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The work of WHO in the European Region, 2004-2005

Biennial report of the Regional Director



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in the European Region,
2004–2005**

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

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Abbreviations and acronyms

Organizations

CDC	Centers for Disease Control and Prevention, United States of America
CE	Council of Europe
CEE-HRN	Central and Eastern European Harm Reduction Network
CIDA	Canadian International Development Agency
EATG	European AIDS Treatment Group
EC	European Commission
DG ENV	Directorate-General for the Environment
DG SANCO	Directorate-General for Health and Consumer Affairs
ECDC	European Centre for Disease Prevention and Control
EEA	European Environment Agency
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
EuroHIV	European Centre for the Epidemiological Monitoring of AIDS
EUROSTAT	Statistical Office of the European Communities
FAO	Food and Agriculture Organization of the United Nations
GTZ	German Agency for Technical Cooperation
IOM	International Organization for Migration
OECD	Organisation for Economic Co-operation and Development
PATH	Program for Appropriate Technology in Health
REC	Regional Environmental Center for Central and Eastern Europe
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECE	United Nations Economic Commission for Europe
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNMIK	United Nations Interim Administration Mission in Kosovo
USAID	United States Agency for International Development
WFP	World Food Programme

Country groups

CCEE	countries of central and eastern Europe
CIS	Commonwealth of Independent States
SEE	south-eastern Europe

Technical and administrative terms

3 by 5	UNAIDS/WHO initiative whose target was that 3 million more people with HIV/AIDS should receive antiretroviral treatment by the end of 2005
ARV/ART	antiretroviral medicines/antiretroviral therapy
BCA	biennial collaborative agreement (with a country)
CEHAPE	Children's Environment and Health Action Plan for Europe
CISID	centralized information system for infectious diseases
DALY	disability-adjusted life-years
DOTS	directly observed treatment, short-course (WHO strategy for tuberculosis control)
DOTS-Plus	WHO strategy to tackle multidrug-resistant tuberculosis
GAVI	Global Alliance for Vaccines and Immunization
GIFT	Global Information Full Text
HAART	highly active antiretroviral therapy
HEN	Health Evidence Network project
Hib	<i>Haemophilus influenzae</i> type b
HINARI	Health InterNetwork Access to Research Initiative
HiTs	Health Systems in Transition (country profiles)
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision
ICF	International Classification of Functioning, Disability and Health
MDGs	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
NGOs	nongovernmental organizations
SARS	severe acute respiratory syndrome
STIs	sexually transmitted infections
TB	tuberculosis
WOW	Way of Working (Regional Office process and group)



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The late Dr LEE Jong-wook, WHO Director-General, 2003–2006 (second from right), with Dr Marc Danzon, WHO Regional Director for Europe (far right)

Introduction

There are many possible ways to report on the work done during a period of two years (2004 and 2005) by a core team of 550 staff with a budget of around US\$ 160 million.

The approach used in this report was chosen to increase understanding of how the resources, both financial and human, allocated by WHO's governing bodies were used in 2004–2005. A desire to improve transparency also guided this choice.

This report provides an opportunity to share with the governing bodies and other interested readers the new internal tools created in 2005 for Executive Management to monitor more efficiently the work of the WHO Regional Office for Europe.

To facilitate understanding of the activities included in the programme budget, the report is built around nine functions corresponding to its nine chapters:

1. operations in countries;
2. health systems;
3. communicable diseases;
4. noncommunicable diseases, lifestyles and health determinants, and family and community health;
5. health and environment;
6. health intelligence and publishing for public health;
7. infrastructure and logistics;
8. administrative services; and
9. governance.

Of course, the traditional information document on the implementation of the programme budget 2004–2005 is also available.¹

For each of the nine functions, the report provides information on the main activities during the biennium, the financial resources spent and the number of staff involved.



Marc Danzon
WHO Regional Director for Europe

¹ *Regional Director's report – Implementation of the programme budget 2004–2005*. Copenhagen, WHO Regional Office for Europe, 2006 (EUR/RC56/Inf.Doc./1; <http://www.euro.who.int/Document/RC56/einfdoc01.pdf>).

1. Operations in countries

Spent: US\$ 12 951 433

Proportion of total expenditure: 8.1%

Staff: 120, including 112 in the field

This chapter makes a distinction between the 29 countries in the WHO European Region where the Regional Office has country offices and BCAs,² and the 23 with no country offices as yet. The Regional Office established country offices in Member States to ensure coordination of the activities in each country and to act as the interface with WHO. Country offices are quite different from the technical centres also located in countries but serving the whole Region on a specific technical matter (2).

Through the strategy for working with countries, "Matching services to new needs" that was adopted in 2000, the Regional Office serves all the Region's 52 Member States in various ways. The following are examples of cooperation in four countries with country offices.

Countries with country offices: examples of cooperation

Kyrgyzstan

Kyrgyzstan is an example of the application of the European approach to strengthening health systems (3), launched in September 2005. It is the first country in the European Region to institutionalize its efforts to reform and strengthen its health system by establishing a Centre for Health System Development, opened by the President of Kyrgyzstan in Bishkek.

The Regional Office continues to support the implementation of the national health reform programme, which moved into its second phase – called Manas Taalimi – in 2005 and is scheduled to continue until 2010. It focuses on aligning medical practices and education with internationally recognized standards, integrating priority programmes such as those on TB and reproductive health into the health system, strengthening health financing, mobilizing society and empowering communities in the field of health promotion.

Turkey

The rapid and well-coordinated response of national and international agencies to the 2005 outbreak of avian influenza is another good example of well-functioning partnerships and collaboration with Member States (see also pp. 11,12,16,18,19–20, 52). Acting as one WHO, the Organization combined

² The BCAs can be found in the information on individual countries available in the Country Information section of the Regional Office web site (1).



Local resident hands over his chickens to a health expert for culling during avian flu outbreak in Turkey

the knowledge and expertise of its national, regional and global experts to support the Turkish Government in coordinating the different ministries and national institutes involved. This in turn ensured a common response from other international agencies such as FAO, the World Bank, the EU and ECDC, thus avoiding duplication of effort and guaranteeing a timely and appropriate response.

Albania

Collaboration with Albania focused on providing strategic support to fight HIV/AIDS along with other United Nations agencies. From 2001 to 2004, the Regional Office chaired a United Nations theme group on HIV/AIDS, which involved UNDP, UNICEF, UNDP, UNFPA, UNHCR, IOM, WFP and the World Bank. The establishment of this theme group improved the coordination of these agencies in the country. The group has run meetings, round-tables, and fora with Albanian government organizations, NGOs and international organizations, which have been identified as an important factor in maintaining a low HIV prevalence in the country.

Russian Federation

In the Russian Federation, the Regional Office, along with several international partners contributed to the development of stewardship and health policy in the Chuvash Republic.

As a result, the Chuvash Ministry of Health published a plan to strengthen the health system by strengthening primary health care, including introducing general practitioners, reducing inpatient beds in hospitals, restructuring emergency and diagnostic services, improving financial and human resources, developing strategies for greater public involvement and emphasizing the development of healthy communities.

This has led to improvement in the key indicators of health and health system performance: a substantial increase in the birth rate, a decrease in the death rate, a decrease of over 30% in infant mortality and an even larger reduction in the maternal mortality rate.

Stability Pact Initiative

In September 2001, the Dubrovnik Pledge (4) was endorsed by eight countries in SEE: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Romania, Serbia and Montenegro and The former Yugoslav Republic of Macedonia. Since then, they have worked closely together, within the framework of the Social Cohesion Initiative of the Stability Pact for South Eastern Europe (5); to carry out cross-border health projects (on mental health, social and health information systems, communicable diseases, food control, blood safety and tobacco control), and to reconstruct their societies and restore neighbourly relations (see also pp. 5,11,19, 29, 33).

The second phase began with the Second Health Ministers' Forum (6), held in November 2005 in Skopje. The participants emphasized that reforming and strengthening the health system in each country were essential to meeting the health challenges of its population; providing high-quality, accessible and affordable health services; and bridging the current health gap between the SEE countries and the EU.

Seventeen partners signed the Skopje Pledge (7), in which ministers of health and finance of the eight countries unanimously agreed that public expenditure in health should not be seen as a cost, but as an investment for the future.

Countries without country offices

In 23 other countries, the Regional Office deployed several processes to tailor its work to the needs of each individual Member State.

The Office enhanced its work on assessing countries' strategic health needs. This formed the background for strategic discussions about potential BCAs with these countries. The assessment reports analyse each country's health system challenges, national health priorities and possible health priorities for Regional Office collaboration (8). Negotiations that may lead to BCAs and plans for their implementation began with Andorra, Belgium, Germany and Norway.

The Regional Office and individual health ministries began mutual secondment of staff to support country-specific collaboration. In Germany, for example, WHO seconded a staff member to the

Ministry of Health to pilot the development and adoption of a BCA and the setting up of a WHO country office in Germany.

Responding to specific requests, the Regional Office also contributed to, for example:

- the adoption and implementation of the national health plan of Portugal;
- a joint OECD–WHO review of the health system of Switzerland;
- the development of a new law on public health in Greece and preparedness for the public health aspects of the Olympic Games in Athens;
- various health activities during the successive EU presidencies of the Netherlands (priority medicines in Europe), Luxembourg (coordination of the EU response to the tsunami in South-east Asia) and the United Kingdom (health inequalities, patient safety and pandemic preparedness); and
- a rapid assessment of public health needs in the Turkish Cypriot community in Cyprus.

Partnerships at country level and resource mobilization

During the biennium, the Regional Office continued its strategic coordination with key partners. At the regional level, it maintained and strengthened collaboration with the EC, the CE, sister United Nations organizations (such as UNICEF, UNFPA and the World Bank), bilateral development agencies, civil-society organizations and private-sector partners.

For the first time, the Office had direct agreements with DG SANCO on five common projects, for a total of €2.5 million, on the surveillance of communicable diseases, mental health, environmental health, health systems and obesity: topics of high priority to the Regional Office. Member States have thereby explicitly supported close collaboration and coordination between the Regional Office and the EC.

The Regional Office supported the creation of ECDC in Stockholm. A Memorandum of Understanding was signed, clarifying the role of each partner and building mechanisms for close collaboration from the start. The Regional Office has seconded two of its staff to provide direct support to ECDC.

As mentioned later in this report, the Regional Office organized ministerial conferences on environmental health in Budapest, Hungary and on mental health in Helsinki, Finland, with strong financial and political support from the EU, the CE, the World Bank and many civil-society organizations (see pp. 30–31, 37–38).

With the World Bank, the Regional Office has developed its activities in the field and in the Flagship courses for Europe (see p. 15), to train relevant staff in the eastern part of the Region in health systems matters.

The main work with the CE took place within the framework of the Stability Pact and the update of the Health for All framework in 2004 (see p. 58).

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Ministerial conferences were held in Budapest and Helsinki with strong support from key partners



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For the last few years, WHO has highlighted the importance of country-focused work and the crucial role of partnerships. The Regional Office made particular efforts in the biennium to strengthen coordination with its key partners at the country level and to build its country offices' capacity to develop partnerships.

Global health agenda and country work

The Regional Office works with countries in both the eastern and western parts of the Region, not as an end in itself, but to pursue the global health agenda in collaboration with Member States.

The Global Fund

The Regional Office has emphasized supporting Member States in their work related to the Global Fund to Fight AIDS, Tuberculosis and Malaria since the Fund's activities began in 2002.

