



World Health  
Organization

REGIONAL OFFICE FOR  
Europe

REGIONAL COMMITTEE FOR EUROPE  
SIXTY-THIRD SESSION

Çeşme Izmir, Turkey, 16–19 September 2013



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Progress reports





**World Health  
Organization**

REGIONAL OFFICE FOR

**Europe**

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**Regional Committee for Europe**

Sixty-third session

EUR/RC63/18

**Çeşme Izmir, Turkey, 16–19 September 2013**

23 July 2013

131409

Provisional agenda item 5(k)

ORIGINAL: ENGLISH

## **Progress reports**

This document contains consolidated progress reports on:

- (a) the implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011–2015
- (b) tobacco control in the WHO European Region
- (c) nutrition, physical activity and obesity in the WHO European Region
- (d) the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016
- (e) the health-related Millennium Development Goals in the WHO European Region: 2013 update
- (f) the implementation of the International Health Regulations (2005)
- (g) the European strategic action plan on antibiotic resistance

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## **Progress report on the implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011–2015**

### ***Introduction***

1. Since the endorsement of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis (M/XDR-TB) in the WHO European Region 2011–2015 and the adoption of its accompanying resolution, EUR/RC61/R7, by the WHO Regional Committee for Europe at its sixty-first session (RC61) in September 2011, most of the milestones outlined in the Consolidated Action Plan have been met. The Secretariat's key achievements include the establishment of the Green Light Committee (GLC), along with the provision of state of the art technical assistance to Member States on multidrug-resistant tuberculosis (MDR-TB), and the launch of the European TB Laboratory Initiative (ELI) to scale up quality diagnosis. Under the aegis of the Regional Director's special project to prevent and combat M/XDR-TB, task forces have been established to improve prevention and control of childhood TB, develop the role of surgery in TB treatment, draft a consensus document on cross-border TB control and care, and assess and address health system and social determinants of TB in line with Health 2020.

2. The Regional Director has conducted several high-level visits to Member States to discuss measures to improve health systems and address TB and M/XDR-TB. In October 2012, the Regional Director met the Prime Minister and the Minister of Health of Romania, together with the European Commissioner for Health and Consumers. The Secretariat and partners provided technical assistance for the introduction of a new revolutionary molecular diagnostic test. Treatment coverage for MDR-TB patients has increased from 63% of estimated MDR-TB patients in 2011 to 96% in 2013, although the treatment outcome (48.5%) is below the 75% target due to a lack of efficient medicines, poor programme performance and inadequate patient-centred approaches, as well as the lack of a mechanism for cross-border care. Of the 15 countries with high MDR-TB burdens, nine had achieved universal access to MDR-TB treatment and care by January 2013. Six other Member States are progressing towards the provision of treatment for all patients. That notwithstanding, gaps persist in some Member States with patients still on waiting lists to receive treatment.

3. Despite having relatively high TB and MDR-TB rates, the Baltic states have successfully halted the further increase of MDR-TB. The impact of the economic crisis on TB as a social disease is yet to be evaluated. The management of patients crossing borders is still not being fully addressed by most Member States.

4. In the absence of effective treatment, resistant strains of TB will spread in health care facilities and communities, with serious consequences for the financial and human resources of health care systems.

### ***Background***

5. The WHO European Region has a broad TB burden, ranging from less than one TB case per 100 000 population in some Member States to over 200 TB cases per 100 000 in others.

Even within countries there is a wide range in TB incidence; in some districts and capitals of western Europe, TB rates above 100 in 100 000 are not uncommon.

6. Regional Committee resolution EUR/R61/R7 requests the Regional Director to assess progress in the prevention and control of M/XDR-TB at the Regional level every other year, starting in 2013, and to report these findings to the Regional Committee. The Consolidated Action Plan, which was developed through broad consultation with Member States, civil society organizations and technical and bilateral agencies and communities, sets the ambitious target of detecting more than 85% of estimated MDR-TB patients and treating at least 75% of them successfully, in order to curb this epidemic.

## **Situation analysis**

### **Epidemiological trends**

7. In 2011,<sup>1</sup> of an estimated 380 000 new TB cases in the European Region, 295 968 new cases were reported. Since 2007, TB notification has been decreasing in the Region by an average of 5% per year. More than 44 000 deaths were attributed to TB in 2011.

8. Among newly reported TB cases, the number of MDR-TB cases increased steadily from 4% in 2005 to 14% in 2011, confirming ongoing transmission. Of an estimated 78 000 MDR-TB cases, about 30 000 (38%) were detected in 2011, 98% of those were reported in 18 high TB priority countries.<sup>2</sup> The prevalence of MDR-TB among previously treated TB patients was 47.22% in 2011: a slight decrease from 48.2% in 2010. Despite having tripled since the endorsement of the Consolidated Action Plan, coverage of second line drug susceptibility testing is still only 9%, proving that up to 2% of all MDR-TB cases are extensively drug resistant.

9. Although TB/HIV co-infection is not as common in the WHO European Region as it is in other WHO regions, an increasing HIV prevalence among TB cases has been observed – from 2.8% in 2007 to 6.4% in 2011.

### **Financing TB and MDR-TB interventions**

10. Several Member States have requested and are receiving assistance from the Regional Office in the revision of their financing mechanisms and support in budgeting for their TB prevention and control interventions, to improve programme efficiency.

11. The Regional Office has been helping eligible countries to apply to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other donors. However, with the Global Fund's cancellation of Round 11 and the delay in announcing the new funding mechanism to replace it, implementation of MDR-TB and health system strengthening interventions have not been scaled up as expected in some Member States.

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<sup>1</sup> Please note that TB surveillance data is collected over the course of one year and analysed the following year. In other words, data used in this progress report (January 2013) refer to the cases registered in 2011. This is to allow countries to verify their data and establish the treatment outcomes for newly and previously treated patients.

<sup>2</sup> Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Romania, Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan.



12. Extensive programme reviews conducted jointly by the Regional Office and the European Centre for Disease Prevention and Control (ECDC) in some countries of the European Union show that some of the results previously achieved may be threatened as a result of the financial crisis and budget cuts.

## **Achievements and Challenges**

### **Intervention area 1: Preventing the development of M/XDR-TB**

13. The Regional Office and partners, in collaboration with Member States, assessed reasons for defaulting from treatment in several settings. Social determinants were included in the drug resistance surveillance system. A TB/MDR-TB health system assessment tool was developed and implemented in several Member States to document the key challenges to the six health systems building blocks and recommend measures both to prevent the emergence of drug resistant TB and to scale up effective treatment. In several Member States, including the Baltic states, MDR-TB rates have stabilized.

14. The emergence and spread of drug resistant forms of the disease, with inadequate treatment and insufficient patient support mechanisms, however, still prevail in some Member States, including some members of the European Union. Some Member States hospitalize patients unnecessarily which, in the absence of adequate airborne infection control, can lead to nosocomial transmission of drug resistant forms of TB. Ambulatory services and other models of care, including home-based treatment, do not function fully in some Member States.

15. There is a lack of evidence of effective prophylactic treatment for contacts of M/XDR-TB patients.

### **Intervention area 2: Increasing access to testing for resistance to first and second line anti-TB drugs and to HIV testing among TB patients**

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

17. Decreases in funding as a result of the financial crisis have led to difficulties for Member States in respect of scaling up their diagnostic capacities and improving biosafety.

### **Intervention area 3: Scaling up access to effective treatment for all forms of drug-resistant TB**

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

19. Member States have increased access to second line anti-TB drugs for treatment of M/XDR-TB patients (96% treatment coverage).

20. The Regional Office has established the GLC and provided technical assistance on the clinical and programmatic management of drug-resistant TB to high MDR-TB burden countries, both through country visits and remote advice. The Regional Office and European Respiratory Society (ERS) have launched an electronic consilium (<https://www.tbconsilium.org/>) for clinical management of difficult-to-treat patients, in English and Russian, for practitioners to consult.

21. Outside the projects supported internationally, by WHO or by the GLC, the success rate for treatment of MDR-TB patients is extremely low (28% in some settings). This is mainly due to incomplete treatment regimens and a lack of full access to all necessary second line TB drugs. In some countries of western Europe, clinical practices are below standard, with long delays in diagnosis due to lack of expertise, poor patient management and inadequate patient follow-up.

#### **Intervention area 4: Improving TB infection control**

22. The Regional Office and other partners have provided technical assistance to Member States to finalize their national TB infection control action plans, to be integrated either into their national TB plans or their national health strategies. The Regional Office has developed a set of key procurement specifications for TB infection control.

23. The Secretariat has been helping Member States to improve airborne infection control in health care facilities and congregate settings. These measures, however, have not yet been scaled up in some Member States, owing to a lack of administrative, environmental and respiratory protection interventions. Health care facilities and congregate settings thus continue to contribute to the further spread of TB and drug-resistant TB. Some Member States deport migrants with TB without considering the public health and human rights issues involved or without taking adequate infection control measures.

#### **Intervention area 5: Strengthening surveillance, including the recording and reporting of drug-resistant TB and monitoring treatment outcome**

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

25. The Regional Office assisted several Member States in conducting nationwide drug resistance surveys.

26. The Regional Office and ECDC have held annual meetings for TB surveillance focal points in order to coordinate surveillance in the Region.

27. Data on testing for second line drug susceptibility is still limited and electronic data management is lacking in many Member States, which adds to difficulties in analysing programme performance. Some Member States in western Europe do not report treatment outcomes and hence miss opportunities to document the efficiency of their TB control interventions.

#### **Intervention area 6: Broadening countries' capacity to scale up the management of drug-resistant TB, including advocacy, partnership and policy guidance**

28. The Regional Office has assisted high TB priority Member States in updating and finalizing their national MDR-TB response plans and organized a Regional workshop to help Member States prepare national TB strategic plans that incorporate MDR-TB. The Regional Office has also developed a TB governance assessment tool and assisted several Member States in improving the structure of their national programmes.

29. The Regional Office, in collaboration with ECDC and the KNCV Tuberculosis Foundation, organized a national TB programme managers' meeting in The Hague, the Netherlands, in May 2013 to discuss progress in implementing national and regional action

plans, including the Consolidated Action Plan to Prevent and Combat M/XDR-TB in the WHO European Region 2011–2015.

30. Based on requests from Member States, the Regional Office and partners organized external programme reviews in Armenia, Azerbaijan, Belarus, Hungary, Kazakhstan, Norway, Slovakia and Ukraine.

31. The Regional Office launched the Regional Interagency Collaborating Committee on TB Control (RICC-TB) in December 2012 to improve partnerships and strengthen coordination among partners.

32. The Regional Office has provided guidance for Member States revising their frameworks for TB-related ethics and human rights.

33. The Secretariat has involved civil society representatives in all Regional meetings and extensive programme reviews. The Regional Office has supported the work of the TB Europe Coalition and other civil society organizations and engaged them in planning and implementing interventions. Although there are some exceptions, there are few Member States in which civil society organizations are involved in TB control. Furthermore, palliative care for TB patients is not available in many Member States.

34. Regional Office representatives attended and made presentations at several European Parliament hearings on TB and MDR-TB. The Regional Office also organized a photography exhibition, “Faces of Tuberculosis”, at the European Parliament on 20 March 2013.

### **Intervention area 7: Addressing the needs of special populations**

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

36. The Secretariat has provided technical assistance to Member States to improve coordination between prison and civilian health services. Guidance and policy papers have been developed and distributed among the Member States through the Health in Prisons Project network. Those efforts notwithstanding, there are still gaps in coordination between civilian and penitentiary services.

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

38. The Regional Office has finalized and published a paper entitled “Minimum package for cross-border TB control and care in the WHO European Region: a Wolfheze consensus statement”.<sup>3</sup>

39. There is an urgent need for research and development on new medicines and vaccines for TB and M/XDR-TB. The Regional Office is assisting Member States in introducing bedaquiline as the new TB medicine under specific conditions and with special attention to

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<sup>3</sup> Dara M et al. Minimum package for cross-border TB control and care in the WHO European Region: a Wolfheze consensus statement. *European Respiratory Journal*, 2012, 40(5):1081–1090.

pharmacovigilance. Another new drug is expected to be introduced in 2014. Vaccine trials in other regions are ongoing.

### **Next steps**

40. The Regional Office will continue to support Member States in their implementation of the Consolidated Action Plan in the context of Regional Director's special project. The Regional Office will continue working with members of the European Parliament, ECDC, the European Commission and other key partners to raise awareness about TB and MDR-TB prevention and control.

41. A compendium of best practices for models of health system interventions for MDR-TB prevention and care will be prepared and a workshop for the WHO European Region will be organized in 2013 in order to share experiences on scaling up patient-centred ambulatory care.

