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FIRST TECHNICAL WORKSHOP OF SOUTH-EAST EUROPE NUTRITION PROJECT

Report on a WHO workshop

Belgrade, Yugoslavia
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SCHERFIGSVEJ 8
DK-2100 COPENHAGEN Ø
DENMARK

TEL.: +45 39 17 17 17

TELEFAX: +45 39 17 18 18

TELEX: 12000

E-MAIL: POSTMASTER@WHO.DK

WEB SITE: [HTTP://WWW.EURO.WHO.INT](http://WWW.EURO.WHO.INT)

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ABSTRACT

The South-East Europe Health Network was established in Sofia in April 2001 as part of the Stability Pact for South Eastern Europe Social Cohesion Initiative.

At the Fourth Meeting of the SEE Health Network, May 2002, support was given to the implementation of the project "Strengthening Food Safety and Nutrition Services in SEE" within the framework of the Stability Pact Initiative. Subsequently, at the Third Workshop on the Development of Food and Nutrition Action Plans in Countries of South-East Europe, September 2002, the issues of nutrition and cardiovascular diseases in the SEE region were recognized to be common and of highest importance for all SEE countries. A project proposal was drafted entitled "Developing and Strengthening Food and Nutrition Strategies to Prevent Cardiovascular Diseases in South-East Europe". The First Technical Workshop of the SEE Nutrition Project will finalize this proposal, agree responsibilities, discuss and agree future steps.

Keywords

NUTRITION – standards
NUTRITION POLICY
FOOD CONTAMINATION – prevention and control
FOOD HYGIENE
STRATEGIC PLANNING
NATIONAL HEALTH PROGRAMS
CARDIOVASCULAR DISEASES – prevention and control
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The enthusiastic participation of all the professionals from Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary, the Republic of Moldova, Poland, Romania, The former Yugoslav Republic of Macedonia and Yugoslavia who attended the consultation is greatly appreciated.

Finally, sincere thanks are due to Dr Zrinka Petrovic, Human Nutrition Department, Croatian National Institute of Public Health, for agreeing to act as Rapporteur and for the compilation of this workshop report.

1. Foreword

This report summarizes the proceedings of the First Technical Workshop of the South East European Health Network Nutrition Project held on 12 November 2002 at Hotel Yugoslavia, Belgrade, Yugoslavia. The Nutrition and Food Security Programme at the WHO Regional Office for Europe organized the consultation. Arrangements at the course site were coordinated by Dr Djordje Stojiljkovic, Director, Federal Institute of Public Health, Belgrade.

Scope and Purpose

At the Fourth Meeting of the SEE Health Network – Health Development Action for South Eastern Europe, held on 26–28 May 2002 in Hillerød, Denmark, the representatives of the seven South-East European countries, the Council of Europe and the WHO Regional Office for Europe recognized with satisfaction the financial pledge of Greece and Italy to support the implementation of the project “Strengthening Food Safety and Nutrition Services in SEE” in the framework of the Stability Pact Initiative for Social Cohesion. A principle decision was made to proceed with the implementation of its Component One subject to further destabilization and final approval by the Network at its next Fifth Meeting.

Component One of the Project consists of the update and modernization of the Food Legislation at subregional level (in line with the EU *acquis* and the Codex Alimentarius Commission) within the framework of the development of the National Food and Nutrition Action Plans.

Activities planned within the implementation of Food Legislation component include:

1. A Subregional workshop in food and nutrition legislation:
 - Modernization of a National Food Legislation;
 - Introduction of the EU legislative framework;
 - Codex Alimentarius Commission standards, recommendations and guidelines;
 - Update on the status of development of Food and Nutrition Policy and Action Plans.
2. National follow up:
 - Establishment of an inter-ministerial commission on Food and Nutrition for review and implementation (IMC) and nomination of a national coordinator;
 - Provision of advisory consultancies at national level;
 - Revisions of the implementation (national and subregional level);
 - Final draft of Food and Nutrition Action Plans in English;
 - Final draft of Food Laws.

At the Third Workshop on the Development of Food and Nutrition Action Plans in Countries of South-East Europe held in Croatia, September 2002, the issues of nutrition and cardiovascular diseases in the SEE region were recognized to be common and of highest importance for all SEE countries. To tackle the existing and growing problems they agreed on a draft project proposal entitled “Developing and Strengthening Food and Nutrition Strategies to Prevent Cardiovascular Diseases in South-East Europe”. The countries of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, The former Yugoslav Republic of Macedonia and Yugoslavia subsequently agreed to proceed with this as an application for funding. They requested the Council of Europe,

the Stability Pact Secretariat and WHO Regional Office for Europe to submit the draft regional project to the EU through the CARDS (Community Assistance for Reconstruction, Democratisation and Stabilization) Programme for potential funding.

