EUROPE

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

This document describes follow-up actions taken in the following areas:

– the European Strategy for Tobacco Control

– the European Environment and Health Committee (annual report)

– the DOTS strategy for tuberculosis and malaria control

– occupational health.

Actions in each of these areas are implemented within the overarching framework of the WHO European Country Strategy and its current phase of Strengthening Health Systems in the European Region, and in accordance with priorities agreed in the Biennial Collaborative Agreements with 28 Member States.

Each of these subjects will be presented and discussed separately during the session.

In addition, as agreed by the Standing Committee of the Regional Committee, a verbal presentation will be made regarding indicators for monitoring the implementation of the Health for All (HFA) policy framework.

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# Tobacco control in the WHO European Region – summary progress report

1. The European Strategy for Tobacco Control (ESTC) was adopted by the WHO Regional Committee for Europe in 2002. This followed three consecutive regional action plans spanning the period from 1987 and the call for a European strategy made at the WHO European Ministerial Conference held in Warsaw, in February 2002. The first progress report to the Regional Committee is due in 2006.

2. In May 2003, the Member States of WHO adopted the Framework Convention on Tobacco Control (FCTC) – the first global public health treaty. The FCTC entered into force in February 2005, and the first Conference of the Parties was convened from 6 to 17 February 2006 to outline and promote its implementation. Several Member States have in recent years updated their policies and legislation, conducted new surveys and strengthened national capacity in tobacco control.

3. The European Tobacco Control Report is now being drawn up by the Regional Office, in collaboration with the network of national counterparts and experts, to address and reflect the above developments. The purpose of this review is three-fold: to describe the tobacco control situation and the status of tobacco control policies in the WHO European Region as of early 2006; to review the progress made following the adoption of the ESTC in 2002; and to establish a baseline for monitoring implementation of the FCTC in the Region. The document presents an overview of the situation regarding tobacco use and related harm in the Region during the period 2002–2006, and of Member States' policy responses to implement national tobacco control measures in line with the recommendations of the ESTC. Reference is also made to the status of policies in countries in the light of the specific requirements of the FCTC. The summary and conclusions provide an overview of the situation and of the progress made, as well as of the challenges ahead and the next steps to be taken in tobacco control in the Region. Lessons learned and challenges faced during the policy-making process are also illustrated by several short national, regional and subregional case studies which are attached to the Report.

4. Between 2002 and 2006 there has been considerable progress in the policy-making area in most Member States, notably in banning advertising, increasing the size of health warnings, strengthening product regulation and, to a certain extent, increasing tobacco taxes.

5. The price of tobacco products rose by an average annual rate of 6.8% above inflation in the European Union (EU) countries, compared to 2.7% observed in the late 1990s. The data are less encouraging in countries in the eastern part of the Region where, in some cases, tobacco has become even more affordable. Six countries reported that they had introduced the earmarking of taxes for tobacco control, but this is still not the case in most countries of the Region. Major developments have taken in place with regard to smoke-free policies: the regulation of smoking in public places has become more restrictive in a large number of countries, while several, led by the example of Ireland and Norway (2004), have introduced bans or strict restrictions on smoking, including in bars and restaurants. Nearly 20 counties have passed stricter laws in this area over the past four years, and currently nearly two thirds of countries ban or restrict smoking in most indoor public places – a substantial improvement since 2001.

6. Since 2002, 24 Member States have reinforced their legislation on direct advertising by either passing new laws or starting to implement previously adopted bills. An EU directive totally banning the advertising of tobacco products in the press, on radio and in the sponsorship of events came into force with cross-border effects, on 31 July 2005. Advertising remains less regulated in the countries of the Commonwealth of Independent States (CIS), although marked progress has been made in most countries since 2002.

7. There has also been marked progress in recent years in other areas of tobacco control policies, with 11 countries introducing or making stricter age limits for the sale of tobacco products to minors and 32 countries implementing substantially larger health warnings on cigarette packages, etc. However, major policy weaknesses still exist in many countries, especially with regard to restricting indirect advertising,

introducing smoking cessation into the national health care system and, most importantly, combating smuggling, which remains a major problem in most countries of the Region.

