World Health Organization

REGIONAL OFFICE FOR Europe

REGIONAL COMMITTEE FOR EUROPE
65TH SESSION

Vilnius, Lithuania, 14–17 September 2015

Progress reports

Working document

World Health Organization

REGIONAL OFFICE FOR Europe

Regional Committee for Europe
65th session

EUR/RC65/12

Vilnius, Lithuania, 14–17 September 2015

31 July 2015
150501

Provisional agenda item 5(j)

ORIGINAL: ENGLISH

Progress reports

This document contains progress reports on:

A. implementation of the Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015 (resolution EUR/RC61/R7) – final report;
B. achieving the health-related Millennium Development Goals (resolution EUR/RC57/R2);
C. behaviour change strategies and health: the role of health systems (resolution EUR/RC58/R8);
D. implementation of the International Health Regulations (2005) (resolution EUR/RC59/R5); and
E. stewardship/governance of health systems in the WHO European Region (resolution EUR/RC58/R4).

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A. Progress on implementation of the Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015 – final report

Introduction

1. The WHO European Region has a disparate tuberculosis burden, ranging from one case of tuberculosis per 100 000 population in some Member States to 160 cases of tuberculosis per 100 000 in others. Even within countries there is a wide range in tuberculosis incidence. In addition, approximately 99% of the burden of multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB) is concentrated in 18 high-priority countries, all in the eastern part of the Region.[1]

2. In response to the increasing problem of M/XDR-TB in the European Region, and in order to scale up a comprehensive response and to prevent and control M/XDR-TB, an action plan was developed for 2011–2015 for all 53 Member States and partners. The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011–2015 (document EUR/RC61/15) was endorsed in resolution EUR/RC61/R7 by the 61st session of the WHO Regional Committee for Europe in Baku, Azerbaijan, on 15 September 2011. The Consolidated Action Plan, which was developed through broad consultation with Member States, civil society organizations, technical and bilateral agencies and communities, set the ambitious targets of detecting more than 85% of estimated multidrug-resistant tuberculosis (MDR-TB) patients and of treating at least 75% of them successfully in order to curb this epidemic.

3. Regional Committee resolution EUR/RC61/R7 requested the Regional Director to assess progress in the prevention and control of M/XDR-TB at the regional level every second year, starting in 2013, and to report these findings to the Regional Committee.

4. Since the endorsement of the Consolidated Action Plan by the Regional Committee in September 2011, the Secretariat has intensified its provision of technical guidance to Member States on diverse areas of the prevention, control and patient care of tuberculosis, TB/HIV infection and M/XDR-TB. Under the auspices of the Regional Director's Special Representative on M/XDR-TB and through interdivisional collaboration with the Division of Health Systems and Public Health, barriers in health systems were identified, and Member States are being supported in reforming their services to make them more efficient, with equitable access to high-quality services, in line with Health 2020. Most of the milestones for the activities to be undertaken by Member States, the Secretariat and partners in the seven areas of intervention of the Consolidated Action Plan have been achieved.

5. The main achievements include increasing the diagnosis of cases of MDR-TB from less than one third of the estimated number in 2011 to half in 2013 (the most

[1] The 18 high-priority countries are: Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Romania, Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan.

recent reporting year)[2] and an increase in treatment coverage of notified cases from 63% in 2011 to universal coverage in 2013. In addition, Millennium Development Goal 6 on reversing the tuberculosis incidence has been achieved; the incidence of tuberculosis in the European Region has been falling at an average rate of 4.5% per year, which is the fastest decline in tuberculosis rates of all WHO regions. The incidence of MDR-TB among previously treated patients has also levelled off since the implementation of the Consolidated Action Plan to 48% in 2013.

6. Along with progress, there are still several key challenges to tuberculosis control. There is ongoing transmission of MDR-TB, as shown by the increase in new MDR-TB cases. Tuberculosis in the Region is becoming more difficult to treat due to the increasing resistance of strains; treatment success remains low and similar to the global level (less than 50% of MDR-TB cases are treated successfully). Tuberculosis is one of the leading causes of death among people living with HIV, and this deadly combination is increasing in the Region. The prevalence of HIV among tuberculosis cases increased from 3.4% in 2008 to 7.8% in 2013.

7. To tackle these challenges and to continue the progress in tuberculosis and MDR-TB control and care in the Region, the global End TB Strategy[3] is being adapted to the regional context with the development of a tuberculosis action plan for the WHO European Region 2016–2020. The goal of the Tuberculosis action plan is to address the challenges and to follow up on the continuing progress in implementing the Consolidated Action Plan.

Epidemiological trends

8. In 2013, an estimated 360 000 incident cases of tuberculosis (39 cases per 100 000 population) occurred in the WHO European Region, of which 297 500 new cases and relapses were detected; the Region's detection rate of 83% is the highest tuberculosis detection rate in the world.

9. The geographical distribution of the tuberculosis burden in the Region has not changed since the endorsement of the Consolidated Action Plan; 85% of the burden occurs in the 18 high-priority countries.[4] Despite the constant decline in mortality over the past 10 years, an estimated 38 000 tuberculosis deaths occurred in the Region in 2013 (4.1 deaths per 100 000 population).

10. In 2013, 17 096 (81.4%) of the estimated 21 000 tuberculosis cases with HIV coinfection in the Region were detected. Almost one fifth of TB/HIV incident cases remained undetected due to only 68% HIV testing coverage among all tuberculosis patients in the Region. There was a slight decrease in antiretroviral therapy coverage

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[2] Please note that tuberculosis surveillance data is collected over the course of one year and analysed the following year. In other words, data used in this progress report (January 2015) refer to cases registered in 2013. This allows countries to verify their data and establish the treatment outcomes for newly and previously treated patients.

[3] Draft global strategy and targets for tuberculosis prevention, care and control after 2015 (document A67/11). Sixty-seventh World Health Assembly, Geneva, 19–24 May 2014 (http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_11-en.pdf?ua=1, accessed 29 July 2015).

[4] See footnote 1.

among HIV-positive tuberculosis patients during 2009–2013, from 60% in 2009 to 54% in 2013.

11. Of the estimated 75 000 MDR-TB cases in the Region in 2013, almost one half (47.3%) were detected. Compared to 2009, 40% more MDR-TB cases were detected, mostly due to the substantial increase in the drug susceptibility testing (DST) coverage (in 2009, 30% of all tuberculosis cases were tested for first-line DST compared to almost 90% in 2013).

12. There was a substantial improvement in coverage of second-line treatment for MDR-TB in 2013 (63% in 2009 compared to universal coverage in 2013). In some countries, the number of patients enrolled exceeded the total number notified because MDR cases from waiting lists of previous years were also enrolled in treatment. In total, 46 710 tuberculosis patients were enrolled in MDR treatment, of whom 45 147 had confirmed MDR-TB.

13. Despite the substantial achievements in MDR-TB detection and treatment coverage, the proportion of MDR among new tuberculosis cases increased from 12% in 2009 to 18% in 2013, indicating the ongoing transmission of MDR-TB. However, the proportion of MDR-TB among previously treated patients has levelled off since 2011.

Financing tuberculosis and MDR-TB interventions

14. Several Member States have requested and are receiving technical assistance from the Regional Office in the revision of their financing mechanisms and support in budgeting for tuberculosis prevention and control interventions to improve programme efficiency. Health financing has also been included in national tuberculosis programme review missions. The Secretariat has provided guidance to Member States with a high MDR-TB burden on increasing domestic resources and raising international funds for tuberculosis and M/XDR-TB control, particularly in collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund).

15. The extensive programme reviews conducted jointly by the Regional Office and the European Centre for Disease Prevention and Control (ECDC) in some countries of the European Union show that some of the progress previously achieved may be threatened as a result of the financial crisis and budget cuts. In addition, adequate financing of tuberculosis control and care is a major challenge for many Member States that no longer receive funding from the Global Fund, for example, the Baltic States and the Russian Federation.

16. The Regional Office has been helping eligible countries to apply to the Global Fund and other donors. In addition, the Regional Office gave substantial technical assistance in 2014–2015 to the drafting and submission of a regional proposal to the Global Fund for tuberculosis health system transformation and financing reform to scale up MDR-TB control (TB-REP) in 11 countries in eastern Europe and central Asia.[5] In

[5] The 11 eligible countries covered by the Global Fund grant are: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan. The Moldovan Centre for Health Policies and Studies is the principal recipient; the WHO Regional Office for Europe is the subrecipient, and will work with the London School of Hygiene and Tropical Medicine, the

line with Health 2020, the proposal foresees the establishment of national intersectoral committees under the offices of the prime ministers, composed of representatives of the ministries of health, justice, interior and social policies.

Achievements and challenges (according to areas of intervention)

Area of intervention 1: Prevent the development of M/XDR-TB cases

17. The Regional Office and other partners, in collaboration with Member States, assessed reasons for defaulting from treatment in several settings. Social determinants were included in the drug resistance surveillance system. A tuberculosis/MDR-TB health systems assessment tool was developed and implemented in several Member States (Armenia, Republic of Moldova, Turkmenistan and Uzbekistan) to document key challenges for the six health systems building blocks and to recommend measures to prevent the emergence of drug-resistant tuberculosis and to scale up effective treatment.

