EUROPE

Regional Committee for Europe
Fifty-fifth session

Bucharest, Romania, 12–15 September 2005

Provisional agenda item 7

EUR/RC55/13
+EUR/RC55/Conf.Doc./8
20 June 2005
53686
ORIGINAL: ENGLISH

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

This document contains information on action taken to follow up on a number of issues discussed at previous sessions of the Regional Committee and on the implementation of resolutions or preparation of major events and strategies. Together with the agenda items on matters arising from the Executive Board and the World Health Assembly and the address of the Regional Director, this item will update the Regional Committee on the main activities that have taken place since previous last session.

The subjects selected for this paper include follow-up on:

(a) the WHO European Ministerial Conference on Mental Health;

(b) the preparations for a European strategy on noncommunicable diseases;

(c) the implementation of resolution EUR/RC52/R9 on scaling up the response to HIV/AIDS;

(d) the European Environment and Health Committee;

(e) Occupational health;

(f) Reproductive health;

(g) Evidence for public health; and

(h) WHO collaborating centres.

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A. Follow-up to the WHO European Ministerial Conference on Mental Health

Summary

1. The WHO Regional Office for Europe has noted the positive reception given to the Mental Health Declaration and Action Plan for Europe (Appendixes 1 and 2), the two outcome documents of the Ministerial Conference held in Helsinki from 12 to 15 January 2005. The Regional Office is now in the process of developing and delivering a programme to support work in the five priority areas and to help Member States reach the milestones set out in the Action Plan. The implementation programme is comprehensive and inclusive; it covers the 12 action points in the Declaration and involves WHO collaborating centres, experts, and nongovernmental and intergovernmental organizations. A draft resolution is attached for consideration by the Regional Committee.

Background

2. Mental health is currently one of the biggest public health challenges facing every country in the WHO European Region, with mental health problems affecting at least one in four people at some time in their lives. Neuro-psychiatric disorders account for over 40% of all chronic disease and are the greatest cause of years lived with disability. In many countries, 35% to 45% of absenteeism from work is due to mental health problems. People with mental health problems and their families are also seriously affected by stigma, discrimination and in some instances, abuse of human rights.

3. While facing this high burden of disease, European countries are also confronted by a vast gap between the need for treatment and the services available. Even in developed countries with well-organized health care systems, about 50% of patients with depression do not receive any form of treatment. At the same time, mental health disorders (particularly depression) cost national economies several billions of dollars in terms of expenditure and loss of productivity.

4. To address these challenges, the WHO Regional Office for Europe organized the first WHO European Ministerial Conference on Mental Health in Helsinki, Finland in January 2005, bringing together health ministers and other high-level decision-makers from the 52 Member States in the Region. The conference was co-organized with the European Commission and the Council of Europe. At the Conference, ministers endorsed the European Declaration on Mental Health and the WHO Mental Health Action Plan for Europe that are expected to drive policy on mental health in the WHO European Region for the next 5–10 years. The Declaration and Action Plan were also supported by nongovernmental organizations (NGOs) representing service users and families, by professionals and by international organizations.

5. The Declaration recognizes that policy and services are striving to achieve well-being and social inclusion, and it takes a comprehensive view of the need for and potential benefits delivered by diverse mental health activities aimed at the population as a whole, groups at risk and people with mental health problems.

Programme and activities

6. The Action Plan sets out the details of the commitments and responsibilities of both Member States and WHO. On the basis of the priorities set out in the Declaration and the Action Plan, and giving expression to European values and principles, the Regional Office has developed a programme to deliver on its commitments, focusing on four core objectives:

- reducing stigma, promoting mental well-being and preventing mental health problems
- implementing policy and services delivered by a competent workforce

- generating and disseminating information and research
- advocating for user empowerment and human rights.

7. These 4 core objectives will be attained by activities in all the 12 work areas specified in the Declaration and Action Plan. In order to make the most efficient use of the resources available and to achieve the greatest impact in countries, collaboration has been instigated between colleagues in country offices, the Regional Office and WHO headquarters, and projects have been launched throughout Europe involving credible and respected organizations and individuals.

8. The Regional Office has invited WHO collaborating centres to take responsibility for the coordination of specific work areas. Activities will be taken forward in partnership with numerous experts and NGOs in a large proportion of European Member States. Lead centres have so far been identified for the following areas of work:

- stigma and discrimination
- mental health promotion
- prevention, including suicide
- service development
- information and dissemination
- involvement and empowerment of service users and carers
- workforce.

9. In many of these areas, support is being given by governments and partner organizations, including NGOs. A workplan will be agreed with each lead collaborating centre, based on the points specified in the Action Plan and including targets, deliverables and resources. One exciting option being explored is an annual summer school, offering programmes in all the areas.

10. Many countries are reviewing their policies and services to reflect the Action Plan. Following the Ministerial Conference, WHO has been taking part in many national and international debates and seminars and is discussing activities in many Member States. The Organization has been collaborating with Andorra, Belgium, the Czech Republic, Israel, Latvia, Lithuania, Kyrgyzstan, Luxembourg, Poland, the Russian Federation, Slovakia, Spain, Ukraine, Uzbekistan and the countries of the Stability Pact for South Eastern Europe.

11. Before the Ministerial Conference, WHO was already working with many central and eastern European countries and newly independent states on different mental health projects, under the Biennial Collaborative Agreements (BCAs) between the Regional Office and ministries of health. Following the Conference, 15 countries (Albania, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Serbia and Montenegro, The former Yugoslav Republic of Macedonia and Uzbekistan) decided to include mental health on their priority agenda for the next period. WHO will support governments in shaping their national mental health policies and legislation and initiating reform of their mental health systems on the basis of the Action Plan.

12. The European Commission and the Council of Europe expressed their commitment in Helsinki to attaining the objectives set out in the Declaration. Close working relationships have been established with these partners to tackle activities of joint interest on the basis of their respective competences. The Regional Office is exploring a project on human rights with the Council of Europe. The European Commission is supporting a project on benchmarking and assistance with delivery of certain components of the Declaration and Action Plan, and it has involved WHO closely in the development of a "green paper" on mental health.

Appendix 1
Mental Health Declaration for Europe

Preamble

1. We, the Ministers of Health of Member States in the European Region of the World Health Organization (WHO), in the presence of the European Commissioner for Health and Consumer Protection, together with the WHO Regional Director for Europe, meeting at the WHO Ministerial Conference on Mental Health, held in Helsinki from 12 to 15 January 2005, acknowledge that mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens. We believe that the primary aim of mental health activity is to enhance people's well-being and functioning by focusing on their strengths and resources, reinforcing resilience and enhancing protective external factors.

2. We recognize that the promotion of mental health and the prevention, treatment, care and rehabilitation of mental health problems are a priority for WHO and its Member States, the European Union (EU) and the Council of Europe, as expressed in resolutions by the World Health Assembly and the WHO Executive Board, the WHO Regional Committee for Europe and the Council of the European Union. These resolutions urge Member States, WHO, the EU and the Council of Europe to take action to relieve the burden of mental health problems and to improve mental well-being.

3. We recall our commitment to resolution EUR/RC51/R5 on the Athens Declaration on Mental Health, Man-made Disasters, Stigma and Community Care and to resolution EUR/RC53/R4 adopted by the WHO Regional Committee for Europe in September 2003, expressing concern that the disease burden from mental disorders in Europe is not diminishing and that many people with mental health problems do not receive the treatment and care they need, despite the development of effective interventions. The Regional Committee requested the Regional Director to:
   - give high priority to mental health issues when implementing activities concerning the update of the Health for All policy;
   - arrange a ministerial conference on mental health in Europe in Helsinki in January 2005.

4. We note resolutions that support an action programme on mental health. Resolution EB109.R8, adopted by the WHO Executive Board in January 2002, supported by World Health Assembly resolution WHA55.10 in May 2002, calls on WHO Member States to:
   - adopt the recommendations contained in *The world health report 2001;*
   - establish mental health policies, programmes and legislation based on current knowledge and considerations regarding human rights, in consultation with all stakeholders in mental health;
   - increase investment in mental health, both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations.

5. Resolutions of the Council of the European Union, recommendations of the Council of Europe and WHO resolutions dating back to 1975 recognize the important role of mental health promotion and the damaging association between mental health problems and social marginalization, unemployment, homelessness and alcohol and other substance use disorders. We accept the importance of the provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms, of the Convention on the Rights of the Child, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and of the European Social Charter, as well as the Council of Europe's commitment to the protection and promotion of mental health which has been developed through the

Declaration of its Ministerial Conference on Mental Health in the Future (Stockholm, 1985) and through its other recommendations adopted in this field, in particular Recommendation R(90)22 on protection of the mental health of certain vulnerable groups in society and Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder.

Scope

6. We note that many aspects of mental health policy and services are experiencing a transformation across the European Region. Policy and services are striving to achieve social inclusion and equity, taking a comprehensive view of the balance between the needs and benefits of diverse mental health activities aimed at the population as a whole, groups at risk and people with mental health problems. Services are being provided in a wide range of community-based settings and no longer exclusively in isolated and large institutions. We believe that this is the right and necessary direction. We welcome the fact that policy and practice on mental health now cover:

   i. the promotion of mental well-being;

   ii. the tackling of stigma, discrimination and social exclusion;

   iii. the prevention of mental health problems;

   iv. care for people with mental health problems, providing comprehensive and effective services and interventions, offering service users and carers[1] involvement and choice;

   v. the recovery and inclusion into society of those who have experienced serious mental health problems.

Priorities

7. We need to build on the platform of reform and modernization in the WHO European Region, learn from our shared experiences and be aware of the unique characteristics of individual countries. We believe that the main priorities for the next decade are to:

   i. foster awareness of the importance of mental well-being;

   ii. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;

   iii. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;

   iv. address the need for a competent workforce, effective in all these areas;

   v. recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

Actions

8. We endorse the statement that there is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment. Therefore we, ministers responsible for health, commit ourselves,

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[1] The term "carer" is used here to describe a family member, friend or other informal care-giver.

subject to national constitutional structures and responsibilities, to recognizing the need for comprehensive evidence-based mental health policies and to considering ways and means of developing, implementing and reinforcing such policies in our countries. These policies, aimed at achieving mental well-being and social inclusion of people with mental health problems, require actions in the following areas:

i. promote the mental well-being of the population as a whole by measures that aim to create awareness and positive change for individuals and families, communities and civil society, educational and working environments, and governments and national agencies;

ii. consider the potential impact of all public policies on mental health, with particular attention to vulnerable groups, demonstrating the centrality of mental health in building a healthy, inclusive and productive society;

iii. tackle stigma and discrimination, ensure the protection of human rights and dignity and implement the necessary legislation in order to empower people at risk or suffering from mental health problems and disabilities to participate fully and equally in society;

iv. offer targeted support and interventions sensitive to the life stages of people at risk, particularly the parenting and education of children and young people and the care of older people;

v. develop and implement measures to reduce the preventable causes of mental health problems, comorbidity and suicide;

vi. build up the capacity and ability of general practitioners and primary care services, networking with specialized medical and non-medical care, to offer effective access, identification and treatments to people with mental health problems;

vii. offer people with severe mental health problems effective and comprehensive care and treatment in a range of settings and in a manner which respects their personal preferences and protects them from neglect and abuse;

viii. establish partnership, coordination and leadership across regions, countries, sectors and agencies that have an influence on the mental health and social inclusion of individuals and families, groups and communities;

ix. design recruitment and education and training programmes to create a sufficient and competent multidisciplinary workforce;

x. assess the mental health status and needs of the population, specific groups and individuals in a manner that allows comparison nationally and internationally;

xi. provide fair and adequate financial resources to deliver these aims;

xii. initiate research and support evaluation and dissemination of the above actions.

