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Putting countries at the centre in the WHO European Region

This report provides an overview of how the WHO Regional Office for Europe has gradually strengthened the delivery of country-specific work in the WHO European Region. It focuses on the main changes and the added value that these changes have brought, and also highlights the challenges and opportunities encountered by WHO in its work at country level, as requested by Member States at the 68th session of the WHO Regional Committee for Europe. The document also looks forward, showing how the development and implementation of Health 2020 has put the European Region in a strong position to implement the 2030 Agenda for Sustainable Development and the Thirteenth General Programme of Work, 2019–2023. In the meantime, the Regional Office continues to adjust its business model to ensure close alignment across the three levels of the Organization and thus to be more agile and achieve the greatest possible impact at country level.

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Contents

Introduction

1. Following the establishment of WHO in 1948, the WHO Regional Office for Europe was established in 1952. At the time, only Turkey had a WHO Representative Office, since WHO's role was mainly to develop norms, standards and guidelines, produce publications and collaborate with countries through a few, mainly vertical, programmes. In 1985, the then 32 Member States in the WHO European Region agreed on their first common policy for health, "Health for All". The number of Member States in the Region increased to 53 as a result of the political and economic upheavals faced in the countries of central and eastern Europe and the emergence of the newly independent states of the former Soviet Union.

2. The situation in the central and eastern parts of the Region had a serious effect on the social determinants of health of the countries concerned, with the disintegration of the social fabric, high unemployment, a sharp decline in purchasing power, shortages of commodities such as vaccines, medicines and other consumables, and changing behaviour patterns, particularly those related to alcohol, tobacco and nutrition. As a result, Europe was facing a higher incidence of communicable and noncommunicable diseases, which in turn led to higher mortality and morbidity rates.

3. The Regional Office recognized the need to act speedily to address these challenges, setting up the "Eurohealth programme for intensified cooperation with central and eastern Europe and the newly independent states", following approval by the WHO Regional Committee for Europe in 1990. The programme was instrumental in developing and scaling up activities in this part of the Region, and about two thirds of the Regional Office's activities were directed towards these countries. This was the first programme to focus on specific countries.

4. To facilitate implementation of this programme, a country health department was established in the Regional Office. Countries were assigned to "desks", each consisting of a professional staff member and a number of administrative personnel. Liaison offices, each with a national professional officer and an administrative staff member, were established in each country of central and eastern Europe in order to ensure a closer interface between these countries and the Regional Office.

5. Despite working with a very limited budget, much was accomplished – as the Eurohealth evaluation showed – and the Regional Office's technical work was channelled to the target countries through the infrastructure created by the Eurohealth programme. This infrastructure was the cornerstone of many other country-specific programmes developed in subsequent decades. The Regional Office strengthened its intercountry mode of working, while providing technical support (including policy advice) to Member States. It also introduced monitoring of health trends with the result that many countries were supported in developing national policies, plans and guidelines based on the normative standards provided by the Organization.

6. After 2000, the Regional Office introduced a new strategy: "Matching services to needs". The strategy was driven by country priorities and called for more resources to be assigned to the country level, resulting in considerable decentralization in both technical and administrative areas. Country offices were strengthened and were supported by a "country help desk" in the office of the WHO Regional Director for Europe. While attention was focused on the countries most in need of support, work with all countries continued through the technical programmes in the Regional Office and in its geographically dispersed offices

(GDOs), as well as through established networks and intercountry programmes. “Futures Fora” was launched in 2001 to provide an impartial environment where top-level decision-makers could share their experience of tackling specific policy topics and develop possible solutions to emerging public health issues.

7. To date, there have been significant advances in many countries of the Region. It remains the largest and one of the most diverse and dynamic of WHO’s regions. With a total population of almost 910 million, and with diverse economies, political systems, cultures and health status, there is still much to be done. Unfortunately, the economic crisis that started in 2008 resulted in unemployment and poverty, which had a heavy impact on health. Also at play were the effects of globalization, climate change and the ageing population, as well as civil unrest and wars within and around the Region. There is still a clear need to tackle the wide health gap between social groups, to address the health issues facing vulnerable populations and to tackle the variations in health status between and within all countries.

8. Since 2008, the work of the Regional Office has had a positive impact in many countries of the Region. Close monitoring of health trends by the Regional Office clearly indicates that health has been improving overall, although not as rapidly as it could or should. In the meantime, political and economic empowerment of certain Member States has taken place, resulting in more countries becoming self-sufficient, with some also able to offer support to other countries in the Region. In parallel, the increase in the number of highly competent academic, research and public health institutions in Europe has enlarged the pool of expertise available to assist in improving public health in the Region.

9. At the start of her mandate in 2010, Dr Zsuzsanna Jakab, the newly elected Regional Director, set out her seven strategic priorities for action at the 60th session of the Regional Committee (RC60) in document EUR/RC60/8. These were: (1) the development of a European health policy as a coherent policy framework; (2) improving governance in the Region and the Regional Office; (3) further strengthening collaboration with Member States; (4) engaging in strategic partnerships for health and creating improved policy coherence; (5) strengthening the European contribution to global health; (6) reaching out through an information and communication strategy; and (7) promoting the Regional Office as an organization with a positive working environment and sustainable funding.

10. Several activities immediately followed in order to ensure that the Regional Office’s work at country level was further strengthened. Innovations were introduced, such as the direct involvement of governing bodies in discussions on the Regional Office’s country strategy, and the gradual changes to the Region’s country offices from liaison offices led by nationals of the country concerned to internationally led offices. Other relevant changes included ensuring the collation of data and monitoring of trends, and the promotion of research and evidence for policy-making. All operational improvements implemented over the years focused on addressing the specificities of the Region and more importantly of the individual countries, but they were also closely aligned with changes proposed at global level. The most significant of these initiatives was the development and implementation of Health 2020: the European policy framework for health and well-being.

11. The European Health Policy Forum for High-Level Government Officials was established in 2010 in response to a request made at RC60 to draft this new European policy framework for health and well-being. The forum facilitated strategic discussions and provided a good opportunity for the Regional Office to work with European Member States in driving

policy and ensuring implementation of effective action throughout the Region. An evaluation report on the work of the Forum was submitted to RC62, after the Standing Committee of the Regional Committee for Europe had recommended that the aims of the Forum had been achieved with the endorsement of Health 2020. The view of the Standing Committee was that the Forum should meet again when a need for extensive consultation was identified.

Health 2020: the European policy for health and well-being

12. The values underpinning Health 2020 are based on those of the WHO Constitution, which envisages the highest attainable standard of health as a human right. Health 2020 was forward looking, and so advanced in its thinking that today it continues to be a tool used by Regional Office staff and Member States alike, not only to address health but also to implement the wider 2030 Agenda for Sustainable Development. Today, it remains highly relevant to ensuring the implementation of the Thirteenth General Programme of Work, 2019–2023 (GPW 13).

