



EUROPE

The work
of WHO
in the
European
Region,
2006–2007

Biennial report of the Regional Director

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The World Health Organization was established in 1948 as the specialized agency of the United Nations responsible for directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health. It fulfils this responsibility in part through its publications programmes, seeking to help countries make policies that benefit public health and address their most pressing public health concerns.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region embraces some 880 million people living in an area stretching from the Arctic Ocean in the north and the Mediterranean Sea in the south and from the Atlantic Ocean in the west to the Pacific Ocean in the east. The European programme of WHO supports all countries in the Region in developing and sustaining their own health policies, systems and programmes; preventing and overcoming threats to health; preparing for future health challenges; and advocating and implementing public health activities.

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The work of WHO in the European Region, 2006–2007

Biennial report of the Regional Director

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Abbreviations

Organizations

CIS	Commonwealth of Independent States
DFID	Department for International Development (United Kingdom)
DG SANCO	Directorate-General for Health and Consumer Protection (European Commission)
DIPECHO	disaster preparedness programme of the European Commission Humanitarian Aid Office
EC	European Commission
ECHO	European Commission Humanitarian Aid Office
ECMT	European Conference of Ministers of Transport
ECDC	European Centre for Disease Prevention and Control
EEA	European Environment Agency
EU	European Union
Eurostat	Statistical Office of the European Communities
IFRC	International Federation of Red Cross and Red Crescent Societies
ILO	International Labour Organization
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
NHS	National Health Service (United Kingdom)
NICE	National Institute for Health and Clinical Excellence
NIVEL	Netherlands Institute for Health Services Research
OECD	Organisation for Economic Co-operation and Development
OIE	World Organization for Animal Health
Sida	Swedish International Development Cooperation Agency
UISAT	Unidad de Investigación sobre el Síndrome del Aceite Tóxico, Instituto de Salud Carlos III (Spain)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECE	United Nations Economic Commission for Europe
UNEP	United Nations Environment Programme
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund

UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
UNTFHS	United Nations Trust Fund for Human Security
USAID	United States Agency for International Development
WMO	World Meteorological Organization

Technical and administrative terms

BCAs	biennial collaborative agreements
CINDI	countrywide integrated noncommunicable diseases intervention (programme)
DALYs	disability-adjusted life-years
FCTC	Framework Convention on Tobacco Control
GS	general service staff
GSM	Global Management System
HAART	highly active antiretroviral therapy
HEN	Health Evidence Network
HINARI	Health InterNetwork Access to Research Initiative
HIPP	Health in Prisons Project
HiT	Health Systems in Transition (country profiles)
HSPA	health system performance assessment
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illness (strategy)
IPOs	international professional officers
IPSAS	International Public Sector Accounting Standards
NGOs	nongovernmental organizations
NPOs	national professional officers
OST	opiate substitution therapy
PATH	Performance Assessment Tool for Quality Improvement in Hospitals (project)
SAFE	Sexual Awareness for Europe (project)
STIs	sexually transmitted infections
TB	tuberculosis
TOS	toxic oil syndrome
YLD	years lived with disability

1. Introduction

This report reflects the work of the WHO Regional Office for Europe in 2006–2007: serving Member States and contributing to health in the WHO European Region, in line with the country strategy “Matching services to new needs” approved by the WHO Regional Committee for Europe in September 2000 (1). In this last biennium, the shift towards working in and with countries continued, exploring the different ways in which the Office worked to meet the needs of both the eastern and the western parts of the Region.

This publication offers interesting and illustrative examples of work done directly with countries to improve health and strengthen health systems. It also highlights the work done on health from a normative and technical perspective. Finally, it looks at the structure, resources and governance that enable the Office to perform as it does in two main ways: first, as a direct service to Member States and, second, in fulfilment of WHO’s mandate as the specialized health agency of the United Nations. Overall, the publication shows the Regional Office as an organization at the service of its Member States.

The report also describes cross-cutting issues – such as partnerships, health intelligence, communication and publishing – that run throughout the Office as they do throughout the report. This reflects the ever-increasing importance of working with other players in the field of health as valuable partners in synergy.

In specific terms, after this introduction, Chapter 2 explains the further shift in emphasis in the last biennium towards work done in and with countries. It explores the Office’s different ways of working to meet the needs of the eastern and western parts of the European Region, and offers a few interesting examples of the work done directly with countries. Some examples focus on health programme themes; some on health systems, and others combine the two.

Chapter 3 reviews the work done to contribute to health in the Region as a whole, presenting the two intertwining approaches to work on health, where specific health programmes provide the content while health systems are the vehicle and the means to the ends (health outcomes). Chapter 4 looks at the Regional Office's organizational aspects, resources and governance, which enable it to do its work. Annex 1 gives an overview of the programme budget and implementation.

I hope you will find this report illustrative and useful.

Marc Danzon

WHO Regional Director for Europe

2. Serving Member States directly

The Eleventh General Programme of Work (2) lists WHO's six core functions:

1. providing leadership on matters critical to health and engaging in partnership where joint action is needed;
2. shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
3. setting norms and standards, and promoting and monitoring their implementation;
4. articulating ethical and evidence-based policy options;
5. providing technical support, catalysing change and building sustainable institutional capacity; and
6. monitoring the health situation and assessing health trends.

Given the importance of country work for the Regional Office, this report begins by covering the last two of these functions. Chapter 3 covers three others, while providing leadership and engaging in partnerships are threads running throughout the report.

Shifting towards direct country support

Since its inception, WHO has successfully served Member States with technical expertise in almost all health-related areas. Recent developments in the Region have led to an understanding of the specific contexts of countries' diverse health systems. Experience shows that, to achieve sustainable health gains, individual health actions have to be embedded in a comprehensive health systems framework. To give true sense to WHO's efforts, therefore, Member States need to have reliable local, regional and national health systems and institutions. This was the driving force behind Regional Office work in the last biennium.

Further, since the update of the Health for All policy framework was approved by the Regional Committee in 2005 (3), the Regional Office has looked at ways of ensuring its impact in countries. The Regional Committee proposed selective country monitoring in 2006 and asked the Standing Committee of the Regional Committee to consider how to implement it, given that the update was non-prescriptive and did not contain targets or benchmarks, making comparisons difficult. The Standing Committee agreed that monitoring should be based on a limited set of available proxy indicators, use evidence currently collated and be

complemented by individual case studies. In addition, the European Observatory on Health Systems and Policies¹ has reviewed target setting in countries (4). While health policies including targets have been widely adopted, there is scant evidence of their effectiveness. The Observatory therefore assessed the experiences of some of the countries using targets, drawing on a series of case studies. In considering what has worked and what has not (5), these studies looked at whether the effectiveness of the health targets was measured, whether they were achieved and whether they had the intended effect. The results were very mixed, but much valuable experience was gained. Further, the examples of work in and with countries given later in this chapter contribute to this impact assessment.

How has country work evolved? The move towards addressing the needs of the Member States, through a distinct country strategy – endorsed by the WHO Regional Committee for Europe in 2000 (6) – was a turning point for the Regional Office. The strategy took account of both diversity and similarity among the 53 countries in the Region, recognizing that it must serve each country in its uniqueness.

In the last biennium, the Regional Office focused on offering country-specific services on health policy and health systems development tailored to each Member State, be it a country in transition, a candidate for accession to or a member of the European Union, or any other country.

Its mission is “to support Member States in developing their own health policies, health systems and public health programmes, preventing and overcoming threats to health, anticipating future challenges, and advocating public health” (7). It has pursued this mission by assisting countries in, for example, addressing public health priorities, building an evidence base and setting up robust health information systems.

In addition, the Office aligned the country strategy with the initiatives of other players in the field, to avoid the duplication and fragmentation of activities. The Office has strengthened its international partnerships, in particular building strong alliances with organizations that are increasingly involved in the health agenda, such as the European Union, the World Bank, the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Shifting towards country-specific support was the logical step. Following the route chosen in 2000, the Regional Office has gradually adapted itself and its functions to better address the needs of individual Member States’ health systems and to deliver at the country level.

¹ The Observatory is a partnership of the Regional Office with international agencies, national governments, research institutions, one region and an international nongovernmental organization; see Chapter 4 for more on the Observatory’s work.

The Office has signed biennial collaborative agreements (BCAs) with 33 countries. The Country Policies and Systems unit, which included specific strategic country desks, provided strategic guidance and analysis. The priority areas selected for inclusion in these agreements were aligned to the four functions of health systems: stewardship (or governance), creating resources (through investment and training), delivering (or providing) services and financing (by collecting, pooling and purchasing).

Direct country presence is a critical factor in delivering WHO support, particularly in the countries with higher disease burdens. The Regional Office has continued acknowledging this factor and pursuing the development of a strong country presence.

In organizational terms, the Operations in Countries unit was consolidated to provide a unified managerial umbrella for all the Regional Office's activities in countries. The terms of reference and functions of country office staff were reviewed and updated. The Country Work Help Desk increased in both staff and operational capacity to provide managerial coordination and support between country offices and all other units and services of the Regional Office.

The Country Work Help Desk has three main functions:

1. ensuring that country offices have all the necessary tools to support and facilitate implementation of BCAs at the country level;
2. supporting Regional Office management in many aspects of country and intercountry work, especially coordination and management; and
3. providing an important outreach to health programmes, as well as the Division of Administration and Finance, in the daily life of the Office.

The Help Desk covers all countries in the Region: both those where WHO has country offices and those where WHO works without permanent presence. The latter are mostly in the western part of the European Region. A link to WHO headquarters through the Department of Country Focus keeps the Regional Office aligned with global WHO initiatives, and able to mobilize the necessary support across the Organization to better serve its Member States.

The Regional Office often works with western European Member States without a permanent WHO presence. On the other hand, the Regional Office has an office in Brussels, Belgium as representation to the European Union, with a recently adopted strategic framework and detailed action plan (see the end of this chapter).

In addition, the Regional Office has tailored its cooperation with western Member States to their specific needs and requests as much as possible. The implementation of BCAs with

Andorra, Belgium and Portugal further strengthened the strategic focus of this collaboration. In addition, during 2006–2007, the Futures Fora series of meetings for health officials continued to stimulate debate among high-level policy-makers on particularly important public health issues.

Focusing the Regional Office's country work on developing health systems and institutions was another important element in enhancing this strategic approach. Indeed, effective health systems are a prerequisite for sustainable improvements in the population's health in the Region, despite the considerable differences between European health systems. Different sets of challenges, priorities and resources in each Member State require tailored sets of approaches and answers matching the needs of each country. The report on the implementation of the Regional Office's country strategy to the Regional Committee in 2004 recognized the challenge to define and agree on what to do to make health systems work better. In 2005, the next phase of the Regional Office's country strategy – strengthening health systems – was launched through Regional Committee resolution EUR/RC55/R8 (8). The aim was to place health systems high on the Office's agenda by reorienting the work performed in all areas, especially in priority health programmes, to better integrate it into strengthened health systems at the country level (9).

Strengthening WHO country offices

The 29 WHO country offices ensure the properly coordinated implementation of the priorities agreed with the countries' health ministries. With country office staff, the Regional Office



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The team of one of the WHO country offices, in Azerbaijan, during a visit by Margaret Chan, WHO Director-General, Marc Danzon, WHO Regional Director for Europe and Nata Menabde, Deputy Regional Director

made strategic assessments of each Member State's health needs, which defined the areas for collaboration recorded in the BCAs for 2006–2007.

The roles and functions of the heads of country offices, defined in 2002–2003, were revisited and adjusted at the Fourth Global Meeting of Heads of WHO Country Offices in November 2007 at WHO headquarters (10). These roles include managing WHO's core functions at the country level; providing leadership in advocacy, partnership and representation, policy development and technical cooperation; and administration and management. The Global Meeting used European examples to brief other regions on how the health systems approach can be incorporated into the planning and implementation of country work.

A review of the overall human resources situation in 2006–2007 identified some imbalances in terms of staff in countries, including the insufficient presence of international staff. The Regional Office has taken measures to correct these imbalances in 2008–2009. These are presented in the country/non-country distribution of Regional Office staff shown in Table 1.

Table 1. Redistribution of staff in countries, by category

Staff	Staff in 2006–2007 (%)				Revisions proposed for 2008–2009 (%)			
	IPOs ^a	NPOs ^b	GS ^c	Total	IPOs	NPOs	GS	Total
Non-country based	84	0	60	60	77	0	61	56
Country based	16	100	40	40	23	100	39	44
Total	100	100	100	100	100	100	100	100

^a IPOs: international professional officers.

^b NPOs: national professional officers.

^c GS: general service staff.

The Regional Office carried out capacity-development activities to strengthen the effectiveness of country office staff. These included training in communications, human resources, general management and key health-related technical areas in the Region.

Examples of work in and with countries

Albania: emergency medical services

At the request of the Ministry of Health, a survey was carried out in January–February 2006 in 16 of Albania's 51 hospitals, to assess the emergency departments and their services. It highlighted the low usage rate of emergency medical services in general and the low quality of the care provided in emergency departments. WHO coordinated a working group of service managers, hospital physicians and health administrators to discuss and make recommendations on how to reform these services. The group developed an operative proposal during late 2006 and the first half of 2007.

In particular, it designed a standard module for an emergency department, staffed with properly trained personnel and equipped with the minimum adequate tools for effective diagnosis and therapy. The working group also developed standardized protocols for screening patients and defining priorities for treatment, along with standardized tools and techniques, based on clinical evidence.

At a national consensus conference in June 2007, the conceptual framework of the proposed reform was then presented to the medical professional community concerned, international donors and ultimately the general public.

Designing the reform took time, but the process involved all concerned stakeholders. Providing a basis for awareness of and consensus on the needs and principles of policy reform is expected significantly to increase the chances of successful implementation. It also resulted in the preparation of a national strategy for emergency medical services, which may attract the support of development partners.

Armenia: support in strengthening the national capacity for health system performance assessment

At the end of 2004, health system reform in Armenia faced the serious challenge of very limited information on the efficiency of resource use and the overall impact of the reforms on the ground. The Ministry of Health's system of monitoring and evaluation could not yet provide a comprehensive picture of health sector performance, and particularly lacked information on coverage, access, equity, quality, effectiveness, efficiency, sustainability and the impact of poverty. The underlying reasons were lack of capacity and institutional constraints on reporting regularly on the health of the population and the functioning of the health care system, as well as the overall need for further strengthening of the stewardship function in the Ministry.