9. We recognize the importance and the urgency of facing the challenges and building solutions based on evidence. We therefore endorse the Mental Health Action Plan for Europe and support its implementation across the WHO European Region, each country adapting the points appropriate to its needs and resources. We are also committed to showing solidarity across the Region and to sharing knowledge, best practice and expertise.

Responsibilities

10. We, the Ministers of Health of the Member States in the WHO European Region, commit ourselves to supporting the implementation of the following measures, in accordance with each country's constitutional structures and policies and national and subnational needs, circumstances and resources:

i. enforce mental health policy and legislation that sets standards for mental health activities and upholds human rights;

ii. coordinate responsibility for the formulation, dissemination and implementation of policies and legislation relevant to mental health within government;

iii. assess the public mental health impact of government action;

iv. eliminate stigma and discrimination and enhance inclusion by increasing public awareness and empowering people at risk;

v. offer people with mental health problems choice and involvement in their own care, sensitive to their needs and culture;

vi. review and if necessary introduce equal opportunity or anti-discrimination legislation;

vii. promote mental health in education and employment, communities and other relevant settings by increasing collaboration between agencies responsible for health and other relevant sectors;

viii. prevent risk factors where they occur, for instance, by supporting the development of working environments conducive to mental health and creating incentives for the provision of support at work or the earliest return for those who have recovered from mental health problems;

ix. address suicide prevention and the causes of harmful stress, violence, depression, anxiety and alcohol and other substance use disorders;

x. recognize and enhance the central role of primary health care and general practitioners and strengthen their capacity to take on responsibility for mental health;

xi. develop community-based services to replace care in large institutions for those with severe mental health problems;

xii. enforce measure that end inhumane and degrading care;

xiii. enhance partnerships between agencies responsible for care and support such as health, benefits, housing, education and employment;

xiv. include mental health in the curricula of all health professionals and design continuous professional education and training programmes for the mental health workforce;

xv. encourage the development of specialized expertise within the mental health workforce, to address the specific needs of groups such as children, young people, older people and those with long-term and severe mental health problems;

xvi. provide sufficient resources for mental health, considering the burden of disease, and make investment in mental health an identifiable part of overall health expenditure, in order to achieve parity with investments in other areas of health;

xvii. develop surveillance of positive mental well-being and mental health problems, including risk factors and help-seeking behaviour, and monitor implementation;

xviii. commission research when and where knowledge or technology is insufficient and disseminate findings.

11. We will support nongovernmental organizations active in the mental health field and stimulate the creation of nongovernmental and service user organizations. We particularly welcome organizations active in:

i. organizing users who are engaged in developing their own activities, including the setting up and running of self-help groups and training in recovery competencies;

ii. empowering vulnerable and marginalized people and advocating their case;

iii. providing community-based services involving users;

iv. developing the caring and coping skills and competencies of families and carers, and their active involvement in care programmes;

v. setting up schemes to improve parenting, education and tolerance and to tackle alcohol and other substance use disorders, violence and crime;

vi. developing local services that target the needs of marginalized groups;

vii. running help lines and internet counselling for people in crisis situations, suffering from violence or at risk of suicide;

viii. creating employment opportunities for disabled people.

12. We call upon the European Commission and the Council of Europe to support the implementation of this WHO Mental Health Declaration for Europe on the basis of their respective competences.

13. We request the Regional Director of WHO Europe to take action in the following areas:

(a) *Partnership*

i. encourage cooperation in this area with intergovernmental organizations, including the European Commission and the Council of Europe.

(b) *Health information*

i. support Member States in the development of mental health surveillance;

ii. produce comparative data on the state and progress of mental health and mental health services in Member States.

(c) *Research*

i. establish a network of mental health collaborating centres that offer opportunities for international partnerships, good quality research and the exchange of researchers;

ii. produce and disseminate the best available evidence on good practice, taking into account the ethical aspects of mental health.

(d) *Policy and service development*

i. support governments by providing expertise to underpin mental health reform through effective mental health policies that include legislation, service design, promotion of mental health and prevention of mental health problems;

ii. offer assistance with setting up “train the trainer” programmes;

iii. initiate exchange schemes for innovators;

iv. assist with the formulation of research policies and questions;

v. encourage change agents by setting up a network of national leaders of reform and key civil servants.

(e) *Advocacy*

i. inform and monitor policies and activities that will promote the human rights and inclusion of people with mental health problems and reduce stigma and discrimination against them;

ii. empower users, carers and nongovernmental organizations with information and coordinate activities across countries;

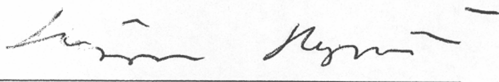
iii. support Member States in developing an information base to help empower the users of mental health services;

iv. facilitate international exchanges of experience by key regional and local nongovernmental organizations;

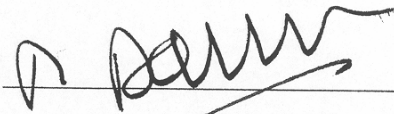
v. provide the media, nongovernmental organizations and other interested groups and individuals with objective and constructive information.

14. We request the WHO Regional Office for Europe to take the necessary steps to ensure that mental health policy development and implementation are fully supported and that adequate priority and resources are given to activities and programmes to fulfil the requirements of this Declaration.

15. We commit ourselves to reporting back to WHO on the progress of implementation of this Declaration in our countries at an intergovernmental meeting to be held before 2010.



Minister of Health and Social Services of Finland



WHO Regional Director for Europe

Appendix 2
Mental Health Action Plan for Europe

This Action Plan is endorsed in the Mental Health Declaration for Europe by ministers of health of the Member States in the WHO European Region. They support its implementation in accordance with each country's needs and resources.

The challenges over the next five to ten years are to develop, implement and evaluate policies and legislation that will deliver mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems. The priorities for the next decade are to:

i. foster awareness of the importance of mental well-being;

ii. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;

iii. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;

iv. address the need for a competent workforce, effective in all these areas;

v. recognize the experience and knowledge of service users and carers[2] as an important basis for planning and developing services.

This Action Plan proposes ways and means of developing, implementing and reinforcing comprehensive mental health policies in the countries of the WHO European Region, requiring action in the 12 areas as set out below. Countries will reflect these policies in their own mental health strategies and plans, to determine what will be delivered over the next five and ten years.

1. Promote mental well-being for all

Challenge

Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies. Public mental health and lifestyles conducive to mental well-being are crucial to achieving this aim. Mental health promotion increases the quality of life and mental well-being of the whole population, including people with mental health problems and their carers. The development and implementation of effective plans to promote mental health will enhance mental well-being for all.

Actions to consider

i. Develop comprehensive strategies for mental health promotion within the context of mental health, public health and other public policies that address the promotion of mental health across the lifespan.

ii. Adopt promotion of mental health as a long-term investment and develop education and information programmes with a long time frame.

iii. Develop and offer effective programmes for parenting support and education, starting during pregnancy.

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[2] The term "carer" is used here to describe a family member, friend or other informal care-giver.

iv. Develop and offer evidence-based programmes that foster skills, provide information and focus on resilience, emotional intelligence and psychosocial functioning in children and young people.

v. Improve access to healthy diets and physical activity for older people.

vi. Promote community-based multilevel interventions involving public awareness campaigns, primary care staff and community facilitators such as teachers, clergy and the media.

vii. Integrate mental health promotion components into existing generic health promotion and public health policies and programmes, such as those supported by WHO health promoting networks.

viii. Encourage the consumption of healthy products and reduce the intake of harmful products.

ix. Create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles.

x. Offer effective mental health promotion activities to groups at risk such as people with enduring mental or physical health problems and carers.

xi. Identify clear mechanisms for empowering the population to take responsibility for health promotion and disease prevention targets, for example by heightening public awareness of the importance of life choices.

2. Demonstrate the centrality of mental health

Challenge

Mental health is central to building a healthy, inclusive and productive society. Sound and integrated public policies, such as those on labour, urban planning and socioeconomic issues, also have a positive impact on mental health and reduce the risk of mental health problems. The mental health implications of all public policy, and particularly its potential impact on groups at risk, therefore need to be considered. Mental health policy requires intersectoral linkages and should incorporate multisectoral and multidisciplinary approaches.

Actions to consider

i. Make mental health an inseparable part of public health.

ii. Incorporate a mental health perspective and relevant actions into new and existing national policies and legislation.

iii. Include mental health in programmes dealing with occupational health and safety.

iv. Assess the potential impact of any new policy on the mental well-being of the population before its introduction and evaluate its results afterwards.

v. Give special consideration to the relative impact of policies on people already suffering from mental health problems and those at risk.

3. Tackle stigma and discrimination

Challenge

Mental health policy development and implementation must not be jeopardized by the widespread stigma attached to mental health problems that leads to discrimination. In many instances, people with

mental health problems suffer from a lack of equal opportunities because of such discrimination. Human rights and respect for people with mental health problems must be protected. Empowerment is a crucial step towards meeting these objectives, as it enhances integration and social inclusion. The lack of empowerment of service users' and carers' organizations and poor advocacy hinder the design and implementation of policies and activities that are sensitive to their needs and wishes. The exclusion experienced by mental health service users, whether in asylums and institutions or in the community, needs to be tackled in a variety of ways.

Actions to consider

i. Instigate activities to counter stigma and discrimination, emphasizing the ubiquity of mental health problems, their general good prognosis and treatability, and the fact that they are rarely associated with violence.

ii. Introduce or scrutinize disability rights legislation to ensure that it covers mental health equally and equitably.

iii. Develop and implement national, sectoral and enterprise policies to eliminate stigma and discrimination in employment practices associated with mental health problems.

iv. Stimulate community involvement in local mental health programmes by supporting initiatives of nongovernmental organizations.

v. Develop a coherent programme of policy and legislation to address stigma and discrimination, incorporating international and regional human rights standards.

vi. Establish constructive dialogue with the media and systematically provide them with information.

vii. Set standards for representation of users and their carers on committees and groups responsible for planning, delivery, review and inspection of mental health activities.

viii. Stimulate the creation and development of local and national nongovernmental and service user-run organizations representing people with mental health problems, their carers and the communities they live in.

ix. Encourage the integration of children and young people with mental health problems and disabilities in the regular educational and vocational training system.

x. Establish vocational training for people suffering from mental health problems and support the adaptation of workplaces and working practices to their special needs, with the aim of securing their entry into competitive employment.

4. Promote activities sensitive to vulnerable life stages

Challenge

Infants, children and young people, and older people are particularly at risk from social, psychological, biological and environmental factors. Given their vulnerability and needs, young and older people should be a high priority for activities related to the promotion of mental health and the prevention and care of mental health problems. However, many countries have inadequate capacity in this area, and services and staff are often poorly prepared to deal with developmental and age-related problems. In particular, disorders in childhood can be important precursors of adult mental disorders. Supporting the mental health of children and adolescents should be seen as a strategic investment which creates many long-term benefits for individuals, societies and health systems.