The expected results and deliverables of this project will include:

1. Development of a national comprehensive and integrated Food and Nutrition Policy in each of the seven countries.
2. A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases in each country.
3. A report comparing the dietary risk factors in each country with those in the EU countries.
4. Ten trained trainers in primary health care in each country who can improve the practice of primary prevention of cardiovascular diseases.
5. Adaptation and translation of the national materials needed to improve the practice of primary prevention of cardiovascular diseases.
6. Ten trained trainers to strengthen the capacity of maternal and child care in each country to promote health and prevent death from cardiovascular diseases.
7. Adaptation and translation of the national materials needed to promote health and prevent death from cardiovascular diseases.
8. Development of a media campaign in each country.
9. Development of health education materials
10. The establishment of one NGO in each country.

The First Technical Workshop of SEE Nutrition and Food Safety Project will finalize this proposal, agree responsibilities, discuss and agree future steps.

2. Opening

Dr Djordje Stojiljkovic, Director of the Federal Institute of Public Health, Yugoslavia

Dr Stojiljkovic welcomed the participants on behalf of Yugoslavia and officially opened the First Technical Workshop of SEE Nutrition and Food Safety Project in Belgrade.

Dr Luigi Migliorini, WHO Office, Yugoslavia

Dr Migliorini welcomed the participants on behalf of the WHO Office, Belgrade and he assured participants of his continued support to Yugoslavia in all areas related to food and nutrition.

Dr Aileen Robertson, Regional Adviser for Nutrition, WHO Regional Office for Europe, Copenhagen

Dr Robertson expressed her pleasure for having this opportunity to meet all the participants and welcomed them on behalf of Dr Marc Danzon. She highlighted the importance of disease prevention through adequate nutrition. Dr Robertson expressed her hope for a good and constructive workshop. She reminded participants that the first day of the WHO meeting will be given to discussions about nutrition and that the second day will be devoted to discussions about food safety.

Professor Gordana Ristić, Institute of Hygiene and Medical Ecology, Department of Food and Nutrition, Yugoslavia

Professor Ristić welcomed the participants and all the countries they represent on behalf of the Institute of Hygiene and Medical Ecology.

3. Priorities for implementing National Food and Nutrition Action Plan – the Stability Pact Initiative

Dr Maria Haralanova, Project Manager, Strategic Country Support Programme, Division of Country Support, WHO Regional Office for Europe

Dr Haralanova welcomed the participants and reminded them that this is the year for project implementation. She mentioned that the purpose of this meeting is twofold. The first focus being the initial project on food safety that has to be finalized and the decisions have to be signed by the National Health Political Coordinators so that the implementation of the project begins. The second focus is on the nutrition policies and new project proposal that was initially discussed in Brijuni meeting (Croatia) in September this year. This new project proposal needs to be further discussed and developed.

Dr Haralanova went on to present the concept and historical background of the Stability Pact Initiative to participants

4. WHO Initiative for South-East Europe

4.1 Historical background: the Stability Pact Process for South-East Europe

After the end of the Kosovo war, on 10 June 1999, at the European Union's (EU) initiative, the Stability Pact (SP) for South-East Europe (SEE) was established in Cologne. The Stability Pact is a new conflict prevention instrument. It is a political commitment and a framework agreement on international cooperation among more than 60 partners for stability and growth in the SEE Region.

It involves eleven countries of the region and their neighbours (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, The former Yugoslav Republic of Macedonia, the Republic of Moldova, Hungary, Romania, Slovenia, Turkey and Yugoslavia). The countries of the Region are equal and full partners in the process.

The Stability Pact objective is to secure a regional dimension to the development by addressing the political and economical deficits within the context of peace, democracy, economic growth and prosperity and internal and external security. Actions have started in parallel in three key sectors:

1. The creation of a secure political environment.
2. The promotion of sustainable democratic systems.
3. The promotion of economic and social wellbeing.

The European Union, which has assumed the leading role in the Stability Pact, undertakes to draw SEE “closer to the perspective of full integration into its structures”, including eventual full membership. The Stabilization and Association was launched at the Zagreb Summit in November 2000. This provides for a medium to long-term time perspective of cooperation.

