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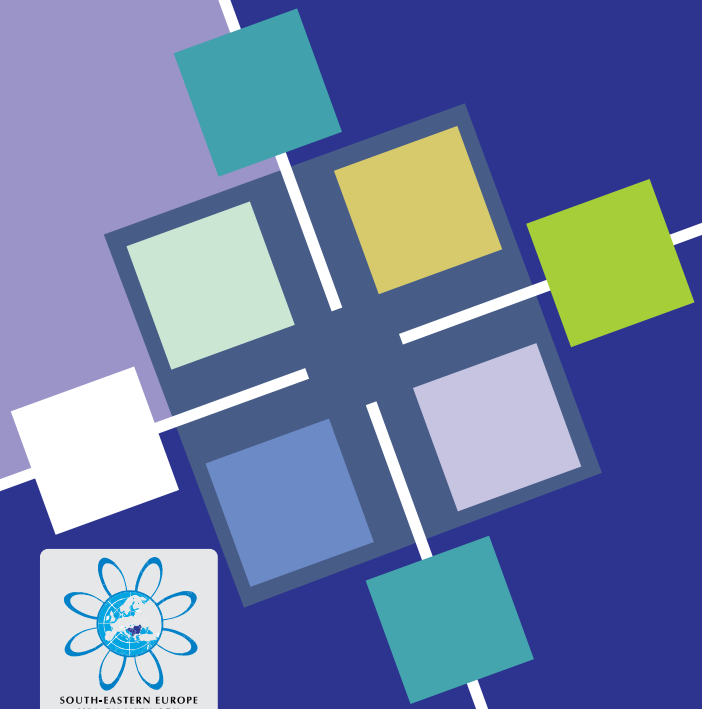
SOUTH-EASTERN EUROPE HEALTH NETWORK

Reversing the Tobacco Epidemic

Saving Lives in South-eastern Europe



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Contents

Abbreviations

CINDI	Countrywide Integrated Non-communicable Diseases Intervention
ESPAD	European School Survey Project on Alcohol and other Drugs
EU	European Union
FCTC	Framework Convention on Tobacco Control
GHPS	WHO/CDC Global Health Professional Survey
GSPS	WHO/CDC Global School Personnel Survey
GYTS	Global Youth Tobacco Survey
HBSC	Health Behaviour in School-Aged Children
SEE	South East Europe
WHO	World Health Organization

Preface

This publication describes the activities of the project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe (also called the South-eastern Europe Tobacco Control Project) from 2005 to 2007. The implementation of the project started in 2005, following the commitment made by the South-eastern Europe health ministers on 2 September 2001 by signing the Dubrovnik Pledge within the framework of the Initiative for Social Cohesion of the Stability Pact for South Eastern Europe. The countries of south-eastern Europe participating in the project were: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Republic of Moldova, Montenegro, Romania, Serbia and The former Yugoslav Republic of Macedonia. The project was led and coordinated by Marta Čivljak of the Andrija Štampar School of Public Health, Medical School University of Zagreb, Croatia. The WHO Regional Office for Europe provided great support in coordinating, fundraising and administrative activities, and the Government of Norway and the Government of Slovenia funded the project. The project aimed to enhance to capacity of the countries in south-eastern Europe in various components of successful tobacco control, most notably in raising awareness of the entry into force of the WHO Framework Convention on Tobacco Control in south-eastern Europe and improving the knowledge and skills of policy-makers and public health leaders in comprehensive tobacco control. Other project activities focused on collecting, analysing and interpreting the most recent data on the prevalence of tobacco use, lung cancer mortality and legal aspects of tobacco control. This publication gives an overview of the activities, achievements and challenges that the country project managers, their teams and the main project partners faced in implementing various activities related to tobacco control during 2005–2007. It also updates the data on the prevalence of smoking in various population groups and mortality related to tobacco consumption as well as new evidence on the legal aspects of tobacco control in south-eastern Europe. As one colleague who acted as a country project manager noted, “the South-eastern Europe Tobacco Control Project was an appropriate and necessary instrument to promote and support tobacco control related actions in the countries. It is hoped that the activities of the project will continue, as there is still much to be done to make tobacco control more effective”.

Acknowledgements

The project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe would not have been possible without the generous support and contributions from the Governments of Norway and Slovenia.

Project implementation and this report were also made possible due to the active participation and contributions of the country project managers in south-eastern Europe, Gazmend Bejtja (Albania), Aida Ramić-Čatak (Bosnia and Herzegovina), Masha Gavrilova (Bulgaria), Luka Vončina (Croatia), Silvia Morgoci (Moldova), Agima Ljaljević (Montenegro), Miron Bogdan and Magdalena Ciobanu (Romania), Srmena Krstev (Serbia) and Mome Spasovski (The former Yugoslav Republic of Macedonia).

Special thanks are also given to the South-eastern Europe Health Network for political support and to the WHO Regional Office for Europe for the technical and administrative support for the numerous activities of the project.

Foreword

Tobacco smoking is a leading contributor to the disease burden in South-eastern Europe. In response to this threat, the global community has united its efforts by endorsing the WHO Framework Convention on Tobacco Control, which aims to protect present and future generations from the devastating health, social, environmental and economic effects of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures.

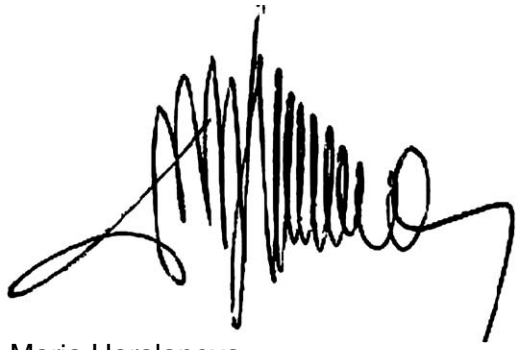
The spread of the tobacco epidemic is a global problem with serious consequences for public health. The situation is the same in south-eastern Europe, as confirmed by the study followed by the report Health and economic development in south-eastern Europe, reflecting the impact of tobacco consumption and exposure to tobacco smoke on health, economy and the environment of countries in south-eastern Europe.

Putting considerable efforts into tobacco control as a response to the impact of tobacco use on the health of communities and individuals is very important, and as such, the South-eastern Europe Ministers of Health highlighted tobacco control as a priority for the region in the Dubrovnik Pledge in 2001 and reconfirmed this in the Skopje Pledge in 2005.

Since then, seven out of nine of the countries in south-eastern Europe have signed and ratified the WHO Framework Convention on Tobacco Control, with the rest expected to ratify it soon, and are building up local and regional capacity to properly address this issue and the gap in health status between south-eastern Europe and the rest of the WHO European Region.

This report focuses on the achievements of the project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe, including the public health, and legal aspects of tobacco control in south-eastern Europe, and marks the beginning for a long and difficult road on tobacco control in south-eastern Europe.

The WHO Regional Office for Europe has provided political, technical and secretarial support to this initiative, helping the countries in south-eastern Europe coordinate and focus their efforts for an important cause, for concrete results in their health systems and ultimately for better health for their people.



Maria Haralanova
Regional Adviser
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1. Introduction

Marta Čivljak
Regional Project Manager

The tobacco epidemic is a global challenge demanding concerted global and national action. With 4.9 million tobacco-related deaths per year, no other consumer product is as dangerous or kills as many people as tobacco. If current trends continue, this figure will rise to about 10 million per year by 2030. To slow the growing global burden of tobacco-related mortality and morbidity and the impact of tobacco use on socioeconomic development, tobacco control has become a public health imperative worldwide.

The extraordinary public health implications of tobacco use long apparent in industrialized societies are now obvious worldwide. In certain regions, including central and eastern Europe, the health effects are particularly devastating (1,2). Upward trends and forecasts of tobacco consumption for countries in this part of Europe are among the steepest in the world.

As smoking declines in high-income countries, the multinational tobacco companies are targeting the low- and middle-income countries and the new markets of central and eastern Europe (3–5). The tobacco epidemic is both increasing and shifting from high-income to middle- and low-income countries, which in due course is followed by rapidly rising trends in tobacco-related diseases.

In 2002, tobacco was the leading contributor to the burden of disease in 31 Member States of the WHO European Region including, in south-eastern Europe, Albania, Bosnia and Herzegovina, Croatia and The former Yugoslav Republic of Macedonia *(6)*. The evidence collected in this and other studies on the high burden of tobacco-related morbidity and mortality and the high prevalence of smoking in south-eastern Europe were the main reasons for establishing the project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe, to be initiated as a part of the Initiative for Social Cohesion of the Stability Pact for SEE. It was implemented following the commitment made by the south-eastern Europe health ministers on 2 September 2001, by signing the Dubrovnik Pledge within the framework of the Initiative for Social Cohesion of the Stability Pact for South Eastern Europe.

The project's main goal was to achieve the long-term development of public health and health system infrastructure related to tobacco control.

The project had three* components:

1. raising awareness and building capacity for the entry into force of the WHO Framework Convention on Tobacco Control in south-eastern Europe;

2. improving the knowledge and skills of policy-makers and public health leaders in comprehensive tobacco control;
3. information campaigns aimed at increasing public awareness of and support for the implementation of tobacco control policy; and

* Note: the fourth component focusing on smoking cessation services was initially planned but never implemented due to lack of funds.

Project component one: raising awareness and building capacity for the entry into force of the WHO Framework Convention on Tobacco Control in south-eastern Europe

In November 2004, in Chisinau, all national health coordinators from the countries in south-eastern Europe, the Government of Norway, the WHO Regional Office for Europe and the Council of Europe signed a decision on component one of the project. Norway became the donor for component one, and implementation started on 1 April 2005, after the first regional technical meeting was held in Zagreb on 30–31 March 2005. Croatia led implementation of the project.

The WHO Framework Convention on Tobacco Control is the first legal instrument designed to reduce tobacco-related deaths and disease around the world *(7,8)*. Among its many measures, the treaty requires countries to impose restrictions on tobacco advertising, sponsorship and promotion; establish new packaging and labelling of tobacco products; establish clean indoor air controls; and strengthen legislation to clamp down on tobacco smuggling. Keeping in mind the advantages that the Convention brings to the countries in south-eastern Europe, the key for the countries was to sign and ratify the Convention as quickly as possible. That is why the main activity implemented during project component one was the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control, held in Sofia, Bulgaria on 29–30 September 2005. The Ministry of Health of Bulgaria (the host country), the Ministry of Health and Social Affairs of Croatia (the project coordinator) and the WHO Regional Office for Europe were the organizers of the event.

The aim was to strengthen the intersectoral cooperation for tobacco control at the regional and national levels and to promote the Convention in south-eastern Europe. The consultation was attended by high-level intersectoral delegations representing, in particular, health, foreign affairs and justice ministries, parliaments and other branches of government as necessary. It created the forum for exchanging views and experiences, identifying common problems, challenges and the way forward for the Convention and promoting intersectoral and intergovernmental cooperation for tobacco control. Short bilateral meetings were held between individual delegations and WHO representatives to clarify and promote country-specific issues and solutions in the further process for the ratification of the Convention.

Participants of the first regional technical meeting,
Zagreb, Croatia, 30–31 March 2005

The consultation resulted in regional conclusions and recommendations. Immediately after the regional meeting, according to the project plan, the countries organized national intersectoral meetings on the WHO Framework Convention on Tobacco Control:

- 30 September 2005, Sofia, Bulgaria;
- 18 November 2005, Podgorica, Montenegro (covering Serbia and Montenegro);
- 6 December 2005 – Skopje, The former Yugoslav Republic of Macedonia;
- 23 December 2005 – Tirana, Albania;
- 30 January 2006 – Chisinau, Republic of Moldova;
- 27 February 2006 – Zagreb, Croatia;
- 21–22 March 2006 – Snagov, Romania; and
- Bosnia and Herzegovina – due to a challenging political situation during that time, the meeting was held during project component two on 29 May 2007 in Banja Luka.

Thanks to the successful implementation of the first component of the project, most countries have seen an active process of legislative initiatives and updates and capacity-building. There has also been remarkable progress in the process of ratifying the WHO Framework Convention on Tobacco Control (Table 1).

Table 1. Status of signing and ratification of the WHO Framework Convention on Tobacco Control for the countries in south-eastern Europe (as of 30 September 2008)

Country	Signature status	Ratification status
Albania	Signed 29 June 2004	Ratified 26 April 2006
Bosnia and Herzegovina	Not signed	Not ratified
Bulgaria	Signed 22 December 2003	Ratified 7 November 2005
Croatia	Signed 2 June 2004	Ratified 14 July 2008
Moldova, Republic of	Signed 29 June 2004	
Montenegro		23 October 2006 (succession)
Romania	Signed 25 June 2004	Ratified 27 January 2006
Serbia	Signed 28 June 2004	Ratified 8 February 2006
The former Yugoslav Republic of Macedonia		Accepted 30 June 2006

First Intersectoral Regional Conference of High-level Government Authorities from South eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control, Sofia, Bulgaria, 29–30 September 2005

Project component two: improving the knowledge and skills of policy-makers and public health leaders in comprehensive tobacco control

The national health coordinators from south-eastern Europe, the Government of Norway, the WHO Regional Office for Europe and the Council of Europe agreed on and signed a decision on component two of the project in June 2005 in Banja Luka at the 10th Meeting of the South-eastern Europe Health Network.

The Government of Norway and the Ministry of Health of Slovenia were donors for component two. Implementation of component two of the project started after the regional technical meeting was held in Zagreb on 30–31 March 2006.

Tobacco control requires a comprehensive approach, using a strategic mix of interventions, policies and legislation. Effective tobacco control requires strengthening national policies through the collaborative efforts of many sectors of government and adopting a comprehensive set of effective measures. Governments may consider a range of interventions that could limit the supply of and reduce the demand for tobacco products. An increase in tobacco taxes is a measure that can effectively reduce short-term tobacco consumption *(9)*. Price has been shown to play an important role in how many young people start smoking and thus influences long-term consumption. Poorer people are more likely to smoke and are more likely to stop smoking when the prices of tobacco go up. Young people are also more responsive to the rise in tobacco prices, so, increasing the tax on tobacco is one of the most cost-effective tobacco control measures. Other demand-related measures that are not price-related include comprehensive advertising bans, policies banning smoking in public places and workplaces, prominent health warnings on cigarette packets, information and advocacy campaigns and cessation programmes. The control of cigarette smuggling, which includes tax stamps, border controls and high penalties for smuggling, is the most effective supply-related measure and is particularly relevant to south-eastern Europe, where cigarette smuggling is widespread.

Full success in tobacco control can only be achieved when these measures are implemented simultaneously. The role of health professionals is vital in tobacco control, but the medical model alone is not enough.

10th Meeting of the South-eastern Europe Health Network, Banja Luka, Bosnia and Herzegovina, 27–29 June 2005

As part of project component two, the WHO Regional Office for Europe in collaboration with Slovenia organized a three-day Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries. The workshop was held on 11–13 October 2006 in Bled in collaboration with and hosted by Slovenia's Ministry of Health.

The objectives of the workshop were:

- to strengthen the intersectoral capacity for tobacco control in the countries in south-eastern Europe;
- to train professionals who could serve as reference focal points in their country in the respective sectors;
- to promote a clear intersectoral understanding of comprehensive tobacco control;
- to promote the need for a team approach and collaboration at the country level between the public health, economic and legal sectors for tobacco control and other sectors as necessary; and
- to identify and promote the legislative, economic, technical, capacity-building and infrastructure measures and activities needed in the countries to lay the groundwork for implementing the WHO Framework Convention.