Actions to consider

i. Ensure that policies on mental health include as priorities the mental health and well-being of children and adolescents and of older people.

ii. Incorporate the international rights of children and adolescents and of older people into mental health legislation.

iii. Involve young people and older people as much as possible in the decision-making process.

iv. Pay special attention to marginalized groups, including children and older people from migrant families.

v. Develop mental health services sensitive to the needs of young and older people, operated in close collaboration with families, schools, day-care centres, neighbours, extended families and friends.

vi. Promote the development of community centres for older people to increase social support and access to interventions.

vii. Ensure that age- and gender-sensitive mental health services are provided by both primary care and specialized health and social care services and operate as integrated networks.

viii. Restrict institutional approaches for the care of children and adolescents and older people that engender social exclusion and neglect.

ix. Improve the quality of dedicated mental health services by establishing or improving the capacity for specialized interventions and care in childhood and adolescence and old age, and by training and employing adequate numbers of specialists.

x. Improve coordination between organizations involved in alcohol and drugs programmes and children's and adolescents' health and mental health at national and international levels, as well as collaboration between their respective networks.

xi. Ensure parity of funding in relation to comparable health services.

5. Prevent mental health problems and suicide

Challenge

People in many countries are exposed to harmful stress-inducing societal changes that affect social cohesion, safety and employment and lead to an increase in anxiety and depression, alcohol and other substance use disorders, violence and suicidal behaviour. The social precipitants of mental health problems are manifold and can range from individual causes of distress to issues that affect a whole community or society. They can be induced or reinforced in many different settings, including the home, educational facilities, the workplace and institutions. Marginalized and vulnerable groups, such as refugees and migrant populations, the unemployed, people in or leaving prisons, people with different sexual orientations, people with physical and sensorial disabilities and people already experiencing mental health problems, can be particularly at risk.

Actions to consider

i. Increase awareness of the prevalence, symptoms and treatability of harmful stress, anxiety, depression and schizophrenia.

ii. Target groups at risk, offering prevention programmes for depression, anxiety, harmful stress, suicide and other risk areas, developed on the basis of their specific needs and sensitive to their background and culture.

iii. Establish self-help groups, telephone help-lines and websites to reduce suicide, particularly targeting high-risk groups.

iv. Establish policies that reduce the availability of the means to commit suicide.

v. Introduce routine assessment of the mental health of new mothers by obstetricians and health visitors and provide interventions where necessary.

vi. For families at risk, provide home-based educational interventions to help proactively to improve parenting skills, health behaviour and interaction between parents and children.

vii. Set up in partnership with other ministers evidence-based education programmes addressing suicide, depression, alcohol and other substance use disorders for young people at schools and universities and involve role models and young people in the making of campaigns.

viii. Support the implementation of community development programmes in high-risk areas and empower nongovernmental agencies, especially those representing marginalized groups.

ix. Ensure adequate professional support and services for people encountering major crises and violence, including war, natural disasters and terrorist attacks in order to prevent post-traumatic stress disorder.

x. Increase awareness among staff employed in health care and related sectors of their own attitudes and prejudices towards suicide and mental health problems.

xi. Monitor work-related mental health through the development of appropriate indicators and instruments.

xii. Develop the capacities for protection and promotion of mental health at work through risk assessment and management of stress and psychosocial factors, training of personnel, and awareness raising.

xiii. Involve mainstream agencies responsible for employment, housing and education in the development and delivery of prevention programmes.

6. Ensure access to good primary care for mental health problems

Challenge

For many countries in the European Region, general practitioners (GPs) and other primary care staff are the initial and main source of help for common mental health problems. However, mental health problems often remain undetected in people attending GPs or primary care services and treatment is not always adequate when they are identified. Many people with mental health problems, particularly those who are vulnerable or marginalized, experience difficulties in accessing and remaining in contact with services. GPs and primary care services need to develop capacity and competence to detect and treat people with mental health problems in the community, supported as required as part of a network with specialist mental health services.

Actions to consider

i. Ensure that all people have good access to mental health services in primary health care settings.

ii. Develop primary care services with the capacity to detect and treat mental health problems, including depression, anxiety, stress-related disorders, substance misuse and psychotic disorders as appropriate by expanding the numbers and skills of primary care staff.

iii. Provide access to psychotropic medication and psychotherapeutic interventions in primary care settings for common as well as severe mental disorders, especially for individuals with long-term and stable mental disorders who are resident in the community.

iv. Encourage primary health care staff to take up mental health promotion and prevention activities, particularly targeting factors that determine or maintain ill-health.

v. Design and implement treatment and referral protocols in primary care, establishing good practice and clearly defining the respective responsibilities in networks of primary care and specialist mental health services.

vi. Create centres of competence and promote networks in each region which health professionals, service users, carers and the media can contact for advice.

vii. Provide and mainstream mental health care in other primary care services and in easily accessible settings such as community centres and general hospitals.

7. Offer effective care in community-based services for people with severe mental health problems

Challenge

Progress is being made across the Region in reforming mental health care. It is essential to acknowledge and support people's right to receive the most effective treatments and interventions while being exposed to the lowest possible risk, based on their individual wishes and needs and taking into account their culture, religion, gender and aspirations. Evidence and experience in many countries support the development of a network of community-based services including hospital beds. There is no place in the twenty-first century for inhumane and degrading treatment and care in large institutions: an increasing number of countries have closed many of their asylums and are now implementing effective community-based services. Special consideration should be given to the emotional, economic and educational needs of families and friends, who are often responsible for intensive support and care and often require support themselves.

Actions to consider

i. Empower service users and carers to access mental health and mainstream services and to take responsibility for their care in partnership with providers.

ii. Plan and implement specialist community-based services, accessible 24 hours a day, seven days a week, with multidisciplinary staff, to care for people with severe problems such as schizophrenia, bipolar disorder, severe depression or dementia.

iii. Provide crisis care, offering services where people live and work, preventing deterioration or hospital admission whenever possible, and only admitting people with very severe needs or those who are a risk to themselves or others.

iv. Offer comprehensive and effective treatments, psychotherapies and medications with as few side effects as possible in community settings, particularly for young people experiencing a first episode of mental health problems.

v. Guarantee access to necessary medicines for people with mental health problems at a cost that the health care system and the individual can afford, in order to achieve appropriate prescription and use of these medicines.

vi. Develop rehabilitation services that aim to optimize people's inclusion in society, while being sensitive to the impact of disabilities related to mental health problems.

vii. Offer services for people with mental health needs who are in non-specialist settings such as general hospitals or prisons.

viii. Offer carers and families assessment of their emotional and economic needs, and involvement in care programmes.

ix. Design programmes to develop the caring and coping skills and competencies of families and carers.

x. Scrutinize whether benefit programmes take account of the economic cost of caring.

xi. Plan and fund model programmes that can be used for dissemination.

xii. Identify and support leaders respected by their peers to spearhead innovation.

xiii. Develop guidelines for good practice and monitor their implementation.

xiv. Introduce legal rights for people subject to involuntary care to choose their independent advocate.

xv. Introduce or reinforce legislation or regulations protecting the standards of care, including the discontinuation of inhuman and degrading care and interventions.

xvi. Establish inspection to reinforce good practice and to stop neglect and abuse in mental health care.

8. Establish partnerships across sectors

Challenge

Essential services which in the past were routinely provided in large institutions or were not considered as relevant to the lives of people with mental health problems are nowadays often fragmented across many agencies. Poor partnership and lack of coordination between services run or funded by different agencies lead to poor care, suffering and inefficiencies. The responsibilities of different bodies for such a wide range of services need coordination and leadership up to and including government level. Service users and their carers need support in accessing and receiving services for issues such as benefits, housing, meals, employment and treatment for physical conditions, including substance misuse.

Actions to consider

i. Organize comprehensive preventive and care services around the needs of and in close cooperation with users.

ii. Create collaborative networks across services that are essential to the quality of life of users and carers, such as social welfare, labour, education, justice, transport and health.

iii. Give staff in mental health services responsibility for identifying and providing support for needs in daily living activities, either by direct action or through coordination with other services.

iv. Educate staff in other related services about the specific needs and rights of people with mental health problems and those at risk of developing mental health problems.

v. Identify and adjust financial and bureaucratic disincentives that obstruct collaboration, including at government level.

9. Create a sufficient and competent workforce

Challenge

Mental health reform demands new staff roles and responsibilities, requiring changes in values and attitudes, knowledge and skills. The working practices of many mental health care workers and staff in other sectors such as teachers, benefit officers, the clergy and volunteers need to be modernized in

order to offer effective and efficient care. New training opportunities must respond to the need for expertise in all roles and tasks to be undertaken.

Actions to consider

i. Recognize the need for new staff roles and responsibilities across the specialist and generic workforce employed in the health service and other relevant areas such as social welfare and education.

ii. Include experience in community settings and multidisciplinary teamwork in the training of all mental health staff.

iii. Develop training in the recognition, prevention and treatment of mental health problems for all staff working in primary care.

iv. Plan and fund, in partnership with educational institutions, programmes that address the education and training needs of both existing and newly recruited staff.

v. Encourage the recruitment of new mental health workers and enhance the retention of existing workers.

vi. Ensure an equitable distribution of mental health workers across the population, particularly among people at risk, by developing incentives.

vii. Address the issue of lack of expertise in new technologies of present trainers, and support the planning of "train the trainers" programmes.

viii. Educate and train mental health staff about the interface between promotion, prevention and treatment.

ix. Educate the workforce across the public sector to recognize the impact of their policies and actions on the mental health of the population.

x. Create an expert workforce by designing and implementing adequate specialist mental health training for all staff working in mental health care.

xi. Develop specialist training streams for areas requiring high levels of expertise such as the care and treatment of children, older people and people suffering from a combination of mental health problems and substance use disorder (comorbidity).

10. Establish good mental health information

Challenge

In order to develop good policy and practice in countries and across the Region, information has to be available about the current state of mental health and mental health activities. The impact of any implementation of new initiatives should be monitored. The mental health status and the help-seeking behaviour of populations, specific groups and individuals should be measured in a manner that allows comparison across the WHO European Region. Indicators should be standardized and comparable locally, nationally and internationally in order to assist in the effective planning, implementation, monitoring and evaluation of an evidence-based strategy and action plan for mental health.

Actions to consider

i. Develop or strengthen a national surveillance system based on internationally standardized, harmonized and comparable indicators and data collection systems, to monitor progress towards local, national and international objectives of improved mental health and well-being.

ii. Develop new indicators and data collection methods for information not yet available, including indicators of mental health promotion, prevention, treatment and recovery.

iii. Support the carrying out of periodic population-based mental health surveys, using agreed methodology across the WHO European Region.

iv. Measure base rates of incidence and prevalence of key conditions, including risk factors, in the population and groups at risk.

v. Monitor existing mental health programmes, services and systems.

vi. Support the development of an integrated system of databases across the WHO European Region to include information on the status of mental health policies, strategies, implementation and delivery of evidence-based promotion, prevention, treatment, care and recovery.

vii. Support the dissemination of information on the impact of good policy and practice nationally and internationally.