8. New data confirm recent observations that the tobacco epidemic is, in general being curbed in the Region, but not in all countries and at different rates. According to available data, at the end of 2005 around 29.4% of the adult population in the Region were regular smokers (29.6% in 2002) – 39.8% of men (40.9% in 2002) and 19.9% of women (19.3% in 2002). After a period of decline, smoking prevalence in most western European countries is now reaching a level where it will be difficult to lower it further, unless substantially stronger measures are implemented. Smoking prevalence has also started to decrease in some countries in the eastern part of Europe; in general, however, it is only stabilizing among men, with no clear overall trends or, in some cases, with a slight rise in prevalence among women. The overall positive trends in male smoking prevalence are now reflected in a Region-wide decrease of standardized death rates for lung cancer, whereas in women lung cancer continues to rise.

9. The continued concentration of smoking in lower socioeconomic groups, observed throughout the Region, could lead to a widening gap in future health outcomes. Although the absolute number of people exposed to socioeconomic disadvantages may be decreasing in some countries, this persisting relative gap emphasizes the need to extend tobacco control policies so as to incorporate broader policy interventions that address the wider social and economic determinants related to smoking.

10. Recent years have also been characterized by significant and increasing public support for strong tobacco control policies and action at both national and international levels. Not only the absolute majority of nonsmokers but also the majority of smokers are now in favour of tougher controls.

11. The Region, in general, has made a significant contribution to the process of negotiation and entry into force of the FCTC. As of May 2006, two thirds of WHO's European Member States (35 countries, as well as the European Community) have ratified and become parties to the FCTC.

12. The Regional Office has provided support to Member States and international partners in strengthening and coordinating policies throughout the Region, carrying out surveillance, building capacity, reviewing and updating legislation, promoting intersectoral links, etc. In particular, this has included supporting the development of national action plans and the updating of legislation, implementing internationally standardized surveys and capacity-building projects focusing on CIS and south-eastern Europe, carrying out information campaigns such as World No Tobacco Day, organizing the work of the network of national counterparts, and updating and extending the European Tobacco Control Database.

## Annual report of the European Environment and Health Committee (EEHC)

### Introduction

13. This report is submitted in compliance with the requirement set out in paragraph 23(b) of the Declaration adopted at the Fourth Ministerial Conference on Environment and Health (Budapest, June 2004), to report annually to the WHO Regional Committee for Europe and to the United Nations Economic Commission for Europe (UNECE) Committee on Environmental Policy, as well as with Regional Committee resolution EUR/RC54/R3. It summarizes the work done and decisions taken by the EEHC since the fifty-fifth session of the WHO Regional Committee for Europe and the twelfth session of the UNECE Committee on Environmental Policy.

14. The EEHC holds two regularly scheduled meetings each year, and it accordingly held its twentieth meeting in Helsinki, hosted by the Finnish Environment Institute (SYKE), in December 2005 and its twenty-first meeting in Oslo, hosted by the Norwegian Directorate for Health and Social Affairs, in May 2006.

15. The website (www.euro.who.int/eehc) is regularly updated and includes the working papers and reports of the EEHC's meetings, as well as those of the Task Force of the Children's Environment and Health Action Plan for Europe (CEHAPE), a calendar of upcoming environment and health events in Europe, and relevant news items of interest.

16. The contributions by Finland, France, Italy and Norway to the operational costs of the EEHC are gratefully acknowledged.

## Topic-oriented meetings

17. In keeping with the decision taken at its meeting in January 2005, the EEHC devotes one day of its meetings to priority issues highlighted in the CEHAPE and the Budapest Conference Declaration. All Member States are invited to participate in these topic-oriented sessions. On each priority issue, new scientific evidence and the policy response by countries to address it are examined.

18. The December 2005 meeting focused on disease and disability from exposure to hazardous chemical, physical and biological agents and hazardous working environments, with participants from 35 Member States and 11 organizations taking part. The May 2006 meeting, attended by representatives of 27 countries and 10 organizations, as well as 2 youth delegates, highlighted the health consequences of accidents and injuries. The reports on implementation by countries and organizations are available on the web-based map (see paragraph 32).

19. The next meeting of the EEHC will take place in Szentendre, Hungary, on 27 and 28 November 2006, hosted by the Regional Environment Centre for Central and Eastern Europe, and will focus on gastrointestinal disease and other health effects from unsafe water and inadequate sanitation.