Currently, 41 "components" in 22 countries in the European Region have been approved in the 5 rounds of applications for grants from the Fund (10 in the fifth round). To date, the European Region has received 11% of the total funding granted. This was achieved with significant involvement

of the Regional Office at both the regional and country levels. In 2003, the Office was a member of around 80% of the Fund's country coordination mechanisms. By the end of the biennium, its representation was 100%.

Collaboration with the Global Fund has been particularly strong on (see also pp. 23, 24, 26):

- TB projects in the Republic of Moldova, Romania, the Russian Federation and Uzbekistan;
- HIV/AIDS projects in Estonia, Kazakhstan, the Republic of Moldova, the Russian Federation, Tajikistan and Ukraine; and
- malaria projects in Georgia, Kyrgyzstan and Tajikistan.

MDGs monitoring and its impact on Regional Office programmes

The Office presented a strategy on the MDGs (9,10) to the WHO Regional Committee for Europe in 2005 and created a task force that oversees its implementation.

Through its country work, the Regional Office has scaled up its support to countries in marking their progress towards achieving the MDGs. Measures to improve monitoring of the indicators for the seven health-related MDGs are being taken in all 52 countries in the Region and a comprehensive assessment was recently conducted. An internal mechanism for monitoring other regions' and organizations' work on the MDGs is being put in place.

According to the recent assessment, the European Region is making uneven progress. Along with other international agencies, the Office has therefore supported work to tackle health-related MDGs in 26 countries, through the implementation of the BCAs. Eight of the CCEE and central Asian countries are likely to achieve five of the seven MDGs, and Hungary and Poland are expected to achieve all seven. Nevertheless, achieving the MDGs remains a big challenge for a number of countries.

Improved management of country work

Better planning and management

Effective work in the country offices is essential to the success of Regional Office programmes in countries.

The BCAs for 2004–2005 (2) were implemented successfully in most countries: 98% of planned activities were implemented. The financial implementation rate for the previous biennium was around 92%.

Performance appraisals of country work

The Regional Office has improved its performance appraisals of country work. Annual reporting to Member States on country-specific collaboration was set up on a country-by-country basis in 2004.

In addition, a number of key performance indicators are being tested to increase transparency and accountability. In 2005, six indicators to measure various aspects of planning and implementing

country work were pilot-tested, with the focus on timeliness and quality. For example, 80% of the signed BCAs were consistent with countries' priority needs as identified by strategic assessment reports (9). In addition, an external audit noted substantial improvement in the reporting from the country offices, with over 80% of reports being of good quality and submitted on time.

In general, the performance appraisal system proved to be useful in increasing the efficiency of country work.

Country days

To raise the profile of country work within the Regional Office, so-called country days were introduced, involving all programmes and divisions, as well as country health officials. A typical country day includes a number of activities in which different aspects of the collaboration between the Office and a particular country are jointly assessed.

Country days help to improve the coordination of the various technical responses to country needs. The most recent country days held in the biennium focused on Estonia, Kyrgyzstan, the Republic of Moldova and Turkey.

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2. Health systems

Spent: US\$ 23 329 000

Proportion of total expenditure: 14.6%

Staff: 65, including 26 in the field

The mission of the Regional Office is to support Member States in developing their own health policies, health systems and public health programmes, preventing and overcoming threats to health, anticipating future challenges and advocating public health.

The BCAs between the Regional Office and 29 Member States (1) are structured according to the four functions of countries' health systems, an approach promoted by the Office. As Regional Office staff implement their programmes, they consider how the programmes affect these functions: service delivery, stewardship, resource generation and financing. The work on health systems carried out with Member States in the biennium is therefore presented under these headings.

Service production and delivery

Strengthening and reforming primary health care

Because strengthening and reforming primary health care is a main priority in most Member States, the Regional Office carried out many activities with this aim in the biennium, in countries such as Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Russian Federation, Turkey and Uzbekistan. The work emphasized improving the quality of care (developing a national quality improvement strategy in Uzbekistan), strengthening the primary level of care (policy dialogues in Georgia and the Russian Federation) and integrating specialized services (workshops on child health in Kazakhstan, family health in Turkey, STIs in Uzbekistan and reproductive health in Kyrgyzstan). The work focused on identifying Member States' needs to improve the performance of their primary health care systems. This was also the basis for the 2006–2007 BCAs (1).

Making hospital reforms

Making successful hospital reforms remains a big challenge for most countries. While important partners have concentrated mainly on hospital infrastructure, the Regional Office put greater emphasis in the biennium on supporting performance assessment, reforms and master plans for hospitals, and quality and safety processes, as well as introducing health promotion activities into the daily routine.

For example, the Office reviewed policies and proposed strategies to improve equity, efficiency and effectiveness in the hospital system.

It also supported the introduction of accreditation systems to improve the quality of hospital care.

It led the project for a performance-assessment tool for quality improvement of hospitals in Europe. The tool is a framework with six dimensions: clinical effectiveness, staff guidance, efficiency, safety, patient-centredness and responsive governance. It has been pilot-tested in 40 hospitals in Belgium, Canada, Denmark, France, Slovakia and South Africa.

The Regional Office also led the health promoting hospitals project, which encompasses 740 European hospitals in a network to improve health promotion and quality in hospitals. The network includes hospitals in 24 European countries: Austria, Belgium, Bulgaria, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Israel, Italy, Kazakhstan, Lithuania, Norway, Poland, the Russian Federation, Slovakia, Spain, Sweden, Switzerland and the United Kingdom.

Finally, the Office developed emergency medical services in Albania, Andorra and Slovenia. It gave special emphasis to accreditation and quality assurance, and tools are being developed in collaboration with partners and WHO collaborating centres. With the threat of a possible pandemic resulting from avian influenza, efforts in 2005 concentrated mainly on advising countries on emergency preparedness plans for hospitals. Triage in emergency medical departments has been introduced in Albania and the Chuvash Republic, Russian Federation.

Strengthening public health services

Several activities to strengthen public health services were initiated and implemented during the biennium. Two major meetings took place – in Malta and Budapest, Hungary – on the reform of the public health services in the countries of the former USSR. A major achievement in the Social Cohesion Initiative of the Stability Pact for South Eastern Europe was focusing on strengthening the delivery of public health services as a part of overall health system reforms in the SEE countries.

Disaster preparedness and response

Providing support to Member States when disaster hits is an important element of the Regional Office's work in and with countries. This includes work on health services; during the biennium, this work focused mainly on continuing to strengthen national health systems' capacity to cope with the health aspects of crises. Based on recommendations published in *Strengthening health systems' response to crisis (2)*, 18 Member States collaborated on promoting disaster-risk reduction in the health sector.

North Caucasus

The North Caucasus region of the Russian Federation – especially the 1.5 million people in the republics of Chechnya, Ingushetia and North Ossetia – remains in the grip of a long-term humanitarian crisis marked by conflict and poverty. The Russian health authorities are working with partners including the Regional Office to address the public health challenges in the region, focusing

particularly on the needs of vulnerable groups. For example, the Office works closely with UNICEF to expand the Integrated Management of Childhood Illness strategy and build capacity in obstetrical and neonatal care through promoting the Making Pregnancy Safer initiative. The Office continues to strengthen primary health care services in the Republic of Chechnya, focusing on reducing mother-to-child transmission of HIV. It also supports programmes offering mental health and psychosocial support to traumatized children and victims of mine accidents.

In addition, the Regional Office works with partners to strengthen health-sector systems to prepare for, respond to and mitigate the consequences of emergencies. In collaboration with the EC, the Office is finalizing a joint United Nations project on capacity building to strengthen the health system in the Republic of Chechnya.

Kosovo (Serbia and Montenegro)

The WHO humanitarian programme in Kosovo focused on addressing the health situation of the internally displaced population in three temporary camps in north Mitrovica. This is the site of one of the most challenging environmental disasters in the European Region, which has not been properly addressed. The Regional Office has succeeded in bringing the problem closer to solution through close collaboration with the UNMIK team in Kosovo.

On top of the extremely poor hygienic conditions in the camps, the results of surveys of soil in the affected area and the blood of the population highlighted the concomitant problem of prolonged exposure to lead and other heavy metals and chemicals. The international community is now addressing this problem, which mostly affects children and pregnant women. The progress achieved is very promising. The Office's response was made possible mainly through the generous support of the Government of Norway and the strong political support of the Minister of Health of Serbia.

Avian influenza

In addition, the Regional Office mobilized technical assistance to strengthen health systems' preparedness to respond to human avian influenza cases in the Region, in such affected countries as Turkey. It continues to work with Member States to upgrade their health systems' capacity to deal with the health consequences of a potential human influenza pandemic.

Natural disasters

Several natural disasters struck Member States in the European Region, predominantly triggered by extreme weather events that caused mudslides and severe floods. Although such disasters rarely attract the broad attention of the international mass media, they destroy the livelihoods of affected communities and overwhelm local health systems. The Regional Office and its country teams organized assessment missions and arranged the delivery of essential medicines and supplies to stricken areas.



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Floods, such as this in Romania in 2005, are the most common natural disaster in the Region

In the aftermath of the devastating earthquakes and subsequent tsunami that affected South-east Asia, several experts joined the global one-WHO response team providing support to the operations of the WHO Regional Office for South-East Asia. The Regional Office provided the same support to the operations of the WHO Regional Office for the Eastern Mediterranean after the earthquake in Pakistan.

The recommendations mentioned above (2) emphasized four core functions of the Regional Office in emergencies:

1. to gather and share relevant health information;
2. to identify gaps in preparedness and response;
3. to ensure coordination of health action; and
4. to strengthen the capacity of local systems.

Resource generation

Pharmaceuticals

The Regional Office supported policies, strategies and regulations for pharmaceuticals, and strategies for the rational use of medicines, with particular emphasis on access to medicine, ensured through either selection or reimbursement policies.

Many countries across the Region have benefited from programmes to improve the mechanisms for medicine selection and regulation, access to ARV, the containment of antimicrobial resistance, and patient safety.

In the area of pharmacy practice, the Regional Office issued a CD-ROM (3), collating all the model programmes of the EuroPharm Forum and providing tools for running professional programmes at the national level, in May 2005.

Human resources for health

Human resources for health are crucial to health systems; lack of them hinders the scaling up of priority health interventions and the attainment of the MDGs. During the biennium, activities were implemented in Member States across the Region on staff migration, the accreditation of basic medical educational programmes with the World Federation for Medical Education, and nursing.

Publications were issued on, for example, programmes of basic nursing and midwifery education in Europe (4) and the implementation of the Munich Declaration on nurses and midwives as a force for health (5). The Regional Office met with the government chief nurses from 85% of the countries in the Region, in December 2005, to discuss educational issues.

Clinical technology

Clinical technology activities focused on policy development, quality management programmes, patient safety, HIV/AIDS prevention and blood safety.

As part of the 3 by 5 initiative, the Regional Office supported the prevention of nosocomial HIV/AIDS transmission, as well as the strengthening of the quality of care delivery and patient safety.

A forum in April 2005 in Austria, involving all western European countries, enhanced dialogue among Member States on patient safety issues. In November 2005, the Regional Office organized a meeting on patient safety, held in London and hosted by the United Kingdom EU presidency, with the 52 European Member States.

e-health

Member States' needs for e-health support and services from the Regional Office increased substantially throughout the biennium, in response to both rising e-readiness (people's mental receptiveness and infrastructures' technical capacity) and the roles and responsibilities detailed in a 2005 World Health Assembly resolution (6).

The first worldwide analysis of the e-health situation in all Member States was performed in 2005 with 52% of European Member States responding and illustrating this increase. The results (7) were used to develop a credible and achievable Regional Office strategy and corresponding work plan.

Based on the survey, several seminars took place in 2005 to better focus the Regional Office's e-health activities. As a result, a position paper was drafted that should lead to a strategy to guide the Regional Office's future activities.

