. The Director, Division of Administration and Finance, presented the report of the Secretariat on budget and financial issues (oversight function of the SCRC) (document EUR/SC23(3)/14). The approved programme budget (PB) for 2014–2015 had increased by 6% over the biennium, from US\$ 225 million to US\$ 239 million; that increase had been allocated to outbreak and crisis response. 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. In 2014–2015, 9% 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. Several lessons learned during the 2014–2015 biennium were outlined in detail in the oversight report.

67. The outlook for PB 2016–2017 was positive. Operational plans had been ready before the start of the biennium and flexible resources at the global level had been allocated early. Flexible resources at the country level had been allocated using the strategic budget space allocation, which would improve funding predictability across the biennium. The impact of WHO's reform of outbreaks and emergencies on the budget and resources for 2016–2017 was not yet known.

68. After being asked to consider whether it would be useful to have the end of biennium assessment presented to RC66 and, if so, at what level of detail, the Twenty-third SCRC agreed that such an assessment should be on the agenda, but that the document should be the shorter of the two options proposed. Responding to a question about the costs associated with WHO's reform of outbreaks and emergencies, the Director, Division of Administration and Finance, said that the establishment of the programme on outbreaks and emergencies would have some funding implications but he understood that there would be no budget increase for the 2016–2017 biennium and that the Regional Office would have to work with funds already available. It is highly likely that corporate funds would be used to set up the new structure and, as a result, it was likely that the amount of flexible funds allocated to the European Region would be lower in 2016–2017 than it had been in 2014–2015. The Director, Division of Communicable Diseases and Health Security, added that all regional offices and WHO headquarters were conducting resource-based planning and reviewing the requirements for fulfilling the commitments to be undertaken by the end of the 2016–2017 biennium; resource implications would be discussed at the World Health

Assembly. Implementation of the new emergency response programme would be phased in gradually over 2016 and 2017, beginning in the African and Eastern Mediterranean regions, with full implementation expected in the 2018–2019 biennium. Within the European Region, additional staffing and operational costs would be needed in the areas of IHR-related activities and building core capacities, including robust risk assessments, in order to deliver the Region's commitments.

## **Membership of WHO bodies and committees**

### ***Vacancies for election and/or nomination at RC66***

69. The Secretariat provided an update on the nominations and elections for membership of the following WHO bodies and committees at RC66:

- Executive Board 2 seats
- Standing Committee of the Regional Committee for Europe 4 seats
- European Environment and Health Ministerial Board 2 seats

### ***Elective posts at the Sixty-ninth World Health Assembly***

70. The Twenty-third SCRC was updated on the candidatures for the posts of Vice-President of the World Health Assembly, Vice-Chairperson of Committee A of the World Health Assembly, Rapporteur of Committee B of the World Health Assembly, five members of the General Committee of the World Health Assembly, three members of the Committee on Credentials of the World Health Assembly and Chairperson of the Executive Board.

## **Other matters, closure of the session**

71. The Director, Division of Information, Evidence, Research and Innovation, called on the Standing Committee to appoint a member to participate in the work of the cultural contexts of health expert group, in order to replace the representative of Austria.

72. After the customary exchange of courtesies, the Chairperson declared the session closed.

## **Annex 1. Agenda**

1. Opening by the Chairperson and the Regional Director
2. Adoption of the provisional agenda and the provisional programme
3. Report by the chairpersons of the three SCRC subgroups
4. Provisional agenda and provisional programme of the 66th session of the Regional Committee (RC66)
5. Discussion on technical agenda items for RC66
  - (a) Midterm progress report on Health 2020 implementation 2012–2016
  - (b) Strategy on women's health in the WHO European Region 2017–2021
  - (c) European action plan for human rights-based sexual and reproductive health 2017–2021
  - (d) Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016–2025
  - (e) Strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery
  - (f) Strategy and action plan for refugee and migrant health in the WHO European Region 2016–2022
  - (g) Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region 2016–2020
6. Oversight report on the work of the Regional Office for Europe
7. Address by a representative of the Staff Association of the European Region of the World Health Organization

## Annex 2. List of documents

### Working documents

EUR/SC23(3)/1 Rev.1	Provisional list of documents
EUR/SC23(3)/2 Rev.1	Provisional agenda
EUR/SC23(3)/3 Rev.1	Provisional programme
EUR/SC23(3)/4	Provisional list of participants
EUR/SC23(3)/5 Rev.1	Draft provisional agenda of the 66th session of the Regional Committee for Europe
EUR/SC23(3)/6	Draft provisional programme of the 66th session of the Regional Committee for Europe
EUR/SC23(3)/7	Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region 2026–2020
EUR/SC23(3)/8	Strategy on women’s health in the WHO European Region 2017–2021
EUR/SC23(3)/9	European action plan for human-rights based sexual and reproductive health 2017–2021
EUR/SC23(3)/10	Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016–2025
EUR/SC23(3)/10 Corr.1	Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016–2025
EUR/SC23(3)/10 Corr.2	Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016–2025
EUR/SC23(3)/11	Strengthening people-centred health systems in the WHO European Region: a European framework for action on integrated health services delivery
EUR/SC23(3)/12	Midterm progress report on Health 2020 implementation 2012–2016
EUR/SC23(3)/13	Strategy and action plan for refugee and migrant health in the WHO European Region 2016–2022
EUR/SC23(3)/13 Corr.1	Strategy and action plan for refugee and migrant health in the WHO European Region 2016–2022
EUR/SC23(3)/14	Report of the Secretariat on budget and financial issues (oversight function of the SCRC)



**Working documents**

EUR/SC23(3)/15                      Items for future Regional Committee meetings

**Information documents**

EUR/SC23(3)/Inf.Doc./1            Hosting a Regional Committee session outside  
Copenhagen

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