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REPORT OF THE REGIONAL DIRECTOR ON THE WORK OF WHO IN THE EUROPEAN REGION 1998–1999

The attached document gives an overview of the main problems and challenges in the WHO European Region during 1998–1999 and WHO's response. It should be read in conjunction with the information document on budgetary performance for 1998–1999 (EUR/RC50/Inf.Doc./1).

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FOREWORD

The 1998–1999 biennium was a very special one for the European regional organization of WHO. In the more eastern part of the Region another economic crisis hit, sending government investment plans and people's hopes for a better future into yet another tailspin. In the Balkans increasing terror against the ethnic Albanian population of Kosovo inflamed the longstanding conflict and led to a full-scale war. Only in western Europe and a few other countries did things look brighter, as the European Union indicated its willingness eventually to include new member states and expand its role as a stabilizing force in the region.

For WHO's Regional Office for Europe (EURO), these and many other developments created new challenges, but they also opened up new opportunities. As this report shows, EURO's programme delivery during this two-year period has been impressive indeed. It is particularly encouraging that the results now show the impact of longer-term, consistent programme work. The systematic approach to helping countries, for instance to develop national Health for All policies and government master plans for their implementation (as in Armenia, Georgia and Kyrgyzstan), has now led to major improvements in national capacity for serious, planned developments. Clearly, the systematic pursuit of the EUROHEALTH programme for the countries of central and eastern Europe and the newly independent states and the large-scale development of long-term cooperation with all Member States through collaborative networks, such as those for healthy cities and health-promoting schools, and the fora for the health professions, have demonstrated how WHO can fully exploit its policy leadership and scientific strength to build country support programmes that are catalytic, relevant and cost-effective. The increasing support that EURO has now been getting for its programme activities from extrabudgetary sources testifies to the fact that this view is shared by others.

In that context, one particularly encouraging development has been the major boost given to the Regional Office in terms of staff and programme resources through the so-called European centres. Started in the early 1990s in the area of environment and health, these centres are established by formal agreement between the Regional Office (which organizes the work) and a country or major region within a country (which covers the expenditure). Such centres are fully managed by WHO, staffed by personnel recruited by the Regional Office and carry out projects that are part of the strategic biennial programme endorsed by the Regional Committee. Three Environment and Health Centres started in the early 1990s; during this biennium, the small one in Nancy, France, closed while the Rome and Bilthoven (Netherlands) centres continued their very active work. Furthermore, following extensive negotiations with different partners, a new Health Policy Centre opened in Brussels in December 1998 and a new Health Service Centre in Barcelona in September 1999, a new Health Promotion Centre will open in Venice in 2000 and a new Environment and Health Centre will be established in Bonn in 2001. Furthermore, a unique new partnership among major organizations and interested Member States led to the creation in February 1999 of the so-called Observatory for Health Care Systems, a major new facility for continued analysis of health care reform experience in European Member States and beyond.

These developments are indeed of major importance. Not only will EURO get a substantial amount of new staff and programme resources for its work in the years to come; even more significantly, they show that the Regional Office has now acquired a solid reputation with its Member States and major international partners, to such an extent that they are willing to invest major resources in cooperation with us for several years ahead.

As the report shows, there have been major achievements in many programme areas during the two years under review. The total interruption of poliovirus transmission, achieved at the end of 1998, was a significant milestone for the Region. It was also to the very well deserved credit of the hundreds of thousands of staff in our 51 Member States, in WHO and in many other collaborating organizations, whose joint efforts led to this remarkable result. The largest health conference ever held in the European Region in terms of political interest and Member States' commitment – the Third Ministerial Conference on Environment and Health, which took place in London in June 1999 – showed that this

EURO-led initiative has created a true Region-wide movement. This movement is now capable of pulling together all the major organizations at the European regional level and stimulating new multisectoral cooperation for environment and health in close to 90% of the countries of the Region. The development of a new family health nurse concept brought an enthusiastic response from the large nursing community. The ten-year review of the St Vincent movement (in Istanbul in October 1999) showed that, as a result of our persistent work to introduce new principles of quality of care for people with diabetes, major improvements in health outcomes can now be demonstrated in many countries. A rapid, large-scale response to the quickly changing situation in Kosovo resulted in two complementary developments: one was an extensive and diversified EURO programme of humanitarian assistance; the second was for WHO to provide health sector leadership within the United Nations administration in that war-torn territory – a new role for the Organization. EURO's long-term fight against tobacco gave the Regional Office a key position within WHO's new global programme on the Tobacco-Free Initiative.

Important as all these developments were, the key event during the biennium was the update of the Health for All policy for the European regional organization of WHO. The adoption of HEALTH21 by the Regional Committee in 1998 marked the end of a two-year process of scientific work. It also represented clear political acceptance from all Member States, both individually and collectively. HEALTH21 reflects changing health status and health determinants in the Region, and it incorporates the best evidence-based strategic advice for promoting healthy lifestyles, ensuring a healthy environment and designing cost-effective and quality-conscious health services.

The crucial significance of this development is not in the details of the policy itself, however. Its fundamental importance is the simple fact that the 51 Member States in the European Region decided to continue the systematic joint effort they started in 1980, i.e. to maintain a common policy framework to guide and inspire their own developments. Furthermore, they once again confirmed their commitment to do so, not as a one-off effort, but as a continuously monitored, periodically evaluated and systematically updated vision for the nearly 900 million people who live in the Region.

For 23 years I have had the pleasure of working for WHO in this Region, with the last 15 spent as Regional Director. Clearly there are challenges ahead, clearly there are problems to be confronted, clearly there are obstacles to overcome. However, never has the strategic vision for the future been more inspirational, the external support stronger and the Regional Office staff more capable than now. The competence, resilience and innovativeness of the women and men who work so hard to realize WHO's ideals in this part of the world bode well for the future!

J.E. Asvall
WHO Regional Director for Europe
Copenhagen, 31 January 2000

HEALTH21

Health for All policy framework updated

1. The updated regional Health for All policy framework (HEALTH21) was approved by the European Member States in September 1998 (resolution EUR/RC48/R5), following an extensive two-year consultation process with experts, networks, sectors, organizations and ministries. The two HEALTH21 publications[1] have been very well received in the Region. In addition to the 20 000 copies (11 000 of the introduction and 9000 of the full version) distributed in the four working languages to governments, WHO networks, collaborating centres and others, translations into national languages have been undertaken in Armenia, Denmark, Italy, Latvia, Lithuania, Poland, Romania, Slovakia, Spain, Sweden, the former Yugoslav Republic of Macedonia and Turkey.

2. The European Member States continue – as they have done now for 15 years – to take initiatives to make national policies in line with the regional Health for All policy. A recent WHO publication, *Exploring health policy developments in Europe*,[2] gives an overview of these activities. Countries which during the past 12 months have started or finalized new or revised national Health for All policy documents include Denmark, Finland, Italy, Kyrgyzstan, Lithuania and the United Kingdom.

3. In Armenia and Georgia the governments, supported by a consultant, organized multisectoral planning efforts to draw up national policies along the lines of HEALTH21. In Georgia the government, acting in cooperation with the Regional Office, was also able to develop a master plan outlining the government's own medium-term developmental response to the national Health for All policy.

Content of HEALTH21

4. HEALTH21 is not "business as usual" but emphasizes the following issues:

- solidarity and equity;
- the determinants of health: socioeconomic factors, genetics and the links between health promotion and the environment;
- the life course of people living in settings;
- multisectoral action and accountability;
- primary health care, especially as delivered by the family nurse and family practitioner;
- outcome-driven care;
- evidence for policy development, with emphasis on local implementation;
- global priorities and partners.

"Futures" as a tool for health policy development

5. Experience with carrying out the Health for All policy is kept under scrutiny by a built-in reporting and monitoring process. In addition, "health futures" meetings have proved to be a valuable tool in ensuring that the successive versions of the policy framework remain valid for the Region as a whole. In cooperation with the Nuffield Trust, a fourth consultation on health futures was held in London at the end of 1999, with a number of papers commissioned from various experts as well as input from the United Kingdom Foresight Programme. The meeting drew attention to the importance of evidence and research, and to the usefulness of forecasting coupled with alternative scenarios.

EQUITY AND SOLIDARITY FOR HEALTH

Between countries

Resource mobilization for humanitarian assistance

6. The Regional Office's ability to mobilize resources for the benefit of countries in need was strengthened through increasingly symmetrical relations with donors and greater in-house capacity to submit project proposals. Additional donors such as the Arabian Gulf Fund for United Nations Development (AGFUND) have been identified and subsequently provided support. A donor database has been built up and will serve as a model for the WHO global database.

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[1] *HEALTH21: an introduction to the health for all policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1998 (European Health for All Series, No. 5). *HEALTH21: the health for all policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).

[2] RITSATAKIS, A. ET AL., ED. *Exploring health policy developments in Europe*. Copenhagen, WHO Regional Office for Europe, 2000 (WHO Regional Publications, European Series, No. 86).

Bosnia and Herzegovina

7. In Bosnia and Herzegovina the situation has been slowly improving over the past biennium, both economically and with regard to health development. WHO maintains its presence in the country – currently it has five offices and some 35 staff, working with the ministries of the two entities in the areas of health policy, health care reform, primary health care, mental health, tuberculosis, HIV/AIDS, and lifestyles and health issues. The Liaison Office and the humanitarian assistance offices have been merged to create a more unified WHO country presence.

A new war in the Balkans

8. In March 1999, the tense situation in the Balkans exploded and NATO forces began attacking the Federal Republic of Yugoslavia. The Regional Office had maintained an office in Belgrade since 1992 and humanitarian assistance offices in Pristina (Kosovo) and in Albania since 1997, and in Podgorica (Montenegro) since 1998. When the war erupted, the Regional Office followed the advice of the United Nations and pulled its international staff out of Belgrade, Pristina and Podgorica.

9. In response to the sudden influx of hundreds of thousands of refugees into Albania and the former Yugoslav Republic of Macedonia, the Regional Office rapidly undertook a major reinforcement of its staff in Tirana and established a new humanitarian office in Skopje. Following this, a series of programmes for refugees were drawn up in very close cooperation with the national governments, other United Nations agencies and nongovernmental organizations (NGOs). When NATO forces entered Pristina, the Regional Office immediately re-established its international presence there, rapidly moving a major part of its humanitarian assistance staff from Skopje and Tirana, and it now has a major humanitarian assistance programme in operation.

10. The Office has helped local health authorities and coordinated health-related humanitarian assistance activities in Albania. Major programmes have been carried out to immunize people against poliomyelitis, upgrade laboratories throughout the country, manage essential drugs and replenish supplies of hepatitis B vaccine. EURO's field staff in Pristina, Podgorica and Belgrade are working closely together on providing humanitarian assistance to refugees from Kosovo.

11. Following the "stabilization pact", the United Nations became responsible for the administration of Kosovo, and WHO staff became the "health arm" of the United Nations administration. This is an extremely important development, not only for the Regional Office but for WHO globally. The Health Commissioner (seconded from EURO) has a team of international staff to help with planning and central functions, as well as five district managers to support the overall health service administration. In addition, the Regional Office's humanitarian field programme has mobilized 55 staff who provide direct assistance, advice and support to the United Nations Mission in Kosovo (UNMIK) and local institutions on all major areas of disease management and health services.

Kyrgyzstan

12. On 6 August 1999 armed guerrillas invaded a remote part of Kyrgyzstan and fighting broke out with Kyrgyz government troops. This resulted in a rapidly increasing number of refugees. The Regional Office participated in a United Nations assessment mission and provided immediate help in the form of medical supplies, at the urgent request of the government.

Dagestan

13. On 7 August 1999 guerrillas from Chechnya entered Dagestan and heavy fighting began with Russian government troops. The Russian government did not consider that international involvement was necessary, however, and WHO has not provided humanitarian assistance in this conflict.

Turkey

14. On 17 August 1999 a strong earthquake hit Turkey, with its epicentre south-east of Istanbul. It soon appeared that this was one of the most serious earthquakes in the Region this century. WHO responded in two ways: a staff member from headquarters specialized in earthquake damage assessment participated in a United Nations assessment mission, and WHO advised the Ministry of Health on how to organize the government's resource mobilization efforts. The earthquake affected a large area, caused massive damage to buildings, killed a large number of

people and wounded many more. While there was considerable criticism about many aspects of management of the disaster, health service interventions were considered to be adequate: the government quickly mobilized a large number of primary health care personnel from other parts of the country, established a helicopter link for evacuating the wounded to the best hospitals in Ankara and Istanbul, and created a public health task force to plan actions and inform the public. The Ministry of Health also quickly opened negotiations with the World Bank to reorient already allocated health development funds, so that they could be used for rapid repair and reconstruction of damaged health care institutions. The Pan-American Health Organization (PAHO) offered to help in that work through its Environment and Health collaborating centre in Santiago, Chile.

Earthquake in Turkey, September 1999

The devastating earthquake shook the ground of a large area covering the provinces of Istanbul, Kocaeli, Bolu, Yalova and Bursa, inhabited by nearly 20 million people. The reported death toll was over 15 000 and the number of injuries about 25 000. Furthermore, the earthquake left a considerable number of people homeless, the majority of whom are still living in temporary settlements. The combination of physical factors – the breakdown in water supplies, public health services and sanitation infrastructures – and the psychological after-effects of the earthquake place these people at high risk of contracting diseases that may turn into epidemics.

Forty-eight hours after the earthquake, international health teams started to arrive in the region. WHO also took immediate action to help with relief efforts and sent kits for the treatment of injuries and diarrhoeal diseases, as well as botulism antitoxin serum. The Director, Programme Management went to the region and supported the Ministry of Health in managing and coordinating the emergency response, in addition to acting as a coordinator for international assistance. An expert from WHO headquarters joined the United Nations Disaster Assessment and Coordination (UNDAC) team on its mission to assess the situation and the country's needs.

The Ministry of Health and WHO decided that the organization's most effective contribution would be to coordinate and manage support for the emergency response, in addition to providing a vision for the necessary public health measures. A team was formed and started working in close collaboration with Ministry of Health officials. The Regional Office has since organized regular missions to the earthquake area.

In order to prevent outbreaks of infectious diseases and provide decent environmental conditions to the inhabitants, three issues have been given priority in the work of WHO advisers: environmental health services, surveillance of communicable diseases and training (of both professionals and public).

No outbreaks have yet been reported, and the slight increase in communicable diseases can be attributed to improved surveillance after the earthquake. Some diseases, and especially diarrhoeal diseases, are being monitored on a daily basis in the region. With the onset of winter, attention has also been directed to acute respiratory diseases. Routine vaccination and monitoring services have been emphasized.

Given the psychosocial effects of a disaster of this extent, a WHO adviser also provided support in this respect. Nevertheless, post-traumatic stress disorders are expected to increase in the coming months.

15. During emergency operations in Turkey and elsewhere, WHO worked with both national authorities and local institutions, thus strengthening national capacities to undertake developmental activities as well as to deal with future emergencies. Its role as coordinating agency in various emergencies has helped the Regional Office to become a stronger advocate for disaster preparedness and to stimulate international cooperation.

16. The Office's disaster guidelines are updated on a continuous basis, and a WHO field manual has been made available. Networks of focal points, interested partners and resources have been

established, and a special "disaster room" has been set up at the Regional Office with dedicated telephone lines, computers and trained staff.

Within countries

17. The HEALTH21 policy framework emphasizes the need to reduce inequities between social groups in countries. The Regional Office's work here is focused on three main strategic elements: (i) support for better national information systems, that can reveal such inequities and their causes; (ii) in cooperation with interested NGOs and its new health communication network, raising awareness of the problem through the mass media and advocacy campaigns directed at more targeted groups; (iii) through analysis of innovative projects in Member States, providing countries with feedback on which interventions prove to be feasible and effective in reducing inequities among social, geographic and other groups.

18. An equity information package for policymakers has been developed. WHO's recently established European Centre for Health Policy supported preparation of the first equity report in Lithuania. This is closely tied in to the policy development process at national and local levels. A meeting of Balkan countries was also organized to promote their collaboration for health.

BETTER HEALTH THROUGHOUT LIFE

The life course approach

19. The life course approach as advocated in the HEALTH21 policy framework is a new way to seek more integrated support for health throughout life. Although many discrete elements are well known, there is no systematic "mapping" of the health values and life skills people need as they progress through life. This prevents objective assessment of such needs in population groups, and it also means that health promotion/health education programmes aimed at the individual are not currently underpinned by the necessary scientific instruments to monitor their impact and progress. The Regional Office will therefore endeavour to develop these fundamental tools. In support of more substantial work in the biennia to come, the Office has started to develop a conceptual framework and design an Office-wide project in this area.

A healthy start in life

20. The Family and Reproductive Health programme expanded rapidly during the biennium, with extra professional staff for child health and reproductive health being assigned to posts both at the Regional Office and in countries.