## CEHAPE Task Force

20. The second meeting of the CEHAPE Task Force in October 2005 was hosted by the United Kingdom Department of Health. Environment and health focal points from 43 countries and 3 organizations met to share experiences and good practice with regard to reducing and preventing disease and disability from exposure to hazardous chemical, physical and biological agents and hazardous working environments. The third meeting in March 2006 was hosted by the Irish Department of Health and Children, with environment and health focal points from 40 countries, as well as 2 youth delegates and representatives of 4 organizations participating. They reported on work under way to reduce and prevent the health consequences of accidents and injuries.

21. Countries are making progress with their implementation of CEHAPE as part of their fulfilment of the Budapest Conference commitments. Eight Member States are already implementing national environment and health action plans (NEHAPs) with child-specific actions, 16 Member States are revising their NEHAPs and 6 countries are preparing their first NEHAPs; 12 countries are preparing CEHAPs, and most countries now have programmes with CEHAPE components. In addition, many countries have set up national coordination groups or held national coordination meetings.

22. The next meeting of the CEHAPE Task Force will take place in Cyprus in October 2006, co-hosted by the Ministry of Health and the Cyprus International Institute for Environment and Health.

23. Additional staffing, funded by Austria, will considerably strengthen the ability of the CEHAPE secretariat to respond to the needs of Member States in their implementation efforts. In addition to Austria, the contributions by Ireland and the United Kingdom to the operational costs of the CEHAPE Task Force are gratefully acknowledged.

24. More detailed information on the work of the CEHAPE Task Force, including reports on implementation by countries and organizations, is available at www.euro.who.int/eehc/20050407_1.

## Activities in countries

25. A series of workshops have been held to support Member States in their efforts to develop national plans and actions to meet the commitments made at the Budapest Conference. The goals of the workshops were to understand the context within which each national action plan is being developed or revised; to identify the priorities, actions, main actors and requirements of this plan; and to ensure drafting, implementation and monitoring of this plan. Such workshops, involving a broad spectrum of sectors and stakeholders, have been held in Bulgaria, Cyprus, Estonia, Lithuania, Malta, Slovakia, and Serbia and Montenegro (two workshops). In the coming months, workshops will also take place in Greece and Israel, and discussions are under way with Kazakhstan, Kyrgyzstan, the Republic of Moldova and Slovenia. Assessments of the impact of these workshops on relevant policy development in the countries will be made before the end of 2006.

26. Capacity-building in countries is being promoted in various ways. A trainers' network is being developed to equip and support health care providers and individuals to carry out training courses and activities to build awareness of environmental health risks to children. Following an international training workshop in late 2005, 15 trainers have held their own national training courses to spread this knowledge and skills. Eighteen countries currently form the network and the goal is to have at least 36 countries in the network by the end of 2006. In addition, training workshops on environmental health risks have been held in Armenia, Belarus, Hungary, Malta, the Russian Federation and The former Yugoslav Republic of Macedonia.

27. Countries have also been translating the Budapest Conference commitments into concrete actions. Malta has carried out a study on transport-related health effects on Maltese children, which will be used as a basis to review legislation. Cyprus has adopted a five-year strategic plan for the prevention of unintentional childhood injuries, prepared with WHO assistance. France has analysed existing regulations on housing and health in seven European countries, with a view to reviewing its own regulations and action plans in the field of housing. In Italy, the municipality of Rome is setting up a "walking bus" scheme which, after successful pilot testing in six primary schools in 2005 with WHO support, is now being expanded to include more schools. The project will give primary school children a safe opportunity to be physically active and to socialize as part of their trip to school. In Portugal, the Municipality of Ferreira do Alentejo has drafted a housing and health action plan based on the work presented at the Budapest Conference. The Republic of Moldova is revising its drinking-water legislation in line with the EU Drinking Water Directive, which is based on the WHO water quality guidelines. In the Russian Federation, a report on road traffic injury prevention, prepared jointly by the European Conference of Ministers of Transport (ECMT), the World Bank and WHO, together with local counterparts, is now forming the basis for road safety policy development. The report was launched on 26 April 2006 at the White House and referred to in the Annual Presidential Address to the Federal Assembly in May 2006.

28. Specific practical measures are also being carried out by countries working together towards meeting their Budapest Conference commitments. Eight new EU members and pre-accession countries have come together to form a network of collaborating institutions to carry out activities related to health impact assessment such as capacity-building, pilot studies, methodological development and implementation exercises. Also in the EU, the updated WHO Air Quality Guidelines have been used in the intensive debate, with a strong focus on public health, on the new EU air quality directive. With more than 80 000 deaths per year associated with air pollution, air quality is also an issue of concern in the countries of Eastern Europe, the Caucasus and Central Asia (EECCA), which have asked WHO to prepare a framework plan for monitoring particulate matter. In addition, WHO is working with 13 countries to provide national and local authorities with guidance on integrating environment and health concerns into housing policies, as well as with 16 countries to help support their commitment to reduce the burden of disease due to extreme weather and climate events. The Protocol on Water and Health, which came into force in August 2005, has now also been ratified by Croatia and the Republic of Moldova.