At the end of 2005, the Ministry decided to develop a national framework for measuring health system performance, based on the WHO framework (11). As a World Bank project on health sector modernization had a component on strengthening government capacity to develop and monitor effective health sector policies, the WHO Country Office, Armenia helped the three parties to join forces.

WHO's BCA with Armenia for 2006–2007 included technical support to the Ministry in strengthening its capacity for health system performance assessment (HSPA). This consisted of the development of the methodology and the instrument, the analysis of the survey data and the shape and development of the first national HSPA report. At a national consultation in

October 2007, the results and findings were presented to the main stakeholders in Armenia's health sector. Throughout the process, the Country Office was the channel for both the technical support from the Regional Office and the partnership with the World Bank, which covered in particular a local working group, some technical assistance and a household health survey.

To institutionalize the process, the local working group, after training from WHO, was located in a centre for analysing health information at the National Institute of Health.

Further strengthening of the Ministry's capacity for HSPA and its link with the decision-making process will require identifying the necessary infrastructure changes, and advising on legal and policy frameworks.

Azerbaijan: reproductive health

Maternal mortality in Azerbaijan is above average for the WHO European Region. Focusing its attention on reproductive and childhood health, the Ministry of Health asked the Regional Office to help analyse the status of reproductive health in the country. The detailed situation analysis revealed that challenges to health systems and community involvement affect access to reproductive health services for women and their families.

Based on this analysis, WHO assisted national policy-makers and experts to develop a national strategy on reproductive health for 2008–2015, which the Minister of Health approved on 30 January 2008. WHO's assistance involved close partnerships, particularly with the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the United States Agency for International Development (USAID). The following areas were identified for action:

- the health of mothers and infants
- reproductive choice, through family planning and safe abortion
- sexually transmitted infections, including cervical cancer and HIV/AIDS
- reproductive health in teenagers
- gender violence and sexual exploitation.

A clear policy and strategy are the first steps in achieving international development goals. The strategy for Azerbaijan includes a two-year action plan. As requested by the Ministry of Health, the Regional Office will monitor implementation of the plan and coordinate international assistance in this regard.

Bulgaria: strengthening the response to avian influenza

Cases of H5N1 infection among wild swans in Bulgaria in February 2006, as well as numerous outbreaks in other European countries (including in human beings in two countries), meant that Bulgaria urgently needed to strengthen its response to avian influenza and its preparedness for a potential influenza pandemic.

The WHO country office, with support from the Regional Office, WHO headquarters and the Ministry of Health, was the overall coordinator of the resulting project. Between May 2006 and December 2007, it identified the country's needs, mobilized donors and partners to fund interventions, and monitored and evaluated the implementation of the project. The Ministry of Health ensured the active participation of different bodies at all levels, such as municipalities, veterinary services, health services and civil protection structures, which highlighted the importance of multidisciplinary teams.

The overall goal of the project was to minimize the possibility of the transmission of avian influenza to human beings by providing appropriate technical information and training in prevention, surveillance, verification and reporting of occurrences of avian influenza and any possible transmission to human beings. Specifically, the aim was to provide the country with technical support to strengthen work in three related areas: the notification of disease, the diagnosis of possible cases, and infection control and case management should human cases be reported and hospitalized.

The project was implemented in the context of overall strengthening of the health system in Bulgaria, the key to effective health security. Workshops were organized on:

- surveillance
- laboratory diagnosis of avian influenza
- infection control and case management
- pandemic preparedness
- communications for journalists
- the 2005 International Health Regulations (IHR) (12), resulting in the development and adoption by the Bulgarian Council of Ministers of a national programme on IHR implementation.

At an annual meeting of epidemiologists from all government structures, a workshop was held on the surveillance of communicable disease in Bulgaria. Some 340 professionals were trained, and received CDs containing the workshop materials. Several participants, who were representatives of medical universities, will use the CDs to teach medical students and to update the curricula on epidemiology and communicable diseases.

The project also involved the development of standard operating procedures and case management documents, the procurement of computer and laboratory equipment, and the development of a web-based information system for influenza surveillance, which became fully operational in 2007. WHO headquarters donated boxes and media for transporting samples from suspected human cases of avian influenza to the national influenza centre.

Italy: Chikungunya fever

On 30 August 2007, the Italian national focal point for the IHR notified the Regional Office of a laboratory-confirmed outbreak of Chikungunya fever in four provinces of the Emilia-Romagna region, in north-eastern Italy (13). Imported cases of Chikungunya virus infection had been recorded in the European Region since the Indian Ocean outbreak in 2005. The outbreak in Emilia-Romagna, however, was the first occurrence of indigenous transmission in Europe.



© WHO/Roberta Andraghetti

A lush garden in north-eastern Italy becomes the perfect breeding site for *Aedes albopictus* mosquitoes, the vector for the debilitating and painful Chikungunya fever

At the invitation of the Italian Ministry of Health, the European Centre for Disease Prevention and Control (ECDC) and the Regional Office undertook a joint risk assessment mission, with multidisciplinary expertise, in September 2007. The mission flagged the outbreak in Italy as a wake-up call for the other European Member States where *Aedes albopictus*, the vector for Chikungunya virus, is established. Its presence is documented in at least 12 European countries: Albania, Belgium, Bosnia and Herzegovina, Croatia, France, Greece, Italy, Montenegro, the Netherlands, Spain, Slovenia and Switzerland.

Chikungunya fever, as well as other vector-borne viruses that could emerge, is likely to be a considerable challenge to public health authorities. Clinicians' probable lack of awareness of the disease would hamper early detection, resulting in a narrow time frame in which to mount an adequate multisectoral response to mitigate the impact of an outbreak. The Regional Office has therefore supported Member States across the Region, primarily those where the vector is documented, in establishing multisectoral preparedness.

Spain: toxic oil syndrome

In May 1981, Spain was confronted with the outbreak of a severe epidemic caused by the consumption of rapeseed oil meant for industrial use but sold illicitly for food use. It claimed the lives of several hundred people almost immediately and affected over 20 000 people, many of whom remain ill today.

The Spanish Ministry of Health and Consumer Affairs approached the Regional Office for assistance with international collaboration to guide research on the new disease, named toxic oil syndrome (TOS). This resulted in over 20 years' scientific collaboration between the Regional Office and the Instituto de Salud Carlos III, Unidad de Investigación sobre el Síndrome del Aceite Tóxico (UISAT), which was designated a WHO collaborating centre for the epidemiology of environment-related diseases in 1998.

The objective of the joint WHO/UISAT Scientific Committee for the Toxic Oil Syndrome was to further scientific knowledge about the epidemiology, pathology, immunology and chemotoxicology of the disease, in order to explain its etiology and prepare for similar occurrences. The Regional Office's role was to raise awareness among other Member States of the possible public health significance of TOS, should similar epidemics break out. The Regional Office published three main reports of the Committee's findings (14–16).

The joint WHO/UISAT Committee met for the last time in August 2007. Its work contributed to better knowledge of the TOS animal model, the identification of risk factors and risk prognosis, and the history of the disease. To place the results gained through this research in a wider context, an international public health symposium will take place in October 2008 in Madrid, addressing the wider topic of environment and health research as an example of evidence-based policy-making. Jointly organized by the Regional Office and the European Commission Directorate-General for Research, it will contribute to the development of a research plan for the European Region, with particular emphasis on a communication strategy for environmental hazards.

Turkmenistan: malaria

Although endemic malaria was eradicated in Turkmenistan in 1960, sporadic cases are occasionally reported. In particular, during a 1998 outbreak, 115 cases were recorded in an area along the border with Afghanistan.

To keep malaria high on the agenda, in 2002 the Regional Committee endorsed resolution EUR/RC52/R10 on scaling up the response in the WHO European Region (17). It urged the countries in the Region that faced a resurgence of the disease to take all possible measures to consolidate the results they had achieved and further reduce the burden of malaria. The ultimate goal of the new regional strategy is to interrupt the transmission of malaria by 2015 and eliminate the disease from the Region.

Responding to WHO's call to combat this disease, Turkmenistan joined the regional strategy for malaria elimination (18), which followed the Tashkent Declaration. "The Move from Malaria Control to Elimination" (19). Close epidemiological control, the use of environment-friendly biological methods of combating the vectors, close collaboration with major international organizations and the raising of the population's awareness reduced the spread of the disease to zero. No case of malaria was registered in Turkmenistan in 2006–2007.

With technical assistance from the Regional Office, the State Sanitary and Epidemiological Service of the Ministry of Health and the Medical Industry developed a national strategic plan for malaria elimination, covering 2008–2010. It is designed to eliminate malaria from the whole country, beginning with the border areas to prevent transmission from outside. The sanitary–epidemiological services carried out close epidemiological control: monitoring the situation using national indicators such as malarial morbidity, improving surveillance, promoting vector control activities, providing prompt and effective treatment to people with malaria, reinforcing health education activities and community participation and training various groups of specialists focusing on malaria.

Given the importance of cross-border transmission, the Ministry is fully committed to collaboration between the WHO European and Eastern Mediterranean regions. Turkmenistan therefore signed the Kabul Declaration on Regional Collaboration in Health at the conference "Health for All, Health by All: Communicable Diseases Recognize No Borders", in April 2006 (20). Turkmenistan also hosted a WHO meeting on progress towards malaria elimination in the WHO European Region, in Ashgabat late in 2007 (21). The Regional Office provided financial and technical support for these activities, while UNICEF supported the printing of information materials and the procurement of anti-malaria drugs, and USAID contributed funds.

Information leaflets and other material were distributed in Turkmenistan during the awareness campaign against malaria in May 2007



© WHO/Jahan Nurmuhamedova

With the Health Information Centre of Turkmenistan and the Ministry of Health and the Medical Industry, the sanitary–epidemiological services carried out a mass awareness-raising campaign on malaria prevention for the general population in May 2007, with mass media support, including articles in national and local newspapers and a special edition of a television health programme devoted to malaria. Family physicians, epidemiologists and specialists from health promotion centres distributed information to the public, while Turkmenistan Airlines crews handed out leaflets on malaria on domestic flights. The Regional Office and UNICEF gave financial support for the development and printing of many of these materials.

This experience helped develop the health system in Turkmenistan. The interventions were designed to contribute to gain health, and improve financial protection of the population and the responsiveness and efficiency of the health system.

United Kingdom: review of the National Institute for Health and Clinical Excellence

The National Institute for Health and Clinical Excellence (NICE) in England, United Kingdom, is the independent organization that provides national guidance on the promotion of good health and the prevention and treatment of ill health. It produces guidance in three areas:

- public health guidance on the promotion of good health and the prevention of ill health for staff of the National Health Service (NHS), local authorities and the wider public and voluntary sector;
- health technologies guidance on the use of new and existing medicines, treatments and procedures in the NHS; and
- clinical practice guidance on the appropriate treatment and care of people with specific diseases and conditions in the NHS.

In 2006, NICE requested WHO to make an independent review of its clinical guidelines programme. The review followed a 2003 review of the NICE programme for technology appraisal. The purpose of the review was to assess the quality of NICE's clinical guidelines. It was conducted by WHO staff (from both the Regional Office and headquarters) and a group of international experts in guideline development.

The review concluded that NICE is one of the largest, most productive and best organized developers of clinical guidelines in the world. It particularly commended the transparency and inclusiveness of NICE's consultation process and its policy on continuous quality improvement.

The reviewers made recommendations on the various types of guideline that NICE produces, the use it makes of systematic reviews, and how different types of economic model relate to decision-makers' needs. They advised NICE to strengthen its collaboration with national and international groups, and to give special attention to the implementation of guidelines. The NICE Board discussed the findings of the review and used many of the recommendations to further strengthen the programme (22).

Main activities in collaboration with the European Union

At its fifty-sixth session, the WHO Regional Committee for Europe identified the European Union (EU) as a partner of unique importance and nature for the Regional Office, and pointed out that cooperation should aim at creating new synergies and improving task sharing. The two organizations share 27 Member States, and the EU has close relations with the Regional Office's other Member States. The European Commission (EC) is a policy-setting and regulatory institution with global outreach and major financial and technical leverage.

The Regional Office and the EU and EC collaborate on political processes and consultations, such as the 2006 WHO European Ministerial Conference on Counteracting Obesity (23), as well as the diet and physical activity platform of the Directorate-General for Health and Consumer

Protection (DG SANCO). The EC participated in the preparations for the WHO European Ministerial Conference on Health Systems, while the Regional Office in turn contributed to the DG-SANCO-led consultation on the EU health strategy during 2006–2007. One of the principles of this EU health strategy is the “health in all policies” approach. The Regional Office and the EC organized a joint workshop in June 2007 on health in all policies with the countries neighbouring the EU. The Office also co-organized the EU Ministerial Conference on “Health in All Policies: Achievements and Challenges”, hosted by Italy’s Ministry of Health, in Rome in December 2007, which resulted in a Declaration explicitly recognizing the broader determinants of health, the links between health and economic development, the need for structures enabling intersectoral action and the application of methods such as health impact assessments.

The Regional Office also supports Member States holding the EU Presidency (24). In 2006–2007, it gave technical support and coordination to the EU presidencies of Austria (on type II diabetes and women’s health), Germany (on prevention, innovation and access to health services), Portugal (on health and migration) and Finland (on health in all policies). It devised an eighteen-month plan for three consecutive presidencies (those of Germany, Portugal and Slovenia).

The Regional Office and the ECDC work under the terms of a Memorandum of Understanding, with joint action plans updated annually. The cooperation is tripartite, with the EC, ECDC and the Regional Office equally involved. The joint response to avian influenza at the start of 2006 in Azerbaijan and Turkey, for instance, shows the improved coordination achieved (see the section on avian influenza in Chapter 3).