21. Encouraging results have been achieved three years after the start of the CARAK project in pilot districts of all the central Asian republics and Azerbaijan. This project has focused on perinatal health, family planning and integrated management of childhood illnesses. Maternal and infant mortality and post-delivery complications have decreased, and the number of breastfeeding mothers has increased.

22. The Office promotes a holistic approach of using evidence-based care and cost-effective interventions for pregnancy, birth, neonatal care and breastfeeding. Several workshops – on essential newborn care and breastfeeding, obstetric care, midwifery and nursing – were organized in the central Asian republics, Azerbaijan, Albania and the Republic of Moldova. A European task force was established in 1998 to outline strategies for carrying out effective perinatal care/safe motherhood activities, with a special focus on countries of central and eastern Europe (CCEE) and the newly independent states (NIS). In the framework of the Safe Motherhood Initiative, perinatal strategies and principles were adapted to the context of the Member States in the Region. These strategies and principles emphasize that maternal and perinatal care should be demedicalized (and based on appropriate technology), it should be multidisciplinary, holistic in approach and family-centred, and it should involve women in decision-making by enabling them to make informed choices. These values and principles have been well received and are being used by partners throughout Europe.

23. A major effort has continued with regard to sexual and reproductive health: the United Nations Population Fund (UNFPA) has been financing projects in an extensive cooperative programme with Armenia, Bosnia and Herzegovina, Georgia, Romania, the Russian Federation, Tajikistan and Turkmenistan. A reduction in abortion rates and wider use of family planning have been observed; and there is clearly a shift of preference from abortions to the use of contraceptives.

24. Another project in Bulgaria – funded by the European Union (EU) and with technical assistance from WHO, the International Planned Parenthood Federation (IPPF), the International Children's Centre (CIE) and other organizations – has laid the foundation for sustainable improvements through long-term changes in the university curricula for medicine, involvement of the mass media and the establishment of new family planning/reproductive health centres.

25. The OBSQID project for continuous quality management and development in perinatal care has helped to define pan-European indicators and variables related to perinatal outcomes, provides software solutions for the collection of data using these indicators, and acts as a node to allow for transnational inter-site comparison and outcome analysis. Centres demonstrating the best perinatal practices and the most rational, cost-efficient use of technologies can then be "twinned" with centres in need of such knowledge and expertise. The OBSQID database now comprises almost 13 million deliveries in 42 European Member States.

26. In 1996 the Regional Office launched a programme on the Integrated Management of Childhood Illness (IMCI), designed to give advice on how to provide basic care for the most common childhood illnesses, as well as on preventive measures and improved family and community practices. To introduce this approach in the European Region, IMCI has been piloted in Kazakhstan, and steps have been taken to give support to a number of other NIS.

Health of young people

27. In the biennium the Health Promoting Schools network, a cooperative venture between the European Commission, the Council of Europe and the Regional Office, grew to involve 40 Member States. Each country has selected a number of pilot schools to form the international network. In several countries, many additional schools are being recruited to form national associations. Through this process, the number of schools involved in the programme grows each year. In addition, national strategic developments for health-promoting schools are being seen in a number of countries, based on the practices developed by pilot networks. Health behaviour in school-age children was surveyed in selected countries and contexts, as part of a longer-term study.

28. *Healthy eating for young people in Europe*[3] summarizes the results of a cross-national school-based survey of nutrition education and the health of young people.

29. Special attention is being paid to adolescent reproductive health in a number of pilot approaches, and there is a component on young people in many country projects.

Health of adult people

30. Family planning and the promotion of sexual health has been a major focus of work in CCEE/NIS. Through the magazine *Entre nous*, policy updates and examples of good practice are regularly provided to countries and partners. A number of networks (including focal points for maternal and child health/family planning, the Scientific Advisory Group on Training and Research in Reproductive Health, the CARAK network, and coordinators of the reproductive health project) helped to speed up work in this area. Country projects on comprehensive reproductive health were carried out in 16 countries.

31. WHO facilitated regional implementation of the Platform for Action adopted at the International Conference on Population and Development (Cairo, Egypt, 1994). This includes a continuously updated database on assessment of progress, through monitoring of reproductive health process and outcome indicators at regional, national and subnational levels. International cooperation has been promoted with UNFPA, the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and EU, as well as bilateral donors.

32. Ministers gathered at the Third Ministerial Conference on Environment and Health (London, June 1999) recognized the importance of instituting workplace measures to meet public health needs and goals, and the right of workers to be involved in the process of making decisions about those measures.

[3] DIXEY, R. ET AL. *Healthy eating for young people in Europe. A school-based nutrition education guide.* Copenhagen, WHO Regional Office for Europe, 1999 (unpublished document available from the secretariat of the European Network of Health Promoting Schools, WHO Regional Office for Europe).

PREVENTING AND CONTROLLING DISEASE AND INJURY

Noncommunicable disease prevention and control

33. The Regional Office has continued to give strong support to the countrywide integrated noncommunicable disease intervention (CINDI) programme. This is a major WHO initiative for preventing noncommunicable diseases (NCDs) and promoting health. It addresses the major health problems in the Region: cardiovascular diseases, cancer, diabetes, chronic respiratory diseases, and others that share the same risk factors. Reducing smoking and tackling unhealthy nutrition, alcohol abuse, physical inactivity and psychosocial stress are priority targets. The programme aims to foster an integrated approach to the prevention and control of major chronic diseases and is focused on putting existing knowledge about prevention to best use – initially through demonstration projects, and subsequently countrywide. Twenty-six countries are now members of this network (24 from the European Region, as well as Cyprus and Canada) at both the demonstration and national levels. In 1999, there were 101 demonstration areas across CINDI countries.

34. Key characteristics of the CINDI programme include a policy framework for prevention, tried and tested preventive measures based on demonstrations at community level, scientific databases for planning and evaluation, trained personnel and guidelines to support preventive practices through primary care, organizational structures grounded in the various health care systems, and broad international cooperation.

35. In 1999, the most important developments were: an expansion of the network, the implementation of measures for changing people's lifestyles, better training for preventive practice, capacity-building in health promotion and disease prevention, and monitoring and evaluation of programme implementation.

36. Collaboration with the CARMEN programme – a PAHO NCD prevention programme that is based on the CINDI concept and methodology – was further strengthened. Two areas – monitoring and interventions regarding physical activity and the prevention of cardiovascular disease in people with diabetes – have been priority areas for joint work. The CINDI programme has been actively involved in drawing up a WHO headquarters document on a global integrated strategy for NCD prevention and control.

37. Seven CINDI participating countries have further developed their NCD prevention policy. Consultations with health policy-makers on NCD prevention and control policy were organized in Bulgaria and Turkmenistan. A forum to analyse inequalities in health and NCD prevention was established in Lithuania. The CINDI handbook on process evaluation in NCD prevention was issued in English and Russian. A database was established on the results of the survey of the use of public health services for NCD prevention.

38. In order to carry out the second comparative analysis of policy development and implementation processes in CINDI programmes, a questionnaire was elaborated and a survey conducted. A protocol and policy guidelines were prepared for the CINDI programme component on "Healthy children in healthy families". A number of countries further strengthened this component: a national protocol for the CINDI children's component was elaborated in the Russian Federation, and the Hungarian CINDI team launched a healthy kindergarten project.

39. Interventions regarding changes in people's lifestyle were focused on investment in smoking prevention and control (the international "Quit and win" smoking cessation campaign for adults), promotion of healthy nutrition, and community action for healthy lifestyles. In 1999, work also began on developing intervention packages for health professionals on smoking prevention and control.

40. In collaboration with the Office's Nutrition and Infant Feeding (NIF) programme, food-based dietary guidelines for health professionals were elaborated and a CINDI healthy nutrition pyramid was produced. Some CINDI member countries were assisted by the NIF programme to develop a healthy nutrition policy. CINDI became a partner in the Regional Office's food and nutrition action plan.

41. In order to improve prevention in primary care, recommendations for promoting good practice were translated/adapted in Belarus, the Czech Republic and Lithuania. A number of countries organized training courses on how to follow these guidelines.

42. In the area of capacity-building in health promotion and disease prevention, the third CINDI winter school training seminar for planners was organized in Helsinki in December 1999. International visitors' weeks, during which interested health professionals can learn how the CINDI concept is being implemented, were organized in Finland and Portugal in 1999. A process was started to develop and implement a Master's degree course in population health, and a number of consultations were organized with the Regional Office's programme for Health Care Delivery on continuing medical education to improve NCD prevention and control.

43. The CINDI data bank was further developed, and a databook was prepared on risk factors in CINDI participating countries. Pilot projects on a local health information system began in Germany and Slovenia.

44. In order to ensure the complementary impact of health promotion and disease prevention programmes, a consultation process was started to develop policy and programme frameworks. To this end an ad hoc committee was established and a paper was written on finding common ground towards a health promotion and disease prevention framework. The second meeting of the Ad Hoc Committee took place in 1998.

45. An information package to help disseminate knowledge of preventive interventions was prepared as part of the group of seven industrialized countries' (G7) project on "Promoting heart health".

Stroke

46. WHO advocates multidisciplinary collaboration to reduce case fatality and improve the quality of life of stroke survivors. The principles set out in the Helsingborg Declaration on Stroke Management[4] remain extremely important. The Declaration was further disseminated through various international and national meetings and associations. An outline of guidelines on the organization of a stroke unit was elaborated. Italy and Norway prepared national guidelines on stroke management; Latvia and Lithuania started regional projects on improving stroke management.

Hypertension

47. A multidisciplinary approach to hypertension management and control was strengthened through collaboration with the EuroPharm Forum and activities carried out by a network of countries. National hypertension guidelines based on WHO material were prepared and training seminars were organized in Estonia, the Republic of Moldova, Slovakia and Ukraine.

Coronary heart disease

48. In order to improve outcomes of coronary heart disease (CHD) rehabilitation and secondary prevention, draft guidelines for general practitioners on the education of CHD patients were designed. In collaboration with the WHO Collaborating Centre for Research and Training in Rehabilitation and Secondary Prevention in Cardiovascular Disease (Udine, Italy), pilot implementation of guidelines for improving the quality of life of CHD patients was started in two regions of Italy.

Diabetes

49. The Regional Office has continued to promote the St Vincent movement for improved management of diabetes, in very close cooperation with the European branch of the International Diabetes Federation and the European Association for the Study of Diabetes. As a result, there are now signs of major improvements in health outcomes and a reduction in health care consumption in many pilot areas in the Region, including the NIS. WHO promotes quality management in diabetes by participating in national, regional and international meetings.

50. Considerable progress has been made in carrying out the St Vincent Declaration[5] programme in all Member States, especially CCEE/NIS. The fifth meeting on implementation of the Declaration was held in Istanbul in October 1999, attended by approximately 700 participants from 57 countries. The Istanbul Commitment was adopted for further improvement of diabetes care, and the programme has become global in scope, spreading successfully to other regions.

[4] *Pan-European consensus meeting on stroke management, Helsingborg, Sweden, 8–10 November 1995*. Copenhagen, WHO Regional Office for Europe, 1996 (unpublished document EUR/ICP/CIND 94 07/MT02).

[5] Diabetes care and research in Europe: the St Vincent Declaration. *Diabetic medicine*, **7**: 360 (1990).

51. In November 1999 the Regional Office organized a first meeting of WHO collaborating centres in diabetes, at which an action plan for the next biennium, in line with the HEALTH21 policy framework and the Istanbul Commitment, was discussed.

Belarus

Thanks to a national programme along the lines of the programme to implement the St Vincent Declaration, the quality of diabetes care has improved and diabetes complications have been reduced: retinopathy has fallen from 35% to 17% (and blindness from 2.1% to 0.46%), and above-knee amputations have been reduced from 1.7% to 0.66%, owing to interventions by the Diabetes Foot Centre. The outcome of diabetic pregnancies has improved. A computerized network for monitoring data on diabetes has been established. Ninety-one centres have been set up to educate people with diabetes and to train them in self-management techniques. An oral health programme, which has achieved good results with the prevention of caries, has been launched as a model for other newly independent states.

Mental health

52. Given the panorama of needs in Europe and the HEALTH21 policy framework, WHO's efforts have concentrated on three topics: (i) fighting helplessness and stress-related morbidity and mortality due to depression, suicide, violence, abuse and other forms of risk-taking and destructive behaviour, which are the main causes of premature death in Europe's societies in transition – and especially among men and in rural populations; (ii) fighting the stigma of being mentally vulnerable, by raising people's awareness, and enhancing early recognition and intervention, humanization and reintegration; and (iii) facilitating, at countries' request, national audits of mental health (MNH), as a prerequisite for drawing up national MNH plans and action programmes.

53. WHO task forces and pilot programmes have been set up on destigmatization (for example, in connection with epilepsy, psychosis and depression), on national MNH assessments (e.g. in Poland and Romania), and on helplessness and stress-related morbidity and mortality (e.g. in Germany and Lithuania). Several countries took steps to draw up national plans to update their legislation on MNH. A network of all the European WHO collaborating centres on MNH was formed, as was one of national counterparts designated by the respective ministries. The Regional Office contributed actively to the Organization-wide discussion on depression and suicide and is expected to play a leading role in future global action in this area.

54. As a matter of the greatest concern and urgency, WHO also had to focus on mental health repercussions of the war and post-war situation in the Balkans. Its initial efforts have been concentrated on alleviating the special situation prevalent in Bosnia and Herzegovina and, more recently, in Kosovo, as well as in the former Yugoslav republic of Macedonia, Albania and Montenegro. Senior professionals have been designated to advise on and coordinate national MNH activities. A special approach to the Balkan region has been adopted, supported by a specific network. A series of activities have been carried out to help countries plan for mental health, build community-based MNH services and start intersectoral cooperation, as well as modernize and humanize mental health structures and legislation. Activities in the Balkan region are currently focused on reconciliation and on improving the accessibility and quality of the MNH services needed by populations afflicted by stress, humiliation, loss of identity and feelings of helplessness.

55. One particularly interesting development within the area of depression is the introduction of the "Wellbeing five" questionnaire, a set of simple questions that measure the level of well-being and can help identify any individual who may have serious depression requiring treatment. The questionnaire, with a "score system" and instructions for scoring answers, can be accessed through the Regional Office's website. This easy-to-use approach allows anyone to do a quick test on the status of their "wellbeing" and will help professionals identify people at high risk of being seriously depressed. There

are several reasons for EURO's involvement in this area, the most important being that unipolar major depression is the leading global cause of disease or injury as measured by disability-adjusted life years (DALYs) – more than twice as important as either tuberculosis or road traffic accidents, the next two leading contributors. An information pack on measuring depression in primary care was finalized and is now in use in various sites, primarily in CCEE/NIS.

56. A pilot programme in the Region has indicated that special training programmes for primary health care personnel can improve the treatment of depression and thus reduce the number of suicides – in particular among women. New research has also revealed a hitherto unknown fact, that postpartum depression is not a female prerogative; men often have serious depression in connection with the first pregnancy in the family, and a considerable proportion of family violence probably starts around such events.

Injuries, accidents, violence

57. A collection of case-based data on domestic violence and mental health, in paper form, has been scanned into the MNH database. A dedicated homepage offers an easily accessible supranational information base of aggregate data and definitions, with approximately 20 contributors. A separate pilot project on violence during pregnancy is under way; the first results were presented at a meeting organized by the Council of Europe.

58. In the area of child protection, activities were carried out in the following fields: child abuse and neglect, domestic violence against women and children, children's health and the environment, and adolescent health. A comprehensive approach was developed, addressing the broader determinants which affect the psychosocial development of children. Strategies for the prevention of violence against women were taken up by Member States. Contributions to the prevention of domestic violence were made by experts from different parts of the world, as well as by the International Society for the Prevention of Child Abuse and Neglect.

59. Violence at work is a growing public health problem, associated with a shift of a large part of the workforce to the service sector. A 1996 European Union survey revealed that 2% of employees complained of sexual harassment, 4% of physical harassment and 9% of psychological harassment. This particularly applies to the increasing number of working women.

Infectious disease prevention and control

Immunization

60. Although the diphtheria epidemic in NIS is now under control, the situation in some countries (Georgia, Kyrgyzstan, Latvia, the Russian Federation and Tajikistan) is still causing great concern. Measles is a serious public health problem in most NIS and some CCEE. While original estimates had suggested hepatitis B surface antigen prevalence of 2–8%, findings ranged from 2% carriers in the Baltic States and northern European countries to 5–10% in Albania, Bulgaria, the Republic of Moldova, Romania and the central Asian republics. Average levels of vaccination coverage are quite high, but they vary greatly from country to country, and efforts need to be made to reach at least 90% coverage for diphtheria, pertussis, measles and tetanus.

