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Report of the Regional Director on the work of WHO in the European Region, 2002–2003

This document contains a review of the actions taken by the WHO Regional Office for Europe during 2002–2003 in order to implement its programme within the framework of the Country Strategy adopted in 2000 by the Regional Committee. It should be read in conjunction with the information document on budgetary performance for 2002–2003 (EUR/RC54/Inf.Doc./1) Additional information on the delivery of technical programmes is available from the Secretariat upon request.

A draft resolution is attached for consideration by the Regional Committee.

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Contents

Page

Introduction

1. During the biennium 2002–2003, the work of the WHO Regional Office for Europe (WHO/EURO) has been geared towards implementation of the Country Strategy "Matching services to new needs", adopted by the Regional Committee in September 2000, and adaptation of the structure, methods of work, knowledge base and required expertise in the Regional Office to better respond to the needs of Member States and to implement the approved programme budget.

2. Particular efforts were made to develop and sharpen the collaboration with countries. For those countries with specific collaborative agreements and WHO country offices, the implementation of planned activities improved in comparison with the previous biennium and a process of in-depth negotiation resulted in the selection of very specific priorities for the next biennium. This was made possible through the strengthening of country offices, including in terms of capacity-building. The Regional Office also collaborated with those countries without country offices, through access to evidence and information, exchange of expertise on request, and participation in the Futures Fora series on major current and future public health issues of high concern to decision-makers.

3. The development of partnerships begun in the previous biennium continued with selected organizations, while efforts were made to initiate new partnerships, with the goal of developing specific joint activities. Collaboration with WHO headquarters and other WHO regions was strengthened in a spirit of transparency and trust, with a view to building one organization able to provide specific services to the diversity of its Member States.

4. Efforts were also made during the biennium to improve the way of working of the Regional Office. Mechanisms were established to enhance the Office's capacity to provide evidence-based advice to Member States. Information management also progressed with the establishment of a new integrative database: the Health Evidence Network (HEN) built in partnership with several national and international organizations. Administrative procedures were streamlined to facilitate support to country activities, and training was offered to staff at the Regional Office and in countries to enhance their competence and job satisfaction.

5. It is not the purpose of this report to present a detailed account of the implementation of technical programmes in the Region. That detailed information is available from the Secretariat upon request. It was decided, in agreement with the Standing Committee of the Regional Committee, that this report should concentrate on the major actions and changes implemented in the Regional Office during the biennium to give effect to the Country Strategy. The report is therefore articulated around seven major processes defined since 2001 that guided the execution of the programme budget in the European Region, namely: (i) providing services to countries; (ii) developing partnerships; (iii) updating the Health for All (HFA) policy framework; (iv) improving evidence and information; (v) developing scientific, technical and managerial competence; (vi) improving communication and visibility; and (vii) improving administrative and management processes.

6. In addition, selected technical issues have been highlighted to illustrate some of the most important activities undertaken to respond to global priorities and/or resolutions of the governing bodies, or in relation with European action plans or major conferences.

7. It is hoped that this new presentation will be found useful by Member States, who have requested on several occasions, as has the Standing Committee of the Regional Committee, that the main documents of the Regional Committee be more concise.

Providing services to countries

Focusing on countries

8. The Regional Office's Country Strategy, "Matching services to new needs", approved by the Regional Committee at its fiftieth session in 2000, emphasizes an orientation towards country work through which Member States in their diversity should find responses to their specific needs in the services offered by the Organization. The mission of the Regional Office is "*to support Member States in developing and sustaining their own health policies, health systems and public health programmes; preventing and overcoming threats to health; preparing for future challenges; and advocating public health*". The Country Strategy is the core of the regional effort to implement the "Country Focus Initiative" launched in 2002 at the Fifty-fifth World Health Assembly as the WHO corporate policy to massively scale up the Organization's work for health and development by improving its performance at country level. The move towards meeting country-specific health needs is supplemented by an effort to build international partnerships for health, as well as partnerships among WHO's European Member States.

9. Since the adoption of the Country Strategy in September 2000, activities have been increasingly specific in the 28 countries of central and eastern Europe that have biennial collaborative agreements (BCAs) with the Regional Office. Activities have also been consistently developed with countries in western Europe with which the Regional Office does not have BCAs.

Programmes with the Stability Pact countries of south-eastern Europe

10. Building on an initiative by the Council of Europe and the Regional Office, eight Member States in south-eastern Europe (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Romania, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia) are using health and social cohesion as the main vehicles for achieving lasting stability, economic development and collaborative progress. Following the Dubrovnik Pledge signed in September 2001, seven project proposals have been produced, three of which (on mental health, food safety and surveillance of communicable diseases) are currently being implemented. The governments of Belgium, France, Greece, Hungary, Italy, Slovenia and Switzerland are supporting these projects. Some other projects also receive the support of the Council of Europe Development Bank.

Strategies for rapid transition countries

11. Strategies are being developed to support the so-called rapid transition countries (mostly those which have recently acceded to membership of the European Union (EU)) in addressing their health needs. This has been done through extensive collaborative work with the Czech Republic, Estonia, Hungary, Poland and Slovenia, and substantial bridge-building efforts with the EU. In addition, research has been carried out to define the best way for the Regional Office to support these countries. Areas of interest to the Member States concerned and potential strategic directions for the Regional Office include the development of health systems, the reorganization of public health institutions and functions in Member States, and health information.

Futures forum series for non-BCA countries

12. In this project for non-BCA countries (mostly western European countries), difficult or new health issues that will be strategic concerns for the years to come, e.g. bioterrorism, the ethics of health systems, tools for decision-making in public health, are studied and debated in order to give Member States the opportunity to share their views and experience. Each forum functions both as a think-tank (offering a vision and guidance in shaping the agenda for the future) and as a network that provides and circulates information to its members and possibly to other Member States. Three futures fora took place in the biennium: in June 2002 in Stockholm on the topic "Ethics of health systems"; while in 2003 a new general theme for the series was launched on "Tools for decision-making in public health", with meetings in June 2003 in Brussels on the topic "Evidence-based recommendations" and in Madrid in December 2003 on "Rapid decision-making".

13. Western European countries are also benefiting from other Regional Office programmes, in particular those involving all European Member States (such as the Framework Convention on Tobacco Control) or those linked to the European perspective of global reports in areas such as mental health and violence. The Regional Office is also looking at the specific needs of these countries, in the field of public health policy.

Examples of services to countries

Health policies and health system reform

14. In order to strengthen the capacity of countries to deliver high-quality health services affordably, efficiently and equitably to all their populations, especially those most vulnerable, WHO promotes evidence and best practices to define health policy options, develop human resources and fulfil the stewardship function. It develops frameworks, strategies and tools to analyse health system changes and reform and to improve the delivery, performance and quality of health services. It provides technical and policy support to countries in order to improve provision of health services and investment in, and use of, human, material and capital resources.

15. WHO provided technical assistance, guidelines and training, and also worked in collaboration with partners, in the four functional areas of the health system: (1) health service delivery (personal and public health services in hospitals and primary care, emergency services, e-health and telemedicine); (2) resource generation, and more specifically, human resources for health (human resource policy and planning, education of health professionals, management development); (3) health financing; and (4) stewardship (support to national health policy development and health system performance assessment).