The Regional Office and the EU also collaborate and support each other at the country level. For instance, the Ministry of Health invited the WHO Country Office, Moldova to take part in consultations on the formulation of health sector activities in the EU/Moldova Action Plan (25), part of the EU’s European Neighbourhood Policy. Several of these activities were implemented with technical support from the Regional Office. The Country Office, the WHO office at the EU and the EC delegation office in Moldova further facilitated consultations between the Ministry of Health and the EU in December 2006. This strengthened the dialogue with and commitment of the EC to support the development of the health system in Moldova.

3. Improving health in the European Region through normative and technical work

As the United Nations specialized agency on health, WHO performs its functions according to the Eleventh General Programme of Work. After covering the Regional Office's work on the two main functions most directly related to country work in Chapter 2, this chapter reports on its work on three others (2):

- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards, and promoting and monitoring their implementation; and
- articulating ethical and evidence-based policy options.

In contrast to Chapter 2, which illustrated the Regional Office's work on a country-by-country basis, this chapter focuses on technical areas, largely mirroring the key challenges facing health and health systems in the European Region. It addresses health programmes first, and then health systems, which includes stewardship, service delivery, resource creation and financing.

Health programmes: highlights of work

Communicable diseases and environmental health

Vaccine-preventable diseases

The cornerstones of WHO's efforts against vaccine-preventable diseases are maintaining the Region's polio-free status and eliminating measles and rubella from the Region and controlling congenital rubella by 2010 (26). The WHO Regional Committee celebrated the fifth consecutive polio-free year in the Region in June 2007. Further, over 60% of Member States have achieved the measles and rubella elimination target set in 2005. Overall, measles incidence in the Region declined by 75% between 2003 and 2007, when some 7000 cases were reported.

Supplementary immunization activities were conducted to reach vulnerable and hard-to-reach populations in four countries: a critical component of the regional plan for elimination of measles and rubella and control of congenital rubella. These activities met the target of 95% immunization coverage set by their health ministries.

Supplementary immunization activities were held in Armenia to reach vulnerable and hard-to-reach populations and a banner over a main road in Yerevan highlights the campaign in October 2007



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European Immunization Week was launched in 2005, and repeated in 2006 and 2007, with more countries participating each time. Most countries in the Region participated in the 2007 Week in April.

Tuberculosis

In 2005, nearly half a million people in the European Region developed tuberculosis (TB) and there were 66 000 TB-related deaths. Multidrug resistance is an increasing concern; 13 of the countries in the world with the highest prevalence of multidrug-resistant TB are in the European Region. Despite serious efforts, the share of the Region's population covered by directly observed treatment, short-course (DOTS) in 2005 remained below 50%. These figures



Key participants at the WHO European Ministerial Forum “All against Tuberculosis” in 2007 stand behind the Berlin Declaration on Tuberculosis

reveal serious difficulties with health systems, underlining the need for WHO to work with countries to develop their systems.

In October 2007 in Berlin, Germany, the Regional Office held the WHO European Ministerial Forum: “All against Tuberculosis”. Its main outcome was the endorsement of the Berlin Declaration (27), aimed at resetting health agendas across the Region to ensure that urgently needed commitment and funds are mobilized to halt the spread of the epidemic and addressing the growing challenge of multi- and extensively drug-resistant TB (28). Member States committed themselves to monitor and evaluate the implementation of this Declaration.

HIV/AIDS

While the European Region continues to have the fastest growing HIV epidemic in the world, access to HIV/AIDS prevention, treatment and care increased significantly during the biennium. A larger number of countries provided highly active antiretroviral therapy (HAART); 38 of the 53 Member States provided HAART to over 75% of people living with HIV who need it. In December 2005, an estimated 343 000 patients in the WHO European Region were on HAART, increasing to 385 000 in 2006 and 435 000 by December 2007. The corresponding figures for central and eastern Europe also rose: from 23 000 patients on HAART in 2005 to 35 000 in 2006 and 55 000 by December 2007. Unfortunately, the number of new patients in central and eastern Europe is rising faster than the number of people with access to treatment.

The main objectives in 2006–2007 were to provide normative guidance, and to advocate and to assist Member States in achieving universal access to HIV/AIDS prevention, treatment and care by 2010. The progress report on implementing the Dublin Declaration summarizes much of the progress and many of the challenges (29). The WHO Regional Office for Europe prepared it in collaboration with partners, with funding from the German EU Presidency, and on behalf of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

In addition, the Regional Office – in collaboration with WHO headquarters, the United Nations Office on Drugs and Crime (UNODC) and UNAIDS – developed targets for universal access to HIV/AIDS prevention, treatment and care for injecting drug users, developed a measurement system for monitoring and evaluation, and provided technical support. In HIV prevention, opiate substitution therapy (OST) has been strongly scaled up in EU countries. The Regional Office has been particularly active in, for example, Ukraine, where it worked with the local authorities to introduce and scale up OST and worked with the chief narcologist to revise the methodological guidelines for methadone substitution therapy. The Regional Office also provided systematic technical assistance to Member States applying to the Global Fund.

As to normative guidance, the Regional Office published WHO European clinical protocols for HIV/AIDS treatment and care in 2007 (30).

Other sexually transmitted infections

The increased risk of HIV infection and transmission compounds the burden of sexually transmitted infections (STIs) in the European Region: a combination of stigmatization, acute illness, infertility, disability and mortality. Notably, STIs increase the risk of acquiring or transmitting HIV, especially in their early phases. Syphilis, for example, and HIV both tend to affect similar population groups, such as men who have sex with men, injecting drug users and their sexual partners, and heterosexual people with frequently changing sexual partners. Chlamydia also increases the risk of HIV infection; it is the most common STI in the European Region, especially among young people, and is often asymptomatic, particularly in women. Lymphogranuloma venereum, caused by *Chlamydia trachomatis*, is increasingly frequent among men who have sex with men. Every year, about 1.2 million STI cases are reported in the European Region.

Ensuring universal access to equitable, effective, safe and affordable prevention, treatment and care remains the key public health challenge in the European Region. The variation in the composition and quality of STI surveillance systems, however, does not allow for comparisons of surveillance data and limits the interpretation of trends. A particular challenge is delivering a coordinated health system response, addressing STIs and HIV simultaneously and integrating services for both. An overarching public health approach is also required to tackle the epidemics' complex underlying factors.

In 2006–2007, the Office's main objectives were providing normative guidance, and advocating and assisting Member States with improved STI prevention, treatment and control (31). The WHO Global Strategy for the Prevention and Control of Sexually Transmitted Infections provides the framework and the public health approach necessary for reducing the burden of STIs.

Viral hepatitis

Globally, an estimated 180 million people are infected with hepatitis C and 350 million with hepatitis B. The prevalence of hepatitis C virus among injecting drug users in the Region is 65–95%; the average co-infection rate with HIV is around 40%, although it varies widely. Liver disease related to hepatitis C virus is the leading cause of death among co-infected patients. Risk factors for hepatitis B virus transmission and infection are similar to those for HIV, although the former is more infectious.

The Regional Office contributed to promoting hepatitis awareness by hosting World Hepatitis Day 2006. It was also a lead contributor to the book *Hepatitis C among injecting drug users in the new EU Member States and neighboring countries: situation, guidelines and recommendations* (32). WHO normative guidance included protocols on the clinical management of HIV and hepatitis B and C co-infection (33).

Malaria

Malaria continues to pose a challenge in six Member States in the Region: Azerbaijan, Georgia, Kyrgyzstan, Tajikistan, Turkey and Uzbekistan. The ultimate goal of the new regional malaria strategy is to eliminate malaria in the European Region by 2015 (18). Towards this end, all malaria-affected countries in the Region have endorsed the Tashkent Declaration. “The Move from Malaria Control to Elimination” (19).

The main obstacle to elimination programmes is their cost, which is usually higher than the resources available. WHO and the Global Fund are at present the main financial sources for interventions at the country and regional levels. A well-functioning health system, able to carry out effective interventions, is crucial. Interventions such as bed-net distribution are not necessarily expensive; the challenge is their distribution and control. As described in the case of Turkmenistan (in Chapter 2), the Regional Office supports this approach with technical experts in the field and awareness raising among the population.

Tropical diseases

In 2007, the Joint Coordinating Board of the UNICEF/United Nations Development Programme (UNDP)/World Bank/WHO Special Programme for Research and Training in Tropical Diseases adopted and endorsed its ten-year vision and strategy “Fostering an effective global research effort on infectious diseases of poverty in which disease endemic countries play a pivotal role” (34). The new strategy revolves around three functions:

- stewardship for research on infectious diseases of poor populations;
- empowerment of researchers and public health professionals from disease-endemic countries; and
- research on neglected priority needs, including those related to emerging diseases.

A new approach to the research agenda was most needed as, over recent decades, the research environment has changed significantly, new challenges have emerged and collective research efforts need to be more responsive to priorities set by disease-endemic countries. An aspirational budget of US\$ 121 million for the 2008–2009 biennium was agreed on. The Special Programme's operations were fully aligned with the new strategy by 1 January 2008.

The Joint Coordinating Board, established in 1975, includes the following Members from the European Region:

- Bulgaria (until the end of 2010) and Uzbekistan (until the end of 2009) as representatives of the Region;
- Germany, the Netherlands, Switzerland, the United Kingdom (until the end of 2008), Norway (until the end of 2009), Belgium and Sweden (until the end of 2010) as contributors of financial resources; and
- Luxembourg (until the end of 2008) as one of the other cooperating parties.

The Board's thirty-first and thirty-second sessions were scheduled to take place in Brazil (in June 2008) and Switzerland (in June 2009).

Avian influenza, pandemic preparedness and the IHR

From 2003 to 31 March 2008, WHO Member States registered 373 human cases of influenza A/H5N1 virus infection globally, including 236 fatal cases. From July 2005 to 21 November 2007, 28 countries in the Region notified the World Organization for Animal Health (OIE) of at least one H5N1 outbreak in animals.

In 2006 in the European Region, 20 human cases (9 resulting in death) were reported: in Turkey (12 cases and 4 deaths) and Azerbaijan (8 cases and 5 deaths). The Regional Office led international missions to these countries to assist their governments' efforts to investigate and respond to the outbreaks in human beings. It worked closely with national intersectoral crisis committees, United Nations agencies, ECDC and EC to strengthen pandemic preparedness in the Region. The report *Making preparation count* (35) summarizes the lessons learnt from the avian influenza outbreak in Turkey, which national and international public health agencies and policy-makers can use to respond effectively to future outbreaks and a possible pandemic.

Epidemics, pandemics and public health emergencies of any kind can place sudden and intense demands on governments, societies and health systems. They expose existing weaknesses in these systems and, in addition to causing morbidity and mortality, can disrupt



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Local doctors and a disinfection team assemble in Salyan, Azerbaijan, in response to human cases of infection with the H5N1 virus in March 2006

economic activity and development. Of course, these threats to health security come not only from communicable diseases but also from natural and human-made disasters, conflicts and complex emergencies, and challenges such as climate change. The WHO Regional Office for Europe strongly emphasized preparations to manage such health security threats during the biennium (see also the section on disaster preparedness and response below).

The IHR (12) provide a renewed framework for managing health security threats, aiming to prevent, protect against, control and provide a public health response to the international spread of diseases. They were approved by the Fifty-eighth World Health Assembly in May 2005 and entered into force on 15 June 2007.

The Regional Office assists Member States in their efforts to implement the IHR by providing technical advice. It pays particular attention to helping countries develop core capacities for surveillance and response at all levels of public health services, as well as at designated points of entry (airports, ports and border crossings). Since 15 June 2007, the WHO IHR Contact Point has considered over 60 events of potential international public health concern. By April 2008, all 53 Member States of the Region, as well as the Holy See, had designated national IHR focal points.

Environment and health

Environmental factors have been estimated to lie behind at least 1.7 million deaths per year in the European Region: some 18% of the total. For people aged 0–19 years, they are

estimated to account for one third of the total disease burden. Against that background, the Intergovernmental Midterm Review meeting in June 2007 was a key milestone for Member States to review and report on progress made in implementing the Budapest Conference Declaration and to renew their commitments for action in environmental health (36).

Similar normative work was developed in other environmental areas. The Protocol on Water and Health (37), for example, entered into force in August 2005 and has been ratified by 21 countries. The updated WHO air quality guidelines, providing policy-makers with a reference to develop evidence-based air quality standards and policies, were widely promoted through the media and scientific events (38).

WHO chairs the Task Force on Health, which provides the United Nations Convention on Long Range Trans-boundary Air Pollution with the evidence that enables it to consider the health effects of air pollution in the policies of countries that are Parties to the Convention. It also supports the Parties to the Protocol on Water and Health, along with the United Nations Economic Commission for Europe (UNECE).

The Regional Office works through a broad range of partnerships and supports networks of national focal points, including taking part in international collaborative projects. It regularly supports countries in developing national environmental health policies through training in capacity building and the development of methodological tools for risk governance and health impact assessment.

Climate change challenges health systems across the Region to address its immediate health consequences by adaptation, as well as to identify, advocate and implement effective mitigation strategies. WHO has developed a number of tools that can help countries study the health effects of climate change and plan adaptation measures, particularly for extreme weather events. Many research initiatives have involved the Regional Office as a coordinator or partner, such as those on climate change and adaptation strategies for human health, the effects of summer climates on human health and allergic disorders. A highlight was the coordination of the human health chapter for the fourth assessment by the Intergovernmental Panel on Climate Change (39), which won the Nobel Peace Prize in 2007. The Regional Office has worked to engage partners from eastern Europe in these research initiatives.

The identification, development, standardization, evaluation and broad use of systems for monitoring and assessing changes in environmental and health indicators started through the Regional Office's cooperation with the European Environment Agency (EEA), and are planned to be extended through the development of an information system on climate, environment

and health. Further work is needed on key indicators of climate change's impact and how to assess trends over time.

The Regional Office works on global change and health with various United Nations bodies, such as the United Nations Environment Programme (UNEP), the World Meteorological Organization (WMO), UNECE and the United Nations Framework Convention on Climate Change (UNFCCC). It is an active partner in the Nairobi Work Programme on Impacts, Vulnerability, and Adaptation to Climate Change. The EC, EEA and ECDC are key partners in work for a better understanding and monitoring of trends over time and for evidence-based solutions to problems such as heat-waves and emerging infectious diseases.