Project component three: information campaigns aimed at increasing public awareness of and support for the implementation of tobacco control policy

The national health coordinators from south-eastern Europe, the Government of Norway, the WHO Regional Office for Europe and the Council of Europe agreed and signed a decision on component three of the project at the 13th Meeting of the South-eastern Europe Health Network held in Sarajevo, Bosnia and Herzegovina, 26–28 June 2006.

In the framework of component three of the project, the Training Workshop on Designing and Carrying Out Anti-Smoking Media Campaigns was held on 14–16 December 2007 in Zagreb, Croatia. The WHO Regional Office for Europe in collaboration with Croatia's Ministry of Health organized the Workshop.

Participants of the Workshop were health professionals involved in tobacco control, journalists, professionals involved in communication in general and representatives of anti-tobacco nongovernmental organizations nominated by the health ministries in the respective countries. WHO invited international experts to share contemporary knowledge and experiences with participants of the Workshop. The approach most discussed was communication for behavioural impact, as it offers a dynamic approach to achieving behavioural results in health and social development.

The main aim of anti-tobacco mass-media campaigns is to provide evidence-based information about the harm caused by both active and passive smoking to current and potential smokers as well as to the general public, which is often involuntarily exposed to passive smoking. Preventing people from smoking and encouraging people

Regional technical meeting,
Zagreb, Croatia, 30–31 March 2006

to quit smoking are among the main strategies in the fight against smoking. National and international tobacco-free days educate the public about the harmful effects of smoking and can motivate tobacco users to try to quit. One of the main aims of preventive action is to stop children and adolescents from taking up smoking. Preventive measures include education, banning tobacco advertising, mandating health warnings on tobacco products, enforcing laws prohibiting tobacco sales to minors and attempting to change social norms and values. Telephone help-lines are a very useful tool as they provide information about the harm caused by smoking to the general public.

Mass-media campaigns can be effective in keeping tobacco control on the social and political agenda, in legitimating community action and in triggering other interventions. Several studies suggest that cessation campaigns supported by the mass media can be an effective part of comprehensive and synergistic tobacco control programmes, reaching individuals directly with cessation messages, and as said previously, influencing their knowledge, attitudes and behaviour. Campaigns have been run in several countries including Australia, Canada, France, Iceland, New Zealand and Poland. Evaluation indicates that effective social marketing and communications campaigns can curtail tobacco use.

During the past six years, the WHO Mediterranean Centre for Vulnerability Reduction in Tunisia has successfully applied the communication for behavioural impact approach as a form of social mobilization to a variety of health issues. The workshop on strategic communication planning and communication for behavioural impact draws on these international experiences and prepares participants to apply the communication for behavioural impact planning and implementation approach to tobacco control programmes in their countries. Participants were introduced to the 10-step planning process of communication for behavioural impact in the strategic planning of communication programmes for behavioural results. Participants were briefly introduced to six main topics: communication and behavioural goals; basic communication techniques (mass media, small group and personal selling, interpersonal communication and counselling); marketing principles and practices; marketing research and programme evaluation; community mobilization, advertising and public relations; and communication for behavioural impact planning.

Objective and personal learning outcome. Participants were prepared to apply the 10-step communication for behavioural impact approach to designing a strategic communication plan for behavioural impact in tobacco control programmes in the countries in south-eastern Europe.

5th Meeting of the Country Project Managers

After the Training Workshop on Designing and Carrying Out Anti-Smoking Media Campaigns in Zagreb, the 5th Meeting of the Country Project Managers was held to review the outcomes of the overall project and its components, challenges faced and lessons learned during its implementation. This was an opportunity for the participants

13th Meeting of the South-eastern Europe Health Network, Sarajevo, Bosnia and Herzegovina, 26–28 June 2006

Awareness campaign workshop, Zagreb, Croatia, 14–16 December 2007

to make suggestions for tobacco control activities at the national and regional level in the future and to discuss the fundraising activities to proceed with planned activities.

All achievements of the project at the national and country level were presented during the first part of the Meeting.

The participants agreed overall that the project had been very successful in:

- significantly raising tobacco control on the political agenda in all of the countries and the region;
- achieving substantial progress in intersectoral links and collaboration;
- increasing public support towards tobacco control measures;
- achieving remarkable progress in ratifying the WHO Framework Convention on Tobacco Control – seven countries in south-eastern Europe have ratified it;
- seeing an active process of legislative initiatives and updates in most of the countries;
- implementing capacity-building in the countries due to the first component of the project;
- supporting the existing network of tobacco control professionals as a very valuable product of the longstanding joint work; and
- recognizing that all countries have seen benefits from the implementation of the project, and the activities of the project therefore need to continue to sustain the momentum.

Main points

- The Initiative for Social Cohesion of the Stability Pact for South Eastern Europe, the WHO Regional Office for Europe and the Council of Europe initiated the project Public Health Capacity Building for Strengthening Tobacco Control in South-Eastern Europe.
- Component one of the project achieved remarkable progress in ratifying the WHO Framework Convention on Tobacco Control, with most countries ratifying the Convention.
- Component two aimed at increasing intersectoral capacity-building for comprehensive tobacco control policies in the south-eastern European countries.
- Component three consisted of capacity-building in designing and carrying out antismoking campaigns and behavioural change programmes in tobacco control.

2. Smoking prevalence and health effects of tobacco use

Marta Čivljak

In order to get a clear picture about the smoking prevalence and the tobacco-related morbidity and mortality, we searched the following databases: the WHO European Health for All database, WHO European Database on Tobacco Control, Tobacco Control Country Profiles, Health Behaviour in School-Aged Children (HBSC), the European School Survey Project on Alcohol and other Drugs (ESPAD) and the Global Youth Tobacco Survey (GYTS). Additional data were sought from the country project managers, who attempted to collect available recent data on tobacco consumption, smoking prevalence and lung cancer mortality.

Tobacco use can be estimated from two major sources, cigarette consumption and smoking prevalence. Prevalence data are more valuable, as they are available from population-based surveys and can be stratified by socio-economic indicators that are often associated with smoking behaviour, such as age, educational level and income level. The key advantage of population-based surveys that use probabilistic sampling techniques is that the estimates of health behaviours are robust and representative of the population they cover. Such surveys, such as the GYTS, the WHO/CDC Global School Personnel Survey (GSPS) and WHO/CDC Global Health Professional Survey (GHPS) have a crucial role in Tobacco Free Initiative surveillance projects (10,11). They enable identification of intercountry and regional differences in smoking behaviour and population groups at increased risk for tobacco-related diseases in terms of age, sex and socioeconomic background. Another advantage is that, using the same sampling frame, serial cross-sectional surveys provide information on changes in smoking behaviour over time. Surveys assessing health behaviour have their own problems of validity and reliability, relying as they do on voluntary participation and self-reported behaviour, with problems of veracity and recall. A range of issues related to respondents' non-participation, measurement error (declining to answer specific items, overreporting and underreporting, properties of the questionnaire and interviewer effects) and recall bias affect the validity and interpretation of data on smoking and health behaviour in general. Triangulation, a synthesis of multiple data sources, including analysis of data from population-based surveys and data on cigarette consumption, provides an opportunity to improve the understanding of the tobacco epidemic as a public health problem and to guide programmatic decision-making to address it more effectively (12).

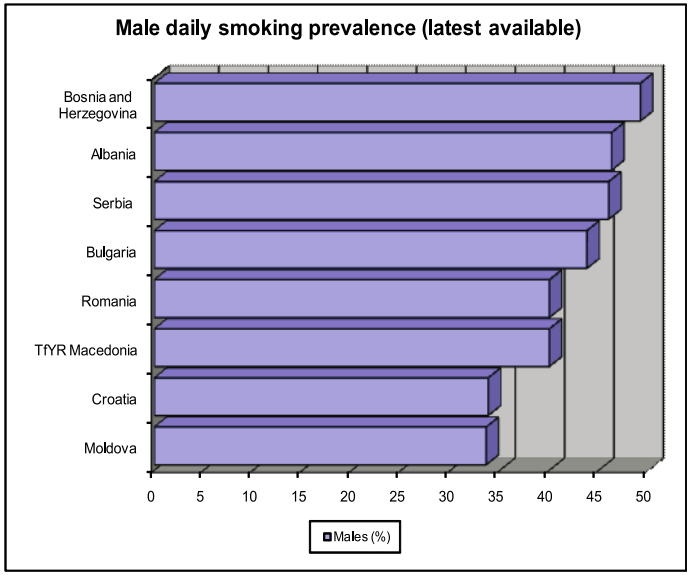
Smoking prevalence among adults

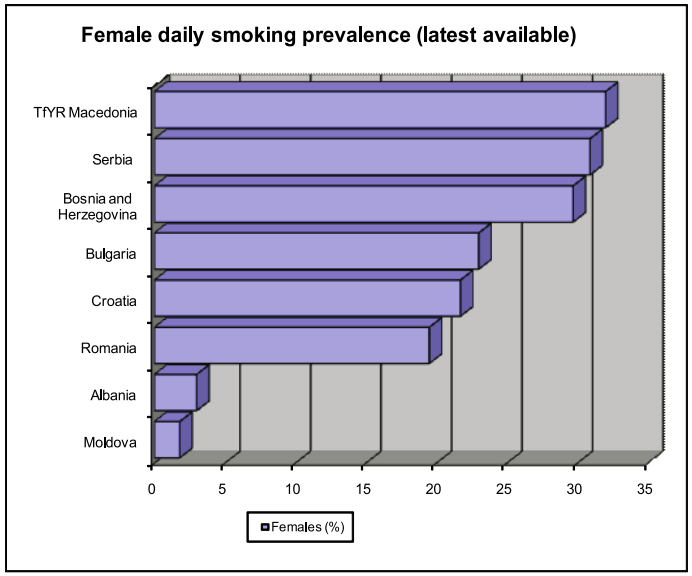
Fig. 1 presents the most recent smoking prevalence data for adults in countries in south-eastern Europe. No data on adult smoking prevalence are available for Montenegro. Comparability of data on adult smoking prevalence is limited by the different survey methods used (13). A key issue, given that age is such a strong determinant of smoking behaviour, is the different age groups sampled (see Fig. 1). The definition of smoking used (daily smoking)

was similar in most surveys, although occasional smokers were included alongside regular smokers in Albania. All samples are thought to be nationally representative.

Key findings are the high rates of smoking among men, which vary from 34% in Croatia to 49% in Bosnia and Herzegovina. The rates in most of the south-eastern European countries are higher than the average for the WHO European Region of 40%. Smoking rates among women are generally lower and vary more widely from some of the very lowest in Europe (2% in Moldova) to some of the highest (31% in Serbia). The countries of the former Yugoslavia have higher rates of smoking among women than elsewhere in south-eastern Europe. As a result, the gender gap in smoking rates is greatest in the countries outside the former Yugoslavia, most notably in Moldova and Albania.

Fig. 1. **Male and female daily smoking prevalence**





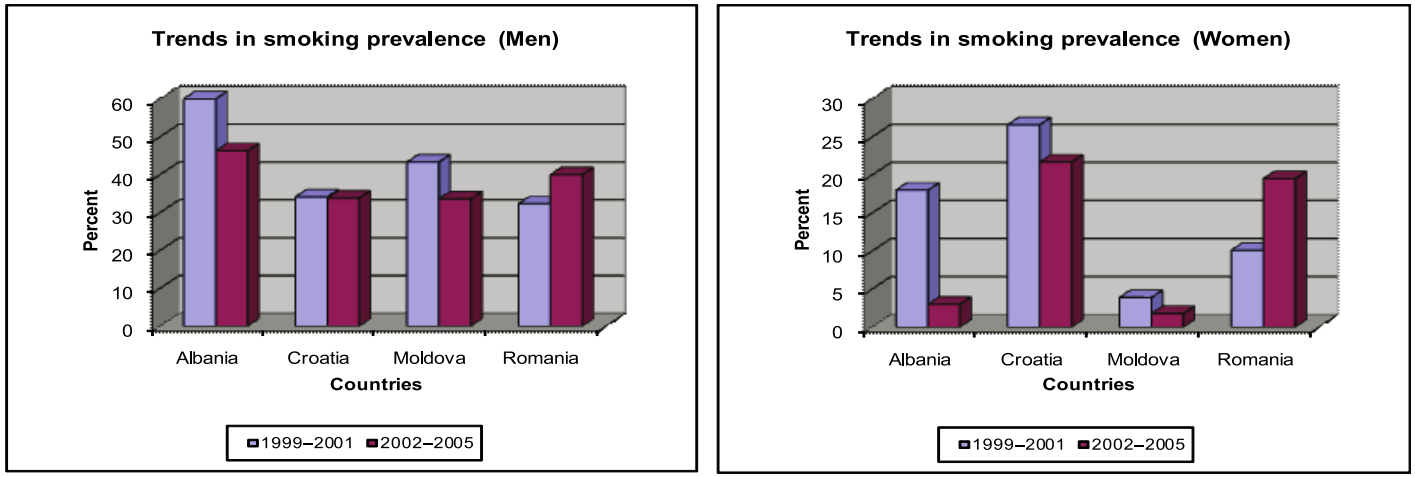
Data from Montenegro are not available;
aData for the Federation of Bosnia and Herzegovina.

Data show that smoking is more common among urban residents in all countries for which data were available (no data were available for Bosnia and Herzegovina, Croatia or The former Yugoslav Republic of Macedonia). In Moldova, this applied only to women (14).

There was an attempt to obtain data on the prevalence of smoking according to educational level. According to the available data, the probability of smoking was positively related to higher educational status in Romania and Serbia. In Albania and Bulgaria, although the prevalence of smoking was positively related to educational achievements, differences by educational status were not statistically significant (personal communication with country project managers). In Moldova, educational status was an important predictor only among men, with those who were less educated being more likely to smoke. More attention could be paid to determining socioeconomic factors associated with smoking, as it enables improved targeting of anti-tobacco activities (15).

Describing trends in smoking prevalence in the region is difficult, as truly comparable longitudinal data are lacking. The data presented in Fig. 2 show trends in smoking prevalence from 1999 to 2005 for Albania, Croatia, Moldova and Romania, the only countries for which data were available from the WHO European Database on Tobacco Control (16).

Fig. 2. Trends in smoking prevalence in Albania, Croatia, Moldova and Romania



Source: WHO European Database on Tobacco Control (16).

As the comparability of these surveys over time is uncertain due to the different survey methods used, making firm conclusions about the trends in smoking rates is difficult. Nevertheless, the data suggest that male smoking rates have fallen in Albania and Moldova while rising in Romania and remaining stable in Croatia. In addition, the high rate observed in Albania in 1999–2001 may be accounted for by the broader definition of smoking used. In Romania, the proportion of women smoking seems to be increasing, in contrast to Albania, where women seemed to smoke less in 2002–2005 than in 1999–2001. The prevalence also declined in Croatia and Moldova, although not so strongly.

Youth smoking prevalence

This report uses data from the GYTS surveillance system to describe the prevalence of tobacco use among young people in the countries of south-eastern Europe (17). Each country participating in the GYTS used similar sampling procedures and methods, a core questionnaire and consistent data-processing procedures to ensure a high degree of accuracy and comparability for cross-country analysis. Although most countries sampled the same age group (13–15 years), two countries had slightly different age groups: Montenegro, where the age group is younger (12–15 years), and Bulgaria, where it is older (13–16 years).