18. In order to improve the transfer of knowledge and experiences among countries and to assist in improving the health systems approach, the Secretariat launched an initiative in 2013 to collect examples of best practices in M/XDR-TB prevention, control and care. Evaluated and selected best practices were published in a compendium.

19. The primary transmission of drug-resistant forms of the disease is associated with inadequate treatment and insufficient patient support mechanisms. However, these conditions still prevail in some Member States, including some countries of the European Union. Some Member States hospitalize patients unnecessarily which, in the absence of adequate airborne infection control, can lead to nosocomial transmission of drug-resistant forms of tuberculosis. Ambulatory services and other models of care, including home-based treatment, do not function fully in some Member States. There is also a lack of evidence of effective prophylactic treatment for those who have had contact with M/XDR-TB patients.

Area of intervention 2: Scale up access to testing for resistance to first- and second-line anti-tuberculosis drugs and to HIV testing and counselling among tuberculosis patients

20. The Regional Office has set up the European Tuberculosis Laboratory Initiative (ELI) and provided technical assistance to Member States to scale up diagnostic capacities and embark on the rapid molecular diagnosis of tuberculosis and MDR-TB. The Regional Office and other partners have also provided technical assistance on joint TB/HIV activities.

21. A diagnostic algorithm was developed using new available tools, such as GeneXpert MTB/RIF. The algorithm has been under peer review in Armenia and Georgia since 2014 and, after finalization, will be disseminated in 2015.

London School of Economics and Political Science, the European Respiratory Society and the Kazakhstan School of Public Health. A decision on the grant proposal from the Global Fund is forthcoming.

22. There remains inadequate active tuberculosis case finding among people living with HIV (68% HIV testing coverage among all tuberculosis patients). There also continues to be low drug-susceptibility testing of second-line drugs among MDR-TB patients; however, the coverage has improved since the implementation of the Consolidated Action Plan (31% were tested in 2009, compared to 51% in 2013).

Area of intervention 3: Scale up access to effective treatment of drug-resistant tuberculosis

23. The Regional Office has assisted Member States in bringing their national MDR-TB and tuberculosis action plans into line with the Consolidated Action Plan.

24. Access to second-line anti-tuberculosis drugs for the treatment of MDR-TB patients has increased significantly – from 63% to universal coverage (≥100%)[6] – in Member States since the launch of the Consolidated Action Plan. While the treatment success rate of MDR-TB cohorts reaches the targeted 75% in some countries, the overall treatment success rate for the Region is 46%. This is mainly due to the increasing resistance of MDR-TB strains and the lack of availability of third-line drugs for XDR-TB in many settings, with registration of medicines under conditional approval.[7] Some Member States with a low incidence of tuberculosis face challenges due to lost expertise, resulting in long delays in diagnosis, poor patient management and inadequate patient follow-up.

25. The Secretariat increased its network of experts with the establishment of a regional Green Light Committee that provides state-of-the-art technical assistance on the clinical and managerial aspects of MDR-TB and of ELI to improve the quality and timeliness of diagnosis. In addition, the Regional Office and the European Respiratory Society have launched an electronic consilium for the clinical management of difficult-to-treat patients, in English and Russian, for practitioners to consult.

26. New medicines for MDR-TB (bedaquiline and delamanid) are also being introduced in Member States with technical assistance provided by the Regional Office on their safe and rational use and pharmacovigilance. The Secretariat held a regional workshop on pharmacovigilance in Denmark in October 2013, and a country training workshop on the introduction of bedaquiline was held in Kazakhstan in September2014. In addition, a webinar was conducted in March 2015 to guide national counterparts on the appropriate conditions under which to use the new medicines and on their management.

Area of intervention 4: Scale up tuberculosis infection control

27. The Regional Office and other partners have provided technical assistance to Member States to finalize their national tuberculosis infection control action plans, to be integrated either into their national tuberculosis plans or their national health strategies.

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[6] The percentage of treatment coverage was greater than 100% in 2012 and 2013 due to prevalent MDR-tuberculosis cases detected during previous years remaining on waiting lists for enrolment into MDR-TB treatment.

[7] In principle, second-line drugs are used in the treatment of MDR-TB and third-line drugs are used in the treatment of XDR-TB.

The Regional Office has developed a set of key procurement specifications for tuberculosis infection control. Updated tuberculosis infection control assessments have also been conducted in key countries, and institutional barriers have been documented.[8]

28. The Secretariat has been assisting Member States to improve airborne infection control in health-care facilities and congregate settings. These measures, however, have not yet been scaled up in some Member States owing to a lack of administrative, environmental and respiratory protection interventions. Health-care facilities and congregate settings thus continue to contribute to the spread of tuberculosis and drug-resistant tuberculosis.

29. Some Member States deport migrants with tuberculosis without considering the public health and human rights issues involved or without taking adequate infection control measures.

Area of intervention 5: Strengthen surveillance, including recording and reporting, of drug-resistant tuberculosis

30. The Secretariat has continued to work with WHO headquarters and the ECDC on data collection and the publication of an annual surveillance and monitoring report.[9]

31. The Regional Office, in consultation with partners, prepared a monitoring framework for follow-up to The Berlin Declaration on Tuberculosis[10] and provided training, coaching and technical assistance to Member States on improving monitoring and evaluation and data use for better programme performance.

32. The Regional Office assisted several Member States in conducting national drug resistance surveys throughout the period of the Consolidated Action Plan.[11]

33. The Regional Office and the ECDC have held annual meetings for tuberculosis surveillance focal points in order to coordinate surveillance in the Region, as well as to implement and strengthen new WHO definitions, standards and benchmarks.

34. By 2013, 47 Member States reported full coverage of electronic case-based surveillance as an integral part of e-health, both for drug-susceptible tuberculosis and MDR-TB patients. Some Member States still do not report treatment outcome monitoring and HIV testing and detection and therefore miss opportunities to document the efficiency of their tuberculosis control interventions.

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[8] Assessments were performed in Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Republic of Moldova and Ukraine.

[9] European Centre for Disease Prevention and Control, WHO Regional Office for Europe. Tuberculosis surveillance and monitoring in Europe 2015. Stockholm: European Centre for Disease Prevention and Control; 2015 (http://ecdc.europa.eu/en/publications/Publications/tuberculosis-surveillance-monitoring-Europe-2015.pdf, accessed 29 July 2015).

[10] The Berlin Declaration on Tuberculosis. WHO European Ministerial Forum: all against tuberculosis; 22 October 2007 (http://www.euro.who.int/__data/assets/pdf_file/0008/68183/E90833.pdf, accessed 15 April 2015).

[11] Drug resistance surveys were conducted in Azerbaijan, Belarus, Bulgaria, Turkmenistan and Ukraine.

35. National assessments of surveillance systems were conducted from 2013–2014 in order to evaluate standards and benchmarks and as a requirement for country application to the new funding mechanism of the Global Fund.

Area of intervention 6: Expand country capacity to scale up the management of drug-resistant tuberculosis, including advocacy, partnership and policy guidance

36. From 2011–2015, at the request of the ministers of health of 12 countries with high MDR-TB burdens and five with low incidences of tuberculosis, the Secretariat conducted extensive programme reviews and made recommendations for improving tuberculosis services.

37. The Regional Office has also been developing a tuberculosis governance assessment tool and has assisted several Member States in improving the structure of their national programmes.[12]

38. Several technical task forces on the Consolidated Action Plan, led by the Secretariat, reviewed evidence and practices from 2013 to 2015 and produced a number of key publications, including on childhood tuberculosis,[13] the role of surgery in tuberculosis[14] and tuberculosis in prisons[15].

39. During 2013–2014, the Regional Office conducted a survey of the practices for anti-tuberculosis drug supply and management systems in 13 countries with a high burden of MDR-TB.[16] The primary objective of the study was to collect comprehensive data on procurement and supply management in high-priority MDR-TB countries in the Region as a basis to provide further technical assistance.

40. The Regional Office, in collaboration with the ECDC and the KNCV Tuberculosis Foundation, organized a national tuberculosis programme managers' meeting in The Hague, the Netherlands, in May 2013, to discuss progress in implementing national and regional action plans, including the Consolidated Action Plan. A second meeting will be held from 27–29 May 2015 and will also discuss and finalize the draft Tuberculosis action plan for the WHO European Region 2016–2020.

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[12] Technical assistance on governance was provided to Georgia, Hungary, Kyrgyzstan, Latvia, Netherlands, Tajikistan and Uzbekistan.

[13] Acosta CD, Rusovich V, Harries AD, Ahmedov S, van den Boom M, Masoud D. A new roadmap for childhood tuberculosis. Lancet Glob Health. 2014; 2(1):e15–e17 (http://dx.doi.org/10.1016/S2214-109X(13)70153-0).

[14] Surgery in the treatment of pulmonary TB and M/XDR-TB. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0005/259691/The-role-of-surgery-in-the-treatment-of-pulmonary-TB-and-multidrug-and-extensively-drug-resistant-TB.pdf, accessed 29 July 2015).

[15] Dara M, Acosta C, Vinkeles Melchers NVS, Al-Darraji HAA, Chorgoliani D, Reyes H et al. Tuberculosis control in prisons: current situation and research gaps. Intl J of Infectious Diseases. 2015;32:111–117 (http://dx.doi.org/10.1016/j.ijid.2014.12.029).