42. The Regional Office and supranational TB reference laboratories, in collaboration with national TB reference laboratories, will develop a three-year TB laboratory development plan in the Region's 18 high TB priority countries by the end of 2013.

43. In follow-up to the drug resistance survey and efforts to update national surveillance systems, the Regional Office will help Member States and other partners to calculate reliable estimates of MDR-TB prevalence by the end of 2013.

44. The Regional Office will provide technical assistance to Member States to improve their TB programme performance and efficiency and to embark on the introduction and rational use of new TB drugs. Extensive programme reviews will be organized in the Republic of Moldova, the Netherlands and Tajikistan in 2013.

45. The Regional Office will support eligible Member States' applications to The Global Fund to Fight AIDS, Tuberculosis and Malaria.

46. In collaboration with ECDC and ERS, the Regional Office will conduct a survey on interventions to move towards TB elimination in countries with low TB incidence. The Regional Office will finalize a consensus document on the role of surgery in TB and M/XDR-TB in 2013.

## Progress report on tobacco control in the WHO European Region

### Introduction and background

47. The European Strategy for Tobacco Control (ESTC) reflects the increased political commitment to, and public health expectations of, tobacco control in the WHO European Region. It was adopted by the WHO Regional Committee for Europe at its fifty-second session in September 2002 in resolution EUR/RC52/R12. The Strategy builds on the lessons learned from assessment of the three consecutive European tobacco action plans,<sup>4</sup> the guiding principles set out in the Warsaw Declaration for a Tobacco-free Europe (2002) and the evidence underpinning tobacco control policy at national, regional and international levels.

48. The ESTC predates the adoption of the WHO Framework Convention on Tobacco Control (WHO FCTC) and is required to be regularly reviewed and strategically adapted as appropriate.

### Situation analysis

49. The European Region currently has the highest tobacco use among adults of all the WHO regions. Although the prevalence of tobacco use among men is higher in the Western Pacific Region than in the European Region, far more women in the European Region use tobacco than in the other regions. In virtually all countries of the European Region, tobacco smoking among women is still lower than among men. Nevertheless, there are several countries where the gap is very small and in a few countries more women than men smoke tobacco on a daily basis.

50. The tobacco industry markets smokeless tobacco as a milder, less harmful alternative to cigarettes and other smoked tobacco. The emerging forms of available smokeless tobacco should be monitored carefully. In the European Region, slightly more than a quarter (15 out of 53) of the Member States currently collect data on smokeless tobacco use. Moreover, although trends cannot be observed from the limited data available, an increase in smokeless tobacco use has been observed in a few countries.

51. The European Region has one of the highest levels of tobacco use among young people. In contrast to the men: women ratio among adults, the boy: girl ratio among adolescents is much smaller. As is the case with adults, some countries actually have a higher prevalence of tobacco use among girls than among boys.

### Current trends and gaps

52. Since the adoption of the WHO FCTC in 2003 and its entry into force in 2005, the European Regional trend has been that of a decrease in tobacco use in men (except for four countries) and a stabilization or reduction in females (except for nine countries). Without gender-specific tobacco control strategies, tobacco use by females will continue to rise and will eventually drive the increase in tobacco-attributable deaths.

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<sup>4</sup> *Action Plan on Tobacco* (document EUR/RC37/7, 1987); *Action Plan for a Tobacco-free Europe* (document EUR/RC42/9, 1992); *Third Action Plan for a Tobacco-free Europe 1997–2001* (document EUR/ICP/LVNG 01 04 01, 1997).

53. Tobacco use among adolescents is increasing; in some countries, its use among young people is very similar to that among adults.

54. There are insufficient data on changes in the use of smokeless tobacco over time. Nevertheless, one can expect to observe an increase in its use, particularly as more countries strengthen their policies of establishing 100% smoke-free public areas.

### ***Achievements and challenges in each strategic direction***

55. The WHO FCTC tackles the tobacco epidemic by providing an internationally coordinated response. Its success can be measured by the level of political commitment to it, the degree of its implementation and the impact of the measures set out in the Convention.

#### **Political commitment**

56. As of February 2013, a total of 49 of the 53 European Member States of WHO, as well as the European Community, are Parties to the Convention. Becoming a Party implies a legal obligation to commit to implementing the provisions of the Convention and also gives Parties the legitimacy to press for strong and comprehensive tobacco control measures.

#### **Implementation of the WHO FCTC**

57. In general, the European Region has made good progress in the implementation of the WHO FCTC since its adoption by the World Health Assembly in 2003, although there remain several areas where improvements can be made.

58. It is important to note that strong, comprehensive tobacco control measures are necessary to prevent and eliminate tobacco use. Several countries in the Region have taken such a comprehensive approach in applying the WHO FCTC, including Hungary, Ireland, Malta, Spain, Turkey, Ukraine and the United Kingdom. The Region leads, globally, in the implementation of Article 6 (Price and tax measures to reduce the demand for tobacco) and Article 14 (Demand reduction measures concerning tobacco dependence and cessation) of the Convention. Between 2008 and 2010, a total of 17 Member States substantially raised taxes on tobacco products. In 42 Member States, taxation comprises 50% or more of the retail price of tobacco products. Two thirds of the countries in the Region offer nicotine replacement therapy and some services to help people quit smoking, for at least one of which the cost is covered. Some 62% of countries offer a telephone service so that callers can have a live discussion on smoking cessation.

59. The European Region is, however, weaker in the implementation of Articles 5 (General obligations), Article 8 (Protection from exposure to tobacco smoke), Article 11 (Packaging and labelling of tobacco products), Article 12 (Education, communication, training and public awareness) and Article 13 (Tobacco advertising, promotion and sponsorship). In their Parties' reports, Parties in the WHO European Region have identified numerous challenges to the implementation of comprehensive tobacco control policy, including: lack of financial and/or human resources, tobacco industry interference, lack of political will, and the need for strengthened intersectoral collaboration and coordination.

#### **Tobacco control in the Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016**

60. The Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 clearly emphasizes the importance of tobacco control, with a strong focus on fiscal and marketing policies.



## *Governance*

61. The Regional Office, together with the Convention Secretariat, has worked closely with national governments and Member States to facilitate the implementation of the WHO FCTC through the support, development and implementation of national legislation, policies and action plans. In 2012, national action plans for the prevention and control of noncommunicable diseases were developed in Bulgaria, Lithuania and Ukraine. In addition, the Regional Office provides technical support to Member States in strengthening community empowerment through the use of national communication campaigns to raise awareness of tobacco control. One example of this is the campaign currently being undertaken in the Republic of Moldova.

## *Strengthening surveillance, monitoring and evaluation, and research*

62. The revised protocol of the Global Youth Tobacco Survey (GYTS) was introduced in 2012 as a result of expert reviews and recommendations aiming to align the surveillance and monitoring of tobacco use by young people with the WHO FCTC. The Global Adult Tobacco Survey (GATS) has been expanded from Poland, Romania, the Russian Federation, Turkey and Ukraine to include Greece and Kazakhstan in 2013/2014, together with a repeat survey in Turkey. Several other countries have expressed interest in GATS, and discussions are ongoing in integrating core GATS questions into existing national health surveys.

63. The Regional Office's Tobacco Control Database was launched in November 2012, initially containing information on the implementation of Article 13 of the Convention. It is unique in providing access to the relevant provisions of national laws, translated into English, and allowing for country comparisons.

64. Data collection and validation for the latest in the annual series of WHO reports on the global tobacco epidemic have been completed for all 53 Member States of the European Region. The report illustrates the implementation of the WHO FCTC and will be launched in the summer of 2013. It draws on a variety of sources, not least the Reports of the Parties to the Convention.

## *Strengthening capacity to respond to tobacco industry interference*

65. A series of advocacy and evidence briefs has been prepared, to be launched in 2013, providing a compilation of evidence from countries in the European Region that have implemented strong tobacco control measures. The series showcases the effectiveness of these measures and rebuts common fallacies disseminated by the tobacco industry.

66. A publication entitled Tobacco industry interference in the WHO European Region was launched on the occasion of World No Tobacco Day 2012. This booklet shows how the industry interferes with tobacco control and how countries respond. Furthermore, the Regional Office has developed specific strategies promoting female empowerment, a demographic area in which tobacco use is on the rise.

## *Promoting health via fiscal and marketing policies*

67. The Regional Office supports Member States in prioritizing the protection of public health by supporting the implementation and adoption of significant legislation, including increasing taxes on and banning the marketing of tobacco products.

68. The Regional Office is currently preparing a collection of case studies featuring "the art of the possible". The case studies, to be issued in 2013, show what can be done, given determination, effort and goodwill, when a country implements the WHO FCTC. Among other

measures, two of the case studies apply to fiscal policies (highlighting Ukraine) and marketing policies (highlighting France).

69. In November 2012, the Regional Office co-organized with WHO headquarters a meeting on tobacco taxation, bringing together high-level officials concerned with finance, customs and health from Belarus, Kazakhstan, the Russian Federation and Ukraine. The aim was to pave the way for a multisectoral technical working group, involving several countries in the Region, which will work on increasing tobacco taxes through taxation modelling. Several other Member States, including Estonia, Latvia, Lithuania and the Republic of Moldova have shown interest in joining the working group.

### *Promoting health in settings*

70. One of the case studies mentioned in paragraph 22 focuses on the experience of Turkey, one of the leaders in the Region with a comprehensive approach to tobacco control and the leader in smoke-free public places. Also, one of the advocacy and evidence briefs mentioned in paragraph 19 focuses on smoke-free environments, providing a compilation of evidence on the effectiveness of this measure from other countries in the Region that have implemented it.

## **The way forward**

### **What it means to meet the proposed global target of a 30% relative reduction in current tobacco use among adults aged 15+ years by 2025**

71. Currently, the prevalence of tobacco use in the countries of the European Region falls mostly within the 21–30% range, followed by a proportion in the 31–40% range. Assuming a 30% relative reduction in each country, in 2025 over 50% of countries in the Region would fall within the 10–20% prevalence range and slightly more than a quarter would fall within the 21–30% range. Only one country would be in the 31–40% range and there would be none in the upper limit.

72. Based on preliminary projections for 2025, various trend patterns are anticipated, with many countries showing either a decreasing or stable prevalence. However, three countries are projected to show an increase in prevalence. Contrary to what would be achieved with a 30% relative reduction in each country, 30% of countries in the Region would fall within the 10–20% prevalence range, 22.5% would fall within the 21–30% range and 22.5% would be in the 31–40% range. Also, 17.5% would fall within the 41–50% range and 7.5% would exceed 51%. Some 10% of countries would have a prevalence of between zero and 9%.

### **What are the priority areas for meeting the proposed global target?**

73. Substantial progress continues to be made in implementing the WHO FCTC and its Guidelines. Clear evidence illustrates that the WHO FCTC, through its legal obligations to Parties, leads governments to take strong action against tobacco. Becoming a Party to the Convention implies a commitment to its provisions and also confers the legitimacy and obligation to press for strong tobacco control measures.

74. As a high priority, in 2014–2015 the Regional Office will:

- continue to support the four remaining countries in the Region in ratifying the WHO FCTC;
- continue to support the comprehensive implementation of the WHO FCTC, while paying special attention to scaling up implementation in the areas where gaps currently exist in the Region, namely Articles 5 (General obligations), 8 (Protection from exposure to



tobacco smoke), 11 (Packaging and labelling of tobacco products) and 13 (Tobacco advertising, promotion and sponsorship) and their Guidelines;

- promote, in close collaboration with the Convention Secretariat, the signature and ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products, which, as a new legal instrument complimenting the WHO FCTC, requires particular attention from governments;
- support the monitoring of and introduce policies to address the accelerated uptake of tobacco use among women and adolescent girls and the observed increase in the use of smokeless tobacco and electronic cigarettes;
- disseminate the experience of countries that are taking strong measures (such as on standardized packaging), since such leaders can further stimulate the momentum in the Region; and
- in line with the Health 2020 policy framework, create and strengthen connections between efforts directed specifically against tobacco and those actions often directed by different players towards the environment (such as smoke-free public places), child and maternal health (such as smoking cessation among pregnant women) and tuberculosis control.



## **Progress report on nutrition, physical activity and obesity in the WHO European Region**

### ***Introduction and background***

75. Poor diet, overweight and obesity are among the most important contributors to many noncommunicable diseases (NCDs), including cardiovascular diseases and cancer, the two main causes of premature death in the WHO European Region. National surveys in most countries reveal a picture of excessive fat intake, low fruit and vegetable consumption and an increasing level of obesity, all of which not only shorten people's life expectancy but also reduce their quality of life. Obesity (a body mass index of 30 or higher) is estimated to kill some 320 000 people in 20 western European countries each year. The rate of obesity in some areas of eastern Europe is also high and has risen more than threefold since 1980. After infancy, a poor diet, too little physical exercise and obesity are often linked to each other and to a cluster of risk factors that are far more common in people on a low income than in more affluent groups. In the European Union, for example, low-income households consume the lowest amount of fruit and vegetables. Women from lower socioeconomic groups in eastern European countries are at particular risk of eating too little fruit and vegetables. There are differences between the sexes in the prevalence of overweight and obesity, with a higher prevalence in males visible from childhood. Children who declared their families to be of lower socioeconomic status reported a higher level of "snacking", that is, eating foods high in fat and added sugar and poor in other nutrients.