61. Two annual meetings of the Interagency Immunization Coordinating Committee (IICC) were held and plans for further activities were revised and agreed. The Committee decided to maintain its function in the future, with the main aim of helping countries to achieve self-sufficiency in supply of the vaccines required for the Expanded Programme on Immunization (EPI).

62. Routine immunization in all NIS was maintained by mobilizing the donor community to supply vaccines. A commitment was made by one of the donors (the government of Japan) to provide sustainable support to three central Asian republics for the next five years.

63. A workshop was organized on quality control and vaccine procurement, and 13 specialists from different countries of the Region attended various training courses on issues related to the quality control of vaccines, within the Global Training Network framework. Missions visited Poland, the Republic of Moldova, Turkey and Ukraine to assess the sustainability of immunization programmes and vaccine quality control.

64. Under the EPI, immunization coverage at two years of age remains high and stable in the Region. Measles is close to being eliminated in some countries, and epidemics have been prevented by mass campaigns in two others.

65. Subregional EPI meetings on measles elimination were held for countries of central and eastern Europe, the central Asian republics and Kazakhstan, member countries of the EU and those participating in the intergovernmental framework for European cooperation in the field of scientific and technical research (COST), while 23 countries of the Region assessed the situation with regard to developing national elimination plans. Safe injection policies relevant for the NIS were included in the new intermediate-level training course and were implemented at national level in some countries with UNICEF support. A five-year subregional plan for the NIS, designed to help meet their needs for cold chain equipment and logistics support, has been recently revised.

66. The measles control campaign in Romania was evaluated in February 1999. In collaboration with the United Kingdom's Public Health Laboratory Service (PHLS) and the Pasteur Institute in Paris, steps have been taken to set up a laboratory network for pertussis surveillance. In addition to the routine EPI surveillance and monitoring system already in place, a database has been developed in cooperation with the Informatics Support Service (ISS) at EURO and with support from WHO headquarters which will allow for the case-based analysis of diphtheria and measles, in the first instance.

67. Meetings of the European Advisory Group and of EPI programme managers took place during the biennium, at which the draft of a strategic plan on immunization and vaccines was developed and the operational targets for the EPI, and on hepatitis B in particular, were adjusted.

68. A revised edition of the cold chain manual was published and distributed in the NIS. A new course for mid-level EPI managers was developed in Russian, based on the experience gained in three pilot sites, and one course was held in 1999 using the new material. Translation into Russian has been extremely prompt and efficient, due to the investment in better communication between the EPI and the Pasteur Institute in St Petersburg.

Diphtheria

69. The European Working Group on Diphtheria meets annually. Thanks to excellent cooperation with the WHO collaborating centre for diphtheria at the PHLS, additional funds have been identified from the EU's Copernicus project to support laboratory research in the NIS. The ribotyping method (the "gold standard" for strain identification) was developed and the software provided to members of the Group, free of charge, by the Pasteur Institute in Paris. Laboratory kits were distributed to Armenia, Belarus and Ukraine, and laboratory media were sent to the Russian Federation. A meeting of laboratory representatives took place in Latvia in December 1999. All Member States have a national reference laboratory for diphtheria. (See below.)

Poliomyelitis eradication

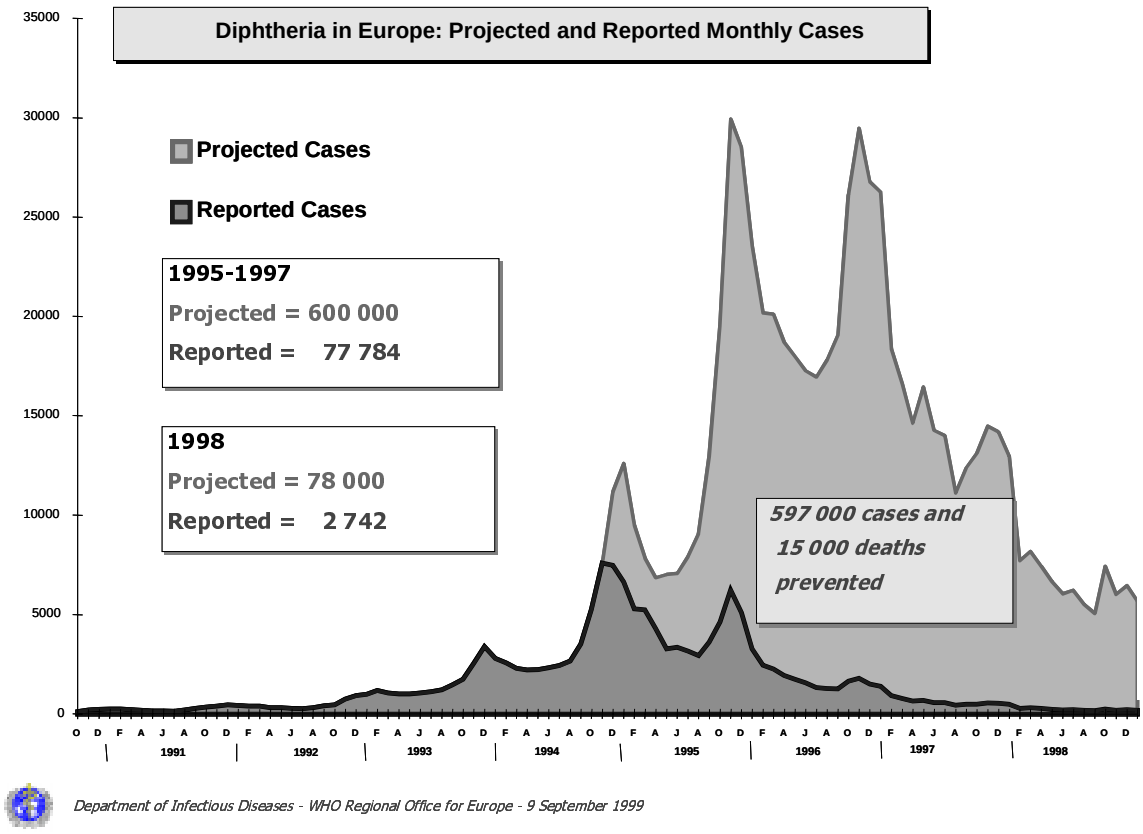
70. Global efforts to eradicate poliomyelitis continue to progress well, with large areas of the world now free of poliomyelitis and a fall of 85% in annual incidence since 1988, when global eradication measures began. Substantial progress has also been seen in the European Region.

71. In 1998, there was poliomyelitis transmission only in Turkey, which resulted in 26 cases. Following a meeting with the Regional Director in December 1998, the country's President undertook to make a personal effort to mobilize all possible resources in an intensified campaign to eradicate the last foci of transmission in the country. This promise was kept: WHO and the Turkish government cooperated on special planning and mobilization of a large number of sectors. In addition, intensified immunization campaigns were carried out in high-risk areas. These activities were undertaken in the spring and autumn of 1999. As a result, no new cases of poliomyelitis or wild polioviruses were detected during 1999.

72. Intensive immunization programmes have continued, and efforts to improve acute flaccid paralysis (AFP) surveillance have been much strengthened in all countries of the Region. This enhancement of surveillance resulted in a non-polio AFP rate, during 1999, of 1.35 in 17 recently endemic countries (as compared with an expected rate of 1.0), with two stool samples being collected in 84% of AFP cases. Ten of the 17 recently endemic countries and 3 of the 22 other countries also undertaking AFP surveillance met the expected standard of 80% or higher of cases with two specimens.

Diphtheria control

The EURO-led international campaigns in partnership with the NIS managed to stamp out the diphtheria epidemic that ravaged the European Region in the middle of the 1990s, and it is estimated that some 600 000 cases and 15 000 deaths were prevented through the large-scale mobilization that EURO organized during 1997–1999, in cooperation with 15 countries and many organizations and donors. Despite this considerable achievement, further efforts need to be made in countries where diphtheria is not yet under control, in order to ensure that it is no longer a public health problem in the Region.



73. The regional poliomyelitis laboratory network continues to operate effectively; 95% of samples from AFP cases are now processed in the network. The Regional Poliomyelitis Eradication Certification Commission reviewed special documentation from 32 non-endemic countries in Europe, so the process to formally certify the Region as truly polio-free by the year 2003 is proceeding well.

74. Operation MECACAR (involving activities in WHO's Eastern Mediterranean Region as well as the area of the Caucasus and the central Asian republics) is the key to achieving the goal of poliomyelitis eradication in the Region. EURO has received strong support from WHO headquarters, UNICEF, the Centers for Disease Control (CDC) in Atlanta, GA (United States), Rotary International, the United States Agency for International Development (USAID) and the United Nations Foundation. Interregional cooperation will continue in the next biennium.

Tuberculosis

75. Tuberculosis has continued to increase sharply in the Region, predominantly in eastern Europe and the NIS, where it is spreading at an alarming rate. One particularly worrying aspect is the substantial multidrug resistance, again predominantly in eastern European countries. In Latvia, for instance, multidrug resistance affects one third of the infected population. Twenty-five countries in the Region are participating in a

supranational laboratory network for surveillance of drug resistance.

76. The Regional Office, in close cooperation with WHO headquarters, has strongly promoted the "DOTS Plus" strategy for case management of multidrug-resistant tuberculosis, which should now be adopted by all countries in the Region. During the biennium, 16 countries started to implement or prepared for DOTS. The Regional Office is now elaborating a new long-term strategy for assistance to all high-incidence countries in eastern Europe, a programme which will be a huge challenge and will require strong support from the Member States. Four international training courses in Estonia and Poland were milestones for tuberculosis training in the Region. National training courses were held in 16 countries. International meetings, training of primary health care personnel and mass media campaigns all helped to raise people's awareness and build up countries' capacity to deal with tuberculosis.

Malaria

77. There was a dramatic resurgence of malaria in a number of countries in the south-eastern part of the Region in the mid-1990s, as a result of economic instability, civil wars, massive population movements and large-scale hydro-agricultural projects. The countries mainly affected are Armenia, Azerbaijan, Tajikistan and Turkey; in 1996, about 90 000 indigenous cases were reported in the Region.

78. Full-time staffing, substantial voluntary contributions and assistance from WHO headquarters allowed EURO to launch the regional Roll Back Malaria programme in 1998. A thorough assessment was made of the malaria situation in the Region, and an overall regional strategy was developed in line with the global effort. Plans of action were prepared for the control of epidemics at subregional and country levels. Project proposals were submitted to donors to elicit financial support.

79. The limited funds available in EURO for epidemic prevention and control were used to provide antimalarial drugs and to reinforce health structures for the immediate implementation of malaria control activities. The Office provided technical assistance for carrying out malaria control projects in Armenia and Tajikistan, with financial support from Denmark, Italy, Norway, Sweden, Japan, the European Community Humanitarian Office (ECHO) and the United Nations Development Programme (UNDP). National guidelines for malaria prevention and control were updated, and manuals and other documents were translated into relevant national languages, printed and distributed. Finally, assistance was coordinated with other international and nongovernmental organizations. Valuable help with training activities was given by the WHO collaborating centres in Rome (Istituto Superiore di Sanità) and Moscow (Martsinovsky Institute and the Central Institute for Postgraduate Medical Training).

80. As a result of the activities implemented during the biennium the malaria epidemics were contained, and in some countries a significant decrease in incidence was observed: there were about 62 000 indigenous cases in 1998, compared with 75 000 cases in 1997. A further decrease was registered in 1999.

HIV/AIDS

81. It is very encouraging indeed that the number of AIDS cases is continuing to fall in the Region: in 1998, there were only about half as many as in the peak year (1994). This is no doubt due to the very strong preventive programmes carried out in western Europe since 1985, and possibly also (during the past few years) to the new drug treatment, which may delay the onset of AIDS in some HIV-positive individuals. Unfortunately, the situation has been less good in the more eastern part of the Region: the opposite trend was observed during the latter part of the 1990s in the Russian Federation, Ukraine and other countries, with intravenous drug use being a major reason.

82. In order to discuss the serious situation in eastern Europe, a meeting was organized during the World Health Assembly in May 1999 among the secretariats of UNAIDS, WHO, UNFPA, UNICEF and the World Bank, where it was agreed that efforts should be intensified and a joint regional strategy should be developed. These organizations, co-sponsors and bilateral agencies subsequently met for this purpose, while the strategy was prepared through a series of technical meetings and consultations with Member States.

Sexually transmitted infections

83. A strong epidemic of syphilis has been observed in the European Region, and also of other less well reported sexually transmitted infections (STI) in the NIS. The Regional Office, in cooperation with many other partners, has therefore made intensified efforts to control this epidemic.

84. At country level, a series of activities have been undertaken to promote the policy recommended by WHO and to build capacity for local control, including the development and support of best practice sites, pilot projects on STI care and prevention for sex workers, and for men having sex with men, promotion of better case management, etc. During the biennium, the WHO policy on STI prevention and care was introduced in practice by ten countries. EURO is working with UNICEF to integrate school sexual health education within the Health Promoting Schools Network and is advising on HIV prevention among injecting drug users in eastern Europe (as a member of the UNAIDS Task Force on HIV). STI/HIV prevention, control and care has started to be addressed as a coordinated and integrated approach in a number of countries.

85. In order to strengthen international assistance in this field, the Regional Office in 1998 set up a task force for the urgent response to the STI epidemic in eastern Europe and central Asia. The Task Force brings together a wide range of United Nations agencies, multilateral and bilateral agencies and NGOs, and has led to the creation of a strategic framework for a harmonized approach. The Task Force is funded by the United Kingdom, the United States and the Soros Foundation. Staffing levels at the Regional Office are being increased, in cooperation with UNAIDS.

Diarrhoeal diseases/acute respiratory infections

86. Diarrhoeal diseases/acute respiratory infections (ARI) are still the main causes of mortality and morbidity among children under five years in most countries in transition in the Region. Many countries have requested more integrated approaches that go beyond individual diseases and address the overall health of the child. The strategy for integrated management of childhood illness (IMCI) constitutes such an approach, by combining improved management of the major childhood diseases with aspects of nutrition, immunization and several other important influences on child health. Programme activities have therefore gradually shifted towards implementation of the IMCI strategy in most of the directly benefiting countries.

87. Translated materials for in-service training in control of diarrhoeal diseases (CDD) and ARI were disseminated for use in courses at national and district levels. Student manuals on diarrhoea and on management of ARI in small hospitals were translated into Russian and distributed to selected medical institutes. A workshop determined strategies for strengthening the teaching of major childhood illnesses in preservice training institutions. Technical support was given to countries in planning, monitoring and consolidation of CDD/ARI activities.

Emerging/re-emerging and other infectious diseases of public health importance

88. An uncontrolled outbreak of a communicable disease in one country is a concern for all countries in the Region, as well as for other continents. The Regional Office has established a special unit to strengthen the Region-wide capacity for surveillance, as well as that of individual programmes in Member States. A new computerized information system on communicable diseases (CISID) was developed in 1999. This will allow the maintenance of a communicable disease database (with direct reporting of disease incidence by counterparts through the World Wide Web), advanced analysis of data, and presentation of outputs also on the Internet. Collaboration with the European Commission (Directorate-General V) is being built up, in order to coordinate the activities of the two organizations in this field. There is close cooperation on epidemiological surveillance of HIV/AIDS in the NIS and Baltic States.

89. The EU's database of surveillance country profiles covers 18 countries and, in collaboration with the WHO collaborating centre in Rome, EURO is extending this approach to other countries of the Region.

90. A draft strategy on surveillance was developed in consultation with WHO headquarters, the EU and other partners, and a comprehensive

strategic plan for capacity-building was drawn up with the same partners.

91. The assessment of dracunculiasis eradication in Uzbekistan was finalized.

MULTISECTORAL STRATEGIES

Environment

The 1999 London Conference

92. Political commitment to the Environment and Health process remains strong across the Region. In 1999 there were major advances in this area. Intensive preparations over the previous two years, led by the European Environment and Health Committee (EEHC) and supported by its Regional Office secretariat, made the London Conference in June 1999 a major success. Many preparatory meetings were held on ten technical areas, to each of which a so-called "lead country" was assigned, in cooperation with WHO, the Economic Commission for Europe (ECE), the European Science Foundation, the United Nations Environment Programme (UNEP) and the European Commission (EC). Extensive background material on each subject was condensed into succinct working papers for the Conference. Particularly important initiatives related to children, public participation, local action, research, transport and water.

93. In the research area, very close cooperation between the European Science Foundation, Directorate-General XII of the European Commission and the Regional Office's Rome and Bilthoven divisions resulted in a key document outlining priorities for environment and health research in Europe. A strong commitment was made by the three organizations to continue their "research platform" for the next five years.