## Development of an Environment and Health Information System (EHIS)

29. The EEHC took note of the further development of a harmonized EHIS in Europe. At the EHIS Working Group meeting convened by WHO in April 2006, experts from 28 Member States agreed that an indicator-based report "Children's health and environment in Europe: first assessment" would be prepared for the Intergovernmental Mid-term Review meeting in 2007 (see paragraphs 34–37). By the time of the 2007 meeting, the information in the system will be accessible through the world-wide web and will form the basis for monitoring the environment and health situation in Europe.

30. A series of international and national projects are providing technical input to EHIS. Of these, the most intensive collaboration focuses on the development of methods for gathering and processing of data, and on the preparation of user-friendly reports. This work is carried out within the framework of the project "Establishment of the Environment and Health Information System supporting policy-making in Europe – ENHIS2", cosponsored by the European Commission's Directorate-General for Health and Consumer Protection (DG SANCO) and involving 18 Member States. WHO activities are implemented in close collaboration with the relevant EU services (i.e. DG SANCO, DG Environment, the Joint Research Centre and the European Environment Agency).

## Youth representation and involvement

31. Progress is being made on youth representation on the EEHC and the CEHAPE Task Force. At the request of the EEHC, a youth workshop, with representatives from eight Nordic and Baltic countries, was organized as a pilot project by the Norwegian Directorate for Health and Social Affairs, in collaboration with the Norwegian Youth Council, the Nordic Council of Ministers and WHO. In addition to debating environment and health issues, the young people elected two delegates (Finland and Norway) to the EEHC and two delegates (Estonia and Hungary) to the CEHAPE Task Force. An electronic youth network has been established and will be expanded in the coming year. It is planned to convene a "youth parliament" at the Intergovernmental Mid-term Review meeting in 2007, and discussions are under way with the European Commission (EC) about the possibility of their hosting a preparatory meeting for young people.

## Communication and implementation tools

32. At the Budapest Conference, Member States made commitments to reduce exposure to environmental health hazards. To chart the progress being made in meeting these commitments, a web-based implementation map (www.euro.who.int/eehc/ctryinfo/ctryinfo) clearly shows how countries are doing. The map is a tool for exchanging information and examples of good practice submitted and updated by the countries themselves. In addition, various support materials, including an international concordance of terminology, have been developed to foster the process.

33. Other tools for implementation include the CEHAPE table of child-specific actions, which is a "menu" of activities and their evidence base for countries to select from, and a set of case studies of country experiences on improving children's health and environment. The table and case studies form the web-based CEHAPE Action Pack, which is being updated and can be viewed at www.euro.who.int/childhealthenv/Policy/20050629_1. In addition, indicators for CEHAPE are being developed.

## Intergovernmental Mid-term Review 2007 (IMR2007)

34. The Budapest Conference Declaration calls on WHO to convene an intergovernmental meeting in 2007 to review the progress made in meeting the commitments entered into at the Conference. It also calls on the EEHC to present detailed proposals for the Fifth Ministerial Conference on Environment and Health to Member States at the sessions of the WHO Regional Committee for Europe and the UNECE Committee on Environmental Policy in 2007.

35. In May 2006, the EEHC held initial discussions on the scope and purpose of the IMR 2007, with a view towards holding the ministerial conference in 2009. There was general agreement that the IMR 2007 should include elements both of reporting back by countries and organizations on the Budapest Conference commitments and of looking forward to the ministerial conference in 2009, by agreeing areas where further or new action is needed. In view of the above, it was agreed that ministers of health and ministers of environment should be invited to the IMR 2007. It was further agreed that the theme of the ministerial conference in 2009 should continue to focus on children's health and environment. More detailed discussion will take place at the EEHC's autumn 2006 meeting.

36. The Intergovernmental Mid-term Review meeting will take place in Vienna on 13–15 June 2007, hosted by the Austrian Federal Ministry of Agriculture, Forestry, Environment and Water Management.