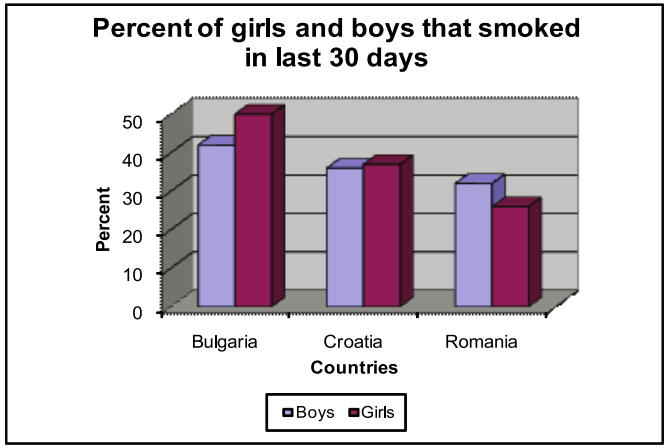
Table 2 presents the results of the GYTS. They show considerable heterogeneity in youth smoking prevalence, with smoking prevalence among boys ranging from 4% in Montenegro to 31% in Bulgaria and among girls from 3% in Montenegro to 43% in Bulgaria. These extremes could be explained by the different age groups sampled in Montenegro and Bulgaria, especially since the results for the other countries lie in between. But very high rates of youth smoking in Bulgaria are also seen in the European School Survey Project on Alcohol and Other Drugs (ESPAD) survey conducted in 2003 (Fig. 3), suggesting that the GYTS data are valid. Croatia and Romania were the only other two countries surveyed in ESPAD. The definition of smoking used was the same, but the age group studied was different, with only 16-year-olds included, accounting for the higher rates of smoking in this compared with the GYTS.

Table 2. Prevalence of smoking among young people in south-eastern Europe

Country	Boys (%)	Girls (%)	Age (years)	Sample size	Year of survey
Albania	15.8	8.8	13–15	58 schools, 4682 students	2004
Bosnia and Herzegovina: Federation of Bosnia and Herzegovina	16.8	10.0	13–15	60 schools, 5198 students	2003
Bosnia and Herzegovina: Republika Srpska	14.0	12.2	13–15	60 schools, 5600 students	2003
Bulgaria	31.3	42.7	13–16	2167 students	2002
Croatia	18.5	14.3	13–15	60 schools, 5038 students	2003
Moldova	24.0	6.9	13–15	60 schools, 5417 students	2003
Montenegro	3.7	3.4	12–15	25 schools, 2090 students	2003
Romania	27.1	19.7	13–15	4118 students	2004
Serbia	15.5	16.8	13–15	4377 students	2003
The former Yugoslav Republic of Macedonia	9.3	6.7	13–15	75 schools, 4020 students	2002

Source: Global Youth Tobacco survey [web site] (17).
The prevalence rates relate to current cigarette smoking (defined as "the percentage of students who smoked cigarettes on one or more days during the past 30 days").

Fig. 3. Proportion of boys and girls who smoked during the last 30 days in south-eastern Europe



Source: Hibell et al. (18).

Both sets of results show the very high rates of youth smoking in some countries of south-eastern Europe. In the ESPAD survey, Bulgaria had the third highest rate of smoking after Greenland and Austria. Excluding Bosnia and Herzegovina and Montenegro, where comparisons with adult data cannot be made, the ratio of male to female smoking is lower among young people than among adults in all countries except The former Yugoslav Republic of Macedonia, implying that smoking is becoming increasingly common among girls and young women. In addition, in three countries, Bulgaria, Moldova and Romania, the rates of smoking among girls are higher than those among older women, suggesting that the rates among women in these countries are set to increase significantly. ESPAD was carried out in Serbia in 2005, and 27% of boys and 35% of girls reported smoking in the past 30 days.

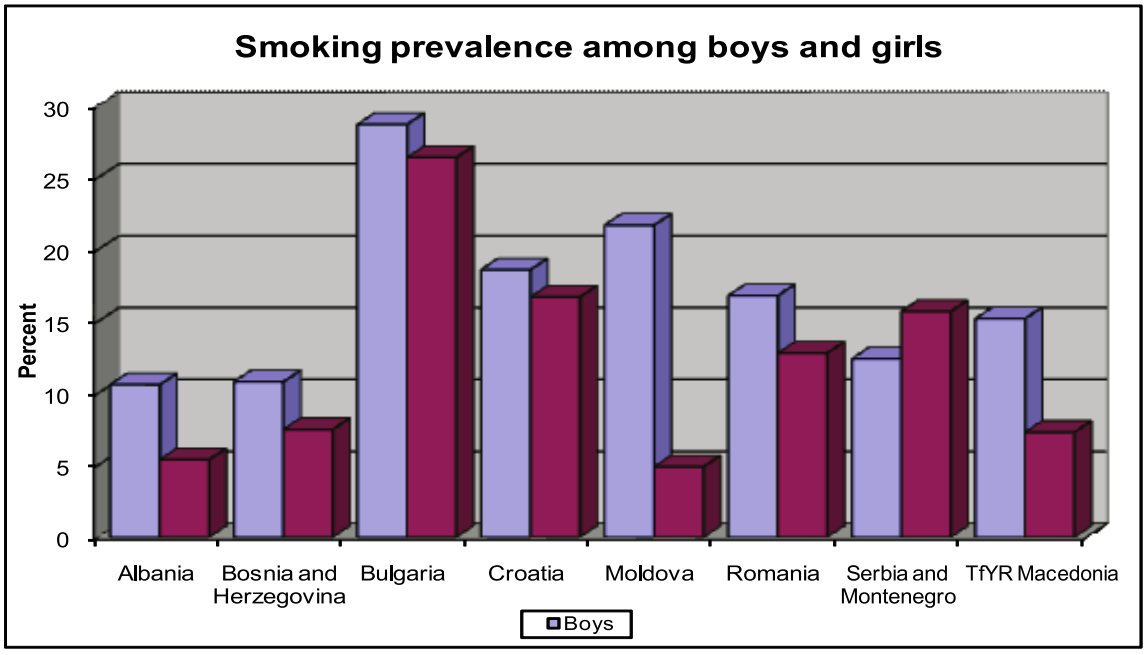
Trends over time in youth smoking can only be assessed in Croatia, the only country in the region to have participated in ESPAD since 1995. These data suggest an increase in smoking among girls and a stabilization of trends of smoking among boys.

The HBSC study is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study aims to gain new insight into and increase understanding of young people's health and well-being and health behaviour and their social context. In 2001/2002, the surveys were conducted only in two countries in south-eastern Europe: Croatia and The former Yugoslav Republic of Macedonia, enabling assessment of health behaviour and socioeconomic inequality among schoolchildren aged 11, 13 and 15 years. Besides demographic and social background, family structure, individual and social resources, each survey questionnaire examines weekly

smoking prevalence rates among schoolchildren. Among 15-year-old children surveyed in HBSC, 23% of boys and 25% of girls in Croatia reported smoking at least once a week versus 13% and 15% in The former Yugoslav Republic of Macedonia respectively. The HBSC averages were 24% and 23% respectively.

Since HBSC was conducted in only two countries in south-eastern Europe, there was an attempt to present data on weekly smoking prevalence from GYTS (Fig. 4). The prevalence of weekly smoking among 15-year-old boys was higher than that among girls in all the countries except Serbia. In Bulgaria and Croatia, the gender-related differences in weekly smoking are small.

Fig. 4. Smoking prevalence (at least one cigarette per week) among 15-year-old boys and girls in south-eastern Europe



Source: The European tobacco control report 2007 (19). Estimations made on GYTS data.
Montenegro and Serbia have been separate countries since 2006.

Tobacco use among health-profession students

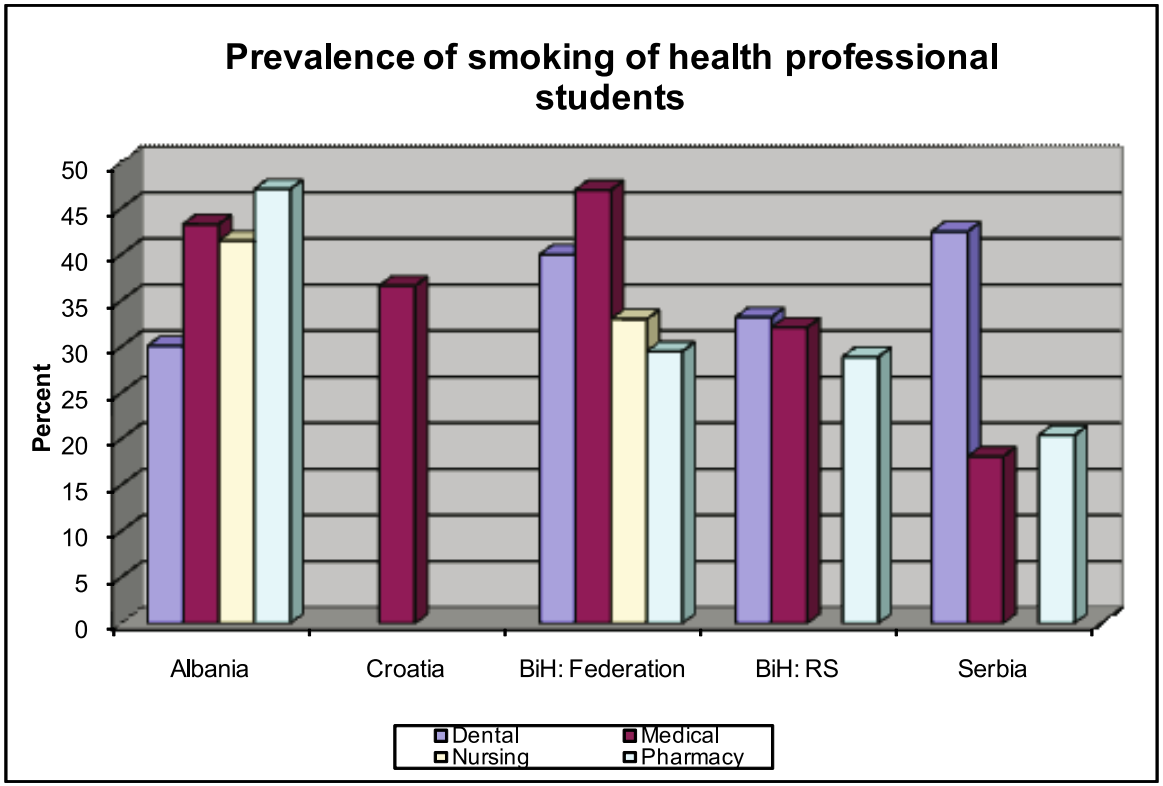
Health professionals are regarded as a source of information and advice on health problems, including the health effects of tobacco use. They are also perceived as role models, and smoking rates are usually lower among health professionals than among the general population as they tend to quit earlier in the tobacco epidemic than non–health professionals. For these reasons, an understanding of smoking rates among health professionals or students of such professions is useful.

To collect data on tobacco use among third-year students in four health disciplines (dentistry, medicine, nursing and pharmacy), WHO, the United States Centers for Disease Control and Prevention and the Canadian Public Health Association developed the Global Health Professional Survey (GHPS) in the late 1990s.

GHPS uses a core-questionnaire on demographics, prevalence of cigarette smoking and other tobacco use and knowledge and attitudes about tobacco use. The surveys were implemented in the first quarter of 2005 in four countries in south-eastern Europe (Albania, Federation of Bosnia and Herzegovina, Croatia and Serbia). Fig. 5 shows these data.

Although the sample sizes are small and the samples may not be representative of all students, several tentative conclusions may be reached. The findings indicate that current smoking rates among health profession students are higher than 30% in most countries and in most disciplines. Rates are generally lower in Serbia than elsewhere (except female dental students). In addition, all the groups of female students surveyed, other than medical and pharmacy students in Serbia, had higher rates of smoking than those in the general population. In contrast, rates in male students are lower or similar to those in the general population. This implies that female smoking is still a relatively new phenomenon in south-eastern Europe that remains common in well-educated groups.

Fig. 5. Prevalence of current cigarette smoking among third-year health-profession students by discipline



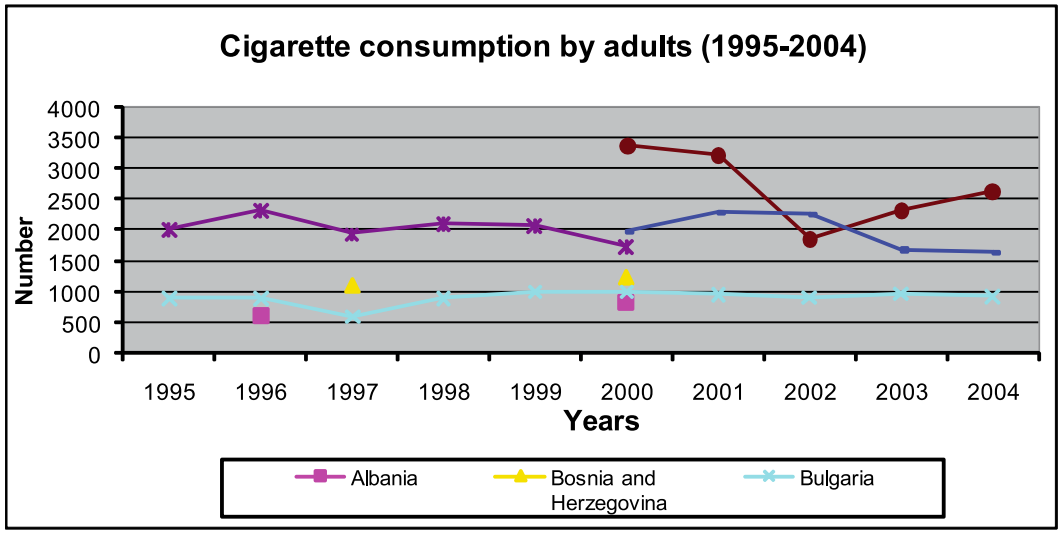
The findings from this survey have important implications for tobacco control programmes. The high level of tobacco use among health profession students suggests that policy-makers could target these students because this behaviour reduces their ability to deliver convincing cessation counselling to their future patients. All health profession schools could inform their students of the health effects of tobacco use, discourage tobacco use among their students and implement programmes to train health professionals in effective cessation counselling techniques. However, a positive message was that, in Belgrade at least, smoking rates among all student groups other than female dentists were lower than in the general population, suggesting that rates in such groups must have fallen and implying that the same could be achieved in the other countries of south-eastern Europe.

Cigarette consumption

As outlined above, in addition to smoking prevalence, tobacco use can be measured based on cigarette consumption. Tobacco consumption is determined as the number of cigarettes or the weight of tobacco consumed per adult per day and has the advantage of being routinely available from sales data. However, as consumption data are generally based on sales of legally traded cigarettes and exclude products acquired through smuggling and cross-border shopping, such figures are of limited use in parts of south-eastern Europe, although corrections can be made if the scale of the illegal trade can be estimated.

Cigarette consumption data were obtained from the reports of country project managers and from the WHO European Health for All database (Fig. 6 and 7 respectively). The WHO European Health for All database (Fig. 7) provides comparative data for six of the eight study countries (no data for Moldova and for Serbia and Montenegro) in 2000, when average annual consumption per person varied from 744 in Albania to 2793 in Bulgaria. High consumption figures are also reported for The former Yugoslav Republic of Macedonia (1794) and Croatia (1737).