Noncommunicable diseases and related risks and challenges

Noncommunicable diseases are estimated to account for 86% of deaths and 77% of the disease burden in the European Region as measured in disability-adjusted life-years (DALYs). Cardiovascular diseases and cancer are the main contributors to this burden and to the almost twenty-year difference in healthy life expectancy across the Region.

An effective response to the challenge of noncommunicable diseases requires integrated action on risk factors and their underlying determinants across sectors, combined with efforts to strengthen health systems to improve prevention and control. Following extensive consultation with countries, the European Strategy for the Prevention and Control of Noncommunicable Diseases was endorsed at the fifty-sixth session of the WHO Regional Committee for Europe and then widely disseminated across the European Region (40).

As visible examples, a meeting on cervical cancer prevention brought together 46 Member States in May 2007 (see the section on reproductive health below), and the Regional Office collaborated with the European Cardiology Society, European Heart Network and EC to develop the European Heart Health Charter, launched in 2007 (41). The countrywide integrated noncommunicable diseases intervention (CINDI) programme is implemented in 31 countries (42).

Tobacco and alcohol

Tobacco remains the leading contributor to the disease burden in over half the European Region. Public support for strong policies and actions for tobacco control is now significant and growing at both the national and international levels. By the end of 2007, the WHO Framework Convention on Tobacco Control (FCTC) (43), WHO's first globally binding public health treaty, had 152 Parties, of which 41 are European Member States, plus the European

Indoor public places such as restaurants, cafés, pubs and bars are now no-smoking areas in many European countries



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Community. These countries have actively contributed to the first two conferences of Parties and the elaboration of the FCTC guidelines and protocols. The most remarkable development was the complete ban on smoking in indoor public places in a number of European countries. The Regional Office:

- reported on the situation of and policies for tobacco control in the European Region (44);
- reviewed progress in implementing the European Strategy for Tobacco Control since its adoption in 2002 (45); and
- established a baseline for monitoring progress in implementing the FCTC in the Region.

The European Region has the highest per capita alcohol intake in the world and the harmful use of alcohol accounts for 10.1% of the disease burden, measured in DALYs. The Regional Office's main objective has been to support Member States, and ensure adequate health promotion, disease prevention and disease management, and research, evaluation and surveillance activities on alcohol consumption and harm, in line with the aims of the framework for alcohol policy (46). Nevertheless, about half of the Region's Member States have not yet adopted an alcohol action plan.

The Regional Office consistently collaborates with the EC on a number of alcohol-related issues. It is a member of the EC working group Alcohol and Health, and contributes to the Northern Dimension Partnership in Public Health and Social Wellbeing project, which includes alcohol as one of its priorities. The Regional Office updated the European Alcohol Information System (47), a database on alcohol consumption, in June 2006; from 2008, it will be combined into an alcohol information system developed with the EC, to streamline data collection and facilitate the development of consistent statistics.

Mental health

Mental health problems are estimated to account for 19.5% of DALYs; they rank as the top cause of years lived with disability (YLD): some 39.7% of YLD attributable to all causes. Unipolar depressive disorder alone causes 13.7% of YLD, making it the leading cause of chronic conditions in the WHO European Region. Institutional care still dominates in most parts of the Region, with more than two thirds of all beds for mental ill health located in psychiatric hospitals. In some countries, maintaining large institutions takes up 85% of the money devoted to mental health. Many mentally disabled children, adults and older people live in social care homes, sometimes in poor conditions.

The objective of the Regional Office's work in 2006–2007 was to implement the priorities of the 2005 Declaration and Action Plan (48). Many countries across the Region have developed mental health strategies. WHO provided technical assistance to 24 Member States to draft or revise their strategies, and to promote the integration of prevention with promotion, and the coordination of primary care with specialist services. Meetings to plan or launch national strategies were held in the Czech Republic, Latvia, Lithuania, Moldova, Poland, The former Yugoslav Republic of Macedonia and Ukraine.

The Regional Office provided technical support to the mental health project in the nine countries in the South-eastern Europe Health Network (49), particularly for workforce development, leadership development and case management training. It carried out missions requested by the health ministries in Lithuania and Romania, and assessed mental health care in Tajikistan. In Albania, where the deinstitutionalization programme is progressing gradually, WHO is coordinating the development of community teams and primary care capacity.

The Regional Office took part in high-level events on mental health, including several EC events, the European Parliament health group and EU Presidency events. WHO also supported the EC and the Council of Europe in creating an analytical inventory of the range of existing policy measures related to mental health. It launched a new mental health web site, in partnership with the Netherlands, and 35 countries are taking part in a detailed baseline assessment of mental health policy implementation. It agreed to publish reports on the state of mental health in Europe (with the EC), social determinants of mental health and epilepsy in Europe.

Obesity, nutrition and physical activity

Poor nutrition is estimated to account for 4.6% of the total disease burden in the Region. Micronutrient deficiencies (vitamin A, iodine and iron) are a concern, and the rate of exclusive breastfeeding at six months is low everywhere: ranging from 1% to 46%. At the same time, the rising epidemic of obesity is estimated to account for an additional 7–8% of DALYs. Some

17–24% of the population do not reach the recommended minimum level of physical activity. More worryingly, overall trends are worsening, with considerable inequalities across the Region (50).

In 2006, the Regional Office held the WHO European Ministerial Conference on Counteracting Obesity (23) in Istanbul, Turkey after wide consultation with Member States, experts and stakeholders. The Conference resulted in the WHO European Charter on Counteracting Obesity (51), which provides a clear policy orientation: to curb and reverse the obesity epidemic in the next decade, through actions designed to change the social, economic and physical environment at all life stages and in different settings. Many of the delegations underlined the importance of physical activity in tackling the obesity epidemic.

To follow up the Istanbul Conference, the Regional Office developed the second WHO European Action Plan for Food and Nutrition Policy (52). The Plan, endorsed by Member States at the Regional Committee in 2007, presents a detailed list of priority actions on nutrition, food safety and food security.

A survey in 2007 indicated good progress on policy since the Istanbul Conference, and the Regional Office developed a more refined analysis tool for key policy areas, systematically to track progress towards the goals adopted at the Conference. It set up a database on nutrition policy, and made an international inventory of documents on promoting physical activity (53). The inventory now contains about 400 items, including national policies on physical activity promotion from 23 countries (including through environmental approaches such as cycling and walking), knowledge and information documents, projects and case studies.

WHO has made several implementation tools available to Member States. The Regional Office presented the new WHO child growth standards at two meetings and disseminated them in



English and Russian (54). Five countries officially adopted them and nineteen indicated that they were considering adoption. The Regional Office assisted several countries in developing food-based dietary guidelines: three countries have developed such guidelines and four have revised them. Sixteen countries have maternal nutrition guidelines and three are developing new complementary feeding guidelines.

Pregnancy, childbirth and sexual and reproductive health

Maternal mortality in the European Region ranges from 210 deaths per 100 000 live births in central Asia to 4–5 per 100 000 in several western European countries. Similarly, neonatal mortality ranges from 27–32 deaths per 1000 live births in central Asia to 3 per 1000 in western European countries, and perinatal mortality ranges from 11.55 per 1000 births to 6.48. Clearly, much needs to be done to make pregnancy safer in the Region, and such improvements are a matter of equity.

The Regional Office implemented WHO recommendations and best practices in collaboration with health ministries in 12 priority countries, to increase awareness of, commitment to and action to improve maternal and perinatal health in the Region. Both financial and technical collaboration with United Nations and nongovernmental partners increased. Using the *Beyond the numbers* tool (55), the Regional Office organized workshops on maternal mortality and morbidity case reviews. It also organized training courses and workshops for health professionals with the recently updated package for effective perinatal care, and published *Improving maternal and perinatal health: European strategic approach for making pregnancy safer* (56). This gives broad guidance to a wide audience – from health associations to policy-makers and other partners – on how to develop or update strategies to improve the health of mothers and babies.

The Regional Office launched a project to strengthen national capacities for improving maternal and neonatal health in south-eastern Europe, which included a workshop for senior health professionals in developing and using clinical guidelines (57). It supported Moldova in strengthening the capacities of families and communities to engage with mothers as partners and to meet their and their babies' needs.

In the related field of reproductive health, the main priorities were improving the sexual and reproductive health of adolescents and young people, the prevention of cervical cancer, and access to high-quality reproductive health services.

Unwanted pregnancies and sexually transmitted diseases are high among young people, reflecting their lack of access to reproductive services. Twenty-six countries in the European Region took part in the Sexual Awareness for Europe (SAFE) project, a European partnership



A health professional in Tajikistan advises a new mother on how to give her newborn baby the best start in life

to promote the sexual and reproductive health and rights of young people. The partners – the EC, the International Planned Parenthood Federation (IPPF) European Network, Lund University and the WHO Regional Office for Europe – aimed to develop new ways to build on existing research and transmit sexual and reproductive health information and services to young people.

Among the project's results were the combination and publishing of information on sexuality education in a multicultural Europe, young people's sexual behaviour and policies to improve health (58). The Regional Office held a consultation at which high-level policy-makers met in December 2006, shared their experience with safeguarding sexual and reproductive health in their countries and planned future steps (59). A final meeting, to evaluate the achievements of

the project and present a policy guide on improving the sexual and reproductive health and rights of young people in Europe, took place in October 2007 (60).

An unacceptably high number of women die each year from cervical cancer, an essentially preventable disease. Vaccines against the human papilloma virus, the main cause of cervical cancer, were approved for clinical use in 2006. A regional meeting in May 2007 and an issue of the magazine *Entre Nous* (61,62) provided sites for an exchange of experiences on the prevention of cervical cancer in the Region, and a WHO strategic note on the implementation of the vaccine in Europe was drafted as evidence-based guidance for countries.

Gender-related health issues

Discrimination, poverty and unequal power in relationships prevent many women from attaining and maintaining the best possible health. Reproductive health problems and gender-based violence are the two main health consequences of gender inequalities. Gender also interacts with other socioeconomic determinants of health, such as education, poverty and ethnicity.

The World Health Assembly approved the Strategy for Integrating Gender Analysis and Actions into the Work of WHO (63) in 2007. It provides the framework for mainstreaming gender into the work of the Regional Office, country offices and countries, mainly through the development of tools, the dissemination of evidence and the identification of gaps and priorities.

In particular, the Office has gained broader knowledge of the evidence of links between gender and health in areas such as:

- HIV, to follow up the Dublin Declaration (64);
- noncommunicable diseases, through the European Strategy for the Prevention and Control of Noncommunicable Diseases (40);
- tuberculosis; and
- fatherhood and its impact on men, women and children (65).

The Regional Office gave direct assistance to:

- Belgium, through a dialogue on the establishment of a women's health unit under the health ministry;
- Moldova, developing the module on domestic violence during pregnancy of the implementation plan for the national reproductive health strategy;
- Spain, for a report on gender and health; and
- Tajikistan, for making a domestic violence law, and integrating the topics of gender and sexual and reproductive health rights into a reproductive health strategy.

It also contributed to a gender and health chapter in a gender assessment by the United Nations Thematic Working Group on Women's Empowerment and Gender Equality.

Child and adolescent health and development

While some countries in the Region have some of the lowest rates of infant and child mortality in the world, others have rates 10 times as high. A child born in the Commonwealth of Independent States (CIS) is three times as likely to die before age 5 as a child born in the EU. This partly results from unequal access to health services; further, women and children comprise the largest segment of the poorest population and are more affected by high mortality and underlying conditions such as malnutrition.

As a place for learning for more than 95% of children and young people in the Region, schools are valuable settings for initiatives for health promotion and disease prevention addressing such issues as smoking, nutrition and alcohol. After years of increasingly successful activities, the technical secretariat of the European Network of Health Promoting Schools, established in 1993 as a tripartite project of the Council of Europe, the EC and the Regional Office, was transferred to a WHO collaborating centre – the Netherlands Institute for Health Promotion and Disease Prevention.

Suicide is the third leading cause of death among young people. Further, those under 25 years of age account for 30–40% of all reported HIV/AIDS cases, and young people account for over a quarter of the newly diagnosed HIV infections in eastern Europe and the CIS. The Russian Federation and Ukraine provide vivid examples of how the HIV epidemic not only affects different cohorts but is also moving into the general population.

Out of a population of 77 million children, an estimated 14 million are overweight and 3 million, obese, and these figures are increasing. At the same time, stunting related to malnutrition remains a problem, particularly in some countries in central Asia.

The Regional Office supported 12 countries in applying the European Strategy for Child and Adolescent Health and Development (66) to develop and implement their own strategies and policies, using a tool kit developed for this purpose (67). The kit consists of tools for:

- assessing existing policies and strategies;
- identifying relevant areas of data for both developing a strategy and monitoring child and adolescent health;
- choosing relevant action to take within the health sector, the health system and other sectors (from a list including internationally agreed strategies and guidelines); and
- ensuring that gender issues are dealt with throughout the process.

In 2006, half the countries in the Region developed strategies, and half of these used the European Strategy as the framework.

Many children do not achieve their potential cognitive development, owing to poverty, poor health and nutrition, and deficient care. WHO's Integrated Management of Childhood Illness (IMCI) strategy uses an intervention for early child development called Care for Development (68). The intervention was incorporated into the pre-service training and post-diploma curricula for health professionals and the primary health care for children in eight countries in the Region (Armenia, Kazakhstan, Kyrgyzstan, Moldova, the Russian Federation, Tajikistan, Turkmenistan and Uzbekistan), to enable them to address this challenge in an integrated way.

With the help of the Regional Office, ten countries (Armenia, Georgia, Kazakhstan, Kyrgyzstan, Moldova, the Russian Federation, Tajikistan, Turkmenistan, Turkey and Uzbekistan) improved the quality of their paediatric care, despite limited resources, through the introduction of a toolkit of adaptable instruments, including a framework for quality improvement, evidence-based clinical guidelines (in the form of the *Pocket book of hospital care for children* (69)), and teaching materials.

The WHO orientation programme on adolescent health for health-care providers is used to build capacity to deliver service to adolescents and young people, including those most at risk (70). In line with the priority of supporting countries in improving the quality of care for young people in the European Region, the Regional Office assisted Moldova to develop standards for the quality of care of youth-friendly health services. The standards were subsequently integrated into an overall proposal to the government to increase the accessibility and appropriateness of youth-friendly health services in the country.