11. Provide fair and adequate funding

Challenge

Resources dedicated to mental health are often inadequate and inequitable compared to those available to other parts of the public sector, and this is reflected in poor access, neglect and discrimination. In some health care systems, insurance coverage of access and rights to treatment discriminate severely against mental health problems. Within the mental health budget, resource allocation should be equitable and proportionate, i.e. offering greatest relative share and benefits to those in greatest need.

Actions to consider

i. Assess whether the proportion of the health budget allocated to mental health fairly reflects the needs and priority status of the people with needs.

ii. Ensure that people with the most severe problems and the poorest in society receive the largest relative benefits.

iii. Assess whether funding is allocated efficiently, taking into account societal benefits, including those generated by promotion, prevention and care.

iv. Evaluate whether coverage is comprehensive and fair in social and private insurance-based systems, on an equal level to that for other conditions, not excluding or discriminating against groups and particularly protecting the most vulnerable.

12. Evaluate effectiveness and generate new evidence

Challenge

Considerable progress is being made in research, but some strategies and interventions still lack the necessary evidence base, meaning that further investment is required. Furthermore, investment in dissemination is also required, since the existing evidence concerning effective new interventions and national and international examples of good practice are not known to many policy-makers, managers, practitioners and researchers. The European research community needs to collaborate to lay the foundations for evidence-based mental health activities. Major research priorities include mental health policy analyses, assessments of the impact of generic policies on mental health, evaluations of mental health promotion programmes, a stronger evidence base for prevention activities and new service models and mental health economics.

Actions to consider

i. Support national research strategies that identify, develop and implement best practice to address the needs of the population, including groups at risk.

ii. Evaluate the impact of mental health systems over time and apply experiences to the formulation of new priorities and the commissioning of the necessary research.

iii. Support research that facilitates the development of preventive programmes aimed at the whole population, including groups at risk. Research is needed on the implications of the interrelated nature of many mental, physical and social health problems for effective preventive programmes and policies.

iv. Promote research focused on estimating the health impacts of non-health sector policies, as there is a clear potential for positive mental health to be improved through such policies.

v. Bridge the knowledge gap between research and practice by facilitating collaboration and partnerships between researchers, policy-makers and practitioners in seminars and accessible publications.

vi. Ensure that research programmes include long-term evaluations of impact not only on mental health but also on physical health, as well as social and economic effects.

vii. Establish sustainable partnerships between practitioners and researchers for the implementation and evaluation of new or existing interventions.

viii. Invest in training in mental health research across academic disciplines, including anthropology, sociology, psychology, management studies and economics, and create incentives for long-term academic partnerships.

ix. Expand European collaboration in mental health research by enhancing networking between WHO's European collaborating centres and other centres with research activities in the field of prevention.

x. Invest in regional collaboration on information and dissemination in order to avoid the duplication of generally applicable research and ignorance of successful and relevant activities elsewhere.

Mental Health for Europe: Facing the Challenges

Milestones

Member States are committed, through the Mental Health Declaration for Europe and this Action Plan, to face the challenges by moving towards the following milestones. Between 2005 and 2010 they should:

1. prepare policies and implement activities to counter stigma and discrimination and promote mental well-being, including in healthy schools and workplaces;
2. scrutinize the mental health impact of public policy;
3. include the prevention of mental health problems and suicide in national policies;
4. develop specialist services capable of addressing the specific challenges of the young and older people, and gender-specific issues;
5. prioritize services that target the mental health problems of marginalized and vulnerable groups, including problems of comorbidity, i.e. where mental health problems occur jointly with other problems such as substance misuse or physical illness;

6. develop partnership for intersectoral working and address disincentives that hinder joint working;
7. introduce human resource strategies to build up a sufficient and competent mental health workforce;
8. define a set of indicators on the determinants and epidemiology of mental health and for the design and delivery of services in partnership with other Member States;
9. confirm health funding, regulation and legislation that is equitable and inclusive of mental health;
10. end inhumane and degrading treatment and care and enact human rights and mental health legislation to comply with the standards of United Nations conventions and international legislation;
11. increase the level of social inclusion of people with mental health problems;
12. ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and inspection of mental health activities.

B. Towards a European strategy on noncommunicable diseases: Follow-up to resolution EUR/RC54/R4

Summary

13. By resolution EUR/RC54/R4 the Regional Committee requested the Regional Director to develop a comprehensive action-oriented strategy for the prevention and control of noncommunicable diseases for the European Region by 2006. To facilitate this process, a network of WHO national counterparts was established in early 2005 and a drafting group of representatives of eight Member States was appointed. Work is on target to produce a first draft of the strategy by October for discussion with national counterparts in late 2005. A final consultation with Member States is expected to take place by the end of March 2006.

Introduction

14. At the fifty-fourth session of the Regional Committee in September 2004, through resolution EUR/RC54/R4, Member States decided to give high priority to noncommunicable diseases (NCD) and to develop a comprehensive action-oriented strategy for the Region by 2006. This was to focus on implementation, to take account of the specificity and diversity of the European Region, and to be prepared in collaboration with Member States, intergovernmental agencies, nongovernmental organizations and other relevant partners. This chapter reports on the progress made since September 2004 on developing the strategy, with due regard for the specifications set out in the resolution.

Collaboration with Member States: national counterparts and drafting group

15. In February 2005, ministries of health in the WHO European Region were asked to nominate national counterparts to work closely with WHO on development of the European NCD strategy. By June 2005, nominations had been received from 46 countries. A meeting of NCD national counterparts took place from 28 to 30 April 2005 at the Regional Office in Copenhagen, attended by representatives of 32 countries.

16. At this first meeting, NCD national counterparts decided on the consultative process by which the European NCD strategy would be developed, as well as began to identify the means to support implementation of the strategy. There was an opportunity for technical discussion on selected aspects of the strategy, and for countries to present case examples from their own experience, particularly in the area of NCD policy.

17. Also at the meeting, representatives of eight countries were appointed to act as the drafting group for preparation of the strategy. This group is balanced in terms of both geography and gender, with members from Croatia, Georgia, Italy, Lithuania, Romania, Russian Federation, Sweden and the United Kingdom; the Chair of the group is Bosse Pettersson (Sweden). The representative of Lithuania is also Chair of the International Management Committee for the Countrywide Noncommunicable Disease Intervention (CINDI) programme, thereby ensuring that the programme's extensive experience can be drawn on. The first meeting of the group took place during the meeting of national counterparts in April; a second meeting was held in Sweden on 13 and 14 June 2005, attended by six of the eight members. The outcomes of the meeting were: detailed guidance for preparation of the first draft of the strategy, including its direction and scope; identification of areas of work requiring external expertise; and proposals for further inventories of related work to support the document's preparation.

18. Following this meeting, external support on specific areas will be commissioned and a first (10–15 page) draft of the strategy will be developed for circulation to members of the drafting group by the end of August. A revised draft incorporating their comments will be discussed at the third meeting of the drafting group in mid-September. The intention is to have the first full draft ready for translation

into Russian and circulation to national counterparts by mid-October. The second meeting of NCD national counterparts will take place in November/December 2005. A third country consultation is expected to take place by the end of March 2006.

Collaboration with intergovernmental and nongovernmental bodies and other relevant partners

19. The European Commission and other parts of WHO are committed to and supportive of the work done so far. Both the Director, Department of Chronic Diseases and Health Promotion, WHO headquarters, and the Head, Health Determinants Unit, Directorate-General of Health and Consumer Protection, European Commission, attended the first meeting of national counterparts and pledged their strong support for development of the strategy. Other WHO regions have been kept informed through the six-monthly global meetings of NCD regional advisors and the Global Forum on Chronic Disease Prevention and Control, which have also given an opportunity to share experience with other regions. The Regional Office for Europe has also been invited to present developments with regard to the strategy at the meeting organized by the European Society of Cardiology, in collaboration with the Luxembourg Presidency of the Council of the European Union and the European Commission, to follow up on the Council's conclusions on heart health of 2 June 2004.

20. It was agreed at the first meeting of national counterparts that wider consultation on the strategy would not take place until a substantial draft had first been prepared and discussed with Member States through the counterpart mechanism in late 2005. A proposal concerning the process for such wider consultation will also be discussed with Member States in late 2005. In the meantime, the Regional Office has been contacted by several members of the food industry for discussion both on the European NCD strategy and on implementation of the Global Strategy on Diet, Physical Activity and Health. A first meeting was held in March 2005 with representatives of the Confederation of the Food and Drink Industries of the European Union. A further meeting has been requested by Unilever and is provisionally scheduled to take place in August 2005.

Pre-existing commitments of Member States and relevant strategies

21. An inventory of Member States' existing commitments and relevant strategies has been prepared and is being used in preparation of the strategy.

22. During the 2004–2006 period of preparation of the European NCD strategy, the European Alcohol Action Plan 2000–2005, the European Strategy for Tobacco Control and the First European Action Plan for Food and Nutrition Policy are all undergoing review. In parallel, the European Strategy for Child and Adolescent Health and Development has been drawn up and the Mental Health Action Plan for Europe has been launched. The Framework for Alcohol Policy in the WHO European Region will be presented to the Regional Committee at its fifty-fifth session, while a report on progress with the tobacco control strategy, will be presented at the fifty-sixth session, when the European NCD strategy will also be submitted for consideration. In order to foster synergies between these various areas of work, the focal point for preparation of the European NCD strategy has participated in the meetings of national counterparts for alcohol, tobacco, and child and adolescent health, as well as the WHO European Ministerial Conference on Mental Health, and in the process for drafting the different Regional Committee papers. To further facilitate communications and joint working within the Regional Office, an internal mechanism has been put in place to bring together the various programmes contributing to NCD prevention and control

Focus on implementation in a diverse Europe

23. At the meeting of NCD national counterparts, speakers from seven countries made presentations sharing their experience of how they are currently meeting the challenge of NCD, particularly regarding development and implementation of national NCD policies. There was also a general

session on the particular challenges countries face in implementation. On the basis of these discussions, a preliminary list of tools and products for helping countries to develop and implement the strategy was drawn up.

24. The Regional Office is participating in a WHO global NCD survey during 2005 to get an up-to-date overview of relevant policies. Completed questionnaires will be followed up by interview. The intention is also that policy documents will be gathered and made accessible to Member States through a portal on the Regional Office website, alongside information on NCD risk factors and other relevant information. On the basis of information received from countries, a series of evidence-based policy case studies will be prepared. Finally, programmes at the Regional Office are collaborating with each other and with WHO headquarters to gather up-to-date, accessible and comparable country data on NCD risk factors and to review the approach to NCD surveillance.

25. The Regional Office has also taken an active part in preparation of the global NCD report *Preventing chronic diseases: A vital investment*, which will be published in October 2005. This will make the case for investment in prevention and bring together the evidence for action to help policy-makers through a step-wise approach to policy development. The national counterparts are also supportive of a European report on NCD being prepared to accompany the fifty-sixth session of the Regional Committee paper as a background or information document. This European version of the global report would provide more specific evidence and examples related to the European situation. A proposal will be prepared during the summer of this year, once the first draft of the European NCD strategy document has been drawn up and the text of the global NCD report has been received.

