World Health Organization

REGIONAL OFFICE FOR Europe

REGIONAL COMMITTEE FOR EUROPE 64TH SESSION

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Progress reports

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Progress reports

Corrigendum

This document contains corrections to section A. “Progress on implementation of the European Action Plan for HIV/AIDS 2012–2015”.

The final sentence of paragraph 20 should read:

“In the west, the number of people receiving ART was high (460 000) and most countries had achieved or were expected to achieve the 80% ART coverage target by 2015.”

In Annex A1. Indicators of progress in implementing the European Action Plan by area of intervention, under the headings:

HIV treatment and care
Number of people currently receiving ART

the data should read:

	559 000	430 000	129 000	659 000	460 000	199 000	18%

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REGIONAL OFFICE FOR **Europe**

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Progress reports

This document contains consolidated progress reports on:

A. implementation of the *European Action Plan for HIV/AIDS 2012–2015*
B. harmful use of alcohol in the WHO European Region
C. implementing resolution EUR/RC55/R9 on “Prevention of injuries in the WHO European Region”
D. the *European strategy for child and adolescent health and development*
E. the *European strategic action plan on antibiotic resistance*..

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A. Progress on implementation of the *European Action Plan for HIV/AIDS 2012–2015*

Introduction and background

1. In resolution EUR/R61/R8, the Regional Committee adopted the *European Action Plan for HIV/AIDS 2012–2015* and requested the Regional Director to report on its implementation at the 64th session of the Regional Committee in 2014. This is an interim report describing progress made since RC61 in September 2011 and the challenges that remain. It should be read in conjunction with the Action Plan.[1]

Situation analysis

2. Substantial progress on increasing the number of people receiving treatment for HIV/AIDS and towards the elimination of mother-to-child transmission (see Annex A1) has been made in the Region. It has become apparent that global and European gains in HIV treatment are unevenly distributed. In the eastern part of the Region,[2] antiretroviral therapy (ART) coverage remains low, with relatively few people who are eligible actually starting ART and achieving viral suppression. As a result, the numbers of AIDS cases and deaths have increased by 47% and 13%, respectively, since 2010. In the western part of the Region,[2] where ART coverage is high, the numbers of AIDS cases and deaths are decreasing.

3. A 7% increase in the reported number of HIV infections in the two years since the European Action Plan was adopted emphasizes the public health challenge of HIV/AIDS in Europe. In 2012, 131 000 new HIV cases were reported, the highest annual number since reporting began, which contribute to a cumulative 1.5 million cases. Most new cases continued to be reported from the east (76% in 2012), where the Russian Federation and Ukraine accounted for 92% of new cases. In the central part of the Region,[2] the number of infections remained low, but increased by 39% between 2010 and 2012. In the west, the epidemic remained stable.

4. The epidemic remains concentrated in populations at higher risk for HIV infection: people who inject drugs and their sexual partners, men who have sex with men, sex workers, prisoners, and migrants. HIV transmission through sex between men predominated in the west and centre, while heterosexual transmission and transmission through injecting drug use were the main modes of transmission in the east (see Annex A1).

5. Injecting drug use remains an important mode of transmission of HIV in the east, having contributed 34% of new cases in 2012; it accounted for only 5% of new cases in the west. HIV

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[1] European action plan for HIV/AIDS 2012–2015. Copenhagen: WHO Regional Office for Europe; 2011 (http://www.euro.who.int/__data/assets/pdf_file/0011/153875/e95953.pdf).

[2] Country groupings follow those used in the joint WHO/European Centre for Disease Prevention and Control annual reports on HIV/AIDS surveillance in Europe, which are based on epidemiological considerations. The eastern part of the Region ("the east") comprises: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan; the central part of the Region ("the centre") comprises: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Hungary, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, The former Yugoslav Republic of Macedonia and Turkey; and the western part of the Region ("the west") comprises: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland and the United Kingdom.

outbreaks among drug injectors in central Europe are becoming increasingly common. Significant progress was achieved in the prevention of mother-to-child transmission of HIV. Elimination of both mother-to-child transmission and congenital syphilis is a regional priority. In the east, tuberculosis (TB) remained the most common AIDS-indicative disease. In 2013, 13.3 million (1.8%) adults in the European Region had hepatitis B, 15.0 million (2.0%) had hepatitis C, and HIV–hepatitis co-infection rates were extremely high.

Achievements

Strategic direction 1: Optimize HIV prevention, diagnosis, treatment and care outcomes.

6. All Member States endorsed the European Action Plan and 20 targeted countries in the centre and east adopted comprehensive policies, strategies and medium-term plans for an approach based on public health systems for addressing HIV infection, targeting populations at higher risk and integrating HIV prevention and control services.

7. The Regional Office assisted Member States in reviewing, adapting and adopting national protocols, in accordance with WHO recommendations and with an emphasis on HIV testing and counselling, comprehensive HIV care and treatment including screening and treatment of co-infection (TB and viral hepatitis), harm reduction services and prevention of mother-to-child transmission.

8. HIV testing and counselling services are increasingly available, accessible and affordable in the Region, in both health care settings and the community. The quality and ethical standards vary, however, and some countries do not adhere to standards of voluntary informed consent, confidentiality and linkage to appropriate treatment, care and support.

9. In 2012, it was estimated that at least 50 million people in the Region had been tested for HIV and the number is increasing. This increase does not, however, reflect better coverage of the population groups most in need, as the percentage of key populations tested remained below the European target of 90% by 2015, with a range of 38–50% (see Annex A1). An estimated 50% of people with newly diagnosed HIV infection present for testing at a late stage (CD4 cell count < 350 per ml blood) and there has been no improvement in earlier diagnosis since 2010.

10. The Regional Office supported efforts of Member States to expand access to HIV testing and counselling, increase early uptake of HIV testing and counselling, respond to the particular needs of vulnerable populations and reduce the size of the undiagnosed population and the number of late diagnoses by improving early diagnosis and earlier enrolment in HIV care. Support included publishing and disseminating a policy framework "Scaling up HIV testing and counselling in the WHO European Region" (2010), supporting the European Union initiative "European HIV testing week" (2013), the pan-European "HIV in Europe" initiative (2012–2103) and related conferences and providing technical assistance directly to Member States.

11. Between 2010 and 2012, six countries achieved and 11 are on track to reach the 2015 European target of a 50% reduction in new HIV infections acquired through injecting drug use; 14 more reported zero or less than two cases due to injecting drug use at baseline and no substantial change in recent years. In the Region, the rate of HIV transmission through injecting drug use remained relatively stable; it decreased in the east and increased in the centre and the west, mainly due to outbreaks in two European Union countries.

12. Most countries implemented the package of interventions recommended by WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) for the prevention, treatment and care of HIV infection among

people who use drugs. Certain components of the package remained unavailable in some countries: opioid substitution therapy was not available in six countries and needle and syringe programmes were not available in four.

13. In 2011, more than 713 000 people were receiving opioid substitution therapy in 45 European countries, including 11 300 people in the east. Coverage of people in need of such therapy ranged from 0% to 82% in the Region, but remained below 5% in most countries in the east.

14. The Regional Office supported Member States in preventing new infections among people who inject drugs, mitigating other health problems of drug users and improving the accessibility and quality of harm reduction services, especially HIV treatment, integrated HIV–TB and HIV–viral hepatitis services and opioid substitution therapy by:

- undertaking social–behavioural research on scaling up access to harm reduction, treatment and care for injecting drug users and identifying structural barriers and environmental risk factors with the European Commission's Executive Agency for Health and Consumers (EAHC), the London School of Hygiene & Tropical Medicine, the World Bank and other partners in 2010–2013;
- contributing to systematic reviews to identify and synthesize prevalence estimates and risk factors among people who inject drugs (with the London School of Hygiene & Tropical Medicine);
- convening workshops and publishing guidance on implementing and scaling up opioid substitution therapy with EAHC and the European Monitoring Centre for Drugs and Drug Addiction in 2013;
- convening a regional technical consultation on prevention of HIV in injecting drug users in the central Asian Member States with UNAIDS and other partners in 2012;
- reporting comprehensive situation overviews, best practices, experiences and challenges regarding HIV prevention in injecting drug users, both in the community and in prisons with UNAIDS, the World Bank and other partners;
- designating a new WHO collaborating centre for harm reduction to develop capacity and provide technical support to promote high-quality, evidence-based approaches to drug use (Public Health Institute, Faculty of Medicine, Vilnius University, Lithuania), 2013; and
- providing technical support and advocacy for harm reduction with the European Centre for Disease Prevention and Control (ECDC) and others.

15. Between 2010 and 2012, 15 countries reduced sexual transmission of HIV by 5% or more, but only three reached or were close to the European 2015 target of a 50% reduction. Sexual transmission increased in the east and the centre and decreased in the west. Heterosexual transmission was associated with transmission from male drug injectors and migrants to their female partners in the east and with migration from countries with generalized HIV epidemics in the west, where migrants account for more than a third of heterosexual cases. Condom use varied by population; in 2012, it was highest among sex workers (88%), lower among men who have sex with men (56%) and lowest among people who inject drugs (42%).

16. The Regional Office supported Member States in preventing sexual transmission by translating and disseminating global guidelines on prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people.

17. In 2012, just 1% of new cases of HIV infection reported were due to mother-to-child transmission. The number of infected children decreased by 10% since 2010, mostly due to a

decrease in the west; 75% of infected children were in the east. In the west, close to 40% of infected children were born to mothers originating from countries with generalized epidemics.

18. The Region achieved and maintained the highest coverage globally of providing ART to reduce the risk for mother-to-child transmission (> 95%), of early infant diagnosis (> 95%) and of HIV testing and counselling for pregnant women (69% in 2011). Progress was made towards the European target of HIV testing and counselling for 95% of pregnant women by 2015. Eleven targeted countries in the east plan to move from the WHO-recommended "option B" for preventing mother-to-child transmission to "option B+"[3] by 2015.

19. The Regional Office supported Member States in eliminating vertical transmission of HIV by:

- promoting and supporting the WHO consolidated guidelines on the use of antiretroviral drugs in regional technical consultations (2013);
- implementing, in collaboration with UNAIDS, the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA), country pilot assessments and country missions to monitor progress in elimination of mother-to-child transmission of both HIV and congenital syphilis, focusing on key populations;
- reviewing progress made and addressing the challenges in defining and eliminating mother-to-child transmission; and
- preparing a regional consultation on elimination of mother-to-child transmission of both HIV and congenital syphilis with UNAIDS, UNFPA, UNICEF, UNODC and others.

20. Member States made significant progress in delivering HIV treatment and care to people living with HIV, including improved laboratory monitoring and delivery of services. ART use has been scaled up across the Region. Although no low- or middle-income country had yet achieved the 2015 European coverage target of 80%, the number of people receiving ART increased considerably, with 70 000 more patients receiving ART in 2012 than in 2010 (see Annex A1). ART coverage in the east increased from 23% (129 000) in 2010 to 35% in 2012 (199 000). In the west, the number of people receiving ART was high (560 000) and most countries had achieved or were expected to achieve the 80% ART coverage target by 2015.

21. The majority of people on ART in the east received a WHO-recommended first-line regimen and fixed-dose combinations of antiretroviral drugs were widely used. Viral load and CD4 cell count testing were available in all but two eastern European countries and national guidelines included the WHO recommendation for testing frequency (every 3–6 months).

22. The Regional Office supported Member States in ensuring universal access to treatment and care for people living with HIV by:

- supporting regional dissemination and implementation of the WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection;[4]
- convening a regional technical consultation on dissemination and implementation of the guidelines in 12 eastern Europe and central Asian countries;

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[3] WHO recommends two options for preventing mother-to-child transmission of HIV: option B is lifelong use of ART only for pregnant and breastfeeding women who are eligible for treatment for their own health (that is, ART should be stopped after delivery and cessation of breastfeeding for ineligible women); option B+ is lifelong ART for all pregnant and breastfeeding women regardless of stage of infection or CD4 cell count.

[4] The new guidelines extend the eligibility criteria for ART and recommend initiation of treatment regardless of CD4 cell count in certain population groups, while maintaining the recommendation to prioritize treatment of people with advanced disease over people with CD4 cell counts of 350–500 cells/mm^3.

- supporting 11 countries in preparing national plans to adapt country policy to the new WHO recommendations;
- designating a new collaborating centre on HIV and viral hepatitis (Copenhagen HIV programme, Faculty of Science, Department of International Health, Immunology and Microbiology, University of Copenhagen, Denmark) to support the Regional Office in providing technical assistance to countries; and
- evaluating and providing recommendations on ART and optimization of ART service delivery to nine countries.

23. In 2012, less than 0.3% of new cases of HIV infection were acquired in health care settings; between 2010 and 2012, however, the number of people infected by nosocomial transmission increased by 178% across the Region, driven by an increase in the east. All Member States are implementing quality-assured HIV screening of all donated blood. To reach the European target of an 80% reduction in nosocomial transmission by 2015, health care-related HIV outbreaks must be better prevented and controlled.

Strategic direction 2: Leverage broader health outcomes through HIV responses.

24. Three priority countries in the east integrated delivery of opioid substitution therapy in ART settings and three more plan to do so by 2015. Two countries have integrated this therapy in TB clinics and three more countries plan to include it in their national policies by 2015.

25. HIV testing coverage of notified TB patients reached 60% in 2012 and 62% of HIV-positive TB patients received ART. All three countries with high burdens of HIV/AIDS and TB were implementing the 12-point policy package on collaborative TB–HIV activities. Ten countries in the east adopted the WHO recommendation that all people living with HIV and TB should receive ART and eight countries specified that ART should be started within eight weeks of initiation of TB treatment.

26. Although screening for viral hepatitis is recommended as part of comprehensive HIV care, only about one third of people in HIV care in the east were screened for hepatitis B and C in 2010–2011.

27. The Regional Office directly contributed to reducing HIV–TB co-infection and sexually transmitted infections by supporting collaborative activities and integrating HIV and TB programmes, including:

- conducting cross-cutting reviews of national HIV, sexually transmitted infection and sexual and reproductive health programmes in collaboration with partners;
- assessing the availability of testing for infections and conditions that affect HIV treatment (TB, viral hepatitis B and C, pregnancy and sexually transmitted infections) in seven priority countries;
- evaluating HIV–TB collaborative activities and integrating services in seven countries;
- providing recommendations for increasing access to testing, diagnosis, treatment and monitoring of TB and HIV in co-infected patients;
- publishing a training manual on developing TB services for people who use drugs with the Eurasian Harm Reduction Network and the European Commission;
- promoting awareness and scaling up of services to strengthen prevention and treatment of viral hepatitis, including a regional campaign for World Hepatitis Day, and publishing a review of hepatitis B and C prevalence; and

- publishing articles and documents addressing barriers to and facilitators of treatment for HIV, hepatitis C and TB and strengthening links between prison health and public health services.

