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Follow-up to previous sessions of the WHO Regional Committee for Europe

In agreement with the Standing Committee of the Regional Committee, it has been decided to add a new item to the agenda of this year's session of the Regional Committee. This new item will be devoted to the follow-up of some major topics discussed at previous sessions of the Regional Committee, i.e. implementation of resolutions or preparation of major events and strategies. Together with the items on matters arising from the Executive Board and the World Health Assembly, and the report of the Regional Director, this new item is intended to update the Regional Committee on activities that have taken place since its last session.

The subjects selected for this background paper include follow-up on (a) the Country Strategy; (b) the Health for All update; (c) *The European health report*; (d) the preparation of the Ministerial Conference on Mental Health; and (e) tuberculosis control.

The first three subjects of this background paper will be emphasized during the session of the Regional Committee.

If this first attempt is judged interesting and useful by Regional Committee participants, it will be repeated every year.

WORLD HEALTH ORGANIZATION • REGIONAL OFFICE FOR EUROPE
Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark Telephone: +45 39 17 17 17 Telefax: +45 39 17 18 18 Telex: 12000 who dk
Electronic mail: postmaster@euro.who.int World Wide Web address: http://www.euro.who.int

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Implementation of the Country Strategy 2000: progress report for the period 2002–2003

1. This summary is intended to report on the progress achieved during the period 2002–2003 in implementing the Country Strategy "Matching Services to New Needs" approved by the fiftieth session of the Regional Committee. It was requested in Resolution EUR/RC53/R2 on Progress in implementing the WHO Regional Office for Europe's Country Strategy.

2. The main areas where progress has been made are:

- **Better coordination of activities throughout WHO.** All the efforts and resources of the WHO Regional Office for Europe (WHO/EURO) have been allocated to working on a number of tangible results that are relevant to the needs of each country. The technical units and programmes of the Regional Office have all contributed to a common workplan that takes due consideration of the circumstances and absorption capacity of each country. Carefully identified national counterparts in the Member States with which the Office has biennial collaborative agreements (BCAs) are expected to contribute to the common effort. Progress has also been made in involving the whole of WHO (headquarters and other regional offices) in support to countries along the same organizational and functional lines. This is having a significant effect on the way work is organized and services are delivered to all Member States in the European Region and is ensuring better accountability for the common results achieved. The dialogue with ministries of health is becoming more focused and a higher sense of ownership is being achieved.
- **Strengthened country presence.** In the past year, the Regional Office has completed the reshaping and strengthening of its country presence in the Member States where it works through BCAs. This has meant taking steps towards bringing all Regional Office staff working in each country under a single managerial structure. Whenever resources have permitted, an international head of the WHO country office is being appointed (Armenia, Republic of Moldova, Tajikistan, Turkey and Uzbekistan). In other cases, the liaison officers have been empowered to carry out that function with the help of upgraded administrative assistants with a strong financial background. A more flexible functional framework and the necessary managerial tools have been prepared to facilitate this work. As a result, WHO country offices are now better equipped to provide support to the respective ministries of health in their efforts to develop national health policies, health services and public health programmes. This work will be continued in the coming years.
- **More competent staff at the service of Member States.** Much work has been and is still being done to improve the technical competence of WHO staff in countries through formal training. This initiative has encompassed both technical and administrative staff, both in WHO country offices and in other parts of the Regional Office (Copenhagen, Barcelona). The training activities consist of a number of core teaching modules that are regularly updated. An ongoing training programme is expected to ensure that staff have the right knowledge, skills and attitudes to meet the Member States' current and emerging needs. The major part of the training focuses on health policy-making and health services issues, management (including financial and human resources management) and communication. This work will be continued in the coming years.
- **Country-specific strategies.** In line with its Country Strategy, the Regional Office for Europe has continued to tailor its efforts to the needs of countries. For the first time, Regional Office collaboration with all the central and eastern European Member States, implemented through BCAs, is based on country-specific strategies. These include the main strategic priorities for the next four to six years and are intended to guide all WHO-supported actions in the various countries in the coming years. They reflect available evidence and the discussions which have taken place on strategic priorities and needs with the ministry of health of each Member State. Each strategy is to be reassessed every two years. Similar strategies are being developed for all the Member States in the European Region, including those where WHO does not have a country presence.