Health financing

Activities comprised mainly country work, based on a framework that facilitates country-specific analysis of the performance, organization and context of health financing systems as a basis for assessment and recommendations. Work took place in many Member States across the Region, focusing principally on dialogue, analysis and recommendations on health financing policy. In addition, guidance was provided on the use of national health accounts.

A new development was the start of work on the intersection of health financing with specific disease control or other vertical programmes. For example, the Regional Office programmes on health financing, TB and HIV/AIDS worked together to address health-system obstacles to the effective delivery of TB and HIV interventions in the Baltic countries.

At the regional level, the Regional Office and the World Bank Institute, under a formal partnership agreement, delivered seven Flagship training courses during the biennium (four Region-wide, two for groups of countries and one for a single country) on health sector reform and sustainable financing and on poverty, equity and health systems. Beyond capacity building, these courses provided an important avenue for the dissemination of the Office's approach to health financing policy in the Region.

An intensive effort was made to improve the quality of the estimates of health expenditure in countries in the European Region that are produced each year for the world health report (8). The result was the reduction of the previous underreporting of private health spending for many of the countries in the eastern part of the Region.

The Regional Office aims to build on the accomplishments of the biennium to promote shared learning from the evidence. In particular, the framework for health financing systems mentioned above, the experience gained from supporting countries and the improved health expenditure estimates will all contribute to a new study by the Regional Office and the European Observatory on Health Systems and Policies on lessons on implementing health financing reforms from and for countries in transition.

Stewardship and governance of the health sector

Role of the ministry of health

Strengthening the ministry's stewardship role has been a priority for health system development in many countries. The CIS countries and CCEE face significant challenges in transforming their health ministries from the providers of health services into the stewards of the system. This requires political will, organizational reform and intensive capacity building. In the biennium, the Regional Office supported Member States by:

- offering policy advice and guidance in developing their national health policy documents and strategic plans for the health sector;

- providing evidence on effective policies and facilitating the exchange of experience among countries; and
- organizing policy dialogues and stakeholders' fora.

Examples of this include:

- a policy dialogue in Tallinn, Estonia in 2005 on health financing reforms;
- policy dialogues in Moscow, Russian Federation on primary health care, in Georgia on stewardship and financing, in Kyiv, Ukraine on options for health system reform, and in Vilnius, Lithuania on human resources policies to improve overall health system performance;
- a meeting in Madrid in April 2005, bringing together senior decision-makers from Bulgaria, Croatia, Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, the Netherlands, Poland, Romania, Slovakia, Slovenia, Spain, the United Kingdom and Turkey, with participation by the EC; and
- a workshop in Banja-Luka, Bosnia and Herzegovina in November 2005 on the appropriate public/private mix in and the regulation of the health sector.

In other countries, such as Armenia and Kazakhstan, the Regional Office started the process to establish and institutionalize assessment of health system performance.

Futures Fora

The Regional Office organized four Futures Fora for senior policy-makers from countries in which the Regional Office does not have country offices. The Fora give policy-makers a platform for sharing know-how and experience in steering their health systems to cope with emerging public health challenges.

- The forum on crisis communication, hosted by Iceland, generated a set of options and tools to assist chief government health policy-makers in communicating during crises, based on country case studies on SARS, avian influenza and dioxin exposure in the environment.
- The forum on unpopular decisions in public health, in Malta, put forward different means of easing the adoption of measures on, for example, tobacco control, alcohol harm reduction, hospital bed closures and health service user charges.
- The forum on governance of patient safety, in Austria, channelled the impetus of the global alliance on patient safety into the European Region, building on the activities of the United Kingdom EU presidency in the second half of 2005.
- The forum on health systems and public participation delivered a logical framework and specific tools for leading health policy-makers to increase public involvement in policy decision-making.

The Regional Office publishes the findings of the Fora as policy briefs in English and Russian (9), and health ministries translate some of them into local languages.

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3. Communicable diseases

Spent: US\$ 32 843 283

Proportion of total expenditure: 20.5%

Staff: 95, including 47 in the field

Despite substantial recent progress in control in most Member States, communicable diseases continue to be an important cause of illness and death, and thus remain a major public health priority in the Region. Key priorities include surveillance and response, immunization systems and the control of vaccine-preventable diseases, TB, STIs and HIV/AIDS, and malaria.

The Regional Office has increasingly supported Member States in developing and improving policies, systems and interventions to reduce mortality and morbidity from major communicable diseases, as well as rapidly to detect, identify and respond to threats from epidemic-prone, pandemic and emerging infectious diseases. Avian influenza and countries' preparedness for a possible new pandemic influenza virus have recently come into special focus.

Surveillance and response

Fighting communicable disease

The Regional Office supported national capacities to detect and react to outbreaks. Several key areas were further developed: strengthening advocacy and partnerships, developing early-warning and response capacity at both the country and regional levels, strengthening national surveillance systems in general and strengthening networks to improve collaboration between countries.

As part of the revision of the International Health Regulations (1), a regional consultation was held with all 52 Member States in the Region, financially supported by the Government of Switzerland.

Capacity building

Priority was given to supporting countries in SEE and the CIS, where surveillance systems are not yet fully adapted for the timely detection and investigation of and response to infectious disease events.

In-depth assessments were made in Bulgaria and Kazakhstan, leading to an EU-funded project to improve the surveillance system in Bulgaria. Technical assistance was given to 20 countries, including national workshops on communicable diseases, and technical expertise to assist Member States in preparing national plans and project proposals to strengthen surveillance systems.

Other work sought to strengthen the prevention and control of priority diseases in selected countries, early warning systems and the use of geographical information systems. The Regional Office also supported national plans to contain the threat of antimicrobial resistance. Two major

disease outbreaks were investigated: Q-fever in Bosnia and Herzegovina and Crimean–Congo haemorrhagic fever in Turkey.

In addition, workshops were organized for the countries participating in the Social Cohesion Initiative of the Stability Pact for South Eastern Europe, in connection with a consultation on hospital-acquired infections.

The Office indirectly supported the 25 Member States of the EU by taking part in advisory and expert fora, such as the health security group of DG SANCO and the advisory board of ECDC.

Finally, the Office's capacity for outbreak alert, verification and response was strengthened, and a more systematic approach to the rumour alert and follow-up process with Member States was established.

Scaling up advocacy and partnerships

Advocacy and partnership relations have been nurtured by a regularly updated web site (2), and a quarterly bulletin, *CD news* (3).

The Office received funding or secondments for communicable disease work from the EC, the governments of France, Belgium, Sweden, Switzerland and the United Kingdom, a partnership programme in the Netherlands, and the Asian Development Bank.

Avian influenza and influenza pandemic threats

The threat of an influenza pandemic has been debated for several years and – with the increasing spread of the avian influenza H5N1 virus in southern Asia – has become a concern for Member States in the European Region, especially for countries bordering China, such as Kazakhstan, Kyrgyzstan, the Russian Federation and Tajikistan. During 2004, discussions among several Member States and DG SANCO led to an initiative to strengthen national preparedness plans for a possible new pandemic influenza virus. The Regional Office organized a first regional workshop on pandemic preparedness planning in collaboration with DG SANCO in March 2005, and a second with DG SANCO and ECDC in October 2005 (4,5).

The first outbreaks of H5N1 were reported in the Russian Federation and Kazakhstan in the summer of 2005. Joint missions of technical experts from the Regional Office, DG SANCO and ECDC visited six countries to assess the strengths and weaknesses of their national preparedness plans for influenza and, increasingly, avian influenza. More attention was given to improving seasonal influenza surveillance, particularly laboratory capacity to diagnose human influenza in all Member States.

In addition, the Regional Office led technical missions to strengthen national preparedness plans in six countries (Greece, Kazakhstan, Poland, Romania, Turkey and the United Kingdom) and to undertake assessments of the risk of H5N1 transmission from poultry to human beings in affected countries, which included Romania and Ukraine in 2005. Finally, the Office joined missions to support

the development of national integrated project proposals for capacity building in national pandemic influenza plans, coordinated by the World Bank.

Vaccine-preventable diseases and immunization

Sustained progress against vaccine-preventable diseases

The Regional Office has developed a number of disease-control initiatives for polio eradication, diphtheria control, measles and rubella elimination, and the prevention of congenital rubella infection. They provide a major opportunity to boost routine immunization programmes.

The Region has made progress in the provision and maintenance of immunization services. Most countries have over 90% coverage with routine vaccines. The introduction of new and underused vaccines into routine immunization programmes has accelerated across the Region. Notably, rubella vaccine is now used in 48 countries, while universal hepatitis B immunization was introduced in 44. By 2005, 33 countries had introduced and routinely implemented immunization with Hib vaccine; a remarkable reduction of reported Hib incidence followed in most of these countries.

A great achievement and historic milestone was the certification of the Region as polio free in June 2002. During the biennium, the Region retained this status through strong polio surveillance and



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Most countries in the Region have over 90% coverage with routine vaccines

quality-assured laboratory work (6). In 2005, it became the first WHO region ever to complete phase I of containment for polioviruses.

The elimination of measles and rubella and the prevention of congenital rubella infections moved closer as 28 countries met the measles-elimination criterion: an incidence of less than 1 per million in 2005. The Regional Office supported campaigns against measles and rubella in Belarus, Cyprus, Italy, Kazakhstan, Tajikistan and Turkey, with the largest targeting 19.8 million children. The 2005 Regional Committee resolution on measles and rubella elimination and the prevention of congenital rubella infection (7) ensured political commitment to and priority for the target. The strategy (8) is to improve surveillance and immunization coverage by strengthening routine immunization systems, an approach unique among WHO regions.

Building capacity for immunization

The Regional Office focused its support to countries on building capacity to strengthen immunization systems, promoting safe, high-quality immunization practices and improving surveillance and monitoring. Member States received policy and technical support:

1. in developing and revising their national immunization policies and plans;
2. for training to build managerial and technical capacity at the national and district levels;
3. in monitoring and assessing performance;
4. in coordinating activities; and
5. for advocacy, communication and partnership.

For instance, country-tailored projects were carried out to strengthen information management systems and monitor district-level performance in Belarus, Bulgaria, the Republic of Moldova and Ukraine. A strategy called Reaching Every District (9) used innovative methods – such as sustainable outreach in Armenia, Azerbaijan, Georgia and Tajikistan – to reach hard-to-reach vulnerable populations.

Governments' understanding of the costs, financing mechanisms and efficacy of immunization programmes was improved, particularly in GAVI-eligible countries. This further reaffirmed countries' ownership of immunization services and responsibility for ensuring that they are sustainable, of good quality and accessible by all population groups. The Office gave technical support, including training, to countries to ensure sustainable long-term national immunization plans.

Continued improvements were made to CISID (10), a web-based tool for collecting, analysing and monitoring information on infectious diseases.

Scaling up advocacy of immunization

The first European Immunization Week (11), in October 2005, was hailed as a success. At least 10 Member States took part, 6 with technical and (in some instances) financial support from the

Office: Belarus, Ireland, Italy, Serbia and Montenegro, Tajikistan and The former Yugoslav Republic of Macedonia.

The goal was to raise awareness of and advocate immunization, with the core message that immunizing every child is vital. Member States used the Week:

- to promote safe immunization practices;
- to provide information to health care providers and parents;
- to advocate immunization to particular communities; and/or
- to improve vaccine coverage among vulnerable populations.

The initiative will be an annual event, involving a growing number of Member States.

Funding and partnerships

Collaboration continued with traditional partners such as UNICEF, CDC, USAID, GAVI, CIDA, the Government of the Netherlands, the Children's Vaccine Programme of PATH, Rotary International and the World Bank.