13. Health 2020 acknowledges the interconnectedness of local, national, regional and global health actors, actions and challenges, and recommends a common outcome-focused, Region-wide approach to health. Through two strategic objectives[1] and its four priority areas for policy action,[2] the policy clearly maps the options and trade-offs when taking action to improve health and reduce inequities. The policy also outlines the essential role of new arrangements for governance for health (applying a whole-of-government and whole-of-society approach) and states the need to ensure the involvement of all stakeholders in finding solutions to improve health and health systems in countries. The essential role of the health sector is highlighted, not only in providing access to patient-centred care and ensuring effective public health functions, but also in leading and building capacity in collaboration with multiple sectors and stakeholders.

14. The implementation of such a broad policy required a major shift in the way the Regional Office provided technical assistance to Member States and maximized impact in countries. Soon after the adoption of Health 2020, every staff member was asked to rethink how her or his work could specifically support the implementation of Health 2020. This led to: creating new ways of working; breaking the existing silos approach; promoting strong coherence across all levels and programmes of the Organization; forging a strong sense of alignment with the core principles and values of Health 2020; and nurturing a strong culture of delivering as “one WHO”, thereby repositioning WHO as the leading public health agency in Europe and beyond.

15. With a WHO workforce fully aligned with the new European policy framework, the Regional Office could present ways for policy-makers to more effectively and efficiently address current social, demographic, epidemiological and financial challenges. This was achieved mainly by resetting priorities, catalysing action in other sectors, and adopting new approaches to organizing the health sector with other stakeholders. With the aim of reaching out to the largest possible number of policy-makers at all levels of governance in Europe, the

[1] The strategic objectives are: (a) improve health for all and reducing health inequalities; and (b) improve leadership and participatory governance for health.
[2] The priority areas are: (a) invest in health through a life-course approach and empower citizens; (b) tackle Europe’s major disease burdens of noncommunicable and communicable diseases; (c) strengthen people-centred health systems and public health capacity, including preparedness and response capacity for dealing with emergencies; and (d) create supportive environments and resilient communities.

decision was taken for the Organization to be represented in all Member States and not only those with a country office.

16. Thus, the Regional Office worked through extensive networks of national counterparts, as well as through thematic focal point networks for each of the major areas of work of Health 2020. This complemented the solid work of the country offices, in which staff engaged with many partners at country level within and outside the health sector on how to work together to achieve better and more equitable health and well-being by ensuring that health is the responsibility of the whole of society and the whole of government – key Health 2020 principles.

17. The Regional Office also strengthened existing political and technical networks, which proved to be cost-effective measures for providing assistance to Member States in an "intercountry" mode of delivery,[3] while also facilitating peer-to-peer learning and exchange of best practices, thereby fuelling a virtuous cycle of Health 2020 implementation. Such networks included, among others, the South-eastern Europe Health Network (SEEHN) and the newly established Small Countries Initiative, as well as networks representing healthy settings such as the Regions for Health Network (RHN) and the WHO European Healthy Cities Network. These elements helped WHO to become more focused and effective in its country-based operations, working closely with partners, engaging in policy dialogue, providing strategic support and technical assistance, and coordinating service delivery, all while taking into account the specific contexts of countries.

18. Health 2020 has extensively promoted whole-of-government, whole-of-society, life-course, and participatory approaches. These have now become commonplace modalities of work in European countries. Over the years, Health 2020 has continued to catalyse political commitment to strengthening governance for health and leaving no one behind, building upon and reinforcing robust mechanisms for intersectoral action for health and well-being, and contributing to the creation of resilient communities and supportive environments for the health and well-being of populations.

19. Health 2020 approaches also support implementation of the 2030 Agenda for Sustainable Development. The Regional Office developed the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being. The roadmap proposes as priorities for the Regional Office: pursuing the coherent implementation of both the 2030 Agenda and Health 2020 in its work and with individual countries; technical support to countries; its contribution to coordination among United Nations agencies; stronger partnerships and initiatives at the regional and subregional levels; and evidence-informed monitoring and reporting.

[3] Intercountry mode of delivery: a mode of operation used to address the common needs of countries through Region-wide approaches.
Multicountry mode of delivery: a mode of operation used when an output within an outcome is relevant to a limited number of countries.
Country-specific mode of delivery: a mode of operation used for outputs that are highly specific to the needs and circumstances of individual countries.

Putting countries at the centre

20. Learning from past experience and building on the work of previous decades, by 2012 the Regional Office had introduced a number of changes in order to place more emphasis on working with and for countries and not only in countries. This meant that there was a need to take into consideration capacity within Member States so as to enable more effective mobilization of resources and sharing of experiences. All countries were encouraged to contribute to this joint venture between them and the Regional Office to improve health and reduce health inequities in Europe.

21. At the regional level, the Regional Office's work has grown increasingly transparent and visible, mainly through Member States' active involvement in the Organization's governing bodies, which continue to shape WHO's outputs. Regional Committee procedures have been reviewed, relevant processes revised, and a more geographically representative Standing Committee of the Regional Committee set up, all based on the guidance provided by Member States in governing body meetings. At the start of the Regional Director's mandate in 2010, there was a drive to discuss and prioritize a plethora of policies and strategies that needed to be reviewed in order to ensure a clear direction for the work of the Regional Office. Many old resolutions were "sunsetted", while others were discussed and endorsed at governing body meetings in order to further increase the impact of the Regional Office at the country level.

22. The development of new policies has been supported by many different sources of knowledge. These include: (i) an analysis of recent Regional Committee resolutions and agreements; (ii) the Health for All database and other databases, as well as country information collected by technical programmes at the Regional Office, its GDOs and country offices; (iii) information from multicountry networks and healthy settings networks as well as from WHO collaborating centres and interested research institutions; and (iv) analyses carried out by countries themselves.

23. In September 2012, an interim country strategy was proposed to RC62 with the aim of clearly outlining the Regional Office's plan for strengthening its country-specific focus, mainly by making the best use of its scant resources and of WHO's comparative advantage. New ways of working were explored and presented to Member States, resulting in the adoption of resolution EUR/RC62/R7, which highlighted countries' expectations of the Regional Office.

24. Other key contributors to a more effective country approach have included a clearly defined regional communication strategy (an internal guidance document), which further strengthened and improved communications practices, and provided clear guidelines for the application of new technologies by the Regional Office and at country level. Other innovations were the use of social media and the introduction of stronger internal communications; all communications since the development of the regional communication strategy in 2012 have been guided by clear standard operating procedures and guidelines.

25. Health 2020 became the driving force for the work of the Regional Office, providing a clear direction for work at the regional and country levels. Its main emphasis was to ensure that all countries across the Region received support as and when they needed it. Health 2020 also highlighted the vital importance of health and well-being as drivers of socioeconomic development, and the need for action to reduce health gaps.

Contributing to country work at the regional level

26. As the work of the Regional Office has diversified beyond the traditional intercountry mode to one promoting more multicountry and country-specific operations, the Regional Office has established the strategic direction for its work at both the regional and country levels in line with the objectives set out by the Regional Director at the start of her mandate. Country-level work has been highly dependent on the capacity and knowledge of staff in the Regional Office (backstopped by WHO headquarters when required), and therefore staff training and capacity building have been vital. Eventually this work expanded to include building additional capacity in Member States.