94. A special Declaration was adopted in London, incorporating the main principles set out in the ten background documents. The whole process of adoption was greatly facilitated by a thorough technical review of the draft Declaration by representatives of all Member States in Bled, Slovenia, in February 1999. A particularly interesting feature of the whole process was the involvement of NGOs. They were invited to participate from the beginning in different working groups and organized a parallel conference in London, the Healthy Planet Forum. The London Conference decided that a fourth Ministerial Conference on Environment and Health would be held in Hungary in 2004. The Conference identified a number of priority issues for the next five years:

- ***A legally binding Protocol on Water and Health*** to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes, designed to help prevent, control and reduce the incidence of water-related disease through collaboration on water management and protection of health and the environment. The new Protocol, which results from close cooperation between the Regional Office and ECE, takes a broad, integrating view of the management of a country's total water resources – drinking-water, recreational water, wastewater, etc. Thirty-five Member States signed the Protocol in London and more may do so in the following 12 months through the United Nations Treaty Office in New York.
- ***A Charter on Transport, Environment and Health***, through which Member States of both the EU and WHO commit themselves, at international and national levels, to reducing the significant adverse health effects and barriers to community development created by transport-related air, soil and water pollution, accidents and noise, greenhouse gas emissions and damage to forests, and to increasing the health benefits of physically active modes of transport, notably cycling and walking (including to and from means of public transport). The Charter is based on pilot studies and analyses that showed the value of looking at the whole range of links between health, transport and the environment. A decision was taken to pursue work to see whether a legally binding Convention should be later elaborated for the countries in the Region.
- ***Implementing NEHAPs in partnership*** – When ministers agreed at the Helsinki Conference in June 1994 to develop national environmental health action plans (NEHAPs), they created an extensive movement. The level of response has been unprecedented; 43 out of 51 countries (84%) have developed or have started to

develop NEHAPs. Over 20 of these countries are already in the implementation phase. Some EU Member States and all countries in the process of acceding to membership of the EU have had their NEHAPs adopted by parliament and/or government and are carrying them out. The NEHAP movement in Europe has fostered increased multilateral and bilateral collaboration at country level. Considerable support and funding was provided by some EU Member States, either to the intercountry activities of the NEHAP programme or to cooperation with some of the accession countries.

- ***Local processes for environment and health actions*** – Local actions to improve health and the environment are to be drawn up and carried out in the countries, either as part of other relevant plans (such as local Agenda 21 or Healthy Cities action plans) or separately, and should be designed to achieve distinct local environment and health improvements.

- ***Access to information, public participation and access to justice in environment and health matters*** – Member States are committed to giving the public effective access to information, improving communication with them, securing their role in decision-making and providing them with access to justice in environment and health matters. In addition, governments are to take steps to promote the development of a comprehensive, easily accessible network of databases on environment and health issues, involving as appropriate representatives of major providers and users of environment and health information.

- ***Health, environment and safety at work*** – The London Declaration recognizes the need for a holistic approach to health and the environment in enterprises. Good practice in this area focuses on improving health by reducing the rates of occupational accidents and diseases, work-related diseases and those which are non-occupational but preventable at the workplace (e.g. AIDS, alcohol abuse), as well as on preserving the general environment through pollution prevention and control, management of product life cycles, and efficient use of environmental resources.

- ***Economic perspectives of environment and health*** – So far as is necessary, Member States will develop their capacities to carry out economic analysis, in order to use this tool in efforts to meet their commitments. In particular, they will strengthen their national systems of strategic environmental impact assessment so as to include health concerns and ensure that environment and health considerations are integrated into policies. Lastly, Member States will promote the full internalization of environment and health costs, and the preparation of strategies for achieving this.

- ***Children's health and the environment*** – The London Conference recognized the special vulnerability of children and reproductive health to environmental threats, and called for policies to be developed and action taken to provide children with a safe environment. The focus is on accident and injury prevention and treatment and on protecting children's health from environmental hazards, aimed in particular at reducing injuries, asthma, allergies and emerging contaminants.

- ***Early human health effects of climate change and stratospheric ozone depletion*** – Member States recommended the establishment of a Europe-wide interagency network for monitoring, researching and reviewing the early human health effects of climate change and stratospheric ozone depletion; for developing and advocating prevention, mitigation and adaptation policies; and for identifying specific research priorities in that field, with the EEHC invited to act as a coordinator.

- ***Environment and health research for Europe*** – Research activities are to be part of an integrated and coordinated pan-European effort supported by EC, the European Science Foundation, WHO and, where relevant, other international organizations.

- The ***European Environment and Health Committee*** will continue, with an extended and strengthened mandate, to coordinate the efforts being made by Member States and international organizations to give effect to the decisions taken at the London Conference.

95. In addition to those action-oriented topics, other items are important in that they form the basis for development and evaluation of an integrated environmental health policy. These relate both to policy-making tools, such as building and maintaining the evidence base or designing risk assessment methodologies, and to media-specific issues such as air, drinking-water and food quality. The latter include:

- food safety
- chemical safety/risk assessment, air quality
- radiation and health
- waste management
- geographical information systems.

96. The WHO Regional Committee for Europe in September 1999 requested the Regional Director to continue to provide leadership to the Environment and Health process in the European Region, and endorsed the decision to extend the remit of the European Environment and Health Committee and to broaden its membership. It also authorized the Regional Director to carry out the secretariat functions for the Protocol on Water and Health (resolution EUR/RC49/R4).

Third Ministerial Conference on Environment and Health

"Action in Partnership"

The third European conference of ministers of health and of the environment took place in London in June 1999. Building on the strong and accelerating momentum of the Frankfurt (1989) and Helsinki (1994) conferences, it became the biggest health-related conference ever held in Europe, attracting 72 ministers and more than 1100 participants from 55 countries.

Three major outcomes were achieved:

- A Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes. The Protocol, a legally binding instrument prepared jointly with the United Nations Economic Commission for Europe, was signed by 35 countries at the London Conference. Many countries expressed strong support for the Protocol and voiced expectations that it would be an effective instrument in tackling the serious burden of water-related diseases and the present problems of water management, water supply and sanitation currently being faced in the European Region.
- A Charter on Transport, Environment and Health. The Conference recognized the value and necessity of mobility for today's society, but it expressed concern that adverse effects on the environment and health would increase and called for urgent steps to be taken to alleviate them as much as possible. The Charter was welcomed as a framework for measures such as integrating health concerns within transport policies; increasing walking and cycling; and internalizing the external costs due to transport. The potential to reduce car use while promoting cycling, walking and public transport was also noted. Future work on the Charter will include an assessment of the need to develop it into a legally binding international instrument.
- The London Declaration. The Declaration summarizes the state of Europe's environment and health at the start of the twenty-first century. It commits Member States to carrying out the actions decided on in the 11 areas addressed at the Conference, and it establishes the framework for the future of the Environment and Health for Europe process, which will lead to a fourth Environment and Health conference in 2004, to be hosted by Hungary.

97. In preparation for the London Conference, a number of activities were carried out.

NEHAPs

98. The NEHAP implementation strategy was prepared by the NEHAP Task Force, based on country input. A strategy document was reviewed and approved by a pan-European meeting of senior government officials, organized jointly by the European Commission and WHO and held in Luxembourg, September 1998. A series of capacity-building workshops for NEHAP implementation were organized at the subregional level. A joint project has been launched with the Danish Environmental Protection Agency on carrying out NEHAPs in the Czech Republic, Estonia, Lithuania, Poland and Slovakia.

99. A strategy for reform of environmental health services was drawn up and translated into Russian. Workshops using this document have already taken place in the central Asian republics (CAR). Given the obvious need to coordinate the actions of environmental health professionals both within countries and across borders, it was decided to produce guidelines on the setting up of associations of environmental health professionals. Great interest was expressed in these guidelines, especially from CAR representatives. Model curricula for environmental health professionals have also been developed. Lastly, a strategy has been developed for reshaping economic instruments so that they help to achieve environment and health objectives.

Local environmental health action plans

100. The implementation of local environmental health action plans (LEHAPs) is being piloted by local authorities in selected cities: Riga and Limbazi (Latvia), Bishkek (Kyrgyzstan), Varna (Bulgaria) and Bratislava (Slovakia). LEHAPs have proved their uniqueness as the only planning process that is truly intersectoral, which is not led by any one sector and where health personnel are among the leading actors. Local Agenda 21 activities are typically environment-driven, whereas city health plans are often driven by health promotion. The LEHAP concept is complementary to existing planning processes. Good partnership with other intergovernmental organizations, NGOs and national governments has made the LEHAP development and implementation project an arena for international cooperation.

Contribution to the Mediterranean Strategic Action Plan

101. A regional network has been set up to improve the health-related aspects of marine pollution monitoring and enforcement of legislation. A document on remedial action for rehabilitation of polluted coastal areas, with a component on tourism, the environment and health, has been prepared for inclusion in Malta's Coastal Areas Management Programme. The elimination of TPBs (substances that are toxic, persistent and liable to bio-accumulate) was a significant addition to the health component of the Mediterranean Strategic Action Plan. A document has been prepared mapping municipal wastewater treatment plants of Mediterranean coastal cities with more than 10 000 inhabitants, and another identified priority marine pollution "hot spots".

Air quality

102. The new WHO *Air quality guidelines for Europe*[6] have rapidly become a major reference document and form the basis of a global WHO document. Tools have been designed for giving effect to these guidelines, with emphasis on monitoring. The Joint Task Force on Health Aspects of Long-range Transboundary Air Pollution was created with the United Nations Economic Commission for Europe (UN/ECE). Its first evaluation report was published, and further work supporting the UN/ECE Convention is under way. The Regional Office contributed to the design of three collaborative studies on health impacts of air pollution in Europe (accepted for funding by the EC in 2000–2001). Work on indoor air quality, carried out jointly with the EC, addressed methods for risk assessment and provided the basis for a publication on assessment and policy-making for indoor air quality.

Chemical safety

103. Work is continuing on assessment of the health risk of persistent environmental pollutants, including dioxins and other endocrine-disrupting chemicals.

Food safety

104. An assessment of the risk of dioxins was carried out, resulting in the publication of a report on food additives and contaminants.

105. A training package for surveillance of Creutzfeldt-Jakob Disease (CJD) has been developed. A paper on the environmental performance review (EPR) process was presented at a conference of the International Society of Environmental Engineers in Athens. Lithuania's review has been published, Ukraine's has been completed and Armenia's has been drafted. A research proposal on "Public perceptions of BSE and CJD risk in Europe" has been accepted for funding by the EC.

Radiation and health

106. Work has continued on the Chernobyl follow-up, while efforts to enhance European

[6] *Air quality guidelines for Europe.* Copenhagen, WHO Regional Office for Europe, 1987 (WHO Regional Publications, European Series, No. 23).

preparedness received support from Germany, Luxembourg and Switzerland. A first draft has been prepared of a common protocol for screening for radiation-induced thyroid cancer. A survey of field activities dealing with iodine deficiency was made in Belarus, the Russian Federation and Ukraine. A common protocol for an integrated database on post-Chernobyl thyroid cancer has been designed and is being implemented.

107. The Helsinki project office for nuclear emergency response and public health, officially opened by the Regional Director at the end of 1998, moved into its new premises in August 1999. The priorities for the Project Office were to issue a 1999 update of the guidelines on stable iodine prophylaxis and to prepare a global strategy for ionizing radiation and public health (to be finalized in 2000).

Climate change

108. The Rome Division of WHO's European Centre for Environment and Health has been making a major effort in the areas of climate change and children, the environment and health, as substantial topics discussed at the 1999 Conference, and also significantly enhanced its activities in the area of public information and communication, both with the general public and with decision-makers.

Toxic oil syndrome

109. Meetings of the Scientific Committee for the Toxic Oil Syndrome, established jointly by WHO and the Spanish Centro de Investigación sobre el Sìndrome del Aceite Toxico (CISAT) were held as scheduled. Research projects were developed and funded within the overall research strategy. In particular, progress was made towards elucidating the etiology of the syndrome through successful simulation of the case oils.

Environmental health pamphlets for local authorities

110. The Regional Office continued to produce its colourful pamphlets to help local authorities deal with practical environment and health problems at local level. The successful series now has 32 titles, with over 200 versions in 24 languages. These pamphlets have created worldwide interest: the Pan-American Health Organization, for instance, is to distribute Portuguese and Spanish translations throughout Latin America. Close cooperation with the Czech government has led not only to translations of pamphlets into Czech but also to joint work on additional titles.

Environment and health information systems

111. The establishment of environment and health information systems is a significant task for WHO, which is now working more closely with other international organizations (the European Environment Agency, Eurostat, the United Nations Environment Programme), as well as with Member States, on the collection and exchange of data. Considerable progress has been made in extending the Health and Environment Geographical Information System (HEGIS) database and identifying relevant environmental health indicators. Further steps have been taken to help Member States set up new environment and health information systems.

112. Environmental health performance reviews contributed to the programme implemented by UN/ECE. Reviews were completed for Croatia, Latvia, Lithuania, the Republic of Moldova, Slovenia and Ukraine.

113. A new European system for electronic communication among environment and health professionals has been launched, with extensive support from the EC and many countries. Issues of the *European bulletin on environment and health* were widely disseminated.

Environmental epidemiology

114. The Regional Office has also done a considerable amount of work on environmental epidemiology. The project on evaluation and use of epidemiological evidence for environmental health risk assessment was widely consulted and sets new standards for the review of scientific evidence. Europe's fifth and sixth summer schools on epidemiology in public health were held in Prague and Cracow, respectively. Sixty-five students from 19 countries, mostly from CCEE, took part in each of those two-week intensive courses. The Office also prepared a monograph on epidemiological approaches to the assessment of health consequences of chemical incidents.

Country work

115. In Bosnia and Herzegovina, the Regional Office cooperated with the EU administration in

Mostar, the Federal Ministry of Health and Médecins sans frontières in destroying 200 tons of expired drugs in an environmentally responsible manner. Similar work was undertaken with the Croatian authorities in Split. In Romania, the Office helped develop a pilot project for improving water supply and sanitation systems at local level and also contributed to developing WHO's "Health through peace" project in Bosnia by training Bosnian water and public health specialists abroad.

116. WHO cooperated intensively with projects to improve water and sanitation in Georgia, Tajikistan, Turkmenistan and Uzbekistan. Finally it published, jointly with UNEP and the World Bank, a publication on managing health care waste.

Socioeconomic determinants

117. Socioeconomic trends in the Region continued to show a rather mixed picture. In western Europe there was reasonable annual growth of some 2.5–3% of gross national product (GNP), but unfortunately only a very slight improvement in the major social scourge of unemployment. In the CCEE and the Baltic states, the recession at the beginning of the 1990s was replaced by reasonable growth of around 4–5% per year – but Albania, Bulgaria and Romania continued to experience negative growth.

118. The NIS, on the other hand, suffered from a 50% or more decline in GNP per inhabitant during the 1990s. There was slight growth in 1997, but since then the situation has again deteriorated sharply. The most recent global figures (1994) showed that no less than 32% of the 415 million people in the CCEE/NIS lived below the poverty line – exactly the same figure as in developing countries. Even more alarmingly, the growth rate at that time of 4.5% in developing countries was contrasted with a 9% fall in the CCEE/NIS as a whole. After the huge economic turmoil in 1998, people in the NIS and some of the CCEE will undoubtedly be facing even more hardship and mounting socioeconomic problems in the years ahead.

119. Several WHO programmes include activities related to the issues of social and economic determinants of health. A "Social determinants campaign" was initiated in 1998, as part of the Healthy Cities movement, with the launch of the publication *Social determinants of health, the solid facts.*[7] This booklet, with thousands of copies issued in more than 15 languages, was one of WHO's best-sellers of the biennium. The campaign is a continuous process of increasing people's awareness of the significance of social determinants, encouraging them to commit themselves to taking action, and developing new guidance. It aims to reach the widest possible audiences of professionals and decision-makers at all levels. The Healthy Cities networks are used as the principal vehicle for the campaign.

Lifestyles and health

Investment for health

120. The approach chosen by WHO of giving effect to the concept and principles of health promotion through "Investment for health" has yielded a clearer understanding of the need for a healthy, sustainable and equitable agenda in Member States. The main vehicle for development, communication and dissemination of strategies and policy advice has been the European Committee for Health Promotion Development (ECHPD), which now covers 75% of Member States. Consultations with members of ECHPD led to the issue of publications and the design of instruments of relevance for policy-making, as well as the initiation of a European audit on health promotion development.

121. Two Member States are currently discussing with the Regional Office the possibility of undertaking a national health promotion audit of the type that was carried out in Hungary and Slovenia, at the request of the parliaments of those two countries.

122. In the area of intercountry technical cooperation on health promotion and investment for health, a major contribution has been made by the English Health Education Authority under a special memorandum of agreement with the Regional Office on "Building competence in health promotion". EURO has also had close cooperation with Italy, both at national level and through the Veneto Region.

[7] WILKINSON, R. & MARMOT, M., ED. *Social determinants of health, the solid facts*. Copenhagen, WHO Regional Office for Europe, 1998.