[16] Procurement and supply management report for the WHO European Region, high MDR-TB priority countries, 2013 (2015) [website] (http://www.euro.who.int/__data/assets/pdf_file/0020/270920/ProcurementMgmtRep_highMDRTB_PriorityCountries2013.pdf?ua=1).

41. The Regional Director established the Regional Collaborating Committee on Tuberculosis Control and Care, supported by the Secretariat. The Committee promotes the involvement of civil society organizations, former patients and community representatives in policy development, country programme reviews and the development and implementation of national plans to combat M/XDR-TB.

42. In order to increase the capacity of Member States to use their data in designing and delivering services, from 2013–2015, the Secretariat, in collaboration with the Special Programme for Research and Training in Tropical Diseases, has been conducting workshops and assisting national scientists in finalizing and publishing studies in international peer-reviewed journals.[17]

43. The Regional Office has provided guidance for Member States revising their frameworks for tuberculosis-related ethics and human rights. A regional workshop was conducted in October 2013 in Copenhagen, and follow-up missions to assess countries' primary and secondary legislation governing involuntary isolation and treatment for tuberculosis and the compassionate use of new anti-tuberculosis drugs have been conducted in five countries during 2014–2015.[18]

44. The Secretariat has involved civil society representatives in all regional meetings and extensive programme reviews. The Regional Office has supported the work of the TB Europe Coalition and other civil society organizations and engaged them in planning and implementing interventions.

45. Regional Office representatives attended and made presentations at several European Parliament hearings on tuberculosis and MDR-TB. The Regional Office also organized an exhibition of photographs, "Faces of Tuberculosis", at the European Parliament on 20 March 2013.

46. The Regional Office organized a high-level event to commemorate World TB Day on 24 March 2014. A high-level panel discussed the progress on the challenges for and next steps in tuberculosis prevention, control and care in the WHO European Region in order to facilitate further work in the Region in the context of the post-2015 global End TB Strategy.

47. The Secretariat co-organized, supported and provided technical input to the high-level first Eastern Partnership Ministerial Conference on TB and MDR-TB, which was held in Riga, Latvia, on 30–31 March 2015 under the Latvian presidency of the Council of the European Union. The Conference was an opportunity to bridge progress in different parts of the European Union and neighbouring countries in order to work towards one tuberculosis elimination goal.

48. In several Member States, there is inefficient management of national programmes and inadequate domestic funding. Although there are some exceptions,

[17] Tuberculosis and drug-resistant tuberculosis in Eastern Europe: operational research from the SORT IT Programme, 2012–2014. Public Health Action, Volume 4, Supplement 2, 21 October 2014 [website] (http://ingentaconnect.com/content/iuatld/pha/2014/00000004/a00202s2;jsessionid=2s483l9eetp51.alice).
[18] Missions on ethics and human rights have been conducted in Armenia, Azerbaijan, Georgia, Republic of Moldova and Ukraine.

there are few Member States in which civil society organizations are involved in tuberculosis control. Furthermore, palliative care for tuberculosis patients is not available in many Member States.

Area of intervention 7: Address the needs of special populations

49. The Regional Office and other partners provided support to Member States revising their national TB/HIV policies to encompass the needs of special populations and to update their health in prison guidelines to include standards for tuberculosis control in prisons. Most countries, however, lack a functioning TB/HIV coordinating mechanism to facilitate the delivery of integrated tuberculosis and HIV (and drug use/narcology) services.

50. The Secretariat has provided technical assistance to Member States to improve coordination between prison and civilian health services. Guidance and policy papers have been developed and distributed among the Member States through the Health in Prisons Project network. In addition, a WHO Collaborating Centre for tuberculosis health in prisons was established in Azerbaijan in coordination with the ministries of health and of justice in 2014. Those efforts notwithstanding, there are still gaps in coordination between civilian and penitentiary services.

51. The Regional Office established a task force on childhood tuberculosis to document current practices with regard to childhood tuberculosis and to adapt international recommendations to the context of the WHO European Region. There is a lack of qualified human resources for addressing childhood tuberculosis in most Member States.

52. The Regional Office published the consensus paper “Minimum package for cross-border tuberculosis control and care in the WHO European region: a Wolfheze consensus statement”.[19]

53. There is an urgent need for research and development on new medicines and vaccines for tuberculosis and M/XDR-TB. The Regional Office is assisting Member States in introducing bedaquiline and delamanid as the new tuberculosis medicines under specific conditions and with special attention to pharmacovigilance. Vaccine trials in other regions are ongoing.

Draft tuberculosis action plan for the WHO European Region 2016–2020

54. Following the endorsement of the post-2015 global End TB Strategy by the Sixty-seventh World Health Assembly in 2014,[20] the Regional Office is adapting the global strategy to the regional context. The Secretariat has prepared a draft tuberculosis action plan for the WHO European Region 2016–2020 (document EUR/RC65/17). The draft Tuberculosis action plan takes into account lessons learned from the seven areas of

[19] Dara M, de Colombani P, Petrova-Benedict R, Centis R, Zellweger JP, Sandgren A, et al. Minimum package for cross-border TB control and care in the WHO European Region: a Wolfheze consensus statement. Eur Respir J. 2012;40(5):1081–1090 (doi:10.1183/09031936.00053012).

[20] See footnote 3.

intervention of the Consolidated Action Plan that are applicable to high-priority countries, as well as those with a low incidence of tuberculosis. In addition, it is aligned with Health 2020, the ECDC's Framework Action Plan to Fight Tuberculosis in the European Union[21] and the framework towards tuberculosis elimination in low-incidence countries supported by WHO and the European Respiratory Society.[22]

55. The draft Tuberculosis action plan will be submitted for consideration by the Regional Committee for Europe at its 65th session in September 2015.

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[21] Framework Action Plan to fight tuberculosis in the European Union. Stockholm: European Centre for Disease Prevention and Control; 2008 (http://ecdc.europa.eu/en/publications/Publications/0803_SPR_TB_Action_plan.pdf, accessed 29 July 2015).

[22] Towards tuberculosis elimination: an action framework for low-incidence countries. Geneva: World Health Organization; 2014 [website] (http://www.who.int/tb/publications/elimination_framework/en/).

B. Progress report on achieving the health-related Millennium Development Goals

1. This report summarizes progress towards achieving the health-related Millennium Development Goals (MDGs) and specific targets in the WHO European Region (resolution EUR/RC57/R2). In the past decade, much progress has been made towards the achievement of health-related MDGs, with unprecedented declines in child mortality and a halt of the epidemics of HIV/AIDS, malaria and tuberculosis. Progress, however, has been uneven.

Goals 4 and 5: reduce child mortality and improve maternal health

2. Both infant and under-five mortality rates have declined steadily in the European Region, with stark inequities, however, within and between countries. The regional average under-five mortality rate decreased from 32 per 1000 live births in 1990 to 12 per 1000 in 2010. This corresponds to a reduction of almost two thirds and is very close to the 2015 target of 11 deaths per 1000 live births. The regional average infant mortality rate decreased from 26 per 1000 live births in 1990 to 10 per 1000 in 2009. In 2009, 11 countries had achieved MDG target 4A.

3. Prematurity, low birth weight, congenital anomalies, birth asphyxia, birth trauma and neonatal infections are among the leading causes of neonatal death; and acute respiratory infections, diarrhoeal diseases, noncommunicable diseases and injuries are among the leading causes of post-neonatal deaths in the European Region.

4. The European regional average maternal mortality rate decreased from 42 per 100 000 live births in 1990 to 17 per 100 000 in 2013. Despite this progress, the average decrease of 3.8% is short of the 5.5% required to reach MDG target 5A. The annual decrease is even less (2.5%) in Central Asia and the Caucasus. There are wide discrepancies within and between countries. The average maternal mortality rate in countries in the European Union remains low; however, analysis of data on different social groups shows diversity within countries, and targeted interventions have been developed.

5. Reliable, comparable data on the prevalence of contraceptive use, unmet needs for family planning and the adolescent birth rate (MDG target 5B indicators) are missing for many countries. The rates of use of modern, effective methods of contraception are alarmingly low in many countries in eastern Europe and Central Asia, sometimes as low as those for the least developed countries. Eastern Europe has the highest abortion rates in the world; in some countries, barriers to safe abortion lead to unsafe practices, resulting in maternal morbidity and even deaths.

6. The WHO Regional Office for Europe supports the inclusion of maternal and child health in national policies within the health systems framework and emphasizes equity in access to quality services. Investing in children: the European child and adolescent health strategy 2015–2020, endorsed by the 64th session of the Regional Committee for Europe in resolution EUR/RC64/R6 in 2014, promotes a life-course approach, which recognizes that adult health and illness are rooted in health and experiences at earlier ages.

7. Support is also provided for in-service training of health-care providers and key policy-makers to improve the quality of care. Evidence-based tools developed by WHO and its partners are adapted to the national context and used for such training and in the context of technical assistance. Support is also given to reformulate the educational curricula of health-care providers. WHO further encourages and supports the development of evidence-based clinical guidelines, and direct technical support is provided to countries, mainly in the eastern part of the Region. In addition, WHO works with other United Nations agencies and partners to develop capacity-building tools that address inequities in progress towards goals 4 and 5, with a particular focus on the Roma population.