16. Perhaps the most significant achievements are related to the effort made to adapt to country level the WHO health system performance framework promulgated in *The world health report 2000*, and the strength of our partnerships. With regard to the former, the Expert Panel and Advisory Group for Health Systems Development contributed to greater coherence and strength of our work in supporting health systems development in the European Region countries. Examples include work on stewardship in Bosnia and Herzegovina and support to link health financing and primary care development in Armenia. The development of national performance monitoring and evaluation frameworks based on *The world health report 2000*, most notably in Kyrgyzstan, was an important step forward in providing an example of translating global concepts to national level. Improved partnership arrangements were evident in many activities with bilateral aid agencies, the EU, the World Bank, the Council of Europe, the Open Society Institute and others. For example, WHO participated in the Council of Europe expert committee on palliative care, the recommendations of which were approved by the Council.

17. Explicit mention should be made of the Regional Office's work (jointly with the European Commission (EC)) in Bulgaria on revising a draft of the new public health law, where various Regional Office technical programmes were involved. Similar work has been done in relation to a review of the new health transformation programme proposed by the Ministry of Health of Turkey, as well as the national health plan of Portugal.

18. In addition, and in order to increase effectiveness and sustainability when working with and in countries, all WHO support in the form of field interventions of a technical nature is supplemented by activities designed to foster health system development and take account of the health policy implications of such interventions. This approach helps countries in their health system reform efforts and opens up a broad health policy debate.

19. An advisory group (including representatives of the World Bank, the EC and other partners) and an expert panel on health systems have been actively involved in operations in countries. Several Member States have progressed in implementing the Munich Declaration on Nursing and Midwifery (2000) by better integrating the nursing and midwifery workforce in their health policy and health systems work. However, still many challenges lie ahead.

20. In the area of pharmaceuticals, the Regional Office has continued to provide support to countries in the further development and implementation of national policies on medicines, as a part of their health systems policy development. Among others, specific support was given to the establishment of the Drug Regulatory Agency in Ukraine, and to inspection of Russian manufacturers of anti-tuberculosis medicines, resulting in increased access to these drugs in the Russian Federation. A review was made of access to anti-retroviral medicines (ARVs) in Romania, a country with large scale access to ARVs, and Ukraine was supported in increasing access to ARVs within the framework of the "3 by 5" initiative. Continued capacity-building on clinical and cost–effectiveness evaluation of medicines for reimbursement was arranged with Poland and the Baltic countries. Finally, the publication of the seventh edition of *Drugs and money* on cost-containment policies should be noted.

21. The Regional Office is also looking at the specific needs of non-BCA countries, in particular helping them to design their public health policy (France and Portugal) or to tackle a specific sector of this policy (evaluation of health promotion policy in Finland). Similarly, mention should be made of the health technology assessment review for the National Institute of Clinical Excellence in the United Kingdom. Instruments for health system coordination in decentralized western European tax-based systems have been offered to the Spanish government, in support of its work on a health care coordination bill.

Response to health crises

22. Responding to Member States' needs during health crises testifies to the improved content and delivery of the Regional Office's services. The most recent examples (from 2002 and 2003) include health emergencies in Andorra, the Czech Republic, Spain and The former Yugoslav Republic of Macedonia. The Andorra crisis was linked to possible exposure of the population to dioxin associated with its release into the environment. The health risk as perceived by the population and emphasized by the media and nongovernmental organizations (NGOs) was very high and extended well beyond the level predictable from scientific knowledge. WHO assisted the Ministry of Health and Well-Being and an interministerial working group and provided clarification to the Parliamentary Committee with regard to the health impact on the population.

23. Another type of health crisis, of a political nature, concerned Kyrgyzstan, where direct intervention by the Regional Office contributed to resolving a problem with the country's health system reform. The challenges to the reform were of concern not only to those in the Ministry of Health (who wanted to extend it) but also to the main external partners supporting the process (the World Bank, the United States Agency for International Development, the United Kingdom's Department for International Development (DFID) and the Swiss Agency for Development and Cooperation). A concerted and successful effort was made by these agencies to renew their support to the reforms.

24. A major domain for WHO action in health crises is the provision of emergency and humanitarian assistance. In order to prevent and prepare for disasters and mitigate their health consequences, WHO provides public health information and management tools, and political and technical support. It also contributes to the strengthening of international partnerships. In 2003, the Regional Office contributed to the preparation of the Health Action in Crises (HAC) global strategy for WHO's work in crisis situations, involving all regions. The operational plan was further elaborated at regional level and incorporated in a three-year proposal to strengthen WHO's capacity-building for disaster preparedness and response activities.

25. During the biennium 2002–2003, two major crises occurred in Afghanistan (2002) and Iraq (2003) that involved the Regional Office in cross-border cooperation activities (coordination, technical and logistic support) with Tajikistan, Turkey, Turkmenistan and Uzbekistan, in close coordination with the WHO Regional Office for the Eastern Mediterranean (EMRO). The WHO/EURO Emergency Steering Committee and the Task Force on Biological, Chemical and Nuclear Warfare (BCNW) were strengthened at this time.

26. Humanitarian assistance continued to be delivered to the Chechen population from the North Caucasus emergency operation, with field offices in Nazran and Vladikavkaz, coordinated by the WHO humanitarian assistance programme office in the Russian Federation. In 2003, the field office in Vladikavkaz was closed. An external evaluation of the North Caucasus operation was undertaken at the end of 2002.

27. Two major earthquakes in the European Region in Georgia (Tbilisi, 2002) and in Turkey (Bingol, 2003) necessitated assistance in the field of disaster preparedness and response, as did the serious floods in Prague in 2002 and in Tirana in 2003.

28. The Regional Office continued to manage humanitarian assistance operations in the Balkan region, refocusing its support on recovery and rehabilitation activities. Special mention should be made of the results achieved by two public health programmes in the Balkan region: the community mental health programme and the early warning system for communicable diseases. Both programmes started during the early phase of the emergencies and continued during the recovery and rehabilitation phases in Albania, Bosnia and Herzegovina, Serbia and Montenegro including the United Nations Administrative Province of Kosovo, and The former Yugoslav Republic of Macedonia. In the biennium 2002–2003, the two programmes were incorporated in the Stability Pact for South Eastern Europe Initiative.

29. Late in 2003 a successful exit strategy was implemented to phase out from the recovery and rehabilitation phase in some countries of the Balkan region and to integrate the humanitarian assistance offices into a “One WHO” country office that now incorporates both humanitarian assistance and development activities within a common BCA framework. In Albania, Tajikistan and The former Yugoslav Republic of Macedonia, this approach has now made it possible to respond in an integrated manner to immediate recovery and rehabilitation needs and also to consistently support deeper health reform processes in the countries.

30. At the same time, WHO continues to play an important coordinating role for all health sector activities, particularly with the many NGOs working in the humanitarian assistance field in the countries. This coordinating role will be further strengthened in the biennium 2004–2005.

Technical programmes

31. The Regional Office provides countries with a wide variety of technical programmes covering the main fields of public health. This is done using the technical resources available in the Secretariat (technical units in the Regional Office and headquarters, specialized WHO centres) and via an extensive network of experts and institutions collaborating with WHO.

32. During the biennium, new BCAs were formulated and implemented more strategically and more collaboratively with Member States. This new approach to BCAs has been instrumental in bringing about the better integration of programmatic areas within a broader health policy and health systems dimension of country work.

33. As mentioned in the introduction, this report does not intend to provide a comprehensive description of the activities and achievements of individual technical programmes. Some highlights are given in the last chapter of the report and a detailed account of achievements is available from the Secretariat upon request. In addition, a country-by-country overview of WHO work and achievements during 2002–2003 is given in document EUR/RC54/Inf.Doc./2.

Improving the delivery of services to countries

Strengthened WHO country offices

34. Unifying and strengthening the Organization’s country presence is a necessity if the Regional Office is to honour its commitments. The concept of a single country office that functionally integrates all of the Regional Office’s interests in each country is being put into effect, so that all matters related to

funding and human resources (whether permanent or temporary, and including humanitarian assistance and disease-specific project teams, etc.) become the full responsibility of the country office, under the auspices of the Division of Country Support at the Regional Office.