Violence and injury prevention

Injuries are estimated to cause some 790 000 deaths in the WHO European Region each year, with great inequalities both between and within countries. Injuries and violence are the leading cause of death in people aged 1–44 years.

The Regional Office assists Member States in reducing the burden of injuries and violence and collectively achieving the commitment made in Regional Committee resolution EUR/RC55/R9 on injury prevention in the Region (71) and related World Health Assembly resolutions. In particular, most Member States now regard the prevention of both road traffic injuries and violence as priorities. The focus has been on developing national policies, strengthening surveillance, supporting evidence-based practice and building capacity, including the stewardship role of health systems.

The Regional Office established a network of national focal points in health ministries, representing 49 Member States, as a forum for sharing best practice and building capacity in violence and injury prevention (72). The first global network meeting was held in April 2006 and the second and third European network meetings were held in June 2006 and November 2007.

The Regional Office strengthened its partnerships with the World Bank and the European Conference of Ministers of Transport (ECMT), through joint work on road traffic injury prevention in the Russian Federation, and with DG SANCO and the EC Directorate-General for Energy and Transport.

Health in prisons

The Regional Office developed a prison health database in collaboration with Member States and the European Monitoring Centre for Drugs and Drug Addiction, and a best practice database in collaboration with the Department of Health, England, United Kingdom. It also published a textbook, *Health in prisons. A WHO guide on the essentials in prison health*, in 2007 (73).

The Health in Prisons Project (HIPP) has a network of 36 countries with national counterparts at ministerial level, acting as a contact between the Regional Office and the Member State (74). The network held two international meetings in 2006 and 2007, and established a steering group with representatives of national and international organizations working or with substantial potential and interest in the field. WHO's policy recommendations and best practices were implemented in collaboration with ministries responsible for health in prisons and ministries of health. A new HIPP action plan for 2006–2010 was adopted. The Regional Office convened technical consultations on priority issues in prison health, such as tuberculosis and mental health.

Highlights on strengthening health systems in the European Region

The world health report 2000 (75) defines health systems as all organizations, people and institutions producing actions whose primary purpose is to improve health. This definition includes personal and population health services, as well as influencing actions taken by other sectors (such as agriculture, education and trade) that affect health. The intrinsic goals of any health system are to improve health status, to ensure financial protection for individuals at risk of being impoverished by medical expenses by distributing the financial burden fairly, to be responsive to population expectations and to be efficient. These goals are pursued through

four main functions (or repeated sets of activities): service delivery, financing, stewardship/governance and resource creation (11).

The Regional Office focuses on supporting the essential components of the four health system functions in Member States, so that they can attain the highest possible level of health. For the last few years, the Regional Office has accordingly worked to better integrate the work of its health and health systems programmes and to improve the coordination between the four functions of health systems.

European countries face substantial challenges in developing their health systems. Developing high-quality services based on primary health care is the key to improving health system performance in both the eastern and the western countries in the Region. In addition, costs are forcing governments to make difficult choices. Health technologies (including pharmaceuticals), research and human resources have become essential elements of innovation and growth, but have proven hard to plan. Good stewardship/governance is promoted, with a focus on accountability, but health ministries and related institutions often lack the necessary tools. The following examples illustrate how the Regional Office assisted responses to the challenges that health systems throughout the Region face to varying degrees.

Service delivery

Primary health care

Strengthening primary health care services is a priority in health reforms throughout the European Region. Western countries need to counter rising costs and meet changing demands, while central and eastern European and the CIS countries need fundamentally to improve quality and coverage to satisfy the largest possible segment of their increasingly demanding populations.

The Office's overall objective is to equip Member States with the evidence-based information and monitoring tools they need to support informed policy decisions and interventions. It therefore supported Member States in assessing the strengths and weaknesses of their primary health care services over time and then linking evidence-based research tools to practical use in countries. This work specifically included:

- monitoring and assessing the development and performance of primary health care through a survey first pilot-tested in the Russian Federation and Turkmenistan, and then fully carried out in Bosnia and Herzegovina, Estonia, the Russian Federation, Turkmenistan and Uzbekistan;

An anxious client seeks advice in an ambulatory primary health care clinic in Kyrgyzstan



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- pilot-testing mechanisms to improve quality in primary health care in Slovenia and Uzbekistan, and then implementing them in Georgia, Kazakhstan, Kyrgyzstan, Slovenia, Ukraine and Uzbekistan; and
- assessing the best ways of integrating specialized vertical programmes into primary care on a pilot basis in Kyrgyzstan and Ukraine, thus supporting the evolution towards integrated delivery systems in Belarus, Kyrgyzstan, Kazakhstan, Georgia, Ukraine and Uzbekistan.

The Netherlands Institute for Health Services Research (NIVEL), a WHO collaborating centre for primary care, carried out these projects.

In addition, the Regional Office organized some policy dialogues around these topics: in Belarus in May 2007, in Estonia in March 2006, in Kazakhstan in November 2006, in Kyrgyzstan in May 2006 and in Uzbekistan in May 2007 (76).

Public health services

In addition to facing challenges in primary health care, many countries in the Region have inadequately developed public health services. In particular, those in central and eastern Europe often have vertically segmented public health programmes, run in parallel (77). In the past biennium, the Regional Office's objectives were to develop a proper definition of public

health services and a robust methodology for their evaluation, and to make recommendations for further strengthening, streamlining and improving their performance. Using the methodology developed by an expert group in 2006, the Regional Office produced a first draft of a technical paper on the core public health services and a detailed questionnaire and a computerized tool for self-assessment, and ran a series of training and policy workshops.

The Regional Office provided policy advice and technical assistance to Estonia, Kyrgyzstan and Slovenia and to the nine countries belonging to the South-eastern Europe Health Network: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Montenegro, Romania, Serbia and The former Yugoslav Republic of Macedonia (78).

The Regional Office has promoted policy development and placed public health services higher on the agenda for national health system reform. Network members elaborated and discussed a draft report on the subject at a regional policy workshop in Romania in November 2007 and the Network's seventeenth meeting, in Croatia in December 2007 (79). One of the main bottlenecks identified during the evaluation was health systems' human resources and their migration.

The Regional Office has acted as coordinator and policy leader for the overall process, with international partners implementing specific projects agreed in advance. The main partners were the Department of Health, England, United Kingdom, the Council of Europe Development Bank and the Valencian School for Health Studies, Spain.

Emergency medical services

As mentioned above (in the section on violence and injury prevention), low- and middle-income countries suffer the vast majority of deaths and disabilities caused by injuries. This is because both rates of injury and the chances of their resulting in death or disability are higher in these countries. They therefore need help to assess the limitations and then strengthen the capacities of their emergency care systems.

In 2006, the Regional Office published a guide for mass-casualty management (80) as a tool for emergency planning; it lists the appropriate measures for hospitals and other health facilities to take to better prepare themselves for any critical situation. This practical tool was part of the preparation of a crisis preparedness plan for hospitals, with special focus on the possibility of a pandemic influenza outbreak. Many countries – including Armenia, Austria, Bulgaria, the Czech Republic, Georgia, Poland, Slovakia and The former Yugoslav Republic of Macedonia – asked WHO to present the document to concerned professionals or run workshops for them.

The Regional Office also launched an initiative supported by the EU to assess the preparedness of emergency medical services in EU Member States. Finally, it is promoting the implementation of a research protocol to study immigrants' use of emergency medical services.

Disaster preparedness and response

The Regional Office's main technical focus here is to enable local systems to manage threats to health security by responding effectively to the health aspects of future disasters and crises. Political and technical instability jeopardizes programme sustainability in some countries, and most health ministries' emergency preparedness programmes have limited capacity and resources. These factors make promoting a comprehensive, multi-hazard, multi-sector approach a challenge.

The Regional Office launched a discussion paper on recent health crises in the European Region, *Towards health security (81)* in connection with World Health Day 2007, whose theme was international health security. The paper reviewed the lessons learnt from tackling recent threats to health security, which include communicable diseases (see the section on avian influenza, pandemic preparedness and IHR), natural disasters and large-scale accidents, conflicts, complex emergencies and climate change (see the section on the environment and health).

The Regional Office carried out technical activities to promote risk reduction and build the emergency management capacities of the health sector across the Region. In two post-conflict environments, the North Caucasus in the Russian Federation and Kosovo,² the Regional Office has addressed recovery and rehabilitation with a focus on rebuilding disrupted health systems.

Because health threats are multisectoral, the health sector must not only take the lead but also collaborate with and guide the responses of other sectors. Similarly, the Regional Office works with and through partnerships with others. WHO is an active partner in the Inter-agency Task Force for Central Asia and took part in several contingency planning initiatives involving central Asian countries, in collaboration with United Nations and nongovernmental organizations (NGOs). Other key partners in this work included the United Kingdom Department for International Development (DFID), the European Commission Humanitarian Aid Office (ECHO), USAID, the EU, Norway, ECHO's disaster preparedness programme (DIPECHO), the Swedish International Development Cooperation Agency (Sida) and the United Nations Trust Fund for Human Security (UNTFHS).

² Throughout this report, "Kosovo" means Kosovo in accordance with Security Council resolution 1244 (1999).

WHO has implemented specific programmes for preparedness and response to health emergencies, working with health ministries to build local health systems' capacities and establish coordination mechanisms to minimize avoidable morbidity and mortality in future crises. A global WHO survey collected and analysed data from 19 Member States in the European Region, to assess the health sector's capacities for emergency preparedness and response (82). A multi-hazard assessment tool, to analyse countries' capacities to manage health security threats, was developed and pilot-tested in 2007 in Armenia and Azerbaijan. The Regional Office held workshops on health systems' emergency preparedness, with a focus on hospital crisis preparedness, in Armenia, Austria, the Czech Republic, Georgia, Poland, Slovakia and The former Yugoslav Republic of Macedonia.

Blood quality and safety

The quality of blood and transplantation services, as well as patient safety, varies widely across the Region and is challenged by increased cross-border movement, the spread of HIV/AIDS and other bloodborne infections, multidrug-resistant TB and emerging diseases, particularly in the eastern part of the Region (83). Blood-related HIV outbreaks have occurred in Kazakhstan and Kyrgyzstan, while transplant-related HIV occurred in Italy.

The Regional Office established an advisory group that worked on guidance for the development of national strategies on blood quality. National regulatory frameworks and blood services were reviewed in 15 countries (Albania, Belarus, Bulgaria, Bosnia and Herzegovina, Croatia, Kazakhstan, Kyrgyzstan, Moldova, Montenegro, Romania, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Ukraine and Uzbekistan) and national blood policies were developed in 9 south-eastern countries (Albania, Bulgaria, Bosnia and Herzegovina, Croatia, Moldova, Montenegro, Romania, Serbia and The former Yugoslav Republic of Macedonia) (84). Regional transplantation practices were reviewed, including the dissemination and updating of WHO guiding principles. As a result, the Regional Office developed a network, and held the first regional meeting of directors of European blood services in June 2007, as well as a first consultation on transplantation in the CIS, including the central Asian republics.

The Regional Office contributed to the WHO global databases on blood safety and transplant services. It provided support to HIV/AIDS prevention through capacity building in blood and injection safety and quality in the countries of central and eastern Europe and the central Asian republics. The Office contributed to the finalization of patient safety solutions, evaluated the national reporting schemes of Hungary and Poland, and held the first regional workshop on patients for patient safety (85,86).

The Regional Office collaborated intensely with other partners, for example with:

- the EC on regulatory work;
- the Council of Europe on guides and recommendations;
- the European School of Transfusion Medicine on education;
- the Global Collaboration for Blood Safety on networking;
- the World Alliance for Patient Safety on patient safety;
- the Organisation for Economic Co-operation and Development (OECD) on quality and patient safety; and
- the Joint Commission International, a WHO collaborating centre, on patient safety solutions and quality standards.

Health system financing

New technologies and rising expectations increase demand and costs in health systems, while demographic and macroeconomic/fiscal constraints limit increases that governments can make in public spending on health. The combination has put the achievement of health systems' objectives at risk, and forced countries to consider reforms to improve the efficiency and equity with which their systems are financed. The two broad challenges in health system financing are:

- fragmentation in the way funds are pooled, which limits the potential for cross-subsidies from the relatively healthy to the relatively sick and creates inefficiencies in the organization of service delivery; and
- misalignment of the instruments of health financing and provision with each other and with policy objectives, resulting in deficits and suboptimal performance.

The Regional Office works to promote better performing health systems by applying a comprehensive, functionally coherent and results-oriented approach to health financing policy. The aim is to develop practical tools for the diagnosis and development of health financing policies.

WHO's work on this topic during the biennium built on its unique position to engage the leaders of national health systems and partner agencies in policy dialogue, aiming to orient debate about options to promote clearly articulated and measurable policy objectives. Through policy dialogues, analytical work and capacity building, the Regional Office promoted and facilitated national-level policy processes that are consistent with the goal of universal coverage and the other health finance policy objectives elucidated in a paper presented to the WHO Regional Committee for Europe in 2006 (87).

This paper defined the objectives, descriptive framework and contextual constraints of health financing policy (88), and a growing number of national policies in the Region reflect these concepts. The Regional Office produced several analytical papers as applications of the financing framework, including analyses of equity and financial protection, descriptive case studies and evaluations of national health financing reforms (89–93). Its work in health financing became more visible with the establishment of a web site and the publication of technical reports and studies (94).

The process of improving the quality of estimates of national health expenditure continued in 2006–2007, so much that unity was achieved between the figures reported globally by WHO and those contained in the Health for All database (95). New health financing aggregates were incorporated into the database, and the comparative data on health expenditure included in the Health Systems in Transition country profiles now reflect these improved and refined estimates (96).

The Regional Office engaged senior decision-makers in national debates on health financing policy in, for example, Azerbaijan, Hungary, Kyrgyzstan and Latvia. The Regional Office presented its analyses of health financing reforms in Estonia, Kyrgyzstan, and Moldova, as well as syntheses of reform experiences in CIS countries, at international scientific conferences such as the Sixth European Health Economics Conference in 2006 and the sixth International Health Economics Association World Congress in 2007. Technical reports on health financing issues in Armenia, Croatia, Poland, and Ukraine (92) were also produced.