Closer links were established with new partners, particularly ECDC, the Vishnevskaya-Rostropovich Foundation, the March of Dimes and the Hib initiative. WHO partners in the GAVI-funded Accelerated Development and Introduction Plans for new vaccines include CDC, Johns Hopkins University and the London School of Hygiene and Tropical Medicine.

Key challenges

Some 600 000 children across the European Region still remain unvaccinated and thus susceptible to preventable diseases. Vulnerable population groups still exist in every country, reflecting great disparities in immunization coverage rates between and within countries. The key challenges are securing resources, political commitment and public awareness, and maintaining demand for immunization services.

Responding to the TB crisis

Fighting TB

TB is out of control in many CCEE and members of the CIS. As a result, the Regional Committee called for a scaled-up response in 2002 (12).

Of the 52 Member States, 43 are implementing the DOTS strategy to varying extents (including all CIS countries), up from 34 in 2001. Some 30 countries have implemented DOTS countrywide as a national TB control strategy. On average, 47% of the population in the Region is currently provided with services using the DOTS strategy, up from 17% in 2001.

As a response to the European epidemic of MDR-TB, DOTS-Plus pilot projects were strengthened in Estonia, Latvia and three *oblasts* in the Russian Federation. Further, 11 new projects were approved

in 8 countries (Azerbaijan, Georgia, Kyrgyzstan, Lithuania, the Republic of Moldova, Romania, the Russian Federation and Uzbekistan) in collaboration with the WHO Green Light Committee. In addition, a WHO collaborating centre for research and training in management of MDR-TB was established at the State Centre of Tuberculosis and Lung Diseases of Latvia at the end of 2004.

A grant from GTZ enabled the Regional Office to help prepare proposals with TB components for the Global Fund to Fight AIDS, Tuberculosis and Malaria. In the fifth round of applications, 12 countries got help from the Office in making proposals, 8 countries submitted proposals to the Fund, and 4 had their proposals approved.

Capacity building

Enabling health systems to achieve more effective TB control is one of the main priorities for the Region. This was discussed at a technical advisory group meeting in 2005, using a paper on the challenges and opportunities for the health systems of the Baltic and CIS countries.

Working closely with many other technical and financial partners, the Regional Office is the leading partner for TB control in countries. With the Regional Office's enhanced TB control programmes at both the Region level and in country offices in Balkan countries, the Caucasus, central Asia, the Russian Federation and Ukraine, TB control in the Region has substantially improved.

In addition, to facilitate the response to the sharp increase in HIV-related TB, the Regional Office launched two projects on TB/HIV co-infection. One, supported by the French Government, focused on the Baltic countries, and the other, supported by the Netherlands Government, covered human resource development in the Region and in groups of countries.

Key challenges

TB remains a serious public health problem in the Region, causing a reported nearly 69 000 deaths and almost 450 000 new cases in 2004, with 80% of cases occurring in the eastern part of the Region. These are some of the highest figures in two decades. In western Europe, social marginalization and immigration from countries with high TB burdens have resulted in spots of increasing incidence, especially in large cities.

Major constraints on effective TB control in the Region are the high rate of MDR-TB, mostly in the countries of the former USSR, the rapid growth of the HIV epidemic in the eastern part of the Region and the still limited political and financial commitment to TB control.

The WHO Regional Director for Europe declared TB a regional emergency in February 2005, in a letter calling on all Member States facing a high TB burden to increase their expenditure on rational, health-systems-based strategies to tackle the disease and the social conditions that encourage it. The Regional Director also called on the Region's wealthier countries and the EU to pay more attention to the crisis and to increase their financial contribution to TB control. A ministerial forum for the European Region will be held in October 2006.

STIs and the HIV/AIDS epidemic

Since the Regional Committee called for a stronger response to HIV/AIDS in 2002 (13), STIs and the HIV/AIDS epidemic have been a top Regional Office priority. An estimated 2.3 million people in the European Region live with HIV/AIDS, and HIV cases and AIDS deaths are rising significantly.

During the biennium, numerous STI outbreaks were documented throughout the Region. Outbreaks of syphilis, gonorrhoea, chlamydia and other STIs often disproportionately affect vulnerable groups, such as men who have sex with men or people living with HIV/AIDS. They are indicators of an overall weakening of prevention efforts in the Region.

Meeting the 3 by 5 regional target

People who have HIV and live in countries that provide HAART, can lead almost normal lives, with significantly better quality of life and extended life expectancy.

The WHO/UNAIDS 3 by 5 initiative aimed to increase access to this life-saving treatment. The European Region met its target: significantly to expand the number of countries providing HAART and to enrol an additional 100 000 patients in treatment programmes. Yet the treatment gap continues to grow, as does the number of people acquiring HIV and progressing to AIDS, especially in eastern Europe.

With the initiative over, it is time to consider how best to move quickly towards satisfying the basic objective of the global WHO plan (14): universal access to prevention, treatment, care and support services by 2010.

Normative guidance and technical assistance

To scale up access to ART, health care professionals were equipped with the most up-to-date advances in the treatment and care that should be offered to people living with HIV/AIDS. In 2004, the Regional Office published HIV/AIDS treatment and care protocols for the CIS (15). These are being revised and expanded.

A significant decrease in the price of ARV was achieved by the end of 2005, through grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria and loans from the World Bank for HIV/AIDS programmes in 19 Member States, and with support from Regional Office country teams. In a number of countries, the Office played a key role in:

- pilot-testing the successful mobilization of resources to expand harm-reduction activities;
- strengthening the involvement of people living with HIV/AIDS in decision-making and ART service delivery;
- supporting the adoption of standardized evidence-based European therapy regimens; and
- training service-providers in ART and key prevention interventions.

Capacity building

The Regional Office and GTZ collaborated on building capacity to scale up HIV/AIDS responses. By pooling knowledge and expertise from the entire Region, they worked to create sustained mechanisms for developing human resources for STI/HIV/AIDS prevention, treatment and care. Three knowledge hubs were created (16):

- in Zagreb, Croatia on STI/HIV/AIDS surveillance, monitoring and evaluation;
- in Vilnius, Lithuania on harm reduction for injecting drug users; and
- in Kyiv, Ukraine on HIV/AIDS treatment and care.

They developed training curricula and materials based on WHO guidance and standards for high-quality, continuing training.

Over 40 courses were given during the biennium to more than 700 health care providers from almost all the CCEE. The goal was to equip them with core competencies to introduce and scale up STI/HIV/AIDS prevention, treatment and care.

Funding and partnerships

Since the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia (17) in February 2004, the Regional Office developed and strengthened strategic partnerships with the EC, including ECDC and the EMCDDA; research centres, such EuroHIV and the Copenhagen HIV Programme; and NGOs, such as EATG, CEE-HRN and AIDS Action Europe.

Key challenges

At the end of 2005, priority challenges included reducing the pervasive stigma of HIV/AIDS and discriminatory attitudes among health providers, and removing legal barriers to essential prevention, treatment and care services for vulnerable groups.

Closing the gap between east and west, and ensuring the sustainable provision of universal STI/HIV/AIDS prevention, treatment and care, require the reorganization of service delivery systems. These will enable and maintain access to safe, effective, affordable and equitable commodities and programmes.

Intensifying the response to malaria

Fighting malaria

The fight against malaria intensified after the endorsement of a Regional Committee resolution (18) in 2002. The aim is to reduce the impact of malaria on the population's health to the lowest possible level achievable with the available financial and human resources and the existing control technologies and tools.

The Regional Office supported countries in preventing deaths due to malaria, containing epidemics, further reducing incidence, preventing the re-establishment of malaria transmission, and maintaining the malaria-free status of countries and territories from which the disease had been eliminated. To do so, the Regional Office focused on:

1. intensifying action by the Roll Back Malaria partnership in the Region and in groups of countries;
2. enhancing national capacities for decision-making;
3. investing in human resources development and capacity building;
4. improving capacities for disease management;
5. strengthening capacities for containing and preventing epidemics;
6. promoting cost-effective preventive measures;
7. strengthening surveillance and operational research capabilities;
8. ensuring community mobilization; and
9. enhancing intersectoral collaboration.

During the biennium, all malaria-affected countries supported by the Regional Office and its partners took all possible epidemic-containment measures.

During the biennium, the Global Fund to Fight AIDS, Tuberculosis and Malaria gave grants to Kyrgyzstan, Tajikistan and Uzbekistan, to support their national response to malaria. As a result, the number of reported cases fell by almost a third from 2003 to 2005. A large regional epidemic was curbed and malaria incidence was reduced so much that interruption of its transmission in some countries may become feasible in the coming years.

Key challenges

A unique opportunity to move from malaria control to elimination was created. To confirm their intent to take up this challenge, all malaria-affected countries in the Region endorsed a declaration on moving from malaria control to elimination (19) in Tashkent, Uzbekistan in 2005.

Despite the conspicuous achievements in the fight against malaria, national control programmes continue to face a number of problems and constraints, mainly financial.

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4. Noncommunicable diseases

Spent: US\$ 19 021 388

Proportion of total expenditure: 11.9%

Staff: 53, including 5 in the field

Good progress was made in the areas of noncommunicable diseases, lifestyles, health determinants, and family and community health.

At the Region level, strategic frameworks and regional action plans were developed and adopted for alcohol policy, child and adolescent health and development, and mental health (following a WHO conference in January 2005). The Regional Office facilitated the Region-wide coordination of acceptance of the WHO Framework Convention on Tobacco Control – the first globally binding public health treaty. At the end of 2005, over half the countries in the Region, and the EC, were Parties to the Convention. The development of a European strategy on noncommunicable diseases reached its final stage, and work began on counteracting obesity, particularly including preparations for a ministerial conference in 2006.

Achievements of Region-wide importance include: the development or update of regional databases and information systems on alcohol, nutrition, obesity and tobacco; the launch of the fourth phase of the Healthy Cities project; the enlargement of the European prison health network to include over half the countries in the Region; and a review of the capacity of health promotion systems in 16 European countries to address socioeconomic determinants of health.

The Regional Office also worked with groups of countries, through projects and activities such as:

- building support for mental health services and for the Framework Convention on Tobacco Control within the countries covered by the Social Cohesion Initiative of the Stability Pact for South Eastern Europe;
- taking part in the working group on social inclusion, lifestyles and work ability of the Northern Dimension Partnership;
- building capacity for tobacco control in the CIS; and
- networking for a health-system-oriented, integrated approach to reproductive health, gender, and maternal, child and adolescent health in the Region.

The Office provided technical support to many countries, particularly in the central and eastern parts of the Region. Some particular achievements were related to the development and adoption of new national legislation and programmes, such as the Public Health Law in Greece, national action plans for tobacco in Armenia and Lithuania, and national nutrition programmes in Bulgaria,

Georgia and Hungary. Work was also carried out in countries to strengthen national capacity, improve surveillance and monitoring, raise public awareness and support multisectoral mechanisms. Work in the western countries in the Region included support to the Greek Government in developing the public health plan for the 2004 Olympic Games in Athens, and joint planning and organization of thematic workshops for the United Kingdom's EU Presidency summit on inequalities and health.

Noncommunicable disease prevention and control

In 2004, the Regional Committee decided to give high priority to noncommunicable diseases and to develop a comprehensive, action-oriented strategy for the Region by 2006 (1). It will focus on implementation, taking account of the specific characteristics of and diversity within the European Region, and be prepared in collaboration with Member States, intergovernmental agencies, NGOs and other relevant partners.