27. Cross-country learning became the modus operandi for the Regional Office and played a facilitating role among Member States in encouraging the use of existing resources in a country to support other countries in tackling priority issues for public health. This has led to the increased relevance of networks such as Healthy Cities, the RHN and Health Promoting Schools. These "settings" networks were already collaborating on vital issues such as formulating public health reports, developing policies to tackle the social determinants of inequalities in health, and developing capacity for and implementing health impact assessments. However, with the Regional Office's help, further dissemination and sharing of knowledge among European Member States was made possible.

28. Direct contact and liaison with countries took on a different form when the Regional Office introduced visits by newly appointed ministers of health to the Regional Office in Copenhagen to learn about WHO's work. The Regional Office hosted an average of one minister per month starting immediately upon the Regional Director taking office. These visits have provided ministers with the opportunity to spend a day in the Regional Office, meet the Regional Director and technical staff to discuss their country's health issues, and ensure a clear plan of action directly with the relevant technical programmes.

29. In accordance with resolution EUR/RC62/R7, a network of national counterparts with clear terms of reference was established to ensure further follow-up and liaison with countries. These national counterparts are appointed in each of the 53 Member States by the minister of health to act as the key focal point for any correspondence or liaison with the Regional Office concerning its activities with and in the country. This network was further strengthened by a network of national technical focal points established in 12 key disease/programmatic areas to ensure a more focused and organized approach to countries' technical needs.

30. Technical support to the countries of the Region has been provided by technical staff in countries when possible, but mainly by programme managers in technical divisions in the Regional Office. The four GDOs (located in Almaty, Kazakhstan; Bonn, Germany; Moscow, Russian Federation; and Venice, Italy), and the office in Barcelona, Spain, which continue to be an integral part of the Regional Office's technical divisions, have often been called upon to assist their respective divisions in the Regional Office in providing technical support at the country level, although their main mandate is research and providing evidence and information for policy-making.[4] Backstopping has also been provided by WHO headquarters at the request of the Regional Office, as well as through deployment of external consultants

[4] An additional GDO on health emergencies is currently being developed with the Turkish Government in Istanbul.

previously trained in the priorities, principles and values of WHO or listed on an official roster of experts maintained by the respective technical division.

31. A Strategic Relations with Countries (SRC) unit replaced the previous help desk in the Regional Director's office to ensure a more strategic focus. SRC has ensured close coordination between technical divisions in the Regional Office and countries (with or without a country presence). The team has been responsible for bottom-up planning and development of biennial collaborative agreements (BCAs). SRC has assisted the roll-out of country cooperation strategies to the countries that requested them and, more recently, has taken responsibility for liaising with all 53 countries in the development of country support plans (CSPs). SRC has also collated country information, helped ensure timely support by technical programmes in response to requests from countries, provided regular information to countries when required (through country offices and national counterparts), and prepared guidance and standard operating procedures applicable at the Regional Office and country levels.

32. WHO collaborating centres are leading national academic, research and public health institutions which carry out activities in support of WHO's programmes at all levels and ensure the scientific validity of its work. The centres themselves benefit from being part of this global network by obtaining greater visibility and recognition from national authorities, and by attracting more public attention to the health issues that they address. They also have increased opportunities to exchange information and develop technical cooperation with other institutions such as public health schools and institutes, and universities. The WHO collaborating centres were reviewed in terms of their activities and contributions to WHO's work to ensure that those relevant to the European programmes continued to supplement research, knowledge-sharing and training provided by these programmes, in fields of particular interest in Europe.

Mobilizing and developing synergies among countries at the subregional level

33. The Member States of the European Union (EU) constitute the largest group of countries with which the Regional Office works in multicountry format. Work with the EU Member States takes into account the relationship that they have with the European Commission and its institutions and is coordinated through the WHO office in Brussels. Collaboration with the EU Member States includes participation by the Regional Director in the biannual informal meeting of health ministers of the EU organized by the EU presidency, participation of senior management in joint events and conferences organized by the EU presidency or the European Commission, regular briefings, and informal meetings with the Brussels-based health attachés of the EU Member States.

34. Furthermore, there is active collaboration between WHO and the various European Commission directorates on priority areas. At RC60, held in Moscow in 2010, the Regional Office and the Commission's Directorate General for Health and Consumer Protection presented a joint declaration aimed at invigorating policy dialogue and technical cooperation. Regular meetings involving senior officials, including those from various EU directorates, follow up on joint commitments, especially those focusing on policy coherence and joint support to Member States. In addition, close collaboration with EU agencies such as the European Centre for Disease Prevention and Control, the European Environment Agency, the European Food Safety Authority and the European Monitoring Centre for Drugs and Drug

Addiction, also provides an opportunity to collaborate on technical support provided to countries while avoiding duplication of work (including on reporting) as much as possible.

35. WHO also works closely with the European Parliament, in particular with the Committee on the Environment, Public Health and Food Safety, providing input through hearings and participating in panel discussions to advocate for the implementation of WHO resolutions and policies. Finally, a memorandum of understanding with the Committee of the Regions has proven to be successful in establishing closer collaboration with cities and regions of EU Member States, which is vital for achieving the Sustainable Development Goals (SDGs).

36. Another subregional grouping is the Commonwealth of Independent States (CIS).[5] The CIS is a regional organization formed during the dissolution of the Soviet Union in 1991. The experience of this group of countries is broad and it was important to utilize this experience. First, there was a need to promote the vast wealth of research, information and case studies found in this subregion. The translation of Russian-language documentation into other languages and its dissemination was key to ensuring the cross-fertilization and transfer of information with and to other subregional groups. Secondly, there was a need to ensure capacity building in the subregion in areas such as global health diplomacy, and in cross-cutting and cross-border features of health, migration, and other areas where integration mechanisms may positively influence health.

37. The collaboration of the Regional Office with CIS institutions at the intergovernmental level is led by the CIS Council for Health Cooperation, which determines priority areas for international cooperation. A memorandum of understanding between the Regional Office and the Council was signed in 2002, which aimed at improving and further integrating efforts by CIS countries to protect public health, and promoting joint health programmes in cooperation with WHO. The Regional Office's participation in the work of the Council was irregular until recently. However, the Regional Office made notable contributions to the 2016 and 2017 meetings of the Council, hosted by Kazakhstan and Kyrgyzstan respectively. The Council's willingness to synergize its work further with the international health agenda, which enabled it to make valuable contributions to health diplomacy and governance in the European Region, led to the establishment of the interstate commission on interaction with WHO in 2017.

38. In March 2018, the Regional Director signed a memorandum of understanding with the Interparliamentary Assembly of Member Nations of the CIS and the Eurasian Economic Union (EAEU). The memorandum provides the Regional Office with a range of mechanisms for cooperation, including, notably, through the provision of technical assistance in the preparation of model laws relevant to health and their adaptation to local contexts. Other mechanisms include information exchanges on health issues relevant to the CIS and beyond, invitations to each other's statutory and other meetings, cooperation through the Interparliamentary Assembly's expert committee on health, and organization of joint events.