- **Country-specific workplans.** Each Member State with which the Regional Office has a biennial collaborative agreement also has a detailed country-strategy implementation workplan for the biennium 2004–2005. This includes clear objectives in terms of expected results. For each expected result, a detailed account is given of the activities to be developed in the country and the time schedule for them. A particularly important addition is that the Regional Office budget and workplan for the countries now include all funds available (from the WHO regular budget as well as from other sources) attached to the expected results. All Regional Office technical programmes are now working along coordinated lines. The workplan is updated every six months or whenever exceptional circumstances make it necessary. Workplans for collaboration with western European Member States will follow the same lines.
- **Relevance of the issues addressed for the Member States.** Relevance for the Member States has been the paramount criterion when preparing the strategic agenda for WHO's support in the coming years. Since the adoption of the Country Strategy, activities have become increasingly focused in the 28 countries of central and eastern Europe with BCAs. The issues and priorities included in the BCAs and workplans have been selected through a careful process of: (i) technical analysis of country-specific health data by Regional Office experts; and (ii) discussion of country-specific priorities and preferences with the national ministries of health. This approach has been supplemented whenever necessary with additional Regional Office support to groups of countries involved in particularly important processes (e.g. accession to the European Union in May 2004 of Member States in rapid transition, the Stability Pact process for countries of south-eastern Europe, the public health system reform initiative for the newly independent states (NIS), etc.). Activities have also been developed consistently with countries in western Europe with which the Regional Office does not have BCAs. In the Futures Forum programme for non-BCA countries (mostly western European countries), difficult or new health issues that will be strategic concerns in the years to come (e.g. bioterrorism, the ethics of health systems, tools for decision-making in public health) have been studied and debated. Western European countries have also benefited from other Regional Office programmes, in particular those involving all Member States in the European Region (such as the Framework Convention on Tobacco Control) and those linked to the European perspective of global reports in areas such as mental health and violence. The Regional Office has also addressed the specific needs of these countries in the field of public health policy.
- **Improved partnership.** Particular attention has been paid to collaboration between the Regional Office for Europe and other international and national agencies in the different countries. These include not only the agencies and bodies of the United Nations system but also other important stakeholders. Regular contact is maintained and issue-specific consultations are now held with the United Nations Children's Fund (UNICEF), the World Bank, the United Nations Development Programme (UNDP), the European Commission, the Council of Europe, civil society, etc. Efforts are being made to first discuss and then implement tailor-made country support activities (for which WHO's country strategy and workplan is offered as a first contribution). Possible synergies with all stakeholders are being sought, sometimes involving joint financing and particular actions. This coordinated approach is highly valued by the ministries of health, which are kept informed of all steps taken.
- **More transparent and accountable management.** Finally, the new arrangements are making it possible to maintain a transparent and accountable relationship with WHO governing bodies, Member States of the European Region and partners. Together with other units in the Regional Office, the Country Work Management Support Programme (Help Desk) ensures permanent contact with country operations, supported by modern communication technology, which has received a boost in recent months. Country work is now regularly evaluated and a set of clear performance indicators are under implementation. Results-oriented evaluation data and activity-related and financial implementation data are being gathered and made available to those who may be interested in them. The country reports contained in document EUR/RC54/Inf.Doc./2 summarize the results achieved and activity lines worked on by Regional Office programmes in the biennium 2002–2003.

Update of the regional Health for All policy framework: progress report

3. The process of updating the European Health for All policy (resolution EUR/RC/48/R5) started at the beginning of 2003 and the next update of the policy should be submitted to the fifty-fifth session of the Regional Committee in 2005. The Standing Committee of the Regional Committee (SCRC) has been consulted regularly on the work on the update. The tenth SCRC monitored progress and regularly approved the approach, methodology and plan of work proposed by the Regional Office for each element of the update. The update was discussed at the fifty-third session of the Regional Committee (agenda item 6c, EUR/RC53/8).

4. Since then, the work on the update of the European Health for All (HFA) policy has advanced steadily according to the concept, milestones and timeframe agreed with the SCRC and the Regional Committee. A first draft of the update will be presented to Member States for consultation and discussion before the end of 2004, in order to give enough time for their contributions to be integrated into the final document to be presented to the Regional Committee in 2005.

5. The update is built on three main pillars.

- Pillar one: the lessons learned from Health for All
- Pillar two: the Health for All values
- Pillar three: the tools for implementation of the Health for All values.

6. This paper outlines the progress made with regard to the three pillars since September 2003.

Pillar one: The lessons learned from Health for All

7. An essential component of the update is analysing and understanding how the Health for All policy framework has been applied in countries throughout the years. Many Member States in the European Region have been driven by the vision underpinning the Health for All movement when developing their national health policies and programmes, and the Health for All policy often lies at the core of the national target-setting and public health agenda. However, so far, no systematic analysis has been made of the actual impact of the Health for All policy in countries. Knowledge of its usability and applicability, and the scale and nature of its implementation is inconsistent; besides, no systematic understanding has been built of the way the Health for All targets have been used in practice by national decision-makers. The first pillar of the update thus comprises two major studies, both carried out by the European Observatory on Health Systems and Policies in Brussels and aimed at filling this knowledge gap.