Mental health

In January 2005, the Regional Office, in partnership with the EC and the CE, organized the first Ministerial Conference on Mental Health, hosted by the Finnish Government in Helsinki (2). The Mental Health Declaration for Europe (3) was signed at the Conference and endorsed by the Regional Committee in September 2005. In the Declaration, health ministers recognize the urgency of facing the challenges and building solutions in mental health. The Mental Health Action Plan for Europe (4) sets out the details of the commitments and the responsibilities of both Member States and WHO, as stipulated in the Declaration. It gives 12 priority areas of action, such as promoting mental wellbeing, incorporating mental health as a vital part of public health policy, reducing stigma and discrimination, targeting services for different stages of life and ensuring access to good primary health care.

After the Conference, the Regional Office prepared an implementation plan for 2005–2010 as a framework for its activities to carry out the Action Plan, identifying the resources required to deliver them. A network of WHO collaborating centres in Finland, Italy, the Netherlands, Sweden and the United Kingdom was established to support work on disorder prevention, mental health promotion, stigma and discrimination, service delivery, information and dissemination, and research. A European network was created to empower service users and caregivers, involving leading European NGOs.

Partnership with the EC was strengthened through close collaboration with DG SANCO on the development of a green paper (5), and the organization with the United Kingdom EU Presidency of an event on inequality and mental health in November 2005. The EC is supporting a project on benchmarking progress towards meeting the milestones of the Declaration and Action Plan. Partnership with the CE may involve a project on legislation.

Country activities included participating in and supporting assessments of countries' needs for and supply of mental health services, supporting the development of national policies and legislation,

supporting the development of pilot community mental health centres and accommodation, and organizing seminars for mental health staff. A priority is the development of workforce capacity, particularly the role and competencies of nurses and social workers.

Family and community health

In 2005, 14 countries in the Region marked World Health Day with activities on the theme "Make every mother and child count" (6), including meetings, conferences, round-tables, seminars, presentations and debates involving health professionals, decision-makers, partners and other stakeholders including the public. Through the event, the Regional Office publicized many facts and figures on maternal and child health in the Region.

The Regional Committee adopted the European Strategy for Child and Adolescent Health and Development (7) in 2005, after two years' consultation with Member States. Its purpose is to assist Member States in formulating their own policies and programmes. The Strategy and an associated toolkit (7) will enable Member States to identify any gaps in their plans and clarify their priorities for future investment. The Strategy also provides an umbrella for the many evidence-based initiatives currently being promoted by the Regional Office to support the health and development of children and adolescents.

The Regional Office took a health-system approach to implementing integrated policies and strategies on reproductive health, gender, and maternal, child and adolescent health. A meeting of focal points in countries was organized in Antalya, Turkey in April 2005 to discuss how the Regional Office and its partners could help countries integrate their policies and strategies in these areas. Representatives of 18 Member States and many international partners acknowledged existing conceptual frameworks for national policies on family and community health, and emphasized the need for better integration of specific or targeted interventions into health systems, to improve implementation in countries. This calls for closer collaboration between governments, health systems specialists and family and community health experts at both the national and international levels.

Social and economic determinants of health

Through its office in Venice, Italy, the Regional Office assessed the relationship between macroeconomic factors and health in low-, middle- and high-income countries in the Region.

The Regional Office has worked in synergy with the efforts of the global Commission on Social Determinants of Health since its launch in March 2005. In particular, this initiative enabled an initial review of the evidence on socioeconomic inequalities in health and the effectiveness of measures to address them. The results will be available to Member States late in 2006.

The collection of case studies – on how health systems can confront the health inequalities caused by socioeconomic factors such as poverty – was expanded during the biennium.

Nutrition and food security

The Regional Office supported the development of food and nutrition policy in the Region, through the implementation of the first regional action plan (8). A recent analysis of nutrition policies in Member States indicated that 45 out of 52 countries have final or draft such policy documents, as a specific action plan or as part of national public health programmes of a broader coverage.

Healthy nutrition still needs to be strengthened, however, as a detailed and comprehensive action plan with sufficient enforcement does not always follow the adoption of a food and nutrition policy. In 2005, the Regional Office, in collaboration with Member States, started evaluating the implementation of the first European action plan and developing the second.



Almost all countries in the Region now have a food and nutrition policy, which advocates healthy eating

The Regional Office engaged in nutrition surveillance by collecting anthropometric data on children, adolescents and adults, and by collecting and analysing country-level data, which will become accessible through an online database later in 2006. Overall surveillance still has to be standardized and improved, and the Office is creating a network of centres for the collection of data on nutritional status and related behaviour in childhood.

The Regional Office is focusing on counteracting obesity as a public health problem of particular magnitude and difficulty. It is organizing a European Ministerial Conference in November 2006, hosted by the Turkish Government in Istanbul, with support from the EC and several other international partners, such as the CE, FAO, the World Bank, and the International Obesity Task Force (9). A series of consultations with Member States, experts and other stakeholders began during the biennium.

Tobacco control

Tobacco control has been high on the agenda of the Regional Office, particularly since the Warsaw Ministerial Conference and the adoption of the European Strategy for Tobacco Control in 2002 (10). The focus is now on facilitating awareness of, coordination of and commitment to the implementation of the WHO Framework Convention on Tobacco Control (11). The Regional Office organized high-level intersectoral meetings to support the Convention in countries, with the governments of the Czech Republic, Serbia and Montenegro, and central Asian and SEE countries. These consultations encouraged Member States to sign and ratify the Convention (12).

The Strategy and Convention are international instruments that strengthened the development of national policies and legislation. The Regional Office provided technical support to several countries, particularly in the eastern part of the Region, in developing and adopting national action plans, strategies and programmes, and in reviewing and updating their legislation. It has also supported the creation of tobacco-control resource centres in countries.

During the biennium, the Office organized training and workshops in several countries to build capacity within governments and civil-society networks.

Finally, a project within the Social Cohesion Initiative of the Stability Pact for South Eastern Europe supported both political commitment to the ratification and entry into force of the Convention, and national capacity for tobacco control in the eight SEE countries.

Alcohol

Work on alcohol policy focused on the implementation of the European Alcohol Action Plan 2000–2005 (13) and the Declaration on Young People and Alcohol (14). A renewed network of national counterparts reviewed the implementation of the Plan and launched a new phase of regional policy in a meeting in Sweden in April 2005.

The Regional Committee adopted a framework for alcohol policy in the European Region (15) in September 2005. The new policy presents strategic guidance and policy options, particularly reflecting recent developments and new challenges in alcohol policy in the Region. It also maintains and reinforces the core principles and measures of the Action Plan, the European Charter on Alcohol (16) and the Declaration to ensure consistency and continuity.

The European alcohol information system (17) is regularly updated in collaboration with national counterparts and international partners. The alcohol control database (18) is an important tool for developing and assessing alcohol policies in Member States, and cross-country analysis of consumption trends and policies. In addition, the Regional Office contributed European data to a global WHO database (19).

The Regional Office gave technical support to several countries, mainly in the eastern part of the Region, in updating their alcohol policies and strengthening national capacity and intersectoral mechanisms for implementation. The Office advanced knowledge of the social and health-care costs of alcohol by supporting a study by the Swedish Ministry of Health and Social Affairs. Collaboration with the EC on a number of alcohol policy issues was strengthened and formalized.

Prison health

A Regional Office project aims to make health in prisons part of the overall national public health agenda and promote links between health ministries and those responsible for prison health. The Health in Prisons Project also aims to promote equity in health and give extra attention to disadvantaged groups. Since the project was revitalized in 2002, thanks to funding from the Dutch Ministry of Foreign Affairs, the active network of European countries has grown from 16 to 33. In 2005, the project celebrated its tenth anniversary at a meeting (20) organized in collaboration with the United Kingdom Department of Health and EU Presidency.

The project's achievements include developing guidance (21) that will promote capacity building on prison health in Member States, and starting a European database.

Support to local governments

Local governments are increasingly seen as key actors in affecting lifestyles and health, as well as providing health and social care. A high percentage of the European population lives in cities covered by national Healthy Cities networks: 43% in Austria, 57% in Belgium, 30% in Germany, 53% in Israel, 25% in Italy, 50% in Norway, 65% in Slovenia, 60% in Spain, 55% in Sweden, and 35% in Turkey.

The fourth phase of the Healthy Cities project was launched in 2004 with a renewed agenda, focusing on healthy ageing, urban planning and health, and health impact assessment. A review was made of the lessons learned from and case studies on intersectoral city strategies and plans from around the Region that addressed the determinants of health, equity and citizen participation.

A special consultation in 2005 on the role of local governments in promoting physical activity contributed to the preparations for the ministerial conference on counteracting obesity.

In the field of ageing, the Regional Office issued two successful publications: *Palliative care. The solid facts (22)* and *Better palliative care for older people (23)*.

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5. Environment and health

Spent: US\$ 18 836 524

Proportion of total expenditure: 11.8%

Staff: 51, including 1 in the field

Environmental health covers aspects of human health and disease that are determined by factors in the environment, including violence and injuries. Two political developments took place in this area during the biennium: the Fourth European Ministerial Conference on Environment and Health in 2004 and the approval of a resolution on violence and injury prevention by the WHO Regional Committee for Europe in 2005.

The activities described here were implemented by Regional Office staff in three locations: Bonn, Germany; Copenhagen, Denmark; and Rome, Italy.

Budapest Conference

The Fourth Ministerial Conference on Environment and Health, held in Budapest, Hungary, was preceded by intense preparatory technical and political work to set the agenda and secure agreement on commitments based on scientific evidence. Hundreds of experts and senior officials from most of the countries in the WHO European Region contributed to this process.

A report (1) showed that, overall, outdoor and indoor air pollution, unsafe water and sanitation, lead contamination and injuries cause about a third of all deaths (100 000) and about 26% of all DALYs (equivalent to 6 million life-years lost to transient or permanent disability) in the Region each year. The Regional Priority Goals spelled out in the CEHAPE (2), signed in Budapest, focus on the actions necessary to reduce this burden of disease, giving special attention to the issues outlined in the above assessment.

The Budapest Conference was attended by some 1200 delegates and observers from 50 Member States, 11 international organizations and 11 NGOs, and 48 ministers from both the health and the environment sectors. By design, 18 delegations included a total of 131 young people who took part in several initiatives, including a youth parliament that developed and approved its own declaration. The ministers of Health and Environment of Hungary and the WHO Regional Director for Europe signed two major documents on behalf of all Member States: the Conference Declaration (3) and the CEHAPE (2). In addition, the EU Commissioners signed a statement in support of the Conference decisions.

The Conference Declaration addresses several key issues for environment and health in Europe and makes strong commitments to future action. The CEHAPE is a broad framework, setting Region-wide

goals. Member States can adapt it to their own needs, to tackle the issues most relevant to them, as selected through their decision-making mechanisms. It is a science-based political commitment, developed by Member States for Member States:

- to orient priority actions and policies addressing both national and regional needs; and
- to enhance the protection of children's health from environmental hazards.

The Regional Committee endorsed the deliberations of the Budapest Conference in September 2004 (4).

The Conference Declaration and the CEHAPE are political commitments that address the most pertinent environment and health issues. While they focus on Member States' action, they also require the Regional Office to support countries' decision-making through, for example, collecting and providing evidence on the effectiveness of policies, providing data and technical tools, and sharing and disseminating information (5). To this end, the Regional Office has developed a set of indicators for the specific issues under its responsibility; the Office will use them to monitor its contribution and report on its achievements and progress to its governing bodies.