39. The Eurasian Economic Commission, the executive arm of the recently formed EAEU is a subregional organization with a broader political and economic mandate than the CIS IPA. Although health is not directly part of the mandate of the EAEU, the Commission

[5] The CIS consists of nine members (Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan and Uzbekistan) and one associate member (Turkmenistan). Georgia withdrew its membership in 2008. Ukraine, which participated as an associate member, ended its participation in CIS statutory bodies in May 2018.

nevertheless provides the Regional Office with an opportunity to address health in the countries concerned by influencing or assisting with the requirements for establishing a common market for medicines and medical products, and common sanitary regulations (including in the veterinary–sanitary and phytosanitary fields). Since May 2017, the Regional Office has been working with the EAEU on pharmaceutical regulations, prevention of noncommunicable diseases and epidemiological surveillance. Collaboration with the EAEU is particularly valuable with regard to the intersectoral and cross-border aspects of public health, and the inclusion of health in the regional integration agenda in the eastern part of the WHO European Region. Furthermore, the EAEU's active pursuit of forming links with other countries and organizations in the Region and beyond (such as the Shanghai Cooperation Organization and the BRICS group of countries[6]) is likely to increase the opportunities for regional cooperation, including on health.

40. SEEHN is a multi-governmental political and institutional forum for regional collaboration on health and well-being.[7] It was set up following the establishment of the Stability Pact for South Eastern Europe in 1999 as a forum for conflict prevention and reconstruction. A health component was subsequently added in 2001. Cooperation at the political and technical levels has resulted in long-term partnerships among SEEHN Member States and numerous partner countries, international organizations and nongovernmental organizations that have supported the Network technically and financially. Over the years the Regional Office has provided political, managerial and technical support to the Network.

41. An important milestone for SEEHN was the Fourth Ministerial Forum held in Chisinau, Moldova, in April 2017. This forum established the secretariat of the Network by formally appointing the secretariat staff, endorsed basic changes to the memorandum of understanding and agreed changes in governance and standard operating procedures. In July 2018, the first Subregional Cooperation Strategy of the Regional Office and SEEHN was signed. Since then the direct involvement of the Regional Director in SEEHN plenary meetings has ensured that the political momentum for health in the subregion was maintained and that ministers of health and state secretaries met yearly to discuss common issues.

42. The Small Countries Initiative was established in 2013 at an informal meeting in Turkey during RC63, to provide a mechanism for European countries with a population of less than 1 million to share their knowledge on implementing Health 2020.[8] The Initiative provides its members with: (a) support to align national policies with WHO strategies and plans; (b) topic-specific technical assistance; (c) opportunities for networking and forming bilateral/multilateral relations; and (d) a forum for mutual learning and for sharing innovative approaches. Moreover, in recent years, the mandate of the Initiative was adjusted to include provision of technical support in relation to the 2030 Agenda for Sustainable Development, in addition to Health 2020. The member countries indicated that the Initiative should continue at a meeting held in July 2018 in Reykjavik, Iceland, where they also agreed to add three more countries (with populations of just over 1 million) to their network.[9]

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[6] BRICS is the acronym used for an association of five major emerging economies: Brazil, Russia, India, China and South Africa.

[7] The SEEHN Member States are: Albania, Bosnia and Herzegovina, Bulgaria, Israel, Montenegro, North Macedonia, Republic of Moldova, Romania and Serbia.

[8] The original eight members of the Initiative are: Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro and San Marino.

[9] Estonia, Latvia and Slovenia.

43. In the six years since its inception, the Small Countries Initiative has developed into a well-recognized forum for mutual learning and the sharing of innovative approaches between countries. With the assistance of the WHO Secretariat, the Initiative produces its own series of featured publications, based mostly on case studies from, and good practice existing in, the small countries in relation to the implementation of Health 2020 and the 2030 Agenda; examples of good practice include taking intersectoral action for health, using the life-course approach, and strengthening resilience at the individual, community and system levels. The Initiative has already made a significant contribution to the Region by establishing a network for health information in small countries, the Small Countries' Health Information Network. One of the first activities of the Network was to bring the "moving average methodology" into the mainstream and ensure that this methodology was accepted across the Region. The methodology has helped countries to overcome the statistical challenges typically present in small countries, such as those resulting from the small numbers of annual cases of diseases with low prevalence.

44. The Small Countries Initiative is beneficial to both its member countries and the Regional Office. The countries benefit from the sharing of best practices on implementation of Health 2020 and the 2030 Agenda. These include practices on strengthening relevant technical capacity; documenting processes involved in implementing WHO strategies, polices and plans and also in resultant outcomes; receiving dedicated technical assistance; and the filling of gaps in European policy-making literature on health policy development in the context of small countries. The Regional Office benefits from the Small Country Initiative as a result of an increased commitment to, and better alignment of national strategies with, Health 2020 and the 2030 Agenda; by acquiring knowledge on how WHO policies are operationalized (practical know-how); by encouraging larger countries to follow the successful examples of the smaller countries; and by using the Initiative as a cost-effective vehicle for providing assistance to countries, especially those without country offices.

45. The Visegrad Initiative for Health is a fairly recent initiative through which the Regional Office works with the WHO representatives (WRs) in the four countries of the Visegrad Group[10] to explore possible collaboration on technical issues. A meeting was organized in Budapest, Hungary, in October 2018 by the Regional Office and the WHO Country Office in Hungary to celebrate the 70th anniversary of WHO. The four participating countries from the Visegrad Group expressed their willingness to strengthen collaboration on health issues that were common across their countries with the support of the Regional Office.

46. In February 2019, under the Presidency of Slovakia (July 2018 to June 2019), a high-level meeting took place in High Tatras, hosted by the Ministry of Health of Slovakia. At this meeting, further discussions were held on the specific health areas and activities for which the Visegrad Group would require technical or other inputs and/or assistance. The meeting was attended by the Regional Director, other senior managerial staff, and the WRs from the Visegrad Group countries; all four countries expressed interest in actively contributing to further collaboration with WHO. In conjunction with this meeting, a training course was held at the WHO Collaborating Centre Working with Vulnerable Population Groups in Central Europe at the National Institute for Tuberculosis, Lung Diseases and Thoracic Surgery in High Tatras. The course, on tackling tuberculosis, especially in vulnerable and marginalized populations, was for health workers from Slovakia and other countries.

[10] Czechia, Hungary, Poland and Slovakia.

47. Other subregional groupings of Member States include the Nordic countries, which have a long history of working closely together. The Nordic Council, formed in 1952, is made up of 87 elected members.[11] The Nordic Council of Ministers has a secretariat of almost 100 people representing all the Nordic countries. The countries cooperate on economic, social and cultural development. Their cooperation on social and health affairs is based on the joint values that underpin the Nordic welfare model. The Nordic School of Public Health and the Nordic Centre for Welfare and Social Issues support their work, as does the Nordic Medico-Statistical Committee.