35. In order to be effective, WHO's country offices must have staff with the necessary skills and legal mandate to carry out their new enhanced role. Three lines of action are being pursued to this end: (1) moving the necessary human resources from the Regional Office in Copenhagen to the countries concerned; (2) appointing international heads of country offices; and (3) upgrading the skills of existing staff, especially liaison officers. At the same time, the posts of liaison officer and administrative assistant and their legal status have been upgraded in 26 countries. The successful candidates for liaison officer positions have undergone appropriate training.

36. The application of a carefully designed training package, with health policy and systems as well as managerial competence (including financial management theory and practice) at its core, is crucial to enhancing skills in country operations. At this stage, about 60 country staff have undergone such training, with positive results as measured by systematic evaluation.

Adjusted management in the Regional Office for Europe to facilitate country support

37. The Country Strategy calls for new approaches, new job profiles and processes of work. An organizational adjustment of the Regional Office based on functions (rather than, as formerly, on programmes and units) has now been accomplished and is operational. Special mention should be made of the Country Work Help Desk, a single unit in charge of coordinating all Regional Office country operations. A country work management system, with explicit performance indicators, is slowly generating a new management culture, thus positively influencing the Regional Office's performance and effectiveness.

38. In line with the Country Focus Initiative's objective of improving the administrative capacity of WHO country offices, administrative guidelines have been developed, and country office staff have been given hands-on training. Administrative support from the Regional Office has been reorganized, with focal points designated in the areas of budget, finance and human resource services. There has been an increase in visits by administrative staff to country offices, in order to better understand local operational conditions and provide direct assistance with solving problems.

39. WHO continues to work in the direction of improving resource planning in country offices and standardizing operational procedures, as well as monitoring performance on the basis of an agreed set of indicators.

Developing partnerships

40. Partnership with other organizations was underlined in the Country Strategy adopted by Member States as an essential principle of the Regional Office's work with countries. Accordingly, the Regional Office has been seeking to develop international partnerships in order to create an atmosphere of shared responsibility and to achieve better outcomes, while overcoming the problems of duplication of efforts and poor coordination of international health work, in a context of imbalance between huge needs and limited resources. Partnership offers opportunities for synergistic approaches between international stakeholders, each of them working from their respective platforms and mandates. Efforts were made during the biennium to establish a formal basis for these partnerships at institutional level. Agreements were signed with most of the organizations concerned, outlining a precise scope and purpose and programme of collaboration. The implementation of these agreements is regularly reviewed.

41. **Existing partnerships** were strengthened, particularly with the EC, the Council of Europe and the World Bank, through participation in yearly high-level and senior management meetings and regular bimonthly coordination meetings.

42. As examples of increased partnership with the EC, staff were seconded to the Health and Consumer Protection Directorate-General (DGSanco) in the field of surveillance of communicable diseases, the Regional Office succeeded in five out of seven financial proposals to the DGSanco Public Health Programme 2003–2008, and it also provided the WHO input to the EC strategy on Environment and Health. Technical cooperation with the EC has expanded to include a range of Commission services such as research, environment, enterprise, humanitarian assistance and external relations. It is expected that this cooperation with the EC will continue to grow, particularly in the field of health intelligence.

43. WHO cooperated with each of the EU presidencies during 2002–2003 (Spain, Greece, Denmark and Italy), providing technical briefings to the health attachés of EU Member States on issues of common concern, including tobacco control, environment and health, cooperation with the new EU Centre on Disease Prevention and Control and revision of the International Health Regulations.

44. Partnership with the Council of Europe concentrated mainly on the programme for the Stability Pact countries of south-eastern Europe. Other fields of collaboration include gender and health – particularly gender-based violence – mental health and human rights. The Council was involved in the preparation of the human rights section of the HFA update.

45. Better coordination of World Bank and the Regional Office projects at country level has been achieved. This cooperation was particularly important in supporting countries' efforts to scale up responses to the HIV/AIDS epidemic and in the field of health systems development.

46. **Partnerships with other United Nations organizations** were developed during the biennium. The annual coordination meeting with the United Nations Children's Fund (UNICEF) was organized. Collaboration with UNICEF included such areas as surveillance of communicable diseases, the Roll Back Malaria initiative, and the health of young people, which also benefits from close collaboration with the United Nations Population Fund (UNFPA). The Regional Office collaborated with the Joint United Nations Programme on HIV/AIDS (UNAIDS) in formulating the European strategy for the prevention of HIV infection in infants and young children.

47. **New partnerships** were also explored. The first general coordination meeting with the German agency for technical cooperation (GTZ), and the German Bank for Reconstruction and Development (KFW), to build up stronger links and to evaluate existing and future cooperation in different areas of work took place in 2003. The Regional Office received support from the Netherlands Organization for Health Research and Development (ZonMw), which is already funding a post in the field of gender and health; further project proposals are under discussion. An extension of the Memorandum of Understanding with the Open Society Institute was finalized in 2003, leading to strong and continuing funding of WHO/EURO projects in a variety of areas of work, especially HIV/AIDS and the European Observatory on Health Care Systems. Finally, first high-level contacts were initiated with the Organisation for Economic Co-operation and Development (OECD) and the United Nations Food and Agriculture Organization (FAO). Coordination meetings took place in 2003 at high senior management level and more practical technical cooperation meetings are to be held with both organizations in the near future.

48. There are numerous **examples of activities conducted in collaboration with partners.** Major projects have been carried out in partnership: the Health Evidence Network – the clearing house for information of use for decision-making in public health – together with national and international organizations (the EC, in particular); surveillance of communicable diseases (with the EC); and preparations for the conference on mental health in 2005 (with the EC and the Council of Europe).

49. Partnership is a key aspect of the Country Strategy. The Regional Office country staff are increasingly working with other stakeholders in the field. Some examples of successful partnerships, as measured by their impact on developments in countries, include reconfirmation of the thrust of the health system reform in Kyrgyzstan, work on HIV/AIDS in Bulgaria and Ukraine, and a review of public health legislation (jointly with the EC) in Bulgaria. Other examples are the promotion of healthy environments

for children on World Health Day in the Russian Federation (in conjunction with an exhibition of works by famous Russian artists) and primary care reform in Georgia (in partnership with the World Bank, DFID and the EC).

50. Member States have been helped to mobilize resources, for instance, from the Global Fund to Fight AIDS, Tuberculosis and Malaria to address their priority health needs. Following an explicit request made at the fifty-second session of the Regional Committee, the Regional Office has been actively involved in this initiative with a precise mandate. Notable progress has been made in supporting the submission of proposals to the Global Fund from Croatia, Estonia and Uzbekistan (HIV/AIDS) and from Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Romania and Ukraine (tuberculosis). The Regional Office is strongly supporting the implementation of projects in countries selected in the first round of applications.

51. Intersectoral partnerships have been explicitly promoted through various programmes. The European Network of Health Promoting Schools, for instance, is co-chaired by the Council of Europe, the EU and the Regional Office. On 7 April 2003, World Health Day, the Network supported Latvia in its national commitment, resulting in a formal agreement between the Latvian ministers of health, education and science, and the Minister for Special Assignments for Children and Family Affairs.

52. The Regional Office has stepped up its efforts to facilitate bilateral collaboration between Member States, in order to promote sustainability and continuity. The Ministry of Health of Israel supported a project in the central Asian republics building up capacity in various aspects of public health, primary health care and family medicine, working through the Regional Office's fellowships programme. Twinning of pharmaceutical associations in Croatia, Estonia and Latvia with those in Germany, Finland and Denmark, facilitated by the Office's EuroPharm Forum, ensured implementation of the patient education campaign "Ask about your medicines".