76. Unfortunately, the picture is not improving in most countries of the Region. On the contrary, figures for about a third of the European Member States show that overweight affects 25–70% of individuals and that between 5% and 30% of adults are obese. National figures for children show that, on average, 24% aged 6–9 years are overweight or obese with a range of 18–45%.

77. Physical inactivity is also undermining Europe's health. Every year, some one million deaths in the European Region are related to physical inactivity. Four out of ten adults do not engage in any form of moderate physical activity in a typical week. More than eight in every ten adolescent girls do not engage in sufficient physical activity.

78. The European Charter on Counteracting Obesity, unanimously approved in 2006 by the European Member States, can be considered the inspiration behind action on nutrition, physical activity and obesity in Europe. In this Charter, the countries identified a set of possible actions and committed themselves to accomplishing them in order to achieve the desired levelling off or reduction of obesity in general and childhood obesity in particular. Other policy statements and resolutions of the World Health Assembly and the WHO Regional Committee for Europe have provided the strong mandate for the action that has subsequently been taken by the Regional Office Secretariat, namely:

- the Global Strategy on Diet, Physical Activity and Health (2004);
- the WHO European Action Plan for Food and Nutrition Policy 2007–2012 (2007);
- the Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases 2008–2013 (2008);
- the set of recommendations on the marketing of foods and non-alcoholic beverages to children (2010);

- the resolution on infant and young child nutrition (resolution WHA63.23) (2010);
- the Political Declaration of the High-level Meeting of the [United Nations] General Assembly on the Prevention and Control of Non-communicable Diseases (2011); and
- the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (2012).

79. To support implementation of the WHO European Action Plan for Food and Nutrition Policy 2007–2012, the Regional Office has worked with its six action networks, consisting of and led by countries committed to implementing specific actions on salt reduction, school nutrition, the marketing of food to children and hospital nutrition.

80. The Regional Office's programme on nutrition, physical activity and obesity under the Division of Noncommunicable Diseases aims to ensure that Member States:

- develop and implement obesity prevention and control action plans, including a focus on healthy eating and physical activity, based on the principles of the European Charter on Counteracting Obesity; and
- develop, implement and evaluate national plans and strategies for the promotion of appropriate nutrition in accordance with the WHO European Action Plan for Food and Nutrition Policy 2007–2012, giving priority to the surveillance of nutritional status and to population monitoring with a focus on children.

### **Situation analysis**

81. The majority of the Member States have set up mechanisms to promote healthy eating and physical activity and prevent obesity as a follow-up to the recommendations of the European Charter on Counteracting Obesity and the WHO European Action Plan for Food and Nutrition Policy 2007–2012. Nevertheless, there is still much to be done in terms of implementation. Overweight is one of the largest public health challenges of the 21st century: all countries are affected to various extents, particularly among lower socioeconomic groups.

82. For some countries and among some minority groups in many countries, undernutrition remains an important issue. Up to 30% of children in some countries show stunting, and the Regional Office is committed to eliminating undernutrition from the Region as soon as possible.

83. Monitoring and surveillance is an important focus of the Regional Office's work on nutrition. In 2011, the Office unveiled the WHO European database on nutrition, obesity and physical activity (NOPA). Created in collaboration with health ministries in countries and with the support from the European Commission, NOPA includes details of more than 300 national and subnational policies in the European Region. The European Childhood Obesity Surveillance Initiative (COSI), established as a standardized European surveillance system, was expanded to include 19 countries in 2012. This tool is already one of the most powerful obesity surveillance mechanisms in the world.

84. Several Member States have strengthened or initiated decisive action to counteract unhealthy types of dietary behaviour that increase the likelihood of people suffering from obesity, diabetes, cardiovascular diseases and cancer. These include the reduction of salt intake (38 countries) and the elimination of *trans* fat from the diet (5 countries).

85. Furthermore, Member States are involved in WHO nutrient profiling initiatives to test different models to be used, for example, in food procurement for schools and hospitals. A total of 21 countries now include in their strategies for the first time restrictions on marketing food to children. Finally, several countries have initiated policies to protect public health through

pricing policies, namely by increasing taxes on “unhealthy” foods and considering subsidizing healthy foods such as fruit and vegetables.

## ***Achievements and challenges***

86. Through the WHO European Action Plan for Food and Nutrition Policy 2007–2012, the Regional Office developed, implemented and evaluated actions to promote healthy diets and proper nutrition in the Region. The Action Plan aimed to establish health, nutrition, food safety and food security goals while developing consistent and coherent actions across government and private sectors. As a result, technical support was provided to Member States in developing governance models through country-specific action plans incorporating strategies that strongly address NCDs. In July 2013, the Regional Office held the WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020 in Vienna, Austria. The conference addressed policy options on nutrition and provided an opportunity to consider nutrition and diet in the Region in the context of Health 2020.

87. The Regional Office has continued to support countries with Biennial Collaborative Agreements (BCA) that include activities to eliminate *trans* fats from the diet. Furthermore, Austria, Denmark, Iceland, Sweden and Switzerland aim to ban *trans* fats from their foods at manufacturer level, and Tajikistan will introduce food sampling in 2013 so that foods can be analysed for *trans* fat content. Industry action has also been conducive to *trans* fat reduction, for example, in the Netherlands and the United Kingdom. Other Member States, such as Finland, have implemented successful policies for reducing saturated fat from the diet and others have, for the first time, included in their policies clear aims with regard to saturated fat reduction.

88. Salt consumption has also been addressed and was one of the core themes of World Health Day in 2013. This event was used to launch an update of salt reduction policies, complemented by a publication addressing current policies in the European Region. The Regional Office has continued to support the implementation of BCA activities in countries in the improved monitoring of salt intake (through 24-hour collection samples), sampling and study design, thus improving the validity of findings. In several countries, such as Albania, Estonia and Portugal, efforts have been made to collaborate with stakeholders on reducing salt in processed foods and increasing awareness through the development of targeted public health messages. Three policy briefs are in the final stages of preparation, with one focusing on obesity and sedentarism. Additional activities include strengthening ties with the European network for the promotion of health-enhancing physical activity (HEPA Europe) to support the development of physical activity guidelines in Portugal and Turkey. Healthy nutrition has also been promoted in the school setting through the development of a collection of papers on school nutrition in the European Region.

## ***The way forward***

89. In response to trends and challenges, the Regional Office should focus on:

- monitoring and surveillance of nutritional status, physical activity levels, dietary habits and policy developments;
- developing tools and programmes for the promotion of physical activity in Member States; and
- within the context of Health 2020, revisiting and implementing the principles of the European Charter on Counteracting Obesity and the WHO European Action Plan for Food and Nutrition Policy 2007–2012, reinforced by:

- the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016;
- the WHO global monitoring framework and targets for prevention and control of NCDs;
- the Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases 2008–2013; and
- plans for implementing the WHO Global Strategy for Infant and Young Child Feeding.

90. Priority should be given to:

- coordinating regional and national actions on:
  - implementing salt reduction strategies
  - tools and programmes for the promotion of physical activity
  - eliminating *trans* fat and reducing saturated fat and added sugar in the diet
  - promoting active transport policies;
- supporting Member States in the evaluation of the WHO European Action Plan for Food and Nutrition Policy 2007–2012, focusing on reducing inequalities; and
- implementing obesity prevention and control mechanisms based on the principles of the European Charter on Counteracting Obesity and the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020.

## **Progress report on the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016**

### ***The global and regional contexts***

91. Over the past two years, noncommunicable diseases (NCDs) have risen on the global public health agenda. The First Global Ministerial Conference on Healthy Lifestyles and NCD Control was held in April 2011, hosted by the Russian Federation, and culminated in the adoption of the Moscow Declaration, which was subsequently endorsed by the World Health Assembly, in its resolution WHA64.11. In September 2011, the WHO Regional Committee for Europe, at its sixty-first session (RC61), adopted the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (European NCD Action Plan 2012–2016). One week later, a High-level Meeting of the United Nations General Assembly gathered together global leaders in New York, and culminated in the adoption of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases (United Nations Political Declaration).

92. Moreover, the Regional Committee, at its sixty-second session, approved the new European policy framework to support action by governments and society for health and well-being, Health 2020. Health 2020 presents a set of effective, integrated strategies and interventions for addressing major health challenges in the Region, including NCDs. The effectiveness of these public health and health care system interventions is based on equity, social determinants of health, empowerment and supportive environments.

### ***This report***

93. In its resolution WHA66.10, the World Health Assembly endorsed the WHO action plan for the prevention and control of noncommunicable diseases 2013–2020 and adopted a comprehensive global monitoring framework including nine voluntary global targets and 25 indicators.

94. This report should be considered an interim report, which will be followed by a full report, the European Noncommunicable Disease Report 2013, to be presented at the WHO European Ministerial Conference on the Prevention and Control of Noncommunicable Diseases to be held in Ashgabat, Turkmenistan, in December 2013. The European Noncommunicable Disease Report 2013 will describe trends, review progress and establish the European baseline for future evaluations.

95. This interim report should be considered in conjunction with the progress reports on tobacco control and on nutrition, physical activity and obesity in the WHO European Region.

### ***“One-WHO” actions on NCDs***

96. The WHO European Region has contributed actively to a number of products that were either adopted by the World Health Assembly in 2013 or presented to the United Nations General Assembly.

## Surveillance

97. Following the adoption of the United Nations Political Declaration by the United Nations General Assembly, WHO prepared a global monitoring framework for tracking progress in preventing and controlling major NCDs and their risk factors. The framework comprises 9 voluntary targets and 25 indicators and was adopted by Member States at the World Health Assembly in May 2013. The NCD indicators and targets in Health 2020 have been aligned with this global framework, with adjustments to take account of the fact that the European cut-off date is 2020, while that for global targets is 2025.

## Multisectoral action

98. As further follow-up to the United Nations Political Declaration, the Director-General prepared a report on options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership, contained in United Nations General Assembly document A/67/373. The report reviews existing partnerships in this area, lessons learned and successful approaches, and proposes models for global partnerships to prevent and control NCDs. The options presented here are consistent with the governance and whole-of-government elements of the European Health 2020 policy.

## Prevention and control

99. The new global action plan for the prevention and control of NCDs 2013–2020 was adopted by WHO Member States in May 2013. Its aim is to operationalize the commitments of the United Nations Political Declaration. It includes a list of cost-effective interventions and policy options for the prevention and control of NCDs, building on what has already been achieved. The structure of the global action plan, in six objectives, closely matches the priorities and actions of the European NCD Action Plan 2012–2016.

## Regional achievements

### Surveillance

100. To maximize the input of the European Member States into the development of the global monitoring framework, the WHO Regional Office for Europe held a Regional technical consultation on NCD surveillance, monitoring and evaluation, hosted by the Government of Norway, on 9 and 10 February 2012. At this meeting, Region-specific feedback and proposals were made on the feasibility and implications of the proposed framework.

101. In addition, as mandated by the World Health Assembly in May 2012, a web-based Regional consultation was organized on the draft global monitoring framework on NCDs in August 2012. The results were presented to RC62 and a decision on the global monitoring framework on NCDs was adopted (EUR/RC62(1)). This decision welcomed the global target of a 25% relative reduction in premature mortality from NCDs by the year 2025, agreed by the World Health Assembly. Furthermore, it referred to the outcome of the web-based consultation and emphasized that the selection of indicators must take into account the current monitoring capacity of Member States, so as not to increase their reporting burden unnecessarily.

102. In response to recent policy and strategy developments at European Union and global levels in the area of surveillance, the WHO Regional Office for Europe will organize a meeting on 9–11 September 2013 in Estonia. The aim will be to improve understanding of the data needs and quality issues for integrated surveillance of NCDs in Europe and of the priorities for action to address the remaining data challenges. National health information systems are being aligned with the global monitoring framework in a joint project between the WHO Regional Office for



Europe and the European Commission, which are also working in close cooperation to draft a new European Health Information Strategy.

### Multisectoral action

103. One of the goals of the European NCD Action Plan 2012–2016 is to “use fiscal policies and marketing controls to full effect to influence demand for tobacco, alcohol and foods high in saturated fats, *trans* fats, salt and sugar”.