C. Scaling up the response to HIV/AIDS in the WHO European Region: Implementation of resolution EUR/RC52/R9

Epidemiological trends of HIV/AIDS in the WHO European Region

26. The HIV/AIDS epidemic in the Region has continued to grow at a very fast pace over the past three years. By the end of May 2005, European Member States had reported to the Regional Office a total of 856 338 HIV cases (584 000 in 2001), 298 297 AIDS cases (263 000 in 2001) and 170 387 AIDS deaths (152 000 in 2001).

27. WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimate that 2.01 million people were living with HIV/AIDS in the Region at the end of 2004 (range: 1.4–2.86 million), with an estimated prevalence of 0.2–0.6% of the population. This represents an increase of almost 30% from the estimated 1.55 million at the end of 2001. However, HIV prevalence rates vary between groups of countries – from less than 0.1% in central and south-eastern Europe to as high as 1.05% in countries in the western part of the Commonwealth of Independent States – CIS (Belarus, the Republic of Moldova, the Russian Federation and Ukraine).

28. The HIV/AIDS epidemic remains concentrated in population groups at high risk throughout the Region. While there is a slow but steady increase in the number of HIV-infected women, the epidemic is mainly among urban males. In western Europe, HIV/AIDS is mostly transmitted sexually – the majority of newly reported cases are among men who have sex with men, and among immigrants (more than half of whom are women) from countries with a generalized HIV epidemic. In eastern Europe, injecting drug use is the transmission route in over 80% of all reported cases where the route of transmission is known. Women represent 28% of all reported HIV cases. Five per cent of all reported HIV cases were children under the age of fifteen years at the time of first HIV diagnosis.

HIV/AIDS prevention, treatment and care

29. It is estimated that 557 000 people needed highly active antiretroviral treatment (HAART) in Europe in mid-2005 and that 330 000 were actually receiving it. Between March 2003 and mid-2005, the number of patients on HAART in western Europe, increased by 32%, from 235 000 to 311 000, and in central and eastern Europe by 157% from 7 000 to over 18 000. Of the total, 378 000 people in need of HAART live in western, Central and south-eastern Europe, and 159 000 in eastern Europe and central Asia. Forty Member States – all of western Europe and most central European countries – are providing universal access to HAART, which is an increase of ten since 2004. Eight Member States provide only partial access to treatment. The number of countries not providing any HAART or less than 1% coverage has decreased from 14 to 4.

30. According to national scale-up plans, it is estimated that 49 out of 52 European Member States of WHO will be providing universal access to HAART by the end of 2005 (with Turkmenistan providing no HAART, and Ukraine and the Russian Federation providing partial access), and that the number of people on HAART will be around 368 500 (332 000 in western Europe and 36 500 in central and eastern Europe).

31. Preliminary results from a survey of all WHO European Member States on antiretroviral treatment (ART) at the end of 2004 show that women represent 32% of people receiving ART (28% of all reported HIV cases), and that children under the age of 15 years represent 5% of those on ART (5% of all reported HIV cases). About one third of all people receiving treatment are also co-infected with hepatitis B and C. Access to ART for injecting drug users has also improved significantly over the past two years, with a growing proportion of people infected with HIV through injecting drug use having access to ART, including active drug users who also have access to opioid substitution treatment in a growing number of countries.

32. Prevention, treatment and care are integral and mutually reinforcing elements of a good public health response to the HIV/AIDS epidemic. While WHO has focused much of its efforts in this biennium on scaling up access to treatment and care, because it was a neglected intervention in many countries of central and eastern Europe, prevention remains an issue of particular concern.

33. Increased access to ART encourages health-seeking behaviour among people at risk of HIV and those living with HIV/AIDS; it promotes wider access to and use of HIV counselling and testing services and therefore access to prevention commodities, such as condoms. However, unless easy-to-access and effective prevention programmes are available on a wide scale targeting those most vulnerable to HIV/AIDS, such as injecting drug users or men who have sex with men, the number of newly infected people in Europe will continue to increase at a very high rate. This in turn, will create tremendous pressure on health care systems to expand services for people living with HIV/AIDS and to significantly increase health expenditure in this area.

34. The Regional Office continues to work closely with Member States advocating for the scaling up of effective, evidence-based and equitable prevention programmes that target those at greatest risk, particularly injecting drug users in eastern Europe. Assistance has been provided to countries such as Estonia, Lithuania and Ukraine in assessing needs, advocating for appropriate harm reduction interventions and evaluating experiences with programmes for injecting drug users.

Matching the Regional Office’s services with the needs of Member States

35. At its fifty-second session the Regional Committee adopted resolution EUR/RC52/R9, “Scaling up the response to HIV/AIDS in the European Region of WHO”, making HIV/AIDS one of the highest priorities and setting the programmatic basis for the Regional Office’s work in this area.

36. Since then, the Office’s staff and activities dedicated to HIV/AIDS have been extensively scaled up, with concomitant support to Member States’ technical resource networks, especially with regard to HIV/AIDS surveillance and the adaptation of normative guidelines and treatment protocols. In June 2005, there were 34 full-time staff members working on HIV/AIDS at the Regional Office in Copenhagen and in twelve country offices.

37. The Regional Office’s expanded capacity in the area of HIV/AIDS has enabled the Secretariat to significantly increase direct technical assistance to Member States. These efforts have been largely focused on drawing-up national treatment scale-up plans, developing guidelines for prevention, treatment and care, helping to design and carry out projects financed by the Global Fund for AIDS, Tuberculosis and Malaria, and increasing the health sector’s capacity to deliver new and expanded prevention, treatment and care services, carry out surveillance of the epidemic and monitor and evaluate the outcomes of those interventions.

Regional advocacy and partnerships

38. In 2002–2003, the Regional Office positioned itself as a leading technical agency, not only by making available key technical tools (e.g. guidelines, protocols and recommendations) to countries and partners, but also by being an active advocate for scaled-up prevention, treatment and care. The fact that the Regional Office continues strongly to promote evidence-based, but sometimes politically contested, best practices (such as harm reduction for injection drug users) has earned respect for the Organization among Member States, civil society and other partners.

39. Resolution EUR/RC52/R9 has been used as a basis for recommendations to and commitments by Member States on other occasions, such as the Ministerial Conference on HIV/AIDS in Europe (Dublin, February 2004) and the follow-up conference in Vilnius in September 2004. The declarations of both meetings called for universal access to prevention, treatment and care services.

40. On 1 December 2003, a WHO strategy document entitled “Treating 3 million by 2005: Making it happen” was launched describing how, with appropriate resources, WHO could contribute to accelerated activities at all levels that would help countries to scale up HIV/AIDS treatment and care. This effort is coming to a close, and despite achieving universal access in 40 countries, partnerships and national efforts will have to be strengthened in order to close the large treatment gap in eastern Europe, which will continue to grow in the coming years faster than the current scale-up of ART.

41. Partnerships with nongovernmental organizations (NGOs), treatment activists and people living with HIV/AIDS have been strengthened by actively involving communities in the work of WHO at regional and country levels. The Regional Office has developed and maintained active partnerships with the Central and East European Harm Reduction Network, the AIDS Foundation East-West, and national associations of people living with HIV such as the All-Ukrainian Network of People Living with HIV, the American International Health Alliance and the European Treatment Action Group.

42. Collaboration with other United Nations agencies, under the overall coordination of UNAIDS, and with other partners has been strengthened at regional and country levels, following the agreed principles of “Three Ones”, i.e. one country policy framework, one national coordinating body for HIV/AIDS and one joint monitoring and evaluation framework.

43. Close technical and funding partnerships have been developed and maintained with the German Technical Cooperation Agency (GTZ), the United Kingdom’s Department for International Development (DfID), the United States Agency for International Development (USAID), the European Commission and other bilateral aid agencies, the governments of France, Germany, Italy, the Netherlands and other Member States, and international partners. The Canadian International Development Agency was the single largest donor for HIV/AIDS to the Regional Office in 2004–2005, through its contribution to the 3 by 5 Initiative through WHO headquarters.

Normative and policy guidance

44. WHO HIV/AIDS treatment and care protocols for the countries of the Commonwealth of Independent States, developed in 2004, are being updated and expanded so that they are relevant for the entire European Region. WHO held consultation meetings in 2005 on the development of new protocols in areas such as reproductive health services for HIV positive people, HIV and hepatitis co-infection, HIV/AIDS treatment and care for injecting drug users, and immunizations for people living with HIV/AIDS.

45. WHO organized a European consensus workshop on WHO clinical staging of HIV/AIDS and AIDS case definitions for surveillance, in collaboration with the European Centre for Disease Prevention and Control (ECDC) and the European Centre for the Epidemiological Monitoring of AIDS (EuroHIV).

46. In collaboration with national counterparts, the Regional Office prepared strategy papers outlining options for achieving ARV price reductions; these are relevant for all CIS countries. A regional meeting was organized (together with UNAIDS) on ARV price reduction strategies for CIS countries in Azerbaijan in February 2005, and a similar one is planned for central Europe for September 2005.

Strategic information

47. The Regional Office has worked with all 52 Member States on regular Region-wide surveillance of STI/HIV and AIDS, in collaboration with EuroHIV.

48. Epidemiological surveillance data have been regularly collected, analysed and published. Training on second-generation surveillance has been provided to Member States, and it has increasingly become accepted as a standard throughout the Region. Other specific activities in

surveillance have included training in epidemiological modelling of HIV/AIDS for all Member States, the production of epidemiological models and HIV/AIDS estimates, surveys of access to care and treatment, and key surveillance studies looking at HIV prevalence and risk behaviour in selected countries and populations.

49. Data collected, analysed and summarized by the Regional Office have been used in important publications such as the WHO headquarters "3 by 5" progress report, the AIDS Epidemic Update (UNAIDS) and country profiles drawn up by the United Nations Office for Drug Control (UNODC). WHO has made original contributions on the epidemic to the British Medical Journal, Choices magazine, Business Briefing, Long-term Healthcare 2005, the Journal of Clinical Medicine, the Scandinavian Journal of Public Health and the Sensoa Yearbook. Regional Office staff have actively participated with abstracts and oral or poster presentations in numerous scientific meetings and conferences, such as the XV International AIDS Conference, the Conference on Retroviruses and Opportunistic Infections, the International AIDS Society Conference, the International Harm Reduction Conference, the Ministerial Conferences in Dublin and Vilnius and the International STI Conference.

50. In 2004–2005, epidemiological fact sheets and regional and country-specific estimates of ART needs and coverage for all 52 Member States were updated. Work has continued on more systematic and comprehensive collection of data on access to HIV/AIDS treatment and treatment outcomes, HIV-related mortality, and HIV-related conditions such as tuberculosis/HIV co-infection and hepatitis C morbidity.

51. A book on 25 years of the HIV/AIDS epidemic in Europe is being prepared as a high corporate priority publication by the Regional Office, and will be released in December 2005. The book will contain an overview of lessons learnt from two and a half decades of responses to the epidemic in this Region, showing how the epidemic has influenced public health responses to one of the largest infectious disease threats, what works in prevention, treatment and care, and what has been the impact of the epidemic in the Region.