Strategic direction 3: Build strong and sustainable systems.

28. Member States made progress to various extents towards building strong, sustainable health systems. Of these, 38 reported having a multisectoral strategy to respond to HIV infection and 33 had an officially recognized national multisectoral AIDS coordination body; 24 had integrated HIV activities into their development plans.

29. Many countries in the east benefited from support provided by The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund). Governments have assumed stronger leadership, and at least three countries (Estonia, Kazakhstan and the Russian Federation) assumed full responsibility for funding their ART programmes after The Global Fund grants ended. International funds covered an average of 93% of programmes for sex workers, 96% of programmes for men who have sex with men and 78% of those for injecting drug users.

30. Stock-outs of antiretroviral drugs remained a concern, mainly in the east, although the reported number of facilities that experienced a stock-out decreased to five in two countries in 2012 (see Annex A1). Several countries opened new ART sites in remote areas or decentralized services to reach key populations, including migrants, through mobile clinics.

31. The Regional Office directly contributed to building strong, sustainable systems by:

- supporting, jointly with UNAIDS, a regional initiative to scale up ART coverage by mapping ART provision in 11 priority countries in the east;
- promoting and providing technical assistance to decentralize HIV treatment and care services; and
- establishing an initiative for improving the quality of HIV prevention in Europe with the German Federal Centre for Health Education and the nongovernmental organization AIDS Action Europe.

32. The Regional Office continued to strengthen strategic information systems for surveillance, monitoring and evaluation of HIV/AIDS in Europe by:

- coordinating surveillance jointly with ECDC [Annual reports have been published by the Regional Office and ECDC, most recently in 2013, reporting on 2012 data. All 53 Member States are invited and supported to submit national HIV/AIDS case surveillance data annually. In 2013, 51 of 53 Member States (96%) submitted data.];
- organizing regular joint HIV surveillance network meetings with ECDC for all WHO European Member States, most recently in Dubrovnik, Croatia (May 2014);
- revising HIV surveillance in Europe with ECDC, for example, by integrating HIV and AIDS surveillance; simplifying data on exposure and including biomedical markers; and monitoring, in collaboration with ECDC, UNAIDS and UNICEF, national responses to HIV infection by annual data collection in a joint online reporting tool hosted by UNAIDS, with harmonized indicators and regular regional and global progress reports on response;
- convening a technical consultation to review models for estimating HIV prevalence and ART needs in collaboration with UNAIDS and the United States Centers for Disease Prevention and Control;
- continuing to strengthen national capacity for implementing effective, sustainable, context-specific HIV surveillance and monitoring and evaluation systems; and

- providing training and technical assistance for surveillance, monitoring and evaluation through the Collaborating Centre for HIV Surveillance in Zagreb, Croatia.

Strategic direction 4: Reduce vulnerability and remove structural barriers to accessing services.

33. Thirteen of 28 countries (46%) reported that some of their laws, regulations or policies presented obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations. People who inject drugs, sex workers, prisoners and migrants were most often affected.

34. Most Member States have made progress in reducing vulnerability: for example, by explicitly addressing or reflecting human rights in national AIDS strategies and consulting and involving civil society in formulating HIV and viral hepatitis policies and decision-making.

35. Some countries have reduced vulnerability and acted to address structural barriers to reducing the rate of new infections. Modelling illustrated the potential impact on HIV incidence and prevalence in other countries.

36. The availability of programmes to reduce HIV-related stigma and discrimination, targeting health care workers, media and the workplace, were reported in 24 countries. Promotion and protection of human rights were explicitly mentioned in the national HIV policies or strategies in 30 of 35 countries (86%).

37. The Regional Office worked closely with civil society on monitoring aspects such as HIV drug stock-outs, HIV testing and counselling practices and programme responses. The Regional Office also gave timely responses on issues raised by national civil society coalitions and regional networks on various topics, such as technical support for preparing a business case for introducing a medicines prequalification process in the Ukraine as a prerequisite for purchasing antiretroviral agents.

38. The Regional Office actively supported civil society involvement and contributions to national strategy development and national programme review, for example, in Azerbaijan, Greece, Kazakhstan and Ukraine.

39. The Regional Office supported the work of regional networks such as the Eurasian Harm Reduction Network through collaboration and financial support, the Eurasian Coalition on Men's Health through technical and financial support, the International Treatment Preparedness Coalition for eastern Europe and central Asia and the European Civil Society Forum through information exchange and inclusion in important regional processes.

40. In most countries, civil society is involved to various degrees in the planning and budgeting of national strategic plans; only 11% of countries reported no civil society involvement. Civil society organizations are increasingly involved in community-based rapid HIV testing and links to HIV care. Civil society involvement in the provision of preventive services is relatively strong in many Member States. National HIV budget spending on activities implemented by civil society varied across the Region, being higher in the west (close to 50%) than in the centre (19%) and the east (7%).

41. In 2013, the Regional Office and the World Bank published a systematic review of evidence on vulnerability to HIV infection and response in all countries of the Region.

42. The Regional Office supported countries in reducing vulnerability and removing structural barriers by:

- responding to attempts to extend mandatory HIV testing policies and practices and continuing to oppose mandatory HIV testing;
- advocating against laws and practices that are barriers to access to prevention and treatment and that marginalize and criminalize key populations;
- contributing to a systematic review to identify and synthesize prevalence estimates and risk factors among people who inject drugs, which found that contact with law enforcement agencies and the legal environment are associated with risk for HIV infection; and
- providing advocacy and assistance to promotion and implementation of policies and practices relating to the HIV response based on evidence and human rights.

Challenges and the way forward

43. Recent international evidence, guidance and recommendations for a public health approach to the use of antiretroviral drugs to treat and prevent HIV moves us closer to controlling the HIV epidemic. Greater strategic use of ART is needed to treat and prevent HIV transmission and to reach the 2015 targets of the European Action Plan.

44. New guidelines extend eligibility for ART initiation; however, it will be difficult for most countries with limited resources and capacity to treat 80% of people in need by 2015. Critical challenges in increasing ART coverage are reducing undiagnosed HIV infection and diagnosis of infection at an advanced stage, ensuring better linkage to and retention in HIV care and increasing access to ART and viral suppression. The “HIV cascade of care” consists of the sequential stages or continuum of care, from HIV diagnosis through linkage to and retention in care, prescription of ART and viral suppression. Constructing, evaluating and comparing HIV treatment cascades and key vulnerable populations in these countries would help in measuring progress towards universal access and, more importantly, in identifying the strengths and weaknesses of HIV programmes.

45. Countries could lower treatment costs, for example, by applying WHO guidelines to optimize drug treatment regimens and using simpler diagnostic and monitoring tools and they could use the economies to increase ART coverage.

46. Certain populations are disproportionately affected by the HIV epidemic in Europe and economic volatility and risks associated with recession are increasing their vulnerability to HIV and other infections. HIV testing policy and practice should focus on reaching population groups that are at risk for HIV infection, including people with viral hepatitis and those with active TB. The coverage of opioid substitution therapy and needle and syringe programmes should be further scaled up in all countries and particularly in the east. Prevention of sexual transmission of HIV presents particular challenges for men who have sex with men in the east, where stigma, discrimination and criminalization impede prevention and treatment.

47. Despite the progress achieved, there remain challenges to eliminating mother-to-child transmission, as there are still pregnant women living with HIV who do not have access to antenatal care or who present late, especially women who inject drugs, sex workers, ethnic minorities, migrant women and prisoners. Links between services for people who inject drugs and maternal and child health services remain weak and expertise in preventing mother-to-child transmission during pregnancies complicated by substance use is often lacking.

48. Inadequate implementation of standard precautions to avoid nosocomial infections remains a problem in some countries.

49. Challenges remain regarding TB–hepatitis co-infection and integration of services. HIV testing of notified TB patients should be further scaled up to ensure effective HIV treatment. The "Three I's"[5] for decreasing the number of deaths from TB among people living with HIV have yet to be fully implemented. Efforts to prevent and control hepatitis and hepatitis treatment costs present particular challenges and require further integration of hepatitis services, particularly for drug injectors. Building stronger, more sustainable systems presents opportunities for further integrated service provision, particularly for populations at higher risk and for a more effective HIV response.

50. Countries will increasingly have to rely on national budgets and take greater responsibility in funding treatment and prevention among vulnerable populations in their HIV programmes and especially harm reduction for drug injectors.

51. Structural barriers to accessing services for HIV and sexually transmitted infections, viral hepatitis and other essential services (including by addressing social determinants of health) should be removed.

52. Strong partnerships with civil society and state actors are essential to the response. Key challenges are the laws and regulations that are obstacles to an effective response, stigma and discrimination and the relative weakness of community systems in some countries. The availability of funding and the changing attitudes of many governments provide the foundations for constructive, sustainable involvement of civil society in the response to the HIV epidemic.

53. The outcome document of the Fourth Conference on HIV/AIDS in eastern Europe and central Asia (Moscow, 12–13 May 2014) noted particular progress in key areas of the HIV/AIDS response: increased access to ART and better procurement procedures and supplies of drugs; greater coverage in preventing mother-to-child transmission of HIV; expansion of social care and support for people living with HIV; better sharing of information among countries and new data on the epidemiological and economic efficiency of prevention activities in key populations. The Conference also noted challenges, including: inadequate funding of HIV/AIDS programmes at national level; inadequate implementation of comprehensive, evidence-based prevention and testing strategies and innovative methods of HIV prevention, particularly for high-risk population groups; low coverage with ART and appropriate diagnostics, especially in correctional facilities; poor involvement of all potential stakeholders (including civil society, the private sector and people living with HIV) in the response to HIV/AIDS; insufficient attention to HIV programmes and services for women and girls; and inadequate education of young people in general on HIV infection.

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[5] Intensified case-finding, isoniazid preventive therapy and infection control for TB.

Annex A1. Indicators of progress in implementing the European Action Plan by area of intervention

	2010				2012				% change
	Europe[a]	West[b]	Centre[c]	East[d]	Europe	West	Centre	East	
HIV diagnoses									
No. of newly reported HIV diagnoses									
	122 684	25 659	2 478	90 258	131 202	27 315	3 715	100 172	7%
HIV testing and counselling									
Percentage of at-risk populations who received an HIV test in the past 12 months and who know the result[e]									
Sex workers	49% (n = 21)	54% (n = 9)		45% (n = 12)	50% (n = 20)	55% (n = 9)		46% (n = 11)	
MSM	48% (n = 29)	51% (n = 10)	50% (n = 9)	42% (n = 10)	38% (n = 33)	44% (n = 12)	33% (n = 8)	37% (n = 13)	
PWID	46% (n = 29)	61% (n = 8)	41% (n = 8)	40% (n = 13)	45% (n = 27)	53% (n = 7)	48% (n = 9)	38% (n = 11)	
Percentage of people with newly diagnosed HIV infection with CD4 cell counts < 350/mm^3 blood at time of diagnosis									
	50% (n = 25)				50% (n = 29)				
Percentage of pregnant women who were tested for HIV infection and received the result[e]									
				63%				69%	10% (east)
Percentage of infants born to HIV-infected women who received a virological test for HIV infection within 2 months of birth[f]									
							> 95% (69% to > 95%)		
HIV transmission through injecting drug use									
Newly diagnosed HIV infections acquired through injecting drug use									
	29 313	1 244	121	27 948	27 511	1 390	273	25 848	–6%
Number of opioid-dependent people on opioid substitution therapy									
	713 000 (n = 45)			11 300 (n = 12)					
Number of opioid substitution therapy sites per 1000 PWID									
		33 (n = 9)	2.4 (n = 9)	0.3 (n = 12)			2.0 (n = 6)	0.2 (n = 8)	
No. of needle and syringe programme sites per 1000 PWID									
		4.5 (n = 7)	1.8 (n = 9)	3.6 (n = 12)			1.3 (n = 6)	1.0 (n = 8)	
Sexual transmission of HIV									
No. of newly diagnosed HIV infections in men infected through sex with men									
	13 092	11 792	758	542	12 944	11 378	975	591	–1%
No. of newly diagnosed HIV infections acquired through heterosexual contact									
	37 175	12 035	687	24 453	38 466	9 654	915	27 897	3%
No. of newly diagnosed HIV infections acquired through sexual contact (MSM and heterosexual combined)									
	50 267	23 827	1 445	24 995	51 410	21 032	1 890	28 488	2%
Percentage of at-risk populations reporting use of condoms at most recent intercourse or client[g]									
Sex workers	79% n = 22)				88% (n = 11)				
MSM	56% (n = 26)				56% (n = 13)				
PWID	42% (n = 23)				42% (n = 15)				
Mother-to-child transmission of HIV									
No. of newly diagnosed HIV infections acquired through mother-to-child transmission									
	1 009	282	31	696	912	193	33	686	–10%
Percentage of HIV-infected pregnant women who received ART to reduce the risk for mother-to-child transmission									
		> 95%		88%		> 95%		> 95%	8% (east)
Percentage of HIV-positive pregnant PWID who received ART to reduce the risk for mother-to-child transmission									
			66% (50% to > 95%) (n = 7)						

	2010				2012				% change
	Europe[a]	West[b]	Centre[c]	East[d]	Europe	West	Centre	East	
Percentage of infants born to HIV-infected women receiving ART for prevention of mother-to-child transmission									
			75% (63% to 91%)				94% (50% to > 95%)		25% (east)
HIV treatment and care									
Number of people currently receiving ART									
	559 000	430 000		129 000	759 000	560 000		199 000	36%
Percentage of eligible adults and children currently receiving ART									
				23%				35%	52% (east)
Estimated no. of AIDS-related deaths									
		7 700		83 000		7 600		91 000	10% (east)
Reported no. of deaths among AIDS cases									
	6 661	1 949	283	4 429	5 983	713	252	5 018	13% (east)
HIV transmission in health care settings									
No. of newly diagnosed HIV infections acquired through nosocomial transmission									
	37	20	1	16	103	6	1	96	178%
No. of newly diagnosed HIV infections acquired through transfusion of blood and its products and among haemophiliacs									
	80	79	1	0	63	55	1	7	–21%
No. of newly diagnosed HIV infections acquired in all health care settings									
	117	99	2	16	166	61	2	103	42%
Tuberculosis programmes									
Percentage of tuberculosis patients with known HIV status (percentage tested who had HIV infection)									
	55% (5.9%)				60% (6.2%)				9%
Percentage of HIV-positive tuberculosis patients started or continued on ART									
	61%				62%				2%
Viral hepatitis programmes									
Percentage of adults and children enrolled in HIV care who were screened for hepatitis B and hepatitis C									
Hepatitis B	36% (n = 25)	88% (n = 6)	38% (n = 9)	30% (n = 10)					
Hepatitis C	39% (n = 25)	97% (n = 4)	29% (n = 12)	38% (n = 9)					
Medicines, diagnostics and other commodities									
No. of health facilities dispensing ART that have experiences stock-out of at least one ART in the past 12 months									
				20 (n = 7)				5 (n = 2)	

n: number of countries reporting; MSM: men who have sex with men; PWID: people who inject drugs;
ART: antiretroviral therapy

[a] Europe: all 53 Member States of the WHO European Region.
[b] West: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, United Kingdom.
[c] Centre: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, The former Yugoslav Republic of Macedonia, Turkey.
[d] East: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.
[e] Data shown for 2009 and 2011.
[f] Data shown for 2011 only.
[g] Data shown for 2009 and 2012.