104. The impact of price on tobacco and alcohol use is well established, and the WHO European Region has much experience in these areas. Over the past two years, many studies have explored the impact of price policies (including taxation and subsidies) on food supplies. Denmark implemented (and later repealed) a tax on saturated fats. Hungary implemented a tax on a range of food products defined as unhealthy within the law. France instituted a tax on certain sugary foods. When evidence was available, these taxes were shown to have an impact on consumer behaviour that may have public health consequences. Studies are still under way in these countries.

105. The WHO Regional Office for Europe has developed a package of supporting documents on fiscal policies,<sup>5</sup> which were used in a training seminar held on 24–26 September 2012 in Lithuania. Health decision-makers from Albania, Bulgaria, Croatia, Estonia, Hungary, Lithuania, Poland, Slovakia and Ukraine were offered an opportunity to understand the different aspects of using price policy to control NCDs and the principles of intersectoral action. The participating countries developed plans for advocacy and possible action in this promising field.

106. Over the past 10 years, the population of the United Kingdom has registered a significant decrease in salt intake, brought about by sound policies that include stakeholder engagement, reformulation and community interventions. This is one of the success stories of the European Salt Action Network, now led by Switzerland, which the Network is seeking to replicate among its other 22 members. Other countries, including Estonia, Finland, Montenegro, Portugal, Slovenia, Spain and Turkey, are preparing policies and showing leadership in this field.

107. Norway leads the 17-member European Marketing Network, the aim of which is to reduce marketing pressure on children. Norway has prepared a regulatory framework to reduce children’s exposure to foods that are high in fats, sugar and salt. It has also taken a series of actions, including nutrient profiling and stakeholder dialogue, with strong leadership from the health sector. Many countries in the Network are preparing approaches that are appropriate to their national contexts.

108. Many intersectoral projects in the field of NCDs were presented at Europe Day during the Eighth Global Conference on Health Promotion, held in Helsinki, Finland, on 10–14 June 2013, on the theme “Health in All Policies”. The Helsinki statement on “Health in All Policies” lends strong support to NCD efforts in the European Region.

### Prevention and control

109. On 25 and 26 January 2012, the WHO Regional Office organized a meeting in Amsterdam, Netherlands, on the contribution of strengthening primary care for the prevention and control of NCDs. The objective was to assist Member States and organizations in

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<sup>5</sup> Can fiscal policies reduce noncommunicable diseases? Copenhagen, WHO Regional Office for Europe, 2012 (<http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/sections/news/2012/10/can-fiscal-policies-reduce-noncommunicable-diseases2>; accessed 7 May 2013).

implementing the primary care actions and interventions described in the European NCD Action Plan 2012–2016, with a focus on cardiometabolic risk assessment.

110. A policy dialogue on strengthening public health services for improved NCD prevention and control was organized on 27–29 June 2012 in Astana, Kazakhstan, with the participation of Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Ukraine and Uzbekistan. A draft of the new global action plan for the prevention and control of NCDs was presented, and participants commented and shared their ideas.

111. The largest gap in implementation of the European NCD Action Plan 2012–2016 has been direct technical support to Member States on disease management approaches. Under the Region's sustainability plan, an investment is being made to recruit specialists in this field and this will be one of the two main objectives of the Regional Office's new geographically dispersed office on NCDs, which is currently under establishment.

### **Capacity building**

112. Four in-depth country assessments were conducted towards the end of 2012 in Armenia, Kyrgyzstan, Tajikistan and Uzbekistan, with the aim of developing national NCD strategies, action plans and policies. These assessments showed that training on NCDs was required for health sector decision-makers. While training courses on the subject are frequently organized, there is limited access to programmes in Russian. A course in Russian is being prepared, with the support of the Government of the Russian Federation and the First Moscow State Medical University, and the first group will be trained in October 2013.

113. In the context of health systems collaboration, more than 50 health professionals from Albania, Armenia, Azerbaijan, Bulgaria, Kazakhstan, Republic of Moldova, Romania, Russian Federation, Serbia, Spain, Tajikistan, Turkey, Ukraine and Uzbekistan participated in the annual Flagship Course on Health System Strengthening, held in Barcelona, Spain, from 25 September to 3 October 2012, which, that year, had a special focus on NCDs.

114. Representatives of Georgia, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation and Uzbekistan participated in international seminars on the public health aspects of NCDs, held on 7–12 May 2012 and 3–8 June 2013, in Geneva and Lausanne, Switzerland, respectively.

### **Health systems strengthening**

115. A collaboration led by the Division of Health Systems and Public Health, WHO Regional Office for Europe, including the Division of Noncommunicable Diseases and Life-course and the Harvard School of Public Health, will deliver two products in 2013: a review of the barriers in health systems to the prevention and control of NCDs, and a guide for decision-makers for self-assessment and planning. The latter is already being used for multidisciplinary assessments in five countries: Hungary, Kyrgyzstan, Republic of Moldova, Tajikistan and Turkey.

### **National achievements**

116. The European Noncommunicable Disease Report 2013, to be launched in Ashgabat, Turkmenistan, will contain detailed analyses of progress at country level. Some examples are given below.

117. Several countries in the Region have strengthened their health information systems, with improvements in routine and ad hoc data collection on NCDs. Azerbaijan, Turkey and

Uzbekistan have used the WHO STEPwise approach to surveillance (STEPS), which is a simple, standardized method for collecting, analysing and disseminating data on the main NCD risk factors. Armenia, Kyrgyzstan, Republic of Moldova, Tajikistan and Turkmenistan are planning to use STEPS during the current biennium.

118. Azerbaijan, Bulgaria, Estonia, Lithuania, Republic of Moldova and Ukraine received support from the Regional Office in preparing NCD strategies and plans. This took the form of missions, desk reviews and visits of country delegations to the Regional Office in Copenhagen, Denmark.

119. A project for strengthening health systems for the prevention and control of NCDs has started in Armenia, Kyrgyzstan, Tajikistan and Uzbekistan. These countries are receiving intensive support from WHO in preparing NCD strategies and policies and in strengthening their integrated surveillance systems. By RC63, these four countries will have conducted a first assessment, organized national multistakeholder consultations, drafted and possibly adopted national NCD strategies, action plans and policies, and be conducting STEPS surveys. As a follow-up to the Regional meeting on primary care and NCDs, a workshop on implementing the package of essential NCD interventions for primary care was organized in Tajikistan in December 2012 and in Uzbekistan in June 2013. These comprehensive initiatives were supported by the Government of the Russian Federation.

120. Within the Programme of Action for Cancer Therapy, WHO, in collaboration with the International Atomic Energy Agency, is helping Member States to optimize their investments in cancer prevention and control by assessing their cancer programmes and making recommendations. During the current biennium, missions will be organized to Armenia, Montenegro, Republic of Moldova, Romania and Tajikistan. The Regional Office supported preparation of a palliative care plan in Ukraine in September 2012 and the second annual "Walking for the Cure" event in Turkey in November 2012, to promote breast cancer awareness.



## **Progress towards health-related Millennium Development Goals in the WHO European Region: 2013 update**

### **Introduction**

121. At its fifty-seventh session, the WHO Regional Committee for Europe adopted resolution EUR/RC57/R2 (1), which calls on the Regional Director to report to the Regional Committee every two years on the progress made in the European Region towards achieving the United Nations Millennium Development Goals (MDGs). The present document provides an update on progress made in the Region towards achieving MDGs 4, 5 and 6, highlighting how they are interlinked and, in particular, their links with MDGs 3 and 7.

122. Integral to the Regional Director's vision of how the Regional Office for Europe could contribute to ensuring better health in Europe is the scaling up of efforts towards the achievement of MDGs. The Regional Office is consolidating its technical assistance to the Member States with the aim of strengthening their capacity to reach specific MDG targets. The following documents provide strategic direction and guidance on accelerating progress to this end: Health 2020: the European policy for health and well-being (2); Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015 (3); European Action Plan for HIV/AIDS 2012–2015 (4); Tallinn Charter: "Health Systems for Health and Wealth" (5); Strengthening public health services and capacity: an action plan for Europe (6); and Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (7).

### **MDG 4. Reduce child mortality**

#### **Situation analysis**

123. Although there has been a steady decline in under-five and infant mortality across the European Region, the rates indicate stark inequities between and within countries. The Region includes countries with the lowest infant and child mortality rates in the world and countries where these rates are 25 times higher.

124. In 2010, 155 000 children in the Region died before their fifth birthdays; 53% of these were infants who died in the first month of life. The regional average rates for under-five mortality decreased from 32 per 1000 live births in 1990 to 13 per 1000 live births in 2010 (8). This corresponds to a reduction of almost two thirds, which is very close to the 2015 target of 11 deaths per 1000 live births. The regional average rates for infant mortality fell from 27 per 1000 live births in 1990 to 11 per 1000 live births in 2011.

125. In the European Region, the leading causes of death in children under the age of five are neonatal conditions, pneumonia and diarrhoea; almost half of these deaths are associated with undernutrition. Prematurity, low birth weight, congenital anomalies, birth asphyxia, birth trauma and neonatal infections are among the leading causes of neonatal death. Post-neonatal death is attributable mainly to acute respiratory infections, diarrhoeal diseases, noncommunicable diseases and injuries.

126. Much of the morbidity and mortality among children and young people is preventable. Two thirds of deaths in children and young people could be prevented by ensuring universal coverage through a limited number of effective, low-cost interventions. Environmental

pollution, poor city environments that aggravate socioeconomic disparities, and increasing socioeconomic inequity across the Region are all factors that can make children more vulnerable. There are warning signs that diseases previously under control, such as diphtheria and tuberculosis, are returning and that noncommunicable diseases due to unhealthy lifestyles are increasing.

### **WHO strategies/actions**

127. In supporting Member States in their efforts to include child health in their national policies using the new European health policy framework, Health 2020 (2), WHO emphasizes the importance of equal access to quality services. Assistance is connected with: the in-service training of health care providers and key policy-makers to improve quality of care; the adaptation to national contexts of evidence-based tools developed by WHO and its partners for training purposes; the reformulation of curricula for the education of health care providers; and the development of evidence-based clinical guidelines. Direct technical support is provided mainly to priority countries in the eastern part of the Region. WHO is working with other United Nations agencies and partners in developing capacity-building tools to help address inequities, with a particular focus on the Roma population.

### **The way forward**

128. WHO will continue to provide technical assistance to Member States for the improvement of newborn and child health; the focus will be on policy building and improving primary health and hospital care for newborn babies and children. Support will be evidence-based and tailored to the needs and contexts of the countries to facilitate implementation of the best clinical practices and the development of new ways of working, in order to change professional attitudes. Service users will be empowered through enhanced information about, and increased involvement in, their own care.

129. Several activities will be linked with work directly related to the social determinants of health, including gender mainstreaming and Roma-related issues. The life-course approach will be predominant to ensure linkages between the different life stages and with strategies for the prevention and management of noncommunicable and communicable diseases and the strengthening of health systems. All in-house processes linked to policy analysis and development, health impact assessment and universal access to health services will be coordinated to optimize resources and maximize impact.

## **MDG 5. Improve maternal health**

### **Situation analysis**

130. Average maternal mortality in the European Region decreased from 44 per 100 000 live births in 1990 to 20 per 100 000 live births in 2010. Despite this progress, the average regional annual mortality decline of 3.8% is short of the 5.5% needed to reach MDG target 5A. In central Asia and the Caucasus, the annual decline is even smaller (2.1%) (9). In addition, there are large discrepancies between and within countries. Although the average maternal mortality ratio for the European Union (EU) countries remains low, however, when data on different social groups are analysed, the diversities within countries are brought to light and targeted interventions can be developed. Evidence from several studies indicates gaps in maternal mortality data collected through routine statistical systems, showing that maternal deaths are under-reported in many countries in the Region, including some EU Member States (10).

131. Reliable, comparable data on rates of contraceptive prevalence, unmet family planning needs and adolescent births (indicators for MDG target 5B) are often missing. The rates of

usage of modern, effective methods of contraception are alarmingly low in many countries of eastern Europe and central Asia, sometimes as low as the averages for the least developed countries in the world (11). In some countries of eastern Europe, where abortion rates are the highest in the world, barriers to safe abortion lead to unsafe practices and, in turn, to maternal morbidity and even death.

132. In many countries, there is a lack of disaggregated national health data relating to ethnicity and other social determinants of health. There is evidence that social determinants, such as level of education, birth place and nutrition of mothers, remain a major factor for poor health outcomes both for mothers and newborns. Although maternal weight before and during pregnancy can affect the course of pregnancy and its outcome, many countries have no available national data on the body mass index of pregnant women (10). However, existing data on antenatal care coverage, low birth weight, breastfeeding prevalence and maternal smoking reveal marked inequities between Roma women and the rest of the population. Other aspects of social exclusion also influence the rates of antenatal-care coverage. Inadequate social protection, at times linked to a lack of the necessary documentation, is an example. The lack of financial coverage for basic health services contributes to higher ratios of maternal mortality among Roma women, especially when family planning and antenatal care services are not covered. Because of poor access to contraceptives, Roma women are more likely to experience unwanted pregnancies.