Updating the Health for All policy framework

53. In 1998, when adopting the Health for All policy framework for the European Region (HEALTH21), the Regional Committee decided that the next update of the regional policy framework should be submitted to it in 2005 (resolution EUR/RC48/R5). The updating process started in early 2003, in collaboration with the Standing Committee of the Regional Committee. Even in the relatively short period of five years since the adoption of HEALTH21, there have been significant changes in the health systems of Member States. The update must therefore integrate the experience and knowledge recently accumulated by countries. The approach supported by the Standing Committee made provision for four processes to be developed in close synergy. The update is thus built on four main pillars: the lessons learned from Health for All; revisiting the values of Health for All; devising tools for decision-makers; and guidelines for implementing the Health for All update.

Pillar one: lessons learned from Health for All

54. In the past two decades, the Health for All policy has been a source of inspiration for countries individually and collectively. It has stimulated and influenced the health policy debate, even in countries that have not formally adopted Health for All targets. However, knowledge of these developments is dispersed, and the actual impact of the Health for All policy in Member States is not yet well understood. The Regional Office launched two studies, led by the WHO European Centre for Health Policy and the European Observatory on Health Systems and Policies in Brussels, to address this knowledge gap: a review of existing evidence related to adoption and use of the Health for All policy in the European Region; and the use of targets as a tool for policy-makers in Member States.

Pillar two: revisiting the values of Health for All

55. A think-tank of experts was established to help reassess the guiding values for health development as part of the Health for All movement in Europe and to link these values to health policy and public health. The think-tank started reviewing and selecting which of the values promoted by the Health for All movement should be reinforced in the forthcoming update.

56. The values and principles already stated in the existing Health for All policy framework and related WHO and United Nations documents remain valid for Europe's public health sector of today. One key issue is the difficulty of linking commonly accepted values with the set of factors that shape the formulation and implementation of health policies and actions. Therefore, one major challenge for the think-tank was to elaborate a system of values that could ensure ethical governance in health. The think-tank developed a proposal for a new setting in which the existing and new values could be interpreted and assembled, in order to help policy-makers assess the ethical dimension of their health policies and actions. The proposed setting is built on three interrelated dimensions: respect of the right to health as a fundamental human right; equity, solidarity and people's involvement as fundamental principles; and ethics in governing health systems.

Pillar three: devising tools for decision-makers

57. This part of the update put forward tools that decision-makers can use to make sure that their health policies and public health programmes are in line with the values of Health for All, both when assessing the present situation and in possible future developments.

58. The aim is to provide policy-makers with specific methodologies that they can use when assessing the degree of conformity of their policies or programmes with the values of Health for All. The expected outcome would be a kind of checklist, including a series of questions that decision-makers could use when analysing the policies and programmes existing in their countries.

59. A second outcome would be a series of suggested tools that could be used by decision-makers when planning reforms of their public health policies and programmes or launching new ones. It is intended to review the quality and relevance of each of the tools suggested with regard to health system development and the values reconfirmed by the Health for All update. Examples of such tools are: methods for health impact assessment; new evidence-based knowledge of good public health practice; and mechanisms to promote excellence and quality, including accreditation.

Pillar four: implementing the Health for All update: guidelines and good practice

60. This work will provide specific, practical recommendations on how to implement the updated Health for All policy. However, it is too early at this stage to give details about this pillar, which can be tackled only after completion of the work on the first three pillars. One possibility could be to include some case studies of policies and programmes that have been developed with clear links between values and action.

61. The work on the Health for All (HFA) update has been fruitful during the biennium in defining the methodology of the update process and the major part of the content of the revised policy. A first draft will be presented for broad consultation with Member States before the end of 2004. The final draft will be discussed and hopefully adopted as planned by the fifty-fifth session of the Regional Committee in September 2005.

Improving evidence and information

62. The WHO/EURO Country Strategy stressed the importance of information and knowledge as a fundamental basis for progress in public health. It gave to the Regional Office the mandate of developing, in close cooperation with countries, modern systems of information and knowledge management; strengthening its capacity for analysing data in support of decision-making; and fostering partnerships with the many bodies that are involved in this sector. The Regional Office is thus committed to the goal of promoting and supporting a more scientific, evidence-based approach to public health. Toward this goal, coordinated initiatives for evidence for public policy and health data and information were taken to ensure that the search, evaluation and dissemination of information and evidence are done in a way that is directly useful to decision-makers, and that staff and programmes in the Regional Office use the best available evidence in their own decisions and in providing advice and recommendations to Member States.

63. Efforts to develop an explicit evidence-based work methodology in the Regional Office began in 2001 when the Division of Information, Evidence and Communication was established and the programme on Evidence on health needs and interventions (ENI) was created. A newly constituted European Advisory Committee on Health Research (EACHR) was given the role of advising the Regional Director on how to better define evidence-based policy. A survey in the Regional Office revealed that there was no consensual understanding of the meaning of "evidence", nor uniformity in the collection, interpretation and use of evidence to provide recommendations for health policy-making. A review of selected reports from the Regional Office for Europe also showed that recommendations often did not follow from the evidence presented. This highlighted the need to transform working practices in order to use evidence systematically.

64. Based on the work of the EACHR and the consultations with programmes and staff, the Regional Office developed a broader and more operational definition and understanding of the concept of evidence to be used in giving advice and recommendations to its Member States. The concept, which is intended to capture a broader scope than merely the results of scientific research, defines evidence as "findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care". The gradual but successful change towards an evidence-based organization has been made possible by the acceptance of this broader understanding of evidence by Regional Office staff. The validity of this concept of evidence was confirmed when a paper jointly written by members of the EACHR entitled *Considerations in defining evidence for public health* was accepted for publication by the International Journal of Technology Assessment in Health Care. It challenged the existing paradigms in the field of evidence and highlighted the challenges in co-relating evidence to recommendations. The paper was distributed to Member States during the fifty-third session of the Regional Committee.

65. The strategy for dissemination and implementation of evidence-based work in the Regional Office for Europe involves "formal" approaches such as staff training, knowledge management, creation of tool kits, etc. Incorporating this vision into routine discussions and daily work will be an ongoing process. The more "formal" approaches outlined above will also be complemented by other "informal" structures for knowledge-sharing such as the establishment of discussion groups on evidence and the build-up of an evidence base at the Regional Office in the form of case studies. The new definition and concept, and the methodology of evidence-based work have been captured in an internal paper entitled, *Evidence policy for the WHO Regional Office for Europe* which will form the basis for future work and evidence-based training workshops.

Evidence for health policy

66. The Health Evidence Network (HEN) launched in 2003, is an information service for public health and health care decision-makers in the WHO European Region. With the assistance of an international editorial board, HEN selects questions from those received and commissions experts to research and write responses that are evidence-based, peer reviewed and periodically updated. It identifies, reviews and

describes relevant databases, selects documents and other information related to public health, and makes this material accessible on one web site. This web-based network provides responses to questions posed by decisions-makers in the form of a detailed synthesis report, with a one-page summary including policy options, or a one-page summary of a response already available from the agencies and organizations collaborating with HEN. The delegations at RC53, which were introduced to the HEN products, praised this Regional Office initiative to address a critical need. Over the course of 2003, the number of people visiting the HEN web site has grown continuously. The HEN now receives questions directly from decision-makers in several countries. Over 20 synthesis reports are now available and new reports are published each month. HEN will continue to add responses to new questions and update existing responses.