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

Summary

52. 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 the provisions of Regional Committee resolution EUR/RC54/R3. It summarizes the work done and decisions taken by the EEHC since the Conference.

Introduction

53. The Fourth Ministerial Conference on Environment and Health, held in Budapest in June 2004, extended the mandate of the European Environment and Health Committee (EEHC) by another five years. The EEHC holds two regularly scheduled meetings each year, and it accordingly met in Paris, hosted by the French Ministry of Health, on 26 and 27 January 2005 and in Copenhagen, hosted by the European Environment Agency and with financial support from the Danish Ministry of Health, on 2 and 3 June 2005.[3]

54. At the fifty-fourth session of the Regional Committee, Armenia, Bulgaria, France, Norway and the Russian Federation were selected as members of the EEHC. Likewise, at the eleventh session of the UNECE Committee on Environmental Policy, Austria, Finland, Georgia, Italy, and Serbia and Montenegro were selected. The following intergovernmental and international organizations are represented on the EEHC: the European Commission (EC), the European Environment Agency (EEA), the Organisation for Economic Co-operation and Development (OECD), the Regional Environmental Centre for Central and Eastern Europe, UNECE, the United Nations Environment Programme (UNEP) and the WHO Regional Office for Europe. Civil society is represented by the European Public Health Alliance, ECOforum, the International Confederation of Free Trade Unions and the World Business Council for Sustainable Development. All members of the Committee nominated in 2004 will serve up to the mid-term intergovernmental review in 2007. The Chair is Professor William Dab (France) and the Vice-chair is Mr Zaal Lomtadze (Georgia).

55. The website (www.euro.who.int/eehc) is regularly updated and includes the working papers and reports of the EEHC's meetings, a calendar of upcoming environment and health events in Europe, and relevant news items of interest.

Key roles of the EEHC and mechanisms for fulfilling them

56. In discussing how best to fulfil its terms of reference, the EEHC considered that it has two key roles. The first is monitoring and reporting, with a view not only to gathering information on the activities being carried out within countries and by organizations to follow up on the Budapest Conference but also to making it widely and readily available. The second key role is promotion and advocacy, which are critical to successful implementation of the outcomes of the Budapest Conference, through a strong communication strategy, by sharing experiences and best practice, and by building partnerships across sectors and with a range of stakeholders. To facilitate monitoring and

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[3] The EEHC, which was established in 1995, has had its five-year mandates extended in 1999 (Third Ministerial Conference on Environment and Health) and again in 2004 (Fourth Ministerial Conference on Environment and Health). In order more accurately to reflect this history, the EEHC agreed at its June 2005 meeting to change the numbering of its meetings. Therefore the meetings on 26–27 January and 2–3 June 2005 are now considered to be the 18th and 19th meetings, respectively, of the EEHC.

reporting, as well as to communicate and disseminate this information to a wide audience, a number of mechanisms have been put in place as described below.

Environment and Health focal points

57. In late 2004, WHO requested ministries of health and ministries of environment to nominate individual or joint Environment and Health focal points to facilitate coordination between national and international activities following the Budapest Conference (see Appendix 3 for terms of reference). The EEHC considered that the focal points would play a crucial role in the follow-up to the Budapest Conference. To date, 77 Environment and Health focal points have been nominated from 50 Member States.

Topic-oriented meetings

58. The EEHC is devoting part of each meeting in 2005 and 2006 to one of the following priority issues highlighted at the Budapest Conference:

- respiratory disease due to outdoor and indoor air pollution (June 2005);
- disease and disability from exposure to hazardous chemical, physical and biological agents and hazardous working environments (12–13 December 2005);
- health consequences of accidents and injuries (spring 2006); and
- gastrointestinal disease and other health effects from unsafe water (autumn 2006).

59. New scientific evidence on each priority issue will be examined, as well as the policy response of countries to address it. While the above issues reflect the regional priority goals in the Children's Environment and Health Action Plan for Europe (CEHAPE), they also relate to relevant paragraphs in the Budapest Conference Declaration. Member States and organizations are invited to participate actively in these topic-oriented sessions.

60. At the June 2005 meeting, which was the first time that the topic-oriented approach was used, 63 participants from 28 countries and 8 organizations took part. The reports on implementation by countries and organizations are available on the web-based map (see paragraph 67).

61. The next meeting of the EEHC will take place in Helsinki, Finland on 12–13 December 2005 and will highlight disease and disability from exposure to hazardous chemicals, physical and biological agents, and hazardous working environments.

CEHAPE Task Force

62. At the invitation of ministers at the Budapest Conference, the EEHC established a task force to help monitor implementation of the CEHAPE. It comprises the officially designated Environment and Health focal points or other representatives appointed by the countries. The first meeting of the CEHAPE Task Force, held on 28 and 29 April 2005 in Vienna and hosted by the Austrian Federal Ministry of Agriculture, Forestry, Environment and Water Management, was attended by 48 participants from 33 countries, as well as representatives of three organizations. Mr Robert Thaler (Austria) was elected Chair. Participants agreed their terms of reference as Environment and Health focal points, as well as the terms of reference and workplan of the CEHAPE Task Force (Appendix 4). The CEHAPE Task Force will meet twice a year. As noted in the workplan, each Task Force meeting will include reporting on the CEHAPE regional priority goal relevant to the next EEHC meeting.

63. CEHAPE tools for implementation and monitoring include the CEHAPE table of child-specific actions, which is being updated and revised, and the catalogue of case studies of actions taken in Member States, which will be published in 2006. In addition, indicators for CEHAPE are being

developed. The reports on implementation by countries and organizations are available on the web-based map (see paragraph 67).

64. More detailed information on the work of the CEHAPE Task Force is available at www.euro.who.int/eehc/20050407_1.

Monitoring of development of an Environmental Health Information System

65. The Working Group on the Environment and Health Information System (EHIS), meeting in Bonn on 10 November 2004, agreed on the framework plan of actions required for EHIS implementation and requested EEHC to ensure overall monitoring of the actions and to provide a high-level steering mechanism for EHIS development. An international coordination group has been created to assist the EEHC in its monitoring function. It includes representatives of countries, EC, EEA, UNECE and UNEP, with WHO serving as secretariat. Technical work on development of EHIS is being carried out through a series of international and national projects. Reinforcing this technical work is a project entitled “Implementing the Environment and Health Information System in Europe”, co-sponsored by the EC Directorate-General for Health and Consumer Affairs, which focuses on development of the elements of the system that supports monitoring of issues relevant for CEHAPE.

66. More detailed information on EHIS is available at www.euro.who.int/EHindicators.

Web-based implementation map

67. Information from Member States and organizations on their implementation of the commitments in Budapest Conference Declaration and CEHAPE will be made available electronically on the EEHC website. A map has been set up on the site (www.euro.who.int/eehc/ctryinfo/ctryinfo) so that one click on a country provides all this information for the country in question. The map is also designed to encourage the exchange of good practice and to promote the development of multilateral partnerships and common projects. It will be regularly updated through the reporting to the EEHC and the CEHAPE Task Force, as well as through input by the Environment and Health focal points. Users will also be offered a variety of other relevant information produced by or on the country.

Youth representation and involvement

68. Youth representation on the EEHC and the CEHAPE Task Force, and involvement of young people in the implementation process, was supported by the ministers at the Budapest Conference. A framework strategy on how such representation and involvement could be carried out in a democratic and transparent way has been prepared under the auspices of the Irish National Children’s Office. A workshop aimed at turning this document into action will take place in Dublin on 27 and 28 September 2005, to which all countries will be invited to participate.

Financial requirements of the EEHC

69. The annual operating costs of the EEHC are estimated to be approximately US$ 300 000. Fundraising efforts are being made with Member States to ensure that resources are identified to meet the needs. The contributions made by Denmark, France and Italy are gratefully acknowledged.

Appendix 3
Terms of reference of Environment and Health focal points

1. Act as the main liaison point and channel of information (e.g. for the dissemination of information and advice on good practice, case studies, implementation activities, etc.) within and between ministries and with other relevant national as well as regional and local bodies, national technical counterparts, civil society (i.e. nongovernmental organizations, business/industry and trade unions), etc. within the country on the implementation of the Budapest Conference commitments.

2. Regularly inform the EEHC on actions taken within their respective countries on such implementation.

3. Help channel information to Environment and Health focal points in other countries on good practice, case studies, implementation activities, etc.

4. At the request of the EEHC, to comprise the CEHAPE Task Force.

Appendix 4
Terms of reference and workplan 2005–2007 of the CEHAPE Task Force

Terms of reference

Paragraph 28 of the CEHAPE, endorsed at the Fourth Ministerial Conference in Budapest, reads:

> "We call upon WHO, and we ourselves undertake, to ensure an adequate follow-up mechanism to the CEHAPE. To this end we invite the European Environment and Health Committee to establish a CEHAPE task force with the participation of Member States, international organizations and NGOs, in order to facilitate and stimulate implementation of the CEHAPE, with particular attention paid to the sharing of best practices and the dissemination of information and experiences among the Member States."

On the basis of this invitation, the EEHC decided at its first meeting (26–27 January 2005) to establish a CEHAPE task force with the following terms of reference.

1. To promote the implementation of the four regional priority goals and identify Member States who may wish to take a leadership role in this process.

2. To serve as a source of knowledge and practical experience and to provide a platform to share policies, good practices and tools that facilitate the implementation of regional priority goals in the Member States.

3. To identify new research needs and to promote the coordination of research programmes on children's health and environment among Member States.

4. To propose international and intercountry projects on children's health and environment and to provide assistance in identifying partners and donors.

5. To promote advocacy, information, education (including capacity-building) and communication with regard to the environment and health impacts on children's health.

6. To report to each EEHC meeting on the above terms of reference.

7. To contribute to the preparation of a comprehensive report and a position paper for the mid-term intergovernmental review meeting in 2007, indicating progress made, difficulties encountered, gaps in policy-making identified and future recommendations on the further implementation and development of the CEHAPE.

CEHAPE Task Force Workplan 2005–2007

When	Topics to be covered
Autumn 2005 (October)	Reporting on regional priority goal (RPG) 4 Reporting on new developments with regard to RPG 3 since last meeting Youth involvement Children's health and environment legislation
Spring 2006 (April)	Reporting on RPG 2 Reporting on new developments with regard to RPG 4 since last meeting Children's health and environment legislation Revised table of child-specific actions Overview of international collaboration
Autumn 2006 (October)	Reporting on RPG I Reporting on new developments with regard to RPG 2 since last meeting Advocacy, information, education, communication Indicators Revised case studies
Spring 2007 (February)	CEHAPE Task Force contribution to the comprehensive report for the mid-term intergovernmental review meeting in 2007

E. Occupational health

Health challenges in the world of work

70. There are more than 400 million workers in the WHO European Region, and all of them have the right to just and favourable working conditions and equal access to preventive health services at the workplace. However, the levels of health risks at many workplaces are still unacceptable. Traditional occupational health hazards, such as airborne particulates, chemicals, ergonomic stressors, carcinogens, noise and work accidents, still affect large segments of the European workforce and, according to the most conservative estimates, are responsible for at least 1.6% of the total burden of disease. In the European Region poor working conditions result in an annual total of 102 000 premature deaths and more than 100 000 new cases of occupational diseases. The lack of occupational health and safety measures causes economic losses amounting to 4% of the gross domestic product of the Region (in the magnitude of hundreds of billions of US dollars).