B. Progress on harmful use of alcohol in the WHO European Region

Introduction and background: the need for strengthened action in Europe

1. In resolution EUR/RC61/R4, the Regional Committee urged Member States to use the European action plan to reduce the harmful use of alcohol in 2012–2020 (document EUR/RC61/13) as a basis for formulating or, if appropriate, reformulating national alcohol policies and action plans. It also requested the Regional Director to assist Member States and organizations in preparing and implementing national policies to prevent or reduce the harm resulting from alcohol consumption; to monitor the progress, impact and implementation of the European action plan; and to use the information collected to revise and update the European Information System on Alcohol and Health.

2. The European Region has the highest adult alcohol consumption of all the WHO regions and almost double the world average. In the period 2008–2010, the European average for alcohol consumption for adults (aged ≥ 15 years) was 10.9 L of pure alcohol, a decline from 12.2 L during the period 2003–2005. Country-specific trends can be seen in Annex B. The average unrecorded consumption for the period 2008–2010 was estimated to be 1.9 L of pure alcohol, which accounts for 17% of the total consumption in the Region; in 2003–2005, the amount was estimated to be 2.7 L of pure alcohol or 22% of the total consumption. The 12-month abstention rate was on average 33.6%; the lowest abstention rates were in western Europe and the highest were in Member States with a large proportion of Muslims, such as Turkey and the central Asian countries. Men drink more than twice as much as women: for drinkers only, the average per capita consumption for 2008–2010 was 22.7 L of pure alcohol for men and 10.1 L for women. Heavy episodic drinking is defined as drinking at least 60 g of alcohol during one drinking occasion. On average and for drinkers only, 31.8% of men and 12.6% of women experienced an incident of heavy episodic drinking during the past month but with large differences among Member States. The proportion of current drinkers in the total population decreased in the Region, from 68.8% in 2003–2005 to 66.4% in 2008–2010.

3. It is estimated that 6.4% of adult men and 1.2% of adult women in the WHO European Region are alcohol dependent, and 12.6% of adult men and 2.9% of adult women have an alcohol use disorder.

Alcohol policy developments – the 10 action areas[1]

Leadership, awareness and commitment

4. Since endorsement of the European action plan to reduce the harmful use of alcohol 2012–2020, countries are either developing or reformulating a national alcohol policy. Of the 53 Member States that had provided information to the Secretariat by April 2014, 38 had a written national policy on alcohol, and 20 of these were updating their policies. Of the 15 Member States without a national policy on alcohol, nine are developing one. Since 2012, 10 Member States have adopted a new national alcohol policy, in line with the European action plan.

[1] For information on which Member States have adopted various measures, please refer to the European Information System on Alcohol and Health [website] (http://apps.who.int/gho/data/?showonly=GISAH&theme=main-euro).

5. Since 2011, the following countries have changed or adopted an alcohol policy: Albania, Belarus, Estonia, Finland, Germany, Iceland, Ireland, Israel, Latvia, Lithuania, Montenegro, Norway, Poland, Republic of Moldova, San Marino, Sweden, Switzerland, Tajikistan, Turkey, Turkmenistan, United Kingdom and Uzbekistan.

Health services' response

6. The health sector plays an important role in both identifying people who drink at a harmful level and those who need treatment for an alcohol use disorder. A number of countries are working to conduct screening and to provide brief interventions in primary health care settings, and 27 Member States[2] have clinical guidelines for brief interventions that have been approved or endorsed by at least one professional health care body.

Community and workplace action

7. Community-based intervention projects involving stakeholders exist in 43 Member States.[2] The most commonly involved partners are nongovernmental organizations (41 Member States) and local government bodies (32 Member States).[2] Involvement of economic operators, which in most cases means the alcoholic beverage industry, was reported by 20 Member States.[2]

8. Eighteen Member States[2] have national guidelines for the prevention of and counselling for alcohol problems at the workplace, and in 17 Member States[2] testing for alcohol at the workplace is governed by legislation. In 19 Member States,[3] social partners representing employers and employees are involved at national level in action to prevent and address alcohol-related harm at the workplace.

Drink–driving policies and countermeasures

9. All but two countries (Malta and the United Kingdom) have a maximum blood alcohol concentration of 0.5 g/L or less for drivers in the general population. Nine countries have legislated a zero tolerance level.

10. All but one Member State reported breath-testing as the usual method for measuring the blood alcohol concentration. Blood or urine analysis is also commonly used (44 Member States). Random breath-testing, in which any driver can be stopped by the police at any time to test his or her breath for alcohol, is used by 46 Member States. Sobriety check-points or roadblocks established by the police on public roadways to control for drink–driving are used by 29 Member States as a means to enforce the maximum legal blood alcohol concentration.

Availability of alcohol

11. All Member States have regulated age limits for the sale of alcoholic beverages. The most frequently applied limit is 18 years for all beverage types, but 10 countries still have a limit of 16 years for off-premises sales of beer and wine. For off-premises sales, 21 countries have restrictions on hours of sale, 32 countries have restrictions during specific events, and 20 countries have restrictions on sales at petrol stations. Twenty-five countries reported that they had banned alcohol consumption in health care establishments, 26 in educational buildings, 22 in government buildings and 17 on public transport.

12. Thirty-six Member States (68%) have reported restrictions on on-premise sales of alcohol to intoxicated persons. The majority of Member States also restrict on- and off-premise sales at

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[2] Data not available for two Member States.
[3] Data not available for four Member States.

specific events. Between 43% and 57% of the Member States have reported restrictions on locations of sales, depending on beverage type, and very few Member States reported restrictions on days of sale or on density of outlets.

Marketing of alcoholic beverages

13. In 47 Member States, there are legally binding regulations on alcohol advertising, and 36 countries have restrictions on alcohol product placement. Ten Member States have reported a total ban on national television advertising of beer, and 14 and 23 Member States have a total ban on national television advertising of wine and spirits, respectively. Twelve Member States reported no restrictions on national television advertising of beer, and nine and six Member States have no restrictions on national television advertising of wine and spirits, respectively. All other countries have either partial or voluntary regulations.

Pricing policies

14. Except in two Member States, alcoholic beverages are subject to value added tax above 0%, the rate varying from 8% to 30%;[2] most countries levy taxes of 15–20%. All Member States reported that excise duty is levied on spirits, and all but one Member State reported that it is levied on beer;[4] 12 Member States do not have an excise duty on wine.[4] Thirteen Member States reported that the level of excise duty is regularly adjusted for inflation.

15. A few countries (Belarus, Kyrgyzstan, Republic of Moldova, Russian Federation and Ukraine) have reported that they impose a minimum retail price on alcoholic beverages. Scotland has passed legislation for introduction of a minimum pricing policy. Poland recently decided to introduce minimum pricing.

Reducing the negative consequences of drinking and alcohol intoxication

16. Approximately 36% of Member States reported that systematic alcohol server training courses are organized regularly. Server training can be mandated by state or local laws, for example, as a prerequisite for obtaining a license to sell or serve alcoholic beverages.

17. Eight Member States legally require the presence of safety messages or health warnings on bottles, cans or other packaging containing alcoholic beverages to inform or remind consumers of the risks associated with alcohol drinking.[5]

18. Nine Member States[4] have reported national legal requirements to display information for consumers on calories, additives and vitamins on the labels of alcohol containers.

Reducing the public health impact of illicit alcohol and informally produced alcohol

19. At the time of data collection, all but four Member States reported that they had national legislation to prevent the illegal production or sale of home- or informally produced alcoholic beverages.

20. Applications of duty-paid, excise or tax stamps or labels on alcoholic beverage containers was reported by 14 Member States for beer, by 20 Member States for wine and by 34 Member States for spirits.[4]

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[4] Data not available for one Member State.
[5] Reflects changes in legislation in Turkey in 2013.

Monitoring and surveillance

21. Thirty-two Member States[4] reported that they had national systems for monitoring alcohol consumption and its health and social consequences, consisting of a data repository containing a range of population-based and health facility data.

22. Twenty Member States reported regular publication of comprehensive reports on the national alcohol situation.[6] The most commonly covered topics include drinking by adults (17 Member States), drink–driving and alcohol-related traffic accidents (17 Member States) and underage drinking (16 Member States). Regular reporting on the retail availability and affordability of alcohol, identified by WHO as areas in which control measures on alcoholic beverages could contribute most to reducing the burden of noncommunicable diseases, is less common.

Key developments in alcohol policy

23. A number of developments have been seen in the Region since the action plan was adopted. It is, of course, not possible to attribute these changes directly to specific actions taken by Member States or to WHO interventions; however, since the *European status report on alcohol and health 2010*[7] was published,[8] some countries have introduced stricter alcohol policies:

- The number of Member States with a written national or subnational policy increased from 30 to 38; 72% of all Member States in the Region now have such a policy.
- The number of Member States that had conducted national awareness-raising activities increased from 39 to 51.
- The number of Member States with a blood alcohol concentration limit of 0.5 g/L or less for drivers in the general population increased from 42 to 51, and random breath-testing is now used by 46 Member States, compared with 27 in 2010.
- The number of Member States with a minimum 18-year age limit for off-premise sales of alcoholic beverages increased from 31 to 43.
- The number of Member States with legally binding regulations on alcohol advertising increased from 42 to 47.
- The number of Member States with legally binding restrictions on alcohol product placement increased from 31 to 36.
- The number of Member States that require health warnings on alcohol advertising increased from 12 to 15.
- The number of Member States in which the level of taxation for alcoholic beverages is adjusted for inflation increased from 7 to 13.
- The number of Member States with legislation to prevent illegal production or sale of home- or informally produced alcoholic beverages increased from 41 to 49.

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[6] Data not available for five Member States.
[7] European status report on alcohol and health 2010. Copenhagen: WHO Regional Office for Europe; 2010 (http://www.euro.who.int/__data/assets/pdf_file/0004/128065/e94533.pdf).
[8] Based on data provided by 45 Member States.

Role of the Secretariat

Governance

24. The European network of WHO national focal points for alcohol policy and for implementation of the European action plan has continued to strengthen collaboration with and facilitate provision of support to Member States. After adoption of the action plan, Member States met in Warsaw, Poland, on 30 May–1 June 2012 at a meeting co-hosted by the Polish State Agency for the Prevention of Alcohol-related Problems and the European Commission. The main objective of the meeting was to exchange information on alcohol policy; a new WHO report, *Alcohol in the European Union: Consumption, harm and policy approaches*,[9] was launched. In 2013, the focal points met in Istanbul, Turkey, on 26–27 April 2013, co-sponsored by the Ministry of Health, Turkey and the Turkish nongovernmental organization Green Crescent, to exchange information on alcohol policy and to discuss the upcoming European status report on alcohol and health. The focal points have supported the Regional Office by providing data on alcohol consumption, harm and policy developments, which were used for the European Information System on Alcohol and Health and for two recent publications.[9,10]

25. The Secretariat has published and distributed the European action plan, [11] with the text of the associated resolution EUR/RC61/R4 and definitions of the indicators for the 10 action areas in English and Russian. The action plan follows the five objectives and 10 action areas of the *Global strategy to reduce the harmful use of alcohol* endorsed by the World Health Assembly in resolution WHA63.13. All the indicators are included in the European Information System on Alcohol and Health.

26. The Secretariat has worked with Member States, intergovernmental organizations and major partners within the United Nations system to promote multisectoral action, build national capacity, identify new partnership opportunities, promote effective and cost-effective approaches to reducing the harmful use of alcohol for the prevention and control of noncommunicable diseases and realize the commitments of the United Nations' Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases[12] and Health 2020 of the WHO Regional Office for Europe.[13]

27. The Secretariat has supported capacity-building workshops on alcohol policy development and implementation, linked to the prevention and control of noncommunicable diseases, in selected countries in the Region and, through these, facilitated the development of alcohol policies. Technical support was provided for meetings on alcohol policy held since 2012

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[9] Alcohol in the European Region: consumption, harm and policy approaches. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf, accessed 6 November 2013).
[10] Status report on alcohol and health in 35 European countries. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf, accessed 6 November 2013).
[11] European action plan to reduce the harmful use of alcohol 2012–2020. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0008/ 178163/E96726.pdf, accessed 6 November 2013).
[12] United Nations General Assembly resolution A/RES/66/2, Annex: Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Sixty-sixth session of the United Nations General Assembly, 24 January 2012. United Nations: New York; 2012 (http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf, accessed 6 November 2013).
[13] Health 2020: a European policy framework and strategy for the 21st century. Copenhagen, WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf, accessed 6 November 2013).

in a number of Member States: Armenia, Belgium, Croatia, Denmark, Estonia, Finland, Italy, Kazakhstan, Kyrgyzstan, Lithuania, Latvia, Luxembourg, Montenegro, Norway, Poland, Portugal, Republic of Moldova, the Russian Federation, Slovakia, Turkey and the United Kingdom. Furthermore, the Secretariat has worked closely with Member States that had updated or drafted new alcohol policies in line with the *European action plan to reduce the harmful use of alcohol 2012–2020*. Dialogue continues with nongovernmental organizations and professional associations about ways in which they can contribute to reducing the harmful use of alcohol. The Secretariat attends meetings organized by nongovernmental organizations, some of which are invited to participate in meetings of the national focal points for alcohol policy.