48. The Northern Dimension is an instrument of cooperation between four partners: the EU, Iceland, Norway and the Russian Federation. Geographically, the Northern Dimension covers the north-west of the Russian Federation, the Baltic Sea and the Arctic regions. Its aim is to support stability, welfare and sustainable development through practical cooperation. Such cooperation takes place through partnerships, particularly those related to the environment and the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS). Canada, France, Germany, Poland, the Russian Federation, the Baltic states, all the Nordic countries, the European Commission, WHO and other United Nations organizations participate in the NDPHS. More recently, a network of universities and the Northern Dimension Business Council have been established. The Northern Dimension's operations are based on joint funding. Every effort will be made to take advantage of meetings of the Northern Dimension to promote the work and technical guidance of the Regional Office in support of the countries concerned and of the whole European Region.

49. For more than a quarter of a century, the RHN has been working to improve health in Europe. Established in 1992, the RHN is unique in that it started "from the bottom up", when the 11 founding regions requested that WHO establish a network of regions to promote health through intersectoral action and to tackle inequalities in health. Its focus is on promoting action by regions in this regard. The RHN originated as a result of the strong and growing support from the countries of the European Region for comprehensive health policy and planning, linked to the concept of Health for All, and the increasing importance of regions within countries in Europe, which were gradually acquiring more power and responsibilities.

50. The network now includes 41 regions within 28 countries in the European Region. Each of the 41 member regions advocates for and supports WHO's objectives in its own country. The secretariat is based in the WHO European Office for Investment for Health and Development in Venice, Italy. The RHN acts as a unique, direct link between WHO and regional policy-makers, acting as a bridge between WHO and the regions, and between national policies within countries and more local initiatives. It ensures that WHO's ambitions are explained to and understood by actors at the regional level inside countries and are appropriate for implementation at that level.

51. The Healthy Cities Network was set up in 1998 initially as a group of cities called the Baltic Region Healthy Cities Association. In addition to its association with WHO, the Healthy Cities Network has forged links with the EU Strategy for the Baltic Sea Region and the NDPHS, taking part in their meetings and developing new projects. Since then, it has become a

[11] The Council has 87 elected members. Denmark, Finland, Norway, and Sweden each have 20 members. Of these, two of the Danish representatives are from the Faroe Islands and two are from Greenland, while Finland has two representatives from Åland. Iceland has seven members.

global movement. In the European Region, over 100 cities have been, or are being, designated as healthy cities while hundreds more are associated through their national networks.

52. The Healthy Cities Network is largely self-funded by fees from its members. From its inception, the Network was designed to promote the values of Health for All at city level. Together, the participating cities decide on the issues that they will focus on over the next five years. Subgroups have also been set up on specific issues in which at least 15 cities have expressed an interest, with one city taking the lead in each subgroup and the results of the work shared among the wider network. In 2018, the Healthy Cities Network met in Copenhagen where the members adopted the Copenhagen Consensus of Mayors: Healthier and Happier Cities for All, which aligns the work of the network with the SDGs.

53. The network of WHO collaborating centres is also a great asset to the Organization, and is much appreciated and utilized, but still needs to be optimized. This network provides WHO with a pool of experts who provide assistance to countries and carry out important research and capacity building, and who are sometimes mobilized to provide technical assistance to countries if Regional Office staff are unavailable.

54. All the networks and settings described above provide the Regional Office with opportunities to influence the health agenda. More importantly they provide direct access to the higher levels of policy-making in countries, allowing the Regional Office to extend its reach, especially in countries without country offices. Impact at the country level is achieved indirectly by guiding and influencing decisions, promoting health and advocating for collaboration on common issues.

Ensuring greater added value at the national level

Strengthening the country offices of the Regional Office

55. Over the years, country offices have played a key role in the Regional Office's relations with countries. Their role in advocating for health, and in facilitating and coordinating technical assistance to countries has been crucial and has enhanced evidence-based policy-making and decision-making processes at national level. Despite changes in governments, country offices have also been important for ensuring continuity in cooperation and coordination with health ministries' implementation of health policies and plans. As strategic partners for WHO's engagement in countries, their in-depth knowledge of country contexts and needs, and their ability to assess the feasibility of health interventions at country level, have been valuable to the Organization.

56. The work of country offices involves policy advice and dialogue, including on health and development cooperation. The main interlocutors are health ministries and United Nations agencies and other partners, with the focus mainly being on integrating health into country development processes and into the work of partners at country level, such as through United Nations Development Assistance Frameworks and sector-wide approaches, adapting the SDGs to national needs and contexts. Country offices are important advocators for health, promoting new initiatives and approaches, such as work on the social determinants of health, human rights and gender equity. Through their daily liaison with national stakeholders they help to strengthen governance mechanisms at the country level.

57. In 2011 the Regional Director commissioned an evaluation of the Regional Office's work in countries by an External Working Group (RWGCo), comprised of retired senior WHO staff (ex-directors of programme management) and some chief medical officers. When the RWGCo reviewed all the country offices in 2010 and explored the need for their continued presence, the feedback they received from countries regarding the value of the country offices was unanimous. Member States clearly indicated that the offices were an asset and asked for them to continue. One of the main recommendations of the RWGCo was that there should be a WHO presence in every country (not only those in which they were already established). The RWGCo warned that the cost–effectiveness of some offices may have decreased since their establishment. Hence, cost-sharing arrangements with governments were encouraged. Since then, there has been marked strengthening of the country offices and the capacity of their staff.

58. WHO has country offices in 30 Member States in the Region, with one more currently under negotiation. These offices are mainly in central and eastern Europe, south-eastern Europe, the CIS and central Asia. Changes in the leadership of these offices have taken place over the past nine years, from being mainly led by national professional officers (NPOs) to being mainly internationally led country offices – only four NPO-led country offices remain in the Region (in Croatia, Estonia, Lithuania and Montenegro).

59. Country office classifications and groupings were first reviewed in 2011, after which the types of office were standardized and core staffing documented by the SRC unit in the Regional Office in an internal document called "the country road map", which became the key document referred to by the Regional Office when recruiting core staff for country offices. Data on health and other areas were collated and used in this exercise, mainly concerning the local situation, the size of the country, and its complexity, stability, and capacity.

60. Since 2011, the technical staffing of the country offices has also been reviewed on a biennial basis, with the aim of aligning technical expertise in the country offices to ensure that work was carried out in line with the programme budget and to deal with country-specific issues. At that time, there was already an emphasis on ensuring uniformity of core staffing profiles within country offices resulting in a similar core presence (which also included administrative capacity) among "like-country offices". Core staffing was funded through assessed contributions. Technical staff were assigned in accordance with the priorities of the biennium (as indicated before) and were funded by both voluntary donations as well as assessed contributions. Due to these early initiatives, originally put in place to ensure broader implementation of Health 2020, the Regional Office is now well prepared and well aligned to deliver GPW 13 and the programme budgets for the period covered by GPW 13.