### **WHO strategies/actions**

133. The Regional Office is supporting Member States in their efforts to include the areas of reproductive, maternal and child health in their national policies with an emphasis on equal access to quality services. This work is being done using the WHO health systems framework (12). Over the past few years, WHO has assisted a number of countries in assessing the quality of their hospitals and outpatient care for pregnant women, mothers and babies. Recommendations on actions to improve care and reduce maternal and perinatal mortality and morbidity have been developed and are being implemented.

134. The WHO approach to analysing maternal mortality and morbidity outlined in the publication, *Beyond the numbers: reviewing maternal deaths and complications to make pregnancy safer* (13), is used in both high- and low-income countries. Its methodology provides ministries of health with analytic information that official data do not provide. Since 2012, the countries targeted by the United Nations Global strategy for women's and children's health (14) (Azerbaijan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) have been receiving technical assistance for improving health information and accountability, with a special focus on maternal death surveillance and response.

135. WHO coordinates the interagency coordination initiative, "Scaling up action towards MDGs 4 and 5 in the context of the Decade of Roma Inclusion and in support of national Roma integration strategies", in which it collaborates with the International Organization for Migration (IOM), the Office of the High Commissioner for Human Rights (OHCHR), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA) and other partners. As part of the initiative, the Regional Office – in collaboration with partner institutes and the Government of Spain – is organizing a multicountry training course on the reorientation of strategies, programmes and activities related to MDGs 4 and 5 towards the achievement of greater health equity with an explicit but not exclusive focus on the Roma population. The interagency partners are also developing a resource package to support health professionals in decision-making processes and the implementation of strategies, programmes and activities related to MDGs 4 and 5. However, the introduction of a multisectoral approach (involving the education, social welfare and other



sectors) for improving maternal health in line with Health 2020 remains a challenge that requires further support from WHO and its partners.

### **The way forward**

136. In planning WHO technical assistance to countries in the area of maternal health, several activities will be linked with work related to the social determinants of health, including gender mainstreaming and Roma issues. A life-course approach will be used to ensure that account is taken of the connections between the social determinants of health and the different life stages and how the social determinants influence efforts to prevent NCDs and communicable diseases and strengthen health systems.

137. Several regional and global activities will analyse the progress achieved in implementing the Programme of action adopted at the International Conference on Population and Development in Cairo, Egypt, on 5–13 September 1994 (15) with a special focus on reproductive health and rights, including adolescent health. A special issue of *Entre Nous*, the European magazine for sexual and reproductive health, will present an overview of regional progress as well as examples from individual countries across the Region.

## **MDG 6. Combat HIV/AIDS, malaria and other diseases**

### **HIV/AIDS**

#### *Situation analysis*

138. While other WHO regions are reporting annual decreases in numbers of new HIV cases, the European Region is facing considerable challenges in meeting MDG target 6A. In 2011, an estimated 2.3 million people in Europe were living with HIV and more than 121 000 new HIV cases were reported, the majority of which were detected in eastern Europe and central Asia. HIV incidence increased from 6.6 per 100 000 population in 2004 to 7.6 in 2011. Because of inadequate access to and uptake of HIV testing and counselling, especially among the key populations, not all HIV cases are diagnosed. Therefore, the estimated number of infections is higher than the number of cases reported through national surveillance systems. It is estimated that 30 000 people (21 000–40 000) were newly infected with HIV in 2011 in western and central Europe and 140 000 (91 000–210 000) in eastern Europe and central Asia.

139. Although the main routes of virus transmission vary by geographical area, in all European countries, HIV disproportionately affects socially marginalized populations – such as migrants – and stigmatized social groups – such as men who have sex with men (MSM) and people who inject drugs. In 2011, 37.6% of the HIV cases detected in the eastern part of the Region were among people who inject drugs and transmission through heterosexual contact had increased as a proportion of total cases: 56.7% of new cases in 2011. Most cases transmitted by heterosexual contact are likely to be the result of sexual transmission from injecting drug users to their partners. The proportion of cases among MSM in the eastern part of the Region is low, although likely underreported. In the western part of the Region, the epidemic remains concentrated among MSM (40% of cases in 2011) and migrants from countries with generalized epidemics (more than one third of heterosexually acquired infections).

140. In 2011, almost 11 000 new AIDS cases were reported by 49 of the 53 European Member States, representing a rate of 1.5 cases per 100 000 population. The highest rate, 22.4 per 100 000, was found in the eastern part of the Region; the rates for the western and central parts of the Region were 6.5 and 1.6 per 100 000, respectively. AIDS cases are vastly underreported, particularly in countries in the eastern part of the Region. In the western part of the Region, the numbers of diagnosed and reported AIDS cases have continued to decline. While the annual number of AIDS-related deaths has been declining in Europe as a whole since 2004, it is



increasing in many countries in eastern Europe and central Asia. In 2011, 2676 people diagnosed with AIDS were reported to have died from the disease.

141. Although the number of people receiving treatment in the Region is increasing annually, it is still far from representative of the actual need. Challenges remain in connection with scaling up antiretroviral (ARV) coverage, assuring access to ARV therapy (ART) for key populations, adherence to treatment, pricing, procurement mechanisms, the provision and prequalification of generic drugs and stock-outs. In 2012, the number of people receiving ART in low- and middle-income countries in the Region was 194 000, while the number of people eligible for treatment was over 500 000. The percentage of pregnant women living with HIV receiving ART to prevent mother-to-child transmission in low- and middle-income countries in the Region is estimated at 95%. There is universal coverage of testing for HIV during pregnancy in nearly all countries of the Region. Access to HIV treatment for children is high; over 85% of those living with HIV receive ART (8500 in 2012). Integrating HIV testing and ART provision into maternal and child health programmes has been an important contributor to the progress achieved over the last years.

142. In some countries, high levels of stigma and discrimination as well as the legal environment, including criminalization of behaviours, such as drug use, MSM and sex work, have hampered efforts to reach the populations most at risk of contracting HIV and the development of evidence-based HIV-prevention policies and interventions, such as opioid substitution therapy. The vertical nature of HIV programmes results in missed opportunities for prevention, testing, counselling, treatment, care and support. Declining international donor support over the last few years has resulted in the scaling down and even closure of key interventions in some countries where national budgets lack a comprehensive response. Furthermore, national economic gains may disqualify or restrict them from obtaining grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria in the future.

#### *WHO strategies/actions*

143. The Regional Office is implementing the European Action Plan for HIV/AIDS 2012–2015 (4), which addresses the challenges of responding to the epidemic and proposes priority areas of intervention. It supports Member States in adopting evidence-based policies on the prevention of HIV in key populations and in implementing the actions included in national AIDS plans, such as interventions aimed at harm reduction and the prevention of sexual transmission. WHO has revised its guidance on ART, calling for the earlier initiation of treatment and the use of simpler, better drug regimens. The implementation of these recommendations has resulted in reduced HIV transmission and lower rates of morbidity and mortality.

144. The WHO European Region has a comprehensive HIV/AIDS surveillance network and all countries submit data to the Regional Office and the European Centre for Disease Prevention and Control on an annual basis. Not only is strategic information about the epidemic more readily available, the standard of the data is higher, resulting in more countries basing their strategies on this evidence. The Regional Office also contributes to the progress reporting processes of the joint WHO/UNICEF/UNAIDS Global HIV/AIDS response and the Global health sector strategy on HIV/AIDS 2011–2015 (16).

145. Countries are engaging more meaningfully with civil society in the development, implementation, monitoring and evaluation of policy guidance. Outreach programmes implemented by civil society serve as low-threshold entry points, enabling health services to reach people most at risk of HIV infection.

### *The way forward*

146. The increase in reported HIV cases highlights the importance of sustaining interventions, even in times of economic austerity. Given limited funds, it is crucial that countries set priorities regarding interventions and target groups and tackle the social and structural causes of HIV risk and vulnerability. This includes enforcing protective laws across the Region and enhancing efforts to protect human rights. The Regional Office will continue to actively support the implementation of the European Action Plan for HIV/AIDS 2012–2015 (4) by providing leadership, strategic direction and technical guidance to Member States.

147. Actions aimed at reducing vulnerability should address key populations in particular and involve patients' and civil society organizations. Scaling up action towards the achievement of MDGs and other development goals and social exclusion processes will help to improve treatment outcomes and prevent or reduce HIV transmission. WHO will engage in global and regional partnerships and advocate for commitment to and resources for strengthening and sustaining the response to HIV. WHO will also continue to monitor and evaluate Member States' progress towards reaching the European goals and targets through a harmonized process of data collection, reporting and analysis. Key actions will include identifying best practices and experiences, facilitating information sharing among Member States, and producing evidence-based tools for an effective HIV response.

## **Malaria**

### *Situation analysis*

148. The European Region aims to interrupt the transmission of malaria and eliminate the disease from the five countries still affected (Azerbaijan, Kyrgyzstan, Tajikistan, Turkey and Uzbekistan) by 2015. Turkmenistan attained malaria-free status in 2010, Armenia in 2011, and Kazakhstan in 2012; Kyrgyzstan may be certified as having eliminated the disease by the end of 2013.

149. The number of locally acquired cases reported has dropped dramatically. Compared to 90 712 cases in 1995, there were only 253 cases in 2012 (reported in Azerbaijan, Georgia, Greece, Tajikistan and Turkey). Action has been accelerated in the remaining countries affected by malaria with a view to eliminating the disease from the Region by 2015. The importation of malaria from endemic to malaria-free countries in the Region has led to the reintroduction and even outbreaks of the disease in some countries.

### *WHO strategies/actions*

150. Since 2008, all malaria-affected countries in the Region have undertaken effective action towards malaria elimination in line with The Tashkent Declaration: "The Move from Malaria Control to Elimination" in the European Region (17) and the Regional strategy: from malaria control to elimination in the WHO European Region 2006–2015 (18).

151. The Regional Office is providing strategic guidance and technical assistance to the five remaining affected countries with a view to preventing the reintroduction of the disease. National capacities for malaria elimination have been strengthened in all five countries. Particular emphasis has been placed on the risk of spreading the disease to neighbouring countries; collaboration with member states in the WHO Eastern Mediterranean Region on coordinating cross-border activities has been intensified.

### *The way forward*

152. There is a need to guide the remaining affected countries towards achieving malaria-free status by 2015 as planned and to provide them with the necessary technical assistance. Particular emphasis will be placed on the surveillance and monitoring of progress towards malaria elimination at the national, subregional and regional levels.

## **Tuberculosis**

### *Situation analysis*

153. MDG target 6C includes halting and beginning to reverse the incidence of tuberculosis (TB) by 2015. This goal has been partially achieved in the European Region: TB incidence fell at a rate of about 5% per year between 2000 and 2011, at which time the prevalence of the disease was estimated at 56 cases per 100 000 population. Thus, the prevalence target of 34 cases per 100 000 population in 2015 is on track. In 2011, TB mortality was 4.9 per 100 000 population compared to 4.4 per 100 000 in 1990, which means that the Region will not reach the target of 50% reduction by 2015. The burden of TB in the Region varies among and within countries, ranging from <1 case per 100 000 population to about 200 cases per 100 000. There are also wide differences among districts where rates of over 100 per 100 000 population can be found, even in countries in the western part of the Region.

154. The major part of the TB burden in the Region is attributable to 18 high-priority countries<sup>6</sup> with 87% of all TB cases and more than 99% of all multidrug-resistant TB (MDR-TB) cases. There are large gaps, also in countries in the western part of the Region, in terms of compliance to best practices, access to the early diagnosis and treatment of all forms of TB, including TB in children, migrants and other vulnerable populations, and adequate mechanisms of patient support to improve adherence to treatment. These challenges have led to the increasing problem of drug-resistant TB (multidrug- and extensively drug-resistant TB (M/XDR-TB)). The European Region has the highest rate of MDR-TB in the world and 15 European Member States are on the list of the top 27 countries in the world with high burden MDR-TB.

155. Although Member States have reported increased access to second-line anti-TB drugs for the treatment of M/XDR-TB patients (the treatment coverage in 2011 was 96%), the treatment success rate is extremely low in some countries (as low as 27%). The main reasons for this are lack of full access to quality second-line TB drugs and the provision of incomplete treatment regimens, particularly for TB/HIV co-infected individuals. Although the prevalence of TB/HIV co-infection is not as high in the European Region as in some other WHO regions, an increasing prevalence of HIV has been observed among TB cases (from 2.8% in 2006 to 6.4% in 2011). The lack of adequate through care and support of patients moving from one country to another also hinders effective TB prevention and control.