Strengthening surveillance, monitoring and evaluation, and research

28. The production and dissemination of knowledge on alcohol consumption, alcohol-attributable harm and policy responses in Member States has been improved by refining data collection, data analysis and dissemination of findings. The Regional Office works with WHO headquarters on this task as well as with the European Commission. A project was carried out with the European Commission during 2011–2013 to ensure identical indicators and a system for data collection and analysis. It is expected that the project will be continued through September 2014. In 2012, the global survey on alcohol and health was implemented in collaboration with European Region Member States. A number of specific regional indicators were included in the surveys, and the data were used for the European status report, [14] which is available on the WHO website and includes alcohol policy data for all 53 Member States.

29. In 2011, the Regional Office started to collect information on alcohol policy developments in Member States since 2006, with links to documents, publications and websites, to facilitate knowledge-sharing on good practice in Member States. The information collected for the years 2006–2012 was included as an annex to the 2013 status report[10] and will be used in an online database to be created during 2014, in which it will be linked to the 10 action areas of the action plan. The Regional Office plans to update the information yearly. The database will be hosted by the Global Health Observatory and thereby linked to other relevant databases, including the European Information System on Alcohol and Health.

30. The Regional Office has developed and used new indicators on alcohol-attributable death rates based on data from the European health for all database (HFA-DB)[15] and will continue to improve the quality of data on alcohol-attributable harm. The Regional Office is also involved in activities focused on harm to people other than the drinkers themselves, such as fetal alcohol spectrum disorders and the relations between the harmful use of alcohol and violence and HIV infection.

31. A new alcohol policy scoring system is being developed to evaluate effective alcohol policies in countries. A profile will be developed for each of the 10 action areas of the European action plan for all Member States, which can be used as guidance in implementing new policies to decrease the harmful use of alcohol. A publication on this topic is planned for 2014.

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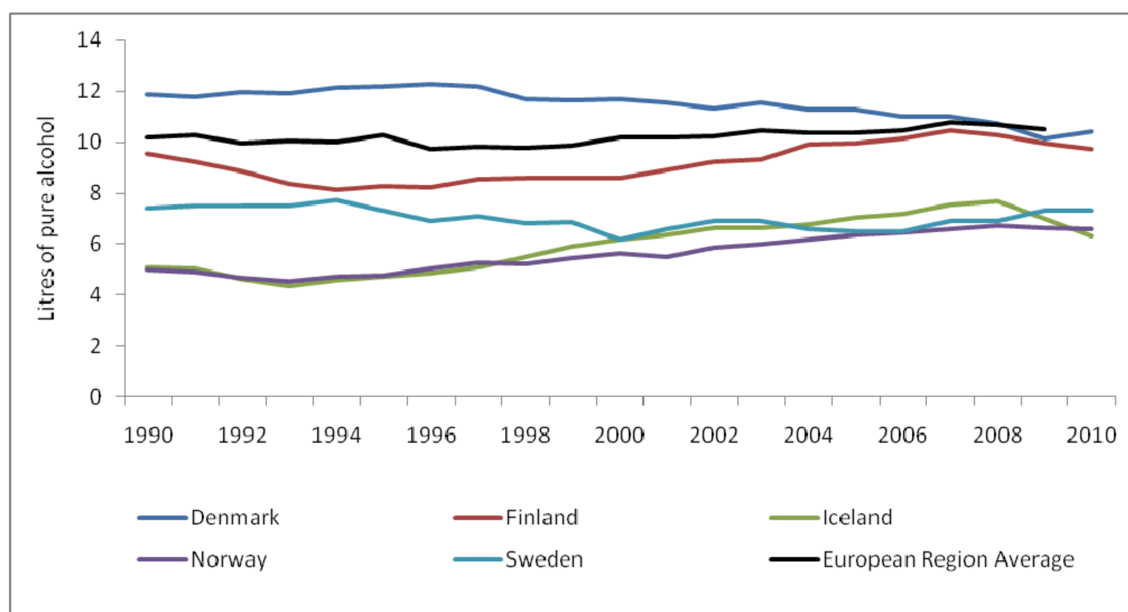
[14] European status report on alcohol and health 2014. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/news/news/2014/03/european-status-report-on-alcohol-and-health-2014, accessed 26 March 2014).
[15] European health for all database [online database]. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-health-for-all-database-hfa-db2, accessed 5 November 2013).

Annex B1. Adult per capita consumption of recorded alcohol by country in the WHO European Region,[16] 1990–2010

Fig. B1. Adult per capita consumption of recorded alcohol by country, 1990–2010, in group 1



[16] For the purpose of this report, Member States are categorized into nine subregional groups. The groups are defined partly by geographical area and partly by drinking patterns and traditions.

group 1: Denmark, Finland, Iceland, Norway, Sweden.
group 2: Austria, Belgium, Germany, Luxembourg, Netherlands, Switzerland.
group 3: Andorra, France, Ireland, Monaco, San Marino, United Kingdom.
group 4: Czech Republic, Poland, Slovakia.
group 5: Armenia, Azerbaijan, Belarus, Georgia, Russian Federation, Ukraine.
group 6: Estonia, Latvia, Lithuania.
group 7: Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan, Turkmenistan.
group 8: Cyprus, Greece, Israel, Italy, Malta, Portugal, Spain, Turkey.
group 9: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary, Montenegro, Republic of Moldova, Romania, Serbia, Slovenia, The former Yugoslav Republic of Macedonia.

Fig. B2. Adult per capita consumption of recorded alcohol by country, 1990–2010, in group 2

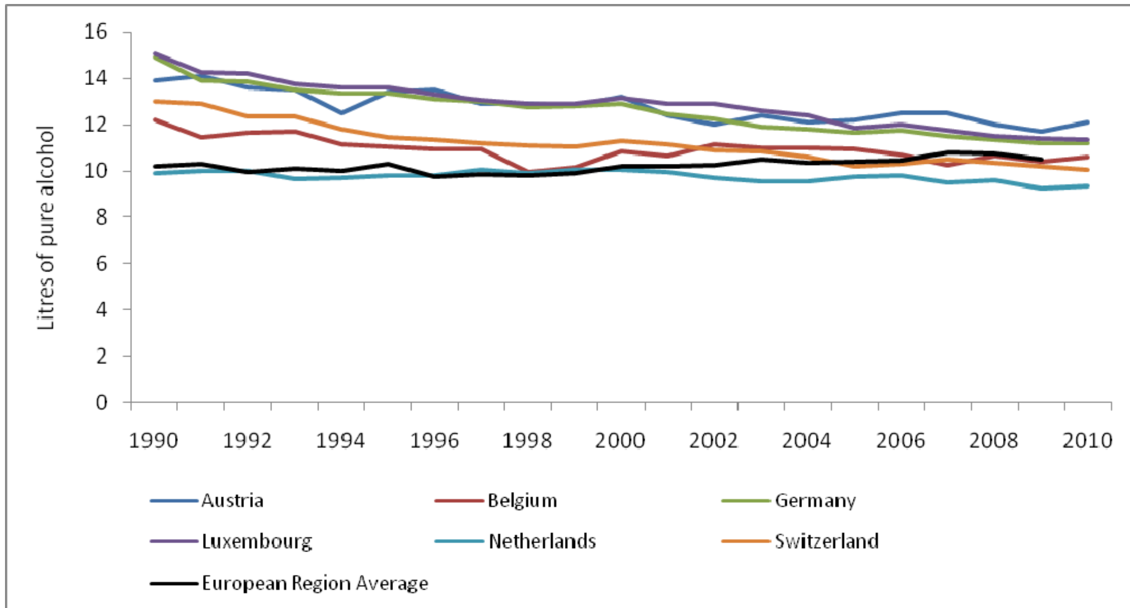
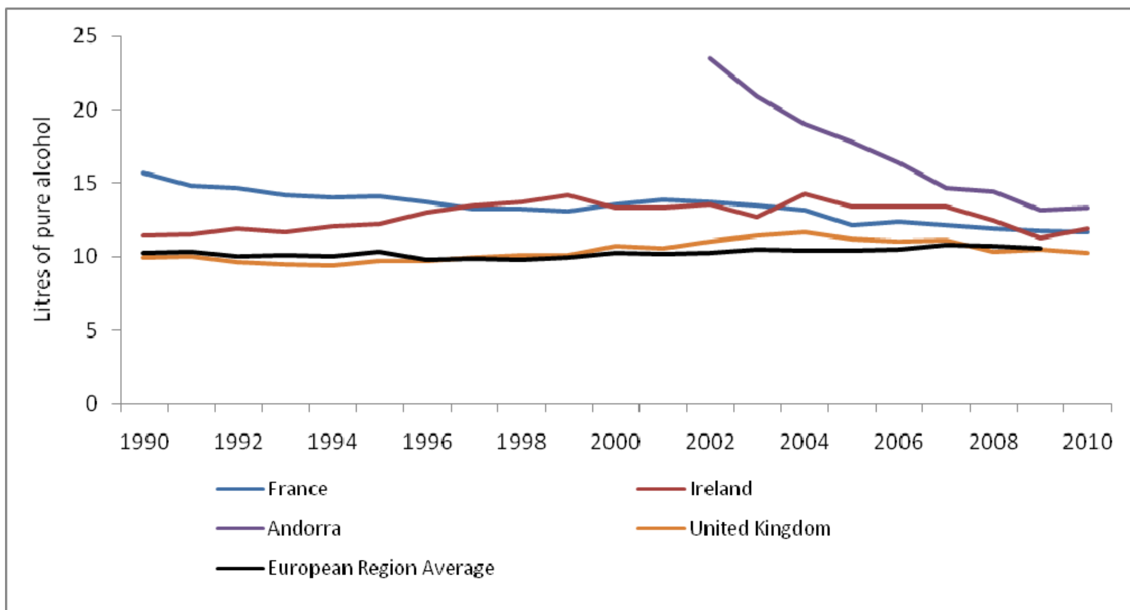


Fig. B3. Adult per capita consumption of recorded alcohol by country,[17] 1990–2010, in group 3



[17] Data not available for Monaco or San Marino.

Fig. B4. Adult per capita consumption of recorded alcohol by country, 1990–2010, in group 4

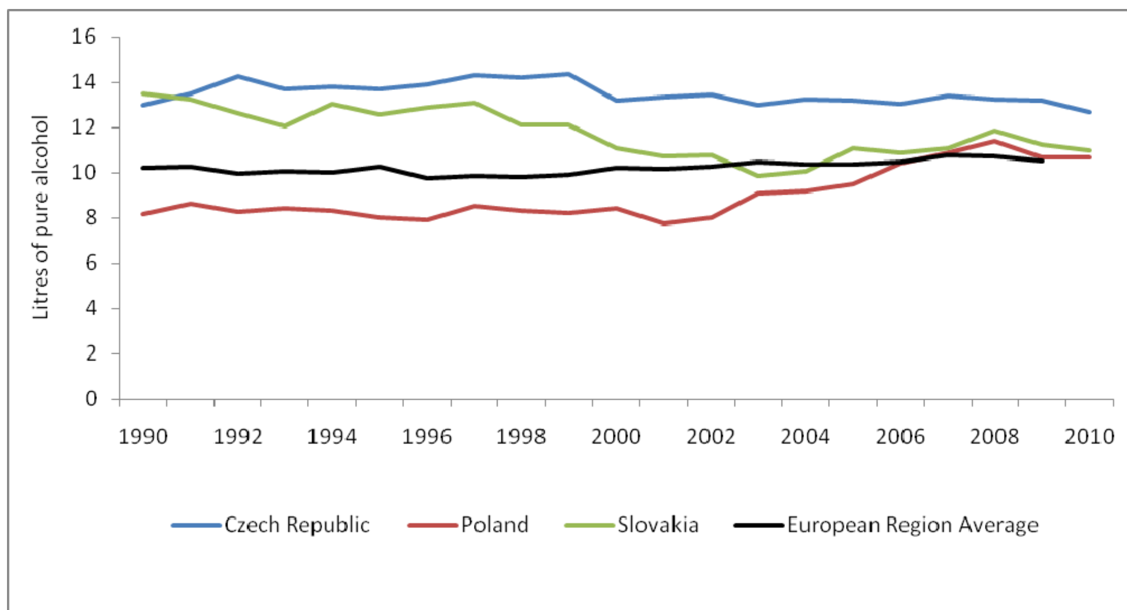


Fig. B5. Adult per capita consumption of recorded alcohol by country, 1990–2010, in group 5

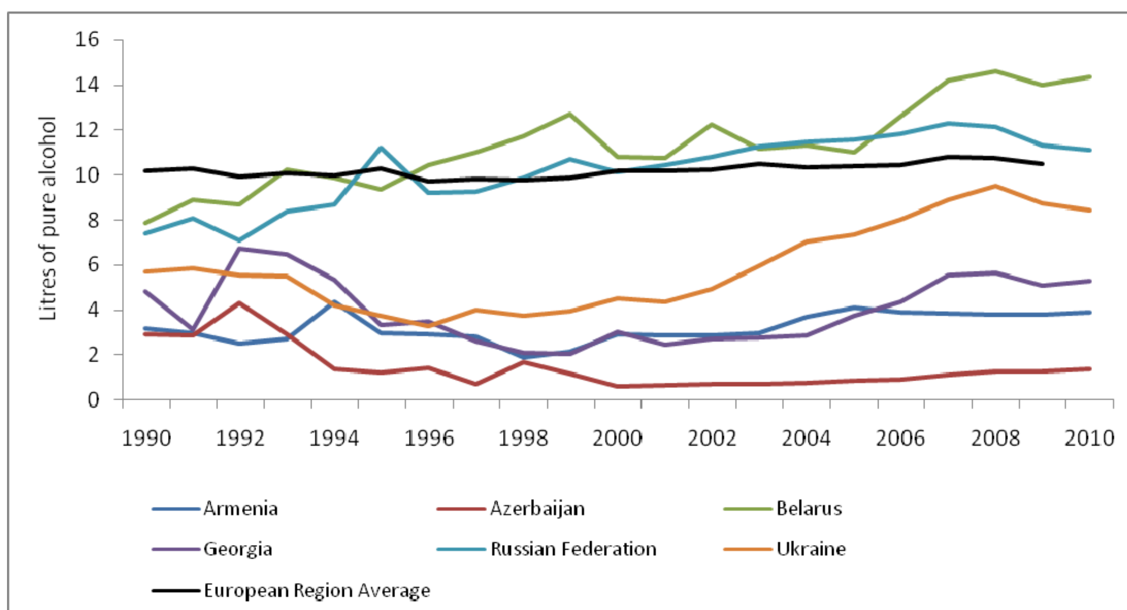


Fig. B6. Adult per capita consumption of recorded alcohol by country, 1990–2010, in group 6