71. Globalization and the transition from an industrial to an information society lead to new types of employment and technologies, as well as to international migration of the workforce. These changes in turn generate newly emerging risks from work-related stress, poor work organization and unhealthy equipment which threaten human health and well-being and add to the burden of disease, particularly in terms of cardiovascular diseases, mental ill health and musculoskeletal disorders. The ageing of the labour force also modifies the way in which occupational risks affect health. In addition, mass impoverishment of certain social groups in some Member States has led to the emergence of hazardous child labour, which was virtually unknown in the past. As social inequality grows, workplace risks are experienced differently across countries, industries, social classes, genders, and ethnic groups. These sweeping changes in the labour process mean that more attention must be paid to occupational health policies and services, particularly for high risk sectors, underserved populations and vulnerable groups, and that new methods of risk prevention and health promotion at the workplace must be introduced.

The WHO response

72. At present, the European occupational health agenda is based on the WHO global strategy for occupational health for all (World Health Assembly resolution WHA49.12 from 1996). This work is supported by a large network of 29 WHO collaborating centres, most of them located in Europe. These centres carry out activities at the request of WHO and foster international collaboration. However, the global strategy is being revised to adapt it to the new challenges outlined above and will be submitted to WHO's governing bodies, possibly in 2006

73. 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. Because of budgetary constraints the programme had been closed in 2001. In order to respond to this call, the Regional Director in October 2004, identified resources to employ an occupational health programme manager under the Special Programme on Health and Environment until the end of the biennium 2004–2005. The renewed programme on occupational health has been working with a limited scope, mainly aiming at supporting the Member States in implementing international public health commitments that are relevant to occupational health, such as those made at the Fourth Ministerial Conference on Environment and Health (Budapest 2004) and the WHO European Ministerial Conference on Mental Health (Helsinki, 2005).

74. Within this framework the following activities have been carried out:

- A special module for training health professionals in recognizing and managing occupational risks for children has been developed, as a follow-up to the Budapest Conference.

- A toolkit on management of mental health risks at the workplace has been prepared and disseminated, as a follow-up to the parallel event on mental health and working life at the Helsinki Conference.
- Five countries received support under their 2004–2005 biennium collaborative agreements with WHO for developing their national occupational health polices and strengthening occupational health services. As a result, national strategies on occupational health and safety have been developed in the Russian Federation, Ukraine and the former Yugoslav Republic of Macedonia, and a plan for establishing occupational health services in being prepared in Armenia.
- On the initiative of the Regional Office and with the support of the South-eastern Europe Health Network, occupational health and safety was included as a cross-cutting programme on the agenda of the Social Cohesion Initiative under the Stability Pact. This programme brings together WHO, the International Labour Organization (ILO), and international organizations of employers and trade unions to strengthen social dialogue for improving working conditions and workers' health in the eight countries of south-eastern Europe. This is also in response to the conclusions of the thirteenth session of the Joint ILO/WHO Committee on Occupational Health which called for an expansion of collaboration between the two organizations, at both global and regional levels.

75. Within their own limited capacity and financial constraints, the network of WHO collaborating centres has supported the occupational health work of the Regional Office, particularly in four areas: (1) occupational risks for children and future generations; (2) work-related stress and psychosocial risks; (3) occupational health services, and (4) the evidence base for occupational health interventions.

The way forward

76. The activities started during the second half of the 2004–2005 biennium were well received by Member States and would need to continue in order to address the serious 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. This will not be possible without adequate and sustainable human and financial resources to allow the programme to run efficiently, rather than on the basis of occasional and limited support. The professional assistance received from the network of WHO collaborating centres is very much appreciated, but it is not and will not be sufficient without a proper coordination and implementation mechanism run by the Regional Office.

77. In order to give a coherent framework to occupational health work in Europe, the need to develop a regional strategy could be considered by WHO's European governing bodies. This should entail the involvement of both Member States and stakeholders within a truly participatory process. If this direction is taken, the regional strategy will have to be linked to the process aimed at developing a global plan of action on occupational health 2006–2015, to be presented to the World Health Assembly in 2006, as well as to the European Commission's strategy on health and safety at work.

F. Reproductive health

78. In the debate following his address at the fifty-fourth session of the Regional Committee in 2004, the Director-General observed that WHO's resources were targeted at technical and scientific support and policy advice, with the aim of being catalytic and enabling WHO to maximize its impact at country level.

79. During the Fifty-seventh World Health Assembly the same year, all 52 Member States in the WHO European Region approved the WHO global reproductive health strategy to accelerate progress towards the attainment of international development goals and targets, thus expressing their commitment to the Programme of Action of the International Conference on Population and Development (Cairo, 1994). A year later, the Fifty-eighth World Health Assembly urged Member States "to commit resources and to accelerate national action towards universal access and coverage with maternal, newborn and child health interventions, through reproductive health care" and requested the Director-General "to intensify technical support to Member States for developing their institutional capacity for achieving international goals and targets through universal access to, and coverage of, reproductive, maternal, newborn and child health programmes, in the context of strengthening health systems" (resolution WHA58.31).

80. To measure progress towards the goals and targets in the WHO global (2004) and the European regional (2001) reproductive health strategies, the available reproductive health indicators are continuously analysed by the Reproductive Health and Research (RHR) programme at the Regional Office. The results are presented in *Entre Nous*, the European magazine for sexual and reproductive health, and to the members of the Regional Advisory Panel (RAP) on Research and Training in Reproductive Health in the European Region.

81. During the past ten years remarkable progress has been made in reducing **maternal mortality** in many WHO European Member States. For example, between 1994 and 2003 the rate in Albania fell from 40 to 17 maternal deaths per 100 000 live births, the Czech Republic from 15 to 4, Estonia from 56 to 8, in Latvia from 57 to 14, in Lithuania from 21 to 3 and in Kazakhstan from 69 to 36. However, there has been no progress in some countries (Armenia, Belarus, Turkmenistan, and Uzbekistan), while in a few others the maternal mortality rate has actually increased (in Georgia from 39 to 49, and in Slovenia from 10 to 17 in 2002). Although some of this increase may be explained by better registration of maternal deaths and the availability of more reliable data, it is necessary to find out the real causes of maternal deaths and prevent them. Even with the progress made, the range of rates is still large. In 2004–2005, the Making Pregnancy Safer initiative at the Regional Office has been assisting 14 countries.

82. To respond to the needs and requests from Member States, the Regional Office has developed a draft proposal for a regional strategy for improving maternal and perinatal health. This was discussed and supported by representatives of ministries of health and WHO's partners during a meeting on national policies and strategies for family and community health held in April 2005. The Regional Committee may wish to consider the importance of working towards a European regional strategy in this area.

83. One of the remaining alarming problems is the fact that up to 30% of maternal death cases in some countries (30.3% in the Republic of Moldova (average over the past 10 years), 20% in Kazakhstan (2004), 16% in the Russian Federation (2004)) are due to **abortion**. The RHR programme at the Regional Office has translated into Russian the WHO publication *Safe abortion: Technical and policy guidance for health systems*; it has organized a workshop on implementation of this guidance using "strategic approach" methodology; it has started to carry out a project on strategic assessment of policy, quality and access issues related to fertility regulation services in the Republic of Moldova; it is helping counterparts in the Russian Federation to develop national guidelines on safe abortion; and, with the financial assistance of the International Planned Parenthood Federation European Network (IPPF EN), it published issue no. 59 of *Entre Nous* on "Abortion in Europe". Preventing unwanted

pregnancy and ensuring safe abortion remains one of the priorities for the RHR programme in Europe in 2006–2007, as approved by the members of the Regional Advisory Panel at their meeting in 2005.

84. Another challenge is the **sexual and reproductive health of adolescents and young people**. The numbers of unwanted pregnancies and cases of sexually transmitted infection remain high in this age group in many countries, both in eastern and in western Europe, and result in lifelong ill-health. WHO is assisting Member States (Belarus, Latvia, Turkey, Ukraine,) who have prioritized this area. In general, these activities are carried out in collaboration with the Regional Office's programmes for Child and Adolescent Health and Health Systems. The European Strategy for Child and Adolescent Health and Development that has been drawn up will be an additional tool for reaching the goal of improving the reproductive health of young people in Europe.

85. The RHR programme, in collaboration with IPPF EN and Lund University (Sweden), has received a European Union grant for a project entitled "The way forward: A European partnership to promote the sexual and reproductive health and rights of youth". Representatives of ministries of health will be informed of the outcome of this project in 2007.

86. Two other challenges that are high on the list of priorities for the WHO European Region are to prevent **cervical cancer** and to improve the **reproductive health of vulnerable groups** (including migrants, refugees and asylum-seekers).

87. The regular budget used by the RHR programme for both Region-wide and country work has decreased from US$ 420 614 in 2002–2003 to US$ 112 960 in 2004–2005. Both WHO headquarters and the Regional Office have tried to raise funds for solving the important reproductive health problems in Europe; however, the increase of voluntary donations compared to the last biennium has been only marginal.

88. WHO is assisting Member States in implementing the regional strategies and in developing their national reproductive health strategies (Kazakhstan, Kyrgyzstan, the Republic of Moldova, Tajikistan) and national action plans (Belarus, Latvia, Ukraine), in close collaboration with health system specialists in Belarus, Kyrgyzstan and Latvia, as their knowledge is crucial for success during the health systems reforms that are taking place in many Member States of the Region.

89. There are 16 designated WHO collaborating centres in the European Region working with WHO headquarters and the Regional Office in the area of reproductive health. In the past four years, a new system of designation and redesignation has been introduced and has already improved the effectiveness and outcomes of collaboration. To improve networking in the research, programmatic and training activities carried out by the centres, the RHR programme is planning the first joint meeting of WHO collaborative centres in 2006.

90. The High-level Consultation on Collaboration between WHO and the United Nations Population Fund (UNFPA) in 2003 approved the Strategic Partnership Programme (SPP) in reproductive health, and good progress is being made in carrying out joint work under the SPP in Europe, in translating into Russian the WHO guidelines on family planning, on prevention and management of sexually transmitted infections and on making pregnancy safer, and in increasing the implementation of the guidelines in Member States. UNFPA remains the main partner of WHO in the field of reproductive health in Europe.

91. The RHR programme is working closely with European professional organizations such as the European Society for Contraception, the European Cervical Cancer Association, the European Society of Human Reproduction and Embryology, as well as with other nongovernmental organizations (e.g. IPPF EN) and family planning associations in Member States.

G. Evidence for public health

Summary

92. The Regional Office would like to ensure that it makes use of the best available evidence when providing advice and recommendations to Member States.

Progress of work on evidence 2001–2004

93. The reconstituted European Advisory Committee for Health Research (EACHR) was charged with advising the Regional Director on how to make better use of evidence for policy-making. The Committee highlighted the need to transform work practices in order to make systematic use of evidence. On the advice of the EACHR, the Regional Office employs a wider and more operational (action-oriented) definition of evidence, to encompass a broader scope than merely the results of scientific research: "Findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care".