61. With regard to professional development and skills, all heads of country offices and WRs are highly trained in management, in policy formulation and in facilitating technical support to national reform processes. This is important, as they ensure that the intercountry work delivered by the Regional Office through its technical programmes and networks is successfully transmitted to the countries concerned. In recent years, they have participated in well-established networks and interest groups and have also been invited to participate in WHO's governing body meetings to ensure their direct involvement in crucial discussions on health policy, health care reforms and health security.

62. Further managerial changes continue to be discussed and implemented with the aim of ensuring appropriate delegation of authority to the WRs in order to expedite their work. This

naturally entails increased levels of accountability for WRs, along with training in public health and diplomacy, which has helped to make them more effective in carrying out their political and leadership roles. In the meantime, all country office staff have also undergone further professional development to better equip them for country work through a set of "iLearn modules", including some mandatory courses on harassment, cyber security and safety.

63. One of the changes required to enhance the quality of leadership at country level was to formalize the methodology whereby candidates are chosen to be included in the global roster of WRs. This is already at an advanced stage, led by WHO headquarters, and will undoubtedly ensure the provision of high-calibre WRs who are effective health leaders and diplomats, well suited to addressing countries' priorities. In the European Region, sustained training and support over past bienniums has ensured that nearly all heads of country offices have been included in the roster, which has also facilitated the upgrading of nearly all of the country offices to being internationally led.

64. In the meantime, development of WRs continues through their own country experiences, which become further enriched by rotation to other countries and regions. In the Regional Office there has been a marked increase in the voluntary rotation and mobility of internationally recruited professional staff and heads of country offices, mainly between the regional and country levels and between the country offices of the European Region. This rotation has also contributed to the successful transition of most of the Region's country offices from being NPO-led to being internationally led.

65. Some challenges remain. Although the provision of technical assistance is a core function of country offices, the country offices of the Region are small and do not have adequate technical staff to fully deliver technical support without technical and normative backup from the Regional Office and, if required, from headquarters. Backstopping by the Regional Office and headquarters, together with a better alignment of WHO's work across the three levels of the Organization, will undoubtedly help to resolve this lack of technical capacity in the country offices. Another challenge faced at the country level is how to ensure a measurable impact of the Regional Office's work within countries, given the limited financial resources that partly result from the uneven distribution of the programme budget. Addressing the impact of United Nations development reform on WHO staff at the country level is another challenge.

WHO collaboration with countries that do not have a country office

66. Member States that do not have a country office have clearly indicated in consultations that their needs are different and go beyond the activities mentioned above. With the implementation of GPW 13, a clear strategy has been established at the global level of the Organization for closer liaison with these countries, which will be important in order to: (i) promote and assist with policy dialogues on key national health issues; (ii) assist with the strengthening of the leadership role of health ministries in intersectoral collaboration with other ministries; (iii) identify opportunities for the twinning of countries to facilitate exchanges of experiences; (iv) provide support and the evidence base for key national events; (v) discuss priority issues such as health budgets or the development of national health policies (in areas such as health financing and the development of national health policies, strategies and action plans); and/or (vi) be involved in discussions on strategic directions,

such as during the preparations for health-related activities under a country's presidency of the EU Council.

67. The national counterpart network has proven to be useful and will continue. However, a review of the criteria originally proposed to ministries of health for use in selecting the counterparts is necessary, to ensure the right candidates are selected and that the highest possible delegation of authority is provided by countries, so that the national counterparts can take timely decisions and reach out to the right level of national governance. Other regular points of contact with countries that do not have country offices include contacts that the staff themselves may have established over the years of technical work, or consultants and focal points in the networks mentioned above.

68. The country networks mentioned above will continue to play an important role in ensuring closer liaison with countries that do not have country offices. Focal points for such networks who regularly work with the Regional Office can liaise between the Regional Office and policy-makers. Similarly, the outpost offices located in Barcelona, Bonn and Venice, and the WHO office in Brussels, all provide locations that can be utilized for more agile mobilization of technical resources as well as for closer liaison with surrounding countries that do not have country offices, currently referred to as multicountry duty stations. Finally, WHO collaborating centres provide another important means of strengthening collaboration with countries that do not have country offices because they address issues that are relevant for the whole European Region.

69. However, the nature of WHO's presence in these Member States needs to be further explored and strengthened. A country presence could be in the form of a national policy-maker who can act as a regular contact point for daily liaison with the country, or alternatively, a WHO country relations officer (known as a strategic desk officer) stationed in the Regional Office who would ensure a constant flow of information to and from the country's ministry of health, without the need to establish a physical office. Various options are also being explored by the Regional Office with regard to positioning strategic desk officers in duty stations outside Copenhagen in already established offices of the Regional Office, which could provide an opportunity for these staff members to be physically closer to a group of countries without country offices that neighbour the duty station. These strategic desk officers would act as WHO representatives/liaison officers for all the neighbouring countries, but would have the advantage of being more readily mobilized for strategic discussions and other requests from these countries, simply as a result of being stationed physically closer to them.

70. The Regional Office is also discussing the possibility of extending the idea to use established WHO offices as multicountry duty stations for other strategic and technical reasons, especially in priority countries. The proposal under discussion is that senior staff would be posted in country offices or GDOs to serve a number of surrounding countries in a more regular and agile manner, enabling them to rapidly respond to demands arising from these countries. An example of such a set up currently exists in three country offices – Georgia, Kyrgyzstan and Serbia – where a senior technical officer on health emergencies is stationed who travels regularly between the neighbouring countries to provide the assistance and capacity building required. The aim is to extend this successful example to other subregions of the Region.

71. The multicountry duty stations would allow the Regional Office to provide more staff at the country level without necessarily increasing the staff compliment in each country office. Staff who could be relocated to a multicountry duty station include external relations officers (for advocacy, communication and resource mobilization purposes) and data and information officers, as well as technical staff. Although stationed remotely from Copenhagen, all outsourced staff stationed in multicountry duty stations will remain an integral part of their divisions in the Regional Office.

72. One final option being considered for closer liaison with countries that do not have country offices includes the appointment of a WHO ambassador (or WHO "friend" or envoy). These persons would be officially nominated or accepted by the ministry of health and ideally should have an in-depth knowledge of the Organization and its procedures. WHO retirees or ex-governing body members would be well-positioned to ensure adequate collaboration between WHO and Member States.

Framing the future work of the Regional Office with Member States

GPW 13 and the transformation process in the Regional Office

73. At the start of the transformation process, the Regional Director appointed a regional transformation coordinator in the Regional Office to work directly with the WHO global transformation team on the new ways of working, in line with GPW 13, and to coordinate the Regional Office's contributions to the global efforts. Through this appointment, the Regional Office ensured that there was regular follow-up and dissemination of information to the country level, to all Regional Office staff and back to headquarters. This helped to ensure a unified approach to the discussions and will be of benefit when the Regional Office implements the changes.

74. In the meantime, the senior leadership of the Regional Office and the WRs participated in various working groups organized by the transformation team in headquarters, which culminated in a presentation at a Global Management Meeting of WHO, held in Nairobi, Kenya, for all managerial staff in December 2018. This meeting was crucial for ensuring that all staff were actively involved in all aspects of the changes required and that they also had an opportunity to participate, contribute and learn what would be expected from them at the implementation stage.