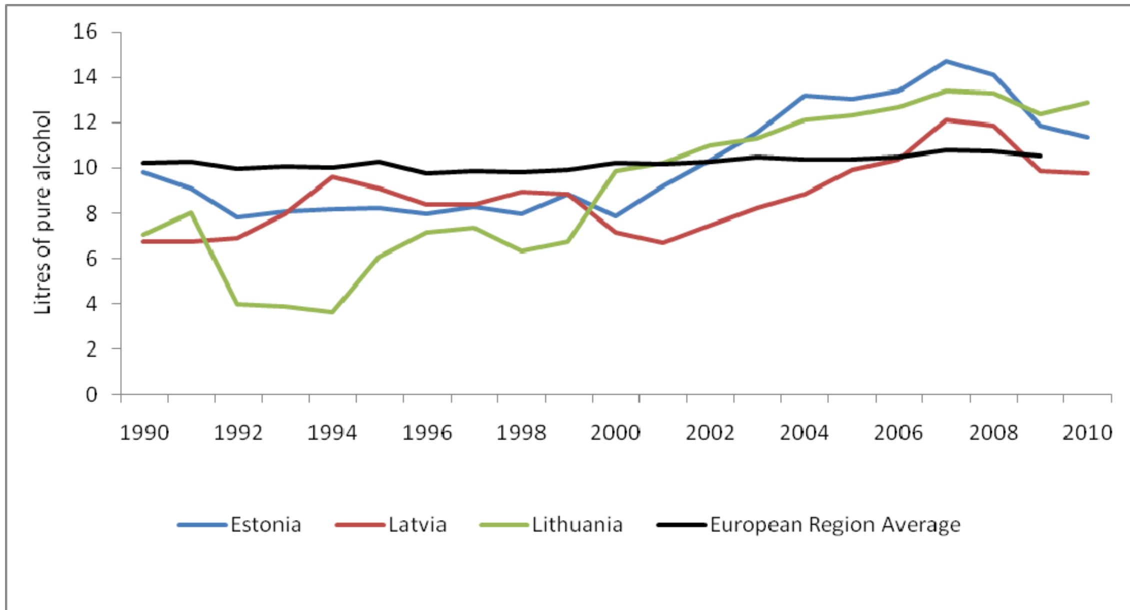


Fig. B7. Adult per capita consumption of recorded alcohol by country, 1990–2010, in group 7

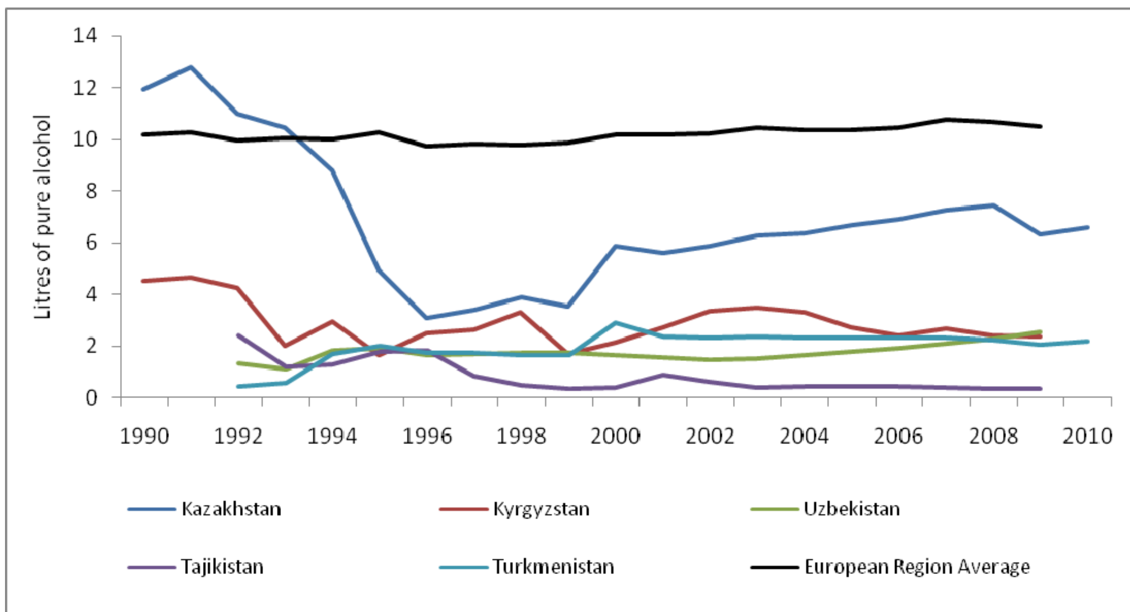


Fig. B8. Adult per capita consumption of recorded alcohol by country, 1990–2010, in group 8

Litres of pure alcohol

16 14 12 10 8 6 4 2 0

1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010

Cyprus Greece Israel
Italy Malta Portugal
Spain Turkey European Region Average

Fig. B9. Adult per capita consumption of recorded alcohol by country, 1990–2010, in group 9

Litres of pure alcohol

20 15 10 5 0

1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010

Albania
Bosnia and Herzegovina
Bulgaria
Croatia
Hungary
Montenegro
Republic of Moldova
Romania
Slovenia
The former Yugoslav Republic of Macedonia
Serbia
European Region Average

C. Progress achieved in implementing resolution EUR/RC55/R9 on "Prevention of injuries in the WHO European Region"

Introduction

1. In 2005, the Regional Committee for Europe adopted resolution EUR/RC55/R9 on the "Prevention of injuries in the WHO European Region", which requests the Regional Director:

(a) "to support Member States in their efforts to strengthen injury prevention and to draw up national action plans;

(b) to facilitate the identification and sharing of good practice in the prevention of violence and unintentional injuries;

(c) to stimulate and support the network of national focal points and further develop collaboration with other relevant networks of experts and professionals;

(d) to provide assistance in building capacity at the technical and policy levels in order to strengthen national response to injuries to include surveillance, evidence-based practice and evaluation;

(e) to provide technical assistance to improve prehospital treatment and care for victims of unintentional injuries and violence;

(f) to promote the development of partnerships and collaboration with the European Union and other international organizations, in particular the Council of Europe, the European Conference of Ministers of Transport, the Organisation for Economic Co-operation and Development, the United Nations Economic Commission for Europe, the United Nations Children's Fund, the International Labour Organization, and nongovernmental organizations, as appropriate, to enhance the response to the challenges posed by different causes of injuries;

(g) to report back to the Regional Committee in 2008 on progress achieved in implementation of this resolution by the Secretariat and the Member States."

2. This document is a report on progress made during the decade since the adoption of resolution EUR/RC55/R9. The situation has improved, from 790 000 deaths due to unintentional injuries and violence at the time the resolution was adopted to the current estimate of 555 000 deaths[1] (Annex C1). Decreases in the number of deaths have been seen in almost all Member States; furthermore, much progress has been made in low- and middle-income countries, where the excess risk for death from injury when compared with high-income countries has decreased from 3.6 times higher in 2000 to 2.4 times higher in 2011. Progress has, however, been unequal across age groups: among children under 15 years, the mortality gap between high-income countries and low- and middle-income countries has widened (Annex C1).

3. Member States, with the support of the Secretariat, have responded to the public health threat of injuries by organized responses across society; for example, all countries now have a national road safety policy, 92% have legislation on all five risk factors for injury and in 49% the legislation is comprehensive.[2] With regard to speed, these proportions of countries have a national law, an urban speed limit ≤ 50 km/h and a local authority that can modify the law. For drink–driving, they have a national law mandating a blood alcohol concentration ≤ 0.05 g/dl.

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[1] Injuries in Europe: a call for public health action. Copenhagen: WHO Regional Office for Europe; 2014.

[2] European facts and global status report on road safety 2013. Copenhagen: WHO Regional Office for Europe; 2013.

For wearing a helmet, they have a national law that applies to all riders, all engines and all passengers; and helmets have mandatory standards. For seat-belts, they have a national law that applies to all occupants and, for child car restraints, they have a national law. Whereas not all progress in reducing the burden of injuries can be attributed to implementation of the resolution, it has made a contribution, as this report shows. Such preventive action should be sustained in order to reduce the continually large burden: injuries remain the third leading cause of death in the Region, after cardiovascular disease and cancer. For people aged 5–49 years, injuries and violence are the leading causes of death in the Region. Reducing inequality in injuries and violence in the Region remains a priority for achieving greater social justice.

4. This report presents the key achievements in violence and injury prevention by the Secretariat, with an emphasis on policy developments by Member States.

Supporting Member States to strengthen injury prevention and develop action plans

5. Member States are increasingly recognizing the gravity of the problem and the importance of cost-effective prevention as evidenced by the steady increase in the number of countries with biennial collaborative agreements, from five in 2004–2005 to 20 in 2014–2015 (with nine in 2006–2007, 15 in 2008–2009, 18 in 2010–2011 and 19 in 2012–2013). Activities undertaken in these agreements focus on the five priorities: policy development, road safety, violence prevention, capacity-building and surveillance.

6. Replies received from 47 Member States to an evaluation survey in 2009 show that the resolution helped to raise violence and injury prevention higher on their policy agenda and to catalyse action, as reported by 75% of Member States. These data should be updated.

7. The proportions of Member States with national policies for causes of injury or violence vary. For example, whereas all countries have national policies for road safety, only 40% have policies for prevention of drowning, 76% for preventing violence against an intimate partner, 62% for preventing youth violence and only 40% for preventing abuse of the elderly.

8. Support was also provided to Member States by two United Nations Global Road Safety Weeks (23–29 April 2007 and 6–12 May 2013) and global advocacy events led by WHO headquarters, which have raised the profile of youth and road and pedestrian safety as priorities. In the European Region, active support was provided to over 20 countries, in which policy dialogues were held in cooperation with WHO country offices and which helped health ministries to engage in multisectoral actions for road safety. The Regional Office collaborates with the European Commission in supporting European Road Safety Days.

9. Further focus on road safety is provided by the *Global status report on road safety*,[3] for which surveys were conducted in 2008, 2012 and 2014. This global project is funded by the Bloomberg Philanthropies and coordinated by WHO headquarters. National data coordinators have been appointed by 51 Member States in which national surveys were undertaken and country profiles were prepared by intersectoral collaboration. Global and regional reports were presented at the First Global Ministerial Conference on Road Safety hosted by the Russian Federation in 2009 and will be presented at the Second Global Ministerial Conference on Road Safety hosted by Brazil in 2015 as part of the mid-term review of the United Nations Decade of Action for Road Safety 2011–2020.

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[3] Global status report on road safety 2013: supporting a decade of action. Geneva: World Health Organization; 2013 (http://www.who.int/violence_injury_prevention/road_safety_status/2013/report/en/, accessed on 14 April 2014).

10. Forty-two Member States are contributing to the *Global status report on violence prevention*.[4] Support has been provided by the Regional Office for the survey, which brings together intersectoral stakeholders and which will form an important baseline for assessing future progress in violence prevention, including the prevention of child maltreatment. It is anticipated that the report will be launched in late 2014 at an event hosted by the Government of Belgium; an accompanying European document will also be produced.

11. Support for the development of national policies for violence and injury prevention has been given to 14 countries (Austria, Belarus, Czech Republic, Cyprus, Estonia, Germany, Hungary, Kyrgyzstan, Latvia, Lithuania, Romania, Russian Federation, The former Yugoslav Republic of Macedonia and Turkey). Policy dialogues have been held in Azerbaijan, Kazakhstan, Montenegro, Republic of Moldova, Tajikistan and Uzbekistan).

Identifying and sharing good practice in prevention

12. A steady flow of publications, policy briefings and fact sheets has brought together state-of-the-art knowledge on the burden of violence and injuries in the Region and evidence-based solutions to address them. These have been disseminated widely to a broad audience of policy-makers, practitioners and scientists, so that best practice can be shared and implemented, not only through the network of focal points but also through other networks. The technical reports were prepared by the Regional Office in collaboration with WHO headquarters and the WHO collaborating centres. A full list of publications since 2005 is given in Annex C2.

13. The publications have been disseminated at events such as the 58th and 63rd sessions of the Regional Committee, sessions of the European Parliament, the Fifth Ministerial Conference on Environment and Health, European and World Conferences on Injury Prevention and Safety Promotion, national and European events for United Nations Global Road Safety Week, stakeholder meetings hosted by the European Commission and all seven network meetings of health ministry focal persons.

Supporting the network of national focal persons and collaborating with other networks

14. Health ministry focal persons for violence and injury prevention were appointed in 49 Member States and seven European network meetings have been held, hosted by the ministries of health of the Netherlands (2005), Austria (2006), Portugal (2007), Finland (2008), Germany (2009), Norway (2011) and Turkey (2012). All the meetings focused on key aspects of resolution EUR/RC55/R9, such as road safety, violence prevention, building capacity, surveillance and advocacy. Participants in the seventh network meeting supported development of a child maltreatment prevention plan as a priority for Europe. In addition, three global meetings of focal persons were held during the World Conference on Injury Prevention and Safety Promotion hosted by South Africa in 2006, Mexico in 2008 and the United Kingdom in 2010, with strong representation from European Member States.

15. Focal persons have supported the Regional Office by collecting data on road safety and violence prevention and have provided valuable input into policy development, such as the European child maltreatment prevention action plan.

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[4] The *Global status report on violence prevention* will be launched in late 2014. For more information about this project, visit http://www.who.int/violence_injury_prevention/violence/status_report/en/, accessed 14 April 2014).

16. Collaboration has also been developed with other networks, such as those of the European Commission Directorates-General for Health and Consumers, Justice, Mobility and Transport, the Alcohol Policy Network in Europe, the South-eastern Europe Health Network (SEEHN) and the Global Campaign for Violence Prevention (meetings hosted by the United Kingdom in 2007 and Italy in 2010).

Capacity-building

17. Much work has gone into strengthening the capacity of national health systems to respond to injuries, with emphasis on surveillance, evidence-based practice and evaluation. Apart from exchange of best practice at focal point meetings, the mainstay has been the curriculum of WHO's Training, Education and Advancing Collaboration in Health on Violence and Injury Prevention (TEACH-VIP) prepared by WHO headquarters; this has also been translated into Russian.