Goal 6: combat HIV/AIDS, malaria and other diseases

HIV/AIDS

8. The European Region faces considerable challenges in meeting HIV/AIDS-related targets. More than 136 000 new cases of HIV infection were reported in the Region in 2013, representing a rate of 15.7 per 100 000 population and contributing to a cumulative total of 1.7 million cases diagnosed since the beginning of reporting. This represents an 80% increase in new cases of HIV infection compared to 2004, when almost 76 000 new cases were diagnosed. This is a marked difference to other regions, which generally show annual decreases in the number of new cases of HIV infection.

9. A total of 15 789 new cases of AIDS were reported in 2013, corresponding to a rate of 2.2 cases per 100 000 population, with many more in eastern Europe and Central Asia (11 292 cases) than in western and central Europe (3606 and 891 cases, respectively). All countries in eastern Europe and Central Asia have reported increasing numbers of diagnoses of AIDS, with a threefold increase in 2013 over 2004. In western Europe, the number of newly diagnosed AIDS cases decreased by 60%.

10. Community-based HIV testing is increasingly accepted and widespread in the western part of the Region, but remains a challenge in the east. The overall increase in the number of people tested in the European Region does not reflect better coverage of those who need testing most, as only 53% of key vulnerable populations are tested, which is well below the European target of 90% for 2015. In addition, the proportion of HIV infections diagnosed late remained high – 49% in 2013 – with no decrease compared to 2010.

11. Countries in the European Region have made progress in delivering treatment and care for patients with HIV infection, including improved testing and counselling, laboratory monitoring and delivery of services. Antiretroviral treatment (ART) has become more accessible in the eastern part of the Region: 70 000 more people received ART in 2012 than in 2010, representing an increase in the coverage rate from 23% to 35%; however, this falls far short of reaching the European target of 80% by 2015. In the western part of the Region, ART coverage is high: 460 000 people received ART in 2012, and most western European countries have achieved the target or are on track to do so.

12. The reduction in mother-to-child transmission of HIV is one of Europe's successes in the fight against HIV/AIDS. This mode of transmission accounted for only

1% of new cases in 2012; the number of children infected in this way has decreased by 10% since 2010, with 75% of mother-to-child transmitted cases reported in the eastern part of the Region. In 2011, European countries had the highest coverage globally of ART for HIV-infected pregnant women (more than 95%).

13. Much needs to be done to halt and reverse the spread of HIV/AIDS. Following adoption of the European Action Plan for HIV/AIDS 2012–2015 (resolution EUR/RC61/R8) by the Regional Committee in 2011, the Regional Office is implementing the action plan, addressing the challenges in responding to the epidemic and promoting priorities for interventions. Support and technical assistance are provided to Member States to adopt evidence-informed policies for treating and preventing HIV infection, particularly among key populations, and to implement harm reduction interventions and programmes for the prevention of sexual transmission in national AIDS plans.

Tuberculosis

14. The target of halting the prevalence of and death associated with tuberculosis (TB) and reversing the incidence has been achieved only partially in the Region. In 2013, the incidence and prevalence of tuberculosis were estimated, respectively, as 39 and 51 cases per 100 000 population. Tuberculosis incidence has been falling at an average rate of 4.5% per year, and the prevalence should reach the target of a 50% reduction against the baseline of 1990. Tuberculosis mortality in 2013 was estimated to be 4.1 deaths per 100 000 population. Despite a constant decrease in estimated mortality over the past few years, the Region is not on track to halve the rate by 2015.

15. The burden of tuberculosis in the European Region varies widely within and between countries, from one case per 100 000 population in some Member States to over 160 cases per 100 000 in others. Even within countries, there is a wide variation, with tuberculosis rates above 100 per 100 000 population in some districts and capitals of western Europe. The major burden is borne by 18 high-priority countries, which have 85% of tuberculosis cases and 99% of all multidrug-resistant (MDR) tuberculosis cases. In 2013, 47.3% of an estimated 75 000 MDR-TB cases had been detected. The prevalence of MDR among new tuberculosis cases in the Region was 16.9%, while the prevalence among previously treated tuberculosis cases was 48%. Although TB-HIV coinfection is not as prevalent as in some other WHO regions, an increasing prevalence of HIV infection among tuberculosis cases has been observed, the percentage increasing from 3.4% in 2008 to 7.8% in 2013.

16. In 2013, the Region reached universal coverage with first- and second-line tuberculosis treatment. The treatment success rate among new and relapsed tuberculosis cases and among MDR-TB cases, however, continues to decrease and has fallen to 76% and 46%, respectively.

17. In collaboration with national and international partners and civil society organizations, the WHO Regional Office for Europe has been implementing the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-resistant Tuberculosis in the WHO European Region 2011–2015, endorsed by the Regional Committee in resolution EUR/RC61/R7, which supports Member States in adopting evidence-based interventions to improve the prevention and control of

tuberculosis, MDR-TB and extensively drug-resistant (XDR) tuberculosis. Almost all high-burden MDR-TB countries have prepared and finalized their national MDR-TB action plans in line with the regional action plan.

18. The Regional Office continues to provide technical assistance to Member States in monitoring and assessing national interventions and improving tuberculosis drug management, infection control, laboratory networks, TB-HIV coinfection, advocacy and communication, surveillance and response, clinical management, recording and reporting, intersectoral collaboration, social determinants of tuberculosis and people-centred approaches to achieve universal access to tuberculosis care in line with Health 2020.

19. The Regional Office established the European Green Light Committee to provide state-of-the-art technical assistance on clinical and managerial aspects of MDR-TB and the European Laboratory Initiative to improve the quality and timeliness of diagnosis. The Regional Collaborating Committee on Tuberculosis Control and Care was established in December 2012 to improve partnerships and coordination. In collaboration with the European Respiratory Society, an electronic consilium was established to support clinicians in improving management of difficult-to-treat tuberculosis and M/XDR-TB patients. The system is being tested for use in cross-border tuberculosis control and care.

20. A consortium, comprising the Centre for Health Policies and Studies (Republic of Moldova), the Regional Office and other partners, has solicited support from The Global Fund to Fight AIDS, Tuberculosis and Malaria to improve health systems strengthening through a regional project in eastern Europe and Central Asia for health systems transformation and financing reform, which will include tuberculosis and MDR-TB control in 11 target countries during the period 2015–2018.

21. In collaboration with Member States and partners, and in line with the post-2015 global End TB Strategy endorsed at the Sixty-seventh World Health Assembly in resolution WHA67.1, the Regional Office is preparing a new tuberculosis action plan for 2016–2020, which will be presented to the Regional Committee in September 2015. The new tuberculosis action plan covers the seven intervention areas of the current M/XDR-TB action plan 2011–2015 and is aligned with Health 2020.

Neglected tropical diseases

22. *Aedes albopictus*, the vector of dengue, has spread rapidly to more than 25 countries in the Region. The threat of dengue outbreaks has therefore returned to Europe, after a lapse of 55 years. Local transmission of the virus was reported in Croatia and France in 2010, and imported cases were detected in several other European countries. A dengue outbreak on the island of Madeira (Portugal) in 2012 resulted in more than 2200 cases and importation of cases into 17 other European countries. The Regional Framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases, adopted by the Regional Committee in resolution EUR/RC63/R6, is used as a framework for actions to support Member States.

Target 7C: halve, by 2015, the proportion of the population without sustainable access to safe drinking-water and basic sanitation

23. In 2012, the majority of the population of the Region had access to "improved" sources of drinking-water (98%) and sanitation facilities (93%), as defined by the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation. However, these figures mask large gaps and disparities within and between countries, between urban and rural areas and between high- and low-income groups. Progress towards water and sanitation coverage has stagnated in the Region.

24. The European Region is not on track to meet target 7C on sanitation coverage, as 67 million people lack access to functioning toilets and safe means to dispose of human faeces. The Region has met target 7C on drinking-water; however, about 100 million people still lack access to piped drinking-water on their premises, and more than 6 million still rely on surface water as their primary water source, posing severe risks to health. Significant inequalities exist in access to drinking-water and sanitation services; rural dwellers and the poor are the most disadvantaged. In the Caucasus and Central Asia, for example, 71% of the rural population lives in homes without access to piped water on the premises, whereas only 14% of town and city residents are similarly disadvantaged.

25. The primary policy instrument, the Protocol on Water and Health, has been ratified by 26 countries in the Region, representing 60% of its population. Under the Protocol, WHO and partners support Member States in setting national policy targets on reducing water-related diseases, strengthening safe management of water and sanitation services, particularly in rural areas, establishing cost-effective surveillance systems for water quality and addressing inequalities in access.

Target 8E: in cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

26. Spending on medical products represents a large share of the health budget in many European countries. While most countries have access to essential medicines, access remains a challenge in some and particularly in the countries of the Commonwealth of Independent States. The Regional Office supports the development of national policies that promote equal access to essential medicines, with both supply and demand measures. With health care budgets under continuous pressure everywhere, access to medicines is increasingly jeopardized by issues of affordability. While pricing and reimbursement policies are primarily the responsibility of Member States, WHO encourages countries to use transparent methods and systems for evaluating the therapeutic value of medicines and evidence-informed decision-making. Achieving fair pricing and ensuring the long-term sustainability of health care systems and access for patients is one of the greatest challenges for health and pharmaceutical systems in Europe and worldwide.