67. The European Observatory on Health Systems and Policies also strongly supports the Regional Office's evidence efforts through its policy analyses, studies and country-based workshops with policy-makers. The Regional Office has worked closely with the other partners of the European Observatory on Health Systems and Policies to bring into focus the needs of countries. The mix of Member States and international agencies on the Observatory Steering Committee and their extensive networks help identify the needs of national health policy-makers and ensure that the Observatory addresses the right questions with evidence that is relevant and accessible. The study on social health insurance in western Europe, for example, tackles what makes this approach work and is a valuable tool for countries introducing and expanding insurance mechanisms as well as for countries adapting long-established systems to new challenges. The most recent study on strategic purchasing makes the link between what societies want in terms of health gain and how they allocate resources to the health systems. It cannot tell any country what to do but it does set out clearly what other countries do and identifies what works better or worse in different contexts. The Observatory also completed studies on pharmaceuticals and on the policy implications of EU enlargement. As part of the process of updating the Health for All policy framework, the Observatory participates in studies on how Health for All has influenced policy in countries and on the use of targets as a tool for policy-makers. The findings of all these analyses are made accessible through summaries, policy briefs and articles and through translations, the web and of course the WHO Health Evidence Network.

68. The Observatory partners work together to help countries use the evidence in practice and to support seminars and workshops, such as the meetings hosted by Hungary and by Poland which allowed new EU Member States to address their core concerns together and in the light of the latest and best analyses of likely threats. The Observatory partnership does not only respond to particular challenges on major issues. It is also conscious of the day-to-day pressures on policy-makers. It therefore continues to provide a clear sense of what is happening in the health system of each Member State through the Health Systems in Transition (HiT) series. The HiT profiles are a standard for health system monitoring and allow countries to take a step back and see where they are, how they compare with others and how the decisions they take work out over time. During the biennium, the Observatory produced 10 profiles in English and five in Russian.

69. Over the past biennium the Observatory has consolidated its early successes and evolved to better reflect the demands of all its partners, to achieve an increasingly responsive approach whose priority is to provide the evidence that practitioners want in a form that they can use. It has also grown physically, moving a team to Brussels, embracing the policy agenda and incorporating into the partnership the governments of Belgium, Finland and Sweden.

Health data and information

70. The HFA statistical database and the programme-specific databases on infectious diseases, tobacco and alcohol form an integrated system of databases. The HFA database also serves as a source of background information for other information products like the Observatory's Health Systems in Transition (HiTs) series, which comprise comparative research on the health systems of Member States, and the Highlights on Health which give major national trends in mortality and morbidity data. By the

end of 2001, Highlights on Health had been produced for 43 countries in the Region. These were complemented in 2002 by a health status overview for central and eastern European candidate countries for accession to the EU. During the biennium, a review of the process led to a new definition of content and format for the 16 reports to be released in 2004 (on 15 EU countries and Israel). The Highlights are accessible on the WHO/EURO web site and are frequently consulted by external users (there were about 100 000 downloads in 2003).

71. An example of work in countries is the national health information systems assessment project, currently active in five Member States with seven more to come. The project is aimed at improving the quality and relevance of the data and information produced nationally for use in decision-making. Production of summary statistics from the first national health interview survey for Malta is an example of the facilitating role played by the Regional Office in breaking new ground in health information in a country, by mobilizing technical support from various countries, especially Denmark and the United Kingdom. Instruments and procedures for the mapping of health information sources in countries were developed through a pilot study in Romania, and applied in all Member States.

72. The project on common health interview surveys in Europe (EUROHIS), a joint project of the Regional Office and the European Commission's Biomedical and Health Research Programme (BIOMED2), developed common instruments for population health interview surveys and tested these in countries. The final report was submitted in March 2002. In 2003, the experience and main results of the project were published and released on the WHO/EURO web site. Several European Member States have already applied the recommended instruments and others are in the process of implementing them in their national surveys.

73. *The European health report* produced in 2002 presented the key dimensions of the public health information promoted by WHO. Forthcoming reports will continue to show the close link between the Regional Office's missions in health information to describe the health of populations in regions and to interpret this to inform health policy-makers. These efforts are being made in close collaboration with headquarters. *The European health report* links to the *World health report* in sharing indicators and data from the World Health Survey while highlighting the specifics of the Region. Headquarters' estimates of measures of population health for assessing the burden of disease are in fact used as inputs in all Regional Office information products.

Developing scientific, technical and managerial competence

74. In order to ensure that people in Europe benefit from high-quality services that respond to their needs and are managed according to best practice, it is essential to develop and maintain scientific, technical and managerial competence both in countries and within the WHO Secretariat.

Contributing to maintaining competence in countries

75. The best health knowledge and the capacities to improve it reside in Member States and it is the responsibility of each country to develop a high-quality health workforce. WHO uses national expertise extensively, through its networks of collaborating centres, experts, technical focal points for specific programmes and secondment of staff. The Regional Office contributes to the capacity-building efforts of Member States through a number of activities at regional and country levels. Many examples can be given of direct WHO contributions through human resources development activities and fellowships. In addition, most activities related to technical cooperation on specific issues in countries include a capacity-building component.

76. Scientific and technical conferences and forums, regional workshops and training programmes, national training courses supported by WHO, the publication of technical manuals, guidelines, case studies and learning materials, and the provision of access to databases and evidence networks all

contribute to the improvement of knowledge in countries. There is, however, a need to streamline this effort and develop a clear and coordinated regional strategy on helping countries to build, update and maintain their capacities in the field of public health.

Staff development and training in the WHO Regional Office for Europe

77. According to Regional Office staff development and training policy, "WHO should be equipped to respond to regional, as well as global, processes by encouraging and promoting strategic thinking, productive networking, technical excellence, innovation, transparency and partnerships. These new emphases will require that WHO develops new processes and ways of working that enhance its efficiency and efficacy". In order to remain a global reference on public health issues, the Regional Office must ensure that staff are at all times at the leading edge of related technical and scientific knowledge. This goal can be achieved through a blend of activities that will lead to maintaining and developing staff members' knowledge and skills required for the delivery of the strategic aims of the Organization.

78. During the biennium 2002–2003, the Regional Office pioneered the use of a wide range of learning tools and opportunities, and for the first time formally linked training with work objectives in the staff member's annual performance management and development system (PMDS). This linkage was clearly established as a priority for the Region, which achieved the highest PMDS completion rate in WHO, with more than 90% in 2003. At the beginning of the 2004–2005 biennium, the Regional Office decided to capitalize on this experience and to crystallize the principles in a new policy for maintaining staff technical competence.

79. Maintaining and developing the technical competence of staff rely on a combination of internal and external activities, selected on the basis of factors such as WHO's global and regional priorities, the staff member's current and future duties, the number of potential participants and the cost–effectiveness of the proposed activity as compared to other available methods.

Internal tools/activities

80. Internal activities designed to maintain and develop technical competence are formal events that normally take place on WHO/EURO premises, using internal and/or external inputs such as trainers, resource materials, networks or other sources of knowledge. These include: sharing knowledge through networks, such as the way of working (WOW) forums and other similar networks (for instance, monthly technical lunch discussions); and inviting external guests to give technical presentations, facilitate debate and share information (during the biennium, staff participated in 11 debates on such issues as health systems in Denmark, Germany and Latvia, health and human rights, evidence for health policy, and health management). In addition, the publication of specialized articles is an important exercise in research and reflection on emerging health issues. Senior staff are expected to contribute actively to quality publications.