After the Conference and in accordance with one of its resolutions, the European Environment and Health Committee (6) was re-established. The Committee is composed of elected representatives of Member States (five each from the health and the environment ministries), the EC (DG SANCO and DG ENV), EEA, other international organizations, the business sector and NGOs. Its task is to monitor and promote the implementation of the commitments made in Budapest. Youth representatives are also included on the Committee and an international mechanism to ensure youth participation at the international level is being set up, supported by Member States such as Ireland and Norway.

To keep the Conference outcomes in focus and facilitate its tasks, the Committee reviews the progress made in implementing one of the four Regional Priority Goals of the CEHAPE at each of its meetings. During the biennium, it reviewed Goals III and IV, on clean air and chemical-free environments. In addition, it established a CEHAPE task force, made up of national technical focal points. The Committee's sessions are open to all Member States, to promote transparency and communication.

Technical activities

The Regional Office supported Member States in implementing the Conference commitments through technical activities that included:

1. workshops to assist policy-makers from all sectors involved in implementation under the leadership of the health authorities in Armenia, Belarus, Cyprus, the Russian Federation and the United Kingdom;
2. revision of the WHO air quality guidelines (7) in October 2005, enabling Member States and the EU to update their existing standards and norms in line with new scientific evidence;



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Health-enhancing physical activity is open to people of all ages

3. case studies on effective practices for addressing children's health and environment at the national and local levels in 26 countries, mainly in the western part of the Region;
4. development of training modules on children's health and environment for public health professionals and two training workshops for the CIS countries and Cyprus;
5. a list of core environmental health indicators for use by the European environment and health information system (8), with implementation of the system begun in 20 countries, mainly in the western and southern parts of the Region;
6. completion and promotion of the results of a research project financed by the EC on adaptation to climate change (9), and support to 10 countries (Austria, France, Germany, Greece, Hungary, Italy, Portugal, Slovenia, Switzerland, United Kingdom) to better understand and further develop mechanisms to help health systems cope with extreme weather events (heat-waves and floods);
7. guidance for Member States on effective decision-making in the presence of scientific uncertainty and the use of the precautionary principle in health and the environment; and
8. launch of an international collaborative project, HEPA Europe (10): a European network for the promotion of health-enhancing physical activity to support implementation of Regional Priority Goal II.

In addition, the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes (11), signed by 36 European Member States, entered into force on 4 August 2005, becoming legally binding on the 16 countries that had ratified it. This will increase the instruments available to countries for implementing Regional Priority Goal I and achieving the relevant MDGs (12).

Violence and injury prevention

Injuries are a major public health issue in the WHO European Region. They kill about 800 000 people per year, representing about 8.3% of all deaths. For every fatal injury, however, an estimated 30 people are hospitalized, and 300 require outpatient treatment in hospital emergency departments. This means about 24 million hospital admissions and 240 million interventions by emergency departments.

Unintentional injuries account for about two thirds (543 000) and violence for one third (257 000) of all deaths. Injuries disproportionately affect young people and are the leading cause of death for those aged 1–45 years.

Injuries cause great expenditure by the health services. Although there are no comprehensive studies providing estimates for the Region, the extrapolation of data available from some western European countries indicates that the cost of fatal and non-fatal injuries to the health sector in the Region may be on the order of €189 billion (€81 billion – €296 billion). One could say that the health sector alone spends no less than €81 billion.

The burden of injury is unequally distributed across the Region. Injury mortality and morbidity rates in the eastern and southern parts of the Region are over eight times those in some western countries. This gap has grown over the past few years.

Nevertheless, these figures also show great potential for improvement, an opportunity for the health system. The achievements of some European countries, now among the safest in the world, indicate that injuries can be prevented, and their effects mitigated by adapting and transferring existing knowledge, accumulated experience and effective practices across the Region (13).

It has been estimated that this approach could prevent almost half a million injury-related deaths – two thirds of the total – including 55 000 deaths from road traffic injuries, 30 000 from drowning, and 55 000 from interpersonal violence. These objectives could be reached by applying well-known cost-effective measures such as child safety seats in cars or helmets for bicycle and motorcycle users.

The Regional Committee called for action to address this problem in 2005 (14), and the Regional Office started a number of supportive activities, including the development of national action plans, the identification and sharing of good practices, and the development of partnerships with the EU and international organizations.

The Regional Office launched a new programme on violence and injury prevention, with support from GTZ.

In addition, the Regional Office contributed intensively to World Health Day 2004, which was devoted to road traffic accidents. A European report (15) was published to complement the *World report on road traffic injury prevention* (16) and press conferences and awareness-raising workshops were held in several countries. To support Regional Office activities at the country level and ensure transfer of know-how and exchange of information and experiences, a network of focal points was established and met in the Netherlands in autumn 2005.

Partnerships

Collaboration with other international agencies, institutions and selected NGOs intensified during the biennium, particularly in connection with the preparations for and follow-up of the Budapest Conference. Main partners were the EC (DG SANCO, DG ENV and the EEA), CE, OECD, REC, UNECE, UNEP and, among NGOs, the European Public Health Alliance, the European Eco-Forum and the International Confederation of Free Trade Unions.

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6. Health intelligence and publishing for public health

Spent: US\$ 16 372 946

Proportion of total expenditure: 10.2%

Staff: 57

During the biennium, the Regional Office strove to improve the quality, accessibility and usefulness for decision-making of the information and knowledge it produced. The Office continued its coordinated initiatives to provide evidence and analysed health information for decision-makers in Member States, while increasing its dissemination and promotion efforts to reach them.

Countries need more refined health intelligence from an independent and objective organization such as WHO. For practical purposes, health intelligence is defined as information useful for the decision-making process. This implies a digested analysis of data and information seen in context, as opposed to the production of unanalysed raw data. By providing health intelligence and knowledge, the Regional Office also indirectly supports the translation of available knowledge into concrete action.

In recent years, the Regional Office increased its capacity to respond to the need for evidence through the work of the European Observatory on Health Systems and Policies, HEN and other sources throughout the Office. It has also worked to enhance the presentation of existing information and its availability through print and electronic media.

To accomplish these objectives, action was taken in the biennium to improve the collection of data, and to provide not just statistics, but data analyses linked with policy considerations and recommendations for policy-makers to consider.

Health data and information

The Regional Office continued to provide countries with the input they required to maintain and improve their national health information systems.

A comprehensive assessment of national statistical health information systems was carried out in 13 countries, preparing the ground for further improvement. The Regional Office continued to support the implementation of ICD-10 (1), with training provided in eight countries and training on ICF (2) in two countries. According to available information, ICD-10 has been fully or partially implemented in 49 countries in the Region.

National databases on health indicators were established or further developed in 11 countries. They are important tools to support health monitoring and decision-making at the national and subnational levels, as they enable health professionals, administrators and researchers easily to access

routinely collected health data. The Regional Office continued to support the use of the international definition of live birth, and more complete birth and death registration. The aim is to increase the accuracy and international comparability of national statistics on infant mortality and other key health indicators.

One of the key practical tools of the Regional Office is the European Health for All database (3), which is widely used to make international analyses of health status. It includes both reported national statistics and WHO estimates on key health indicators (such as child mortality), thus allowing assessment of possible inaccuracies in reported data. The database continued to be regularly updated and its existing content was further improved.

The European mortality database (4) was also further expanded to include subnational data for selected countries, thus allowing analysis of health inequity and trends at this level. The collection of hospital morbidity data started to cover the current gap in international statistics for specific diseases. The Regional Office published a brochure with data on core health indicators for all 52 countries in the Region in 2005 (5).

The Regional Office collaborates with EUROSTAT and OECD to harmonize the collection of mortality and hospital data, to reduce the burden of reporting on countries.

One of the key contributions in the biennium was the publishing of *The European health report 2005* (6), as requested by the Regional Committee. The report brings together evidence and analyses from the Regional Office, WHO headquarters and various other recognized sources, to introduce readers to a selection of successful initiatives and interventions whose wider use has the potential to improve public health across the Region.

The report was the first to present estimates of the burden of disease from particular conditions and risk factors in each country in the Region. The report has a special focus on children's health, because health in childhood determines health throughout life and action to protect and promote it can have lifelong benefits. The report underlines that, while much of the knowledge required to improve health for everyone in the Region is already available, transforming it into action is the challenge.

To provide a comprehensive analysis of health status in countries, the Regional Office developed profiles for each of the 52 Member States (7). These highlights on health are multi-layered, web-enabled publications that provide overviews of health and the health-related situation in a given country and compare, where possible, its position with those of others in the Region. The highlights, with their user-friendly interface and full-text online resources, both disseminate the analyses made by the Office and offer a portal to databases and publications from various sources.

Evidence for health policy

The Regional Office continued to play a role in providing and strengthening the evidence base to guide policy recommendations on critical areas.



The Office played a major role in the European Observatory on Health Systems and Policies partnership. It supported the delivery of the highly respected HiTs series (8): 17 country profiles were produced, providing a clear picture of changes in health service functions and reforms over time in the European Region.

The Observatory also published studies on key topics (9): health policy and EU enlargement, pharmaceutical regulation, social health insurance in western Europe, purchasing as a tool for improving health systems, human resources and primary care. Further occasional studies were published on the transition countries' experiences, voluntary health insurance, public health decision-making, screening, and the impact of health systems change. Policy briefs (10) were produced, summarizing evidence on mental health care in the community, financing and policy directions, hospital configuration and bed numbers. The Observatory's periodicals (11,12) appeared regularly. Communicating the outcomes of analysis is a crucial component of the Observatory's work, so its web site (13) was further developed to make information more accessible.

The Regional Office's other contributions to the Observatory's work were to support Russian translations of its publications and a series of policy dialogues, which allow senior decision-makers to assemble and discuss evidence and what it means for them in practice.

In the Regional Office's quest to provide policy-makers with brief information about what is known to work in public health, the HEN project, launched in 2003, continued and expanded its work during the biennium. In collaboration with some 30 HEN members, it produced 33 web-based reports in response to specific queries from policy-makers (14). In addition, HEN received about 100 questions by e-mail from policy-makers, health care practitioners, researchers, members and other interested users, and answered them in collaboration with its members. To make the information more useful to Member States, HEN made the full evidence reports available in Russian, as well as English, on the Regional Office web site.

Further, HEN continued to revise and update its selection of documents and databases that policy-makers can search (15). For ease of searching, the information provided is categorized by topic and original source.

One measure of the utility of the HEN reports is requests to translate them. The Office granted licenses for translations into eight languages: Chinese, Finnish, French, Lithuanian, Polish, Portuguese, Spanish and Turkish.

To ensure that technical recommendations and advice to Member States are based on strong evidence, in 2004 the Regional Office adopted, with support from the European Advisory Committee for Health Research, an evidence policy to guide its work. The policy uses a broad definition of evidence, extending beyond the findings of scientific research. The Regional Office's programmes received guidance and tools for searching for and analysing evidence. They also took part in workshops on evidence-based peer review and writing country-focused case studies.

Publishing and communication for public health

Publishing and information supply

During the biennium, the Regional Office continued to plan, produce and disseminate publications within the framework of its strategies and policy for managing health information. It made every effort to ensure the widest possible access by all Member States to Regional Office information and publications. One important objective for 2005 was to strengthen the availability of its information products in the four official languages (English, French, German and Russian), as appropriate.

The Regional Office issued 83 publications; 12 of them were designated as having high priority because they addressed the top-priority areas of work in the biennium (16). Some 30% of all titles were produced in Russian, as well as English, testifying to the Regional Office's continued commitment to increase access to relevant health information by its target audiences in Russian-speaking countries.