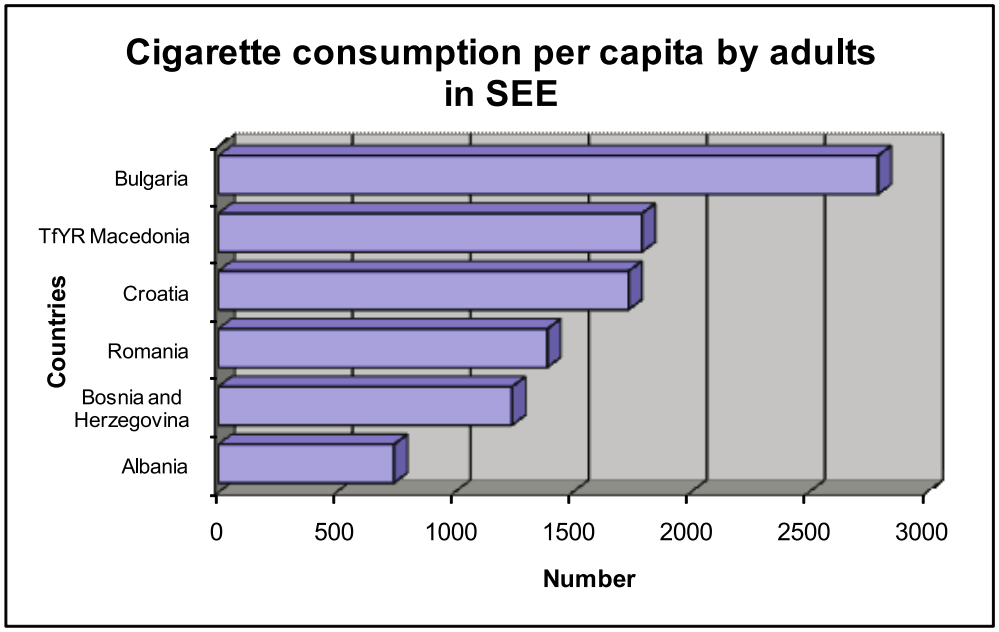
Fig. 6. Per capita consumption of cigarettes in countries in south-eastern Europe among adults aged 15 years and older, 1995–2004



Sources: [1]Data from the economic review for the Tobacco Control Project in Moldova, 2005. [2]According to the Ministry of Agriculture, the cigarette consumption has been constant over the years at about 35 000–40 000 tonnes. [3]Based on the household questionnaire survey, Serbian Statistical Office.

Discrepancies between the two data sources for Albania and Bulgaria highlight some of the difficulties in obtaining accurate consumption data. The consumption figures shown for Albania (744–837 cigarettes per capita in 2000) are likely to be gross underestimates, particularly given that the national survey conducted in 2000 estimated that 60% of men and 18% of women smoke regularly or occasionally. This underestimate is likely due to the high level of smuggling there. ERC Statistics International (quoted in Božičević et al. (6)) cites a more accurate estimate of 2150 cigarettes per person per year in 1999. Similarly, the data for Bulgaria cited in Fig. 7 (2793 in 2000) are more likely to be accurate than the figure of 1000 quoted in Fig. 6. Given these shortfalls, further comments on these data cannot be made with certainty.

Fig. 7. Per capita consumption of cigarettes in countries in south-eastern Europe among adults aged 15 years and older



Source: European Health for All database (21).

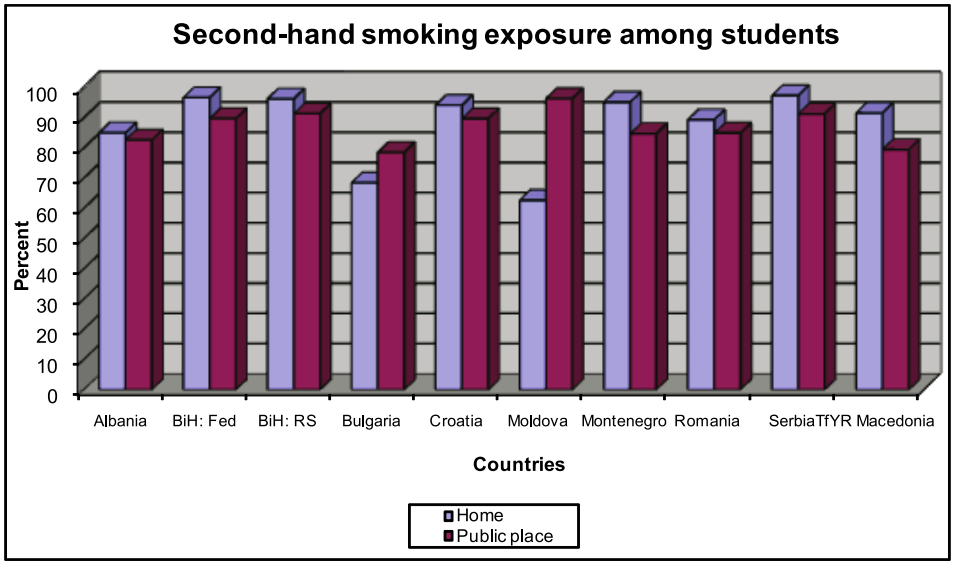
According to Božičević et al. (20), in 1999, average cigarette consumption in countries in south-eastern Europe (2235) was 5% higher than in the countries of central and eastern Europe (2129) and 35% higher than the EU average (1653).

Exposure to second-hand smoke

Second-hand smoke is a mixture of the smoke given off by the burning ends of a cigarette or other smoked product (sidestream smoke) and the smoke emitted at the mouthpiece and exhaled from the lungs of smokers (mainstream smoke). Over the past two decades, research has shown that second-hand smoke is a risk factor for lung cancer (22,23). It contains at least 250 chemicals known to be toxic or cause cancer. Unfortunately, the general public is exposed to much more second-hand smoke than most people realize.

The GYTS described above and conducted in all countries in south-eastern Europe provides data on exposure to second-hand smoke among students 13–15 years old. The questions asked for this purpose were as follows. 1) During the past seven days, on how many days have people smoked in your home in your presence? 2) During the past seven days, on how many days have people smoked in your presence in places other than in your home? This shows that second-hand smoke is a major public health problem in the region, with most adolescents being exposed both at home (where the proportion exposed varies from 63% to 97%) and in public places (79–96%) (Fig. 8).

Fig. 8. Exposure to second-hand smoke among students 13–15 years old in countries in south-eastern Europe



Source: Global Youth Tobacco Survey [web site] (17).

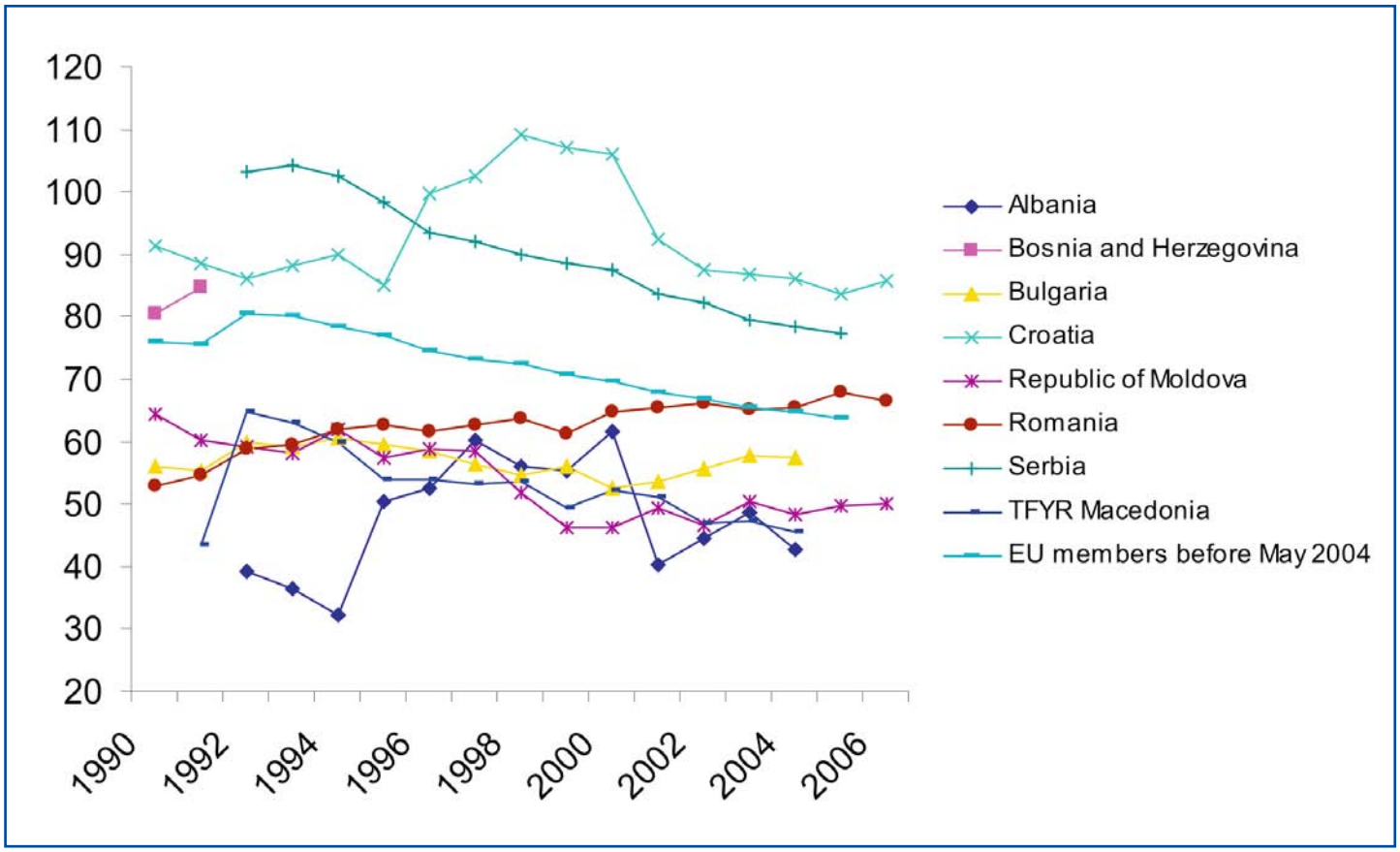
There have been several attempts in the countries in south-eastern Europe to get more information about the exposure of adults to second-hand smoke, including efforts in Bosnia and Herzegovina, Moldova, Romania and Serbia. Such data are not comparable and are not therefore presented here.

Mortality data on cancer of the trachea, bronchus and lung

Half of all long-term smokers will eventually be killed by tobacco and of these, half will die during middle age, losing 20–25 years of life (24,25).

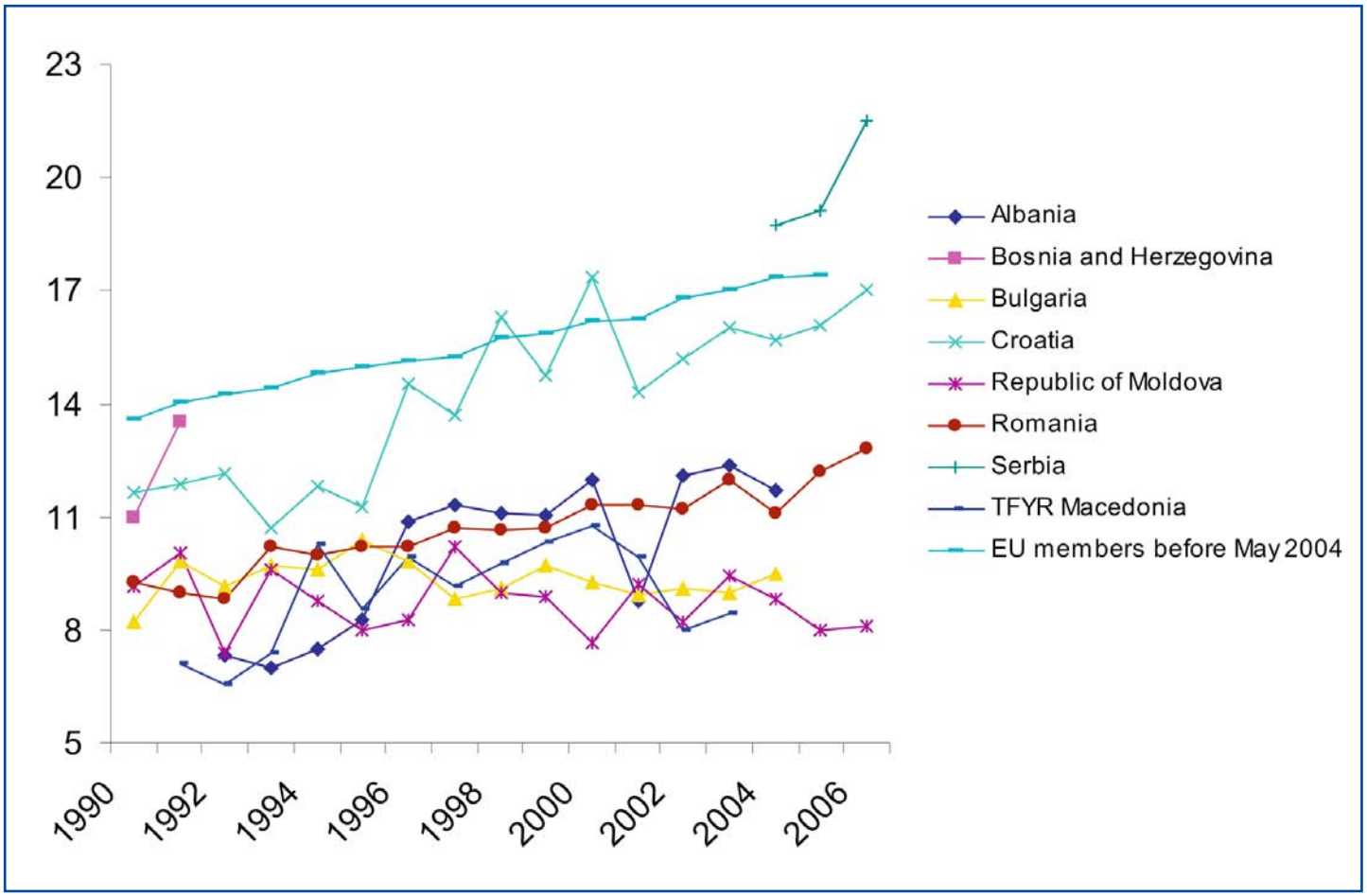
To describe the trends in mortality from trachea, bronchus and lung cancer since 1990, we used data from the WHO European Health for All database (Fig. 9 and 10). Among men, Croatia has the highest lung cancer mortality rate in south-eastern Europe (85.7 per 100 000 population in 2006) and Albania the lowest (42.7 per 100 000 population in 2004). Croatia, Serbia and Romania have higher death rates from cancer of the trachea, bronchus and lung in men than the average of the 15 EU members before May 2004. There is an apparent trend of an increase in mortality in Romania and a decrease in Serbia. In other countries, trends have been rather stable since 1990 with some fluctuation (Bulgaria, Croatia, Moldova and The former Yugoslav Republic of Macedonia) or considerable fluctuation (Albania). In women, fluctuation in trends in death rates is more pronounced due to small numerators. Serbia has the highest mortality among women (21.5 per 100 000 population in 2006) and Moldova the lowest (8.1 per 100 000 population). Serbia is the only country that has higher mortality than the average of the 15 EU members before May 2004. In most of the countries, death rates among women are increasing (Albania, Croatia, Romania, Serbia and The former Yugoslav Republic of Macedonia) while in Bulgaria and Moldova they seem to be have been stable since 1990. Relatively low death rates among women in Moldova can be somewhat explained by low reported smoking rates, while death rates among women in Albania are not compatible with the reportedly low smoking rates. Mortality data have not been available for Bosnia and Herzegovina since 1991, and at that time lung cancer mortality was 84.6 per 100 000 among men and 13.5 per 100 000 among women. Data from the WHO European Health for All database are not available for Montenegro, but the country project manager provided the following data: the trachea, bronchus and lung cancer mortality rate was 27.0 per 100 000 among women and 85.2 per 100 000 among men in 2006, among the highest rates in south-eastern Europe. This is a considerable increase compared with 1991, when the rate was 10.7 per 100 000 among women and 45.8 per 100 000 among men.