External learning

81. In order to keep abreast of new techniques, findings and developments in areas relevant to WHO's mandate, staff are expected to bring in new knowledge as it becomes available. In this context, the following tools are considered: staff who are members of recognized professional associations should have the opportunity to participate in their associations' annual meetings, as a way of updating their technical knowledge; attendance at selected specialized conferences in areas of interest to WHO should be encouraged; after a number of years of service, key technical, advisory and management staff need to benefit from intensive refresher courses or seminars in their sector.

82. In the longer run, the Regional Office could help senior staff members to further their education or perfect their expertise through work within or contributions to other organizations or partners of WHO. Consideration is also given to supporting individual study that may not be directly relevant to the staff member's current assignment but which is relevant to the prospective needs of the Organization or the future development of the staff member.

Funding

83. The budget allocated for staff development and training (SDT) is primarily committed to group training with general capacity-building objectives within the regional training framework. Staff-specific activities designed to maintain and develop technical competence are expected to be covered under each division's respective budget, in consultation with the SDT unit. It is estimated that 2.5% of the division's staff costs should be allocated to activities designed to maintain and develop the competence of its staff. In addition, the Regional Office plans to use the new WHO global learning opportunities for its staff, as appropriate.

Improving communication and visibility

84. One of the most important services the Regional Office for Europe can offer is to provide high-quality, up-to-date information and evidence that are relevant to decision-makers in the public health field and to health professionals, and can be translated into useful messages to the general public. It is therefore essential to ensure that information products and corporate messages are disseminated and communicated in a timely fashion to the Regional Office's target audiences and partners, through the most appropriate dissemination channels and communication tools.

85. Explicit policies and strategies have been formulated for WHO/EURO information products and services, including publications, the WHO/EURO web site and external communication. The Regional Office has moved into its second biennium with a clear publishing plan. For the Regional Office to convey coherent messages to its target audiences in Member States, it must clarify its overall corporate priorities and publish accordingly. Therefore, based on proposals from across the Office, 12 information products (books, web material and databases) were selected that reflected the Organization's priorities for this biennium. They form the core of the publications programme's work. Most of the high-priority corporate information products are translated into one or more working languages of the Regional Office.

86. A newly structured web site was launched in January 2002. It includes information of broad interest in the four working languages of the Office. The Health for All database is available in English and Russian, with French and German due to come on stream in 2004–2005. In addition, there are now about 60 topic-specific subsites. The number of visits to the site continues to grow. At the end of 2002, there were about 80 000 visits per month. By the end of 2003, the figures had increased to about 130 000 visits per month. The most frequently downloaded items were *The European health report 2002* and *The solid facts*, as well as the updated *Air quality guidelines for Europe*. Commercial publishers have asked to publish several high-corporate-priority products in non-working languages, a sure sign of the usefulness of the publications and of the web as a dissemination channel.

87. During the biennium the Regional Office has identified, produced and disseminated core information products (high-corporate-priority information products) according to the needs of WHO/EURO target audiences in the Member States. The capacity for translating WHO documentation into Russian has not matched the requirements of the Russian Federation and the newly independent states (NIS). The Regional Office has pursued different options in an attempt to improve the availability of Russian translations of WHO documentation in the Russian-speaking countries (from translating ourselves to co-publishing with Russian publishers), all with limited success.

88. In addition to electronic dissemination through the web and traditional mailing of hard copy versions, WHO/EURO information products also reach the public by being catalogued in the European component of the WHO global bibliographic database (WHOLIS). All sales publications can also be browsed or purchased through the catalogues on both the Regional Office and headquarters web sites. The publication in 2003 of the first comprehensive WHO Regional Office for Europe *Information products catalogue* (in print and on CD-ROM) has also helped increase the visibility and dissemination of our products. For additional information on all WHO/EURO's information products, please consult the

Regional Office's web site http://www.euro.who.int. The catalogue of products[1] is also available on request.

89. The Regional Office is aware of the need to improve its capacity to mobilize and work with the media. Efforts were made during the biennium to make informative press material available, convene representatives of the media in various forums for discussion and exchange, and draw attention to major events such as the Ministerial Conference for a Tobacco-Free Europe, special days like World Health Day, World No Tobacco Day, World Tuberculosis Day, and World AIDS Day, and to global campaigns like the World Campaign against Violence, the Polio Eradication Campaign and Roll Back Malaria.

90. Improving the communication infrastructure and processes must remain high on the agenda of the Regional Office. Additional efforts are needed to strengthen the Regional Office's capacity to make WHO activities and products better known.

Improving administrative and management processes

91. In order to further improve managerial processes in the Regional Office, a series of reforms were implemented to align the Office's work more closely with the priority given to country focus and responsiveness to the needs of Member States. The objectives were: to provide the Regional Office with improved working methods so that more staff time would be spent on direct programmatic activities; to allow for increased, more systematic, logical and efficient delegation of authority; and to enhance reporting systems.

Programme planning, monitoring and evaluation

92. For the first time, the Regional Office used a results-based approach to develop its programme plans. Contrary to traditional resource-based budgeting that focused primarily on available resources, results-based budgeting focuses on what needs to be achieved and on an assessment of the resources needed to deliver. The underlying philosophy for planning has thus changed in WHO as a whole. In the Regional Office for Europe the point of departure has also changed, in that the starting point for 2004–2005 programme budgeting was firmly anchored in the needs of the countries. The planning process is now based on active and iterative consultation with Member States that ends with the signing of bilateral collaborative agreements (BCAs). The BCAs become a firm commitment of what the countries can expect from the Regional Office in a two-year period. A description of specific outcomes is also central to the intercountry programme. Through this process, the planning for 2004–2005 gives an overall picture of the products to be delivered, the actions to be undertaken and the funds needed for that purpose. This planning process gives the Regional Office a more precise idea of the funds it needs to raise and their purpose, and hence to focus resource mobilization efforts.

93. The activity management system (AMS) is the tool that hosts all this information. Improvements in reporting capability have been achieved based on specific user needs. Several features of the AMS are now web-based, allowing easier access to information by country offices.

94. As part of WHO's global evaluation framework, WHO/EURO's regional evaluation for 2002–2003 was in the area of mental health. This evaluation set out to appraise the Regional Office's mental health programme performance since 2001 with particular reference to: matching mental health services to the needs of countries; increasing scientific knowledge and evidence in mental health; and producing solid policy guidance.

[1] *Information products catalogue 2001–Spring 2003*. Copenhagen, WHO Regional Office for Europe, 2003.

Review of administrative procedures

95. In 2003, the Regional Office started a participative and systematic review of its work processes. Through dialogue within work teams, greater emphasis is now put on collective problem-solving. The processes successfully reworked include the processing of travel claims, short-term recruitment procedures, payments, United Nations Development Programme (UNDP) transfers and purchase orders.

96. The Table of Authority was reconfigured to eliminate unnecessary redundancies in transactional flows, reduce transactional times to a minimum, empower field managers in the management of their projects/activities, and implement simple but efficient oversight and technical support mechanisms from the Regional Office. Intensive training is provided for field managers. Field offices are being merged/consolidated, where appropriate. Authority levels, in particular for field managers, have been harmonized and are in the process of being increased to better correspond to the increased capacity of the staff and the improvement of the Regional Office's management oversight controls. Discussions are underway towards completing the integration of all project and project offices, liaison offices and WHO representatives offices into a single, homogeneous management structure. All WHO/EURO liaison offices and WHO representatives offices have been given operational work plans, and the authority and training to make them directly responsible for day-to-day management. Budgets have been delegated to heads of offices, who are now in daily contact with the relevant units in the Administration and Finance division.