### *WHO strategies/actions*

156. In collaboration with national and international partners and civil society, the Regional Office is implementing the Consolidated Action Plan to prevent and combat M/XDR-TB in the WHO European Region 2011–2015 (3). Support is being provided to help Member States adapt evidence-based interventions to improve TB and M/XDR-TB prevention and control through the harmonization of national strategies in accordance with the Consolidated Action Plan,

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<sup>6</sup> Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Romania, Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan.

address the social determinants of health and health systems challenges, ensure early diagnosis and effective treatment for all, improve infection control and surveillance and address the needs of special populations.

157. Most of the countries in the Region with a high burden of MDR-TB have prepared their national action plans in line with the Consolidated Action Plan (3). The Regional Office has established the European Green Light Committee and the European TB Laboratory Initiative to assist countries in developing and/or adjusting their national plans with a view to detecting 85% of the estimated MDR-TB cases and treating at least 75% and decreasing the proportion of MDR-TB among previously treated patients.

158. The Regional Interagency Collaborating Committee on Tuberculosis Control and Care was established in December 2012 to improve and coordinate partnerships. In collaboration with the European Respiratory Society, the Regional Office is piloting an electronic consilium to support clinicians in improving the management of difficult-to-treat TB and M/XDR-TB patients. The Regional Office is providing Member States with technical assistance in monitoring and assessing national interventions and identifying and addressing the social determinants of TB. It is also involved in measures to improve: TB drug management; infection control; laboratory networking; TB-HIV collaboration; advocacy and communication; surveillance and response; clinical management; recording and reporting; intersectoral collaboration; and people-centred approaches to achieving universal access to TB care, in line with Health 2020 (2).

159. In collaboration with the WHO country offices, the Regional Office is conducting health systems performance assessments in Member States and providing them with the necessary technical assistance to improve their health systems. The aim is to prevent and control M/XDR-TB in high-priority countries and plan for TB elimination in countries with a low incidence of the disease. In addition, the Regional Office is assisting Member States in their efforts to acquire funding from bilateral agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

### *The way forward*

160. The Regional Office will continue to support Member States in implementing the Consolidated Action Plan (3), identifying and addressing social determinants of the disease and removing health-system barriers to the efficient prevention and control of TB and care of those with the disease.

161. In collaboration with partner agencies, civil society and health authorities, the Regional Office will conduct programme reviews in countries with the aim of advising them on measures to be taken to accelerate progress towards the achievement of MDGs and raise public awareness about the importance of detecting TB early and treating it adequately.

### ***Interlinkages with MDG 3***

162. Gender equality and empowerment of women are recognized as prerequisites for sustainable development and are particularly important for achieving MDGs 4 and 5. Although the WHO European Region has some of the highest levels of gender equality, there are still significant inequalities within countries and across the Region.

163. WHO is making an effort to mainstream gender in its technical assistance to countries and Health 2020 has become a strong platform for emphasizing the importance of addressing gender in order to reduce health inequalities. Priority is given to the collection and use of data disaggregated by sex.

164. Violence against women is a widespread public health problem, a violation of human rights and a consequence of gender inequality. The recently launched WHO report *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (19)* states that 27% of women in Europe experience intimate partner violence and/or non-partner violence. The Regional Office is organizing a conference on violence against women in November 2013 in Vienna, Austria, to present and adapt the WHO clinical and policy guidelines issued with the report.

### **Interlinkages with MDG 7**

165. Progress in the area of water and sanitation has stagnated in the Region. The WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation states that over 48 million people do not have access to improved drinking-water sources and over 70 million people do not have access to improved sanitation facilities (20). In some countries in the eastern part of the Region, sanitation coverage declined from 90% in 1990 to 89% in 2010 and drinking-water coverage improved by only one percentage point (from 93% to 94%) during the same period (20). In eastern European countries more than 50% of the rural population still live in homes without connection to a drinking-water supply. There are important disparities within and among countries, between urban and rural areas, and between high- and low-income groups. WHO and its partners are undertaking initiatives to assist Member States to strengthen the monitoring of water supply and sanitation, introduce and implement water safety plans focusing on small-scale water supply areas and promote household water treatment and safe storage. Under the Protocol on Water and Health (21), which was ratified by 25 European Member States, WHO is supporting the Parties to set targets and report on progress made in relation to water supply, sanitation and the reduction of water-related diseases.

166. The health impact of climate change, including flooding, heat waves, increased erosion, and droughts, has been well documented in the European Region. The annual emissions of greenhouse gases in the EU in 2008 (latest available data) amounted to roughly 10 tonnes of CO<sub>2</sub> equivalent per head, well above the sustainable per capita target of 2 tonnes (22). Despite progress, a number of countries – in eastern Europe, the Caucasus and central Asia – remain among the least energy efficient and most carbon-intensive economies in the world (23).

167. The Regional Office is contributing to the implementation of the WHO workplan on climate change and health (24). The *Commitment to Act* made at the Fifth Ministerial Conference on Environment and Health in Parma, Italy, from 10–12 March 2010, and *Protecting health in an environment challenged by climate change: A Regional Framework for Action* provide policy references for implementing adaptation and mitigation measures (25). Several European countries have participated in the implementation of these policies by assessing the effects of climate change and preparing adaptation strategies or action plans.

### **The post-2015 development agenda**

#### **Global thematic consultation on health**

168. The United Nations global consultation on health comprised a series of thematic consultations, aiming to catalyse a “global conversation” on the post-2015 development agenda. Convened jointly by the Governments of Botswana and Sweden, UNICEF and WHO, the consultations have reached out to people and organizations around the world, gathering their inputs and views on how best to ensure the health of future generations. An online consultation drew 150 000 participants, more than 100 papers were submitted and over 1500 individuals took



part in 13 face-to-face consultations in Africa, Asia, Europe, North America and South America.<sup>7</sup> All inputs were synthesized in a draft report, which was presented for consideration at the High-level Dialogue on Health in the Post-2015 Development Agenda in Gaborone, Botswana, on 4–6 March 2013.

169. The dialogue brought together 50 high-level participants, including ministers of health, members of the High-Level Panel of Eminent Persons and their representatives, heads of international organizations, representatives of civil society and the private sector, academics, public health experts and youth. Based on comments made at the meeting, the draft report was revised and finalized and a brief was prepared and submitted to those members of the High-level Panel of Eminent Persons, before the Panel's meeting in Bali, Indonesia on 25–27 March 2013.

170. Health in the post-2015 United Nations development agenda was also the theme of the 66th World Health Assembly. The Assembly adopted resolution WHA66.11, urging Member States to sustain and accelerate efforts towards the achievement of the health-related MDGs and to ensure that health is central to the post-2015 United Nations development agenda. The resolution calls on the Director-General to ensure that WHO consultations on the issue are inclusive and open to all regions and to advocate for resources to support acceleration of the health-related MDG targets by 2015. The Secretariat is requested to include a discussion on health in the post-2015 United Nations development agenda in the 2013 meetings of the WHO regional committees and to present a report to the 67th World Health Assembly. The WHO Regional Committee for Europe, at its sixty-third session, will address the post-2015 United Nations development agenda under its agenda item on matters arising from the World Health Assembly and the Executive Board.

171. At the Regional level, intensive consultations have taken place in the context of the Regional Coordination Mechanism (RCM) and the United Nations Development Group (UNDG) Regional Team for Europe and Central Asia. An advocacy document and a series of related issue briefs detailing the main achievements and challenges faced with regard to the MDGs, as well as setting an overall vision for the Region on the development agenda beyond 2015 have been prepared and submitted to the members of the High-level Panel of Eminent Persons as a contribution to the Secretary-General's report, to be presented at the United Nations General Assembly special event on 25 September 2013. Furthermore, a Regional consultation will take place on 4–6 September 2013, as a platform for a multistakeholder dialogue, with high-level representatives from governments, civil society, academia and others. It will be jointly organized by UNICEF, UNDP and UNECE and hosted by Turkey.

### **Towards a framework for future health goals**

172. Any future goal for health must be universally relevant. Every country is home to families and individuals who lack the means to prevent or treat illness or to care for those who are ill. In planning future health goals, it is necessary to ensure that these universal realities are reflected and that the values of equity and human rights, including gender, are “hard-wired” throughout. However, no two countries are the same and, therefore, future goals must be adaptable to the realities of each country. After extensive global consultations, health in the post-2015 United Nations development agenda is beginning to take shape around the following themes:

- **Recognize that health and development are inextricably linked.** An overarching development goal for the post-2015 agenda could be sustainable well-being for all, positioning health as a critical contributor to, and outcome of, sustainable development and human well-being. This would respond to the increasing call to go beyond the gross

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<sup>7</sup> All contributions available: [www.worldwewant2015.org/health](http://www.worldwewant2015.org/health), accessed 11 July 2013.

domestic product in measuring healthy growth and sustainable development and widen the focus on equity. It also acknowledges that good health is determined as much by the many aspects of development – including education, the sustainability of energy, nutrition, water and sanitation and the adaptation and mitigation of climate change – as by the prevention and treatment of disease. Goals related to developmental issues, such as the environment, could include health-related targets, such as the reduction of indoor air pollution.

- **Maximize health in all life stages.** This could be an overarching health goal in which the health sector plays a greater but far from exclusive role. It should include accelerating actions to achieve the health-related MDGs, reducing the burden of noncommunicable diseases and ensuring universal health coverage and access to health services. The post-2015 agenda could include targets to: end preventable maternal and child death; provide universal access to sexual and reproductive health services; eliminate malaria and eradicate polio; realize the vision of a generation free from AIDS and tuberculosis; reduce cardiovascular diseases, cancer, diabetes and respiratory illness as well as their associated risk factors; and ensure equity by closing gaps and disaggregating indicators.
- **Make health services accessible and affordable.** Ensuring universal health coverage and access to comprehensive, high-quality health services for all people is a means of achieving better health outcomes. It is also a desirable goal that people value in its own right: the assurance of having access to a health system that strives to prevent and treat illness effectively and affordably in their communities and homes with referral to clinics and hospitals when required. Health systems must also ensure that 100 million people do not fall into poverty each year due to the cost of health services they need as is the case today.

### Implementation of the post-2015 agenda

173. The changing global environment requires commitment to doing things differently to advance the future agenda for global health. More attention must be paid to governance structures and institutional capacity at global and national levels and to the possible need to adapt the global health architecture to the 21st century and the post-2015 goals. The post-2015 world will require: the participation of communities empowered to implement change; the engagement of civil society and the private sector; societal changes to overcome gender and ethnic inequalities, prevent discrimination and ensure the right to health; a better understanding of how the different sectors can collaborate to create and protect health; stronger, independent accountability mechanisms (including in-country and global oversight structures); and accelerated efforts to strengthen and consolidate institutions tasked with delivering better health at both global and national levels.

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## **Progress report on the implementation of the International Health Regulations (2005)**

### ***Introduction and background***

174. The International Health Regulations (2005) (IHR) is an international legally binding instrument to prevent, protect against, control and provide a public health response to the international spread of disease. It constitutes an essential element of global health security and its implementation has been a gradual process since its entry into force in 2007. States Parties to the IHR have the legal obligation to meet some core capacities for surveillance and response for all public health events (infectious diseases, environmental, chemical or radiological events). States Parties must also conduct day-to-day operations required under the IHR at points of entry (ports, airports and ground crossings). In 2009, all 53 Member States of the WHO European Region, through the Regional Committee for Europe, adopted Resolution EUR/RC59/R5.

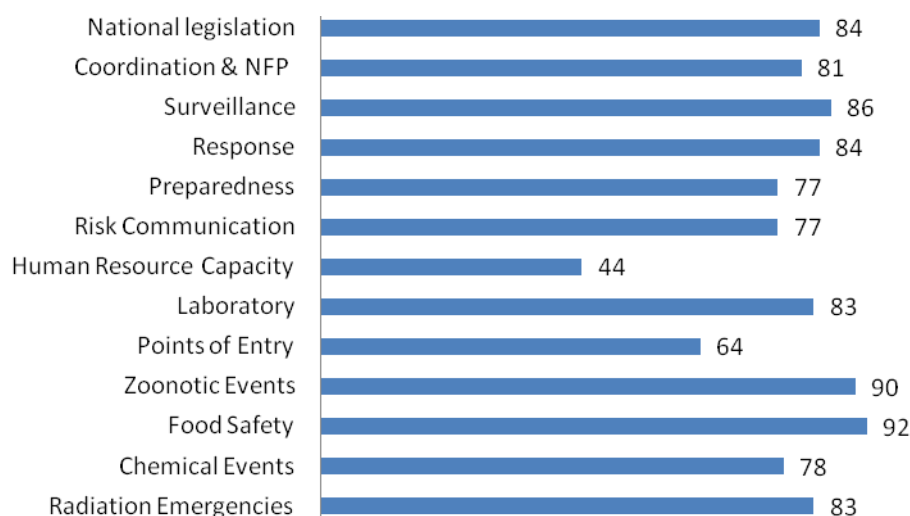
175. Resolution EUR/RC59/R5 urges Member States and the WHO Regional Office for Europe to support the development and/or maintenance by 2012 of the core capacities required under the IHR. It also urges Member States to develop national IHR action plans. The WHO Regional Office for Europe and partners are working together with Member States' governments to implement their strategic IHR action plans.