Fig. 9. Standardized death rate (SDR) for cancer of the trachea, bronchus and lung per 100 000 males of all ages, 1990–2007



Source: WHO European Health for All database (21).

Fig. 10. Standardized death rate (SDR) for cancer of the trachea, bronchus and lung per 100 000 females of all ages, 1990–2007



Source: WHO European Health for All database (21).

Main points

- The rates of smoking among adult men are high, ranging from 34% in Croatia to 49% in Bosnia and Herzegovina. Among women, they are the lowest in Moldova (2%) and the highest in Serbia and Montenegro (31%).
- Data are lacking on the socioeconomic determinants of smoking.
- Though not entirely comparable due to the different age groups surveyed in GYTS, smoking prevalence among boys ranges from 4% in Montenegro to 31% in Bulgaria and among girls from 3% in Montenegro to 43% in Bulgaria. Among 15-year-old students surveyed in the HBSC study, 23% of boys and 25% of girls in Croatia reported smoking at least once a week versus 13% and 15% (respectively) in The former Yugoslav Republic of Macedonia. GYTS data show that second-hand smoke is a major public health problem in south-eastern Europe, as most adolescents are exposed at home (63–97%) and in public places (79–96%).
- The findings from the GHPS indicate that current smoking rates among health profession students in Albania, Bosnia and Herzegovina, Croatia and Serbia are higher than 30% in most of these countries and in most disciplines.
- The highest lung cancer mortality rate is in Croatia (85.7 per 100 000 population in 2006) and the lowest is in Albania (42.7 per 100 000 population in 2004). Mortality is increasing in Romania and decreasing in Serbia. In other countries, trends are rather stable since 1990 with some fluctuation (Bulgaria, Croatia, Moldova and The former Yugoslav Republic of Macedonia) or considerable fluctuation (Albania). Serbia has the highest mortality among women (21.5 per 100 000 population in 2006) and Moldova the lowest (8.1 per 100 000 population). In most of the countries (Albania, Croatia, Romania, Serbia and The former Yugoslav Republic of Macedonia), death rates are increasing among women, whereas these trends seem to be stable in Bulgaria and Moldova.

3. Overview of the national tobacco control policies in light of the WHO Framework Convention on Tobacco Control

Kristina Mauer-Stender

Tobacco use is the leading cause of avoidable disease and premature death. Improving this situation requires effective policies and enforcing them. The public health implications of tobacco, long apparent in high-income countries, are now obvious worldwide. In certain regions, such as south-eastern Europe, the health effects are particularly worrisome. These findings suggest that, unless concerted action is taken, the health threat posed by smoking in south-eastern Europe will remain enormous and even continue to increase.

As an example of joint action, the project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe was initiated in 2004. It followed the Dubrovnik Pledge, signed by the health ministers of eight countries in south-eastern Europe in 2001, selecting tobacco control as one of the seven key areas for action. The project's overall objective is to strengthen tobacco control activities in the region and decrease the burden of disease attributable to tobacco in the long term. The first component of the project aimed to raise awareness and build the intersectoral capacity for the entry into force of the WHO Framework Convention on Tobacco Control in the region. This overview of the national legislation in tobacco control is part of the national capacity-building, with an attempt to prepare for the effective implementation of the Convention and further strengthening national tobacco control policies.

Overview of the tobacco control policies in south-eastern Europe

Recent years have shown significant and increasing public support in favour of national and international efforts to develop and strengthen policies for tobacco control. Strong public opinion along with increased political commitment has lead to recent substantial changes in tobacco control policies in south-eastern Europe.

The best example of concerted action at the international level is the unanimous adoption of the WHO Framework Convention on Tobacco Control by the World Health Assembly in May 2003. By 1 October 2008, seven of the nine countries in south-eastern Europe, Albania, Bulgaria, Croatia, Montenegro, Romania, Serbia and The former Yugoslav Republic of Macedonia, had ratified the treaty. The second Conference of Parties was held in Bangkok in June 2007. The six countries in the region had the right to participate with voting rights, whereas other states that were not parties to the Convention could participate as observers.

Given the positive changes in tobacco control policy in recent years, examining the current policy situation in south-eastern Europe is important.

Price and taxation policies

According to information for 35 countries in the WHO European Region, during the past five years, tobacco products became less affordable in 13 countries and more affordable in 20 countries (22). Countries in south-eastern Europe, except Bulgaria, belong to the second group with more affordable tobacco products. Bulgaria and Romania, which became members of the EU in 2007, have adopted tax regimes similar to the EU, although a transitional period has been agreed. Some other countries in south-eastern Europe are tending towards harmonization with the EU framework.

Exposure to tobacco smoke

Smoking in public places has been regulated more restrictively in all countries in south-eastern Europe in recent years. Along with the guidelines for the implementation of the WHO Framework Convention on Tobacco Control and an increasing number of countries banning smoking in public places, the progress towards smoke-free places is expected to be even stronger. Smoking is banned in all health, educational, governmental and cultural premises, except in Moldova. The Convention will eventually ban smoking in all public places. Smoking is restricted in restaurants and bars in all countries in south-eastern Europe, again except for Moldova. At the same time, effective enforcement of existing legislation remains a problem throughout south-eastern Europe and needs further attention in terms of adequate penalties and monitoring systems as well as public information and awareness.

Product control and consumer information

In 2006, 33 countries in the WHO European Region, especially EU countries, regulated the levels of tar, nicotine and carbon monoxide in cigarettes (12). In south-eastern Europe, Bulgaria, Croatia, Montenegro, Romania and Serbia and were among these countries. The use of misleading terms such as “low tar”, “light”, “ultralight” and “mild” is banned in most countries in south-eastern Europe except Bosnia and Herzegovina and Moldova. All countries in south-eastern Europe require health warnings, but their level differs greatly. Bulgaria and Romania have transposed EU Directive 2001/37/EC and thus have specific requirements for the content, location, languages, area to cover, colours and font size of health warnings. In all other countries, requirements for the size and content of warnings remain at the weaker level, and further efforts in strengthening this are therefore needed. Pictorial warnings are to be used on cigarette packages in Romania beginning on 1 July 2008.

Advertising, promotion and sponsorship

Most countries in south-eastern Europe have recently reinforced their legislation on direct advertising either by adopting new laws or by strengthening the existing ones. Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Montenegro, Romania, Serbia and The former Yugoslav Republic of Macedonia have enforced a ban on advertising on national television, radio and local printed magazines and newspapers. Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Romania, Serbia and The former Yugoslav Republic of Macedonia have also banned advertising on billboards and outdoor walls. Using points of sale as the channel for direct advertising remains weakly regulated throughout the region. The compliance with bans on direct advertising is generally considered to be high. South-eastern Europe has made some progress since 2002 in indirect advertising, including promotion, sponsorship and brand-sharing, but this remains less regulated and enforced than direct advertising. Romania transposed Directive 2003/33/EC on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products, which bans cross-border advertising and sponsorship, a measure the countries in south-eastern Europe could also apply in the future.

Availability of tobacco to young people

Restricting the availability of cigarettes to young people is an important aspect of tobacco control policy. In the eastern part of the WHO European Region, GYTS data on minors' access to tobacco show that the age restrictions are far from being fully enforced. In all countries in south-eastern Europe that had an age restriction when the GYTS was conducted, more than two thirds of the current smokers aged 13–15 years had bought their cigarettes in a shop and had not been refused during the 30 previous days. The range of non-compliance varied from 88% in Croatia to 73% in Romania. All countries in south-eastern Europe have introduced age restrictions for the sale of tobacco products. Compliance with the laws on sales restrictions needs to be improved in most countries. In addition to age restrictions, some countries have introduced regulation on impersonal modes of sale. Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania and Serbia ban the sale of tobacco products through vending machines and self-service displays. Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Romania and Serbia have banned the sale of single or unpacked cigarettes (19).

Main points

- Most of the countries in south-eastern Europe (Albania, Bulgaria, Croatia, Montenegro, Romania, Serbia and The former Yugoslav Republic of Macedonia) have ratified the WHO Framework Convention on Tobacco Control and are parties to the Convention. Tobacco control in these countries could benefit from the coherence of national, regional and global actions on tobacco control.
- During the past five years, tobacco products became more affordable in all the countries in south-eastern Europe except Bulgaria.
- Smoking is banned in all health, educational, government and cultural premises except for Moldova.
- Bulgaria and Romania have accepted the EU requirements on the health warning messages on packets of tobacco products. In all other countries the content of warnings is weaker.
- The GYTS data suggest that the legislation on age restrictions for the sale of tobacco products is poorly enforced.

4. Country summaries

Albania

Prepared by:

Gazmend Bejtja
Country Project Manager for Albania

1. General information on the country

Size	28 648 m^2
Population	3.1 million
Median age	28.9 years

Total health expenditure per person per year (PPP in US$, WHO estimate)
2004: 339

Total health expenditure as a % of gross domestic product (WHO estimate):
2004: 6.7%

PPP: purchasing power parity.

2. Report on project implementation

Control of the tobacco epidemic is one of the greatest public health challenges facing Albania today and requires coordinated multisectoral action. About 25% of Albanian adults smoke (men: 46%; women: 3%). The exposure to second-hand smoke among students 13–15 years old is at 83% in public places and 85% in home environments.

The WHO Framework Convention on Tobacco Control and Albania's Law on the Protection of Health from Tobacco Products represent the legal instruments for more successful tobacco control.

The South-eastern Europe Tobacco Control Project was instrumental in building the national capacity for tobacco control, which includes: political commitment for tobacco control; multisectoral collaboration; national laws and regulations to comply with the WHO Framework Convention on Tobacco Control; designation of comprehensive educational, communications, public awareness and training programmes; and an enabling environment for civil society.

The Institute of Public Health provided office space for the project. The Country Project Manager and the national counterpart for tobacco control are both accommodated in this office. Hence, this office is considered as the seat of the National Programme for Tobacco Control. The project funded office equipment, including computer, printer, scanner, photocopy machine, fax machine and other supporting items.

One of the main achievements of the project was the establishment of intersectoral cooperation. Experts in law, economics and public health were identified. Their tasks consisted of preparing the policy papers and identifying the challenges of tobacco control in the country.

Intensive contacts with the key stakeholders of the Parliamentary Commission on Health, Ministry of Health, Ministry of Justice and Ministry of Foreign Affairs started in September 2005. Copies of the WHO Framework Convention on Tobacco Control were sent to them along with a short description of the project. As a result, a complete delegation from Albania participated at the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control held in Sofia, Bulgaria on 29–30 September 2005. The Director of the Cabinet of the Minister of Health headed the delegation. Representatives of the Parliamentary Commission on Health, Ministry of Health, Ministry of Justice and Ministry of Foreign Affairs were part of the delegation. The political will of the Government of Albania to work on passing the Law on the Protection of Health from Tobacco Products and on ratifying the WHO Framework Convention on Tobacco Control was expressed.

Following the regional conference, the national meeting on the WHO Framework Convention on Tobacco Control was held in Tirana on 23 December 2005. Members of the Parliament expressed their willingness to push for ratifying the WHO Framework Convention on Tobacco Control. Representatives of the Ministry of Integration, Ministry of Justice and Ministry of Foreign Affairs presented legal procedures for ratifying the WHO Framework Convention on Tobacco Control. The representatives expressed their opinion that, without the WHO Framework Convention on Tobacco Control, any action to control tobacco is not likely to be successful.

The Parliament ratified the WHO Framework Convention on Tobacco Control on 9 February 2006. The South-eastern Europe Tobacco Control Project catalysed the process of ratification. The First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control in Sofia had a strong impact because of the messages conveyed and the right timing. The good will of the new government was crucial. Key to the ratification was the lobbying strategy adopted by the tobacco control team.

The instruments (documentation) of the ratification were deposited at the United Nations in New York on 26 April 2006.

In the framework of project component two, Albania's delegation was presented in the Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries in Bled, Slovenia on 11–13 October 2006. Active participation in each of the sessions of the workshop was considered very important in light of the expected activities at the national level. Following the above-mentioned workshop, the activities of the tobacco control team in Albania were highlighted by the Parliament adopting the Law for the Protection of Health from Tobacco Products. Although the tobacco companies attempted to undermine the approval of the Law in the version proposed by the government, the determination of the government and the attention of anti-tobacco circles prevailed. Despite the intense debates in the Parliamentary Commission on Health and later in the Parliament, the Law was passed on 6 November 2006 and entered into force on 26 May 2007. The Law for the Protection of Health from Tobacco Products is considered an advanced law that reflects the provisions of the WHO Framework Convention on Tobacco Control. Its implementation is a challenge, and the funding of promotional campaigns remains the weak point. The Law indicates no specific funding. The mass media gave regular overviews of the provisions of the Law in the period after the Law was passed. The prospect of Albania joining the EU was the key argument in justifying the urgency of passing the Law.

The Albanian Conference on Public Health, held in Tirana on 11–13 December 2006, served to articulate and expose the tobacco control achievements and expectations to the interested audience.

The period December 2006 to January 2007 was marked by the study work of the tobacco control team on the modalities of the implementation of the Law for the Protection of Health from Tobacco Products.

The organization of the national intersectoral workshop on health promotion, planning and management of comprehensive tobacco control, as a follow-up of the Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries held in Bled, Slovenia, was timed appropriately since the Law was to enter into force in May 2007.

The following successes and challenges were faced during the implementation of the project

- The Intersectoral Committee for Tobacco Control, comprising high-level officials of the Ministry of Health, Ministry of Justice, Ministry of Interior, Ministry of Economics and Ministry of Finance, functioned well. The Intersectoral Committee for Tobacco Control is responsible for formulating the policies and strategies needed for successfully implementing the Law.
- The Parliament was lobbied to ensure earmarked funding from tobacco taxation.
- The State Sanitary Inspectorate was consolidated as the main agency in charge of enforcing the Law. The revision of the structure, competencies and instruments of the State Sanitary Inspectorate was considered necessary. In addition, the training of the sanitary inspectors was deemed very important.
- The State Sanitary Inspectorate cooperates with the Municipality and Commune Police and Taxation Police.
- Civil society is encouraged to become actively involved in implementing the Law.
- An information campaign was implemented on the provisions of the Law.

Bosnia and Herzegovina

Prepared by:

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Country Project Manager for
Bosnia and Herzegovina

1. General information on the country

Size	51 209 m^2
Population	3.8 million
Median age	38.4 years

Total health expenditure per person per year (PPP in US$, WHO estimate)
2004: 603

Total health expenditure as a % of gross domestic product (WHO estimate):
2004: 8.3%

2. Report on project implementation

Since the General Framework Agreement for Peace in Bosnia and Herzegovina (Dayton Agreement) was reached in 1995, Bosnia and Herzegovina has comprised the two entities Federation of Bosnia and Herzegovina and Republika Srpska. In addition, the District Brcko was established in 2002 as a self-governing administrative unit. The health sector is under the responsibility of the health ministries of the entities, with assistance and coordination by the Ministry of Civil Affairs. Intensive discussions on new political and administrative reforms are ongoing.