97. 2003 was a major year for the Regional Office for Europe with regard to the updating of its management systems. The first step was the cleaning of its physical and electronic data management facilities. A significant effort was made in the areas of archives, inventory count and resource mobilization. With the development of a global approach towards the improvement of WHO management systems, the Regional Office has been an active player in a number of senior-level reform working groups, in particular in the areas of human resources, procurement, WHO representatives' profiles and terms of references, and global management systems. The Office has also implemented an electronic recruitment (E Recruitment) system, and now, an electronic procurement (E Procurement) system.

Improved work environment

98. The Regional Office initiated work process reviews concerning recruitment. It also embarked on a series of discussions aimed at drastically simplifying its selection guidelines. A new policy on maintaining technical competence of staff was released. Finally, while awaiting a global WHO rotation and mobility scheme, the Office has already begun a series of short-term rotations between (e.g. Venice, Copenhagen, Moscow) and within (Copenhagen) offices. As a result, significant improvements have been generated in terms of sharing knowledge and improving communications between units and offices.

99. In the field of contractual reform, the objective is to adjust the Regional Office workforce configuration to a proportion of short-term staff members consistent with the WHO global average, while avoiding having to release an excessive number of staff in 2006 (when the WHO deadline on the employment of long-term short-term (LTST) staff is enforced). A series of intensive bilateral discussions with headquarters, the Staff Association of the WHO European Region (EURSA) and within the Regional Office helped to clarify long-term human resources needs. An accurate financial feasibility study was undertaken to prioritize areas where contract regularization should be done. The final step of the process is the conversion of priority positions into posts (providing that funding is available) and the reassignment of other qualified LTST staff to vacant positions wherever possible.

100. Negotiations are underway to improve the legal framework under which WHO staff operate in countries of the European Region and to regularize WHO legal presence in the countries, through the ratification of basic agreements and conventions on immunity and privileges.

101. The Regional Office is in the process of significantly upgrading its field office configuration through the improvement of office space, equipment, location and contractual conditions of field staff. All

the liaison officer positions were regularized last year, while an additional 26 administrative assistant posts are currently being filled. An additional US$ 150 000 was invested at the end of last year to further improve five field offices, while the Office currently aims to spend an additional US$ 200 000 per year this biennium, to continue in the same direction. The objective is to provide all Regional Office field staff with the same modern and efficient office infrastructure conditions. A number of field offices have been either merged or relocated to United Nations facilities (as part of the United Nations house/family approach).

102. In light of the increase in cases of aggression against humanitarian and United Nations organizations, the Regional Office has taken a firm stand on improving passive and active security measures in all its offices. Significant investments have been made in providing key field offices with proper protection devices/equipment, including cameras, fencing, building reinforcement, blast-resistant film, etc. Similarly, in collaboration with headquarters, the Regional Office has undertaken a wide training effort to upgrade the security awareness and knowledge of its entire staff. In this process the Office has negotiated additional support from headquarters in providing field security staff support.

103. Within WHO, the Regional Office for Europe has pioneered the use of work groups to review its work processes/methods. It is also a leader in developing communities of practice designed to facilitate collective staff involvement in issues of interest to the organization. For this purpose, a team of elected staff members from the different divisions – the Way of Working Committee – was set up, to facilitate group problem-solving within units. In the same line of thought, the Office has now chosen to systematically capitalize on its general and divisional staff meetings to share overall management information related to programme priorities, funding gaps, staffing, etc. Additional information-sharing tools such as internal newsletters like “The Bridge” and the intranet (soon to include country web pages, staff web pages, etc.) have been implemented or enhanced. This high level of transparency allows more staff participation, suggestions and ownership of WHO/EURO programmes and achievements.

Spotlight on selected technical issues

104. As mentioned in the introduction, this report does not provide a detailed account of the activities and achievements of Regional Office technical programmes during the biennium. That information is available from the Secretariat upon request. Instead, a few technical issues have been highlighted. The main criteria for this selection were: that the issue was discussed by the Regional Committee which in most cases adopted a resolution; that the issue corresponds to a WHO global priority; or that the issue was the subject of a major conference and/or European action plan.

Communicable diseases

105. In 2002, the Regional Committee adopted a resolution on **HIV/AIDS** which became the programmatic basis for Regional Office work in this area. The resolution has been used as a basis for recommendations to and commitments from Member States on other occasions such as the Ministerial Conference on HIV/AIDS in Europe, Dublin, February 2004. The explicit list of interventions and principles given in the resolution formed the policy basis for action on HIV/AIDS in Europe, including beyond the limits of WHO. The European strategic framework for elimination of HIV/AIDS in infants and children was developed in partnership with other United Nations agencies and other partners. This strategy became part of the commitments of Member States at the above-mentioned Ministerial Conference.

106. At its fifty-second session, the Regional Committee recognized that **tuberculosis** is out of control in many countries of central and eastern Europe as well as in the Commonwealth of Independent States (CIS). It also recognized that the rates of multidrug-resistant tuberculosis are the highest in the world among the European countries surveyed and unknown in most of the CIS countries. Furthermore, the Committee adopted a resolution on “Scaling up the response to tuberculosis in the European Region of

WHO". Within this resolution the "DOTS expansion plan to stop tuberculosis in the WHO European Region 2002–2006" was endorsed. The Plan aims to accelerate DOTS expansion in the Region in order to achieve the global targets. In 2002–2003 DOTS implementation began in seven more countries, so that 42 countries are now using it. On average, 40% of the population in the Region is currently provided with services using this strategy. Fifteen countries developed a five-year plan for DOTS expansion and 24 countries established country coordinating mechanisms.

107. The Regional Committee also adopted a resolution in 2002 requesting the Regional Director to ensure that the control and prevention of **malaria** remain a high priority on the European health agenda, as well as to promote appropriate strategies and provide technical guidance for Roll Back Malaria efforts. Roll Back Malaria partnership actions in affected countries of central Asia have been scaled up. A project entitled "Roll Back Malaria in central Asia" has gained the financial support of USAID.

108. The major success in the field of **vaccine-preventable diseases and immunization** was the declaration in 2002 of the European Region as poliomyelitis-free. This was the result of a massive poliomyelitis eradication initiative, coordinated by the Regional Office, which covered the entire Region, including war zones and minority communities, until the 200 annual cases of poliomyelitis (reported by Member States in the early 1990s) was reduced to zero in 1999. The Fifty-sixth World Health Assembly (May 2003) adopted a resolution to reduce measles mortality globally. The European Regional Strategic Plan for measles elimination and congenital rubella infection prevention was published in 2003, accompanied by a field guide for planning and implementing supplementary immunization activities and guidelines for surveillance. The Regional Office is supporting all Member States in developing and implementing their national plans with the goal of measles elimination by 2010. Through the Global Alliance for Vaccines and Immunization (GAVI), 11 countries in the European Region introduced new and under-used antigens such as hepatitis B and *Haemophilus influenza t*ype b, in addition to strengthening the immunization safety components of their national programmes. In 2003, 41 countries in the European Region had universal hepatitis B coverage in their immunization programmes.

Noncommunicable diseases and mental health

109. The WHO European Ministerial Conference for a **Tobacco-free Europe** was held in Warsaw, on 18 and 19 February 2002. It marked an increased political will and commitment on the part of Member States to tackle the tobacco epidemic in the region and globally. The Warsaw Declaration provides political guidelines for tobacco control strategies in the Region. In 2002, the Regional Committee for Europe adopted the European Strategy for Tobacco Control (ESTC), the regional policy framework that follows the three consecutive action plans spanning the period 1987–2001. The ESTC sets out strategic directions for action in the Region, to be carried out through national policies, legislation and international cooperation. Nine Member States, with technical support provided by the Regional Office for Europe, finalized their national action plans based on the ESTC and five other countries are expected to do so in 2004. Two meetings of national counterparts reviewed the draft ESTC in 2002 and the status of its implementation in 2003. The first "topical" policy paper on smoking cessation envisaged by the European Strategy was prepared and published in 2003. In line with the ESTC and the Regional Committee resolution, the Regional Office also developed and launched a comprehensive European Tobacco Control Database, with data from 49 Member States, to assist in monitoring smoking prevalence, tobacco-related harm and national policies in the Region.