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C. Progress on behaviour change strategies and health: the role of health systems

Introduction and context

1. At its 58th session in Tbilisi, Georgia, the WHO Regional Committee for Europe (RC) endorsed resolution EUR/RC58/R8, which urges Member States to continue collaborating in the context of the WHO Regional Office for Europe's country strategy and identifies a number of areas for action for both Member States and the Regional Director. Shortly before RC58, the final report of the Global Commission on Social Determinants of Health[1] was published and the WHO European Ministerial Conference on Health Systems: "Health Systems for Health and Wealth" was held in Tallinn, Estonia, on 25–27 June 2008.

2. The Ministerial Conference on Health Systems, the adoption of the Tallinn Charter: Health Systems for Health and Wealth[2] and its subsequent endorsement by RC58 in September 2008 (resolution EUR/RC58/R4) were direct responses to the increasing evidence that investing in health systems not only is valuable in itself but also contributes directly to population health and economic wealth, which in turn contribute to societal well-being and stability.

3. Following the work of the Global Commission on Social Determinants of Health in 2008, the financial and economic crises and their growing impact on health inequalities, the WHO Regional Office for Europe developed a new, contextualized health policy, which was adopted unanimously in resolution EUR/RC62/R4 at RC62 in 2012. The aim of the new policy framework, Health 2020,[3] is to significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure sustainable, people-centred health systems.

4. Health 2020 is based on the final report of the review of social determinants and the health divide in the WHO European Region,[4] which summarizes the scientific evidence on health inequalities in the Region during the past 35 years. Extending the concept of individual behaviour change that had prevailed during the previous decades, Health 2020 proposes looking at the "causes of the causes" and offers a vast range of meaningful interventions to address the determinants of poor health. It provides a framework for strengthening mutually reinforcing intersectoral action, such as between

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[1] Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization; 2008 (http://www.who.int/social_determinants/thecommission/finalreport/en/, accessed 28 July 2015).
[2] The Tallinn Charter: Health systems for health and wealth. Copenhagen: WHO Regional Office for Europe; 2008 (http://www.euro.who.int/en/publications/policy-documents/tallinn-charter-health-systems-for-health-and-wealth, accessed 28 July 2015).
[3] Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/publications/abstracts/health-2020-a-european-policy-framework-and-strategy-for-the-21st-century, accessed 28 July 2015).
[4] Review of social determinants and the health divide in the WHO European Region: final report (updated reprint). Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-final-report, accessed 28 July 2015).

education and health for the prevention of noncommunicable diseases (NCDs) and between social affairs and health for the social protection of the most vulnerable segments of society, through whole-of-government and whole-of-society approaches.

5. The review of social determinants and the health divide shows that resilience is the product of historical and social processes rather than an inherent characteristic of individuals. People, communities, places and institutions are resilient given the appropriate conditions – such as supportive environments, including good governance of local institutions, support for access to resources and for providers of local services.[5] The capacity for resilience, however, can be undermined by inappropriate action, policy and/or professional practices.

6. In the past, programme recommendations have often tended to focus on individual behaviour, that is, proximal causal factors, and on specific groups, households or individuals rather than on the distal factors rooted in politics, economics, commercial interests and history. This process has been labelled "lifestyle drift".[5]

7. The review of social determinants and the health divide underscores the importance of understanding exclusion, vulnerability and disadvantage as dynamic, multidimensional, historical and social processes rather than individual states of being. Such processes can be understood as being driven by actors operating at the local, national, pan-national and regional levels. Different types of exclusion and vulnerability interact and interlink, including environmental, institutional, economic and social forms. They create inequalities in influence and resources, resulting in diverse opportunities for people to improve their life chances and differential exposure to vulnerable spaces. Effective action to address such processes requires engagement by those most severely affected as active agents of change.[5]

8. Progress has been made on health promotion in a globalized world, strengthening health systems, child and adolescent health, food and nutrition policy, and environment and health and addressing public health problems associated with the use of tobacco (resolution WHA56.1) and the harmful use of alcohol (resolution WHA58.26). The importance of and political commitment to NCDs have increased since 2008, and there are good opportunities for intersectoral action on their prevention. The First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, held in April 2011 and hosted by the Russian Federation, led to the adoption of the Moscow Declaration, which was subsequently endorsed by the Sixty-fourth World Health Assembly in resolution WHA64.11. In September 2011, RC61 adopted the Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (document EUR/RC61/12) in resolution EUR/RC61/R3.

9. In September 2011, a high-level meeting at the United Nations in New York culminated in the adoption of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. In May 2013, the Sixty-sixth World Health Assembly endorsed the Global Action Plan for

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[5] Popay J, Whitehead M, Hunter DJ. Injustice is killing people on a large scale – but what is to be done about it? J Public Health (Oxf). 2010 Jun;32(2):148-9. doi:10.1093/pubmed/fdq029.

the Prevention and Control of Noncommunicable Diseases 2013–2020 and adopted a comprehensive global monitoring framework comprising nine voluntary global targets and 25 indicators in resolution WHA66.10. In July 2014, a high-level meeting of the General Assembly of the United Nations agreed on a comprehensive review and assessment of the progress achieved in the prevention and control of NCDs.

Progress on resolution EUR/RC58/R8 since 2008

10. This progress report focuses on the work accomplished by Member States with the support of the Regional Office in responding to the requests in resolution EUR/RC58/R8, given the fast-evolving context described above. Examples of progress in policies and programmes, information sharing and exchange of ideas are provided for various areas.

Addressing the wider determinants of health through intersectoral action

11. Health 2020 and the review of social determinants of health in the European Region resulted in significant progress in health promotion throughout the Region (see also resolution EB117/R9 of the Executive Board, which led to resolution WHA60.24 on health promotion in a globalized world in 2007). Resolution EUR/RC58/R8 drew on the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion and the Bangkok Charter for Health Promotion in a Globalized World, and sets out strategic directions for equitable improvements in health in the first decades of the 21st century, confirming the importance of also addressing the wider determinants of health.

12. Health 2020 is relevant to the whole of government and the whole of society. It envisages actions and outcomes well beyond the boundaries of the health sector, proposing that health ministries reach out to and work with other ministries, departments, sectors, organizations, stakeholders and civil society organizations. It also proposes that governments involve citizens, patients and consumers. An action framework is being prepared, outlining strategic priorities for intersectoral action in the areas of health and foreign policy towards strengthened interagency collaboration; health, education, social and employment policy on social determinants, early childhood development, health literacy and empowerment of people throughout the life-cycle; and health, environment and transport.[6] A growing number of Member States in the European Region are showing interest in sharing experiences involving wider government response, be it at the local (subnational) or national level.

13. Progress towards the goals of Health 2020 will require policies in four areas: investing in health through a life-course approach and empowering citizens; tackling Europe's burdens of noncommunicable and communicable diseases; strengthening people-centred health systems and public health capacity, including preparedness and response capacity for dealing with emergencies; and creating supportive environments and resilient communities.[7]

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[6] Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice (EUR/RC65/16). Copenhagen: WHO Regional Office for Europe; 2015.
[7] Final report on implementation of the Tallinn Charter – summary (EUR/RC65/8). Copenhagen: WHO Regional Office for Europe; 2015.

Life-course approach to health and well-being

14. Implementation of Health 2020 includes prioritizing a life-course approach and empowering people for decision-making with a view to sustaining improved childhood immunization coverage, the promotion of early childhood development and strong partnership initiatives on children and the environment.[8]

15. The European Region includes not only the countries with the lowest rates of infant and child mortality in the world but also those with rates that are 25 times higher. Injuries, mental disorders, tobacco and alcohol abuse, obesity and malnutrition cause premature death among adolescents or jeopardize their future health. The European child and adolescent health strategy 2015–2020 (document EUR/RC64/12) adopted by RC64 in resolution EUR/RC64/R6 in 2014, builds on the fundamental principles of Health 2020, including the promotion of strong partnerships and intersectoral collaboration.

16. Health 2020 also focuses on preventing child maltreatment in the context of a human rights violation and a determinant of future health and well-being through national assessments and systematic reviews of the evidence. It also addresses strengthening work on healthy ageing by building on the achievements of 25 years of the WHO European Healthy Cities programme and by developing cross-sectoral resources and tools for creating “age-friendly environments” in Europe.[8]

Strengthening public health

17. In 2012, RC62 endorsed the European Action Plan for Strengthening Public Health Capacities and Services (document EUR/RC62/12 Rev.1) in resolution EUR/RC62/R5, and acknowledged the revised 10 essential public health operations and the respective avenues for action by Member States, the Regional Office and partners from 2012 to 2020. The preparation of the European Action Plan involved an evaluation of public health services by the Regional Office in more than 20 European countries, a review of public health capacity in the European Union, and additional studies on policy tools and instruments for public health, as well as a “snapshot analysis” of organizational models for delivering essential public health operations.