The Regional Office works on health financing with the World Bank, USAID, DFID and Sida. The Regional Flagship Course on capacity building for health financing, developed and delivered with the World Bank, is a particular example of successful collaboration (94).

Stewardship/governance

Strengthening Member States' institutions

Strengthening health ministries' stewardship role is a priority for health systems in many countries. In particular, the CIS and the countries of central and eastern Europe face the critical challenge of transforming their health ministries from providers of health services into stewards of the health system, focusing more on health system outcomes, strategy and regulation than on operational issues.

In 2006–2007, the Regional Office worked to provide advice, guidance and evidence on effective policies to Member States, so they could develop their health policies, strategic plans

and regulatory tools. It organized policy workshops, dialogues and stakeholders' fora, and built capacities for implementing the new stewardship approaches (97).

The Regional Office supported 18 countries with core products, such as health system performance assessment (HSPA), strategy and health policy development, capacity building for policy-makers, health system governance assessment and health policy reviews. It also provided support to countries applying to global health initiatives such as the GAVI Alliance (see the section on partnerships in Chapter 4) to improve health system issues in immunization work.

1. The Office provided guidance on organizational restructuring and strategies for strengthening the stewardship function of health ministries to Azerbaijan, Moldova, Romania, Slovakia and Turkey.
2. HSPAs took place in Armenia, Georgia, Kazakhstan, the Russian Federation, Ukraine and Uzbekistan.
3. The Office provided technical support for the development, implementation and evaluation of plans for health system reform in Bosnia and Herzegovina, Portugal and Tajikistan.
4. Health policy reviews were carried out for Azerbaijan, Croatia, Lithuania, Portugal and Tajikistan.
5. With OECD, the Regional Office carried out a health system review in Switzerland.
6. National case studies on how to improve the governance of health systems were completed for Estonia, Latvia and Lithuania, and health laws were reviewed for Armenia and Kazakhstan.
7. With the European Observatory on Health Systems and Policies, the Office ran policy dialogues in Albania and Moldova on the public–private mix in health care, in Croatia (for several countries of central and eastern Europe) on deficits and inefficiencies in health systems, and in Estonia (for the three Baltic countries) on health system governance (76).
8. The Performance Assessment Tool for Quality Improvement in Hospitals (PATH) project was implemented in eight countries and over 100 hospitals in the European Region (98).

Futures Fora meetings on selected policy issues were held in 2006 and 2007 with a network of senior policy-makers in western European countries; they addressed steering towards equity in health and the ethical governance of pandemic influenza preparedness, respectively (99,100).

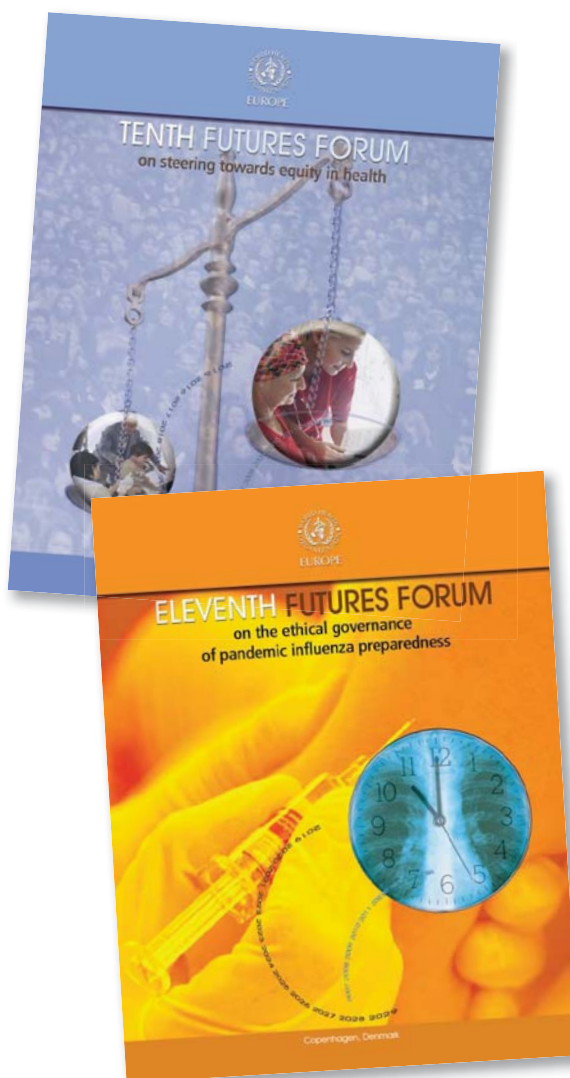
The Office's main partners in this work were the World Bank and UNDP.

Poverty and health

Any health system seeks to improve the health of socioeconomically vulnerable populations, but insufficient know-how has been systematically applied to provide evidence-based advice. The Regional Office has therefore worked with health ministries in the Region to produce national case studies of the health systems that have addressed poverty and health.

In conjunction with other United Nations agencies and international bodies and experts, the Regional Office created a databank of health systems' actions to promote the health of poor and vulnerable groups (101). The databank synthesizes evidence on health inequities and vulnerable population groups; building on it, the Regional Office organized a technical consultation in 2007 on the policy implications of and lessons learnt from strengthening health systems' performance to address poverty-related health problems in these groups (102).

Over half the Region's Member States took part in these activities. Some key case studies include the following. Austria developed a programme, Team Neuner HAUSARZT, in Vienna to safeguard and improve homeless people's access to standard health services. Georgia designed a state-funded medical assistance programme to improve financial access to health care for families living below the poverty line. Poland changed its system to ensure poor people better access to health care, including: mandatory insurance of all eligible people regardless of their socioeconomic status, voluntary insurance in the universal health insurance system and free access to publicly financed health care services for uninsured poor people. Finally, Romania launched a community-based information, education and communication campaign to expand knowledge of TB in vulnerable groups and Roma, reduce stigma and negative attitudes towards TB (as a "disease of poverty") and increase case detection and treatment adherence (102).



Social determinants of health

The gap in mortality and morbidity within and between population groups across European Member States seems to be increasing, and follows a strong social gradient. While the knowledge and epidemiological evidence on social determinants of health grow, much relates to problem definition and awareness, rather than to policy options and know-how to implement solutions. Two multicountry consultations were held in 2006 and 2007 with 70% of all European Member States; they addressed the priorities for capacity building and know-how for tackling social determinants of health and reducing health inequities. These consultations involved the World Bank, the EU and the Council of Europe, and were conducted in close collaboration with the Department of Health, England, United Kingdom.

The Regional Office also gave technical assistance to Estonia, the Russian Federation and countries in south-eastern Europe, which wanted to strengthen their health ministries' capacity to make economic arguments for health investment, promote health and reduce health inequities.

Resource creation

Health technologies and pharmaceuticals

Many countries in the European Region face the challenge of insufficient public expenditure to ensure access to treatment. They also confront problems with the rational use of medicines, the procurement and provision of medicines and diagnostic tools, and ineffective regulatory systems. Their main tasks are:

- to increase people's access to essential treatment;
- to balance the pros and cons of new medicines, vaccines and other technologies that meet new disease threats but cause additional expense; and
- to develop arrangements for a public–private mix that are satisfactory for both sectors (103).

In response, WHO provided methodological support and evidence-based approaches to diagnosis, treatment, care and harm reduction, and played a coordinating role in the development and implementation of evidence-based medicine in Armenia, Azerbaijan, Croatia, Georgia, Kyrgyzstan, Moldova, Tajikistan and Uzbekistan. A training module was developed for specialists from Armenia, Moldova and Uzbekistan in the context of this project. The Regional Office facilitated the implementation of a medicines policy by: networking on pricing and reimbursement policies in EU countries; providing direct assistance to Bulgaria, the Czech Republic, Hungary, Latvia, Poland, Slovakia and The former Yugoslav Republic of Macedonia; and developing and monitoring indicators of the national drug policy implementation process in most CIS countries.

Further, national and regional training programmes have continued to build capacities in quality assurance and provide access to priority generic medicines of good quality. The Office provided support and capacity building in medicines provision and reimbursement arrangements to Bulgaria, the Czech Republic, Hungary, Kyrgyzstan, Latvia, Poland, Slovakia and The former Yugoslav Republic of Macedonia.

The Office has worked with all major partners in the pharmaceutical area, at both the country level (with the World Bank, the Global Fund, UNICEF and bilateral donors) and the regional level (with the EU and the Council of Europe). Other donors have included the Ministry of Health, Welfare and Sport of the Netherlands, DFID and USAID.

Health workforce

The health workforce is central to managing and delivering health services in all countries, and the health system depends on its availability, skills, knowledge and motivation. Nevertheless, WHO estimates a global deficit of 4 million health workers. Many European countries face growing shortages of health professionals and imbalances in their distribution, and these shortages are projected to increase over the next 20 years. International recruitment may solve the shortages in some countries, but it creates shortages in others, particularly developing countries. Health workers' migration has therefore become a prominent public policy concern and an issue of special attention for WHO, which has urged its Member States to develop strategies to mitigate its adverse effects (104).

The WHO Regional Committee for Europe discussed the issue in 2007, and adopted a resolution calling on the Regional Office to give high priority to monitoring the situation and facilitating the development of an ethical framework for the international recruitment of health workers into and within the European Region (105). In response, the Regional Office started a dialogue on international migration between source and destination countries. It continued to assess migration flows in countries, using two frameworks: one for country case studies and the other for monitoring migration. The Office published a report on the evidence on these flows in five Member States in September 2006 (106). It also conducted a number of policy dialogues on human resources for health in countries, in collaboration with the European Observatory on Health Systems and Policies (76).

The Regional Office has worked with many counterparts in this field, in particular the Global Health Workforce Alliance, OECD, the International Organization for Migration (IOM) and the International Labour Organization (ILO).

WHO European Ministerial Conference on Health Systems: “Health Systems, Health and Wealth”

The WHO European Ministerial Conference on Health Systems: “Health Systems, Health and Wealth” (9), hosted by Estonia in Tallinn on 25–27 June 2008 in close coordination between the Regional Office and the Estonian Ministry of Social Affairs, provides the best illustration of the importance to the Regional Office of health-systems-related work with Member States.

In consultations in Austria and Spain in 2006, Member States identified topics of key concern, as well as the central concept of the relationship between health systems, health and wealth, as the main focus areas for the Conference. Three preparatory events took place in 2007, on health systems performance (in Brussels, Belgium), health workforce policies (during the Regional Committee session in Belgrade, Serbia) and health service delivery (in Bled, Slovenia) (9).

A Charter Drafting Group, comprising experts from 26 Member States as well as partners, developed a European Charter on Health Systems for adoption at the Conference. An External Advisory Board – experts from ministries of health, universities and partner organizations – met four times over the biennium to provide advice on the topics, programme, research agenda and participation of partner organizations. The Regional Office emphasized engaging relevant partners from both the health and the finance fields, including the Council of Europe, ECDC, the EC, the European Investment Bank, OECD and the World Bank, to ensure the Conference’s intersectoral relevance.

Leading authors produced two background studies on health systems’ performance and on health systems, health and wealth, as well as a series of policy briefs on related issues (107).

4. WHO Regional Office for Europe: cross-cutting services, organization, resources and governance

This chapter addresses the organizational work that supports the other activities and functions of the Regional Office: its structure, partnerships and fund-raising, external communications, health intelligence, administration, human resources, information technology, budget and finance, infrastructure and governance.

The WHO Regional Office for Europe, with 690 staff, has its headquarters in Copenhagen, Denmark, five geographically dispersed offices (in Barcelona, Spain; Bonn, Germany; Brussels, Belgium; and Rome and Venice, Italy) and country offices in 29 Member States across the Region (108). The dispersed offices perform technical functions at the service of the whole Region on specific technical matters, as do many of the staff in Copenhagen. Those in Barcelona and Venice cover country health policies and systems, while the offices in Bonn and Rome cover noncommunicable diseases and the environment. The office in Brussels primarily liaises with the EC. The European Observatory for Health Policies and Systems also has its headquarters in Brussels.

At the 2007 Regional Committee, Greece proposed to establish a geographically dispersed office in Athens to strengthen technical work on noncommunicable diseases and hence the implementation of the European strategy on noncommunicable diseases (40) across the Region. The Regional Committee welcomed the proposal as an opportunity to strengthen the Regional Office's capacity. Extensive discussions followed on the proposed area of work, as well as technical, financial and managerial details; the Standing Committee of the Regional Committee monitored progress at each of its meetings. The Standing Committee carefully reviewed the comprehensive agreement that was developed, and agreed to the final version, into which its views and comments had been incorporated.

Cross-cutting services Partnerships

As this report shows, the Regional Office's key partners are naturally the EU and its institutions, the Council of Europe, OECD, the World Bank and other United Nations agencies (109). Interestingly, while the World Bank and the Open Society Institute/Soros foundations are reducing their work in the European Region, the EU is expanding its activities in health,

particularly through the ECDC, with which WHO has had a Memorandum of Understanding since 2005.

To better harmonize donors' and partners' approaches in support of country work, the Regional Office developed internal strategic approaches to partnership development and a framework for resource mobilization in the past biennium. Another objective was increasing the country focus in partnership building and development, to enable the WHO country offices to better support Member States through mechanisms and tools developed at the regional level. The move of many WHO country offices into United Nations premises ensured a better coordinated approach to country assistance within the United Nations family.

Further, staff from the country offices, building on their wide experience of working in partnerships in countries across the Region and with support from the Regional Office, have developed tools to identify, build, maintain and evaluate partnerships at the country level. These tools, such as harmonized stakeholder analysis and a continuous evaluation system, are now at the disposal of the entire Organization.

The European Observatory on Health Systems and Policies is living proof of the importance the Regional Office gives to partnership. The Observatory is a partnership of the Regional Office with the World Bank, the European Investment Bank, the Open Society Institute, the London School of Hygiene & Tropical Medicine, the London School of Economics and Political Science and the governments of Belgium, Finland, Greece, Norway, Slovenia, Spain and Sweden, as well as the Veneto region of Italy (110).