## Tuberculosis and malaria control

### The DOTS strategy for tuberculosis control in the WHO European Region

#### *Background*

37. At its fifty-second session, the WHO Regional Committee for Europe recognized that tuberculosis (TB) is out of control in many countries of central and eastern Europe and in the CIS. It also recognized that the rates of multidrug-resistant TB (MDR-TB) in the WHO European Region are the highest in the world. At that session, the Regional Committee therefore, adopted a resolution (EUR/RC52/R8) on "Scaling up the response to TB in the European Region of WHO" that included endorsement of the "DOTS expansion plan to stop TB in the European Region, 2002–2006". As a follow up to this resolution, the Regional Committee considered a progress report at its fifty-fourth session in 2004.

#### *Progress made*

38. According to the most recent WHO official statistics, 42 out of 52 countries, including all of the former Soviet Union, (as compared to 34 countries in 2001), are implementing the DOTS strategy to varying extents. Of these 42 countries, 30 have implemented DOTS countrywide as a national tuberculosis control strategy.

39. As a response to the epidemic of MDR-TB in the European Region, DOTS-Plus pilot projects were strengthened in Estonia, Latvia and three provinces ("oblasts") in the Russian Federation, and new projects were approved in Azerbaijan, Georgia, Kyrgyzstan, Lithuania, the Republic of Moldova, Romania, the Russian Federation (Archangelsk oblast) and Uzbekistan (Karakalpakstan) in collaboration with the Green Light Committee. In addition, a WHO collaborating centre for research and training in the management of MDR-TB was established in Riga, Latvia at the end of 2004.

40. In order to ensure an uninterrupted supply of high-quality drugs for all forms of TB, two of the eight eligible countries in the Region still not supported were granted Global Drug Facility support. Technical assistance has been provided by the Regional Office, under a grant from the German Agency for Technical Cooperation (GTZ), for preparation of proposals with a TB component for submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). In round 5, 12 countries were assisted by WHO, 8 countries submitted proposals to GFATM and 4 countries had their proposals approved by the Fund. The Russian Federation concluded an agreement with the Regional Office for technical assistance in implementing activities funded by the recently signed TB grant.

41. Strengthening health systems for effective TB control is one of the main priorities in the European Region of WHO. A pocket guide on TB for primary health care providers in the Region was published in 2004. Major issues related to the place of TB control in changing health systems were discussed at a meeting of the Technical Advisory Group (TAG) in 2005. A special background paper prepared for that meeting (*Enabling health systems for effective TB control: challenges and opportunities for the Former Soviet Union countries*) was positively received by WHO headquarters and other Regional Office

programmes, in particular the latter's health systems team, and was used to strengthen collaboration between two divisions in implementing the Regional Office's health systems approach across disease-specific programmes.

42. In order to respond to the rapid growth of the HIV/AIDS epidemic in eastern Europe and central Asia and the consequent sharp increase in HIV-related TB, two projects on TB/HIV co-infection were initiated by WHO, one supported by the French government and focusing on the Baltic States, and another wider one, supported by the Netherlands government and covering regional and subregional human resource development, technical assistance to countries in need and operational research. Collaboration was strengthened between the Regional Office's programmes for sexually transmitted infections and HIV/AIDS (SHA) and tuberculosis (TUB). A first regional training course on HIV surveillance among TB patients was organized in Croatia, in collaboration with the United States Centers for Disease Control and Prevention (CDC) and the HIV "knowledge hub" in Zagreb. In addition, the *European framework to decrease the burden of TB/HIV*[1] and a TB/HIV clinical manual[2] have been published.

43. The WHO Regional Office for Europe is the lead partner for the countries in TB control, and its tuberculosis programme is "in the front line", providing technical guidelines and specific training, organizing surveillance of TB and MDR-TB, carrying out demonstration projects and ensuring coordination with partners; collaboration with Member States, as well as partnership and coordination, has been strengthened through establishment of the European Region TAG (2004) and the Laboratory Strengthening Task Force for TB control for the European Region (2005) and their regular annual meetings. There is also closer collaboration with technical and financial partners such as the United States Agency for International Development (USAID), the German credit institute for reconstruction (KfW), CDC, the World Bank, the Royal Netherlands Tuberculosis Foundation (KNCV), the International Federation of Red Cross and Red Crescent Societies (IFRC), and Project Hope, as well as the Austrian, French and Swedish governments and others. A special session on TB in eastern Europe was held during the Stop TB Coordinating Board's conference in November 2005, in Assisi, Italy, as a follow-up to the letter which the WHO Regional Director sent to all European Member States at the beginning of 2005 declaring TB to be a regional emergency. In addition, the establishment and strengthening of the TB control programme in the Regional Office and of subregional/country tuberculosis offices in the Russian Federation, central Asia, Ukraine, the Balkans and the Caucasus have contributed substantially to TB control in the Region.