18. These operations can be adapted by countries to their own context, with WHO leadership and support, to assess and plan for stronger public health services and capacity. The overall vision of the Action Plan is to promote greater health and well-being in a sustainable way, while strengthening integrated public health services and reducing inequality.

19. The Action Plan provides an opportunity to renew the European Region’s commitment to public health capacity and services, tackle the social determinants of health and inequities in health experience, develop public health within national health systems and across other sectors and levels of society, strengthen human resources

[8] Implementing Health 2020: 2012–2014. Copenhagen: WHO Regional Office for Europe; 2014 (EUR/RC64/8 Rev.2; http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/64th-session/documentation/working-documents/eurrc648-rev.-2-implementing-health-2020-20122014, accessed 28 July 2015).

capacity in public health, integrate interconnected health-related policy areas in a coherent way and further strengthen public health in all health and social care services, in particular primary health care, as foreseen in the holistic approach to health systems set out in the Tallinn Charter.

20. The strengthening of public health by WHO together with Member States involves the assessment, organizational reform and planning of both public health services and the public health workforce.

21. As part of the Action Plan, a tool, developed for self-assessment of essential public health operations, was applied in 17 Member States. The results were used to develop national health strategies and public health action plans, strengthen the public health workforce and reform the organization and funding of public health services. The tool was updated in September 2014 to incorporate innovations, provide more detail and include references to other WHO assessment tools. Four Member States have conducted assessments with the new version of the tool (Armenia, Poland, Slovenia and the former Yugoslav Republic of Macedonia).

Identifying critical health systems challenges and increasing coverage of population interventions to curb NCDs

22. During the past five years, the Regional Office has worked with Member States, intergovernmental organizations and major partners in the United Nations system to promote intersectoral action, build national capacity, identify new partnership opportunities, promote cost-effective approaches for the prevention and control of NCDs and meet the commitments of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases within the framework of Health 2020.

23. Large-scale population interventions (such as tobacco control or physical activity) must be combined with effective individual health services (for example, diabetes detection and management) for the prevention and control of NCDs. The Regional Office supports Member States in strengthening the response of their health systems to NCDs through an interdivisional work programme based on analysis, technical assistance, policy dialogue and knowledge exchange.

24. Guidelines for country assessments have been prepared jointly with Member States in a structured process to identify health systems challenges and opportunities to improve outcomes with regard to NCDs.[9] The current guide outlines a five-step process to formulate policy-relevant, contextualized conclusions, starting from an analysis of key indicators for NCD outcomes at the national and subnational levels, the coverage rate of population-wide interventions for tobacco control, alcohol policies, nutrition and physical activity, and the coverage of individual health services (prevention, early detection and disease management). Fifteen health systems challenges are examined,

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[9] Better noncommunicable disease outcomes: challenges and opportunities for health systems. Country assessment guide. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/publications/2014/better-noncommunicable-disease-outcomes,-challenges-and-opportunities-for-health-systems.-country-assessment-guide, accessed 28 July 2015).

such as the reluctance to empower populations in decision-making or poor priority setting,[10] which precludes more extensive coverage of interventions and services; opportunities for change are identified. While work is under way elsewhere, country-specific policy recommendations were made in eight countries in 2013–2014 (Belarus, Croatia, Estonia, Hungary, Kyrgyzstan, the Republic of Moldova, Tajikistan and Turkey).[11] The countrywide assessments also take into account innovations and good practices that can be used as examples for other countries. The exchange of experiences among Member States ensures that they are properly evaluated and that they generate evidence and highlight linkages with health systems stewardship, thereby enabling lessons to be learned and achievements to be replicated.

Food and nutrition

25. The European Food and Nutrition Action Plan 2015–2020 (document EUR/RC64/14) adopted by RC64 in resolution EUR/RC64/R7 in 2014, addresses unhealthy diets as a major risk factor for the growing burden of NCDs in the European Region. In 46 of the 53 Member States, more than 50% of adults are overweight or obese; in several of those countries the rate is nearly 70% and increasing. Every year, an estimated 320 000 people in 20 countries in western Europe die due to overweight and obesity. In some eastern parts of the Region, the rates of overweight and obesity have risen more than threefold since 1980.

26. Priorities include better nutrition labelling, stronger controls on food marketing to children, expanded school food policies and a continuous commitment to salt reduction through product reformulation. The Action Plan also addresses the role of prevention by health services, opportunities to promote healthy diets through food and agriculture policies and sophisticated surveillance systems to monitor and evaluate progress.

Implementation of the WHO Framework Convention on Tobacco Control (FCTC)

27. As of 2015, 10 years after its entry into force in resolution WHA56.1, the WHO FCTC had been ratified by 50 countries in the European Region. Despite the high number of ratifications and important changes in tobacco control policies and their execution, full implementation of the treaty remains limited. In order to support countries in implementing the WHO FCTC through intersectoral cooperation, the Regional Office has organized several regional meetings and has prepared policy tools. A legal database that reflects the prevalence of tobacco use and current tobacco control policies and legislation in the Region was established so that countries can learn from one another.

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[10] Roberts MJ, Stevenson MA. Improving outcomes for noncommunicable diseases through health system strengthening. Copenhagen: WHO Regional Office for Europe; (in press).

[11] Better noncommunicable disease outcomes, challenges and opportunities for health systems. In: WHO/Europe, Health topics, Health systems, Health systems response to noncommunicable diseases, Publications [website]. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/en/health-topics/Health-systems/pages/health-systems-response-to-noncommunicable-diseases/publications, accessed 28 July 2015).

28. Several country case studies on implementation of the WHO FCTC have been made available in English and Russian, particularly with regard to smoke-free public places, taxes, health warnings and advertising. Annual meetings of all countries in the Region are held, in close collaboration with the Convention Secretariat, to exchange experiences on implementation of the WHO FCTC in Europe. There have also been several thematic regional meetings, for example, on trade and tobacco control, bringing together the health and trade sectors of governments.

29. To complement the regional work, the Secretariat works with some 20 countries in support of the treaty. The key partners at the national level are heads of governments and members of parliament, as well as ministries of health and the broader health community. Monitoring has shown a decreasing prevalence in tobacco use, fewer acute admissions to hospitals, strong policies in line with the WHO FCTC and their effective enforcement.

Harmful use of alcohol

30. Prior to the Sixty-third World Health Assembly's endorsement of the Global strategy to reduce the harmful use of alcohol in 2010 in resolution WHA63.13, the Regional Office organized a consultation to discuss the proposed actions to reduce alcohol consumption and harm in the European Region. In 2011, RC61 adopted the European action plan to reduce the harmful use of alcohol 2012–2020 (document EUR/RC61/13) in resolution EUR/RC61/R4. The action plan follows the five objectives and 10 action areas of the global strategy. All the indicators in the global strategy are included in the European Information System on Alcohol and Health, which was launched in 2010.

31. The Regional Office has supported capacity-building workshops on alcohol policy development and implementation, linked to the prevention and control of NCDs, in selected countries in the European Region (Armenia, Belgium, Croatia, Denmark, Estonia, Finland, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Montenegro, Norway, Poland, Portugal, the Republic of Moldova, the Russian Federation, Serbia, Slovakia, Turkey and the United Kingdom); through these, it has facilitated the development of alcohol policies.

32. In 2011, the Regional Office started collecting information on alcohol policy developments in Member States from 2006 onwards, with links to documents, publications and websites, to facilitate knowledge sharing on good practice. The information collected for 2006–2012 was included in a 2013 publication[12] and will be available in an online database to be created during 2015.

33. The production and dissemination of knowledge on alcohol consumption, alcohol-attributable harm and policy responses by Member States have been improved through refining data collection and analysis and disseminating the findings. The Regional Office works with WHO headquarters, as well as with the European Commission, on

[12] Status report on alcohol and health in 35 European countries 2013. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/publications/2013/status-report-on-alcohol-and-health-in-35-european-countries-2013, accessed 28 July 2015).

this task. A project carried out with the European Commission in 2011–2013 ensures identical indicators and a common system for data collection and analysis.

Mental health

34. The Regional Office drew up the European Mental Health Action Plan (document EUR/RC63/11), which RC63 endorsed in resolution EUR/RC63/R10 in 2013. Under objective 1, the Action Plan urges raised awareness of mental well-being and the factors that support it in lifestyles, in the family, at work, in kindergartens and schools, in the community and in wider society. There is available evidence with regard to preventing depression and e-health mechanisms, identifying best practice in the Region. The Regional Office has assessed the quality and capacity of mental health services in countries that requested support, including Albania, Armenia, Bulgaria, the Czech Republic, Hungary, Kazakhstan, Kyrgyzstan, Portugal, the Republic of Moldova, Slovenia, Turkey and Turkmenistan. A set of recommendations was provided for each of these countries and follow-up support was offered.

35. Community capacity-building for mental health has been a major focus in Member States, supported by the Regional Office to ensure the availability and accessibility of community resources within the scope of the Action Plan. Under objectives 3 and 4, the Plan proposes that primary care with capacity to deliver treatment for common mental disorders, including psychological and social interventions, be established as the first point of access for people with mental health problems, respecting the dignity and preferences of service users and, where indicated, their families. In Turkey, an extensive programme, co-funded by the European Union, has put in place community building for people with mental disabilities, combining drafting policies, workforce education and engagement of service users and communities.