Study on the adoption and use of the Health for All policy in Member States in the European Region

8. The aims of this study were to: provide baseline information on the formal adoption of HFA in all Member States in the European Region; assess its use in national policies in a sample of Member States; and illustrate its impact on policy development through a number of detailed case studies. The sample of countries selected reflects the wide diversity of the Region, and the research design draws on a variety of methodologies including a mapping exercise, a literature search, country case reports and interviews.

9. The first preliminary findings suggest that Health for All has had and is still having a considerable impact on health policy formulation throughout the European Region, at both national and subnational levels.

- Out of 52 Member States, 31 have formulated a health policy that reflects HFA and 10 Member States have drafted policy documents.
- Most of these documents refer explicitly to either HFA or the Health for All policy for the European Region (HEALTH21).

- Almost all of these documents endorse the HFA values explicitly.
- Member States have not lost interest in formulating health policies that are based on HFA. Some Member States have a long record in formulating HFA policies.
- At subnational level, HFA policies were identified in 24 Member States.
- Member States use different means to formulate their HFA policies, ranging from reports and white papers to cabinet resolutions and laws.
- HFA has influenced sectoral policy formulation, even where a comprehensive health policy has never been adopted.

10. Health for All has had a more limited impact on health policy implementation. Results from the literature search and the country reports provide evidence that some elements of the HFA policies reach implementation. But the level of implementation varies greatly between Member States in terms of:

- spread (local, regional, national programmes)
- intensity (pilot, standard intervention)
- cross-fertilization with other programmes and projects.

11. Often, national health policy formulation has been directly influenced by HFA. In regard to health policy implementation, however, HFA has often been neglected or was only one source of influence among others. Still, it should be noted that the transfer or diffusion of policies is often a lengthy process stretching over decades. In this respect, HFA has acted as an important stimulus for health policy debate and re-orientation of policies in many Member States.

Study on the use of targets as a tool for policy-makers in Member States

12. This three-year project assesses experience in setting national health targets, focusing on good practice and the impact of different methodological and political strategies on various outcome dimensions such as equity or efficiency. The methodological approach includes a literature review, analytical studies and six country case studies. The knowledge gathered is thought to be potentially useful to policy-makers who wish to improve their long-established health target programmes and to those who are in the process of formulating targets. It may also be helpful for those policy-makers who have not so far been involved in health target-setting.

13. A first product from this research is an online health target database. The web site contains fact sheets on policy documents that give health targets for 41 countries. The database will gradually extend towards single sector targets, regional targets and targets in member countries of the Organisation for Economic Co-operation and Development outside the WHO European Region. The facts are organized according to eight categories:

- general information;
- status of document;
- value orientation;
- general information on targets (number; quantified, qualitative or mixed; subtargets included; indicators suggested, etc.);
- priority areas, topics, targets and objectives;
- list of areas, aims, topics, targets or objectives;
- provision made in document for implementation;
- WHO participation in drafting or publishing of the policy document in question.

Pillar two: the Health for All values

14. A think-tank of experts was established to have a new look at the guiding values for health development as part of the Health for All movement. The group consists of people with various areas of expertise – academics, decision-makers, public-health advisers from 11 countries, as well as representatives from the Council of Europe and WHO headquarters. Three meetings took place (in May 2003, November 2003 and April 2004). The experts discussed which of the core Health for All values remain relevant to decision-making today and how these values link to health policy and public health. The think-tank:

- elaborated on the terminology and interpretation of values, as well as their legal aspects;
- analysed inconsistencies and compromises made with values when they "compete" with other factors influencing decision-making;
- outlined examples of how values are implemented in practice in countries;
- produced an overall framework of ways in which the values system endorsed by the public health sector in countries may ensure ethical governance in health; and
- proposed possible ways of making values more operational, applicable and useful.

15. The Health for All update looks at values in a spirit of continuity from the previous Health for All and HEALTH21 policies. This approach is accompanied by an in-depth analysis of the relevance and applicability of values. In order to deal with this complexity, the update offers two possible "entry points" to values.