Fine-tuning the WHO business model for the European Region

75. The development of an aligned and agile WHO operating model to achieve better impact at country level requires some modifications to the existing model. The business model for the European Region has been regularly discussed with staff throughout the past months, in order to better achieve implementation of Health 2020 and contribute to GPW 13. The business model will need some fine-tuning, especially to take into account the priority issues raised by countries without country offices.

76. Health 2020, which was originally designed to help overcome some of the principal barriers that had, until then, inhibited progress in relation to health, still provides a vision for the work of the Regional Office. By clearly setting out a strategic path, a set of priorities and a

range of suggestions for work at country level that are based on research and experience in many countries within and beyond Europe, Health 2020 continues to empower the Regional Office's leadership on country work and with the governments of the Region. This gives European Member States a unique head start in implementing GPW 13.

77. Transparent discussions on this subject have been taking place with the regional governing bodies, which have been provided with detailed information on the Regional Office's country work. Over the past few years, increased efforts have been made by the Regional Office to ensure that informed discussions can be held in all governing body meetings. These included a series of visits to countries by European members of WHO governing bodies between 2017 and 2019; side events at governing body meetings; direct interaction sessions between WRs and Member States held in the margins of Regional Committee meetings; and regular WebEx briefings for Member States involving national counterparts, ambassadors and the national communication focal points of ministries.

78. The Regional Office is also looking to strengthen the support provided to all countries in order to better align its work with GPW 13 and to ensure three-level alignment between the country offices and the other two levels of the Organization. Guided by the transformation discussions with headquarters, an exercise is under way to review countries' priorities for the biennium 2020–2021 and thereby identify the additional staffing that will be required to ensure impact at country level. This includes grouping countries according to their common health needs and political affiliations, which will allow for the identification of standardized core staffing for all the country offices for routine strategic work, as well as of the additional expertise required by multicountry duty stations to deliver technical assistance in an agile manner.

79. The SRC team will continue to serve a dual purpose by: (a) providing strategic advice to the technical divisions, acting at all times as the central point for collation of country information and intelligence, thereby ensuring effective coordination of country activities that are implemented by the Regional Office; and (b) serving as the main liaison point for strategic and policy issues with those countries that do not have a country office. The functions and responsibilities of the SRC team are currently being reviewed with a view to adding the new responsibilities envisaged in GPW 13 (such as the development, implementation and monitoring of CSPs).

80. One of the main shifts in the work of WHO will be to ensure more strategic policy dialogues with Member States, which will be sought at every opportunity and every level, thereby ensuring that collaboration is not simply reactive but is also proactive. In order to make an impact and deliver the triple billion targets, country work must not only be timely (reacting immediately to needs such as emergencies and public health crises as soon as they arise) but must also be effective in preventing the causes of ill-health (through addressing the social determinants of health, issues related to gender and human rights, lifestyles and health promotion) and be results-oriented, so that noticeable improvements in countries' health status are achieved. These will continue to be the main components of support to countries.

81. In the light of GPW 13, and the Programme budget 2020–2021, technical support will continue to be provided to countries mainly by the Regional Office, which will use its technical staff based in Copenhagen who will be supported by the highly integrated GDOs. However, to ensure that technical capacity is brought closer to where delivery is expected, one new option under consideration by the Regional Office is the establishment of multicountry duty stations as

described above, from which senior technical (and strategic) staff can be deployed quickly and effectively to neighbouring countries. These multicountry duty stations will allow senior technical experts to be positioned closer to countries that require regular support, thereby enabling the Regional Office to be more agile and responsive. They will make use of existing locations where WHO has already established offices. Moreover, there may also be a need to reorganize some staffing profiles into cross-functional teams so that critical, time-bound products can be delivered quickly in response to changing country needs.

Aligning the tools used in the European Region

82. The work of the Regional Office in countries is driven by standardized policies, procedures and tools that are not necessarily known to counterparts in countries without country offices. So far, the BCA has been the main tool through which the Regional Office has delivered technical assistance to most countries in the Region. The BCA is drawn up through bottom-up planning between the ministry of health and the WR, which results in a clear set of activities, to which a small budget is allocated in the form of assessed contributions, to ensure implementation. Over the years, these agreements between the Regional Office and countries have ensured that planning takes place in a bottom-up manner, and have given the Regional Office the opportunity to help frame priorities at national level and the expected outcomes for countries during a biennium. BCAs are in place for 29 countries with country offices and for three countries without country offices (Andorra, Malta and Portugal).

83. In other WHO regions, the main tool used by Member States for cooperation with WHO is the country cooperation strategy (CCS). In accordance with resolution EUR/RC62/R7, CCSs were put in place with countries at their request. The Regional Office has received many requests and enquiries, but until now only six of the 53 European Member States have a fully developed CCS.[12]

84. Many other tools have been developed over the years to address various health issues and common requests raised by Member States. An example is the Regional Office's work on promoting universal health coverage by strengthening health systems, as reflected in the Tallinn Charter of 2008 and again at the high-level regional meeting, Health Systems for Prosperity and Solidarity: Leaving No One Behind, held on the 10th anniversary of the Tallinn Charter in 2018. These emphasized the need to improve the quality of health care and health systems, including health financing arrangements that promote health. As a result, essential public health operations were reviewed and improvements were made and continue to be implemented in all countries according to their national laws. The areas receiving attention have included disease surveillance, primary prevention and health promotion. Tools to analyse systemic weaknesses and policies to tackle them have been developed and many missions to countries have been carried out to support their health systems performance analyses, resulting in significant improvements in countries. Assistance from the Barcelona office on health financing and the courses on health systems strengthening have proved to be particularly popular and effective within and beyond the European Region.

85. Other tools that have helped to provide direction to the Regional Office's work in countries include legal commitments made by Member States. These are comprised of "hard" law such as the International Health Regulations (IHR) (2005) and the WHO Framework

[12] Belgium, Cyprus, Malta, Portugal, Russian Federation and Switzerland. New CCSs are currently being developed with Israel and Turkey.

Convention on Tobacco Control, multilateral agreements such as environmental agreements in which WHO has clear responsibilities (e.g. the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes, and the Convention on Long-range Transboundary Air Pollution). However, WHO has also made much progress at the country level through "soft law" such as declarations and charters adopted at ministerial conferences, as well as strategies and action plans that have been endorsed at global and regional governing body meetings, supported by the adoption of accompanying resolutions.

86. GPW 13 now provides the Regional Office with a clear mandate to establish closer relations with all 53 countries in the European Region, which have been asked to identify and provide the Secretariat with key priority issues that are to be included in the CSPs of the Organization. These plans will build upon and link to the CCSs, taking into account national health policies, strategies and plans and United Nations Development Assistance Frameworks, where they exist at country level. GPW 13 will also ensure that closer attention is paid to the 2030 Agenda for Sustainable Development and the United Nations development reform process at country level.