18. Capacity-building workshops have been held for VIP focal persons to develop the lead role of the health sector in mounting a multisectoral response to injury prevention. Train-the-trainer workshops for Russian-speaking participants and participants from SEEHN were held in 2007 and 2009, respectively. WHO has provided support for the translation and local adaptation of TEACH-VIP in Albania, Azerbaijan, Belarus, Czech Republic, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia, Spain, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Turkey, United Kingdom and Uzbekistan. Introducing the material into health professional curricula and training trainers have contributed to the sustainability of the information in many countries. Specific capacity-building workshops have also been held for prevention of violence related to alcohol in the Baltic, Nordic and SEEHN countries. In total, TEACH-VIP activities have been held for participants from 39 countries and an estimated 8500 participants have been trained.

19. Documentation of non-fatal injuries and their health and social consequences is incomplete in most countries. Hospital-based injury surveillance has been supported in Lithuania and the Russian Federation. Capacity-building workshops on injury surveillance have been held to facilitate exchange of expertise in the focal point network and also for SEEHN countries. In addition, WHO is a member of the advisory committee of injury registers in countries such as the Czech Republic, Hungary and Slovakia and of the European Commission-funded project, the European Injury Data Base.

20. With regard to child maltreatment, surveys of adverse childhood experiences have been conducted among young people in 10 countries in order to document and disseminate the prevalence of past maltreatment. The results have been presented at policy dialogues for the prevention of child maltreatment in Albania, Czech Republic, Latvia, Lithuania, Montenegro, Romania and The former Yugoslav Republic of Macedonia and are being planned in the Russian Federation, Serbia and Turkey.

Technical assistance to improve care for victims

21. A regional consultation on preparation of the *World report on disability*[5] was hosted by the Italian Government in June 2008 and a regional consultation on the *Draft WHO global*

[5] World Health Organization, the World Bank. World report on disability. Geneva: World Health Organization; 2011.

disability action plan 2014–2021: Better health for all people with disabilities[6] was held in August 2013. Guidelines have been disseminated on essential trauma care, pre-hospital care and medico-legal care for victims of sexual violence. Translation into Russian is under way, and workshops on strengthening trauma care have been held in the Russian Federation and Turkey.

Development of partnerships and collaboration with the European Union and other international governmental and nongovernmental organizations

22. Partnerships have been strengthened with the European Commission Directorates-General for Health and Consumers (in a co-funded proposal in 2007), Justice, and Transport and Mobility; joint work is being done with the World Bank and the International Transport Forum. Contributions are being made to international projects such as Road safety in 10 countries; substantial increases in the use of seat-belts and child restraint devices and decreases in speeding have been achieved in the Russian Federation and Turkey. Collaboration with the Council of Europe, the Organisation for Economic Co-operation and Development, the United Nations Economic Commission for Europe and the United Nations Children's Fund is also under way. The European Association for Injury Prevention and Safety Promotion (EuroSafe) is a strong network of academic and public institutions that champion injury prevention in the European Union and is an important partner for WHO.

Reporting

23. Formal evaluations of implementation of the resolution were conducted in 2008[7] and 2010[8] by Member States and the Secretariat; a progress report was made to the Regional Committee in 2008.

Conclusions and indications for further work

24. The resolution has been instrumental in the work of the Regional Office with Member States and other partners to reduce the burden of injuries. In spite of the progress made, however, the burden is still large and inequalities in Member States pose a public health threat. The widened gap in childhood mortality between high-income countries and low- and middle-income countries highlights the need for renewed efforts.

25. The response to injuries and violence is multisectoral and requires a life-course and whole-of-society approach, with an emphasis on greater equity. It requires strong health governance by health systems as emphasized in Health 2020. There are opportunities for synergies with other areas of regional health policy, such as the *European action plan to reduce the harmful use of alcohol 2012–2020* (document EUR/RC61/13), *The European Mental Health*

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[6] Draft WHO global disability action plan 2014–2021: better health for all people with disabilities. Geneva: World Health Organization; 2014 (EB134/16; http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_16-en.pdf, accessed 14 April 2014).

[7] Sethi D, Racioppi F, Frerick B, Frempong N. Progress in preventing injuries in the WHO European Region: implementing the WHO Regional Committee for Europe resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region and the recommendation of the Council of the European Union on the prevention of injury and promotion of safety. Copenhagen: WHO Regional Office for Europe; 2008 (http://www.euro.who.int/__data/assets/pdf_file/0008/98423/E91710.pdf, accessed 14 April 2014).

[8] Sethi D, Mitis F, Racioppi F. Preventing injuries in Europe. from international collaboration to local implementation. Copenhagen: WHO Regional Office for Europe, 2010 (http://www.euro.who.int/__data/assets/pdf_file/0011/96455/E93567.pdf, accessed 14 April 2014).

Action Plan (document EUR/RC63/11), the *Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016* (document EUR/RC61/12) and the revised European strategy for child and adolescent health and development.

26. Future implementation of the resolution will depend on continued political commitment by Member States and continued investment in networks, such as that of health ministry focal persons, to build capacity and exchange expertise and thus create a community of knowledge. It is proposed that a progress report be made in 2018.

27. Violence and injury prevention is part of the WHO Twelfth General Programme of Work 2014–2019 and the Regional Office is grateful for resources for its work in this area from the European Commission and from Austria, Finland, Germany, Italy, Netherlands, Norway, Portugal, Sweden and the United Kingdom.

Annex C1. Burden of injuries and violence in Europe

In 2011, there were an estimated 555 000 deaths from injuries in the WHO European Region, constituting 6.1% of all deaths. Unintentional injuries (397 000 deaths) were responsible for 72% of the deaths and were due mainly to road traffic injuries (92 000 deaths), falls (78 000), drowning (37 000), fires (27 000) and poisoning (22 000). Deaths from intentional injuries (158 000) were due mainly to suicides (124 000 deaths) and interpersonal violence (32 000). One quarter of all injuries (140 000 deaths) were due to the heterogeneous category of "other unintentional injuries". Three leading causes of death – suicides, road traffic injuries and falls – accounted for more than 50% of all deaths due to injuries *(1)*.

In people aged 5–49 years, injuries were a leading cause of death in the Region and road traffic injuries were the worst killer in people aged 5–29 years, followed by suicides, unintentional injuries, drowning and interpersonal violence. Seven out of ten deaths were of males, whose mortality rate was 3.1 higher than that of females. The burden of injury is unequally distributed across the Region. Low- and middle-income countries have some of the highest mortality rates in the world, while high-income countries tend to have the lowest rates: 60% of deaths occurred in low- and middle-income countries, where the mortality rates were 2.4 times higher than in high-income countries. Large differences have also been observed within countries and injuries and violence are closely linked to socioeconomic determinants. For example, the death rates of child pedestrians and cyclists in the most deprived social groups are 20 times higher than in other groups. Children and older people are particularly vulnerable to both injuries and violence, as described in reports on prevention of child injuries *(2)*, child maltreatment *(3)* and maltreatment of the elderly *(4)*.

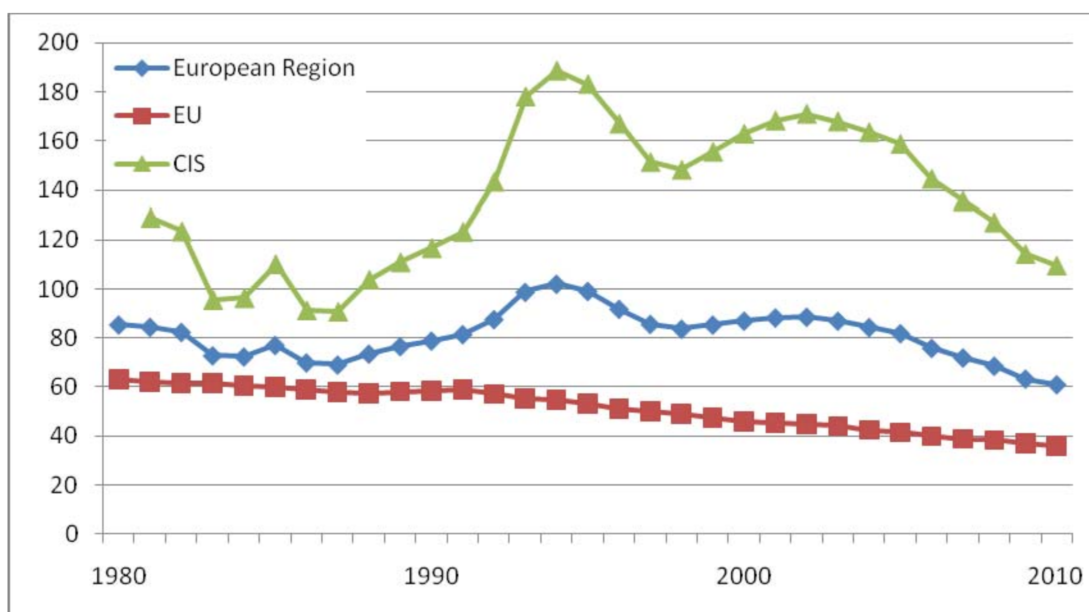
During the past decade, the situation in the Region improved considerably. Since a peak of mortality in the Commonwealth of Independent States in 2002, mortality rates have declined sharply. Countries belonging to the European Union have witnessed a steady but less steep decline since 1980, from a mortality rate of 63.1 per 100 000 population to 35.6 per 100 000 in 2011. There is nevertheless still a large gap: in 2010, the death rate from injuries was three times higher in the Commonwealth of Independent States than in the European Union *(5)* (see Fig. C1). Some of the greatest progress has been achieved in the field of road safety, where mortality decreased by 25% between 2007 and 2010 despite an increase of 6% in registered vehicles during the period *(6)*.

The *European report on child injury prevention (2)* shows that childhood injuries are a priority, as they are the leading cause of death in children aged 0–19 years, with 42 000 deaths. There is inadequate information on non-fatal injuries, but it is estimated that there were millions of hospitalizations and emergency department visits in the Region. Road traffic injuries are the leading cause of death among children, followed by drowning, poisoning, thermal injuries and falls. Child injury prevention remains a priority in the Region. A comparison of mortality rate ratios for road traffic injuries between low- and middle-income countries and high-income countries among children under 15 years of age shows that the gap has widened. The mortality rate ratio for all unintentional injuries increased from 4.2 in 2000 to 6.1 in 2011 and the rate ratio for road traffic injuries increased from 1.9 to 3.8 during this period (Fig. C2). Renewed effort is therefore necessary, particularly in low- and middle-income countries, to address this increased inequality.

Child maltreatment is thought to result in 852 homicides of children under 15 years of age in the Region *(3)*. This is one of the hidden forms of violence, however, and the prevalence is certainly much higher. In a meta-analysis, it was estimated that 18 million children have suffered from sexual abuse, 44 million from physical abuse and 55 million from mental abuse.

Falls are a particular problem for older people. More than 50% of fall-related deaths (44 000) occurred in people aged over 70 years. A large number of fatal and non-fatal home and leisure injuries are due to falls among the elderly, and attention should be paid to designing age-friendly environments.

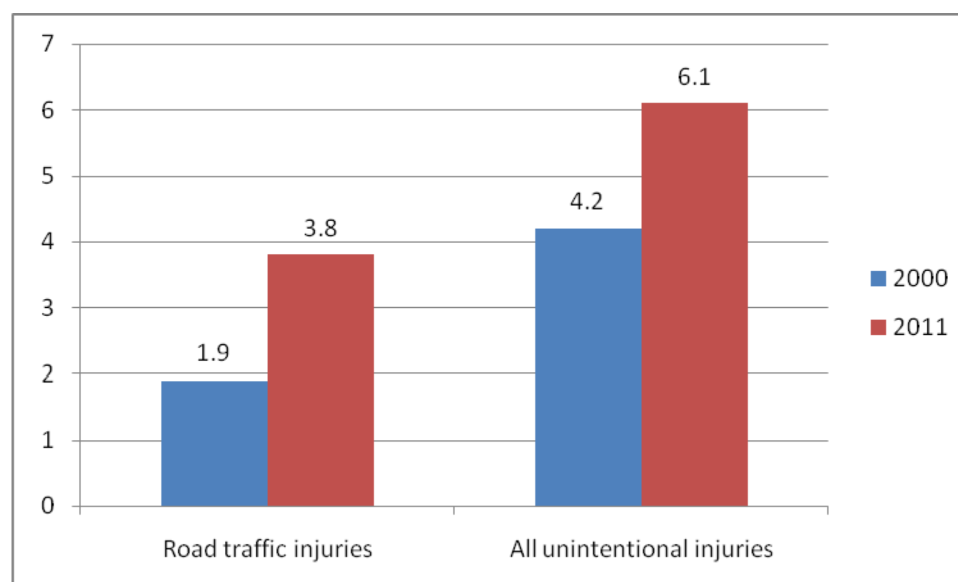
Fig. C1. External causes of injury and poisoning in the WHO European Region, the Commonwealth of Independent States (CIS) and the European Union (EU) (age-standardized death rates per 100 000, 1980–2011)



Older people are also vulnerable to violence: 8500 people aged over 60 years are murdered annually. This is an underestimate of the size of the problem, however, as surveys indicate that four million elderly people suffer from physical abuse, one million from sexual abuse, 29 million from mental abuse and six million from financial abuse.

Deaths from injuries are only the tip of the iceberg. For each death, it is estimated that there are 24 hospital admissions and 145 hospital emergency department attendances. This suggests that injuries present an enormous burden on health systems. The estimated 13 million hospital admissions and 80 million emergency department attendances in the Region result in high health care and societal costs, making demands on already overstretched resources. It has been estimated that up to 3.9% of the gross domestic product is lost due to the consequences of road crashes *(6)*; the cost related to violence among young people in England and Wales has been estimated at £13 billion *(7)*; and studies suggest that the societal costs of intimate partner violence represent as much as 2% of the gross domestic product *(8)*.

Fig. C2. Mortality rate ratios in low- and middle-income countries compared to high-income countries among children aged under 15 years for all unintentional injuries and for road traffic injuries in 2000 and 2011



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3. Sethi D, Bellis M, Hughes K, Gilbert R, Mitis F, Galea G, eds. European report on preventing child maltreatment. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf, accessed 14 April 2014).