### *Constraints and future challenges*

44. Despite the efforts outlined above, the TB situation is still a serious public health problem in the European Region, and tens of thousands of people die from the disease each year. According to the most recent WHO official statistics, there were 354 954 new TB cases reported in the Region in 2004, one of the highest figures in two decades (231 651 in 1991, 373 670 in 2002, 338 643 in 2003). Eighty percent of the reported cases occurred in 16 countries, i.e. the CIS, the Baltic States and Romania. In western Europe, "hot spots" of social marginalization and immigration from high TB burden countries have resulted in an increasing incidence of TB, especially in major cities such as London, Paris, Madrid and Rome. TB is a disease without borders and needs to be tackled jointly by all Member States in the Region.

45. Major constraints for effective TB control in the European Region are: the high rate of MDR-TB; the rapid growth of the HIV epidemic in eastern Europe and central Asia and the consequent sharp increase in HIV-related TB; the need to reform the health sector, with closer involvement of primary health care in TB control; the still limited political and financial commitment to TB control; and a lack of advocacy, communication and social mobilization.

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[1] De Colomiani P. et al. *European framework to decrease the burden of TB/HIV*. Copenhagen, WHO Regional Office for Europe, 2003 (document EUR/03/5037600).

[2] Harries A. et al. *TB/HIV. A clinical manual*, 2nd ed. Geneva, World Health Organization, 2004 (document WHO/HTM/TB/2004.329)

46. As mentioned above, in February 2005, the Regional Director declared TB to be a regional emergency and called on Member States faced with the high burden of TB to increase their national expenditure on rational strategies to address TB and its accompanying social conditions. He also called on the wealthier countries in the Region and the EU to pay more attention to the TB crisis in the Region and to increase their financial contribution to TB control. As a follow-up to this letter, it has been decided to hold a high-level ministerial forum on TB control in the European Region in early 2007, in order to increase European donor countries' and the EU's awareness of the current TB emergency, to increase the national financing of TB control measures in high-priority countries of eastern Europe, and to raise financial support for TB control from European donor countries and the EU. Preparation of the forum is in progress.

## Scaling up the response to malaria in the WHO European Region

47. The fifty-sixth session of the Regional Committee takes place four years after the endorsement by all Member States of the resolution on "Scaling up the response to malaria in the WHO European Region" (EUR/RC52/R10) and its successful implementation in malaria affected countries of the WHO European Region. The aims of that resolution were:

- to ensure that action to control malaria is placed high on the health and development agenda throughout affected countries in the Region;
- to match the political commitments to the actual magnitude of the malaria problem in each country;
- to ensure implementation of national malaria programmes in accordance with the regional strategy on malaria; and
- to establish and intensify actions in partnership at country level through the mobilization of external resources, including technical support to Member States in need, so that they may develop proposals for accessing the GFATM.

48. After the endorsement of that resolution in 2002, the fight against malaria has been intensified, in order to reduce the impact of the disease on the health of the population to the lowest possible level that can be achieved with the available financial and human resources, existing control technologies and tools. The objectives of the regional strategy, which were to prevent deaths due to malaria, contain malaria epidemics, further reduce the incidence of malaria, prevent the re-establishment of malaria transmission, and maintain malaria-free status in countries and territories where malaria had been eliminated, were successfully reached by 2005. In order to achieve this, the regional Roll Back Malaria (RBM) programme focused on:

- expanding and intensifying subregional and country-level RBM partnership actions;
- enhancing national capacities for decision-making;
- investing in human development and capacity-building;
- improving capacities for disease management; as well as for containment and prevention of epidemics;
- promoting cost-effective preventive measures;
- strengthening surveillance and operational research capabilities;
- ensuring community mobilization; and
- enhancing intersectoral collaboration.