176. The WHO European Region counts 55 IHR States Parties: all Member States in the Region plus The Holy See and Liechtenstein, which voluntarily joined the IHR in May 2005 and March 2012, respectively. Montenegro became a State Party in February 2008. Consequently, both Liechtenstein and Montenegro have a different legal calendar for acquiring the IHR core capacities than the other States Parties in the Region. Another particularity of the WHO European Region is the overseas territories of some of its Member States, which require special arrangements, both at national level and through other WHO regional offices, to effectively implement the IHR.

### ***Situation analysis***

177. Data reported by States Parties in the European Region in the annual self-assessment questionnaire show relatively good achievements in building capacities for surveillance, food safety and zoonotic events detection and response (Fig. 1). While on the whole the IHR have been used to strengthen the role of the health sector, the implementation and maintenance of core capacities continues to present a challenge in many other technical areas, especially multisectoral coordination, capacities at designated points of entry, human resource development, legislation and risk communication. The broad scope of IHR implementation, including all hazards and public health risks of biological, chemical and radio-nuclear origin, also remains challenging.

Fig. 1: Regional average score (%) of the IHR core capacities according to the annual self-assessment questionnaire 2012



178. Since the deadline of 15 June 2012, to date 21 (38%) States Parties in the WHO European Region have requested an extension for the implementation process until June 2014, of which 15 have developed a specific implementation plan. The European Region is the region with the lowest proportion of extension requests.

179. Requests for extension were national decisions and about half of the countries that requested an extension were well-developed countries, which shows that certain cultural, political and historical factors, such as the presence of overseas territories, affected these decisions. In many cases the national decision process did not focus only on developed capacities, but also on operational arrangements and liability issues.

### ***Actions taken and progress made***

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

#### **Work area 1: Evaluating, strengthening and monitoring national IHR core capacities**

181. Over the past three years, the Secretariat has conducted national IHR assessments and IHR consultations in most priority States Parties in the European Region, in order to assist States Parties in developing the required IHR core capacities.

182. States Parties have provided information on implementation of the IHR, using the format proposed by the Secretariat for the submission of States Parties' annual reports and the corresponding tools, based on a monitoring framework developed by WHO to address the national core capacity requirements set out in Annex 1 of the Regulations.

183. The Secretariat will continue to evaluate and monitor national IHR capacities primarily through the annual self-assessment questionnaire and will provide guidance on strengthening these capacities.

## **Work area 2: Promoting high-level political ownership of the IHR implementation process**

184. The Secretariat has conducted national and multicountry awareness-raising workshops for all States Parties in the Region. In order to provide new impetus for implementation activities, the Secretariat held a European Strategy Meeting for implementation of the International Health Regulations (2005) in February 2013. This meeting brought together participants from the subregional, Regional and global levels; stakeholders, partners and traditional and non-traditional donors, in order to share experiences related to the implementation of the IHR, map all potential resources and address common challenges.

185. The Secretariat will continue to support IHR implementation according to individual country circumstances and will make key relevant WHO documents available in all official languages of the European Region, particularly Russian. There are plans to conduct meetings tailored specifically for senior public health officials.

## **Work area 3: Updating legislation and regulatory mechanisms**

186. The Secretariat has conducted a multicountry workshop for Member States in Central Asia and the Caucasus to review existing guiding material on IHR legislation and to share best practices among Member States. The workshop was followed by individual assessment visits to each country.

## **Work area 4: Empowering national IHR focal points**

187. National IHR focal points (NFPs) should be empowered if they are to influence and be responsible for IHR implementation across sectors within their countries. This influence can be more readily obtained if the NFPs are further trained in understanding the IHR principles and in catalysing existing resources to build IHR capacities. The Secretariat has conducted national and multicountry workshops for all States Parties to update and train NFPs about their legal role within the IHR framework. The event information site also provides a platform for NFPs and WHO to share NFPs' contact information and the status of IHR implementation in States Parties in the Region, as reported through the self-assessment questionnaire.

## **Work area 5: Undertaking awareness and advocacy efforts beyond the health sector**

188. Intersectoral collaboration makes better use of resources by avoiding duplication and enhancing coordination among multisectoral activities. Effective advocacy will convince sectoral policy-makers of the benefits of such collaboration, and this requires interpreting the IHR in terms of each sector's activities and interests. Facilitating countries to coordinate national IHR activities will be achieved by improving intersectoral awareness, advocacy and collaboration as well as by improving risk communication within and across sectors. The Secretariat will continue to conduct multisectoral workshops and training in States Parties to bring together all stakeholders from different sectors with a role to play in IHR implementation.

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

189. Making IHR guidance available in local languages is a crucial element of this support. The Secretariat has conducted high-level national awareness-raising and technical training activities, such as exercises to assess IHR core capacities. During the past two years, these exercises have included multisectoral and multicountry training workshops that have been very successful in increasing awareness and creating peer groups. Adapting the global IHR course

and offering it in Russian, so that it can serve as training for Russian-speaking NFP staff and key national experts, will be one of the most urgent tasks in the next months.

### **Work area 7: Strengthening IHR capacities at points of entry**

190. Because of their vulnerability to transient hazards, points of entry have a particularly important role in preventing the importation and spread of disease on a day-to-day basis and special control measures should be ready to be implemented in case of an emergency. The Secretariat continues to organize, in collaboration with relevant partners, training workshops for ship inspections and emergency preparedness in the aviation sector, as well as, where appropriate, multicountry workshops, also involving other WHO regions, for countries to exchange information and develop bilateral agreements for certain ground crossings and IHR capacities at ports.

### ***The way forward***

191. Coordination and cooperation with all relevant partners in the Region remains a priority of the Secretariat.

### **Cooperation and coordination with partners in the European Region**

192. The European Strategy Meeting for implementation of the International Health Regulations (2005) (see paragraph 184 above), organized together with the European Commission in Luxembourg, aimed to map the current status of IHR implementation in the WHO European Region and to define challenges and a roadmap for joint implementation. The Meeting brought together 50 IHR States Parties and stakeholders, partners and donors from regional and global levels.

193. The European Commission has submitted to its Member States a directive to address cross-border health threats. WHO is working closely with the European Commission and its institutions and will continue to coordinate its activities for Member States members of the European Union with the European Commission and its technical agencies, such as the European Centre for Disease Prevention and Control (ECDC) and the European Food Safety Authority (EFSA).

### **Criteria for extension in 2014**

194. The IHR gives the Director-General a very specific role that includes taking decisions about granting further extensions after June 2014 and obtaining the view of the IHR Review Committee. Resolution WHA65.23 requests the Director-General “to develop and publish the criteria to be used in 2014 by the Director-General (...) when making decisions about the granting of any further extensions”.

195. These criteria were discussed by the World Health Assembly at its 66th session in May 2013, during which it proposed that at their meetings in 2013, the regional committees could obtain further input from Member States regarding the criteria to be used by the Secretariat when considering requests for additional extensions to the deadline for establishing the core capacity requirements for surveillance and response. The criteria to be used in 2014 for further extensions will be discussed at the 63rd session of the Regional Committee for Europe under the agenda item on matters arising out of the 66th session of the World Health Assembly.

## **Conclusions**

196. The IHR are legally binding to all States Parties and involve not only the health sector but also all other relevant sectors. WHO is facilitating the implementation process by providing technical guidance and coordinating countries' efforts, which includes creating mechanisms for international and cross-border collaboration. The Regional Office for Europe focuses on the most important elements for achieving IHR implementation in the Region.

197. The IHR must be better integrated into generic national preparedness activities and plans in countries. The Health 2020 European health policy framework, endorsed by the Regional Committee, aims to significantly improve the health and well-being of populations and reduce health inequalities by strengthening public health and supporting action across government and society. Thus, Health 2020 is crucial for facilitating intersectoral collaboration for the implementation of the IHR.

198. Effective implementation of national plans requires significant, sustainable financial investment and political commitment from national governments, as well as external support from donors and partners. Resource mobilization, as well as limited WHO human resources, remains insufficient to meet all needs in full and accelerate the implementation of IHR, as the deadline for all States Parties to acquire the necessary core capacities is approaching.

199. The Regional Office will continue to work with the relevant sectors of States Parties' governments to ensure political commitment and resources and to support the work of intersectoral coordination committees.





## **Progress report on the European strategic action plan on antibiotic resistance**

### ***Introduction and background***

200. In response to the growing public health threat of antimicrobial resistance (AMR), on World Health Day 2011, WHO called on countries to combat drug resistance, using the slogan: “No action today, no cure tomorrow”. In the same year, all 53 countries of the WHO European Region, through the Regional Committee for Europe, adopted Regional Committee resolution EUR/RC61/R6 and the European strategic action plan on antibiotic resistance (EUR/RC61/14). The strategic action plan contains seven strategic objectives, developed through extensive consultation with experts and policy-makers and based on the latest research, which are intended to provide guidance to governments for addressing complex factors related to bacterial resistance and its driver, antibiotic usage; especially overuse and misuse.

201. Resolution EUR/RC61/R6 urges Member States to secure the political commitment and resources necessary to implement the WHO Global Strategy for the Containment of Antimicrobial Resistance through the European strategic action plan for antibiotic resistance. It also urges them to identify key national priorities from the seven strategic objectives in the European strategic action plan and to develop national plans. The WHO Regional Office for Europe and partners are working together with Member States’ governments to implement the strategic action plan.

202. The sixty-sixth World Health Assembly highlighted antimicrobial resistance (AMR) as a critical concern; Member States requested WHO to further strengthen its programme and activities on AMR, including the rational use of medicines with emphasis on antimicrobials. Furthermore, it was proposed that AMR should be a substantive item on governing body discussions for the agenda in 2014, with the Secretariat reporting to the Executive Board in January 2014 on WHO’s work to implement World Health Assembly resolution WHA58.27. Member States asked that the Twelfth General Programme of Work (GPW 12) be amended to highlight the importance of antimicrobial resistance and the risk it poses to public health.

### ***Situation analysis***

203. In two out of three countries in the eastern part of the WHO European Region, antibiotics can be obtained over the counter, without prescription from a doctor. Furthermore, adherence to treatment is a challenge in many countries. This is an important driver of antibiotic resistance and thereby decreases the number of effective antibiotics. Furthermore, it is alarming that no new antibiotic classes have been discovered in the last 25 years, despite research efforts.

204. Antimicrobial resistance in general and resistance to antibiotics in particular constitute an increasing global public health threat. In the WHO European Region, more than 50% of some pathogens are resistant to one or more antibiotics in some countries and bacteria with new resistant mechanisms are emerging and spreading rapidly. In the European Union, Iceland and Norway, for example, 400 000 infections with resistant pathogens are estimated to occur every year which, according to the European Centre for Disease Prevention and Control (ECDC), leads to about 25 000 deaths. In the wider WHO European Region, which comprises 53 Member States, the full burden is not known as data are not available or shared systematically by all countries. Anecdotal evidence from some of these countries, however, suggests that the situation is similar or worse. In the last few years, the situation has worsened, owing to the easy

transmission of carbapenem-resistant bacteria between patients and the increasing introduction of these bacteria into Europe from countries where they are widespread.

## ***Actions taken and progress made***

205. This section describes the actions taken, progress made and challenges faced with regard to meeting the strategic objectives set out in the strategic action plan on antibiotic resistance.

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

206. The Secretariat is supporting countries' efforts to appoint a national AMR focal point, establish a national coordinating committee for the containment of antibiotic resistance, identify key areas where action must be taken and develop or update their strategic action plan on AMR. A total of 20 Member States have committed to implementing the strategic action plan by prioritizing AMR activities in their biennial collaborative agreements (BCAs). The main challenge is to involve all relevant sectors in national coordinating committees and to ensure that these committees are granted an official status and mandate.