36. The Regional Office has organized several workshops on primary care competence and suicide prevention for countries in the south-eastern part of the Region in partnership with the Regional Health Development Centre on Mental Health in South-eastern Europe, the central Asian countries and the Russian Federation. It has facilitated visits by staff from ministries of health and technical experts to projects demonstrating good practice in other countries, such as from the Czech Republic to the United Kingdom, from Turkey to Italy and Turkmenistan, and from Kyrgyzstan and Uzbekistan to Turkey. It also contributed to the publication *Preventing suicide: a global imperative*,[13] which provides a knowledge base on suicide and actionable steps for countries to move forward in suicide prevention.

Progress evaluation and information sharing

37. Progress and reporting are evaluated regularly through the monitoring framework for Health 2020 targets and indicators,[14] and are described in annual reports of the

[13] Preventing suicide: a global imperative. Geneva: World Health Organization; 2014 (http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/, accessed 29 July 2105).
[14] Targets and indicators for Health 2020. Version 2. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-

Regional Director. More detailed evaluations are carried out in the European health reports, the annual core health indicator series, the revitalized *Highlights on health* series of country profiles (compiled in direct collaboration with Member States) and the new health information and evidence web portal at the Regional Office, which includes the European Health for All Database. The annual flagship Autumn School on Health Information and Evidence for Policy-making builds capacity to strengthen health information collation, analysis and reporting in Member States. In response to a petition from Member States to the Regional Director, additional advanced courses are being organized throughout the year. The Evidence-informed Policy Network, established at the Regional Office in 2012, is a major vehicle for translating evidence into policy and for reporting on successes. Subregional health information networks, including the Central Asian Republics Health Information Network, have been set up to promote the harmonization and standardization of health reporting. *Public Health Panorama*, the Regional Office's new bilingual English/Russian public health journal, reports on intersectoral action and highlights successes in implementing policy in countries. The Health Evidence Network has gained renewed vigour, with several new evidence syntheses, including the integration of health information systems and chronic disease management; a series on migration and health will be presented at RC65. In addition, the Regional Office provides direct technical support to strengthen national health information and reporting systems and e-health strategies and activities for public health monitoring.

38. In the area of monitoring and evaluation, the Regional Office's activities include harmonization and standardization, guided by the WHO European Health Information Initiative, which has the support of Member States, WHO collaborating centres, the European Commission, the Organisation for Economic Co-operation and Development and foundations. A recent steering group meeting confirmed this initiative and provided a concrete workplan.

Proposal for follow-up

39. A progress report on implementing Health 2020 (document EUR/RC64/8 Rev.2) was submitted to RC64 in 2014. A summary of the final report on support provided to Member States by the Regional Office and the progress made by Member States in following up on the WHO European Ministerial Conference on Health Systems, held in Tallinn in 2008, is available in document EUR/RC65/8.

40. In view of resolution EUR/RC63/R8 on the status of resolutions adopted by previous RC sessions and recommendations for sunsetting and reporting requirements, RC65 may consider this document as an integrated report of interdivisional work within the framework of Health 2020 and as a final report on the implementation of behaviour change strategies and health. The Twenty-second Standing Committee of the Regional Committee for Europe recommended, during its fourth session in May 2015, sunsetting resolution EUR/R58/R8.

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health-and-well-being/publications/2014/targets-and-indicators-for-health-2020.-version-2, accessed 29 July 2015).

D. Progress on implementation of the International Health Regulations (2005)

Introduction and background

1. The current Ebola virus disease (EVD) outbreak has underscored the importance of having strong national and international mechanisms and capacities in place to rapidly detect, respond and take preventive measures to contain a serious public health threat. At the same time, it has highlighted the fragile nature of health systems in some countries, as well as the importance of a multisectoral approach.

2. The second International Health Regulations (IHR) Review Committee, which convened on 13–14 November 2014, concluded in its report[1] that the IHR have helped the international community to manage acute public health events and emergencies significantly better. Many States Parties have successfully assessed and strengthened their core national and local capacities.

3. The Review Committee indicated that implementation of the IHR, and the strengthening of public health capacities in particular, should be seen as a continuous process, as opposed to one that comes to an end on any particular date, including in 2016. These important shifts in perspective emphasize the integral relationship between the IHR, health systems and the need for sustained investment.

4. The Review Committee deliberated further that there are still many States Parties that are not yet ready to use and apply the IHR (2005)[2] on a daily basis in an operational way despite capacities being available. Annex 1A of the IHR (2005) outlines the minimum requirements, which most countries have achieved. Besides this general observation, the Committee emphasized the following key impediments to the IHR: insufficient authority/capacity of IHR National Focal Points (NFPs); high staff turnover; the specific needs of small island states and States Parties with overseas territories; the focus on IHR deadline extensions rather than on an expansion of capacities; and a perception that implementation is a rigid legal process with little emphasis on operational implications and learning from experience.

5. The Review Committee also underlined that the self-assessment of IHR implementation by States Parties is limited by the variable quality and reliability of the information provided. There is a need to standardize capacities and performance regarding information sharing. To date, IHR monitoring has focused more on administration, procedures and equipment (hard) and less on operational and outcome-based (soft) capacities. IHR implementation should advance stepwise from simple checklists to a more action-oriented approach to the periodic evaluation of functional capacities. The Review Committee discussed methodologies that can better assess

[1] Implementation of the International Health Regulations (2005): Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation. Geneva: World Health Organization; 2015 (EB136/22 Add.1; http://apps.who.int/gb/ebwha/pdf_files/EB136/B136_22Add1-en.pdf, accessed 7 July 2015).
[2] International Health Regulations (2005). Second edition. Geneva: World Health Organization; 2005 (http://www.who.int/ihr/publications/9789241596664/en/, accessed 7 July 2015).

quality and functional performance. The options discussed included assisted self-assessments, voluntary independent evaluations, peer reviews and certifications. It was also noted that there are no processes or systems currently in place to make the collection and dissemination of event-related observations and lessons learned an established practice. At the same time, the WHO Secretariat should promote a series of formal regional evaluations or meta-evaluations of the outbreak reviews, managed by the regional offices, to facilitate cross-regional learning and to assess lessons learned for future IHR programming. A new monitoring and evaluation scheme should be developed with the active involvement of the WHO regional offices. It would then be proposed to all Member States through the WHO governing bodies' process.

Situation analysis in the WHO European Region

6. Ten States Parties (18%) in the European Region had requested an additional extension until 2016 in order to further develop and strengthen capacities – the lowest proportion of extension requests of all WHO regions. Extension requests were national decisions and about half of the countries that requested an extension were developed countries. That shows that certain cultural, political and historical factors, such as the presence of overseas territories, affected these decisions. In many cases, the national decision process focused not only on developed capacities but also on operational arrangements and liability issues.

7. The information from the self-assessment questionnaire submitted by the European States Parties indicates quite high scores for all capacities. The functionality of the IHR in the European Region is limited mainly owing to issues not related to capacity, such as a lack of awareness, or by the inability to manage capacities, training gaps and the IHR as an operational tool. IHR implementation is often understood as a rigid legal process with no operational implications. Moreover, many countries with limited capacities did not request an extension. Finally, some countries misinterpret the relationship between the minimum requirements stipulated in Annex 1A of the IHR (2005) and (core) capacities in general based on the assumption that the IHR can be fulfilled only when all capacities are at maximum level.

8. In that regard, the Review Committee's discussion and report mark a new phase in working with the IHR, shifting the focus from the IHR as a capacity development framework to a tool that informs epidemic intelligence on a day-to-day basis in an operational way. For that reason, the designation of a team of NFPs and its authorization within all government agencies concerned are crucial. The IHR highlights the important role of NFPs, which serve as a communication hub between States Parties and WHO at all times. This information flow and exchange is the major component for epidemic intelligence and health security. However, some States Parties in the Region are not yet ready to use and apply the IHR in a timely manner.

9. The States Parties and the WHO Regional Office for Europe were involved in the response to major public health events both regionally and globally. A total of 61 public health events with serious potential international consequences were recorded in the WHO event management system for the WHO European Region between 1 January 2014 and 12 June 2015. Actions included the response to the Balkan floods of May 2014, which had devastating consequences in Bosnia and Herzegovina, Croatia and Serbia and significantly increased the risk of vector-borne diseases, and to imported

cases of Middle East respiratory syndrome coronavirus in Austria, Germany, Greece, the Netherlands and Turkey in 2014 and 2015 (as of 11 June 2015).

10. The Regional Office also proactively contributed to the management of the EVD outbreak in West Africa and related preparedness activities in the European Region. Together with the European Commission and the European Centre for Disease Prevention and Control (ECDC), it assessed the level of preparedness in Member States for events in relation to EVD or similar threats, provided tailored technical guidance to Member States to strengthen their preparedness, supported the medical evacuation of 13 Ebola responders (as of 12 June 2015) from West Africa, facilitated the management of and the contact tracing in the three cases of EVD diagnosed in the WHO European Region, and coordinated the inclusion of the clinicians treating a total of 16 cases in the WHO-managed International Severe Acute Respiratory and Emerging Infection Consortium, a peer network for practical support. The Regional Office followed the medical evacuation of 25 responders after high-risk exposure. Overall, the Regional Office contributed to the EVD crisis response with more than 1300 staff days, mainly through staff deployments to affected countries.