49. The following criteria or aims were taken into consideration for strengthening national malaria control programmes:

- formulation of goals, objectives and targets based on the commitments and capabilities of each country, and implementation of malaria programmes adjusted to epidemiological patterns, existing tools and resources available;
- properly functioning system for easy access to early diagnosis and adequate treatment for every inhabitant of a malaria-affected area;
- a built-in rapid response capability to cope with emergency situations;
- vector control guided by consideration of technical feasibility, operational applicability and effectiveness;
- surveillance mechanisms and information systems to allow for planning, monitoring and evaluating control interventions;
- training programmes continuously adapted to the appropriate implementation strategy and making increasing use of newly developed technical manuals, practical guidelines and innovative tools;
- core groups of adequately trained professionals with the necessary epidemiological expertise and competence established and functional;
- research findings used to make malaria control more effective;
- community and family care and prevention practices strengthened through development of targeted information/education/communication (IEC) materials, awareness sessions, community support, knowledge-building activities and use of the mass media;
- cross-border collaboration promoted between neighbouring countries and regions.

50. The strong international commitments, the serious political attention paid to tackling the disease at national level, and the high level of advocacy for action against malaria have all been translated into collective action by countries, international agencies, bilateral organizations and NGOs to increase the amount of overall resources available for malaria in the WHO European Region. During the last four years all malaria-affected countries supported by WHO and RBM partners (including USAID, CDC, UNICEF, the World Food Programme, Medical Emergency Relief International – MERLIN, and the Agency for Technical Cooperation and Development – ACTED), have managed to take all possible epidemic containment measures. The GFATM has provided grants to Georgia, Uzbekistan, Kyrgyzstan and Tajikistan to support their national response to malaria in 2004–2010. As a result, a substantial (almost four-fold) reduction in malaria cases has been reported over the past four years (2002–2006). The large-scale regional epidemic of malaria has been curbed and its incidence has been brought down to such levels that, in some countries, interruption of its transmission may become a feasible objective in the coming years.

51. Despite these conspicuous achievements in the fight against malaria, national malaria control programmes continue to face a number of problems and constraints. They include:

- the limited financial resources invested in malaria control by governments, and the chronic dependence of all national malaria control programmes on external support;
- a positive response from the international community comes only after a malaria epidemic has occurred and is rarely sustained longer than three years; and
- a traditionally weak response by partners in situations of small-scale outbreaks, occurrence of sporadic cases and risk of malaria resurgence.

52. How to sustain donor interest in situations where epidemics of malaria have been curbed but where the disease still presents a public health problem, and how to generate donor interest in supporting the new malaria elimination initiative are the two main challenges in coping with malaria in the WHO European Region.

53. Each milestone reached in the reduction of a disease allows for the establishment of new and more demanding objectives along the path towards achieving eradication. The demonstrated feasibility of malaria elimination in the past, the visible impact of malaria control interventions at present, the strong political commitment to having a greater impact on the malaria situation at national level, and the availability of effective tools to control and eliminate malaria in the regional context have all created a unique opportunity to move further on malaria control to elimination. The above is reinforced by solid evidence of some countries in other WHO regions attaining malaria-free status.

54. In order to underpin the new efforts towards elimination, the Tashkent Declaration, entitled "The move from malaria control to elimination", was recently endorsed by all malaria-affected countries in the WHO European Region. In the years ahead, the impact of malaria could be reduced to levels low enough that it no longer represents a public health problem in the Region. The ultimate goal of the new regional strategy on malaria, which has been developed recently, is to interrupt the transmission of *Plasmodium falciparum* malaria in central Asia by 2010 and, finally, to eliminate the disease in the WHO European Region by 2015.

## Progress in occupational health

### Introduction

55. At the fifty-fourth session of the Regional Committee, several national delegations called for activities in the area of occupational health in Europe to be strengthened. This call was driven by growing concern at the situation in the European Region, where workers face risks to their health from accidents or diseases caused by exposure to hazards at work such as asbestos dust, chemicals, noise or stress. Increasing globalization and economic restructuring in Europe are giving rise to newly emerging risks from work-related stress, poor work organization and unhealthy equipment, which threaten human health and wellbeing. The ageing of the labour force also modifies the way in which occupational risks affect people's health. Within this new context, occupational health services need to adapt and renew themselves in order to adequately protect workers' health.

56. In response to this call, the Regional Office in 2004 strengthened its work on occupational health within the Special Programme on Health and Environment. The aim is to support Member States in implementing international public health commitments that are relevant to occupational health, such as the decisions taken at the Fourth Ministerial Conference on Environment and Health (Budapest, 2004) and the European Ministerial Conference on Mental Health (Helsinki, 2005). This work is being carried on through the Bonn Office of the WHO European Centre for Environment and Health.