The Verona Initiative

123. The "Verona Initiative" was launched in 1998 as a follow-up to the 1997 Jakarta Declaration on Health Promotion. This multi-partner venture brings together political, business, academic and nongovernmental leaders to explore, develop and extend people's understanding of investment for health and how it can be used to support countries, regions and local communities. The aim is to develop thinking about government policies that are supportive of health investment, and their relation to the economic, social and human environment.

124. The initiative is a response to major changes taking place across the European Region – in national and international politics, in social and economic performance, in institutions and in technology. There are widening gaps in health status – both in countries that are in economic crisis and in those which are prospering. Good health is fundamental to people's wellbeing and central to sustainable economic development. Although this is known to be true, health is all too often ignored or excluded in matters of economic and social policy.

125. The Verona Initiative is structured around three "arena meetings" in the three-year period from October 1998 to 2000. Arena meetings provide an opportunity for participants to meet, discuss and exchange views in a search for consensus. The meetings are designed to provide a learning and working environment that is quite different to the conventional conference agenda. But the Verona Initiative is more than this – there is an ongoing process throughout the three years and beyond which involves a much wider network of participants than those invited to the meetings.

126. The first two arena meetings have provided international visibility, a concrete opportunity for advocacy and an innovative platform for practical implementation of heath promotion strategies through an investment for health approach. The impact has been visible at European, national and subnational levels of decision-making, resulting in an awareness of the central role of health promotion in the new HEALTH21 policy framework.

Arena meeting I (14–17 October 1998)

The Verona Benchmark: Established the characteristics of systems that support investment for health. This helped countries, regions and communities to understand what needs to be in place before investment for health can happen.

The Verona Initiative

Arena meeting II (29 September – 2 October 1999)

The Verona Guidelines: Defined the characteristics of the decision- and policy-making process that will promote the health of a population. This yields an understanding of how the different interests involved in health, social and economic development can work together for mutual benefit.

Arena meeting III (July 2000)

The Verona Resolution on Investment for Health: This will focus on ensuring that the lessons learnt about investment for health as a result of the Verona Initiative can be used to influence policy-makers everywhere. The resolution will be instrumental both in positioning health promotion for the twenty-first century and in fostering political commitment to taking action.

Tobacco

127. There were three important events during the biennium. First, in 1998 the Director-General launched a major new global effort – the Tobacco Free Initiative – and the Regional Committee adopted the third five-year regional action plan for a tobacco-free Europe. The programme has therefore been enhanced and additional resources have been made available, from both regional and global funds. Secondly, in the European Region, the decision by the Health Council of the European Union to ban the advertisement and sponsorship of tobacco products in EU countries will have a major impact over the

coming years, not only on the 15 EU Member States but also on the accession countries and, indirectly, on other countries in the Region. The importance of a strict ban on tobacco advertisement is clearly demonstrated by the fact that the French ban of 1991, the so-called Evin Law, has since resulted in a 15% drop in cigarette consumption. Finally, the Committee for a Tobacco-free Europe (CTE) met for the first time in June 1999. The main activities of CTE in the coming period will be to advise on the European regional input to the global WHO Framework Convention on Tobacco Control and preparations for the European regional ministerial conference on tobacco (to be held in Poland in 2001).

128. During 1998 and 1999, EURO staff undertook six missions to support the formulation of national policies and held three intercountry professional development workshops to prepare country-based action plans on tobacco – all concentrated on the EUROHEALTH countries. Considerable efforts were made to promote widespread smoking cessation programmes in primary health care facilities and pharmacies – the latter through cooperation with the Forum of National Pharmacy Associations and WHO. The British Medical Association is hosting a joint endeavour by WHO and the EC to support national medical associations in their anti-tobacco activities, and this will markedly strengthen efforts to help doctors stop smoking. Similarly, the establishment of a task force on smoking within the rapidly expanding and dynamic European Forum of Nursing Associations and WHO will also start making an impact on the high level of smoking among European nurses.

129. All Member States are starting to reorient their tobacco control policies in line with developments towards the Framework Convention. CTE has brought together all key intergovernmental organizations (IGOs) and NGOs around a common work plan on tobacco. The European Region has been given the technical responsibility to advise on two potential areas for protocols under the Framework Convention, the treatment of tobacco dependence and controls on advertising and sponsorship. Tobacco issues have also been integrated into the European Health Communication Network, and a global media advocacy programme was launched in November 1999.

130. The year 1999 saw the launch of WHO's European partnership project on tobacco dependence, which aims to reduce tobacco-related death and disease among smokers. The project, which is open to appropriate partners in the private, non-commercial and public sectors, supports work towards the key strategic goals of WHO's Tobacco Free Initiative. The strength of the partnership project lies in the fact that it has brought together major pharmaceutical companies which manufacture products for the treatment of tobacco dependence, to support a common goal that will have a significant impact on public health. The project provides a model of working that opens the door to future partnerships with the private sector in other important health areas.

Alcohol and drug abuse

131. An intensive evaluation was made of the effects of the first two phases of the European Alcohol Action Plan and the European Charter on Alcohol, and a full report was submitted to the Regional Committee.

132. The third phase of the Action Plan was strongly endorsed by the Regional Committee (resolution EUR/RC49/R8). Four major international actions are being carried out as part of the Action Plan. The Supply Side Initiative is an international group of researchers working on the question to what extent the alcohol supply side influences demand for and consumption of alcoholic beverages, and thus the extent of alcohol-related problems. The Alcohol and Public Policy Project, which produced an authoritative report on alcohol policies at the time of the Paris conference in 1995, has been revived in view of the coming conference on young people and alcohol (Stockholm, February 2001). It is expected that some results of this group's work will be available for the conference, with the final report due to appear in 2002.

133. Another major international effort in the alcohol area is the Phase IV study. This is an effort to mobilize more intensively the primary health care sector in the prevention and early treatment of alcohol problems. The emphasis in this phase is on applying, at national level, the knowledge gained in previous ones. The fourth area of international action is a study of the social harm related to alcohol consumption. There is a relatively clear view of the typical medical consequences of alcohol consumption. There are

very few quantified data, however, on the social harms resulting from alcohol use. This project is endeavouring to map these social consequences in different parts of the Region.

134. The European Network of Alcohol Action met in Poland at the kind invitation of the State Agency for the Prevention and Control of Alcohol Problems. This network of national counterparts is extremely valuable and active.

135. In the area of drug abuse, initiatives have concentrated on preventing HIV infection among intravenous drug users: the rapid spread of such drug abuse in the NIS – from Tajikistan to Ukraine – is a major cause of concern. The guidance which the Regional Office gives on this subject through its publication *Principles for preventing HIV infection among drug users*[8] continues to be widely distributed. It is being used by many governmental and nongovernmental agencies. The Office also takes part in the UNAIDS Task Force on the Prevention of HIV/AIDS among Drug Users in CCEE and NIS.

136. The alcohol and drug abuse programme is also involved in other international activities, such as those being carried out by the Council of Europe's Pompidou Group and by the EC and the EU's agency for drugs and drug abuse (EMCDDA). The Regional Office is represented on the Board of this agency and therefore participates in the planning of activities.

137. A particularly interesting experiment has been undertaken by the health authorities in Switzerland, who – as part of a broad strategy to prevent drug abuse and treat victims – added one component which aimed at improving the health of chronic heroin abusers and cut the links to criminal groups and thus reduced criminality in general. This component includes prescribing heroin, under strict medical supervision, to chronic users of the drug who have gone through a series of unsuccessful attempts for treatment of their addiction. The results of a pilot study between 1997 and 1999 were so positive that the Swiss population voted overwhelmingly in favour of making this new approach a permanent part of the country's health and social programmes.

[8] *Principles for preventing HIV infection among drug users.* Copenhagen, WHO Regional Office for Europe, 1998 (document EUR/ICP/LVNG 02 06 01).

Nutrition policy, infant feeding and food security

138. In 1998 the Standing Committee of the Regional Committee endorsed the idea that the Regional Office should develop a food and nutrition action plan for the European Region, and several steps have been taken to that end. Counterparts from all Member States met in Malta in 1999 to discuss the first draft of the Action Plan.

139. A particularly encouraging development in this process has been the close cooperation between the government of France, the EC and the Regional Office. A conference on public health is to take place in Paris in December 2000, and a session on nutrition will be organized by France during its term of EU Presidency.

140. WHO has made a comparative analysis of food and nutrition policies in European Member States, from which it was evident that greater efforts have to be made to raise political awareness, so that the necessary structures and mechanisms can be set up to support the development and implementation of policy.

141. Intersectoral nutrition policy workshops for the prevention of noncommunicable diseases were organized in the Russian Federation in 1998 and 1999. Dietary guidelines and posters were developed for use in the countrywide noncommunicable diseases intervention (CINDI) programme. In addition, a three-day training module for health professionals on the development of food and nutrition policy, specifically for women and their families, was finalized and tested in Armenia and the Russian Federation, along with booklets for mothers on healthy eating during pregnancy and lactation.

142. The three Baltic states carried out their first national food consumption and nutritional status surveys during 1997, and the final report was published in 1999 in collaboration with the London School of Hygiene & Tropical Medicine. The data from these surveys form the basis for the next step, which is to draw up national food and nutrition action plans.

143. A comparative analysis of the degree of implementation of the Innocenti Declaration in Member States was carried out by WHO in 1998. This showed that only 25 countries have established breastfeeding committees, and only

12 are complying with the International Code of Marketing of Breast-Milk Substitutes. In the north-west of the Russian Federation, the Barents breastfeeding promotion project has continued, thanks to the support of the Norwegian government, and has now been expanded to include healthy nutrition of mothers and older infants and children.

144. Iodine deficiency, which is still prevalent in a number of countries (especially those of the former Soviet Union), causes preventable mental retardation. There is thus a strong need for re-establishing the universal salt iodization that ceased with the collapse of the Soviet Union. In 1998/1999 the comparative analysis of this disease in Member States provided updated information on the steps taken in countries to combat this problem.

145. A joint UNICEF/WHO consultation was held in Geneva in February 1999 to address the problems related to iron deficiency anaemia, and practical steps to solve the problem were recommended. One of these, which has been taken, was to issue a set of nutrition and feeding guidelines for infants and young children, covering the control of iron deficiency in the period 0–3 years of age.

146. An urban food and nutrition action plan has also been developed, in collaboration with the Healthy Cities movement (see below) and the nongovernmental organization ETC, following wide consultation. The network of counterparts was strengthened, and a Web site was developed during 1999 to aid the flow of information and improve communication with authorities trying to improve food and nutrition security in the Region.

Settings

Healthy Cities

147. Eagerness by cities from all parts of the Region to join Phase III of the Healthy Cities Network reflected the increasing recognition that action at local level is an essential component of any national or subnational health strategy or programme. Thirty-nine cities in 29 countries have been successfully designated as members of the network following a rigorous assessment procedure, while 15 cities are being assessed. Healthy Cities national networks in 27 countries involve approximately 1200 cities and towns in this movement. Priority has been given to building capacity for the formation of Healthy Cities networks in the more eastern parts of the Region. A WHO collaborating centre has been established to support this effort. Capacity-building activities have already been carried out in Bulgaria, the central Asian republics and the Baltic area.

148. A major conference of the Healthy Cities Network took place in Athens in June 1998, celebrating the tenth anniversary of the movement (see below). One important outcome of this conference was the signing of the Athens Declaration for Healthy Cities by 125 mayors and senior politicians from 29 countries across Europe. Cities are continuing to sign up to this political declaration, pledging their commitment to improving the health of their citizens, guided by the principles of Health for All and with an emphasis on equity, sustainability, intersectoral cooperation and solidarity.

149. The findings of a multi-centre, external evaluation of the second phase (1993–1997) of the Healthy Cities project clearly revealed the major role that the movement plays in mobilizing many new partners in hundreds of local communities throughout the Region. The research showed that the Healthy City model was successful and could be adapted to different political and sociocultural contexts. It also demonstrated the added value of Healthy Cities in terms of supporting the process of carrying out plans based on the principles of Health for All, promoting innovation and sustaining political commitment.

150. In the third phase of the project (1998–2002), particular emphasis is being placed on three crucial issues: equity, social development and sustainability. The strategy for Phase III is to engage all 51 Member States of the European Region in the Healthy Cities movement, with an emphasis on meeting the needs of Baltic, CEE and NIS cities. Priority themes include equity and social exclusion, social determinants of health, indicators, healthy settings, and integrated city health and environment planning.

151. Work was also done on defining the concept and strategy for a future Health Promoting Universities network.

International Healthy Cities Conference

"... marking a decade of Healthy Cities action"

The International Healthy Cities Conference took place in Athens in June 1998. A key strategic event in the life of the European and global Healthy Cities movement, it was attended by over 600 political representatives and technical experts in many areas of urban health and development, from 206 cities in 56 countries. Each of the six WHO regions was represented.

The main outcomes of the Conference were that:

- The Athens Declaration was signed by 125 mayors and senior politicians from 29 countries across Europe. Cities pledged their commitment to improving the health of their citizens, guided by the key principles of equity, sustainability, intersectoral cooperation and solidarity. They also stressed the importance of local action as an essential component of any national or subnational strategy aimed at health and sustainable development and tackling the determinants of health.
- The WHO Regional Office for Europe's strategy and plans for urban health – Healthy Cities (Phase III, 1998–2002) – were launched, giving effect to the pledges of the Athens Declaration.
- A series of new Healthy Cities books and materials were published, including *Social determinants of health, the solid facts*. This booklet heralded the start of a campaign which aims to reach the widest possible audiences of professionals and decision-makers at all levels and to promote awareness, debate and action on the social determinants of health.
- The Conference provided a forum for exchange of experience, learning, discussion, debate and networking for the networks and groups already involved in the Healthy Cities movement, as well as for potential new partners and those people interested to learn about Healthy Cities.

152. New publications included *City health profiles: a review of progress; Community participation in local health and sustainable development; Health Promoting Universities;* and a draft *Healthy urban planning manual.*[9]

Health at work

153. A project on health and work has been developed, and components currently being implemented include environmental safety and health promotion, economic incentives for healthy products, and the contribution that enterprises can make to health in the community.

154. The Office has also been very much involved in occupational health. An international coalition was built up between representatives of governments, international agencies, business and industry, preventive services at the workplace, research and educational institutions and NGOs.

155. A review of occupational health in the European Region formed part of a document entitled *Overview of environment and health in Europe in the 1990s*.[10] Guidelines were drawn up on quality assurance in the management of multidisciplinary occupational health services. Another draft guidance document, on the education and training of occupational health physicians, was prepared and distributed to WHO collaborating centres and members of relevant professional associations in Europe. A consensus workshop was organized in Bilthoven, the Netherlands, resulting in the issue of a document on the scope and competencies of occupational medicine in Europe. Lastly, a document was drafted on the role of the occupational health nurse in workplace health management.

156. A project was launched to promote national action plans on health, environment and safety management in enterprises (HESME). The Baltic Sea telematic network on occupational health and safety, which provides mechanisms for sharing information, building capacity and harmonization of HESME, has been further strengthened and annual meetings of the network were held.

[9] All available from the Healthy Cities unit at the Regional Office (documents EUR/ICP/CHVD 03 01 01/1, EUR/ICP/POLC 06 03 05D, EUR/ICP/CHVD 03 09 01 and EUR/ICP/CHVD 03 03 03, respectively).

[10] Available from the unit of Health and the Environment at the Regional Office (document EUR/ICP/EHCO 02 02 05/6).

Prisons

157. The Health in Prisons network has grown to comprise 15 Member States, with three other countries currently considering joining. The EC, Council of Europe and three major NGOs are currently observers of this innovative movement, which brings together representatives of ministries of health and of justice, as well as other partners in countries.

Multisectoral responsibilities for health

158. Progress was made on defining the scope and concept of health impact assessment (HIA) and, following a review of available HIA models, a consensus paper was drafted. The importance of developing an agreed methodology is underlined by Article 152 of the European Community's Amsterdam Treaty, which states that the impact on health of all policies and actions should be considered.

AN OUTCOME-ORIENTED HEALTH CARE SECTOR

Primary health care

Policy

159. Primary health care (PHC) features prominently in the HEALTH21 policy framework. Progress towards the aims of the original Declaration of Alma-Ata was reviewed at an international meeting in Almaty, Kazakhstan, in November 1998, to which the Regional Office made a major contribution. While some progress was noted, especially on aspects of medical care ("primary care"), the original concept of PHC in the sense of multisectoral comprehensive and participative health care in the community needs to be given stronger emphasis and put into practice in all countries. To help do this, the conference called for the preparation of a regional and global "roadmap" to take PHC forward. The roadmap is intended to promote strategic health systems research and relevant PHC demonstration models, including the dissemination and linkage systems required to carry out decentralization and to make communities effective partners in PHC. It will also suggest ways of working with health care practitioners to design new systems and tools for identifying problems, setting priorities and developing the corresponding strategies. A consensus statement from the conference outlined the principles and actions that characterize PHC at global level: these include measures to strengthen equity, health gain, quality, gender sensitivity, acceptability, participation and cost–effectiveness.