As a measure of impact, readers bought over 3000 hard copies of Regional Office books in the biennium, in addition to those distributed free of charge. The Office received 1600 requests for hard copies of its information products, 200 requests to quote from them and requests to include 169 products in specialized databases accessible by subscription. It granted 54 licenses for translation

of Office publications into non-official languages. In addition, readers download hundreds of titles every month from the Office web site.

To increase awareness of public health issues, the Regional Office's experts published 37 articles in both the general and the specialized press during the biennium.

To continue fulfilling its statutory obligations to Member States, the Regional Office produced the required documentation in the four official languages (5785 pages) for sessions of the Regional Committee and the Standing Committee of the Regional Committee. In addition, the Office produced the documentation for its ministerial conferences on the environment and health and mental health (about 2700 pages in the four official languages) and translated and processed about 6000 pages of other material (such as publications, meeting documentation, booklets, press releases and official correspondence) during the biennium.

To reduce production time to the minimum, the Regional Office uses not only in-house resources (including computer-assisted translation software) but also networks of accredited freelance editors, translators, designers and printers.

In addition to producing, promoting and disseminating publications for external audiences, the Regional Office continued to work to ensure better access for all its staff to the internal and external information they need for their work. The Regional Office library services supplied subscriptions to 75 scientific journals and scientific databases, current awareness services and particular documents/articles. Free or nearly free access to other major international biomedical journals and databases is provided to the Regional Office through GIFT, and to institutions and ministries in low-income countries through HINARI, a programme of WHO and major publishers.

In addition, the Regional Office library, in cooperation with Member States, continued to improve health science libraries in the 38 WHO documentation centres, by providing copies of the Regional Office's publications and supporting improvements of the centres' web sites.

The Regional Office improved its web site (17) in several ways during the biennium. These included enhancing its design and functionality, using Google to facilitate searching and extending the categorization of information by health topics. This brought the Office's content presentation into line with several other WHO regional offices and headquarters. Improved tools were introduced to analyse site usage, and make adjustments as needed. Each month, the site had about 150 000 individual visitors, who viewed at least 300 000–400 000 pages.

External communication

One of the Office's key communication objectives is to keep its Member States up to date with the latest public health news and developments in the Region and globally. To achieve this, the Regional Office produced high-profile communication documents for the launches of particularly important publications, such as the world health reports (18), *Young people's health in context* (19), *The European health report 2005* (6) and *Health policy and European Union enlargement* (20). In addition external communication coverage was organized during regional and global WHO events such as

Her Royal Highness Crown Princess Mary of Denmark is welcomed to the Regional Office by Dr Marc Danzon, WHO Regional Director for Europe



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public health theme days (World Health Day, and global campaigns such as World No Tobacco Day and World Tuberculosis Day), and the ministerial conferences on the environment and health and on mental health (21).

Further, activities such as exhibits, press conferences and briefings, interviews and the distribution of press packs were organized in conjunction with important Regional Office meetings, such as the Regional Committee sessions, influenza preparedness meetings and the Second Health Ministers' Forum for the SEE countries in November 2005.

The Regional Office found support from well-known people who are willing to help promote public health messages in the Region. In March 2005, Sylvie Vartan was appointed WHO's Goodwill Ambassador for Maternal and Child Health in the European Region and, in May 2005, Her Royal Highness Crown Princess Mary of Denmark agreed to become Patroness of the Regional Office.

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7. Infrastructure and logistics

Spent: US\$ 17 329 637

Proportion of total expenditure: 10.8%

Staff: 38

The infrastructure and logistics function of the Regional Office covers the management of the Office's premises across the Region, their safety and operational efficiency, the reception of visitors and suppliers, and management information systems.

As in the previous biennium, action in these areas continued to improve the work environment and management capacity on all the Office's premises.

Infrastructure

During the biennium, the Office invested in its infrastructure through a three-pronged strategy: integrating field offices and improving both the work environment and security and emergency response.

Integration of field offices

The field offices were integrated both physically and operationally to maximize economies of scale, eliminate duplication of administrative work and increase efficiency. The guiding principle was: one country, one country office, one workplan, one team. When possible, the field offices were linked with other partners of WHO and the United Nations family in joint offices or initiatives.

Technical teams previously in separate offices thus moved into a single WHO country office, in countries such as Romania and Ukraine, while some staff previously in Copenhagen were relocated closer to other partners, such as the European Observatory on Health Systems and Policies and the office for EURO Representation to the EU, now in Brussels.

Improving the work environment

The WHO country presence developed from a small office on ministry of health premises, to a fully fledged office with the space and modern management tools needed to meet today's efficiency standards. This meant that more country offices were equipped with modern furniture, computers, telecommunications equipment and other necessities.

Successful negotiations with the Government of Denmark led to the Regional Office's obtaining a new building adjacent to its existing premises in Copenhagen.

Security and emergency response

The increase in global terrorism prompted the United Nations Secretary-General to call for a drastic strengthening of security measures in all areas where WHO and its sister agencies operate. Thus, investments had to be made to improve the capacity of all the premises in the Region to avoid or resist attempts to harm staff or damage assets.

In addition to infrastructure investments, the Regional Office also procured special equipment to protect its staff or to facilitate their intervention, if called on, in disaster-struck or other dangerous areas in the Region. These measures were accompanied by security training from experts at WHO headquarters and the pool of specialists involved in the fight against communicable diseases, such as avian influenza.

The Copenhagen office has modern telecommunication equipment, back-up emergency systems, videoconference facilities and large-capacity Internet access. This allows the staff to communicate simultaneously with many different centres around the world, and to participate actively in common responses to crises affecting the Region. The situation rooms at WHO headquarters and the regional offices are often linked.

Management information systems

The second component of the infrastructure and logistics function is information technology and telecommunications.

During the biennium, WHO as a whole redesigned the way it manages its information systems. The Regional Office made a comprehensive review of its old and sometimes obsolete information systems, confirming the need to restructure its administrative databases and reporting systems and its means of sharing information with its staff in Copenhagen and in the field.

The Office made this review in close collaboration with WHO headquarters, which simultaneously initiated a global overhaul of information technology with the design of the new Global Management System. The Regional Office actively participated in the design, to ensure that the System would meet the information and transactional needs of WHO staff and Member States.

To prepare for the implementation of the Global Management System in 2007–2008, and to streamline and optimize existing systems, the Office began to integrate and bridge its administrative databases.

8. Administrative services

Spent: US\$ 7 688 428

Proportion of total expenditure: 4.8%

Staff: 38

The Regional Office's administrative services support the technical programmes in the efficient use of resources, so they can achieve the goals set by the Member States, while complying with the rules and legal obligations of WHO.

Most of the administrative services are still located in the Copenhagen office, but, as field offices grow in number and management capacity, the Office will gradually further delegate authority and administrative operations to them. To facilitate this during the biennium, the Office provided all administrative assistants in the field with intensive, hands-on training and began the recruitment of new administrative officers to work in its largest offices.

This delegation of authority is governed by a framework table of authority that was developed and implemented during the biennium. It will have a major impact on the budget and finance functions in particular. In parallel, the Office reviewed transaction codes, and developed management reports and made them available on the intranet, to allow for a better overview of decentralized functions.

Human resources, staff development and the Ombudsperson

During the biennium, the Regional Office not only managed the contracts of its 700 staff members but also processed over 3000 consultants' and experts' contracts. With WHO headquarters, it also organized staff's participation in global, regional and local training.

The Office designed and implemented an integrated approach to occupational health: for the first time, it linked the input of a physiotherapist, nutritionist, occupational health physician, physical education teacher and other advisers, in a comprehensive approach to the health of its employees in Copenhagen, both when in the office and during travel. This integrated approach is supported by the Staff Health Promotion Committee. Composed of staff from each division, the Committee leads two task forces: one focusing on occupational health (called the Occupational Health Committee) and one focusing on social activities designed to promote physical activity and psychological well-being.

This approach, a first in WHO, was tested in the Regional Office. Discussions are now under way, with the Staff Association and with headquarters, on ways to expand the concept to all the WHO offices in the Region and beyond.

Contractual reform reversed the previous proportion of fixed-term to short-term staff: fixed-term staff grew from 40% to 60% of the total by the end of the biennium. This exercise was carried out in

collaboration with representatives of Regional Office programmes and the Staff Association. This is only the beginning of the process, however. The Office is committed to the new challenge set by the late WHO Director-General: to increase the proportion of fixed-term staff to at least 70%. This can only be done through better human resources planning by all WHO managers, supported by better planning and monitoring tools.

The human resources function consists mostly of identifying, contracting and retaining valuable staff for the Office. Another important function is maintaining sound labour relations, in both dealing with individuals and advising senior management on all human resources issues.

Nevertheless, some staff members may feel misunderstood or simply prefer to share their problems and seek solutions with an independent person. For this purpose, Regional Office staff elect an Ombudsperson, someone they deem to have not only wide knowledge of WHO's rules and regulations but also diplomatic, communication and conciliation skills. The Ombudsperson is therefore a human resources manager provided by the administrative services.

Staff Association

During the biennium, the tradition of constructive dialogue between the administration and the Staff Association of the Regional Office continued. This dialogue unfolds in regular meetings (bi-monthly with the Regional Director and monthly with the Director of Administration and Finance and the Human Resources Manager), as well as in ad-hoc meetings to resolve particular issues.

As the Staff Association's main concern remains the granting of fair and equitable conditions of service, it was involved in the contractual reforms. The Office must now ensure that, with better human resource planning, it can prevent excess numbers of short-term contracts from building up again.

In consultation with individual staff and the Staff Association, the Regional Office began to develop a long-term staff-management policy that focuses on further improving working conditions and preventing problems. Although the administration and the Staff Association do not necessarily agree on everything, experience shows that constructive dialogue is the best way of moving forward.

Budget and finance

Funds are made available to the technical programmes where and when needed. This work extends from the moment funds are given to WHO to the moment they are fully used and, in the case of voluntary donations, accounted for to their donors.

Processing transactions is a large part of the budget and finance function, as the existing financial systems allow for very limited processing in the field. Processing involves reserving funds, transferring them, collecting and paying income, and reporting on funds for the entire Region. With the arrival of the new Global Management System in the next biennium, a significant part of this work will be transferred to the field offices.

The Regional Office also has an overview function, to ensure that funds are used only for the purposes agreed with the donors. Reports to donors and Member States must accurately reflect the status of the assets given to the Office. Internal and external auditors regularly visit the Office to verify the quality of this control.

9. Governance

Spent: US\$ 11 521 298

Proportion of total expenditure: 7.2%

Staff: 36

This chapter relates to the functions of Executive Management, including the Regional Director and the programmes responsible for the governing bodies, and planning, monitoring and implementation.

WHO is a Member State organization with a decentralized structure; in practical terms, governance at the Region level revolves around the dialogue between the secretariat and Member States on issues related to directing and coordinating the health work of the Region, as well as the provision of advice and assistance to individual countries, both on a contractual basis and on request.

Internal governance of the secretariat deals with defining strategic directions, developing policies, overseeing implementation and, finally, evaluating the delivery of the work.

Global governance

The biennium benefited European Member States by allowing them more fully to play their role in the global governance of WHO. The ratification of amendments to Articles 24 and 25 of the WHO Constitution (1) increased the number of European members of the Executive Board from 7 to 8, out of a total of 34 seats worldwide.

For a relatively long period, the rights of some countries of the former USSR to vote in the World Health Assembly were suspended, owing to cumulative arrears of payment. By the end of the biennium, four countries had recovered their voting rights – Ukraine in 2004 and Georgia, the Republic of Moldova and Tajikistan in 2005 – while those of three remained suspended.