57. In the past year, activities have been directed mainly towards providing an occupational health input to major public health initiatives relevant to health at the workplace, as well as to ensuring Regional Office input into global processes. The global WHO strategy on occupational health is being revised to adapt it to the new challenges outlined above and will be submitted to the World Health Assembly in 2007.

### Policy developments in occupational health

58. All the WHO collaborating centres in occupational health in the European Region, as well as the focal points in ministries of health, were asked to report on the activities carried out since the Budapest Ministerial Conference, in order to evaluate the extent to which the commitments on child labour taken there have been met. The information gathered by the programme demonstrated that 46 out of the 52 countries in the Region have ratified ILO Convention No. 182 on elimination of the worst forms of child labour, which was referred to in the Budapest Declaration. However at the meeting of the CEHAPE Task Force in Edinburgh in October 2005, national focal points reported that in some countries in the Region the worst forms of child labour still existed, despite successful ratification of the Convention. Intensive

action is therefore required to support full implementation of the Convention and of the Budapest Conference commitments in this area.

59. The Occupational health programme contributed to the concluding expert meeting of "Health in the world of work", a project carried out by the Finnish Institute of Occupational Health under the auspices of the Finnish Ministry of Social Affairs and Health in preparation of the Finnish presidency of the EU in the second half of 2006.

60. Regional Office staff also participated in and contributed to the meeting of the Planning Committee for finalization of the global occupational health network's workplan 2006–2010, held in Johannesburg, South Africa, in September 2005. The workplan concentrates on six activity areas for the next five years (http://www.who.int/occupational_health/network/workplan2006.pdf). In order to monitor progress in carrying out this workplan, Regional Office staff attended the meeting of the global network of WHO collaborating centres which took place at the International Commission on Occupational Health's twenty-eighth international congress in June 2006.

61. Five countries (Armenia, Poland, the Russian Federation, The former Yugoslav Republic of Macedonia, and Ukraine) are receiving support, under their 2006–2007 biennium collaborative agreements, with developing their national occupational health polices and strengthening occupational health services. These activities partly continue those already implemented in the previous biennium through the same mechanism.

## Promoting technical assistance and information dissemination

### *Network of national contact points on occupational health in ministries of health*

62. The network of national contact points on occupational health, established at government level in 2005, made a direct contribution to implementing the CEHAPE in the area of occupational health. They also provided a channel for disseminating the Regional Office's information products on occupational health to the countries.

### *European network of collaborating centres*

63. The European network of WHO collaborating centres in occupational health also continued to support the work of the Regional Office in 2005/2006. During the year, the agreements with some institutes were reviewed and when appropriate their re-designation took place, to ensure their continued contribution to implementation of the occupational health programme. Preliminary discussions took place with some other institutes, including the Cyprus International Institute for the Environment and Public Health.

### *Raising awareness*

64. Regional Office staff have participated in a number of international meetings since the last session of the Regional Committee, in an effort to raise awareness of different aspects of occupational health. These included the second CEHAPE Task Force meeting (Edinburgh, October 2005), the Fourth All-Russian Congress on Occupation and Health (Moscow, October 2005), the annual meeting of the Baltic Sea Network on Occupational Health and Safety (Oslo, November 2005), a Northern Dimension Partnership meeting (Stockholm, November 2005), and a meeting to launch a project on social dialogue in occupational health and safety in south-east Europe (Brussels, November 2005).

65. Finally, the Regional Office's occupational health website (http://www.euro.who.int/occhealth) has been revised and routine updates arranged.

## The way forward

66. The activities started during the 2004–2005 biennium will continue, in order to tackle public health problems related to occupational health in the Region. There is a particular need to address the occupational health of workers in the eastern part of the Region, where old problems overlap with new emerging threats associated with the evolving working environment. The Regional Office is planning to further review internal working arrangements and continue to mobilize external resources in order to ensure proper continuation of work. The Regional Office's coordination and implementation mechanisms will facilitate effective use of the highly appreciated professional assistance received from the network of collaborating centres.

67. The Regional Office will contribute to development of the Global Plan of Action on Occupational Health 2006–2015 to be presented to the World Health Assembly in 2007, thus updating resolution WHA49.12, and will continue to link its activities closely to the European Commission's strategy on health and safety at work.