Family health nurse

160. One of the key elements of PHC is the development of family health nurses and family health physicians, as well as the arrangement of community organization mechanisms that can bring together family health and other PHC initiatives at local level. The Regional Office has moved energetically ahead with the agenda to promote the concept of the family health nurse, the frontline health worker who can bring to individual families basic services of lifestyle counselling, home nursing care, early identification of emerging family health problems, etc. In its work to ensure that family health is seen as an important element of PHC, the Office has created powerful allies through the new nursing and midwifery forum, which reaches out to national nursing and midwifery associations in 27 Member States of the Region, as well as a second network of government chief nurses. Analytical work in this area has been finished, and the role, functions, tasks and educational requirements for family health nurses have been identified. Pilot programmes can now be launched to develop this new service in all interested Member States.

161. An education strategy for nursing and midwifery in Europe has been developed to guide the initial education of nurses and midwives and ensure a workforce that is both competent and fit for the purpose now and in the years to come.

162. Intensive preparations are being made for the second WHO Ministerial Conference on Nursing and Midwifery in Europe, to be held in Munich, Germany, in June 2000 (the first took place in Vienna in 1988). This ministerial-level event will seek the commitment of all WHO's European Member States to a pan-European strategy for nursing and midwifery for the next twenty years. To this end, a declaration and strategies for action will be prepared. This will be a unique occasion for building support for the new family health nurse concept, as well as for spreading knowledge of other important nursing and midwifery initiatives being taken in cooperation with the partners mentioned above, such as to develop indicators of the quality of nursing

outcomes and other measures to improve quality management in this part of the health sector.

163. A "toolkit" has been prepared to highlight the contributions that nurses and midwives can make to the whole range of HEALTH21 targets.

General practitioner/family health physician

164. At a meeting in Copenhagen in February 1998, participants analysed the feedback from a consultation on the working draft of a Charter for general practice/family medicine (GP/FM) in Europe and agreed on a number of changes. The resulting framework for professional and administrative development of GP/FM in Europe is available in four languages and is widely used and disseminated at international meetings. A book on the role of general practice in PHC, also co-published in 1998, gives a very clear picture of the current role and functions of general practitioners in the European Member States.

165. A network focused on strategies for the development of family practice, with the participation of nominated experts from central and eastern European countries, has regularly been convened by WHO since 1995. Two meetings were held in the biennium, in Zagreb (Croatia) in September 1998 and in Tartu (Estonia) in October 1999.

166. The St Petersburg Initiative network brings together academics and decision-makers from the twelve NIS. Its main aim is to define basic medical education and postgraduate vocational training in GP/FM. It provides a forum for discussion and exchange of experience on curriculum development and other specific educational issues. Network meetings were held in Lviv (Ukraine) in October 1998 and Bishkek (Kyrgyzstan) in November 1999.

167. A first meeting on needs and outcomes assessment in PHC was held in Heraklion (Greece) in May 1998. The network formed at the meeting brings together PHC professionals to review the methodology used in consensus needs and outcomes assessment, to identify the basic elements of a common approach and to explore the possibilities for implementing methodology in different contexts.

168. WHO has also supported an innovative network that promotes "Tipping the balance towards primary health care", which gives districts the opportunity to learn from each other and to join in common projects. Following the signature of a memorandum of understanding with the TTB network in March 1998, it has been represented at other network meetings throughout the biennium; conversely, EURO is represented at its annual meeting, while the TTB Steering Committee meeting is held at the Regional Office each year.

169. A pilot project has been started in the Aral Sea area of Uzbekistan, in order to see what practical help can be given to the populations that live under the terrible conditions created by the huge environmental disasters in that region. This "Munjak Project" provides a blend of programmes from the more classical family planning and child health, through nurse training and family health, to some advanced computer-based approaches to the quality of care and telemedicine.

170. Under the plan to carry out the "Lukman Project" in Turkmenistan, action is being taken in selected facilities to demonstrate the PHC model chosen, which covers health care, the environment and multisectoral health promotion. In addition to work on training and infrastructure, guidelines have been drawn up for improving operational management.

171. At the opposite end of the NIS area, the Regional Office has recently proposed to the Barents Council a similar approach to strengthening PHC which incorporates environmental components. Finally, a project on PHC in the central Asian republics has been prepared and will be carried out as an Office-wide initiative.

Integrated health care delivery

Linking hospital and primary health care

172. A variety of activities have focused on establishing the evidence needed to advocate the move from hospitals to home health care, to optimize emergency services and to improve hospital management. The Steering Committee for the project on home health care and out-of-hospital emergency medical services met twice during the biennium, and databases on both these areas have been compiled. A workshop on linking hospitals and PHC identified good practices, the benefits of integration and the requirements for implementation. The Health Promoting Hospitals Network

had two international meetings during the biennium, as well as annual national conferences. A database has been established, and information is being disseminated through newsletters and a Web site. A book was published on evaluating hospital efficiency.

Patients' rights and consumer involvement

173. Following the pioneering Amsterdam Declaration on the Promotion of Patients' Rights (1994), and in line with the Ljubljana Charter on Reforming Health Care (1996), interest in and awareness of patients' rights have increased strongly through Europe. In 1997 the Regional Office therefore established a network in this area. The second meeting of the expert network was held in the United Kingdom in July 1998, bringing together representatives of 21 countries from both western and eastern Europe, the Council of Europe, the Nordic Council of Ministers, patients' and consumers' groups, academia, etc. A plan of action was adopted to monitor and enhance the development of patients' rights and the involvement of citizens in decision-making in the Member States, and to encourage the creation of national networks on patients' rights. All Member States were invited to join the network, and to date 11 have responded favourably. Six Member States have endorsed national laws regulating patients' rights.

Health care management

174. A report on reshaping health systems towards health outcomes and guidelines on health care practice have both been finalized. This work shows how little is really known about the effects on health status of many system changes (such as in organization, financing and governance). It is recommended that action-oriented research should be pursued on tracing these effects through changes in the behaviour of health care providers, consumers and administrators.

175. A meeting on health insurance schemes was held in Germany, with participation from western and eastern European countries. A survey on health services provision "packages" has been finalized.

Quality of care development

176. Over the past two decades, the Regional Office has been heavily involved in promoting the elaboration of national and professional policies, information feedback systems for continuous quality development and pilot programmes in Member States. This work has been carried out in close cooperation with different Member States and key organizations of health professionals.

Quality of care in noncommunicable disease management

177. The Regional Office has continued to promote the St Vincent movement for improved management of diabetes, as a model for development of the quality of care in NCD (this is being done in close cooperation with the European branch of the International Diabetes Federation and the European Association for the Study of Diabetes). The St Vincent movement has now started to demonstrate major improvement in health care outcomes and a reduction in health care consumption in many pilot areas in the Region, including the NIS.

178. A number of new tools have been developed for data collection, such as a basic information sheet (BIS) for diabetes retinopathy, diabetes in pregnancy, children with diabetes and diabetes nephropathy. Several intercountry nodes for data collection have been set up (Bucharest, Romania for the countries surrounding the Black Sea, and Graz, Austria for Austria and Germany), as well as many national nodes (France, Norway, Portugal, the United Kingdom, etc.). In some of them (Norway and the United Kingdom), the BIS has been adapted for use in a PHC setting.

179. A WHO office for quality of care in NCD was set up in London in February 1998, in collaboration with the United Kingdom Department of Health. It acts as a focal point for the identification, and where necessary facilitates the development, of quality management programmes for use in central and eastern Europe. It also works to identify centres in the United Kingdom that are demonstrating best clinical practice, initially in the areas of diabetes, asthma, musculoskeletal disorders, chronic diseases, stroke, mental health, blood transfusion and perinatal care, so that their experience and expertise can be disseminated and exploited.

Data collection and analysis

180. During 1999, an Internet server (http://qct.who.dk) was opened which permits health care institutions and public health administrators all over the Region to compare instantly

their own results in terms of patient management outcome with those of EURO's regional database. Data on perinatal care (using the common OBSQID quality indicators) and diabetes management (using the DIABCARE data set) can currently be accessed in this way; new areas will be added as the systems become available. A workshop in Israel in November 1998 and an OBSQID satellite meeting in Istanbul reviewed aspects of data collection and exchanged experience on what has or has not worked and where improvements are needed.

181. A data collection tool based on the generic EpiInfo software is available in English and Russian and is being used mainly but not exclusively in CCEE/NIS. Dedicated software includes tools for data collection, analysis and transfer. A network in CCEE/NIS participates in data collection, using case-based and aggregate quality indicators.

182. A particularly interesting innovation has been the development of "Wellbeing five", a set of simple questions that can help screen for undiagnosed depression and measure the efficacy of anti-depression therapy. A meeting devoted to quality of care in depression and its impact on cost was held in London in October 1999. It was evident that the poor quality of antidepressive care was resulting in considerable unnecessary use of resources and suffering problems which should be urgently addressed.

Patient education

183. Work done by WHO and its collaborating centres during the biennium showed that patient education can be a very important factor in improving health outcomes and the quality of life for people with chronic disease; it can also reduce health care expenditure. The first WHO working group report on this subject was produced in 1998, building on joint work with the WHO collaborating centre at the Geneva cantonal hospital. This showed *inter alia* an 80% reduction in the rate of hospitalization of asthmatic patients, a 90% reduction for diabetic coma and a 75% reduction in diabetic amputations, as well as a 50% cut in absenteeism in patients with back pain – all major improvements achieved through this very simple, but fundamental, approach.

Indicators

184. An update was made of indicators of oral health status in Europe at ages 6, 12, 35–44 and 65–74 years, and a draft was prepared of a report on measures to improve the quality of oral health care at national level. The oral health information systems that have been established document a decline in dental caries in children in Hungary and Poland through activities undertaken in 1999. A similar node has been set up in Belarus to be a model for the NIS.

185. A first set of generic quality indicators for PHC covering mental health, health of the elderly, oral health, musculoskeletal disorders and diabetes mellitus was developed at a meeting in Denmark in February 1999. The first draft of case-based indicators for renal disease has been developed and is being piloted in Scandinavian countries.

Blood use

186. Technology assessment programmes, particularly in the rational use of blood, have been initiated in clinical settings, based on a project in Albania and experience gained in Romania. The former resulted in a substantial improvement of infrastructure and laboratory facilities at the National Blood Transfusion Centre and regional centres throughout Albania, as well as capacity-building for and promotion of voluntary, non-remunerated blood donation. In addition, a basic information sheet was created for the collection of data on the use of blood and its impact on patients, and this was then piloted in several clinical settings (obstetrics, haematology and cardiac surgery). A national meeting was organized with the Ministry of Health and the National Blood Transfusion Centre to promote the rational use of blood and blood replacement therapy. Attended by surgeons, obstetricians, and other high users, it resulted in plans to set up a task force to produce and implement guidelines in this area.

Pharmaceuticals and medical supplies

Pharmaceuticals

187. The philosophy of Health for All is the leitmotif for the development of national drug policies in terms of access, quality and rational use; this very much builds on increased partici-

pation by, and accountability of, all stakeholders in the pharmaceutical sector.

188. WHO has acted as the advocate for health, as the provider of evidence-based tools, as the information centre for pharmaceutical policies, as the platform and initiator of networks, and as the catalyst for action. New approaches and knowledge have been identified in the areas of improving drug use, the role of the pharmacist in health promotion, and increased efficiency in pharmaceutical spending.

189. During this biennium a strategy and paper setting out the implications of the HEALTH21 policy framework for the pharmaceutical sector in NIS were prepared and published, in collaboration with authorities in all those countries. Approaches and strategies for countries and for WHO were then adapted and brought into line with these policies.

190. National drug policies are being developed, shaped and improved in a number of European countries. Meetings were organized on pricing and reimbursement policies for CCEE, on economic evaluations of medicines (EU countries and CCEE), on hospital pharmacy management (CCEE), on improving prescribing practices (EU countries and CCEE), and on drug regulation (the International Conference of Drug Regulatory Authorities with WHO headquarters). A publication on cost-containment policies is in draft, and a clearing-house on drug policies is being set up in the London School of Economics' Health Unit.

191. Through direct country support and networking among professionals and policy-makers, a large United Kingdom-funded special project for pharmaceutical reform in the NIS has resulted in new drug laws and more effective regulatory agencies in those countries. In addition, the project has led to a sharper focus on access to drugs for poor people and those with high drug costs, pilot schemes on drug reimbursement, new concepts of hospital drug management, more and better tools to improve drug selection and prescribing, dissemination of more appropriate drug information, and improvements in pharmacy practice and the implementation of regulations. Training and networking in rational pharmacotherapy has brought new approaches to several universities, especially in Armenia, Georgia, Kyrgyzstan, the Russian Federation, Tajikistan and Uzbekistan.

192. In the aftermath of conflicts in the former Yugoslavia, emergency relief operations were improved by encouraging relief organizations to follow guidelines on drug donations, and Denmark, France, Italy, Norway and the United Kingdom funded measures to help establish a functional and efficient pharmaceutical sector. Country projects in Albania, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, and in Kosovo, also focused on developing national policies on medicines; drug regulation; supply, reimbursement and pricing issues; and improving the use of medicines.

193. Collaboration was further developed with the EC (on regulatory and reimbursement issues, as well as with regard to the accession countries and the European Medicines Evaluation Agency), OECD, the Council of Europe, different countries (bilateral support), the World Bank and professional networks (the European Drug Utilization Review Group, the Pharmaceutical Care Network Europe, etc.).

Medical supplies

194. WHO's European Information System for Medical Supplies (ISMS) was originally established to provide potential donors with up-to-date information on the specific health needs of the NIS. Given their socioeconomic situation, the majority of NIS relied to a great extent on support from external partners to ensure the provision of vaccines, essential drugs and basic medical equipment. The availability of accurate and timely information was crucial to ensuring adequate support and supplies. ISMS acted as a clearing house and, through quarterly and annual reports, ensured the collection, processing and distribution of a broad range of health-related information and data on the health status and needs of people in the NIS. The project was completed, having fully achieved its objectives.

Health care reforms

European Observatory on Health Care Systems

195. The Observatory, officially launched in February 1999, is a large new partnership project between the Regional Office, the governments of Norway and of Spain, the European Investment Bank, the International Bank for Re-

construction and Development, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine, in association with the Open Society Institute. A WHO collaborating centre was established at the Institute Carlos III in Madrid, as part of the Observatory.

196. The Observatory supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe. It also provides Member States with up-to-date information on the experience gained from changes in health care organization, management and financing through a series of information products such as comparative and analytical studies, an Internet site (http://www.observatory.dk), a newsletter, a comprehensive publication[11] and a series of profiles of health care systems in transition (HiT) for individual countries in the Region. Forty such profiles are under way, and 28 were produced by the end of 1999.

197. The Observatory is also an important contributor to WHO's global efforts to ensure that evidence is systematically gathered and used in making policy. Recent themes have been regulating entrepreneurial behaviour and the appropriate role of hospitals.

Health care reform networks

198. Assistance to countries with health care reform was delivered partly through bilateral country projects, and partly through collaborative, geographically-based networks (CARNET, EASTNET, MIDNET and SOUTHNET).

199. The CARNET group was particularly active: its work on hospital services was finalized, and two other areas – sanitary/epidemiological services, and lifestyles and primary health care – were taken up. Direct support continued to be given to individual countries. Of particular importance was the continuation of the Manas programme in Kyrgyzstan, to which the Regional Office sent missions every six months. During 1998–1999, specific areas of support included human resource development, nursing and communication. In Turkmenistan, the Lukman project was finalized, and a pilot PHC project started in selected facilities; other activities are

[11] SALTMAN, R.B. & FIGUERAS, J. *European health care reform. Analysis of current strategies.* Copenhagen, WHO Regional Office for Europe, 1997 (WHO Regional Publications, European Series, No. 72).

ongoing. In Tajikistan, the Somoni health care reform project was initiated, along the lines of the Manas model. A national team was formed, and a resident project officer from EURO was based in the country to provide full-time support to the team; the strategy is currently being incorporated into a government master plan for development.

200. The MIDNET and EASTNET groups analysed issues of priority-setting and rationing, the effectiveness and efficiency of health care services, and the public/private mix. In-depth advisory support was given to a number of countries that are members of these networks.

201. SOUTHNET placed particular emphasis on reforms in PHC. At its second and third meetings (Salonica, Greece, December 1998 and Jerusalem, Israel, November 1999), it determined practical ways to "tip the balance" of care in favour of PHC. Participants welcomed the ability to exchange experience between Mediterranean, Balkan and Caucasian countries.