The biennium also witnessed a change in the operations of Executive Board subcommittees. The three previous committees were amalgamated into the Programme Budget Administration Committee, which had its first meeting in January 2005. European Executive Board members have two seats on this Committee; at its outset, these seats were filled by representatives from the Czech Republic and France.

In 2005, the chairmanship of the Board was in the hands of Iceland, in the person of Dr David Gunnarsson, and the president of the World Health Assembly was Ms Elena Salgado of Spain.

The Programme Budget 2004–2005 (2) was the second consolidated budget, articulating the totality of WHO's work in defined Organization-wide expected results. The successful delivery of these results depends on input from all levels of the Organization.

Making a single budget the source of all WHO's work has been instrumental in aligning the actions of headquarters and the regions and giving them sharper focus. In particular, this enforces

complementarity of actions in support of globally endorsed agendas and has led to a greater harmonization of implementation. The unified budget also helps to align the issues addressed by regional structures (the WHO Regional Committee for Europe and the Standing Committee of the Regional Committee) with those addressed by global structures (the Executive Board and the World Health Assembly).

Another direct result of this unified process is regular meetings of staff from all parts of the Organization dealing with similar issues. This protects against the duplication of work, allows learning from best practices and fosters fast collective action in times of crisis. Such networks exist as systematic entities at all levels of the organization, including assistant directors-general and directors of programme management, and cover both technical and administrative domains. The Regional Office has made clear its dedication to investing in this mechanism for global coordination and sharing, and hosted a number of global meetings during the biennium.

A practical example of this consolidation of overall WHO action was the immediate deployment of Regional Office staff to other regions both in response to the tsunami in South-east Asia and the earthquake in Pakistan (see p. 13).

Regional governance

Regional governance is exercised through the annual meetings of the Regional Committee, while this governance function between sessions is in the hands of the Standing Committee of the Regional Committee. The frequency, length and methods of the work of these two committees did not change substantially during the biennium.

Regional Committee

The fifty-fourth session in 2004 (3) included four policy and technical subjects:

- the European strategy on noncommunicable diseases;
- the proposed programme budget for 2006–2007;
- a strategy for the Regional Office's geographically dispersed offices; and
- follow-up to the Fourth Ministerial Conference on Environment and Health.

A technical briefing on the International Health Regulations took place in addition to the regular session. To ensure better continuity between sessions of the Regional Committee, a new follow-up session was introduced in 2004; it gives the Regional Committee updates on important discussions and resolutions from previous sessions.

At its fifty-fifth session in 2005, the Regional Committee (4) addressed five substantive technical issues:

The European Strategy for Child and Adolescent Health emphasizes the lifelong benefits of a good start in life



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- the framework for alcohol policy in the WHO European Region;
- the updated Health for All policy framework for the WHO European Region;
- the next phase of the WHO Regional Office's country strategy: strengthening health systems;
- the European Strategy for Child and Adolescent Health and Development (whose discussion included strengthening national immunization systems by eliminating measles and rubella and preventing congenital rubella infection); and
- the burden of and policy response to injuries in the WHO European Region.

In addition, there was a first presentation of WHO's Eleventh General Programme of Work 2006–2015.

As side events, technical briefings were held on the organization of the health system of Romania (organized by the Ministry of Health of Romania) and on obesity, diet and physical activity and strengthening preparedness to respond to a potential influenza pandemic.

Standing Committee of the Regional Committee

A number of governance topics recur at meetings of the Standing Committee (5) and can be seen as common threads in its work. Some of these issues reached conclusions during the biennium; some initiatives have only just started, and some global issues continue.

The Standing Committee first addressed the status of the Regional Office's geographically dispersed offices in depth, with all its practical and political implications, in 2003. It proposed a clear policy for the future. A working group pursued the issue; after much reflection and deliberation, it was successfully concluded by the Regional Committee in 2004 (6).

The Regional Committee's endorsement of the Health for All update in 2005 concluded two years of work in which the Standing Committee had been a very active partner, holding many debates on the best way to proceed. The result is an update that reaffirms the basic principles of the policy, but also takes a fresh viewpoint, is non-prescriptive and is presented as a framework, offering national policy-makers a possible architecture for health policies based on values (7).

The Eleventh General Programme of Work was a recurring item on the Standing Committee's agenda. At its request, a European consultation took place in Copenhagen on 10–11 January 2006 immediately before the Executive Board's meeting. Although the document could not be reviewed in depth, this consultative mechanism responded to the Standing Committee's concerns: namely, that the European members of the Board should take a broad regional view in appraising the document.

The large number of WHO collaborating centres in the European Region and the questions asked about them at Regional Committee sessions prompted the Standing Committee to discuss them at several meetings. The Standing Committee has followed the clean-up process to discontinue centres that no longer had viable relations with WHO, and the efforts to ensure that remaining centres' terms of reference and workplans better fit WHO's priorities and objectives.

The Standing Committee has supported the idea that the next thematic evaluation carried out throughout WHO will deal with collaborating centres, and this has led to the Regional Office secretariat's playing an increasingly strong role in this evaluation. It is hoped that this evaluation might lead to innovative ways to make the best use of the resources in the collaborating centres. In addition, some Member States with many centres desire some quantifiable measure of the support that they give to WHO through this mechanism.

In 2004, the Regional Committee asked the Regional Director to develop a strategic vision of the role and position of the Regional Office in the future (up to 2020). It was suggested that a working group be established and report to the Standing Committee.

A multidisciplinary working group was established in 2005, consisting of four members of the Standing Committee and six experts in sociology, futurology, health economics, epidemiology, politics and journalism. The first meeting, looking at health trends and scenarios for health in Europe in 2020, took place in Copenhagen in September 2005. Its outcome was reported to the Standing Committee in November 2005, as well as a plan for the remaining work to be undertaken. The result of this work will be presented to the Regional Committee in 2006.

Finally, the Standing Committee made an in-depth review of the new proposal for guiding principles for resource allocation to WHO regions, and the accompanying validation mechanism. In general, the Committee supported the original proposal and expressed its satisfaction with the approach taken. While this supportive position was transmitted to the European members of the

Programme Budget Administration Committee, full consensus on the proposal was not reached, so the Executive Board asked for further work to be undertaken.

Governance of the secretariat

Eleven development processes

In mapping out the strategic direction for the Regional Office for his second five-year term, the Regional Director developed a plan for covering 11 cross-cutting themes. They are called the 11 development processes and cover the following topics:

1. strengthening health systems
2. strengthening the information/intelligence function
3. coordinating country activities
4. developing partnerships
5. increasing visibility
6. evaluating and reporting on achievements
7. updating Health for All
8. selecting and highlighting key public health challenges
9. sustaining and developing skills
10. streamlining administrative procedures
11. raising funds.

These 11 processes differ widely in character. They aim at ensuring a collective and convergent effort from the entire secretariat, to improve its services to Member States. These processes have collective ownership and require horizontal action. A member of Executive Management leads each one. In line with the overall focus on results-based management, each process has defined expected outcomes and indicators by which to measure their achievement, as well as a list of the steps to be taken.

An internal document, which has been discussed in Executive Management and divisional retreats and explained at staff meetings, describes the processes, outcomes and indicators. As such, it is an unofficial contract between the Regional Office staff and the Regional Director. Although the document guides the work of the secretariat, several products will be provided for external use and many of the processes shared with the governing bodies, particularly the Standing Committee. Not all processes are at the same stage of development, but some products are already finished, such as a number of tools for better reporting.

A consultative group created in 2000, called WOW, facilitates convergence, efficiency and teamwork. WOW is both a unit and a mechanism used by staff from all divisions, collectively to analyse common problems or focus on issues of common interest. Initiatives often take the shape

of quality circles, where processes are dissected, streamlined and improved to resolve gaps, delays or other problems identified by the group. Alternatively, staff wishing to learn more about topics relevant to their work create informal groups (communities of practice) that meet occasionally to share experience, ideas, new techniques or general information.

Management tools

It was long clear that the Regional Office lacked some tools for good internal management and for ensuring transparency and consistency in reporting. Such tools were needed to give strategic direction to the Office's work, follow its internal processes and provide condensed information useful to external partners and Member States.

The problem was not so much a lack of information but the consolidation of information from different domains: technical areas, budget and finance, and human resources. In addition, differences in the level of detail and formats in which Office-wide information was produced gave rise to complications and confusion, both internally and in communication with external partners.

One of the most useful tools, developed towards the end of 2005, is called the Regional Office's roadmap, part of which is reproduced in Annex 1. It allows the Office to take the intentions expressed in the Programme Budget and convert them into one single Office-wide workplan for the biennium. The plan describes the total financial and human-resource needs of the Office, along with its programmatic commitments, for the period. The financial needs cover all sources of funds and all actions of the Regional Office, including its country operations. This tool will be used to monitor budget implementation.

Monitoring of the Tenth General Programme of Work

The biennium marked the end of the period covered by the General Programme of Work (2002–2005) (8). It mapped out four strategic directions that provided the broad framework for the whole of WHO's technical work. It also articulated six core functions that should focus the activities of the WHO secretariat. In line with this, the Regional Office mapped and monitored its technical work against these six core functions during the two biennia covered by the Programme. While some activities covered two core functions and others were not readily classifiable, this internal monitoring allowed the Office to align the overall delivery of its technical work with the six core functions (Table 1).

Table 1. Percentage of Regional Office technical work supporting the six core functions of WHO listed in the tenth General Programme of Work

Functions	Technical work (%)
1. Articulating consistent ethical and evidence-based policy and advocacy positions	15
2. Managing information by assessing trends and comparing performance; setting the agenda for, and stimulating, research and development	19
3. Catalyzing change through technical and policy support , in ways that stimulate cooperation and action and help to build sustainable national and intercountry capacity	43
4. Negotiating and sustaining national and global partnerships	6
5. Setting, validating, monitoring and pursuing the proper implementation of norms and standards	8
6. Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management, and service delivery	9

Source: *General Programme of Work, 2002–2005 (8)*.

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Annex 1

Programme management and implementation

The data on spending and human resources in the table were used for the different chapters of the report.

Function	Spending		Human resources (full-time equivalents ^a)			
	US\$	%	Copenhagen/ Centres		Countries	
			P ^b	GS ^c	P	GS
Operations in countries	12 951 433	8.1	3.3	3.9	47.1	65.2
Health systems	23 329 000	14.6	22.1	16.1	12.4	13.9
Communicable diseases	32 843 283	20.5	27.7	19.7	27.3	20.1
Noncommunicable diseases, lifestyles and health determinants, family and community health	19 021 388	11.9	27.4	21.5	4.1	0.4
Health and environment	18 836 524	11.8	25.5	24.1	1.0	0.0
Health intelligence and publishing for public health	16 372 946	10.2	31.1	25.9	0.0	0.0
Infrastructure and logistics	17 329 637	10.8	8.0	29.1	0.4	0.0
Administrative services	7 688 428	4.8	6.1	32.3	0.0	0.0
Governance	11 521 298	7.2	14.5	21.4	0.0	0.0
Total	159 893 937	100.0	165.5	194.0	92.2	99.5

^a Calculated in total person-months.

^b Professional staff.

^c General service staff.

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This report describes the work done by the WHO Regional Office for Europe in 2004–2005 with about 550 core staff and a budget of US\$ 159 893 937. It is built around nine functions:

1. operations in countries;
2. health systems;
3. communicable diseases;
4. noncommunicable diseases, lifestyles and health determinants, and family and community health;
5. health and environment;
6. health intelligence and publishing for public health;
7. infrastructure and logistics;
8. administrative services; and
9. governance.

The aim is to show more transparently how the Regional Office used its human and financial resources in its efforts to provide services matched to countries' needs.

The WHO Regional Office for Europe

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

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
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