The human rights legal framework

16. Health is a fundamental human right, indispensable for the exercise of other human rights. The Health for All update links the values and ethics of health systems to the existing framework of international treaties and instruments, since realization of the right to health may be pursued through numerous complimentary approaches. In addition to this, many other human rights, norms, standards and principles apply to health systems and are highly relevant to the design, monitoring, implementation and evaluation of health policies and programmes.

17. Every Member State in the WHO European Region has signed at least one international treaty, convention or other international human rights instrument. There is, therefore, great potential for translating these commitments into the health sector. Such an approach may be very empowering, in that it moves public health policy-making into the area of international legal entitlements, thus supporting health ministries when they exercise their stewardship role. There are two additional advantages in using the right to health approach and the whole human rights framework: they concern not only patients but the population as a whole; and they facilitate and even require a holistic, cross-sectoral approach, because many aspects of different policies affect health and well-being directly.

The ethical framework

18. When interpreting values from the ethics entry point, there is no final, clear-cut answer to what values mean; they vary widely according to the specific context in which they are applied. The update put on the table the difficult choice that each country may make by facing the uncertainty of understanding values. The think-tank reviewed a rich variety of sources with the latest and best knowledge of the values and ethics of health systems. The experts themselves provided abundant examples of how values are implemented in actual policy-making in countries. On the basis of this, one possible scheme for seeing and interpreting values was developed by the think-tank. It is not in any way prescriptive, exhaustive or unchallengeable, and it is designed to leave a lot of space for flexibility by national decision-makers when applying it in their work.

19. Three fundamental values are still seen as essential for achieving the ultimate goal of any health policy – realizing the maximum potential for health gains.

- **Equity**: in the Health for All update context, equity is seen as providing all population groups in a country with a fair and equal opportunity to attain their own full health potential.
- **Solidarity**: this core value is interpreted in the context of the distribution of resources and opportunities and is seen as the societal, collective responsibility of all members of a society to support each other.
- **Participation**: on either a collective or an individual level, participation refers to the direct involvement of people in all processes and activities that comprise public health.

20. **Ethical, value-based governance** is seen in the Health for All update as the way to link values to action. Increasingly, ethical performance is seen as an integral part of the overall performance of health systems, i.e. adherence to values is becoming an important constituent of the implementation of health policy. The degree to which governance is ethical is strongly influenced by factors both internal and external to public health. Therefore, decision-makers may consider it useful to be able to assess whether, and to what extent, the decisions made and actions taken in their countries are in accordance with some core values of the public health sector and of society at large. The update suggests how important and beneficial it may be to have the possibility of interrogating policies, programmes and actions by reference to an ethical framework.

Pillar three: the tools for implementation of Health for All values

21. This pillar of the update presents tools to be used by health ministries when they shape their public health policies and programmes. The need for such a policy tool-box lies in the will to provide decision-makers not only with a set of principles and values, but also with effective means to implement them. Such tools reflect the realities of the beginning of the twenty-first century, when social, economical, geographical and cultural inequities in the access to health care have increasingly become the main challenge for countries. Besides, such tools can be widely used in times when controlling the rising cost of health care has to be considered, while at the same time equitable distribution and quality of care should not be compromised. Because of this, it is essential that decision-makers are supported in developing a more equitable health policy based on evidence and continuous evaluation of the impact of health policies.

22. This pillar therefore focuses on tools for supporting a public health policy that:

- draws inspiration from the Health for All values, which are generally shared by the international community: equity, solidarity, responsibility of individuals and communities, good governance, respect for human rights;
- takes into account the mutual interactions between health and development;
- builds on an in-depth understanding of ill health and its multiple causes;
- includes a comprehensive and multisectoral understanding of health, integrating the viewpoints of all the stakeholders concerned, both within the health sector and from other sectors (economy and finance, development, social care, education, etc.);
- uses measures and interventions with demonstrated effectiveness, whether from within the health care system or from any other sector;
- allows decisions to be taken on the basis of rationale rather than intuition, using more and better data, and the latest and best available evidence;
- takes into consideration the expectations and needs of the population;
- allows a range of options for assessment of programmes and actions, as well as for quality improvement on the basis of standards and values shared by all stakeholders – professionals, stewards, patients and users.

23. The tools suggested within this pillar have been analysed in terms of their quality and relevance. Good tools are those which have been well assessed, are easy to implement following national and international experience, and are available and affordable. Decision-makers themselves will choose which specific tools to apply in their national context; this pillar of the update only underlines the potentials of each tool while making clear its limitations and the complexity of its use. Being part of the Health for All policy framework, these tools are also intended to support health ministries in exercising ethical governance.

24. The tools selected so far in the third pillar of the update are grouped in three categories, according to their purpose.