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D. Progress on the *European strategy for child and adolescent health and development*

Introduction

1. The WHO *European strategy for child and adolescent health and development*,[1] approved by the Regional Committee for Europe at its 55th session in 2005, was based on a wide range of data about children's and adolescents' health behaviour, which reflects lifestyle, behavioural, cultural and socioeconomic factors. It set out three objectives:

- to provide a framework for evidence-based review and improvement of national policies and programmes for child and adolescent health and development from a life-course perspective;
- to promote intersectoral action to address the main issues in child and adolescent health, with collaboration outside the health sector seen as essential and educational settings identified as particularly important; and
- to identify the role of the health sector in the development and coordination of policies and service delivery to meet the needs of children and adolescents.

2. The strategy is based on four guiding principles:

- **a life-course approach**: policies and programmes should address the health challenges at each stage of development, from prenatal life to adolescence;
- **equity**: the needs of the most disadvantaged should be taken into account explicitly when assessing health status and formulating policy and planning services;
- **intersectoral action**: an intersectoral, public health approach that addresses the fundamental determinants of health should be adopted when devising policies and plans to improve the health of children and adolescents; and
- **participation**: the public and young people themselves should be involved in the planning, delivery and monitoring of policies and services.

The toolkit

3. A toolkit[1] was developed to support Member States in developing and implementing the strategy. Initially, the toolkit consisted of a set of self-assessment guides designed:

- to assess existing child and adolescent health policies and strategies;
- to identify the data and information necessary to develop policies and strategies for children and adolescents;
- to start priority actions for improving child and adolescent health; and
- to incorporate gender analysis into child and adolescent health programmes and identify effective interventions with a gender perspective.

[1] European strategy for child and adolescent health and development. Copenhagen: WHO Regional Office for Europe; 2005 (http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/policy/european-strategy-for-child-and-adolescent-health-and-development, accessed 16 April 2014).

4. Later, a set of tools for evidence-based action for adolescent health and a tool for monitoring implementation of the objectives and the principles of the strategy at national level were developed. Countries have used the tools for both planning and monitoring implementation of national strategies (see Annex E1).

Implementing the strategy

5. Since introduction of the strategy in 2005, the WHO Regional Office for Europe has actively supported 20 Member States in developing and revising child and adolescent health strategies (Annex E1), focusing on:

- conducting a situation analysis of participating countries, with a detailed country profile and information about the organization of its health system, the status of maternal, child and adolescent health and challenges to supporting child and adolescent health and well-being;
- conducting workshops in the countries to introduce the strategy, map current developments in child health and related programmes and determine a way forward at national level; and
- supporting the development of a strategy and a costed action plan for approval by the government or parliament.

6. Progress in implementing child and adolescent health strategies was evaluated in depth from 2006 to 2008[2] in two steps: a questionnaire-based survey, which supplied simple data that could be generalized across countries and regions, and country case studies.

7. The main aim of the survey was to collect information on implementation of the strategy, including:

- political and organizational activities resulting from implementation and the involvement of partners;
- political commitment;
- child and adolescent health services;
- information systems; and
- human resources.

Results of the survey

Policies and programmes should address the health challenges at each stage of development, from prenatal life to adolescence (life-course).

8. The number of countries that addressed different age groups in their national strategies increased from two to eight in 2008. At least 12 countries currently address different age groups in their national strategies. Six countries reported that they had adopted the life-course approach in their national strategies.

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[2] European strategy for child and adolescent health and development: from resolution to action, 2005–2008. Copenhagen: WHO Regional Office for Europe; 2008 (http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2008/european-strategy-for-child-and-adolescent-health-and-development-from-resolution-to-action,-20052008, accessed 31 March 2014).

The needs of the most disadvantaged should be taken into account explicitly when assessing health status and formulating policy and planning services.

9. Health gaps within or between different population groups were assessed to a larger extent and 15 countries detected substantial inequities in child and adolescent health among groups. The number of countries that addressed inequity among different population groups in their national strategy increased from nine to 17.

An intersectoral, public health approach that addresses the fundamental determinants of health should be adopted when devising policies and plans to improve the health of children and adolescents.

10. The number of countries that reported having an intersectoral task force increased from zero to 13.

The public and young people should be involved in the planning, delivery and monitoring of policies and services.

11. The proportion of countries that involved young people in strategy development increased. Young people were often involved through nongovernmental organizations, such as youth parliaments and other youth movements. In terms of wider public involvement, over half of the countries involved nongovernmental organizations in strategy development. This suggests that the process is opening up to a broader group of experts.

Case studies

12. Five country case studies[3] were conducted, which provided extensive information for future work in these and other countries (see Annex E2).

Post-2008

13. During the period 2008–2013, the WHO Regional Office for Europe continued to support Member States in improving child health and development by providing technical support for preparation and implementation of national strategies and action plans for child and adolescent health and thus also supporting Member States in reaching Millennium Development Goal 4. The Regional Office has provided technical support to 18 countries for policy development and health systems support for child and adolescent health.

14. Kazakhstan included a child and adolescent health component in the overall national health plan. Armenia and Uzbekistan both evaluated their existing strategies and are preparing new policies for the next five to six years. Kyrgyzstan, Republic of Moldova and Turkmenistan are preparing strategies and approved policies are expected by the end of 2014.

15. Capacity for performing costing analyses in policy development was established in eight countries and support to reorient and improve the quality of school health services was provided for Republic of Moldova, Ukraine and Uzbekistan.

16. With WHO technical guidance, countries with biennial collaborative agreements (Armenia, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan) have made evidence-based assessment of clinical practices in primary

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[3] Barnekow V, Smith L, Simonelli F, Majer K, Fernandes Guerreiro AI. Development of national strategies–case studies from five countries. European Strategy for Child and Adolescent Health and Development. Copenhagen: WHO Regional Office for Europe; 2008 (http://www.euro.who.int/__data/assets/pdf_file/0010/53929/e92117.pdf, accessed 16 April 2014).

and secondary health services, have adapted or developed and disseminated guidelines and tools for delivering high-quality care for children and have strengthened health systems for child health interventions. In Uzbekistan, for example, national policy guidance and tools were developed for an integrated supportive supervisory system in mother and child health services and national capacity has been built with the support of partners. In Armenia, a national child hospital strategy triggered an increase in national funding for health care and the introduction of a child health certificate improved access to care and contributed to a 45% decrease in hospital deaths due to pneumonia in infants and to a 35% reduction in mortality among children aged one to five years.

17. On the basis of WHO recommendations, Armenia, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan set policy and developed capacity to improve the quality of health services nationwide. The quality of hospital care and children's rights in health services have been strengthened with WHO tools in four countries (Kyrgyzstan, Republic of Moldova, Tajikistan and Uzbekistan) after assessment of the gap between full respect of children's rights in hospitals and actual practice and taking concrete steps for improvement.

Conclusions

18. Countries have shown political will to support strategy development, but action has been less evident. Government budgetary allocations or reallocations of dedicated resources for child and adolescent health have been problematic and, therefore, in most countries work on the strategy has been carried out with no government resources. Little by little, however, financial resources are being directed towards this area and the proportion of countries with specific financing for strategy development rose from two to four between 2006 and 2008, while an additional seven countries reported that they had partially secured financial resources for strategy development.

19. One of the reasons for inconsistent financing for child and adolescent health may be the paucity of data on the subject. Robust data on health status and patterns are needed to support requests for resources; however, the 2008 follow-up survey showed that only about half of the countries had a national database of information relevant to child and adolescent health. Some countries do not have a database on child health as a single structure and the information is integrated in other registers or databases. Morbidity and mortality data are collected in most countries and disaggregation by age group is more and more frequent, but data on socioeconomic conditions and ethnic groups are still lacking. Collecting disaggregated data is a demanding, time-consuming task; nevertheless, some countries are beginning to collect data disaggregated by, for instance, gender and age. Disaggregated data on socioeconomic status and ethnicity are more difficult to obtain.

20. In summary, experience has shown that the following conditions are necessary for integrating the WHO *European strategy for child and adolescent health and development* into country policies and strategies:

- integration of implementation of the strategy into the health systems approach;
- identification of other strategies, gaps and unmet needs in a situation analysis;
- leadership from the health ministry (or the most relevant ministry) for the situation analysis and for defining priorities;
- political will and strong commitment and support from the government for child and adolescent health and intersectoral action;
- a clear, common system, sponsored by the government, to coordinate stakeholder activities, with an identified lead ministry and a high-level intersectoral working group;

- definition of the status of the strategy and the responsibilities of each sector for its implementation; and
- definition of the financial and other resources that each partner will contribute, with clearly defined and costed action plans for implementation.

21. There are numerous threats to the health and well-being of children and young people in the Region, such as obesity, sexually transmitted diseases and psychosocial and mental health disorders that add to the existing threats of malnutrition, perinatal problems and infectious diseases. Concern has also been raised about the current and future threats to health and well-being posed by polluted environments and the adoption of health-compromising behaviours and lifestyles by young people.

22. The renewed strategy being proposed for 2014–2025 will address these issues directly.

Annex D1. Status of strategy development by country in 2008

Countries that have received intensive support from WHO	Countries that have asked for intensive support from WHO	Countries that have a draft child and adolescent health strategy	Countries that have an approved child and adolescent health strategy
Albania	Azerbaijan	Armenia	Hungary
Armenia	Ireland	Georgia	Scotland*
Georgia	Kazakhstan	Kyrgyzstan	Slovakia
Hungary	Russian Federation	Republic of Moldova	Slovenia
Kyrgyzstan	Turkmenistan	Uzbekistan	Tajikistan
Republic of Moldova			Ukraine
Romania			
Slovakia			
Tajikistan			
Turkey			
Ukraine			
Uzbekistan			

*Scotland does not have a separate strategy for child and adolescent health, but it has used the toolkit to create a framework for children and young people.

Many of the countries listed above have continued to receive support to monitor and revise their national strategies on child and adolescent health. In addition, support has been provided to Belarus and Kosovo.[1]

[1] In accordance with United Nations Security Council resolution 1244 (1999).

Annex D2. Some lessons learnt from the case studies[1]

Moving from policy to action and implementation is a continuous process and a positive start had been made in all countries. In terms of gaining finance for the implementation phase, most countries face a conundrum in that money is not being offered without the existence of a coherent, agreed strategy and strategy development is being hampered by a lack of commitment to provide resources.

Political commitment is of paramount importance in making progress and this commitment needs to be backed by strong political action and resource allocation.

The *life-course approach* is evident in the countries, although its application is not always coherent and there is a general perceived need to pay more attention to adolescent health in national strategies.

Higher priority needs to be given to identifying and meeting the needs of at-risk population groups to increase equity. Gender inequity issues are problematic; gender is starting to become more recognized as an e*quity* issue in the countries and is now being incorporated in policies and actions, but, in general, gender differences are still not being fully acknowledged within the area of child and adolescent health and gender expertise is missing in most of the countries. Gender issues should be addressed in a systematic way.

Intersectoral collaboration has been identified as a major strength across the case study countries, with ministries of health having an important leadership role. The extent of *integration with other policy developments*, however, varies widely between countries. Intersectoral coordination groups can also be adversely influenced by the instability of the political environment and by too many changes of representatives.

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[1] European strategy for child and adolescent health and development. from resolution to action, 2005–2008. Copenhagen: WHO Regional Office for Europe; 2008. Extract from page 10 (http://www.euro.who.int/__data/assets/pdf_file/0003/81831/E91655.pdf, accessed 16 April 2014).

E. Progress on the *European strategic action plan on antibiotic resistance*

Introduction and background

European strategic action plan on antibiotic resistance

1. At the 61st session of the Regional Committee for Europe in 2011, all 53 countries of the Region adopted resolution EUR/RC61/R6 and the *European strategic action plan on antibiotic resistance* (document EUR/RC61/14). The strategic action plan contains seven strategic objectives, intended to comprehensively cover the complex factors related to bacterial resistance.

2. Resolution EUR/RC61/R6 urges Member States to: secure the political commitment and resources necessary to implement the strategic action plan; support the development of national systems for surveillance and monitoring of antibiotic resistance and consumption; initiate and formalize national, intersectoral, all-inclusive coordinating mechanisms; and support national campaigns to raise awareness of the causes of antibiotic resistance.

3. Resolution EUR/RC61/R6 requests the Regional Director to continue to provide leadership, tools, guidance and technical support to Member States in assessing their current situations with regard to antibiotic resistance, antibiotic consumption and their capacity to develop and implement national action plans. In addition, the resolution requests the Regional Office to facilitate information exchange on trends and drivers of antibiotic resistance, including creating a regional platform for sharing and analysing data. Finally, it requests the Regional Director to report to the Regional Committee on progress made in implementing the European strategic action plan each year until 2014 and every second year thereafter, with final reporting in 2020.

Global action on antibiotic resistance

4. On World Health Day 2011, WHO called on countries to combat antimicrobial resistance (AMR), using the slogan, “no action today, no cure tomorrow”. This message highlighted the need for urgent action across borders, sectors and disciplines to avoid the loss of hard-won gains in health and development due to increasing resistance against antimicrobial agents in general, and antibiotics in particular. Currently, there is unprecedented global momentum with the increasing awareness that AMR is one of the major global health threats of our time.

5. In September 2013, the Director-General of WHO convened the Strategic and Technical Advisory Group on Antimicrobial Resistance (STAG-AMR), the principal technical advisory group to WHO on AMR. STAG-AMR held its first meeting on 19 and 20 September 2013 at WHO headquarters in Geneva, Switzerland. Its main recommendation was that WHO lead in developing a global action plan to combat AMR. This recommendation was endorsed in January 2014 by the Executive Board, which welcomed the establishment of a WHO Global Task Force on Antimicrobial Resistance, which will ensure close coordination and collaboration between AMR-related technical programmes at WHO headquarters and the regional offices. STAG-AMR further recommended that the World Health Assembly adopt a resolution on combating AMR during the Sixty-seventh World Health Assembly. On 30 April 2014, before the Health Assembly, WHO published the first global report on AMR, to which the Regional Office and the European Centre for Disease Prevention and Control (ECDC) contributed significantly.

Actions taken and progress made

Implementation of the *European strategic action plan on antibiotic resistance*

6. At the Regional Office, implementation of the *European strategic action plan on antibiotic resistance* depends on close collaboration among several technical programmes and their networks of partners as well as with Member States' governments. This report highlights the most recent activities and accomplishments of the Regional Office and partners in implementing the seven strategic objectives of the plan.

Strategic objective 1: Strengthen national multisectoral coordination for the containment of antibiotic resistance.