Smoking is the single most important risk factor in all population groups, with increasing trends in tobacco-related diseases and deaths. Addressing the tobacco-related burden of disease requires effective interventions to reduce the: (1) high prevalence of cigarette smoking (49% among men and 30% among women in 2002); (2) high availability of tobacco products as a result of their low and affordable prices; (3) and high exposure of children to second-hand smoke. In addition, what makes tobacco control very challenging in Bosnia and Herzegovina is that there is no ban on tobacco advertising; both the domestic and international tobacco industries provide sponsorship and promotion; a strategic approach to cessation services is lacking; involvement of tobacco prevention in school programmes is insufficient; and permanent funding of health promotion programmes and campaigns is lacking.

The following are the achievements in tobacco control:

- collaboration between tobacco control entity counterparts, appointed by the entities' health ministries;
- in collaboration with WHO, the establishment of national tobacco control centres in both entities' public health institutes in Sarajevo and Banja Luka;
- completed national tobacco control strategies in both entities, accepted by the entities' governments;
- surveys conducted: CINDI (countrywide integrated noncommunicable diseases intervention) programme 2000, HBSC 2002, GYTS 2003, GHPS 2005 for students of nursing and GHPS 2006 for medical, dentistry and pharmacy students;
- improvements in tobacco control legislation: drafted amendments on the Tobacco Control Law in the Federation of Bosnia and Herzegovina and three new laws enforced in Republika Srpska – banning smoking in public places, banning the sale of tobacco products to people younger than 18 years and banning tobacco advertisement;
- pilot projects on tobacco prevention and cessation programmes in family medicine by the Public Health Institute of the Federation of Bosnia and Herzegovina; and
- strengthened collaboration with nongovernmental organizations.

The project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe started in Bosnia and Herzegovina in April 2005. As a part of the project and in support and collaboration with the entities' health ministries and the regional project office in Zagreb, significant activities have taken place that have strongly influenced the intersectoral tobacco control mechanisms in Bosnia and Herzegovina.

During the period 2005–2006, as part of project component one, the country office was established at the Federal Public Health Institute in Sarajevo, with the appointment of Aida Ramić-Čatak as Country Project Manager and Darko Marković as coordinator for Republika Srpska.

Intersectoral cooperation was established in the framework of the project. Legal, economic and public health experts from Bosnia and Herzegovina, supported by WHO tobacco control experts, worked on the legal, economic and prevalence studies. The main activities included the intensive work on collecting and analysing data on the prevalence of smoking and smoking-related diseases, on different economic variables, national legislation related to tobacco control and compliance with the WHO Framework Convention on Tobacco Control for the above-mentioned studies.

With the support of the WHO Regional Office for Europe, national representatives participated in the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control held in Sofia, Bulgaria on 29–30 September 2005.

In the period 2006–2007, as part of project component two, with the support of the WHO Regional Office for Europe, the national representatives participated in the Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries held in Bled, Slovenia.

The national conference on tobacco control was held on 29 May 2007 in Banja Luka, with the participation of the representatives of WHO headquarters, the Ministry of Civil Affairs of Bosnia and Herzegovina, the State Parliament, the entities' health, justice, education and agriculture ministries and the entities' public health institutes. This meeting underlined the significance of the WHO Framework Convention on Tobacco Control and started a more active advocacy approach with state decision-makers and political representatives with the aim of facilitating the process of implementing the WHO Framework Convention on Tobacco Control in Bosnia and Herzegovina.

With the support of the entities' health ministries, the national team comprising the Country Project Manager, health professionals and nongovernmental organizations involved in tobacco control were nominated to participate in the training meeting in Zagreb, Croatia in December 2007 dedicated to the regional tobacco control campaigns.

Challenges faced while implementing the project and lessons learned

Thanks to the implementation of the project, we have developed a network and active collaboration between the countries in south-eastern Europe supported by the WHO Regional Office for Europe. International meetings and sharing of experience and lessons learned between countries significantly affected the enforcement of tobacco control mechanisms in Bosnia and Herzegovina. Facilitating administrative procedures of decision-making and advocating for more active involvement of the state authorities in implementing the WHO Framework Convention on Tobacco Control are the main current challenges.

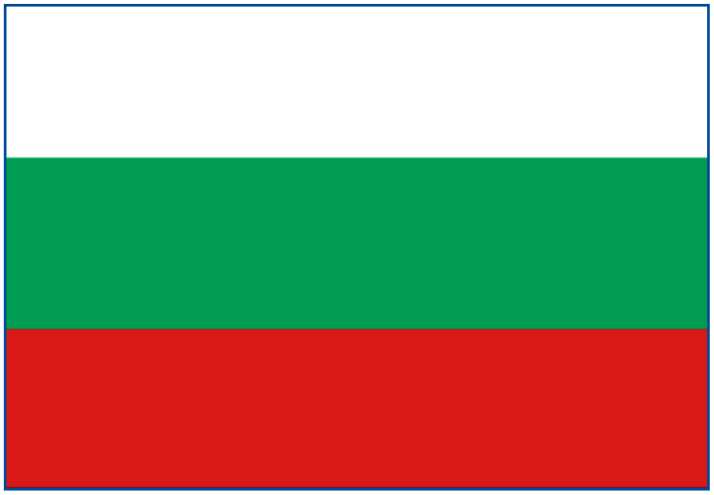
Visions for tobacco control in the future

The main efforts from the state level could be focused on intersectoral public health interventions in capacity-building and political support to ratify and implement the WHO Framework Convention on Tobacco Control. Ratifying and implementing the WHO Framework Convention on Tobacco Control will help to address the issues that have received little attention so far in Bosnia and Herzegovina such as: a decrease of the high prevalence of smoking through advocacy by increasing prices on tobacco products, protection from second-hand smoke by enforcing a ban on smoking in public places, enforcing tobacco prevention and cessation programmes in school curricula and enforcing available cessation services in family medicine units. Raising population awareness on the harmful consequences of tobacco smoke, implementing prevention and cessation programmes and establishing national health promotion funds for their permanent financing are considered to be priorities of the future tobacco control programmes.

Bulgaria

Prepared by:

Masha Gavrilova
Country Project Manager for Bulgaria



1. General information on the country

Size	111 000 m^2
Population	7.7 million (2006)
Median age	41.4 years (2006)

Total health expenditure per person per year (PPP in US$, WHO estimate)
2004: 671

Total health expenditure as a % of gross domestic product (WHO estimate):
2004: 8.0%

2. Report on project implementation

The project office is based at the Department of Public Health of the Ministry of Health. A project team with professionals from different sectors was set up. Project work began immediately because Bulgaria undertook to develop an economic review focused on the economic aspects of tobacco control policies of the nine countries in south-eastern Europe (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Montenegro, Romania, Serbia and The former Yugoslav Republic of Macedonia). The necessary data, which are part of the prevalence study, were also collected.

The most important commitment of Bulgaria during 2005 was to organize the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control in Sofia. The Governments of Bulgaria and Croatia organized the meeting in cooperation with the WHO Regional Office for Europe. As a result, the process of ratification of the WHO Framework Convention on Tobacco Control was accelerated for the countries in south-eastern Europe, including Bulgaria.

Personal contacts were established with some members of the parliamentary commissions and especially with the members of the Health Care Commission in order to further advance the discussion on the draft of the law by all members of Parliament in a plenary session. The excellent preparatory work was a prerequisite for the unanimous adoption of the Law for Ratification of the WHO Framework Convention on Tobacco Control on 18 October 2005.

Maximum efforts were made to overcome all bureaucratic requirements, which gave us the opportunity to submit the ratification papers to the United Nations in New York on 7 November 2005. By observing this deadline, Bulgaria became a member of the Conference of Parties to the WHO Framework Convention on Tobacco Control and participated with representatives at both the First Meeting in Geneva in February 2006 and the Second Meeting in July 2007 in Bangkok. A national meeting on the WHO Framework Convention on Tobacco Control was conducted on 30 September 2005 in Sofia, with 42 participants from state departments and 10 participants from nongovernmental organizations. The participants arrived at the following conclusions during the meeting.

- They suggested the need for more frequent meetings for exchanging ideas and good practices.
- They noted that there was no coordination between the different institutions.
- The tobacco control activities were not efficient enough.
- The state had to clearly formulate its priorities on health and on tobacco production.
- Proposals were made for changes in the Law on Tobacco and Tobacco Products and the regulation on labelling.
- A nongovernmental organization proposed a total smoking ban in public places.
- More financial resources for projects are needed.
- Measures could be taken to decrease the smoking prevalence among health professionals, teachers and the Roma communities.

The Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries in October 2006 in Bled, Slovenia, improved intersectoral collaboration in Bulgaria. The appropriate choice of the delegation members and representatives of different ministries engaged with tobacco control in Bulgaria contributed to improving and energizing the relations between the ministries.

The experts who took part in the Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries in Bled worked very actively for the most important document in tobacco control – the national programme for the limitation of tobacco smoking in Bulgaria for 2007–2010. The Bulgarian Council of Ministers adopted this on 2 February 2007. The experts participated in preparing the next national meeting on capacity-building for strengthening intersectoral cooperation in implementing tobacco control in Bulgaria, where they acted as trainers.

A national meeting took place in early 2007 in Velingrad. The meeting started with many discussions and very intensive informal conversations among 60 participants from the field of tobacco control. The representatives of the regional inspectorates for public health protection and the regional structures of the commission for consumer protection took positions on the implementation of legislation concerning tobacco smoking cessation.

The collaboration between participants of the national meeting is continuing with various activities. A group e-mail address was created and enabled continual connection between all the institutions to promote more effective cooperation on tobacco control in Bulgaria. Thanks to this connection, we exchanged our positions regarding the European Commission's green paper Towards a Europe free from tobacco smoke: policy options at EU level (31). All the participants received the authors' presentations, which were presented at the meeting in Velingrad. The Internet space allowed for the exchange of more ideas related to the World No Tobacco Day to cover different regions more effectively. After the meeting in Velingrad, we began to send translated materials from different international sources to all the participants of the meeting.

We learned several important things.

- Establishing the health network for collaboration between the services and experts from the tobacco control field was very useful and could continue in one form or another.
- An especially valuable lesson was to become aware that all the experts in the field of tobacco control must join forces for tobacco smoking restrictions. The Ministry of Health cannot cope alone with this problem. The efforts of different sectors – employers, union trades, sectoral organizations, nongovernmental organizations and citizens – need to be coordinated.
- All of us are convinced that we have to find the most proper way to work with Bulgaria's population to reduce tolerance of tobacco smoking, because tobacco restriction cannot be managed solely by control. Nonsmokers have to defend their rights all the time and everywhere.
- This is why the forthcoming events are intended:

- to reduce the population tolerance of tobacco smoking through campaigns oriented to different target groups;
- carrying out consultations for introducing a total smoking ban in public places;
- limiting tobacco products in advertising; and
- introducing colour warning photographs on packages of tobacco products.

Croatia

Prepared by:

Luka Vončina
Country Project Manager for Croatia

1. General information on the country

Size	56 542 m^2
Population	4.4 million
Median age	40.0 years

Total health expenditure per person per year (PPP in US$, WHO estimate)
2004: 917

Total health expenditure as a % of gross domestic product (WHO estimate):
2004: 7.7%

2. Report on project implementation

In 2005, the Country Project Office was founded and placed at the Andrija Štampar School of Public Health in Zagreb. It has remained there for the full duration of the project. As Croatia had the honour of coordinating this project, the office also hosted the Regional Project Manager, Marta Čivljak.

In its first year, the main project activities included the preparation of the project's prevalence study (including data from all the countries that implemented the project), which was coordinated by Croatia. Further, we collected national data for the project's economic and legal studies that were developed by Bulgaria and Romania, respectively. In addition, the Country Project Office undertook preparations for the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control held in September 2005 in Sofia, Bulgaria. The meeting was organized by the Ministry of Health of Bulgaria, the Ministry of Health and Social Welfare of Croatia, the Project Coordinator and the WHO Regional Office for Europe. Croatia's national meeting on the ratification of the WHO Framework Convention on Tobacco Control was organized and held in Zagreb on 27 February 2006. On 30–31 March 2006, Croatia hosted the project's regional technical meeting in Zagreb. The WHO Regional Office for Europe organized the meeting together with the Ministry of Health of Croatia. The aim of this meeting was twofold: to summarize the first phase of the project and to kick off its second phase.

In the second year of the project, the main activities included preparations for the Intersectoral Workshop on Capacity Building in Tobacco Control for South-eastern European Countries, which was hosted in Slovenia in October 2006. After the workshop, Croatia held its own national meeting for strengthening intersectoral cooperation in the field of tobacco control on 16–17 April 2007. The meeting was co-organized with Croatia's Ministry of Health and Social Affairs and its National Committee on Tobacco Control and Prevention.

When the project started, the main challenge was that public health professionals were isolated in the fight against the tobacco epidemic in Croatia. As there was very little intersectoral collaboration in the fight against tobacco, these dedicated professionals were not able to produce enough momentum to place the tobacco epidemic where it belongs – high on the policy-makers' agenda.

The main achievement of this project in Croatia was a marked move towards better intersectoral collaboration between those involved in tobacco control. The number of professionals from different institutions involved in tobacco control has increased, as the project involved professionals from the Andrija Štampar School of Public Health, the National Institute of Public Health, the Ministry of Health and Social Welfare, the Ministry of Finance, the Ministry of Science, Education and Sports, the Customs Directorate, the Sanitary Inspectorate (in charge of implementing tobacco-related legislation) and many others. Further, as a result of the national meeting for strengthening intersec-

toral cooperation in the field of tobacco control held in 2007, the Minister of Health and Social Welfare has received official guidelines on how to improve the implementation of current legislation. Also, the Croatian Project Office has coordinated the development and maintenance of the project's web site: www.see-tobacco-control.org.

The WHO FCTC was signed on 2 June 2004 and ratified in 14 July 2008.

Republic of Moldova

Prepared by:

Silvia Morgoci
Country Project Manager for Republic of Moldova

1. General information on the country

Size	33 800 m2
Population	3.6 million
Median age	32.3 years

Total health expenditure per person per year (PPP in US$, WHO estimate)
2004: 138

Total health expenditure as a % of gross domestic product (WHO estimate):
2004: 7.4%

Note: these statistics do not include the Transnistria region.

2. Report on project implementation

In 2004, Republic of Moldova supported the initiation of the South-eastern Europe Tobacco Control Project as part of the Initiative on Social Cohesion of the Stability Pact for South Eastern Europe. The project was launched in July 2005. Unfortunately, the late appointment of the Country Project Manager delayed the project's launching in Republic of Moldova by about two months compared with the other countries involved.

Republic of Moldova's authorities, especially the Ministry of Health, recognize the need for establishing tobacco control as a public health priority. Smoking is, indeed, a widespread problem and must be adequately addressed. During the period of project implementation, several very important activities have been carried out. Further, considerable efforts were directed towards ratifying the WHO Framework Convention on Tobacco Control.

From the very beginning, Republic of Moldova's authorities determined that two areas of concern could be carefully addressed.

- Some government institutions are reluctant to enact anti-tobacco measures, as this is viewed as directly conflicting with the economic interests of the state.
- Republic of Moldova's Ministry of Health has insufficient resources available to reinforce and provide continuity and sustainability for existing tobacco control policy in the country.

To achieve the objectives of the project, additional efforts have been required to build political will, including targeted advocacy to educate policy-makers about the magnitude of the tobacco problem and to persuade them to support efforts to curtail tobacco use.