- **Sustaining and improving the ethical framework:**
  - international treaties, covenants and other legal instruments ratified by countries;
  - priority-setting, for instance the Millennium Development Goals strategy with its core priority of fighting poverty;
  - consideration of the needs and expectations of citizens.
- **Basing the policy on observation, knowledge and expertise:**
  - observation and monitoring of health and health determinants through permanent data collection and analyses;
  - assessment of health risks, health crisis watch and alert systems;
  - evaluation of the overall performance of health systems;
  - evaluation of the quality of health settings and units through sound systems of accreditation.
- **Improving decision-making:**
  - analysis of the regional, national or local context;
  - health impact assessment (evaluation of the health consequences of societal choices);
  - sound use of scientific knowledge (evidence-based health policies).

25. The Health for All policy update will be drafted on the basis of the work done on the three pillars as described above. An additional chapter will give some guidelines for implementing the updated Health for All policy. A first draft will hopefully be available before the end of 2004 for consultation with Member States and the final update will be submitted to the fifty-fifth session of the Regional Committee in 2005.

The European health report 2005 – Knowledge into action: progress report

26. This progress report informs the Regional Committee of the action taken as a result of Resolution EUR/RC51/R3 which asked the Regional Director to support the Regional Office in developing a knowledge-based service and to publish a European health report every three years in a manner consistent with *The world health report*.

27. The Regional Office for Europe has streamlined its health information and evidence functions in response to the Resolution. This is reflected in two key developments:

i) an evidence-based approach now underpins the activities of all technical programmes; and

ii) the Regional Office operates an integrated system of databases (e.g. Health for All database and the infectious diseases, tobacco and alcohol databases), using data collected by Member States and international agencies.

28. To enable staff to base their advice and recommendations on the best available information and evidence, the Office has formulated specific policies, developed training packages and tool kits, and established a range of knowledge-sharing opportunities. In so doing, the Regional Office programmes on information and evidence have been supported by the European Advisory Committee on Health Research (EACHR) and other expert groups. As a result of this work, the Office has now adopted the following operational definition of evidence:

"Findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care."

29. One specific example of the application of this new definition is the Health Evidence Network (HEN), a practical information service for public heath and health care decision-makers.

30. The Regional Office for Europe has developed even closer cooperation with the Evidence and Information for Policy cluster at WHO headquarters (EIP/HQ). Direct collaboration has also been established with the Global Burden of Disease project, which for the first time has provided country-specific estimates of the burden of disease for all countries in the WHO European Region. These estimates cover the whole population as well as providing child-specific information. This new information helps decision-makers to determine priorities and assists them in drawing up effective plans for action.

31. The developments described and the strengthened basic health information functions also contributed significantly to the preparation of *The European health report 2005*.

The European health report 2005

32. Preparation for the next European health report, scheduled for publication in May 2005, started in 2003. The report has three main parts.

33. **Part One** gives an overview of the public health situation. It briefly describes past and current trends in the Region, the leading causes of the burden of ill health and the major risk factors. The impact on health of socioeconomic determinants is emphasized. The report reinforces the interaction between health and development by using the UNDP Human Development Index (HDI). This innovative approach is a response to the new circumstances within the Region, where the historical east-west differences in health expectations can now be seen as a development gap. The 2005 report suggests that this situation should be viewed as a development ladder, rather than a development divide. The message is that every country is confronted with continuous adjustments and reforms. Member States are all faced with the same issues, but to varying degrees. Inequalities in health status between social and economic groups, health-related lifestyle and the quest for cost–effectiveness of interventions are universal considerations, as is the need to translate new knowledge into effective action.

34. HDI values in the Region are used to define five groupings of roughly equal size, each representing about 20% of the 52 countries in each group. These quintiles are in principle more homogeneous than the geopolitically defined country groupings used in previous issues of *The European health report*.

35. The 2005 report has a special focus on disease prevention and health promotion. The trends in health outcomes amenable to effective prevention show that the averages for all country groupings improved during the 1990s for some indicators, but not all. There are also examples of stagnation or deceleration of progress. Two clear conclusions can be drawn:

i) there is considerable scope for health improvement in all countries through the more effective use of evidence and the application of existing knowledge; and

ii) no country scores consistently the best or the worst overall. Every country has some health challenges where it can learn from international good practice and some areas where it can provide an example to others.

36. An analysis of health status is the launching pad for comparing the strengths of and challenges for public health practice across the Region, with the goal of sharing experience and pooling knowledge and resources internationally. Comprehensive public health programmes, tailored to meet the specific circumstances and needs of individual Member States, are needed to address the growing health challenges of the modern world. *The European health report 2005* signposts the main public health interventions known to be effective.