7. The Regional Office, in collaboration with the National Institute for Public Health and the Environment (RIVM) of the Netherlands and the European Society of Clinical Microbiology and Infectious Diseases (ESCMID), is analysing country situations to assess Member States' capacity to prevent and control antibiotic resistance through surveillance, prudent use of antibiotics and infection control. Teams of WHO and external experts visit Member States to discuss the current status of the AMR response with nominated focal points and other relevant national stakeholders in the human and veterinary health sectors and to visit several laboratories and health care facilities. In 2013–2014, country situation analyses were performed in Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Republic of Moldova, and Uzbekistan. Analyses are planned in 2014–2015 in Albania, Kazakhstan, Tajikistan, Turkmenistan and Ukraine.

8. At the request of the Secretariat, almost all Member States have appointed a national AMR focal point, whose function is to facilitate the formation of an intersectoral coordination mechanism for AMR (such as a taskforce, steering committee, board or council) and to lead the drafting of a national action plan that includes objectives, policies, surveillance and control. Through the intersectoral coordination mechanism, the national AMR focal point ensures regular data collection and information-sharing and facilitates communication and coordination among its members and their constituents. Since adoption of the strategic action plan, Armenia, Belarus, Georgia, Kyrgyzstan, Montenegro, Republic of Moldova, The former Yugoslav Republic of Macedonia, Turkey and Uzbekistan either have or are in the process of forming an intersectoral coordination mechanism and developing a national action plan on AMR. The Secretariat provides technical support and access to experts for the development and advancement of national plans and related governance structures.

Strategic objective 2: Strengthen surveillance of antibiotic resistance.

9. Surveillance of antibiotic resistance is considered the backbone of the European strategic action plan; it is necessary in order to document the extent of the problem, follow the emergence of and trends in specific pathogen–agent combinations and evaluate the effectiveness of targeted interventions. Although many countries in the Region that are not members of the European Union do not systematically collect and share data on antibiotic resistance, the Regional Office, together with RIVM and ESCMID, established the Central Asian and Eastern European Surveillance of Antimicrobial Resistance (CAESAR) Network in 2012 to assist countries in setting up and/or strengthening national AMR surveillance and to contribute to region-wide AMR surveillance.

10. The CAESAR Network focuses on countries that are not part of the European Antimicrobial Resistance Surveillance Network (EARS-Net), which is hosted by ECDC. It will complement surveillance conducted in the European Union and by the European Environment Agency to complete the regional picture, in close collaboration with ECDC and by using compatible methodology. Currently, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina,

Georgia, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Switzerland, The former Yugoslav Republic of Macedonia, Turkey and Uzbekistan, in addition to Kosovo,[1] are engaged in CAESAR at various stages of development and participation.

11. Five countries, namely Belarus, Serbia, Switzerland, The former Yugoslav Republic of Macedonia and Turkey, have submitted data to the CAESAR database. The Regional Office and partners will work to include all remaining countries, as a harmonized, coordinated surveillance network in all countries of the European Region is crucial to protect health from emerging cross-border threats of AMR. By the end of 2014, the Secretariat plans to publish the first CAESAR annual report, with data on antibiotic resistance for at least the five countries mentioned above.

12. In November 2013, a first external quality assessment of antimicrobial susceptibility testing by 121 laboratories in nine countries and areas engaged in CAESAR was conducted by the United Kingdom National External Quality Assessment Service for Microbiology. External quality assessment of antimicrobial susceptibility testing in diagnostic laboratories is a valuable tool for validity, enabling comparison of data between laboratories. The results of the assessment were discussed at the second CAESAR network meeting in Barcelona, Spain, in May 2014.

13. The Secretariat and partners organized a multicountry workshop on AMR in Georgia in July 2014, with two parts: a multicountry seminar for a broad audience of health professionals to raise general awareness, and a laboratory workshop for medical microbiologists to strengthen laboratory capacity for national and international AMR surveillance. The countries that participated in the workshop were Armenia, Azerbaijan, Georgia, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Turkey, Turkmenistan and Uzbekistan, The workshop was followed by a meeting of Georgian national stakeholders, who discussed the draft national action plan.

14. The Secretariat supported and participated in the first regional meeting of the focal points on antibiotic resistance of the 11 South-eastern Europe Health Network (SEEHN) Member States in Bulgaria in November 2013. The purpose of the meeting was to discuss the most important issues in antibiotic resistance surveillance in these SEEHN countries and to align their activities with the European strategic action plan on antibiotic resistance.

Strategic objective 3: Promote strategies for rational use of antibiotics, and strengthen surveillance of antibiotic consumption.

15. Efforts continue to expand the network for surveillance of antimicrobial consumption in Member States in the European Region to complement the information derived from the EARS-Net using the same methods. Eighteen non-European Union Member States (Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Ukraine and Uzbekistan) and Kosovo[1] have joined the network so far and are collecting data. The WHO antimicrobial consumption network was established in collaboration with external partners and with funding from the Netherlands. Work on surveillance of antimicrobial consumption in Member States has triggered policy actions at national level and follow up in several countries, including Armenia and Turkey.

16. Antimicrobial consumption data for 2011 from 13 Member States that are not members of the European Union were collected through the network, analysed in collaboration with Antwerp University, Belgium, and compared with data from ECDC for the ESAC-Net. The

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[1] In accordance with United Nations Security Council resolution 1244 (1999).

results, published in *The Lancet Infectious Diseases* in March 2014,[2] indicate an almost four-fold difference between the lowest and the highest antibiotic users among 42 countries and regions in the WHO European Region (within and outside the European Union) and provide a clear picture of the use of different groups of antibiotics. Antibiotic consumption differed significantly among the countries participating in the study. When compared with members of the European Union, some countries ranked as high consumers (for example, Montenegro, Tajikistan and Turkey) and others as low consumers (for example, Armenia, Azerbaijan, Belarus and Bosnia and Herzegovina).

17. Low antibiotic use may reflect underuse due to limited access for significant parts of the population. Penicillins were the most frequently used antibiotics by all participants, with a high use of broad-spectrum penicillins (amoxicillin and ampicillin), especially in the newly independent states. Participants in south-eastern Europe consumed higher volumes of first-generation cephalosporins than northern European Union countries. Montenegro and Serbia, in particular, used a high volume of the long-acting macrolide azithromycin. Remarkably high use of antibiotic injection treatment was observed in all the newly independent states.

18. Evidence generated by this and other studies provides a foundation for arguments to counteract AMR, although additional resources will be required to sustain activities and to follow up and address the findings. Gaining momentum will require commitment, including financing by stakeholders, in line with the comprehensive *European strategic action plan on antibiotic resistance*.

19. In addition to surveillance of antimicrobial consumption, the Secretariat conducts several activities designed to change the behaviour of both health professionals and consumers in the Region, including work on clarifying the role and responsibility of pharmacists in prudent use of antimicrobial medicines. Collaboration with professional associations such as the Pharmaceutical Group of the European Union and the EuroPharm Forum has been established to map national initiatives that have had an impact on the prudent use of antimicrobial medicines, to suggest new initiatives and to support implementation of good pharmaceutical practices in support of the rational use of medicines.

Strategic objective 4: Strengthen infection control and surveillance of antibiotic resistance in health care settings.

20. The WHO “SAVE LIVES: Clean Your Hands” global campaign in 2014 highlighted the role of hand hygiene in combating AMR by protecting patients from resistant pathogens and also emphasized that AMR can arise during patient care.

21. The Secretariat continues to collaborate with the Baltic Antibiotic Resistance collaborative Network and the Global Infection Prevention and Control Network. It is following up the outcome of three back-to-back meetings in Estonia in May 2013 to define a national curriculum for education in infection prevention and control.

22. In the country situation analyses described under strategic objective 1, infection prevention and control activities in health care facilities are being assessed and observed on site. In supporting the drafting of national AMR action plans, the Secretariat actively promotes the inclusion of infection prevention and control measures, including vaccines, and provides specific recommendations.

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[2] Versporten A, Bolokhovets G, Ghazaryan L, Abilova V, Pyshnik G, Spasojevic T, et al. Antibiotic use in eastern Europe: a cross-national database study in coordination with the WHO Regional Office for Europe. Lancet Infect Dis. 2014; 2–14; doi: 10.1016/S1473-3099(14)70071-4 (http://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2814%2970071-4/).

23. The Secretariat was invited to participate in a debate on AMR in health care and in the community in March 2014 in São Paulo, Brazil, to report WHO's experience in the European Region. The event was part of a series of debates on public policies for infection control and patient safety involving members of governmental health departments, universities and professionals directly involved in the field. This event was one of an increasing number of inter-regional exchanges of experience on AMR.

24. The Regional Office is providing financial and technical support for capacity-building workshops in clinical microbiology and antibiotic stewardship, with the participation of specialists in infectious diseases, intensive care and other relevant medical disciplines.

Strategic objective 5: Prevent and control the development and spread of antibiotic resistance in the veterinary and agricultural sectors.

25. Activities have been conducted in several countries to raise awareness about AMR in food and to strengthen surveillance of AMR in foodborne pathogens. In Albania in December 2013 and in Serbia in May 2014, intersectoral food safety workshops were held, which included a session on AMR from a food safety perspective and stimulated good discussion and engagement. In Uzbekistan, the importance of addressing antibiotic resistance from the perspective of food safety was highlighted at a high-level international conference held in Tashkent in June 2014.

26. Under the auspices of the WHO Global Foodborne Infections Network, national five-day intersectoral training courses were held in Tajikistan (May 2013), Turkmenistan (September 2013) and Uzbekistan (November 2013), and intersectoral training for Albania and Kosovo[1] was held in Albania in July 2014. The courses brought together officials from the public health, veterinary and agricultural sectors and included training for laboratory diagnosis of antibiotic-resistant *Salmonella* and *Campylobacter* and related AMR.

27. The WHO Advisory Group on Integrated Surveillance of Antimicrobial Resistance funded a project on integrated surveillance of AMR in Kosovo,[1] which started in November 2012 and successfully concluded in March 2014. The surveillance project generated data on AMR in the veterinary sector, in particular, on *Salmonella* in egg production. The project also addressed the levels and patterns of antibiotic consumption in primary health care settings. This intersectoral project provided important information on antibiotic use and resistance in Kosovo,[1] which will inform future activities and measures to reduce the spread of AMR.

28. With funds from the World Bank and the World Organisation for Animal Health, national surveys on AMR for *Salmonella* in the food chain in Albania and in the food chain and among humans in Tajikistan were carried out between November 2013 and April 2014. Surveillance of AMR in Albania poultry farms revealed a high level of AMR among bacterial isolates from poultry and wide geographical spread across the country. The report from the project will call for action to set appropriate regulations and prudent policies for veterinary antimicrobial use in Albania. Similar studies are needed in more countries in the Region to map trends and sources of AMR in food production and stimulate targeted interventions.

29. WHO is closely following the European Commission project "European Surveillance of Veterinary Antibiotic consumption", coordinated by the European Medicines Agency (EMA) for members of the European Union. The Regional Office will support the EMA in conducting similar surveys in some countries that are not members of the European Union towards the end of 2014.

Strategic objective 6: Promote innovation and research on new drugs and technology.

30. The Joint Programming initiative on Antimicrobial Resistance launched its strategic research agenda on 3 April 2014 in Brussels, Belgium. The Regional Office, a member of the stakeholder advisory board, provided input to the research agenda. Both WHO headquarters and the Regional Office Secretariat participated in a workshop on "Antibiotics and their alternatives – fixing and feeding the pipeline", organized by the European Commission Directorate-General for Research and Innovation. The Secretariat continues to engage with nongovernmental groups and networks, such as ReAct and Antibiotic Action, to promote innovation and develop new business models that stimulate research and discourage aggressive marketing of new antibiotics.

Strategic objective 7: Improve awareness, patient safety and partnerships.

31. As overuse and misuse of antibiotics are the main drivers of antibiotic resistance, it is important to create awareness about the associated risks at both individual and society levels and to change these practices. Through a project sponsored by the Belgian government, the Secretariat will provide small grants for the development and implementation of pilot campaigns or educational programmes to improve infection prevention and prudent use and prudent prescription of antibiotics in countries of the Region that are not members of the European Union. Such activities and products could include educational materials, promotion materials, toolkits, campaigns, television spots and digital media tailored to country needs and activities related to the launch of such products and activities, for example, during European Antibiotic Awareness Day in November 2014.

32. During 2013, the Regional Office continued to collaborate with ECDC and the European Commission to mark European Antibiotic Awareness Day. As in 2012, the Secretariat prepared promotion materials to help WHO country offices support Member States that wished to participate. In 2013, a number of non-European Union Member States participated: Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey and Uzbekistan, as did Kosovo.[1] The Regional Office took part in the official launch of the awareness day on 15 November in Brussels.

33. Based on the successful publication, *Guide to tailoring immunization programmes*,[3] the Secretariat is preparing a *Guide to tailoring AMR programmes*, in collaboration with RIVM, which will provide Member States with tools to identify the audiences that contribute significantly to the issues around AMR and to design targeted strategies to bring about behaviour change (such as prudent antibiotic use). The Secretariat is planning to pilot the guide in Sweden and the United Kingdom.

34. On 6–8 November 2013, the Regional Office organized a regional workshop on Surveillance of Antibiotic Resistance, Consumption and Awareness, hosted by RIVM, in collaboration with Antwerp University, the Belgian Antibiotic Policy Coordination Committee and ESCMID. The aim of the workshop was to connect three initiatives that are part of the European strategic action plan on antibiotic resistance: (1) surveillance of AMR (CAESAR), (2) surveillance of antimicrobial consumption and (3) support to countries in setting up AMR

[3] The guide to tailoring immunization programmes (TIP): increasing coverage of infant and child vaccination in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0003/187347/The-Guide-to-Tailoring-Immunization-Programmes-TIP.pdf).

awareness campaigns by facilitating the development of networks in countries that are not members of the European Union.

35. The workshop included plenary sessions and workshops on laboratory diagnosis, data analysis and consumption awareness campaigns, facilitated by relevant experts from the Regional Office and collaborating institutions. Seventeen European countries participated, shared their experiences and developed follow-up plans to sustain and strengthen surveillance and contain AMR and to address their findings.

36. As a result of this workshop, several participating countries (Armenia, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Montenegro, Serbia and The former Yugoslav Republic of Macedonia) successfully applied for funding to carry out AMR awareness-raising activities in the second half of 2014. Funding was awarded by a joint review committee consisting of the Belgian Antibiotic Policy Coordination Committee, RIVM, ECDC and the Regional Office.

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