### **Strategic objective 2: Strengthen surveillance of antibiotic resistance**

207. The Secretariat is performing country assessments to determine Member States' status with respect to the prevention and control of antibiotic resistance through surveillance, prudent use of antibiotics and infection control, and with a specific focus on promoting national coordination and strengthening the surveillance of antibiotic resistance. Tailor-made national AMR assessments were performed in Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Kyrgyzstan, Montenegro, Switzerland and Turkey; resulting in the appointment of national AMR focal points, the establishment of intersectoral coordination mechanisms and the development of national strategic action plans (reviewed or drafted if not already in place), as well as the strengthening of national AMR surveillance. National workshops on AMR were held in Belarus, the former Yugoslav Republic of Macedonia, Turkey and Uzbekistan.

208. The WHO Regional Office for Europe signed a Memorandum of Understanding with the National Institute for Public Health and the Environment (RIVM) of the Netherlands and the European Society of Clinical Microbiology and Infectious Diseases (ESCMID) on 30 October 2012 to establish the Central Asian and Eastern European Surveillance of Antimicrobial Resistance (CAESAR) Network for Member States in the Region that are not part of the ECDC-coordinated European Antimicrobial Resistance Surveillance Network (EARS-Net). Through close collaboration with ECDC to make the networks comparable, the Regional Office will gain an overview of the situation across the whole Region. The Regional Office organizes regular CAESAR project group meetings, face-to-face and through telephone conferences.

209. The Secretariat, together with its partners, developed the CAESAR project plan, which describes the project's mission, structure, work packages, timelines, practical implementation and the responsibilities of the partners. The CAESAR manual was also drafted, to provide guidance for participating countries. It describes the objectives, methodology and organization of CAESAR, the steps that countries must take to participate, the measures necessary for routine data collection and the protocols and AMR case definitions to be used.

210. Letters of agreement on data sharing were signed between the Regional Office, on behalf of the CAESAR Network, and the institutes nominated as national AMR focal points in Belarus, Serbia, Switzerland and Turkey.

211. The CAESAR “kick-off” meeting was held on 29 April 2013 during the 23rd European Congress of Clinical Microbiology and Infectious Diseases, in Berlin, Germany. AMR focal points from nine countries and areas participating in CAESAR (Belarus, Bosnia and Herzegovina, Kyrgyzstan, Russian Federation, Serbia, Switzerland, the former Yugoslav Republic of Macedonia, Turkey and Kosovo<sup>9</sup>) presented their AMR activities and challenges.

212. In June 2013, the Secretariat facilitated a study visit of a Montenegrin delegation to the Swedish Public Health Institute. The purpose of the visit was to gain knowledge about the roles and responsibilities of a national AMR reference laboratory and to negotiate a twinning arrangement with the Swedish Public Health Institute to provide technical support to establish the National AMR Reference Laboratory in Montenegro.

213. Challenges include bringing laboratory methods into line with international standards, setting up an infrastructure for central data collection at a national reference laboratory, and the limited resources available to address the need for laboratory capacity building.

### **Strategic objective 3: Promote strategies for the rational use of antibiotics and strengthen surveillance of antibiotic consumption**

214. Since December 2011, the WHO Regional Office for Europe, together with Antwerp University, in collaboration with ECDC and the Netherlands Institute for Health Services Research (NIVEL), has held three workshops on antimicrobial use with participants from Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Montenegro, Republic of Moldova, Serbia, Switzerland, the former Yugoslav Republic of Macedonia, Tajikistan, Turkey, Ukraine, Uzbekistan and Kosovo. Joint efforts with the University of Antwerp are continuing to set up a network, compatible with the ECDC-hosted European Surveillance of Antimicrobial Consumption Network (ESAC-Net), for the surveillance of antimicrobial consumption in Member States in the European Region that are not members of the European Union. Antimicrobial consumption data collected from 11 countries through the Network in 2011 are in the process of being published.

215. In 2012 and 2013, the WHO Regional Office for Europe, in collaboration with the Danish College of Pharmacy Practice, the Netherlands Institute for Health Services Research (NIVEL) and the Institute of Rational Pharmacotherapy (IVM) organized study tours on the rational use of medicines.

216. The Secretariat works closely with ECDC: since 2012 the Regional Office has initiated monthly coordination calls with counterparts in ECDC. WHO is an active member of the EARS-Net coordinating group and has participated in several meetings organized by ECDC to coordinate activities on AMR surveillance, antimicrobial consumption and European Antibiotic Awareness Day in 2012 and 2013.

217. The Regional Office collaborates closely with the Global AMR Task Force, which is coordinated by WHO headquarters: it has monthly calls with the Task Force and takes part in video calls with all regional offices to fine-tune global AMR activities. During 2012 and 2013, the Regional Office took part in the strategic planning meeting to combat AMR for the period 2012–2015, the global technical consultation on AMR surveillance and the meeting of the AMR Task Force in 2013. The Regional Office also moderated panel discussions, organized by the delegations of Ghana and Sweden, during an AMR side event at the World Health Assembly on 21 May 2012.

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<sup>9</sup> For the purposes of this document all references to “Kosovo” should be understood/read as “Kosovo (in accordance with United Nations Security Council Resolution 1244 (1999))”.

218. The main challenge is insufficient resources for national and subregional workshops and training.

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

219. The Secretariat participated in and chaired a meeting of the Baltic Antibiotic Resistance collaborative Network (BARN) on the prevention of surgical site infection, which took place in Visby, Sweden, in October 2012. Participating countries included Estonia, Latvia, Lithuania and the Russian Federation. Together with WHO headquarters and the WHO Country Office in Estonia, the Regional Office for Europe organized three back-to-back meetings in Estonia in May 2013: the Global Infection Prevention and Control Network (GIPCN) working group meeting on generic curricula, a national workshop for the development of a training curriculum on infection prevention and control and a roundtable on antimicrobial resistance in Europe and in Estonia.

220. The main challenge is the lack of a dedicated programme at the Regional Office to devote the necessary time and resources to the implementation of this strategic objective.

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

221. The Secretariat is actively raising awareness about the food safety perspective of AMR. Many countries do not acknowledge the public health risks associated with the use of antibiotics in food animals. On the occasion of the World Health Day 2011, the Secretariat published the booklet “Tackling antibiotic resistance from a food safety perspective in Europe”, with input from many international experts and organizations. To further disseminate the knowledge captured in this booklet, as well as to build technical capacity, the Secretariat organized a subregional intersectoral workshop in May 2012 in Albania on antibiotic resistance from a food safety perspective with representatives from Albania, Croatia, Montenegro, Romania and Serbia, and a joint WHO/United States Centre for Disease Control (CDC) subregional workshop on foodborne disease surveillance and control under the Global Foodborne Infections Network (GFN), held in Kazakhstan in November 2012, was attended by representatives from Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. National meetings on AMR from a food safety perspective were held in Albania, Croatia, Montenegro, Serbia and Tajikistan in 2012 and 2013.

222. There is a long-standing and close collaboration between the Regional Office and the Food and Agricultural Organization of the United Nations (FAO) on food safety, which is the basis for joint work on AMR from a food safety perspective, such as the joint training on developing capacity on Codex work in selected countries of Europe and Central Asia, held in Kyrgyzstan in 2012 and for the Balkan countries in Croatia in June 2013. Both FAO and the World Organisation for Animal Health (OIE) have contributed to the booklet “Tackling antibiotic resistance from a food safety perspective in Europe”.<sup>10</sup>

223. The main challenges are: raising awareness among health and agricultural sectors that antibiotic usage in animals represents a public health risk; bridging the barriers between health and agriculture ministries through regular and sustained collaboration, integrated surveillance and cross-cutting policies; and the lack of resources to set up integrated surveillance and necessary capacity building.

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<sup>10</sup> *Tackling antibiotic resistance from a food safety perspective in Europe*. Copenhagen, World Health Organization Regional Office for Europe, 2011 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0005/136454/e94889.pdf](http://www.euro.who.int/__data/assets/pdf_file/0005/136454/e94889.pdf), accessed 1 July 2013).

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

224. The concept of joint programming (JP) was launched by the European Commission in 2008 with the aim of increasing the value of national and European Union research funding through the joint planning, implementation and evaluation of national research programmes. Early in 2010, Italy and Sweden proposed the Joint Programming Initiative on Antimicrobial Resistance (JPIAMR). The WHO Regional Office for Europe and WHO headquarters are engaged in this initiative to provide input into the research agenda in the area of AMR and to engage in broad regional and global partnerships to promote innovation and research. WHO is also engaged with other nongovernmental groups and networks, such as ReAct and Antibiotic Action, to promote innovation, as well as to develop new business models that stimulate research and discourage aggressive marketing of new antibiotics.

225. The main challenge is to initiate dialogue with the private sector and other stakeholders.

### **Strategic objective 7: Improve awareness, patient safety and partnership**

226. Her Royal Highness Crown Princess Mary of Denmark became Patron of the WHO Regional Office for Europe in 2005. As part of her commitment to the Regional Office's work, Her Royal Highness advocated for action against antimicrobial resistance in a statement on European Antibiotic Awareness Day (EAAD) on 16 November 2012. The Regional Office's campaign targeted consumers in the European Region, calling on them to behave responsibly and take antibiotics only as and when prescribed by a doctor. EAAD is a European health initiative coordinated by ECDC, which WHO has joined in order to extend it to all countries in the Region. EAAD was marked by 43 Member States in the Region, 8 of which were participating for the first time. The WHO Regional Office for Europe developed and distributed an awareness package to all WHO country offices in the Region and posted additional information on the AMR website.

227. Since the adoption of the European strategic action plan on antibiotic resistance (EUR/RC61/14 and EUR/RC61/R6) in September 2011, the Secretariat has participated actively in several national and international workshops, conferences and meetings on containing AMR and raising awareness. These took place in Albania, Austria, Belgium, Croatia, Denmark, Estonia, France, Germany, Kazakhstan, Lithuania, the Netherlands, Poland, Switzerland, the former Yugoslav Republic of Macedonia, Turkey, Ukraine, the United Kingdom, the United States of America and Uzbekistan. The main challenge is to translate the awareness campaign, health promotion and educational materials in order to increase the uptake of information throughout the Region.

228. The Regional Office is working jointly with an increasing number of institutes, networks and initiatives as well as the European Commission and its technical agencies (ECDC, the European Food Safety Authority (EFSA) and the European Medicines Agency (EMA)) and United Nations agencies such as FAO. Partnership includes regular exchanges of information, coordination of activities and organization of joint missions, workshops and training. An example of collaboration with dedicated networks is the initiative, under the aegis of the South-eastern Europe Health Network (SEEHN), to establish the Regional Health Development Centre on Antibiotic Resistance at the National Centre of Infectious and Parasitic Diseases in Sofia, Bulgaria.

229. Belgium, Germany, the Netherlands, South Korea and the United States are supporting activities for the implementation of the strategic action plan on antibiotic resistance by providing financial support and human resources.



## ***The way forward***

230. The implementation and monitoring of the strategic action plan will follow a stepwise approach of performing country assessments, promoting national committees, supporting national action plans and road maps and building surveillance capacity. Alongside this, the Regional Office will work towards getting a Regional overview of the major trends in antimicrobial consumption and resistance, which will be used to inform national and international interventions. This work requires additional funding for 2014–2015 to build action and sustainability at country level.

231. The following countries have requested an AMR assessment: Albania, Georgia, the former Yugoslav Republic of Macedonia, Ukraine and Uzbekistan. These assessments will be conducted in 2013 and practical workshops and meetings will be held to prepare data submissions for the CAESAR database. Follow-up activities will be based on the recommendations made during the country assessments. Furthermore, the Secretariat will focus on laboratory capacity building and external quality assurance, together with WHO Collaborating Centres and ESCMID.

232. Throughout 2013 WHO has supported and will continue to support the national surveillance networks for antimicrobial consumption; the next consultation with countries for analysis of 2013 data is planned for November 2013. Publication of antimicrobial consumption data and analysis will be available on the WHO website by the end of 2013.

233. The Regional Office will continue to engage with ECDC and other partners to provide Member States with materials for EAAD in November 2013.

## ***Conclusions***

234. The first two years of the implementation of the strategic action plan were dedicated to coordinating activities between the relevant WHO programmes, raising awareness of the strategic action plan at meetings, workshops and symposia, mobilizing collaborators and setting up partnerships, developing a project plan and manual for AMR surveillance, setting up a database for CAESAR, organizing workshops for antibiotic consumption and resistance, aligning efforts with ECDC, developing and refining country assessment tools, piloting these tools, and developing and disseminating awareness materials through WHO country offices for EAAD.

235. This high level of activity has contributed to the continued visibility and momentum, both in the public health community and in the media, of the threat of AMR. As the implementation of the strategic action plan on antibiotic resistance progresses, the Regional Office will continue to call on the relevant sectors of government in Member States to ensure political commitment and resources and to support the work of intersectoral coordination committees.