37. The report also addresses the question of public health capacity and the infrastructure required for effective delivery. The key questions that public health authorities need to ask are highlighted, with the aim of helping policy-makers better identify the most appropriate public health solutions for their own populations. The style is supportive and nonprescriptive.

38. **Part Two** takes a closer look at the 0–18 years age group. The emphasis is on child health and development, not survival. Infants, young children, older children and adolescents are covered. Predictors of morbidity and mortality, such as relative poverty and educational attainment, are addressed and the need for comprehensive, multisectoral action, targeted at the root causes of poor health, is emphasized.

39. Children are our investment in the future, hence the focus on child and adolescent health. Moreover, young people are key to a number of Regional Office initiatives, like the European Child and Adolescent Health Strategy to be presented at the fifty-fifth session of the Regional Committee, the Fourth Ministerial Conference on Environment and Health held in June 2004 and the Ministerial Conference on Mental Health planned for January 2005.

40. The emphasis on this age group also underpins the move to a more new child-centred approach to information provision, adapting existing data collection and information processes to produce a more holistic view of child health. Currently, information is somewhat fragmented and resides in different institutions within many countries. This is an impediment to effective action.

41. Although there were some temporary deteriorations in the early and mid-1990s in the central and eastern parts of the WHO European Region, the main indicators show that children's health has generally improved. However, there is still room for considerable improvement in every Member State.

42. In **Part Three**, the report concludes with an analysis of the public health system and the requirements for effective public health over the next decade. Health information, evidence-based decision-making, and the monitoring and evaluation of programme implementation are all addressed. Health impact assessment and health technology are considered. The need to enhance the arrangements for the stewardship of public health across different sectors is reviewed and the importance of strengthening accountability highlighted.

The process

43. An editorial board was established in 2003. The Board directs and reviews the development of the report, including the structure and main messages.

44. The Regional Office has carried out a special data collection exercise in support of the move to a more child-centred approach. This draws upon data from dispersed sources in the countries of the Region to provide a more integrated and comprehensive database. All Member States have been invited to nominate focal points and collect data according to a common format. Forty-two Member States are currently working with the Regional Office on this exercise and, by March 2004, 25 countries had provided the necessary data. *The European health report 2005* will use this to provide data against some 8 to 10 key indicators. All the results will be made available as a separate product on the WHO/EURO web site.

45. The development of the report to date has been an interactive exercise, involving all divisions and relevant programmes within the Regional Office. In addition, the EIP/HQ cluster has provided age-

specific estimates of the burden of disease for each individual Member State of the WHO European Region.

46. The draft report will be available to the fifty-fourth session of the Regional Committee, unedited and in English only. The draft will be revised following the Regional Committee and submitted to a peer review meeting later in the year.

Conclusion

47. A new brand of European health report is being developed which:

- is produced as a response to an Regional Committee resolution
- addresses issues that require policy attention in all countries
- includes formal interaction with the countries to validate the information
- seeks to maximize synergies within the organization and with other international organizations.

The Ministerial Conference on Mental Health (January 2005): progress report

48. Organization of this event began in 2002. The Regional Office is:

- running pre-events;
- finalizing the organization of the main event and the programme;
- preparing the background documents, the conference outcome and other documents;
- planning to send invitations to governments after the Regional Committee session in September 2004.

Pre-events

49. The pre-events are expert meetings that are producing evidence-based conclusions and recommendations on themes to be addressed at the Conference. Pre-events are attended by experts nominated by national counterparts and members of relevant taskforces. Altogether there will be seven pre-events:

Time	Place	Theme	Organizers
5–7 February 2003	Copenhagen	Human rights, stigma and exclusion	Council of Europe, WHO
27–29 March 2003	Athens	Stigma policies	European Union (EU), Government of Greece, WHO
11–12 March 2004	Brussels	Suicide prevention policies	Government of Belgium, WHO
3–5 June 2004	Moscow	Societal stress	WHO, Government of Russian Federation
30 June 2004	Paris	Monitoring and comparing mental health	EU, Government of France, WHO
20–21 Sept 2004	Luxembourg	Mental health of children and adolescents	EU, Government of Luxembourg, WHO
4–5 Oct 2004	Tallinn	Working life and mental health	WHO, Government of Estonia

The main Conference

50. The organization of the Conference facilities, accommodation and practical arrangements has been concluded and a memorandum of understanding signed with the host, the Ministry of Social Affairs and Health of Finland.