POLICIES AND MECHANISMS FOR MANAGING CHANGE

Public health role and capacity

202. A strategy paper on strengthening public health was discussed by the Regional Committee in 1998, and a revised version was adopted the following year (resolution EUR/RC49/R9). The Regional Office is developing tools, guidance and integrative action plans to support Member States' work to review and modernize their public health functions and infrastructures. Special emphasis is to be given to strengthening public health training and research capacities at country and subregional levels. A compendium of public health responsibilities at national, regional and local levels in the countries of the European Region was issued, and a revised edition is already in process.

203. The new Kazakhstan School of Public Health, opened in 1998 as a result of extensive collaboration between the Regional Office and the government, will give major support to the south-east of the Region. Several steps have been taken during the biennium to create strong international links to the new School, which will serve as an example for other NIS and also be a facility for training fellowship-holders from neighbouring countries in that part of the Region.

204. An initiative is under way to develop health economics learning modules, covering the economics of health, the health sector and health care management. The modules available already have been tested in Hungary, Kazakhstan and the Russian Federation. A project with the Soros Foundation on research in health economics, that focuses on strengthening primary care and building capacity in health economics, is also being carried out in Hungary. The Office is making a further contribution to capacity-building in this area by participating in an EU "Leonardo da Vinci" project.

The Minister of Health of Kazakhstan expressed the intention to establish a school of public health and requested the assistance of the Regional Office. The Kazakhstan School of Public Health (KSPH) was duly established by government decree in August 1997. KSPH aims to provide not only training and education but also research and expert consultancy services in the areas of health policy, health economics and finance, environmental and occupational health, health promotion and social sciences, and epidemiology and statistics.

During the biennium, core staff have been recruited and are being trained overseas and in the country. At the beginning of 1999, KSPH started to offer short-term courses on various topics for existing health administrators. The Master's degree in public health (MPH) curriculum is under development and is scheduled to be launched in the autumn of 2000.

Partnerships have been forged with other institutions. A management training programme was developed and provided together with McGill University, Canada. A two-year partnership with the Virginia Commonwealth University in the United States, secured with the support of the American Industrial Hygiene Association, has benefited work on both short-term courses and the MPH curriculum.

Health policy

Health policy development

205. With the assistance and guidance of health policy advisers provided through the Office's EUROHEALTH programme, the process of policy development continued in a number of CCEE and NIS. This work included drawing up and carrying out plans for the revision of such policies and developing a robust infrastructure for future policy formulation, implementation and monitoring. In 1998–1999, permanent and ad hoc public health advisers were active in a number of countries covered by the programme, and funds are currently being raised (also in the form of secondments from donor countries and institutions) to establish a permanent presence of such advisers in countries. At the same time, ministers of health and key government officials have been invited to the Regional Office for briefing on the HEALTH21 policy framework and related strategies.

206. Following a comparative analysis of country experiences as well as a series of in-depth studies, a report on health policy development in Europe was finalized.[12] It points on the one hand to the wide penetration of the concept of Health for All, and on the other to a more cautious and traditional focus on narrower policies. With the support of the United Kingdom King's Fund and other partners, WHO's recently established European Centre for Health Policy organized a meeting to consider effective ways of setting up "dialogues for health" with various sectors. The Centre also promoted work on the methodological basis for health policy analysis and formulation. This included health impact assessment; methodologies for target-setting in public health; structures and incentives for partnerships in health development; sectoral dialogues for health; and issues of relevance to countries that are candidates for accession to membership of the EU.

Regions for health

207. The Regions for Health network is acquiring increasing importance, since more countries are creating and developing regional structures. The EU's Committee of the Regions and the Council of Europe's Congress of Local and Regional Authorities in Europe are examples of bodies that reflect this trend. The Regional Office's network now covers 21 regions in 13 countries, representing over 70 million people; three new regions are in the process of joining. Using twinning projects, workshops and small networks, specific support is being provided to CCEE/NIS, especially EU accession countries, so that their regions have the tools to formulate and implement the full HEALTH21 policy framework. A four-country project on this subject has been carried out and evaluated.

Information and new HFA indicators

208. The HFA database is now being continuously updated and, as part of the annual data collection cycle, a user-friendly version is produced and disseminated (including via the Internet) in January and June each year.

209. Adaptation of the existing HFA indicators to the new HEALTH21 policy framework is particularly important for monitoring progress towards the 21 new targets. Trends and projections were analysed and used for formulation of the new targets. The HFA indicators continue to offer potential for international cooperation.

210. It is encouraging to see that many Member States – in both eastern and western Europe – have now adapted the Regional Office's HFA database system for national and subnational use. National databases are being developed in CCEE (and more gradually in NIS), and training materials in Russian were prepared to facilitate their practical use. This work was carried out in part under country medium-term programmes, while more substantial implementation was effected through the joint EU/WHO European Public Health Information Network for Eastern Europe (EUPHIN-EAST). More recently, interest has also been expressed by Austria, Italy, Switzerland, some Länder in Germany and some regions of France.

Highlights

211. "Highlights on health" have been finalized for all the 15 EU countries, as a joint project with the EC. These reports are considered as one of the most suitable ways of presenting general information on health on a country-by-country basis for a wide range of

[12] *Op. cit.* (see page 1).

users, and they continue to be a product on which WHO cooperates with the Member States concerned, donors and other international organizations such as the EC. Finland seconded a staff member to work on highlights for the CCEE/accession countries, while Israel provided external consultants for the CAR highlights. The production of public health reports by Member States also gathered pace in the biennium, with Israel, Italy and Portugal, among others, producing initial or revised versions.

Information network

212. EUPHIN-EAST is a particularly important development. It will telematically link the national databases of 23 CCEE and NIS, giving users easy interactive access, as well as the ability to report on key health indicators and data to WHO. It is intended to interconnect EUPHIN-EAST with a similar network being developed by and for the 15 EU countries. Although the EU-funded phase of the project will soon come to an end, it is planned to continue the network and extend the number of countries participating "live" from the current nine to all CCEE and NIS.

Health interview surveys

213. The European health interview survey (EUROHIS) project, started with Statistics Netherlands, is now progressing well, developing common protocols and instruments for such surveys throughout the Region. This project, jointly funded by the EC and the Regional Office, has been extended to all Member States wishing to participate. EUROHIS is the first-ever WHO project from BIOMED2 (previously the EC's Directorate-General XII). Not only is it pioneering in its technical approach, it should also therefore serve to open up BIOMED to other WHO programmes.

Health statistics

214. A joint ECE/WHO meeting on health statistics took place in Rome in 1998, hosted by the Italian statistics office (ISTAT) and with support from the ECE, EC, UNFPA, UNICEF and the World Bank. In addition to the above international agencies, participants included representatives of all Member States, as well as of OECD and the United Nations Statistical Office. An international compendium of health indicators is being developed to support interagency and intercountry cooperation. The Office is an observer at meetings of the Management Committee of the EU Health Monitoring Programme and participates in all its associated working parties and that of EUROSTAT.

215. Support continued to be given to implementation of the tenth revision of the International Classification of Diseases (ICD-10). A Russian-language training course was organized for the NIS. A computer-based self-training package (TENDON) is being translated by the Russian Federation, with financial support from the US National Office for Statistics.

Partnerships

216. A task force on external relations was set up at the Regional Office to define a corporate partnership policy. During the biennium, work progressed well with the EU, the World Bank and NGOs.

European Union

217. A major initiative was taken in January 1999 when WHO's Director-General, during a visit to Brussels, decided with the then President of the European Commission, Mr Santer, to develop a new agreement between WHO and the EC. This development was taken forward with the new Prodi administration during 1999 and will form the political framework under which the Regional Office can establish strategic and more systematic forms of technical cooperation with the EC and other EU institutions.

218. The new public health provisions of the Treaty of Amsterdam and the EC Communication (COM(98)230 final) inspired an extensive public debate about public health policy in the EU during the biennium. The Regional Office took an active part in this debate, submitting comments on the EC Communication and providing expert advice on the public health aspects of the process for countries' accession to EU membership. In 1999, a project was initiated, in collaboration with the WHO Office at the European Union in Brussels, to make a substantiated response to the new public health framework for the EU, taking account of recent structural and functional developments in the EU's institutions.

219. During 1998 and 1999, the EC was EURO's most important collaborative partner in the Region, and cooperation with the Commission continued to improve: specifically, the Regional Office produced highlights on health for each of the 15 EU member countries; it provided input to the Commission's first report on the state of health in the EU, and it cooperated on the health interview survey project (EUROHIS) and the public health information network (EUPHIN-EAST) for the 23 CCEE and NIS. EURO also continued to support and advise the EC on its health information programmes, such as that on health monitoring and the interchange of data between administrations (IDA-HIEMS) and the "G7 information society" initiative.

220. The first joint project with the EU's PHARE programme, addressing health care issues in Bulgaria, Estonia, Hungary, Latvia, Lithuania and Romania, was successfully concluded, and the Regional Office continues to cooperate closely with the EC on the Health Promoting Schools initiative. WHO also collaborates with the EU on the surveillance of tuberculosis in the European Region through the Centre européen pour la surveillance epidémiologique du sida (CESES).

221. One of the most important recent developments has been the invitation from the EC to cooperate with regard to the so-called "accession countries". These are the ten CCEE that are to join the EU and which will, therefore, be the subject of considerable assistance from the Commission. The Regional Office has already delivered a number of projects to the Commission in this connection and further cooperation is planned. The process of drawing up national environmental health action plans (NEHAPs) has now been completed in all of these countries; they provide a ready-made, practical and prioritized framework of investment that can be used as a major basis for discussing assistance in this field.

222. The Regional Office has also collaborated actively with the European Environmental Agency, for instance on making a major review of the state of the environment in the European Union at the turn of the century. EURO also sends an observer to meetings of chief medical officers of the EU.

Council of Europe

223. The theme of the sixth Conference of European Health Ministers, which was held in Greece in April 1999, was "Ageing in the 21st century – the need for a balanced approach towards healthy ageing". The Regional Director delivered an address on "Ageing – exploding the myths; taking the Health for All approach".

224. The CE has been a counterpart of the Regional Office in the patients' rights and citizens' empowerment network since it was launched in 1997. EURO is currently consolidating and streamlining the work of this network and hopes to combine its clearing-house function with the CE's Web site on this subject. The Region has also benefited from the assessments that the Council has made of citizens' participation and waiting lists.

225. The Council continues to be an active partner in the ongoing development of the European Network of Health Promoting Schools and helps representatives of schools in the network to attend the many meetings and training events organized by the ENHPS technical secretariat throughout the year.

226. In addition, WHO has been represented at meetings of the European Health Committee (CDSP), where contributions were submitted on agenda items such as human rights, patients' rights, medical examinations in the field of employment and insurance, hospital waiting lists, health promotion and health education (ENHPS), blood transfusion, and bone marrow and organ transplantation (including xenotransplantation), best medical practices, health care services for people in marginal situations and for elderly persons in institutions, and preventive medicine.

United Nations bodies and other intergovernmental organizations

227. Close collaboration has been maintained with other IGOs, such as the United Nations Economic Commission for Europe (ECE), the Organisation for Economic Co-operation and Development (OECD), the United Nations Environment Programme (UNEP) and the World Bank, in the work of the European Environment and Health Committee.

228. The Regional Office has supported the role of United Nations resident coordinators, endorsed the concept of an integrated United Nations presence and participated in the United Nations Development Assistance Framework (UNDAF) exercises within the context of the United Nations reform process. In the European Region, Romania and Turkey are pilot countries for UNDAF exercises, and the Regional Director has asked WHO representatives and liaison officers in the European Region to participate fully in the process. WHO's philosophy and its Health for All polices, programmes, database and documents have been well received in this context.

229. EURO has had close and harmonious cooperation with the United Nations Children's Fund (UNICEF) in a number of areas, such as a project in the central Asian republics and Kazakhstan (the CARAK project).

230. Staff from the Regional Office's programme on sexually transmitted infections (STIs) and HIV/AIDS work in close consultation and collaboration with those at the Joint United Nations Programme on HIV/AIDS (UNAIDS) and its other co-sponsors. A UNAIDS intercountry technical adviser is based in the Regional Office, and a Medical Officer post was established for STIs, the costs of which are shared with UNAIDS. UNAIDS provided financial support for some of EURO's activities (a total of US $130 000 for the biennium), and a series of joint activities were carried out with UNAIDS and other co-sponsors.

231. The statutory four-yearly joint ECE/WHO meeting on health statistics took place in Rome in October 1998. Staff from the Regional Office (and WHO headquarters) also participated in the Conference of European Statisticians in June 1999. The Regional Office and ECE have established a joint task force on the health effects of long-range transboundary air pollution.

232. The Regional Office's unit for Women's and Reproductive Health has been cooperating with the United Nations Population Fund (UNFPA) on reproductive health projects in nine NIS. *Entre nous*, the European magazine for reproductive and sexual health, is produced and distributed in six languages (English, French, Hungarian, Portuguese, Russian and Spanish). All the projects mentioned are financed by UNFPA.

233. The United Nations Development Programme (UNDP) is a key partner in all EURO's country operations, both humanitarian and development-oriented. EURO evaluated the UNDP-funded project to support health care reform in Lithuania in 1997. Collaboration between EURO and UNDP (in the form of the exchange of information and participation in national workshops) also took place in Georgia and the Republic of Moldova.

234. There has been close cooperation with the Office of the United Nations High Commissioner for Refugees (UNHCR) in all the fields where EURO provides humanitarian assistance. One current joint operation is in the south Balkans, where WHO has been acting as public health adviser to UNHCR with particular reference to the needs of refugees in camps. WHO has also worked with UNHCR on carrying out specific public health programmes, for example related to water, sanitation and solid waste.

235. The President of the World Bank has proposed setting up comprehensive frameworks for development assistance to countries, involving all relevant sectors and actors. The overall aim is to bring together social and economic development objectives within a framework which assigns due importance to the former. This proposal is strongly supported by EURO. The World Bank is a founding partner of the European Observatory on Health Care Systems, together with EURO, the governments of Norway and Spain, the European Investment Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. National tuberculosis programmes benefited from World Bank support in a number of CCEE/NIS.

236. WHO's Director-General recently discussed new forms of more intensive collaboration between WHO, the International Monetary Fund (IMF) and the World Bank. Areas of cooperation that were identified included safeguarding essential health and social functions in some or all of the six Expanded Structural Adjustment Facility (ESAF) pilot countries, and developing benchmarks for monitoring trends in health sector performance.

Nongovernmental organizations

237. Policy-setting initiatives were strengthened through the European Forum of Medical Associations and WHO (EFMA), which promotes the Regional Office's programmes. The EFMA meeting in Tel Aviv in March 1999 was hosted by the Israel Medical Association. The main agenda items included: educational needs for medical risk management; quality of care development; tobacco; health care resources, their allocation and use; the autonomy of physicians; the tuberculosis programme in EURO; and the concepts of medical accountability and responsibility. Joint statements were adopted by EFMA and WHO on physicians' autonomy and tuberculosis control, while the national medical associations present at the meeting issued a statement on the ethical obligations of physicians regarding torture.

238. Membership of the Forum of Nursing and Midwifery Associations and WHO, established in 1997, has grown to forty national nursing associations and five national midwifery associations (the latter selected as official representatives of the International Confederation of Midwives). The third annual meeting of the Forum took place in Budapest in April 1999. The focus of the meeting was on chronic disease and the role of nurses in its prevention and management. A special session was devoted to smoking, with particular emphasis on nurses themselves and their importance as role models, both in health generally and more specifically as non-smokers.

239. The seventh annual meeting of the EuroPharm Forum took place in Copenhagen in November 1998. The theme of the professional session was the pharmaceutical service, looked at from the points of view of both education and practice. The eighth annual meeting, in Lisbon in November 1999, included an asthma symposium; both of these events were held in conjunction with the Third International Symposium on the Role of the Pharmacist in Health Promotion and Disease Prevention. Two new members from CCEE/NIS joined the Forum, bringing the total number of member countries to 34. In addition to the five projects currently running, two new activities were approved – a project on HIV/AIDS and a twinning programme. The Pan-American Health Organization (PAHO) has now also established a partnership with the pharmaceutical associations of its member states, along the lines of the EuroPharm Forum.

240. Active collaboration also took place with a wide range of other bodies, including the Soros Foundation, the European Society of General Practice/Family Medicine (as the European branch of the World Organization of Family Doctors), the International Federation of Red Cross and Red Crescent Societies, the International Confederation of Midwives, the International Council of Nurses, Services International, Consumers International, the World Medical Association, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine, the Association of Schools of Public Health in the European Region, the European Public Health Association, "Tipping the Balance", the European Union of General Practitioners, the International Federation of Gynaecology and Obstetrics, the European Association of Perinatal Medicine, the European Association for the Study of Diabetes, the International Diabetes Foundation (global and Europe), and the International Society for Environmental Epidemiology.