11. Throughout the year, the Regional Office attended all audio conferences and meetings of the European Commission Health Security Committee. During the latter part of the year, these took place weekly and provided an important platform for coordinating international preparedness and response to public health events in the Region and beyond.

Actions taken and progress made

12. This section describes the actions taken, progress made and challenges faced with regard to the seven areas of work that the Regional Office has developed. These areas of work are designed to respond to and to prioritize IHR needs in the European Region.

Work area 1: evaluating, strengthening and monitoring national IHR core capacities

13. While the Secretariat has continued to evaluate and to monitor national IHR capacities primarily through the annual self-assessment questionnaire and has provided guidance on strengthening these capacities, it has also contributed to the global discussion on a future monitoring approach.

14. The Secretariat was also invited to provide input on the approach to monitoring preparedness under Article 4 of Decision No 1082/2013/EU of the European Parliament on serious cross-border threats to health,[3] and to participate in pilot assessment missions of the Global Health Security Agenda.

[3] Article 4: preparedness and response planning of Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC. Official Journal of the European Union. 2013;L293:1–15 (http://ec.europa.eu/health/preparedness_response/docs/decision_serious_crossborder_threats_22102013_en.pdf, accessed 7 July 2015).

15. The Regional Office facilitated the pilot testing of an approach to align IHR assessment tools and the Tool for the Evaluation of Performance of Veterinary Services of the World Organisation for Animal Health in the European Region. The results will be used for the planned revision of the IHR monitoring process.

Work area 2: promoting high-level political ownership of the IHR implementation process

16. In order to increase whole-of-government ownership of the IHR, the Secretariat has organized bilateral high-level consultations and participated in national multisectoral interministerial working groups in eastern European countries. This included a discussion with the Director-General of the European Commission Department for Humanitarian Aid and Civil Protection to strengthen collaboration.

17. The Secretariat has continued to make key relevant WHO documents available in all official languages of the European Region, particularly Russian. One such publication is the guide for public health emergency contingency planning at designated points of entry.[4]

Work area 3: updating legislation and regulatory mechanisms

18. Another effective way to enhance high-level political ownership and multisectoral collaboration is to review existing legislation and to incorporate the IHR principles. The Regional Office continued to conduct legislative reviews in four States Parties in collaboration with WHO headquarters. Two more reviews will take place in the autumn of 2015.

Work area 4: empowering NFPs

19. NFPs should be empowered if they are to influence and be responsible for IHR implementation across sectors within their countries. This influence can be more readily obtained if NFPs are further trained in understanding the IHR principles and in catalysing existing resources to build and to manage IHR capacities. In its daily work with NFPs in the Region, the Regional Office provides guidance and training for risk assessment and reporting through its IHR contact point. A training course for NFPs is planned for October 2015.

Work area 5: undertaking awareness and advocacy efforts beyond the health sector

20. Intersectoral collaboration makes better use of resources by avoiding duplication and by enhancing coordination. Effective advocacy highlighting the benefits of the IHR will better convince sectoral policy-makers than focusing solely on obligations. This requires interpreting the IHR in terms of each sector's activities and interests. The Secretariat has developed a fact sheet and an infographic targeted at non-health experts

[4] International health regulations (2005): a guide for public health emergency contingency planning at designated points of entry. Geneva: World Health Organization; 2012 (http://www.who.int/ihr/publications/9789290615668/en/, accessed 7 July 2015).

and, by the end of the year, will have conducted three national workshops and exercises in the Balkan region to bring together the stakeholders from the different sectors.

Work area 6: training national personnel in building, managing and maintaining the capacities necessary for their country to comply fully with the IHR

21. After several years of preparation, the Secretariat developed and launched the first IHR course for the European Region, International Health Regulations in practice, held in Vihula Manor, Estonia, on 22–26 September 2014 in order to train Russian-speaking experts. In addition to staff working as NFPs, other key national experts from the countries were invited. It is planned to repeat the course for other countries and experts in January 2016.

22. Capacity for risk communication has been identified as one of the key priorities for effective use of the IHR at the national and international level. A series of training courses for national communications experts and emergency responders is planned. The first such course took place in Belgrade, Serbia, on 14–16 October 2014 and the second, for countries in eastern Europe and the Caucasus in Chisinau, Moldova, on 30 June–2 July 2015.

Work area 7: strengthening IHR capacities at points of entry

23. Because of their vulnerability to transient hazards, points of entry have a particularly important role in preventing the importation and spread of disease on a day-to-day basis, and special control measures should be ready for implementation in the case of an emergency. The Secretariat continues to organize, in collaboration with relevant partners, training workshops for ship inspections and emergency preparedness in the aviation sector, as well as, where appropriate, multicountry workshops, also involving other WHO regions, for neighbouring countries to exchange best practices and to develop bilateral agreements for certain ground crossings. In collaboration with the WHO Regional Office for the Eastern Mediterranean, a biregional workshop for the Caucasus, central Asian and eastern Mediterranean countries on cross-border collaboration was conducted in September 2014.

24. In March 2015, the Regional Office, the European and North Atlantic Office of the International Civil Aviation Organization (ICAO) and the National Institute for Public Health and the Environment of the Netherlands jointly organized the Fourth European Meeting of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA) at Amsterdam Airport Schiphol in the Netherlands. The discussions among 118 experts from 41 Member States from two different sectors and various levels resulted in a common understanding about gaps and practices in civil aviation in the European Region. The approach of the European Meeting is considered a best practice for the global CAPSCA process, and the model was presented during the ICAO–WHO CAPSCA Global Symposium, held in Montreal, Canada, in April 2015.

The way forward

25. Applying the IHR, providing training, strengthening priority capacities, and coordination and cooperation with all relevant partners in the Region remain priorities of the Secretariat. In particular, the Secretariat will continue to work with the European Commission and its technical agencies, such as the ECDC, to coordinate implementation of Decision No 1082/2013/EU and the IHR. The Secretariat has also identified Member States with specific expertise and partners in countries of the Commonwealth of Independent States to provide training and the exchange of best practices.

26. The Sixty-eighth World Health Assembly requested the Director-General to establish a Review Committee under the IHR (2005) to examine the role of the IHR in the Ebola outbreak and response, with the following objectives:

(a) to assess the effectiveness of the IHR (2005) with regard to the prevention, preparedness and response to the Ebola outbreak, with a particular focus on notification and related incentives, temporary recommendations, additional measures, declaration of a public health emergency of international concern, national core capacities, and context and links to the Emergency Response Framework and other humanitarian responsibilities of the Organization;

(b) to assess the status of implementation of recommendations from the first IHR Review Committee in 2011 and related impact on the current Ebola outbreak; and

(c) to recommend steps to improve the functioning, transparency, effectiveness and efficiency of the IHR (2005), including the WHO response, and to strengthen preparedness and response for future emergencies with health consequences, with proposed timelines for any such steps.

27. In response to that the Director-General will convene the third IHR Review Committee on 24 and 25 August 2015.

28. During its 136th session in January 2015, the Executive Board, in resolution EB136.R6, recommended implementation of the recommendations made by the second IHR Review Committee,[5] which was subsequently endorsed by the Sixty-eighth World Health Assembly in resolution WHA68.5 in May 2015. The Regional Office continues to provide input to the global discussion on how best to revise the approach to monitoring capacities in the long term and how to measure the quality of information sharing and the performance of NFPs. In July 2015, a concept note was developed by WHO headquarters and made available to European Member States through a web consultation. The Member States and the Regional Committee were invited to comment on whether they were in agreement with:

(a) the new principles proposed by the WHO Secretariat for an IHR monitoring and evaluation framework, following the recommendations of the second IHR Review Committee;

(b) the progressive change in monitoring, namely, from the self-assessment of capacities to a more function-oriented approach; and

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[5] See footnote 1.

(c) the proposed development process, that is, the tools and protocols to be developed further by the WHO Secretariat through technical and expert consultations with Member States.

Conclusions

29. The IHR is an operational framework with procedures and capacities that are legally binding for all States Parties. WHO supports the efforts of countries to implement the IHR, including the development of mechanisms for multisectoral and cross-border collaboration by facilitating common platforms for discussion and training at both national and international levels. The Regional Office focuses on elements and key capacities for the European Region to accelerate the operational use of the IHR on a day-to-day basis, taking into account lessons learned from the preparedness and response activities in relation to the Ebola crisis.

30. The IHR must be better integrated into generic national preparedness activities and plans in countries. The Regional Office will continue to work with the relevant sectors of governments of States Parties to ensure political commitment and resources and to support the work of intersectoral coordination committees. In that regard, Health 2020, the European health policy framework, is crucial for facilitating intersectoral collaboration towards implementing the IHR in relation to a broad range of hazards.

31. Sustainable financial investment and political commitment by national governments, as well as the external support of donors and partners, will be required for the effective implementation of the IHR.

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E. Progress on stewardship/governance of health systems in the WHO European Region (resolution EUR/RC58/R4)

1. The summary of the final report on implementation of the Tallinn Charter (document EUR/RC65/8) serves as the progress report on stewardship/governance of health systems in the WHO European Region (resolution EUR/RC58/R4).

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