51. The Conference steering committee has held seven meetings since 2002. The main sections of the Conference programme have been finalized and plenary speakers have been invited. Almost all have already accepted. We have asked chairs of taskforces and other experts to be speakers for parallel sessions, and organization of these sessions is gradually being completed.

52. Special attention has been given to the involvement of nongovernmental organizations (NGOs), such as those representing service users and family representatives. It is suggested that a user representative should address the meeting on the first day. Another user representative will speak in the plenary section on mental health services. In addition to this, NGO presentations will be included in several parallel sessions. The Finnish Government is planning to hold a meeting between the representatives of NGOs from other European countries and NGO representatives from the host country the day before the Conference (Tuesday).

53. It is anticipated that ministers will arrive on the Friday at the latest, in order to participate in a round table discussion and to adopt and sign the declaration. A ministerial dinner will be held on the Friday evening. It is hoped that some ministers and officials will stay for the Saturday morning session on implementation of the conclusions of the Conference.

Invitations

54. A first announcement was circulated last year and a second announcement will be sent out within the next two weeks to highlight the importance of this event.

55. Formal government invitations will be sent out after the Regional Committee in September, in accordance with WHO protocol. In the invitation letter to the ministers of health, the Secretariat will recommend that one representative of civil society should be included in the delegation of each Member State.

56. Nongovernmental organizations across Europe are also being identified and sponsorship is being considered for invitations for about 20 NGO representatives.

Declaration and other documentation

57. Ministers will be asked to adopt and sign the declaration on the Friday afternoon. We are preparing a short and concise declaration, referring to earlier resolutions, identifying progress, raising issues and setting expectations for an action plan by member states, civil society and the Regional Director. Subjects we aim to include are:

- human rights
- parity of mental health services
- stigma and discrimination (in housing, benefits, employment, legislation)
- stress, suicide and substance misuse prevention and level
- availability of information
- access to care in least restrictive settings (primary care, community services, asylum)
- evidence-based interventions

- change management and research capacity.

58. In order to achieve political agreement on the declaration, a pre-conference event is planned for officials from member countries to meet and discuss the declaration and the action plan in detail.

59. The timetable is:

- First draft agreed internally: end of June 2004
- Sent for translation: 1 August 2004
- Sent to Governments: end of August 2004
- Pre-conference event: end of October 2004

60. A background document is being produced with Dr Itzhak Levav as editor; it will be ready for distribution in September. The document will describe the diversity and social context of mental health in Europe, and will give background information about the themes on the Conference agenda. It will be sent to all delegates.

Tuberculosis control in the WHO European Region: progress report following resolution EUR/RC52/R8 adopted in 2002

Background

61. At its fifty-second session, the Regional Committee recognized that tuberculosis (TB) is out of control in many countries of central and eastern Europe and 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 the majority of the CIS countries. Furthermore, the fifty-second session adopted a resolution on "Scaling up the Response to Tuberculosis in the European Region of WHO" that included endorsement of the "DOTS Expansion Plan to Stop TB in the WHO European Region 2002–2006". The Plan aims to accelerate expansion of the directly observed treatment, short course (DOTS) strategy in the Region in order to achieve by 2005 the global targets set by the World Health Assembly (to detect 70% of estimated infectious cases of tuberculosis and to successfully treat 85% of them).

62. The tuberculosis situation in the Region is still very serious. According to the most recent WHO report there were almost 374 000 new cases in the Region in 2002, the highest figure in two decades (231 608 in 1991, 368 136 in 2001). Most cases occur in the NIS and Romania. However, increased immigration from counties with high prevalence of tuberculosis has resulted in cases in immigrants outnumbering indigenous cases in western Europe. The serious constraints for effective tuberculosis control are the high rate of multidrug-resistant tuberculosis, the need for a comprehensive reform of the health sector with close involvement of primary health care in tuberculosis control, the rapid increase in HIV-related tuberculosis, and the still limited commitment to the DOTS strategy.

63. DOTS expansion is the main priority for tuberculosis control in the Region. Forty-one out of 52 countries are now using the DOTS strategy (as compared to 34 countries in 2001). Of these 41 countries, 24 have implemented DOTS countrywide as a national tuberculosis control strategy. In addition, two countries (Belarus and Croatia) have announced that they will begin DOTS implementation. On average, 40% of the population in the Region is currently provided with services using the DOTS strategy (17% in 2001). Fifteen countries have developed a five-year plan for DOTS expansion and 24 countries now have a country coordinating mechanism. The strengthening of the Tuberculosis Interagency Coordinating Committee and the tuberculosis high-level working group, together with the adoption of an executive order (prikaz number 109), have contributed positively to tuberculosis control in the Russian Federation.