241. The International Union against Tuberculosis and Lung Diseases (IUATLD), the national tuberculosis and lung associations in Finland, the Netherlands and Norway, the Finnish Lung Health Association, the Norwegian Heart and Lung Association, the Swiss-Bulgarian association, Médecins sans frontières and the ICRC are all actively helping countries in eastern Europe to develop and sustain tuberculosis control pilot projects and training courses and to plan monitoring and surveillance activities. For the past five years, the Netherlands association has also hosted an annual European workshop on tuberculosis surveillance and policy, in collaboration with WHO and IUATLD.

Research

242. The European Advisory Committee on Health Research (EACHR) was involved in updating the regional Health for All policy framework, reviewing issues related to research and evidence. Thanks to support from the Finnish Government, a consultation on health research policy and programmes in CCEE and NIS, and a meeting of the EACHR, were convened in Finland in September 1998. The Committee felt that strong leadership is required to mobilize

research communities and stimulate the translation of research findings into public health practice, if the demanding agenda set by HEALTH21 is to be achieved.

243. At its meeting in London in December 1999, the Committee redefined its terms of reference to include advice on research carried out within WHO, thereby covering the issues of trends and forecasting in relation to health policy development.

Resource mobilization

244. EURO's potential for resource mobilization was strengthened through better relations with donors, and in-house capacity for submitting projects was increased through training and direct assistance provided by the Partnerships unit. Additional donors were identified and subsequently provided support (e.g. the Arabian Gulf Fund for United Nations Development). A donor database has been established which will serve as a model for the WHO global database.

Communication strategy

245. Good progress has been made in implementing the Regional Office's communication strategy "Good work alone is not enough". In keeping with this strategy, attention was focused on enhancing the ability of the Regional Office and Member States to deliver scientifically and ethically sound health messages to mass audiences, particularly through broadcast media. This process involved staff training, a new newsletter *Health catalyst*, and regional and country-based partnership activities with Worldwide Television News, the BBC World Service and the International Press Institute.

246. The WHO European Health Communications Network (EHCN) was launched in 1998. Five groups of health communicators are targeted – policy communicators, public health educators and advocates, advertising agencies and the media. The core functions of the EHCN are to provide intercountry and country-based mechanisms for representatives of these groups to share experience and resources, and to support countries (particularly CCEE/NIS) in developing their health and environment communication capacities.

247. The outcomes of a major regional consultation in Moscow in May 1998 and country- and city-based workshops in Armenia, France, Georgia, Germany, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Romania and Uzbekistan indicate that EHCN is helping to define an effective new approach to the development of health literacy. This combines the scientific base of academics/professionals, the immediacy of the media, the participation of NGOs, the "savvy" of advertisers, and the political clout of policymakers. EHCN working groups are developing WHO communication guidelines, including a new professional code for health communicators.

248. "Health reporting 2000", the second annual EHCN regional meeting held in Copenhagen in December 1999, brought together 150 journalists from 47 countries with a combined audience of more than 600 million people. Key outcomes included a new HEALTH21 broadcast series, to be launched in March 2000.

Publications

249. In 1998 the Regional Office pilot-tested a system for decentralized indexing and cataloguing of WHO publications and documents. This testing was successful, and Regional Office documentation is now entered directly on WHO's global bibliographic database on the World Wide Web, eliminating duplication of efforts by staff and making the database freely available to Internet users worldwide.

250. In 1998/1999, the Regional Office produced ten publications in English and 13 in French, German and Russian. It handled four co-publications, granted translation rights in some 30 publications, produced two issues of *Health catalyst*, and made its publications catalogue available on the Internet.

COUNTRY PROGRAMME STRATEGY

251. Despite serious cuts in its regular budget during the 1990s, EURO responded successfully to the changes in the political, economic, social and health situation in the European Region. Medium-term programmes of cooperation (MTPs) for 1998–1999 were signed in all CCEE/NIS. Monitoring of MTP implementation and regular reports from WHO's liaison offices

(quarterly or monthly as required) were organized in accordance with approved criteria. Periodic reports on evaluation of EUROHEALTH activities were submitted to the SCRC and the Regional Committee; preparations for the most recent evaluation started during 1999, with the report due to be presented to the Regional Committee in 2000.

252. In 1998 and 1999 the Regional Committee discussed and agreed on the distribution of an increased budget allocation to countries, to be divided equally among the six "low-income" countries (Armenia, Azerbaijan, Bosnia and Herzegovina, Kyrgyzstan, the Republic of Moldova and Tajikistan) (see below, Administration and Budget). A new planning approach is being introduced for countries with an increased budget allocation, which includes country visits by multi-departmental teams from EURO and WHO headquarters.

253. Five Member States (the Czech Republic, Estonia, Hungary, Poland and Slovenia) are to become members of the EU in a few years' time, while another five (Bulgaria, Latvia, Lithuania, Romania and Slovakia) are due to join at a later date. These countries are already working to bring their legislation and standards into line with those in the EU. At the request of the European Commission, the Regional Office in 1998 provided a health situation assessment and overview of EURO's partnership with these countries, highlighting key health-related issues and requirements still to be met.

254. WHO liaison officers were in post in 25 countries, and during 1998–1999 were granted the status of national professional officers, i.e. full-time WHO staff. A pilot project in Romania fostered moves towards closer cooperation between different United Nations agencies at country level: the common country assessment was finalized, and work was being done on drawing up a United Nations Development Assistance Framework (UNDAF). A similar process started in Turkey. In Latvia, WHO has been a partner since January 1999 in a "UN common house" concept. For financial reasons, the Office of the WHO Representative in Turkey was replaced by a liaison office. The humanitarian assistance and liaison offices in Sarajevo and Dushanbe were merged, to provide a more unified presence in Bosnia and Herzegovina and Tajikistan.

255. A new development during 1998–1999 was the opening of an office of the Special Representative of the Director-General in Moscow. A staff member from the Regional Office for Europe was assigned to this post. The office gives advice to United Nations agencies and other bodies on humanitarian aid and other health-related issues, and helps to coordinate assistance to the health sector; during 1999, activities focused on tuberculosis and HIV/AIDS, as well as on structural issues related to the provision of essential drugs. The Special Representative facilitated the formulation of the biennial MTP between WHO and the Russian Federation. In support of its operation, EURO received a generous donation from the Nordic countries (US $800 000).

Fellowships

256. At national level the HFA movement was stimulated by providing specialists from CCEE and NIS with fellowships. Strategies and methodologies were further developed, and the process of selecting fellows was improved. Selection committees in different subjects, particularly reproductive health, were set up in a number of countries.

257. During the biennium, 124 specialists from the European Region were awarded WHO fellowships, an increase of 55%. All except three fellows were from EUROHEALTH countries. As reproductive health/family planning is one of the major priorities in EUROHEALTH countries, 67 of the 124 fellows were trained in this subject. EURO also manages, administers and places fellows from four other regions (the African, American, South-east Asian and Western Pacific regions) in training institutions in European countries. In 1998–1999, 302 fellows were placed within the European Region (109 fewer than in 1996–1997).

258. The final version of the fellowships computerized database has been developed. The system is currently being used by the Regional Office for South-East Asia as a prototype for the global fellowships system.

MANAGEMENT AND ADMINISTRATION

Centres

259. EURO's capacity has been greatly enhanced through the establishment of centres, funded mainly from voluntary donations. Such centres are considered to be part of the Regional Office and act as extra operational arms at country level.

260. One especially interesting development in the 1990s was the establishment of Environment and Health divisions in Bilthoven, Nancy and Rome, with strong financial and other support from France, Italy and the Netherlands, as well as from a number of other countries. The Rome division has grown to twice its original size, and currently comprises some 24 staff. The division in Nancy fulfilled its mandate to undertake public health engineering projects in a number of CCEE/NIS. Despite a positive report on the division's work by external evaluators, the French Government in 1998 decided to withdraw its support. In 1999, an agreement was signed with Germany to establish a new centre in Bonn as from 2001.

261. Other field offices in the area of the environment and health include the Athens Office, which continued to make a considerable contribution to the Mediterranean Pollution Programme (MEDPOL), in close cooperation with UNEP. A new unit was established at the Institute for Nuclear Disaster Preparedness (STUK) in Helsinki, to enhance the European Region's ability to make quick and appropriate responses in cases of nuclear accidents in the Region. This project is being carried out in close cooperation with WHO headquarters and with strong support from the Finnish Government.

262. In 1998, after extensive preparation, the Regional Office succeeded in bringing together a number of partners to create a new entity – the European Observatory on Health Care Systems. The intention was to secure, on a permanent basis, the capacity for analysing health care reform that EURO had mounted in preparation for the 1996 ministerial conference in Ljubljana. The Observatory, which was officially inaugurated in February 1999, is a prime example of the Regional Office's commitment to forging partnerships and providing "cutting edge" support to Member States in key areas of health development. Partners include the governments of Norway and Spain, the World Bank, the European Investment Bank, and two distinguished academic institutions – the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM). The Observatory is made up of three hubs: Copenhagen (EURO), London (LSE and LSHTM) and Madrid (National School of Public Health).

263. A new European Centre for Health Policy was established at the end of 1998 in cooperation with the governments of Austria, Belgium and Finland. Strategically located in Brussels, the Centre is expected to work closely with the European Union, but its mandate is Europe-wide, drawing on a network of collaborating institutions and groups throughout the Region.

264. Also at the end of 1998, an agreement was signed with the Government of Catalunya Region in Spain to establish a new centre that would strengthen EURO's capacity in the areas of primary health care, hospital care and development of human resources for health. The new European Observatory on Integrated Health Care Delivery, in Barcelona, was opened in September 1999. Together with the European Observatory on Health Care Systems, these centres will more than treble the professional human resources at EURO's disposal to support key issues of health care reform in WHO's European Member States.

265. Agreement has been reached to establish, as from 2000, a new European centre in Venice. This will more than double the Office's present capacity to deal with health promotion issues and will give strong support to the Region as a whole in efforts to take forward this key component of HEALTH21 strategies.

266. In January 1998, the WHO Centre for Urban Health was launched with the mission of strengthening the Regional Office's capacity to promote health and improve the environment and living conditions in cities and towns in the European Region. The Centre's other aims are to further enhance the visibility of urban health and issues that can be tackled through local action, and to strengthen links with all technical units within WHO and with other agencies active in urban development.

WHO collaborating centres

267. A review of the management and use of WHO collaborating centres, made at both regional and global levels during 1998–1999, resulted in a reduction in the number of centres. Discussions on an improved process for their designation and management are continuing and are expected to result in new guidelines and better use of such centres in future.

Programme change and development

268. In view of the expansion of infectious diseases in the Region and a substantial increase in staffing, a new Department for Infectious Diseases was established in July 1998. The Mental Health programme was re-established with the appointment of a full-time programme manager in January 1999. A new Child Health and Development programme started in 1997, in line with WHO's "Safe Motherhood Initiative".

269. Following the Regional Committee's approval of the HEALTH21 policy framework in September 1998, a major effort was made to ensure that it was fully understood, accepted and "internalized" by all Regional Office staff, and special workshops were held to that end between February and May 1999, in which the targets and strategic directions of HEALTH21 were analysed with regard to possible new ideas, strategies and products for the Regional Office to take up during 2000–2005. The new global priorities, including the Tobacco Free Initiative and the Roll Back Malaria campaign, were part and parcel of the Office-wide discussions.

Reform

270. At the end of 1997, a private management consulting firm (Deloitte & Touche) presented a report on their review of the Executive Management unit and the Department of Administration and Finance. Most of their recommendations have now been implemented.

271. In February 1999, the Director-General urged all regional offices to conduct an internal review to ascertain whether their organizational structure, management and administration needed revision. In response, the Regional Director established a European Reform Task Force (ERTF) which, supported by a "change management facilitator" from WHO headquarters, convened a series of brainstorming meetings with all regional staff and subsequently drew up a series of recommendations. The Task Force's report was ready at the beginning of July 1999 and was sent out to all staff for consultation. This consultation process was completed towards the end of August, and the European Regional Cabinet (the senior management group at the Regional Office) started to make its analysis of the recommendations. The Staff Association participated in these discussions. The Regional Director then took a first set of decisions at the beginning of September (related to the departmental infrastructure of the Office). After the Regional Committee's nomination of a candidate for the position of Regional Director for a five-year period starting in February 2000, it was decided to postpone further work until the year 2000.

272. In these as in other areas, developments during 1999 were characterized by a new culture in the Organization of much closer involvement of both regional and headquarters staff. The creation in July of a new "global cabinet" – consisting of the Director-General and the regional directors – was felt by all regions to be a very important step towards establishing a clear channel for overall development of the Organization. It will no doubt be a major tool for taking forward the concept of "one WHO" that has been so strongly advocated by the Director-General.

Governing bodies

273. The Regional Director acts as the Secretary to the regional governing bodies. The Regional Committee met in Copenhagen in 1998 and in Florence, at the invitation of the Minister of Health of Italy, in 1999. Arrangements for the 1999 session (RC49) were facilitated by the fact that EURO was given full responsibility for the disbursement of funds and organization of the meeting. Since 1998, Regional Committee documentation has been available in four languages on EURO's Web site.

274. The Standing Committee of the Regional Committee (SCRC) acts for and represents the Regional Committee and ensures that its decisions and policies are followed through. Ten sessions of the SCRC were held during the biennium, and at an ad hoc meeting in July 1999 the SCRC proposed (subsequently agreed to by RC49) that a new system will be introduced in

2003, whereby agreement on Executive Board candidates will be guided by objective criteria; meanwhile, France and the United Kingdom each agreed to postpone their candidatures for the Board by one year. The Secretariat regularly reports on work in progress to the SCRC, and the SCRC Chairperson and the Regional Director meet European Board members on the eve of the Board's January session, to brief them on matters of particular concern to the Region.

275. A regional search group for candidates for the post of Regional Director was appointed in 1998, and it reported on its work to the Regional Committee in September 1999.

Administration and budget

276. The decision by the World Health Assembly in May 1999 not to allocate funds to the Organization to compensate for the expected cost increases in the 2000–2001 biennium was very disappointing news to all WHO staff. Each region will have to bear the brunt of its own deficit arising from this decision. EURO has not received any increase in regular budget staffing since 1979; on the contrary, in the past ten years it has experienced a succession of cuts in its regular budget (totalling close to 25%). In spite of this, the Office has managed, by streamlining its administrative services, to reorient its activities and rationalize operations in such a way that country programmes and technical activities have been protected. However, the point has now been reached where any further cuts in regular budget funds will have repercussions on the funding and staffing of technical programmes.

277. On a more positive note, the World Health Assembly in 1998 decided that the regional, intercountry and country allocations of WHO's programme budget should in future be guided for the most part by a model drawing on UNDP's Human Development Index (HDI). This will mean an increased country programme allocation for EURO, spread over a number of years, starting with 2000–2001. The Regional Committee agreed on a model for distribution at the regional level, based on HDI, at its session in 1999 (resolution EUR/RC49/R5).

278. During 1999, the Regional Office piloted development of the Organization's new computerized system for programme management (AMS), which became operational in January 2000 and is being used for drawing up and monitoring work plans for 2000–2001.

279. Details of implementation of the regional programme budget in 1998–1999 are contained in the information document (EUR/RC50/Inf.Doc./1) that should be read in conjunction with this report.

Staffing policy

280. The number of fixed-term posts is set according to the regular budget allocation, and for 1998–1999 it was reduced from 183 to 177. The number of time-limited posts continues to increase, necessitating close follow-up of the funding and employment status of such staff. Short-term staff now represent 64% of the total, and the number of contracts has increased by 18% since 1996, especially in the humanitarian assistance area. The average length of contract has decreased from 3.31 to 2.36 months since 1996, but this is mainly due to the very short contracts issued during the Kosovo crisis. There has been an increase in out-posted staff (currently 45% at 42 duty stations), and the resulting wide variety of local conditions make the provision of support for staff outside Copenhagen a complex and time-consuming task.

281. Professional staff come from 29 countries (30 staff from Priority A, 26 from Priority B, and 25 from Priority C countries). There are 81 professional fixed-term staff, of whom 32% are women. Three of the seven department directors are women.

282. Retirements of professional and general service staff are closely monitored, to allow for adequate succession planning and give maximum opportunities for restructuring services. Considerable progress was recently made within EURO in terms of matching staff skills to the main areas of work under the HEALTH21 policy framework. Strong emphasis will continue to be placed on public health leadership, including more training of staff in areas such as strategic management, team leadership, project management, policy development, marketing, working with other sectors, and communication. The new Director-General's policy for increasing staff rotation among different parts of the Organization is welcomed in EURO, as is the develop-

ment of a new global appraisal system. Better career development opportunities for general service staff would be a popular move among staff.

283. The personnel database became fully operational and documented during the biennium, and it has been exported for use at the Eastern Mediterranean Regional Office.