To establish contacts and working relationships with the relevant institutions and officials, including those at the senior level and to promote the project's objectives, the Country Project Manager therefore had a series of meetings with the Chair of the Parliamentary Commission on Health, Deputy Minister of Health and Social Protection, National Health Coordinator, Head of the External Relations Department of the Ministry of Health, the Liaison Officer of the WHO Country Office in Republic of Moldova and other officials.

The Country Project Manager also initiated and drafted letters that were eventually signed by the Minister of Health and sent to all relevant ministries with the purpose of establishing an interministerial committee with the mandate to review the situation of tobacco control and to examine the socioeconomic factors that impeded the speedy ratification of the WHO Framework Convention on Tobacco Control by Republic of Moldova.

The issue of funding further implementation of the WHO Framework Convention on Tobacco Control is, therefore, a matter of interest, especially for tobacco-producing countries such as Republic of Moldova. In this context, we are encouraged by the action in this regard by the United Nations Ad Hoc Interagency Task Force on Tobacco Control. We welcome also the relevant proposals put forward within the Open-ended Intergovernmental Working Group on the WHO Framework Convention on Tobacco Control in accordance with the Article 26 of the Convention.

Challenges faced during the implementation of the project

- The regulation of the content of tobacco products still represents a problem that has not yet been solved. In this sense, there is an evident need to adjust the national normative acts and legislation that will take into account the latest perspectives and international positions in this field.
- Implementing effective tobacco control measures also requires addressing the illegal smuggling of tobacco products in Republic of Moldova.

Activities planned for the future

- After ratifying the WHO Framework Convention on Tobacco Control, Republic of Moldova is developing a national strategy or action plan for tobacco control through 2011, coordinated by a structure unit created within the Ministry of Health that will be responsible for implementing tobacco control activities.
- The intersectoral government mechanism of collaboration could be strengthened by reinforcing the interministerial working group for tobacco control operating, as necessary, in consultation with civil society, professional and mass-media networks.
- More legislative measures could be developed and adopted in accordance with the requirements of the WHO Framework Convention on Tobacco Control that will reinforce and provide continuity and sustainability for existing tobacco control policy in the country.

All present and future project activities will be of high relevance and help in this regard. In conclusion, the South-eastern Europe Tobacco Control Project is a appropriate and necessary instrument to promote and support tobacco control action in south-eastern Europe. Republic of Moldova has already seen its benefits. It is hoped that the successful implementation started under the project will continue to bring Republic of Moldova closer to the noble objectives pursued by the WHO Framework Convention on Tobacco Control.

Montenegro

Prepared by:

Agima Ljaljević
Country Project Manager for Montenegro

1. General information on the country

Size 13 812 m2

Population 0.6 million

Age distribution
0–14 years 20.7%
15–64 years 67.2%
>65 years 12.1%

2. Report on project implementation

On April 2005, the project started in Serbia and Montenegro by appointing the country project managers for Serbia and for Montenegro, and it was implemented jointly in both countries. In 2006, Montenegro gained independence and has taken initiatives for its own activities since then.

In the first year, the main activities of the project included intensive work on collecting and analysing data on the prevalence of smoking and smoking-related diseases, various economic variables, legislation related to tobacco control in Montenegro and compliance with the WHO Framework Convention on Tobacco Control for the prevalence, legal and economic studies. Most of the data were obtained from institutions that work with tobacco and state statistics. Unfortunately, no data are available on the prevalence of smoking among adults, since no studies have been conducted in Montenegro except for the GYTS.

The activities of the project continued at the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control held in Sofia in September 2005. The first national conference on the ratification of the WHO Framework Convention on Tobacco Control in Serbia and Montenegro was organized in November 2005 in Podgorica, Montenegro. The conference was very successful and attended by 20 participants from Serbia, 30 participants from Montenegro and many representatives from the mass media. As a result of the successful meeting, Serbia and Montenegro ratified the WHO Framework Convention on Tobacco Control, and this ratification entered into force on 9 May 2006. After Montenegro became independent, Serbia became the legal successor for ratification, and Montenegro had to formally ratify the Convention. The importance of the urgency of this procedure for Montenegro was emphasized at all meetings.

The main activity of project component two was the Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries held in Bled, Slovenia on 11–13 October 2006. The workshop was an opportunity to present the situation of tobacco control activities in Montenegro. Following the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control, a national workshop on tobacco control was organized on 8–9 February 2007 in Tivat, Montenegro. More than 50 participants from various institutions involved in tobacco control and a huge number of mass-media representatives attended the workshop. The participants agreed that the activities on continual implementation of the project are very supportive to the national strategic plan on tobacco control.

Some of difficulties and lessons learned during the implementation of the project were in connection with the lack of data on tobacco use and economic variables of tobacco, a clumsy national administrative apparatus from the beginning of the project and the small number of health care workers motivated to be educated and involved in tobacco control.

In 2003, the Government of Montenegro recognized the problem of tobacco as a public health priority and defined activities to solve this problem. The Ministry of Health was nominated as an institution of basic importance for tobacco control, and it has delegated the Institute for Public Health as the responsible institution. With the definition of the Law on Tobacco Control and a national strategy and action plan, a vision has been established of decreasing the number of smokers in Montenegro, which will reduce tobacco-related mortality and morbidity and the impact of tobacco use on economic indicators.

Romania

Prepared by:

Miron Bogdan
Country Project Manager for Romania

1. General information on the country

Size	238 500 m2
Population	21.6 million
Median age	36.6 years

Total health expenditure per person per year (PPP in US$, WHO estimate)
2004: 433

Total health expenditure as a % of gross domestic product (WHO estimate):
2004: 5.1%

2. Report on project implementation

The project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe started in Romania in April 2005 with the selection and recruitment of the team. Miron Bogdan was appointed Country Project Manager and organized the technical team: Andreea Szakacs (legal adviser), Simona Ilie (economics expert), Florentina Furtunescu (public health expert) and Magdalena Ciobanu, Assistant to the Country Project Manager. The Project Office was established at the Marius Nasta Institute of Pneumology.

The main objectives of the project were to support the ratification of the WHO Framework Convention on Tobacco Control and to begin implementing the Convention in Romania by promoting interministerial cooperation. Meanwhile, some documents were produced as the output of the two-year project: Romania's legal and economic tobacco-related reviews, a draft of the national strategy for tobacco control and the translation of some WHO publications about tobacco control.

Within the framework of the project, two intersectoral meetings were organized – in Snagov (2006) and in Bucharest (2007) – with the participation of representatives of the main ministries involved in tobacco control. Journalists were also invited to the second meeting to improve their knowledge about tobacco control and to demonstrate the intersectoral approach of this problem as the key to success.

At the regional level, the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control in Sofia helped us to define the strategy and the major steps for the following years in tobacco control. As a concrete result, the WHO Framework Convention on Tobacco Control was ratified soon after this meeting. The experts trained during the Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries in Bled actively contributed in the last year to developing tobacco control activities. We consider that this regional approach was a success because it helped us to find solutions to problems common to every country in south-eastern Europe.

The main achievements of this project are the ratification of the WHO Framework Convention on Tobacco Control and the establishment of an interministerial team. Although the strategy and the interministerial committee on tobacco control have not yet been officially established, we consider as a great success the initiation of the dialogue and the increase in the knowledge of tobacco control issues of the main decision-makers and stakeholders. In the last two years, Romania achieved important successes in tobacco control: an earmarked tax on cigarettes the Ministry of Health uses for tobacco control activities, introduction of a system for smoking-cessation treatment free of charge, improvement of the education and information campaigns, introduction of the pictorial warnings on the cigarettes packs beginning on 1 July 2008 and restrictions on tobacco advertising.

The main lesson learned from this project is that correct and comprehensive knowledge about the consequences of tobacco use and the effective methods for controlling this epidemic can promote tobacco control activities. An intersectoral approach is vital for a coherent policy having reducing tobacco use as the main goal.

The main challenge remains formalizing the cooperation between the authorities involved, in the form of an interministerial committee on tobacco control, to implement more rapidly the measures that require an intersectoral approach.

Today, as most of the countries in south-eastern Europe have ratified the WHO Framework Convention on Tobacco Control, the major challenge is implementing the Convention.

The network established as a result of the project could be a basis for future action and programmes developed in the aspects of implementing the WHO Framework Convention on Tobacco Control that require cooperation between countries: cross-border advertising and sponsorship, illicit trade and counterfeiting and regulation of tobacco products. Special attention could be given to the protocol for illicit trade, as smuggling is a common problem in south-eastern Europe, requiring a common approach.

Serbia

Prepared by:

Srmena Krstev
Country Project Manager for Serbia

1. General information on the country

Size	77 474 m2
Population	7.5 million
Median age	40.4 years

Note: these statistics exclude Kosovo.

2. Report on project implementation

Soon after the project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe started in Zagreb in April 2005, the Country Project Office for Serbia was placed at the Institute of Occupational Health, Clinical Centre of Serbia in Belgrade. During the implementation of component one, the main activities included intensive work on collecting and analysing data on the prevalence of smoking and smoking-related diseases, various economic variables, Serbia's legislation related to tobacco control and compliance with the WHO Framework Convention on Tobacco Control for the prevalence, legal and economic studies. A group of respective experts in these fields was engaged in this work. Later, efforts were made to prepare for a high-level ministerial delegation and the report for the First Intersectoral Regional Conference of High-level Government Authorities from South-eastern Europe on Entry into Force of the WHO Framework Convention on Tobacco Control in Sofia in November 2005 and organizing the one-day national conference on the ratification of the WHO Framework Convention on Tobacco Control jointly for Serbia and Montenegro on 18 November 2005 in Podgorica. Fifty participants attended the meeting, and seven presentations initiated a fruitful further discussion. Leaflets on the WHO Framework Convention on Tobacco Control and Serbia's tobacco control strategy were published and widely distributed.

The main activities of the second component of the project were to prepare the multisectoral delegation of Serbia and to present the process of ratifying the WHO Framework Convention on Tobacco Control in Serbia to the Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries held in Slovenia in October 2006. After the Intersectoral Workshop on Capacity Building in Tobacco Control for the South-eastern European Countries in Bled, the Intersectoral Workshop on Capacity Building in Tobacco Control for Serbia was organized on 21–23 February 2007 in Fruška Gora. There were 33 participants and 16 presentations covering a variety of tobacco control topics as well as discussions in small groups. A similar multisectoral workshop was repeated on 13–14 November 2007 in Vrsac with 37 participants and 15 presentations.

During the implementation of third component of the project, a delegation was selected to attend the Training Workshop on Designing and Carrying Out Anti-Smoking Media Campaigns in Zagreb on 14–16 December 2007.

The main achievement of the project was the Parliament of the State Union of Serbia and Montenegro ratifying the WHO Framework Convention on Tobacco Control. Second, movement towards better intersectoral cooperation, broadening the number of stakeholders and institutions involved in tobacco control, has been successful. Third, knowledge of different tobacco control aspects among various experts in Serbia has improved, which allows them to successfully answer all the questions and to confront the tobacco industry in the country. Further important achievements were the adoption of the national strategy for tobacco control in Serbia in January 2007, the establishment of an intergovernmental coordinating body and the introduction of earmarking on every single tobacco package. As a result, the prevalence of smoking declined from 2000 to 2006 by 9.8 percentage points among men and by 3.8 per-

centage points among women. Public awareness on the hazardous effects of smoking significantly increased from 35% in 2000 to 57% in 2006. Strong support from the WHO Regional Office for Europe, the WHO Country Office in Serbia and especially the Minister of Health of Serbia was crucial for better understanding the tobacco control actions.

The challenges faced were to find the best way to strengthen the public pressure for ratifying the WHO Framework Convention on Tobacco Control in the Parliament and to develop a network of people from sectors engaged in certain areas of tobacco control to answer various questions that might arise.

In the future, we would like to develop a new law banning smoking in enclosed premises and to create further pressure on the policy-makers and the public to strengthen and better enforce tobacco control legislation. Our goal is also to enlarge the network of experts in tobacco control, and to raise awareness, by all means possible, on the harmful effects of tobacco consumption.

The former Yugoslav Republic of Macedonia

Prepared by:

Mome Spasovski
Country Project Manager for The former Yugoslav Republic of Macedonia

1. General information on the country

Size	25 713 m2
Population	2.0 million
Median age	34.1 years

Total health expenditure per person per year (PPP in US$, WHO estimate)
2004: 471

Total health expenditure as a % of gross domestic product (WHO estimate):
2004: 8.0%

2. Report on project implementation

Tobacco growing and the production of tobacco products in The former Yugoslav Republic of Macedonia is an old and existing tradition and has increased over time. In addition, tobacco is highly available due to substantial import of the product.

The National Tobacco Control Strategy for Provision and Promotion of Health Protection of the Population in The former Yugoslav Republic of Macedonia 2005–2010 states that 25% of all deaths are due to cardiovascular diseases. Thus, the leading cause of death in the country is associated with smoking. Cigarette smoking is one of the most important risk factors for the ill health of a significant segment of the population. It is a cause of poor health and premature death for many people.

The project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe started in April 2005. The Country Project Office was established in collaboration with the Faculty of Medicine of the "Ss. Cyril and Methodius" University in Skopje, which provided the facilities for the Country Project Manager and for the necessary administrative activities. With the approval of the Dean of the Faculty, the project's meetings were held in the premises of the Faculty of Medicine.

Experts and professionals from various areas were contacted to establish the core group, which would act as the task force group for implementing the activities of the project. In this regard, the project was introduced to the main stakeholders, such as the Ministry of Health, Ministry of Finance, Health Insurance Fund, Institute of Social Medicine, School of Public Health and Faculty of Medicine.

The main activities of the Country Project Office and the main achievements were: legal measures synchronized with the laws governing tobacco in the EU as well as the WHO Framework Convention on Tobacco Control; signing of the WHO Framework Convention on Tobacco Control; a ban on direct and indirect advertising of tobacco products; a ban on distribution of tobacco products; a ban on smoking in health organizations, educational facilities, government facilities, restaurants, cafeterias, offices, theatres and cinemas; and a ban on smoking in the means of public transport. During the implementation of the project, it was challenging to face strengthening of economic measures in the aspects of production and trading of tobacco products as well as raising prices and taxes on tobacco products. Undertaking broader and more intensive activities towards identifying the legal and illegal trade of tobacco and tobacco products, stricter control of the use of revenue stamps and strengthening the fight against tobacco smuggling were equally challenging to address. Despite all these challenges, bold action has included imposing separate taxes on tobacco intended for the public health sector (5 denars (€0.08) per pack of cigarettes); introducing a registry for tobacco, tobacco products, manufacturers, distributors, tobacco brands and tobacco products; more strictly controlling tobacco import and export; and implementing health promotion activities.

Challenges faced during the implementation of the project and lessons learned

The project strengthened intersectoral cooperation and a multidisciplinary approach. The ministries and agencies taking responsibility for implementing the research projects related to tobacco control are:

- Ministry of Finance – set an optimal level of prices and taxes of tobacco products;
- Ministry of Interior – acted on the trade in illicit tobacco and tobacco products;
- Ministry of Economy – explored the influence of international trade agreements on tobacco;
- Ministry of Health and Republic Institute for Health Protection – set regulations for preventing smoking;
- Republic Institute for Health Protection and Institute of Occupational Health in partnership with the Agency for Sport and Youth – developed new approaches for preventing smoking among children, adolescents and women (including pregnant women) as well as professional hazards from growing tobacco and the production process;
- Ministry of Agriculture – researched alternatives to tobacco production;
- Ministry of the Environment – found an association between tobacco production and the destruction of ecosystems;
- Ministry of Health along with nongovernmental organizations – studied smoking in various population groups, especially vulnerable groups.