64. Strengthening of laboratory performance to improve tuberculosis case detection is crucial if the global targets are to be achieved. Collaboration has already been established with partners with the aim of increasing technical assistance to the Member States in this very important area.

65. In order to ensure an uninterrupted supply of high quality drugs for all forms of tuberculosis, 10 of 19 eligible countries in the Region have applied for Global Drug Facility assistance and 9 have been approved. Furthermore, 13 countries have also submitted requests for support in the area of tuberculosis to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and 6 have been approved. Technical assistance in preparing applications to GFATM was provided with the help of a grant from the German Agency for Technical Cooperation (GTZ) and the Canadian International Development Agency (CIDA).

66. As a response to the epidemic of multidrug-resistant tuberculosis in the Region, drug-resistance surveillance has been introduced in five countries: Israel, Lithuania, Poland, the Russian Federation (Orel oblast), Turkmenistan (Aral Sea area) and Uzbekistan (Karakalpakstan), in addition to the existing projects in Estonia, Latvia and Tomsk oblast in the Russian Federation. DOTS-Plus pilot projects were strengthened in Estonia, Latvia and three oblasts in the Russian Federation and new projects were implemented in Ivanovo oblast in the Russian Federation and Karakalpakstan in Uzbekistan in collaboration with the Green Light Committee.

67. Many countries in the Region have increased their national capacity for advocacy, social mobilization and programme management and have developed an improved capacity for regional and national tuberculosis surveillance system as well. All 52 Member States provide annual reports on tuberculosis surveillance to WHO and the WHO Collaborating Centre on tuberculosis surveillance in Europe (EuroTB). Accuracy and timing of reporting were excellent in about 80% of countries.

68. A number of factors have contributed to the achievement of these results. They include: the strengthening of collaboration with the Member States, in particular with the ministries of health and national tuberculosis control programmes; the strengthening of partnership and coordination through the establishment of the Technical Advisory Group for the WHO European Region and the Regional Interagency Coordinating Committee on tuberculosis and their regular annual meetings. A regional Stop TB partnership was also established recently. Since 2003, collaboration has been strengthened with technical and financial partners such as the United States Agency for International Development (USAID), GTZ, the German credit institute for reconstruction (KfW), the Centers for Disease Control and Prevention (CDC), the World Bank, the Royal Netherlands Tuberculosis Foundation (KNCV) and Project Hope as well as the Austrian, French and Swedish governments and others. In addition, the establishment and strengthening of the tuberculosis programme in the Regional Office and the WHO subregional/country tuberculosis offices in the Russian Federation, central Asia, Ukraine, the Balkans and the Caucasus has contributed substantially to tuberculosis control in the Region.

Challenges

69. Although there has been clear progress in tuberculosis control in the Region, the pace of effective DOTS expansion (including addressing multidrug-resistant tuberculosis and HIV-related tuberculosis) must be increased rapidly in order to bring these benefits to persons with tuberculosis and to achieve the global targets by 2005. The latest figures in the Region for tuberculosis case detection and treatment success are 40% and 78% respectively. The current trend indicates that the cure rate global target may be achieved by 2005 in most European countries but not the detection target. Quality DOTS Expansion is therefore a top priority for governments to help them achieve full geographical coverage towards the Millennium Development Goals for tuberculosis (to have halved mortality by 2015, and begun to reverse the incidence of tuberculosis). The implementation of tuberculosis control and prevention activities in some countries has still not been consolidated. Some of the most important bottlenecks relate, for example, to an inadequate tuberculosis surveillance system; weakness of laboratory performance in case detection; absence of linkages with prison, army or other health services as well as with the private sector;

lack of community involvement; insufficient information, education and communication activities towards the population; high default and mortality rate among tuberculosis patients; and the high level of multidrug-resistant tuberculosis. The lack of funds and plans of action for tuberculosis control as well as an absence of country coordinating mechanisms in some countries are critical impediments to delivery of the expected results.

70. Furthermore, higher political commitment to the implementation of DOTS is needed in some countries if the Region is to progress as rapidly as would be wished in this process. Declared political commitments by some countries in the Region have not yet been transformed into resource allocation and action. We call on Member States to increase their national expenditure on rational strategies to address tuberculosis and its accompanying social conditions. Eligible countries should apply to the GFATM for support for both HIV/AIDS and tuberculosis activities. WHO and its partners should become an important source of technical assistance and coordination. The sustainability of tuberculosis control depends largely on working with and mobilizing new partners to maximize and optimize efforts and resources.