One of the Observatory's core functions is to ensure that it communicates its evidence and analysis effectively to decision-makers. It does this not only through its policy dialogues (76), but by regularly holding book launches, publishing journal articles and promoting the translation of its publications. The Observatory has published 22 studies and 18 new or updated Health Systems in Transition (HiT) country profiles (96). The HiTs, now using an updated template, are a systematic collection and analysis of data on national health systems in practice. In addition to conducting policy dialogues with high-level decision-makers in the eastern part of the Region (see the section on stewardship in Chapter 3), the Observatory held international policy dialogues, such as that on implementing health impact assessment with senior policy-makers from 14 European countries, in Spain.

During Portugal's EU presidency, the Observatory worked with the country on the Portuguese HiT, health impact assessment and health systems. The Observatory conducted a study with Finland during its EU presidency on health in all policies, participated in a workshop in Brussels

in June 2007 on health in all policies in EU neighbouring countries, contributed to the EU Ministerial Conference on “Health in All Policies: Achievements and Challenges” in December 2007 (see Chapter 2) and supported the health-in-all-policies agenda of the governments of Belgium and the Netherlands. Making the case for investing in health requires evidence, and the Regional Office published two books on the topic on the Observatory’s behalf (111,112). The Observatory also ran a senior-level policy dialogue on rethinking financial sustainability and a special workshop on health systems, health and wealth, at the 2007 European Health Forum in Gastein, Austria. As mentioned, it also contributed substantially to the development of evidence and policy papers for the WHO European Ministerial Conference on Health Systems (107).

Fund-raising

As global partnership initiatives and funds such as the GAVI Alliance and the Global Fund channel more and more funding for health to the country level, WHO has increasingly helped facilitate Member States’ access to the available funding. The Regional Office has set up internal structures to coordinate and link the different programmes involved. It also participates in global, regional and national mechanisms for stakeholder coordination.

This has considerably increased the success rate of countries’ applications. By the end of 2007, WHO had provided technical assistance to five out of eight countries eligible to apply to the GAVI Alliance for assistance in strengthening their health systems, at various stages of proposal development: Armenia, Kyrgyzstan, Tajikistan and Uzbekistan (for the proposal writing phase through in-country missions, a regional workshop and a desk review) and Georgia (for a stakeholder review).

The Regional Office facilitated and harmonized its various fund-raising efforts related to DG SANCO’s call for proposals and Dutch, French and Swedish partnership agreements. This resulted in increased mobilization of resources for the priorities identified in the BCAs.

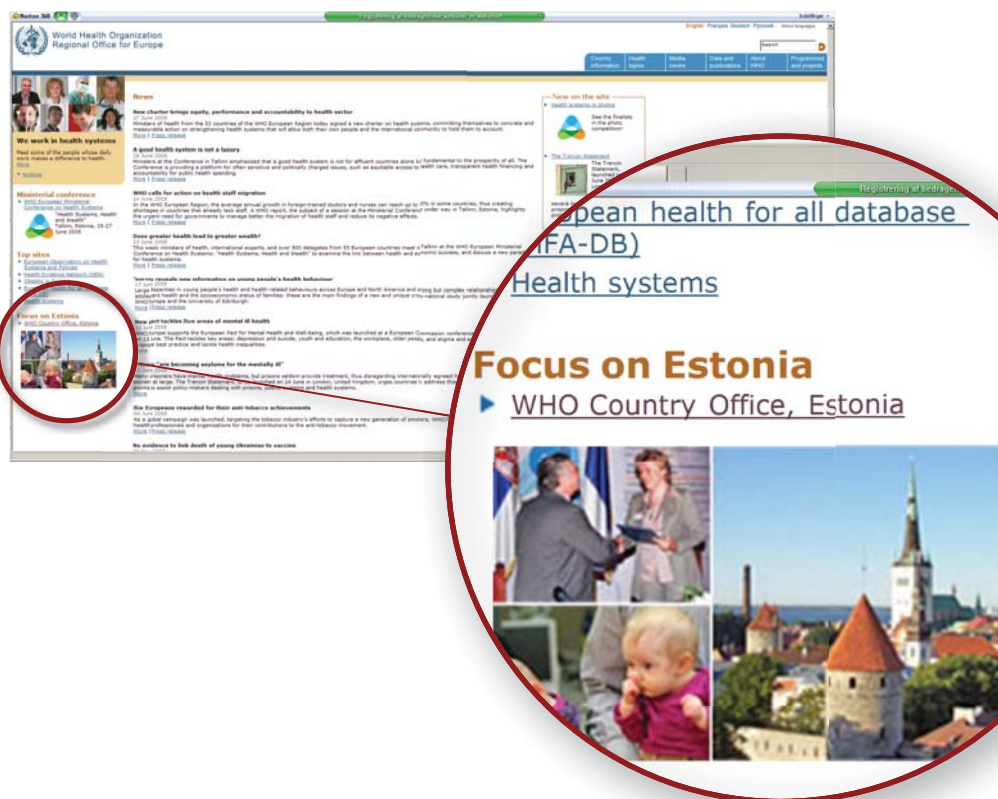
The Regional Office also improved its relations with NGOs, as shown by their increased requests for official relations, legal accreditation, use of the WHO emblem on their products and participation of Regional Office staff in their events.

External communications and the web

Many actors produce and distribute an enormous amount of health-related information every day, in the European Region and beyond. This creates an intense communications race to attract the attention of policy- and decision-makers, health professionals, the mass

media, opinion makers and the general public. The challenge for the WHO Regional Office is to guarantee the validity of its policy messages and the quality of its technical information, and to disseminate them in a timely and effective way in forms tailored to its various target audiences.

The web site of the Regional Office plays a particularly important role in the competitive field of health information. It not only keeps the profile of the Office high among policy-makers, professionals, the media and the public but is the primary means of publishing the Regional Office's data, information and publications. To give higher visibility to work in countries, a country focus section was set up on the home page and, by the end of 2007, seven country focus sections had been published. A section on each country office is also being set up.



From January 2006 to December 2007, visits to the web site increased by 11%. Readers downloaded 476 850 copies of Regional Office products in the biennium. The most frequently downloaded products were the European Health for All database (95), the European Charter on Counteracting Obesity (51), *Social determinants of health: the solid facts* (113) and *Air quality guidelines: global update 2005* (38).

Health intelligence

Health information systems

Health information plays a critical role in strengthening health systems and requires a structured production cycle based on standards for collection, processing and display of data for each Member State. The Regional Office has continued to strengthen national health information systems by offering support in both the collection and use of data in the national context. Almost 30 countries use WHO software to display health indicators at various levels of the national health system.

The Regional Office broadened data availability by setting up the European Hospital Morbidity Database (114), which contains data on hospital discharges from over 20 countries, providing a unique opportunity for the analysis and international comparison of morbidity and hospital activity patterns in countries. In addition, a new type of detailed mortality database was developed, enabling user-friendly access to data on specific causes of death. To reduce the burden of data collection for Member States, the Regional Office intensified collaboration with the Statistical Office of the European Communities (Eurostat) and OECD by harmonizing definitions and time-lines for core health data collection from countries.

Health Evidence Network

The Health Evidence Network (HEN), a network of 36 international agencies and institutions coordinated by the Regional Office, is a highly acclaimed source of information on relevant health topics (115). Requests for HEN membership continued to rise, indicating its overall popularity, and external sources increasingly cited HEN reports.

The HEN web pages were the second most accessed pages of the Regional Office web site, with a steady number of about 8000 visitors per month. During the biennium, HEN launched a joint series of policy briefs with the European Observatory on Health Systems and Policies, and developed several products for the Ministerial Conference on Health Systems in June 2008 (107).

Publishing, languages and information dissemination and promotion

The Regional Office publishes both in print and on the web site, and in the Office's four official languages. As a measure of impact, readers bought over 2900 hard copies of Regional Office books in the biennium, in addition to those distributed free of charge and the many thousands of copies downloaded from the web site. The Regional Office also granted licences to institutes and other agencies to translate and publish 165 Regional Office publications in non-official languages, and 72 titles were selected for inclusion in four independent, specialized databases accessible by paying subscribers.

The Regional Office supports 38 WHO documentation centres run by Member States, providing them with copies of its publications for the public to read. The Office also offers free or nearly free access to major international biomedical journals and databases to institutions and ministries in low-income countries through HINARI (the Health InterNetwork Access to Research Initiative) (116).

Further, the Regional Office translated the documentation for the 2006 and 2007 sessions of the Regional Committee from English into the other three working languages, and that for the eight sessions of the Standing Committee of the Regional Committee into English and Russian (117–119). In addition, it translated into French, German and Russian the working papers for the WHO European Ministerial Conference on Counteracting Obesity (23) and the WHO European Ministerial Forum on Tuberculosis, and the reports of the preparatory meetings for the WHO European Ministerial Conference on Health Systems (9).

eHealth

The Office strengthened its work in information technologies and eHealth: the use of information and communication technologies for health. It defined its role and position relative to other international partners and recognized the importance of the appropriate use of new tools and technologies for the transformation of health systems in the 21st century (120). A network of over 522 eHealth experts from around the globe (125 in the European Region) was established through the WHO Global Observatory for eHealth. This network provides the basis on which country and technical work in the field can be developed. The programme strengthened WHO's own capabilities in the use of eHealth through internal awareness, outreach and training sessions.

Organizational structure and resources

Administrative services

During the biennium, the administrative services of the Regional Office concentrated on preparing for the implementation of WHO's Global Management System (GSM) from 2008; GSM will change the way the Organization has worked for the last 60 years. This one system will serve all WHO offices, and be accessible via the Internet from anywhere in the world, 24 hours a day. The Regional Office contributed heavily to GSM's design, analysing current workflows and agreeing on a set of future global business processes and a definition of functional roles. A cross-sectional transition team analysed GSM's likely impact, focusing on the preparatory work during both the transition and the implementation phase in 2008–2009.

The Office paid particular attention to the information technology and budget and finance aspects. This included linking both the WHO country offices and the geographically dispersed

offices to the Organization's Global Private Network, which will be the vehicle for GSM data and voice traffic, creating the Global Data Hub to store transactional data from GSM and beginning to make the Regional Office a part of the WHO Identity Management System, a single sign-on facility for access to global applications.

Planning the new roles and responsibilities of the budget and finance staff was one of management's challenges during 2007. These staff will move away from processing transactions, towards more control and auditing work, and the offices in the field will process more of their own financial transactions. The Office's financial database underwent data cleansing to prepare for migration to GSM.

Human resources and staff development

Human resources (both staff and services) in the Regional Office received considerable attention in 2006–2007. A staff development plan for 2007–2008 resulted from the steps laid down in development process 9 (of the 11 developmental processes promoted by the Regional Director in 2005) on sustaining and developing skills. Further, to strengthen its performance at the country level, the Office emphasized capacity building in two key strategic areas:

- general management, preparing staff for the greater empowerment and consequent accountability that GSM will bring; and
- health systems development, the most important area of the Regional Office's work.

The planning of human resources was an integral part of the discussions on medium-term strategic planning. Managers were required to determine the type and duration of the functions necessary to deliver Office-wide expected results. This provided valuable input to the corporate human resources plan for 2008–2009: the first-ever strategic plan on human resources for the Regional Office. The changes in human resources planning were closely linked to adjustments in the organizational structure of the Office, which further consolidated the function-based approach in its work. The plan placed essential human resources in four broad functional categories: direction and strategy, external relations and customer services, technical service production and administrative support.

The human resources plan also addresses the imbalance of internationally recruited staff at country level. As indicated in the section on country offices (Table 1), the international professional staff stationed in country offices will increase from 16% to 23% over 2008–2009.

The implementation of the global contractual reform, begun in 2004–2005, reinforced this strategic approach to human resources. It introduced three types of staff appointments:

continuing, fixed and temporary. Efforts continued in 2006–2007 to ensure positions filled by existing staff were in line with the reform and supported strategic directions. During the biennium, the Regional Office not only managed the contracts of its 690 staff members but also established 174 posts. The contractual reform saw a further increase in fixed-term contracts compared to the end of 2005. The current figures are: 68% of staff have fixed-term contracts and 32%, short-term. The percentage of fixed-term posts is expected to reach 70% by the end of 2009, which will reduce the costs of contract management.

Staff Association

During the biennium, the administration and the Staff Association continued their tradition of constructive dialogue. This dialogue unfolds in regular meetings with the Director, Administration and Finance and the Human Resources Manager and with the Regional Director and the Deputy Regional Director, and in ad-hoc meetings to resolve particular issues. Progress in collaboration includes the successful implementation of the contract reform, the adoption of new selection procedures, the creation of an organizational development unit, the establishment of the new committee to promote a healthy and safe workplace, and the new human resources plan, based on strategic objectives rather than area of work.

Management information systems

With the introduction of a global WHO strategy for information and communication technologies, with eight key objectives and administered under a newly established governance network, the Regional Office defined its own strategy for information technology. This is intended to facilitate delivery of the global objectives and key regional priorities over the coming 3–5 years. A revision of the profiles of information technology staff followed, including the restructuring of the service desk team, a new facility for remote connectivity of the country offices to the corporate network and the holding of clinics on the most requested areas of training. The intranet was redesigned in early 2007, enabling staff from across the Region to gain access to policies and procedures, and the information and tools needed to carry them out.

Budget and finance

An overview of the Regional Office's programme budget and implementation in 2006–2007 can be found in Annex 1.

The Office continued its work in coordinating and monitoring budgets, making funds available to units and country offices, making timely payments and providing financial reports to donors. In particular, it started implementing elements from the International Public Sector

Accounting Standards (IPSAS), thus beginning to align the Organization's accounting with the best modern practices. Particular attention was paid to involving country offices.

Infrastructure and logistics

The Danish Government made a new office building available to the Regional Office in Copenhagen. The building is adjacent to the existing premises and was included within a secured perimeter fence. The conference facilities were also refurbished with modern equipment, allowing geographically dispersed offices to partake in meetings organized in Copenhagen.

Negotiations began in 2007 between the United Nations agencies in Copenhagen and the Danish Government to plan for the establishment of a United Nations city by 2012–2014.