The intersectoral approach mentioned above will contribute to a coordinated response to prevent tobacco consumption and to enhance tobacco control through:

-
- developing a comprehensive and intersectoral plan of activities;
- developing stronger coordination among all involved parties;
- developing supportive environments for smoking cessation; and
- developing programmes for training health workers on tobacco control.

Visions for tobacco control in the future in The former Yugoslav Republic of Macedonia include:

- raising population awareness about the harm of smoking, promotion of healthy lifestyles and smoking cessation;
- establishing programmes for diagnosing, counselling and treating smoking addicts; and
- improving the system for registering diseases associated with smoking (registration and reporting).

5. Conclusions and recommendations

The study revealed that the tobacco continues to be a leading contributor to the burden of disease in south-eastern Europe and will continue to be so, as smoking is highly prevalent among young people. The tasks to undertake in the tobacco epidemic are challenging for public health professionals, as the tobacco industry remains politically influential. Public health advocacy has therefore a crucial role to play in raising awareness among the general population, health care professionals and policy-makers about the harmful effects of tobacco consumption to population health and the costs it imposes on health systems.

The project Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe achieved major successes. Albania, Bulgaria, Croatia, Montenegro, Romania, Serbia and The former Yugoslav Republic of Macedonia ratified the WHO Framework Convention on Tobacco Control. Two countries introduced earmarking of tobacco taxes for national tobacco control programmes: Romania (since 2002) and Serbia (since 2005). Due to the considerable efforts of country project managers and their teams, many consultative meetings and workshops were held with the aim of increasing public health capacity in tobacco control, including those of government and nongovernmental institutions.

The existing tobacco control measures are not sufficient to decrease the magnitude of tobacco-related morbidity and mortality. Intersectoral measures developed within the project require further involvment of health services in promoting smoking cessation and in the primary and secondary prevention of tobacco-related diseases, as do further efforts to increase taxes on tobacco and to earmark them for health purposes. Enforcing legislation is a long-term challenge in south-eastern Europe and can only be achieved by working together with regulatory and legislative authorities. Efforts to control and stop cigarette smuggling in the SEE region should also be strengthened.

Strong political and public support provides an opportunity for countries to use this momentum to strengthen already existing tobacco control policies. This momentum also opens up the opportunity for improving compliance with legislation through adequate enforcement mechanisms. Recent years have also shown significant and increasing public support among nonsmokers and smokers to strengthen tobacco control policies. Further progress can be made by supporting other countries in becoming parties to the Convention by establishing an effective mechanism for international collaboration, exchange of experience and reporting.

The studies done within the project identified several areas that require strengthening and that could be addressed by further research and other public health activities.

Recommendations for further research

- National surveillance systems for tobacco and tobacco-related morbidity and mortality need to be established in all countries in south-eastern Europe. Standardized survey instruments could be used to collect comparable data on tobacco use in predefined age groups.
- Consideration could be given to analysing the available socioeconomic determinants of tobacco use. This is important for targeting population groups at higher risk for tobacco-related diseases. The World Bank Living Standard Measurement Study (32) can be analysed for this purpose, as this used a standardized questionnaire. The latest datasets and survey reports are available for Albania (2005), Bosnia and Herzegovina (2004), Bulgaria (2001) and Romania (1995). Other countries could seek available national-based probability surveys or, if possible, carry them out.
- The project provided the opportunity to address the economic aspects of the tobacco epidemic. Further research could continue to explore the impact of certain interventions on smoking prevalence, particularly increasing the prices of tobacco (price elasticity studies) and the economic burden of tobacco consumption on households and the health sector.

Recommendations for policy development

- The project and collaboration between the countries in south-eastern Europe need to be continued as the situation and problems in tobacco control are similar and joint efforts of all the countries, supported by the WHO Regional Office for Europe, can strongly help all the governments.
- Further efforts could be established for finding funding sources for implementing tobacco control activities. One of the sources could be the income raised from tobacco taxes as well as other government funds earmarked solely for tobacco control purposes.
- At the country level, consultations could be held with policy-makers to decide which interventions are the most cost-effective and could be implemented in the short and long term. As tobacco is one of the leading contributors to the burden of disease in south-eastern Europe, each country could have a strategy that lists the types of tobacco control activities that will be implemented in the short and long term, their scale and the potential impact based on experience from elsewhere.
- To improve secondary prevention efforts, health care practitioners could be more involved in smoking cessation programmes by offering advice related to smoking cessation and referral to other smoking-cessation services. More attention to tobacco as a public health and social problem could be given to students of health-related disciplines such as medicine, pharmacy and nursing, as a large proportion of them smoke.
- GYTS data provide clear evidence on the substantial exposure of children to second-hand smoke. Mass-media campaigns could be used to provide information to the general public about how second-hand smoke harms health. Legislative mechanisms could also ensure that laws that ban smoking at work and other public places are enforced.
- Ratifying the WHO Framework Convention on Tobacco Control in all the countries is crucial. This would enable better international collaboration in tobacco control and more effective action at the country level, depending on how effectively the governments are committed to implementing the obligations.
- Public health advocacy is a powerful tool in fighting the tobacco epidemic. Success in south-eastern Europe requires strong collaboration with journalists, nongovernmental organizations and other committed partners within and outside the health sector. Many success stories in and outside south-eastern Europe have demonstrated that public health advocacy succeeded in drawing the attention of public policy-makers to the importance of reducing tobacco consumption for the health of the population.

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Annex 1.

The Dubrovnik Pledge

The Dubrovnik Pledge

Meeting the Health Needs of Vulnerable Populations in South East Europe

We the Ministers of Health of South East Europe (SEE), gathered here today at the Health Ministers' Forum for Regional Health Development Action in South East Europe recognize the damaging effects on health of recent wars, continuing unrest and conflict, as well as the economic hardships faced by the populations of SEE during their countries' transition to market economies. We accept the challenge to play a key role in strengthening the fundamental human rights of our societies and of vulnerable populations and individuals within them to effective health care, social wellbeing and human development, in line with the principles of the World Health Organization and the Council of Europe.

Focus on specific strategies

We, the Ministers of Health of: Albania; Bosnia and Herzegovina; Bulgaria; Croatia; Romania and the former Yugoslav Republic of Macedonia; and the Federal Secretary for Labour, Health and Social Welfare of Yugoslavia commit ourselves through government action to the following goals.

WE WILL WORK IN PARTNERSHIP with relevant national and international bodies and organizations: to ensure equity, health gain and a better quality of life and health care (including reduced inequalities in its infrastructure and balanced primary and secondary services and public health interventions for the populations of SEE); and to collaborate on issues of common concern, including the harmonization of policies, legislation and information systems, institutional capacity building and networking to build an infrastructure to pursue regional goals and future European integration.

WE WILL MEET THE HEALTH NEEDS OF VULNERABLE POPULATIONS IN SEE, mobilizing human and financial resources to the extent possible to:

- increase citizens' access to appropriate, affordable and high-quality health care services;
- intensify social cohesion by strengthening community mental health services;
- increase the quality of and regional self-sufficiency in the provision of safe blood and blood products;
- develop integrated emergency health care services that are offered free of charge to the user;
- strengthen the surveillance and control of communicable diseases;
- strengthen institutional capacity and intersectoral collaboration for access to affordable and safe food products; and
- establish regional networks and systems for the collection and exchange of social and health information.

Plea to international stakeholders

The Health Ministers' Forum for Regional Health Development Action in South East Europe recognizes the need for assistance from international stakeholders to achieve the goals of this Pledge.

WE LOOK TO the Council of Europe and the World Health Organization for strategic guidance in developing mechanisms to coordinate partnership with national and international agencies in the fulfilment of this Pledge and request their support in organizing a first meeting to monitor and evaluate the progress achieved by such partnership.

WE ASK THAT the international community assist, within the framework of the Stability Pact for South East Europe, by providing resources to support the implementation of the above-mentioned urgent action areas for health reconstruction and development. In so doing, we commit ourselves to transparency and dedication in the implementation and reporting of all project activities and their results.

WE REQUEST that the World Health Organization Regional Office for Europe and the Council of Europe report to their governing bodies about this Pledge and the progress achieved towards its goals.

SIGNATORIES

Albania	**Romania**
Ms Ruki Kondaj Secretary General of the Ministry of Health for The Minister of Health of Albania	Dr Daniela Bartos Minister of Health of Romania
Bosnia and Herzegovina	**The former Yugoslav Republic of Macedonia**
Dr Zelko Misanovic Minister of Health of the Federation of Bosnia and Herzegovina Dr Milorad Balaban Minister of Health of the Republika Srpska	Professor Petar Milosevski Minister of Health of the former Yugoslav Republic of Macedonia
Bulgaria	**Yugoslavia**
Dr Bojidar Finkov Minister of Health of Bulgaria	Dr Miodrag Kovac Federal Secretary for Labour, Health and Social Welfare of Yugoslavia
Croatia	**For the Secretariat of the Meeting**
Dr Ana Stavljenic Rukavina Minister of Health of Croatia	Mrs Gabriella Battaini-Dragoni Director General for Social Cohesion Council of Europe Dr Marc Danzon Regional Director for Europe World Health Organization

Dubrovnik, 2 September 2001

Annex 2.

The Skopje Pledge

COUNCIL OF EUROPE CONSEIL DE L'EUROPE

CEB
COUNCIL OF EUROPE DEVELOPMENT BANK

WORLD HEALTH ORGANIZATION
EUROPE

Reversing the tobacco epidemic
Saving lives in south-eastern Europe

Second Health Ministers' Forum
With the special participation of ministers of finance

Health and Economic Development in South-eastern Europe in the 21st Century
Skopje, The former Yugoslav Republic of Macedonia,
25–26 November 2005

EUR/05/5056095
15 November 2005
54634
Original English

The Skopje Pledge

We, the Ministers of Health of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Romania, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, have gathered for the Second Health Ministers' Forum for Health and Economic Development in South-eastern Europe in Skopje, The former Yugoslav Republic of Macedonia on 25 and 26 November 2005 with the purpose of discussing progress achieved towards the goals of the Dubrovnik Pledge.

Current situation

We acknowledge the importance of the role of the South-eastern Europe (SEE) Health Network – in partnership with the World Health Organization (WHO) Regional Office for Europe and the Council of Europe, supported by the Council of Europe Development Bank and in the framework of the Initiative for Social Cohesion of the Stability Pact for South Eastern Europe – in meeting the challenges related to the health needs of vulnerable populations in the SEE region.

We:

- recognize that health, as an integral determinant of social cohesion, and an investment and a major factor in development, is essential to lasting peace, stability and economic progress;
- recognize that regional cooperation in the field of health is a vital part of the European Union (EU) integration process;
- recognize that health and the health systems in the SEE region are facing important challenges;
- recognize that there is a need to continue to develop, strengthen and support work being carried out in this area in general and, in particular, to improve the access of vulnerable populations in society to the health services of the region;
- recognize that there is a need to promote the exchange of experiences within the area of health systems and health system reform, at international, regional and national levels;
- express our gratitude for the support received from international and bilateral institutions and governments, and particularly the important analytical and policy development work of the Council of Europe, the Council of Europe Development Bank and the WHO Regional Office for Europe.

Looking forward

Having reviewed the concerted action taken over the last five years in health development as a bridge to reconciliation, peace and development, we accept the challenge of reforming the health systems in the region and thus contributing to its economic development in the twenty-first century.

WE UNANIMOUSLY AGREE:

- to continue to cooperate beyond 2005 on the initiative: “Health development action for south-eastern Europe: the South-Eastern Europe Health Network” (hereinafter referred to as the SEE Health Network);
- to further consolidate the SEE Health Network alliance at regional level, according to its agreed Statutes, which form an integral part of this Pledge (Annex);
- to assume full responsibility for regional cooperation on health and health-related projects;
- to continue regional cooperation and concerted efforts to improve the health systems of the countries in the SEE region in order to secure universal access to high-quality public health services for the populations of the region, based on sustainable financing;
- to confirm our commitment to implement action in the thematic areas identified in the Dubrovnik Pledge and, in doing so, to develop and apply the common criteria and procedures outlined in the Statutes;
- to demonstrate the economic potential of health as a means to increase productivity and decrease public expenditure on illness: a healthy population works better and produces more;
- to strengthen regional collaboration and coordination on preparedness planning for emerging priorities and to put this forward as a priority for action within the SEE Health Network;
- to advocate that national governments could put health higher on the political agenda and ensure that health is reflected in the policies and strategies of other sectors;
- to empower health professionals to ensure a sustainable long-term improvement in public health.

WE COMMIT OURSELVES to transparency and dedication in the implementation and reporting of all project activities and their results.

Plea to international stakeholders

The Second Health Ministers' Forum on Health and Economic Development in South-eastern Europe recognizes the need for assistance from international stakeholders to achieve the goals of this Pledge.

WE LOOK TO the Council of Europe and the WHO Regional Office for Europe for strategic guidance in further consolidating regional cooperation through concerted action to improve the health systems in the region and provide its populations with universal access to high quality health services. We also request their support in the further implementation of action related to the thematic areas outlined in the Dubrovnik Pledge and in fulfilling the commitments of this Pledge.

WE ASK THAT the international community assist by providing resources to support the implementation of urgent action for health and economic development in the above-mentioned areas. In doing so, we commit ourselves to transparency and dedication in the implementation and reporting of all project activities and their results, in accordance with the Statutes of the SEE Health Network.

WE REQUEST THAT the WHO Regional Office for Europe and the Council of Europe report to their governing bodies on this Pledge and the progress achieved towards its goals.

SIGNATORIES

Ministers of Health of the SEE Member States

ALBANIA
Dr Maksim Cikuli
Minister of Health

BOSNIA AND HERZEGOVINA
Mr Zlatko Horvat
Secretary, Ministry of Civil Affairs

BULGARIA
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Professor Ion Ababii
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ROMANIA
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SERBIA and MONTENEGRO
Professor Miodrag Pavlicic
Minister of Health of the Republic of Montenegro

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA
Professor Vladimir Dimov
Minister of Health

Witnessed in the presence of:
Partner States

BELGIUM
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GREECE
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NORWAY
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SLOVENIA
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SWITZERLAND
Mr Romain Darbellay,
Deputy Chief of Mission, Embassy of Switzerland to The former Yugoslav Republic of Macedonia

Partner Organizations

Council of Europe
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Director General, Directorate General III-Social Cohesion

Council of Europe Development Bank
Mr Krzysztof Ners
Vice-Governor

Social Cohesion Initiative of the Stability Pact for South Eastern Europe
Mr Laurent Guye, Director of Working Table II-Economy

WHO Regional Office for Europe
Dr Marc Danzon
Regional Director for Europe

Skopje, The former Yugoslav Republic of Macedonia, 26 November 2005

Annex 3.

Regional Project Manager and country project managers

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SOUTH EASTERN EUROPE HEALTH NETWORK

"Health Development Action for south eastern Europe"

Members:

Albania
Bosnia and Herzegovina
Bulgaria
Croatia
Republic of Moldova
Montenegro
Romania
Serbia
The Former Yugoslav Republic of Macedonia

Donors and Neighbours:

Belgium
France
Greece
Hungary
Italy
Norway
Slovenia
Sweden
Switzerland

Organizations:

Council of Europe
Council of Europe Development Bank
WHO Regional Office for Europe