94. This broader definition stimulated the Regional Office to draw up a plan of action for introducing an evidence-based work methodology. An internal policy paper, *Evidence policy for the WHO Regional Office for Europe,* was written to lay the foundation for future work, and the new methodology was implemented by means of staff training and the preparation and dissemination of an evidence handbook that includes a number of "tool kits" for rapid appraisal of evidence. The gradual but successful move towards an evidence-based organization has been achieved thanks to acceptance of this broader understanding of evidence by staff at the Regional Office.

What has been accomplished?

95. Several initiatives were launched in parallel to implement the evidence-based methodology:

- collection of basic health information and evidence and maintenance of the corresponding databases;
- analysis and interpretation of the information and evidence collected; and
- sharing and dissemination of information and evidence in a coordinated way.

96. The Health Evidence Network (HEN) project was launched in 2003. It maintains a fully searchable, regularly updated website that meets policy-makers' needs for accessible and reliable information to inform their decisions in public health. It provides not only scientifically assessed and peer-reviewed reports but also reliable descriptions of other relevant websites, databases and policy documents. HEN now receives questions direct from policy-makers in several countries. Over 35 evidence reports in response to those questions are now available, and new reports are published each month.

97. The European Observatory on Health Systems and Policies has strongly supported the Regional Office's efforts to promote the use of evidence through its wide-ranging analytical work. The Observatory monitors health system developments throughout the Region and beyond, producing a series of country reports entitled "Health care systems in transition" (HiT) profiles. In-depth studies, including policy briefs, explore key issues for health policy-making in Europe. Topics addressed include financing, hospitals, pharmaceuticals, enlargement of the European Union, and social and voluntary health insurance. Forthcoming volumes will analyse topics such as primary health care, mental health, communicable diseases and human resources for health. The Observatory's strong focus on country-based workshops, seminars and policy dialogues ensures that policy-makers have a lively forum within which to share experience and discuss reform options at international, national and local levels. The Observatory's findings are disseminated through a website as well as in peer-reviewed journals.

The integrated evidence system

98. The integrated evidence system brings together a number of complementary databases, the HiT profiles, "Highlights on Health" and other tools and products. The Regional Office maintains a comprehensive Health for All statistical database (HFA-DB), as well as programme-specific databases on infectious diseases, tobacco and alcohol. The HFA-DB serves as one of the key sources of background information for the various products described below (the HiT profiles, Highlights on Health, etc.).

99. The HiT profiles comprehensively analyse the organization and funding of a country's health system, health care provision structures and health reform initiatives, in a comparative format. The series covers all the WHO European Member States, as well as selected additional countries that are members of the Organisation for Economic Co-operation and Development (OECD). The series is an ongoing initiative, and the reports can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation, as well as to feed into comparative analyses of health care systems. Concise web-based HiT summaries ensure that information is easily accessible and serve as the basis for live updates of country information.

100. The Highlights on Health provide country "snapshots" and comparative information on the main causes of death and illness, as well as on risk factors. These reports help to inform decision-makers by linking key country findings to relevant public health policies developed by the Regional Office, other agencies and countries themselves. The new web-based format allows easy navigation to references and other information sources, and easy browsing; it also permits updates when new information becomes available. During this biennium, the Regional Office will have completed updating of the Highlights on a majority of European Member States.

101. The *European health report 2005* describes key aspects of the health of populations in the Region and interprets these to inform health policy-makers. The report also supports the European Strategy for Child and Adolescent Health which will be presented to the Regional Committee at its fifty-fifth session this year. The report was drawn up in close collaboration with WHO headquarters and it links to the *World health report* by sharing indicators and data while highlighting specific features of the European Region.

Moving forward: towards health intelligence

102. The Regional Office has decided to further develop and consolidate its information and evidence work, in order to offer an even broader field of health intelligence for policy-makers. This move is based on the following reasoning:

- The Office has to strengthen its capacity to respond to the information and evidence needs of policy-makers.
- The current fundamental problem is to understand how the Regional Office can ensure that useful information reaches decision-makers.
- A pro-active approach must therefore be adopted in order to get the right information and evidence to policy-makers.

103. Efforts in the future will further integrate related key initiatives from the work of several technical programmes and projects, including HEN, the Observatory and the Highlights on Health, ensure that the Regional Office is in a position to provide public health knowledge and evidence when needed. In essence, this approach implies being able to anticipate questions and needs from policy-makers and to customize and contextualize the answers and advice provided. This will allow knowledge to be shared both in-house and through external communication channels.

104. Actions for the upcoming biennium include the following:

- strengthen networks, anticipate needs and disseminate key data, information and operational evidence in response to these needs;
- develop a system for channelling questions from policy-makers or requests for information;
- develop a response pattern in which information needs will be categorized by degree of urgency (e.g. as "urgent reply", "policy discussion" or "long-term response") making optimal use of information available from the Regional Office and other organizations; and
- develop the Regional Office's competences to include a broad mix of public health expertise with skills in journalism, communication, dissemination, etc., in order to provide support to this health intelligence process.

H. WHO Collaborating Centres

Summary

105. Following discussions at the fifty-fourth session of the Regional Committee and as requested by the SCRC at its session held in Copenhagen from 21 to 23 March 2005, this section provides information on the status and current process for designation of WHO collaborating centres. It also covers the discussions held by the Global Screening Committee at its meeting on 20 January 2005.

The concept

106. WHO requires expert advice in order to give overall scientific and technical guidance, as well as to provide direct support to global, interregional and regional technical cooperation for national health development. WHO collaborating centres (CCs) are considered to be an essential and cost-effective mechanism allowing the Organization to fulfil its mandated activities and to harness resources far exceeding its own. The CC mechanism gives WHO access to centres of excellence worldwide and the institutional capacity to ensure the scientific validity of global health work.

107. For the institution concerned, designation as a WHO CC provides it with enhanced visibility and recognition. At national level, CC status may help to call public attention to the health issues on which it works. CC status also opens up opportunities for exchange of information and technical cooperation with other institutions, in particular at international level.

108. WHO CCs must be able, in close coordination with the WHO technical counterpart programme, to provide support to the Organization to meet two main needs:

- implementing WHO's mandated work and programme objectives;
- developing and strengthening institutional capacity in countries and regions.

Review of the management of WHO collaborating centres

109. CCs have been part of WHO nearly since the foundation of the Organization. In the late 1990s their management was taken up for discussion as a new management framework was laid down.[4] The new management practices can be summarized as set out below.

Criteria for the selection of WHO collaborating centres

110. CCs should be selected in fields that are relevant to WHO's programme activities. Other criteria for selection should include the scientific and technical standing of the institution, its actual degree of commitment at national, regional and international levels, and its ability to strengthen national and regional capacity for health development. CCs should have the capacity, and institutional stability, to develop relations with other institutions. They should be willing and prepared to use their own resources to implement the collaborative activities proposed in the workplans.

Designation procedure for WHO collaborating centres

111. The designation procedure is the same for all parts of the Organization and is globally adhered to. Designation is based on a stringent review of performance and future workplans. Evaluation is seen as a constructive exercise aimed at strengthening the capacity of all partners involved. Final authority to designate a WHO CC rests with the Director-General. The designation of a CC is time-limited – normally four years. The institution should have successfully and actively collaborated with WHO for at least two years in carrying out jointly planned activities before the designation procedure can start.

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[4] *Research strategy and mechanisms for cooperation (follow up)*. Geneva, World Health Organization, 1999 (document EB105/21)

Screening committees

112. As part of the renewed managerial framework for CCs, it was recommended that screening committees for CCs should be established at both global and regional levels. This was done in mid-2000.

113. **The Global Screening Committee (GSC)** acts as an interregional body advising the Director-General on issues pertaining to CCs. Its role includes making recommendations to the regional directors concerning the acceptance or rejection of proposals to designate an institution as a CC. The GSC is chaired by a senior staff member from WHO headquarters, currently the Assistant Director-General of the Evidence and Information for Policy cluster.

114. Following the establishment of the GSC, **regional screening committees** or equivalent mechanisms for formal screening at regional level were mandated to be set up. In the European Region, the Regional Screening Committee is composed of the members of the Regional Office's Executive Management.

Administration of collaborating centres

115. During the review of CCs it also became apparent that it was necessary to tighten up the rules applicable to the (re)designation and discontinuation process. To ensure that this was done in a consistent manner across WHO, it was decided that focal points would be nominated in each regional office and at headquarters. Their overall role would be to ensure liaison and communication between technical units at headquarters and in the regions, WHO country offices, CCs and governments. Focal points manage and coordinate statutory information and administrative procedures relevant to CCs.

116. To facilitate management, cooperation and networking, a global information system on all CCs[5] was developed and made accessible to WHO staff, CCs, Member States and the public health community at large.

117. The new administrative procedures came into effect in August 2001, notably without any distribution of central funds to the regions who would be shouldering the major burden of the administrative work. The total cost of managing CCs has been conservatively estimated at US$ 1.5 million per biennium.

Clean-up process

118. With the establishment of the global database on CCs, it quickly became evident that there were a large number of seemingly dormant CCs with whom WHO no longer had documented active collaboration. In order to regularize this situation, a clean-up operation was started.

Implications for the Regional Office

119. One hundred and eight CCs in 22 countries in the European Region were discontinued in the first phase of the clean-up process. This process was laborious and led to concern both from technical units and the CCs concerned, as well as from some governments. In fact, what was thought to be a rather straightforward administrative action with regard to centres whose agreements had long expired created more turbulence than anticipated, and representatives of several Member States intervened on this issue at the last session of the Regional Committee in September 2004.

Current status

120. The process has led to a marked reduction in the total number of centres, especially in the European Region. However the number of CCs is always changing; while the clean-up process is still underway, new centres are also simultaneously being designated.

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[5] http://whocc.who.int

Table 1. WHO collaborating centres by region of location, 2002 and 2005

Year	Africa	Americas	Eastern Mediterraean	Europe	South-east Asia	Western Pacific	Total
2002	36	264	56	**483**	88	210	1137
2005 (1 June)	27	197	58	**350**	78	193	903
Trend	*-9*	*-67*	*+2*	*-133*	*-10*	*-17*	*-234*

121. Of the current 350 CCs in the European Region, 264 are mainly working with WHO headquarters, 85 with the Regional Office for Europe, and one with another regional office (SEARO).

Table 2. Status of WHO collaborating centres in the European Region, 1 June 2005

Initiated by	HQ	SEARO	EURO	Total
Active	242	1	75	318
Pending (redesignation/discontinuation)	22	–	10	32
Total	264	1	85	350

Future strategy

122. Between 1999 and the present, substantial improvements have been made to the administrative aspects of managing CCs. At present it is fair to say that the administrative process has been streamlined, as common protocols and electronic tools have been developed for the designation/redesignation process.

123. However, there are still a number of shortcomings in the manner in which the Organization deals with CCs, related to the lack of an overall strategy and plan for WHO's interaction with them.

Next steps

124. Within WHO's statutory evaluation framework, the GSC has proposed that the thematic evaluation for the biennium 2006–2007 should be on the CCs and would involve all regions. The outcome of this evaluation would then be discussed in WHO's governing bodies at both regional and global levels, and steps would be taken to establish a future strategy on CCs in light of the recommendations from that evaluation.