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A new open-plan office was made available to staff in Copenhagen by the Danish Government, within the secured perimeter fence, in 2006

Governance of the Region

Member States continued to become more involved in the global governance of WHO. The European Region now has eight seats on the Executive Board, with a good geographical distribution across the Region. European Executive Board members have two seats on the Programme Budget Administration Committee; since May 2006, these have been occupied by Denmark and Portugal. Portugal (Professor José Pereira Miguel) held the chairmanship of the Committee for the year starting in May 2007.

The fifty-sixth session of the Regional Committee in 2006 included four policy and technical subjects (121):

- the European Strategy for the Prevention and Control of Noncommunicable Diseases;
- the proposed programme budget 2008–2009 and the medium-term strategic plan 2008–2013;
- the future of the WHO Regional Office for Europe; and
- enhancing health security

As side events, four technical briefings took place, on:

- influenza;
- approaching health financing policy in the WHO European Region;
- preparations for the WHO European Ministerial Conference on Counteracting Obesity; and
- HIV/AIDS prevention.

At its fifty-seventh session in 2007, the Regional Committee addressed three policy and technical subjects (122):

- health workforce policies in the WHO European Region;
- the Second European Action Plan for Food and Nutrition Policy; and
- the Millennium Development Goals in the WHO European Region: health systems and the health of mothers and children – lessons learned.

In addition to the regular session, technical briefings took place on:

- achievements and limitations of the health reform in Serbia (organized by the Ministry of Health of Serbia);
- the IHR;
- the citizen's voice in public health; and
- the Region's situation with regard to water-related diseases and the Protocol on Water and Health.

The Standing Committee of the Regional Committee for Europe held 11 sessions during the biennium. It advised on the preparation of Regional Committee documentation on the financial, administrative, policy and technical subjects addressed during the biennium (119). It also advised on the desirability of ensuring geographical balance between the various parts of the European Region on WHO bodies and committees.

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Annex 1.

Programme budget and implementation

The process for programme budget performance assessment evaluates the secretariat's performance in achieving the Organization-wide expected results for which it is accountable. It is an integral part of WHO's results-based management framework. This biennial process includes periodic workplan monitoring and a mid-term review of progress towards the achievement of expected results. The findings of the programme budget performance assessment inform decisions about reprogramming and the preparation of the programme budget for the next biennium. The assessment highlights the main achievements of the secretariat and identifies success factors, constraints and lessons learnt, and actions required to improve performance. It is a bottom-up exercise, from country to regional level, that reviews the delivery of products and services in workplans, the attainment of indicator targets for expected results and the preparation of narrative on the realization of those results.

The exercise for 2006–2007 was chiefly a self-assessment exercise carried out for the first time and it requires methodological improvements to achieve a consistent assessment based on common indicators and criteria. A global quality-assurance committee, comprising two external experts and one senior WHO staff member, was established to improve the reliability and accuracy of the assessment findings across all major WHO offices. The committee identified a number of limitations and areas for improvement, which are relevant to some extent for the WHO Regional Office for Europe.

- The indicators do not measure all aspects of an expected result; thus reliance on indicator values alone to determine the extent to which an Organization-wide expected result is achieved can be a methodological limitation.
- Some indicators have inaccurate or no baseline values.
- Some indicators were of poor quality and did not lend themselves to measurement.
- Some expected results and indicator targets were over-ambitious.

Table 1 is an overview of both financial implementation (section A) and attainment of expected results (section B) in the European Region.

For each area of work, section A shows the available programme budget together with total expenditure, the percentage expenditure invested at country and regional/intercountry levels,

and the percentage budget implementation rate. The expenditure at regional/intercountry level includes the salaries of staff who are based in Copenhagen or in geographically dispersed offices but who also contribute to the achievement of country expected results. The source for the programme budget and total expenditure figures is the audited financial report for 1 January 2006 to 31 December 2007.¹ The figures are net of all credits such as exchange rate hedging and reimbursements received from other agencies, and reflect a net implementation of US\$ 180 million, an increase of 16% over the previous biennium.

Section B shows the percentage of expected results fully achieved at country, intercountry and regional levels by area of work. The remaining expected results are either partially achieved or not achieved. There is a one-to-many relationship between a regional expected result on the one hand and country and intercountry expected results on the other. Thus, a regional expected result is achieved through the attainment of multiple underlying country and intercountry expected results. The figures shown form part of the aggregated global results in the 2006–2007 programme budget performance assessment document.²

In 2006–2007, WHO's work was built around 36 areas of work while, as of 2008, the programme budget is based on a medium-term strategic plan with 13 strategic objectives. To allow better comparability of the financial data between the biennia and in the future, an exercise was carried out to convert the 36 areas of work into 13 strategic objectives. Table 2 presents these converted data for the approved programme budget and the expenditures for 2004–2005 and 2006–2007 by strategic objective.

Sections A and B show the approved programme budget, total expenditures and budget implementation rates by strategic objective and in total for 2004–2005 and 2006–2007. The total expenditure for 2006–2007 is slightly different from the audited financial report figure because it reflects gross expenditure, including such elements as exchange rate hedging and reimbursements from other agencies. This adjustment led to an increase in the overall budget implementation rate from 85% to 90%.

Section C shows the efforts made to increase the programme budget between the two biennia, across most of the strategic objectives and overall by 34.6%. On the expenditure side, however, this was not fully achieved and resulted in an overall expenditure increase of

¹ *Financial report and audited financial statements for the financial period 1 January 2006 – 31 December 2007*. Geneva, World Health Organization, 2008 (document A61/20; http://www.who.int/gb/ebwha/pdf_files/A61/A61_20-en.pdf, accessed 19 June 2008); and *Financial report and audited financial statements for the financial period 1 January 2006 – 31 December 2007. Annex. Extrabudgetary resources for programme activities*. Geneva, World Health Organization, 2008 (document A61/20 Add. 1; http://www.who.int/gb/ebwha/pdf_files/A61/A61_20Add1-en.pdf, accessed 19 June 2008).

² *Programme budget 2006–2007: performance assessment report*. Geneva, World Health Organization, 2008.

20.1%, with variations between strategic objectives. This discrepancy in expenditure pattern as compared to the programme budget is related to a number of factors: (i) the earmarking of much of the funding provided to the Organization and subsequent underfunding of certain strategic objectives, despite robust funding overall; (ii) insufficient implementation; (iii) increasing dependency on voluntary contributions requiring a sizeable carry-over to ensure continued implementation into the next biennium without programmatic disruption; (iv) donations coming in late in the biennium or donations stretching across biennia, but being recorded in full in one biennium. For further details, see the World Health Assembly document on the performance assessment of the programme budget 2006–2007.³ In addition, the fall in the value of the US dollar and local currency inflation had an impact across all strategic objectives, but especially 12 and 13, which reflect the substantial increase in the running costs of all the offices (in 35 locations) between the two biennia.

³ *Programme budget 2006–2007: performance assessment. Report by the Secretariat.* Geneva, World Health Organization, 2008 (document A61/19; http://www.who.int/gb/ebwha/pdf_files/A61/A61_19-en.pdf, accessed 23 June 2008).

Table 1. Implementation by area of work, 2006–2007

Area of work	Financial implementation	
	Revised programme budget (US\$ thousands)	Total expenditure (US\$ thousands)
Communicable disease prevention and control	100	138
Communicable disease research	300	100
Epidemic alert and response	16 950	10 174
Malaria	1 800	1 340
Tuberculosis	14 500	11 584
HIV/AIDS	12 050	11 301
Surveillance, prevention and management of chronic, noncommunicable diseases	4 300	2 924
Health promotion	5 135	797
Mental health and substance abuse	4 500	3 967
Tobacco	3 000	2 098
Nutrition	1 900	3 195
Health and environment	19 734	15 845
Food safety	1 500	629
Violence, injuries and disabilities	1 298	1 193
Reproductive health	1 900	910
Making pregnancy safer	4 950	1 694
Gender, women and health	1 256	389
Child and adolescent health	5 500	2 940
Immunization and vaccine development	14 813	14 843
Essential medicines	3 250	1 975
Essential health technologies	1 232	813
Policy-making for health in development	3 500	5 191
Health system policies and service delivery	8 230	11 472
Human resources for health	2 083	1 239
Health financing and social protection	3 500	2 041
Health information, evidence and research policy	10 750	10 064
Emergency preparedness and response	8 255	9 029
WHO's core presence in countries	18 885	10 891
Knowledge management and information technology	13 300	6 833
Planning, resource coordination and oversight	1 448	1 043
Human resources management in WHO	3 600	4 148
Budget and financial management	3 430	2 936
Infrastructure and logistics	7 279	13 503
Governing bodies	4 334	4 090
External relations	1 866	2 142
Direction	1 967	6 675
Real estate fund	700	
Total	213 095	180 146

^aNo expenditure was incurred at country level for these areas of work. ^bThere were no country expected results for these areas of work.

B Attainment of expected results

Implementation rate (expenditure as percentage of programme budget)	Proportion of expenditure		Percentage of expected results fully achieved		
	at country level	at regional/intercountry level	at country level	at intercountry level	at regional level
138%	43%	57%	67%	67%	0%
33%	0%	100%	0%	0%	0%
60%	46%	54%	41%	33%	80%
74%	20%	80%	100%	100%	100%
80%	74%	26%	90%	90%	86%
94%	48%	52%	94%	100%	86%
68%	16%	84%	91%	70%	60%
16%	7%	93%	100%	100%	100%
88%	37%	63%	76%	91%	80%
70%	32%	68%	29%	33%	57%
168%	6%	94%	100%	86%	83%
80%	2%	98%	81%	90%	33%
42%	20%	80%	100%	100%	100%
92%	9%	91%	100%	92%	86%
48%	38%	62%	89%	100%	83%
34%	34%	66%	91%	100%	75%
31%	0%	100%	0%	50%	67%
53%	29%	71%	88%	67%	75%
100%	5%	95%	100%	86%	80%
61%	19%	81%	78%	92%	83%
66%	22%	78%	82%	67%	60%
148%	2%	98%	100%	83%	75%
139%	41%	59%	76%	50%	75%
59%	15%	85%	100%	100%	100%
58%	16%	84%	27%	63%	75%
94%	1%	99%	71%	69%	60%
109%	67%	33%	80%	71%	75%
58%	76%	24%	100%	100%	100%
51%	^a	100%	^b	93%	88%
72%	^a	100%	^b	40%	60%
115%	^a	100%	^b	75%	67%
86%	^a	100%	^b	83%	83%
186%	^a	100%	^b	100%	100%
94%	^a	100%	^b	100%	100%
115%	^a	100%	^b	100%	100%
339%	^a	100%	^b	100%	100%
85%	25%	75%	84%	81%	79%

Table 2. Comparison of programme budget and expenditures, 2004–2005 and 2006–2007

Strategic objective	A 2004–2005	
	Revised programme budget (US\$ thousands)	Percent of total budget
1 To reduce the health, social and economic burden of communicable diseases	20 402	12.9%
2 To combat HIV/AIDS, tuberculosis and malaria	23 632	14.9%
3 To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment	7 464	4.7%
4 To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	9 155	5.8%
5 To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	7 705	4.9%
6 To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	6 038	3.8%
7 To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	1 820	1.2%
8 To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	16 171	10.2%
9 To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	4 568	2.9%
10 To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	23 456	14.8%
11 To ensure improved access, quality and use of medical products and technologies	2 105	1.3%
12 To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	13 371	8.4%
13 To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	22 395	14.1%
Total	158 282	100.0%

		B 2006–2007				C Percentage change (2006–2007 compared to 2004–2005)	
Expenditure (US\$ thousands)	Implemen- tation rate (expenditure as percentage of programme budget)	Revised programme budget (US\$ thousands)	Percent of total budget	Expenditure (US\$ thousands)	Implemen- tation rate (expenditure as percentage of programme budget)	Programme budget	Expenditure
14 020	68.7%	32 163	15.1%	26 190	81.4%	57.6%	86.8%
19 085	80.8%	28 350	13.3%	25 560	90.2%	20.0%	33.9%
8 049	107.8%	9 541	4.5%	5 400	56.6%	27.8%	–32.9%
4 470	48.8%	12 350	5.8%	5 280	42.8%	34.9%	18.1%
8 439	109.5%	10 678	5.0%	11 380	106.6%	38.6%	34.9%
6 568	108.8%	8 243	3.9%	4 270	51.8%	36.5%	–35.0%
1 076	59.1%	3 356	1.6%	3 130	93.3%	84.4%	190.9%
16 377	101.3%	17 761	8.3%	14 780	83.2%	9.8%	–9.8%
1 950	42.7%	3 400	1.6%	3 950	116.2%	–25.6%	102.6%
35 197	150.1%	36 253	17.0%	31 070	85.7%	54.6%	–11.7%
3 222	153.1%	4 482	2.1%	2 540	56.7%	112.9%	–21.2%
16 915	126.5%	25 003	11.7%	25 100	100.4%	87.0%	48.4%
24 631	110.0%	21 515	10.1%	33 440	155.4%	–3.9%	35.8%
160 000	101.1%	213 095	100.0%	192 090	90.1%	34.6%	20.1%



EUROPE

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

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

This report reflects the work of the WHO Regional Office for Europe in 2006–2007: serving its Member States and contributing to health in the WHO European Region.

In the last biennium, the Regional Office focused on offering country-specific services on health policy and health systems development tailored to each Member State. With the continuing shift towards working in and with countries, the Office explored the different ways in which to meet the needs of both the eastern and the western parts of the Region.

This publication offers interesting and illustrative examples of work done directly with countries to improve health and strengthen health systems. Some examples focus on health programme themes, some on health systems, and others combine the two. It also highlights the work done on health from a normative and technical perspective, presenting the two intertwining approaches to work on health, where specific health programmes provide the content while health systems are the vehicle and the means to the ends. Finally, it looks at the structure, resources and governance that enable the Office to perform as it does in two main ways: first, as a direct service to Member States and, second, in fulfilment of WHO's mandate as the specialized health agency of the United Nations. An annex gives an overview of the programme budget and implementation.

The report also describes cross-cutting issues – such as partnerships, health intelligence, communication and publishing – that run throughout the Office as they do throughout the report. This reflects the ever-increasing importance of working with other players in the field of health as valuable partners in synergy.

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