Programme budget 2020–2021

87. A key aspect of the Programme budget 2020–2021 is that the priorities were identified by the countries themselves and that the corresponding list of priorities is now being used to build a global and regional plan of action. The Regional Office is working inter-divisionally and with the country offices to turn the Programme budget 2020–2021 into an operational plan. Taking these priorities into account, the Regional Office is finalizing the country operational model for 2020–2021, which will include more targeted core and technical staff in strengthened country offices as well as in multicountry duty stations to address increased demand.

Resource mobilization and allocation

88. Providing technical assistance and support to countries requires resources. When resources are not available, resource mobilization will be vital in ensuring that funds are available for those priority areas of work that are identified by the Organization's governing bodies or governments. This will be part of the Organization's overall resource mobilization strategy, with a core team planned to direct this work located in headquarters, supported by external relations officers located in regional offices and selected country offices. In the meantime, efforts will be made to ensure the best use of existing resources within each country or to mobilize resources from neighbouring or other countries.

89. In the meantime, Member States will continue to be encouraged to mobilize their own resources in order to assist other countries through multicountry approaches. Such approaches will be promoted by the Regional Office, as they have proved to be successful in the past. By working closely with Member States that are ready to invest human and financial resources to address health issues in which they have experience and expertise, the Regional Office will achieve more extensive and effective impact at country level.

90. At country level, the budgets related to BCAs have always been aligned, as far as possible, with the priorities of the Member States concerned. The Region-wide budget includes the priorities of all countries (with and without BCAs) and the activities of the

Regional Office are therefore interconnected with the budgets related to BCAs. At the corporate level, allocation of flexible funding has been geared towards programme areas given the highest priority by Member States. Early establishment of workplans allows continuity of programmes from one biennium to the next, resulting in increased efficiency in the use of available financial resources.

91. To promote predictability and transparency in the allocation of flexible resources at the country level, the Regional Office has utilized a strategic budget space allocation approach to resource distribution. This approach is needs-based, and decisions on resource allocations are clearly explained. Seventy-five per cent of resources were distributed at the beginning of the current biennium and the remaining 25% were distributed in accordance with satisfactory implementation of flexible funds and voluntary contributions, taking country-level needs into consideration.

92. The Regional Office is analysing potential synergies and current collaboration arrangements with other partners to further the allocation agenda, while utilizing resources efficiently. Currently, framework agreements exist between WHO and France, Germany and the Netherlands, in which a dedicated amount of the partnership funds are to be allocated to the Regional Office, usually after the agreement of common priorities. The partnership agreements with France and the Netherlands were put in place several years ago. The first Dutch partnership agreement, originating in 2005, strengthened relations between the Ministry of Health, other Dutch institutions and the Regional Office. It also provided vital funding which, for example, helped to build the programmes on primary health care and antimicrobial resistance and the European Health Information Initiative in the Regional Office. The French contribution through its framework agreement has been supporting implementation of the International Health Regulations (2005) in eastern Europe for many years and previously supported other important initiatives, such as SEEHN. The first multiannual German partnership agreement was signed in 2018 (previous agreements were annual). Other Member States in the Region which had, or have, framework agreements with WHO globally are Luxembourg, Norway, Sweden and the United Kingdom of Great Britain and Northern Ireland.

The impact of United Nations development reform at country level

93. The Regional Office has always underscored the need to work with all partners at country level, and in particular with United Nations sister agencies. The regular attendance of the Regional Director and other senior staff of the Regional Office at meetings of the regional United Nations Development Group has resulted in increased influence on, and impact of, the work of United Nations country teams at country level, specifically through ensuring a greater focus on health issues and determinants by all United Nations agencies. The Regional Office has proposed and set up issue-based coalitions at the regional level, in which one agency leads and other agencies support. So far, five different coalitions have been established, one of which focuses on primary health care. Other topics include noncommunicable diseases, HIV/AIDS, migration and access to medicines. WHO is also significantly involved in efforts to achieve the SDGs, in which the Global Action Plan for Healthy Lives and Well-being for All is a vital component (with 10 supporting organizations); the United Nations development reform process is closely linked with implementation of that Action Plan. In accordance with WHO’s mandate, the Regional Office will aim to ensure that health becomes an even stronger focus within United Nations Sustainable Development Cooperation Frameworks (UNSDCFs) – the United Nations mechanism for intersectoral cooperation.

94. WHO and its country offices have already played a key leadership role in the development and implementation of UNSDCFs, ensuring that health and the health-related SDGs are well represented in them. This has been the case over the past three years, as all 18 UNSDCFs in the European Region have been renewed. Three countries (Albania, Kyrgyzstan and Montenegro) participate in the "delivering as one" programme, while Bosnia and Herzegovina and the Republic of Moldova have adopted most of the pillars of this programme. Numerous countries are taking part in the "one United Nations" programme. WHO participates in United Nations thematic or results groups on health in 22 Member States in the Region.

95. WHO welcomes United Nations development reform and the new United Nations Resident Coordinator (UNRC) system and looks forward to its full implementation. Linking with United Nations country teams under the leadership of the United Nations Regional Coordinator will undoubtedly provide more resources – human as well as financial – for addressing health issues. The WRs, who are integral members of these teams, may guide the work to address these issues but will not necessarily deliver it directly. The more coordinated approach of United Nations country teams under the leadership of the UNRC is therefore likely to strengthen intersectoral collaboration at country level and WHO will support these efforts. United Nations development reform will also give WHO improved access to sectors beyond health at country level.

96. However, there are some challenges that need to be resolved for WHO to be able to safeguard its normative function. Although the United Nations Deputy Secretary-General, Amina Mohamed, recognized the role of WHO as a normative agency during the WHO Global Management Meeting, WHO can only ensure that its normative function is maintained if continued access to various levels of government is guaranteed for WRs, and not only through the UNRC. While United Nations development system reform is an ongoing process, further clarity is still expected on the sharing of human and financial resources by the various organizations (further clarity is needed, for example, on how WHO can collaborate and yet protect its own resources); the dual accountability of the WRs, i.e. to the UNRC and to the WHO Regional Director; and the different planning cycles of WHO's BCAs, CCSs and CSPs on the one hand, and the UNSDCFs on the other. In the European Region, only 17 countries have a UNSDCF/UNRC presence.

97. In most cases, the funding of country work is not sufficient to address countries' health priorities, and hence resource mobilization is crucial to the country offices' ability to deliver on countries' expectations and needs. The United Nations development reform process is a step in the right direction to ensure that United Nations country teams work together, pooling their limited resources on common health issues, but there is still a need for further clarification of mandates, levels of accountability and sharing of these resources at country level.

Conclusion

98. In line with the Regional Director's original vision, as set out in 2010 and clearly framed in Health 2020, and in full alignment with GPW 13 and the Programme budget 2020–2021, the Regional Office is well-positioned to continue to put countries at the centre of its work. Moreover, GPW 13 sets the direction for all levels of the Organization to ensure that resources and efforts are more effectively directed to the country level. Working closely with and in countries is not new for the Regional Office, but the strategic shifts and changes that

will result from the transformation process will ensure that there is clear alignment in WHO's way of working across all three levels of the Organization and across all regional offices.

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