110. A substantially increased level of coordination among Member States has been achieved within the Framework Convention on Tobacco Control (FCTC). The role and contribution of the Regional Office became much more visible and was widely acknowledged. In response to requests from countries, the Office organized subregional coordination meetings for CIS, Baltic and south-eastern European countries during the negotiation process, as well as awareness-raising events to further the process towards signing and ratification (the most significant event was the high-level consultative meeting for the central Asian republics held in Bishkek, December 2003). At the end of the biennium 26 European countries and the European Union had signed the FCTC and two of them, Malta and Norway, had ratified it.

111. **Mental health** was one of the main topics of the Regional Committee meeting in Vienna in 2003, which adopted a resolution requesting that a WHO Ministerial Conference be organized in 2005 in Helsinki. During 2003, all activities in mental health were geared to preparations for the Conference and its pre-events. An important area of work was the elaboration of common activities with the EU on mental health needs, mental health as a public health issue, and support for the countries acceding to the EU. As a contribution to raising international and global awareness, the Regional Office collaborated in the organization of several events such as the Council of Europe meeting on mental health and human rights, Copenhagen; the global conference on suicide prevention, Stockholm; the launch of the European campaign against epilepsy; the European Union ministerial conference on mental health and stigma (hosted by the Greek government); meetings on mental health promotion and prevention (universities of Bilbao and Ljubljana); the coordination of European meetings on mental health and primary health care together with the EC, Dubrovnik; and several national meetings on suicide prevention. Information and education was given to all national counterparts on formulation, development and implementation of mental health policies and plans. The Office collaborated with five countries in the review and reorganization of their legislation on mental health.

112. The Regional Office organized two meetings for national **alcohol** counterparts and cooperated with international governmental and nongovernmental organizations in facilitating the implementation of the European Alcohol Action Plan (EAAP) 2000–2005 and increasing awareness of drug-related problems in Europe. The Regional Office provided support to 12 Member States in developing national action plans on alcohol policy, based on the recommendations of EAAP. Following EAAP and the Regional Committee resolutions, the Office developed and launched the European Alcohol Information System, a comprehensive database on alcohol consumption and alcohol policies in the Region that currently includes 46 countries and contributes to the monitoring of the alcohol-related situation and the implementation of EAAP in the Region.

Family and community health

113. The Regional Committee discussed **child and adolescent health** in 2003 and recommended that a strategy be developed for the European Region. A plan for the strategy development and a consultative process has been initiated. The implementation of the WHO European regional strategy on **sexual and reproductive health**, developed in 2001, was initiated in six countries. Gender mainstreaming was adopted as a cross-cutting initiative in 2002 and introduced as a part of several programme activities at regional and country level. The focal points for **maternal and child health** from 17 countries held a meeting in Malta in October 2002 covering perinatal care, Integrated Management of Childhood Illness (IMCI), Making Pregnancy Safer (MPS), and prevention of child abuse and neglect. The meeting resulted in a set of recommendations for WHO support to Member States in the area of maternal and child health. The recommendations have been used as a guide for the programme's work for the rest of the biennium. A similar meeting was held in April 2004 in Cyprus for focal points of all programmes in family and community health. A meeting of partners was held in Stratford-on-Avon in May 2003. The main outcome was a consensus on scaling up WHO strategies for maternal and child health and achieving better coordination between partners involved in country support.

114. The Regional Office participated actively in the launch of the World Health Report on **violence and health** in 10 countries. This included the development of communication material (fact sheets, press release), web pages and the organization of a workshop within the context of the Regional Committee. Training of antenatal care providers to identify and address the problem of violence during pregnancy has been carried out. Collaboration was strengthened with the Council of Europe and GTZ on violence against women. The European health promoting schools programme is supporting activities to tackle violence, promote conflict resolution and protection, and specific programmes on mental health, creating safe and supportive school environments, and preventing mobbing or bullying. The child and adolescent health and development programme is promoting a public health approach to child abuse and neglect. A training package targeted at social workers on primary and secondary prevention of child abuse and

neglect was pilot tested in Armenia, Georgia, Kyrgyzstan, Romania, the Russian Federation and Uzbekistan. A network of national focal points for interpersonal violence was established.

Sustainable development and healthy environments

115. One of the most important focuses of the Regional Office's work in **nutrition and food security** was to collaborate with Member States in the development of their national food and nutrition policies and action plans. At the end of the biennium 28 Member States have completed the elaboration of their food and nutrition action plans and 10 have already started their implementation. Furthermore, the Office provided technical assistance in the development and implementation of regional nutrition policies in eight regions of the Russian Federation. Scientific evidence was published to support the development of food and nutrition policies and action plans. The Regional Office publication *Food and health in Europe: a new basis for action* (an office-wide high corporate priority) was published in English (the Russian translation will soon be available) and a summary version for policy-makers was published in English and Russian. These two publications provide the scientific basis for food and nutrition policies and are important for both policy-makers and technical experts.

116. The agenda of the Fourth WHO Ministerial Conference on **Environment and Health** (Budapest, 23–25 June 2004) and the main theme "The future for our children" were approved by the WHO Regional Committee and the United Nations Economic Commission for Europe Committee on Environmental Policy. This conference has been intensively prepared in consultation with Member States through three senior official intergovernmental meetings involving the health and environment sectors, major international governmental organizations and civil society representatives. In addition, a number of Member States participated actively in technical working groups on specific subjects, thus significantly contributing to the development of policy directions in relevant areas. A draft declaration by the ministers and a Children's Environment and Health Action Plan for Europe have been developed and are under negotiation for their approval at the Conference in June 2004.

117. Contributing to the development of **poverty reduction** strategies is an indispensable mechanism for attaining the United Nations Millennium Development Goals and for securing investments in health, as recommended by the Commission on Macroeconomics and Health. In 2002, an expert meeting was held in Düsseldorf to distil the evidence on explicit policies and strategies taken by Member States to tackle poverty and health. The Regional Committee reviewed this work in 2002 and adopted a resolution that became the programmatic basis for the Regional Office's work on poverty and health. As a result, *Health systems confront poverty* was published in 2003 and disseminated in the four WHO/EURO official languages. A databank of case studies was made available on the web and is continuously updated. Specific technical support on addressing poverty and socioeconomic determinants of health was requested and delivered in countries such as Azerbaijan, Estonia and Georgia.

Conclusion

118. During the biennium 2002–2003, the major directions taken in the previous biennium were reinforced, while at the same time very practical activities were developed in and with Member States in the whole range of the Regional Office's functions and missions. On this basis, the Office is in a position to sustain the implementation of the processes described in this report and to further develop directions and priorities to respond properly to the needs and demands of Member States, in particular in such domains as the strengthening of health services in countries, the production of health information analyses (intelligence), the updating of the Health for All policy and the promotion of evaluation methodology. Regarding public health issues, the emphasis will be placed on major WHO global programmes such as HIV/AIDS, diet and physical activity; on European action plans and the outcome of major conferences, such as those on tobacco, alcohol, nutrition, mental health and the environment; and on questions that require more attention, such as health of the elderly and the rapid response of health systems to health threats.