As stated above, the Stability Pact is a political declaration of commitment. It is not a new international organization. There are three Working Tables, which operate under the Regional Table and cover different agenda issues within the three broad areas:

Working Table I: Democratisation and Human Rights
 Working Table II: Economic Reconstruction, Cooperation and Development
 Working Table III: Security Issues (with two Sub-Tables: Security and Defence and Justice and Home Affairs)

Until May 2001 health and other social issues were not included in the Stability Pact agenda. Only after the very intensive and proactive collaborative of several interested organizations, the main ones being the Council of Europe (CoE), the Council of Europe Development Bank, the International Labour Organization (ILO) and WHO. Supported by the SEE countries, health was recently included as one of the five subject areas of the Social Cohesion Initiative of Stability Pact Working Table II on Economic Reconstruction, Cooperation and Development.

The most important feature of the work of the Stability Pact is its regional dimension and approach. The objective is to stimulate multilateral agreements and cooperation. Another special feature is that at the Regional and Working Tables, representatives of the SEE countries are, for the first time, on an equal footing with those of international organizations and financial institutions. Primarily, intercountry investment projects are selected for financial support.

4.2 Initiation of WHO action

In the light of the developments in South-Eastern Europe during the past couple of years and particularly after the end of the Kosovo war (1995–1999), the Regional Director of WHO Regional Office for Europe launched the “Stability Pact Initiative” through a three months project entitled “WHO Partnership and the Stability Pact in the Countries of South-East Europe”.

The objectives were:

1. To provide a framework for including health on the agenda of the Stability Pact process, exploring the potential for mobilizing available resources for it, and for making the Regional Office an important partner.
2. To make strategic recommendations on the role of the European office; proposing a strategy and an action plan for the Regional Office’s action for and with South-East European Member States, including within the Stability Pact process.

4.3 Rationale for WHO Involvement and Activity

Rationale with regard to the Stability Pact process for South-East Europe

The whole WHO initiative and action should be considered in the context of the Stability Pact’s process for the South-East European Region and that the SEE countries will be moving closer to the European Union with the perspective of full integration into EU structures:

- Importance of Health: Health is recognized as a basic human right. Being both a social product as well as a vital contributor to social and economic progress, it plays an important

role to the overall peace and development process. Therefore, health is instrumental to the Stability Pact development agenda. Strong health institutions, infrastructure and standards are important elements of assimilation and integration into the EU structures. Additionally, it is widely recognized that health cooperation is a politically neutral issue, which can contribute to the establishment of transboundary agreements and cooperative networks, and thus can play a leading role in generating stability in the SEE Region.

- Health as Catalyst for Regional Cooperation: The Stability Pact for South Eastern Europe seeks to foster lasting peace, prosperity and stability throughout the region affected by many recent conflicts. Regional cooperation is one of the fundamental instruments to achieve the objective of the Stability Pact. Health cooperation can play a very useful role in fostering wider regional cooperation and is now recognized as one of the key regional activities that can contribute to the overall aims of the Stability Pact. Experience has shown that it has been possible to reinforce regional health cooperation in spite of wider political difficulties. This, in return, has helped to foster wider political dialogue. Thus in South-East Europe, regional cooperation in the field of health can foster greater regional cooperation in other areas and thereby can contribute to the reconstruction of the institutions, governments and viable civil society in the region.
- Geographic Focus: The main geographic focus of the action plan will be Albania (ALB), Bosnia and Herzegovina (BIH), Bulgaria (BUL), Croatia (CRO), The former Yugoslav Republic of Macedonia (TFY), Romania (ROM) and Yugoslavia (FRY). Other EU countries and candidate countries (Hungary and Slovenia) in the region will play a role in the implementation of the action plan by sharing their expertise, technologies and experiences in regional cooperation and in the EU association process.
- Health: quick results and long-term benefits: As the WHO experience in SEE demonstrates, *short- and mid-term cooperation and projects*, which focus on the development of health institutions and infrastructure, are *readily accepted by governments and communities* and can be quickly evidenced as having a tangible, beneficial impact on the quality of life of individuals. WHO, and the many other agencies and funding institutions that are currently operating in the SEE region, are well-placed and equipped to continue supporting and working with SEE governments to implement health actions and projects.

In addition, the integration of health into the very beginning of the development process will ensure that all activities will serve to foster the *long-term sustainable development* of the region. Any reconstruction process of the Balkan region must focus on long-term effects if the goal is to develop stable, democratic and pluralistic societies, which are economically viable and which are able to solve their own problems themselves in the long run.

Rationale with regard to developments at the Regional Office

The following developments at the Regional Office are of greatest relevance to the decision to undertake the described WHO initial project and multicountry public health initiative:

First, in February 1998, representatives from Albania, Bosnia and Herzegovina, Bulgaria, Greece, Romania and Turkey came together in a WHO supported workshop to share experiences and explore ways in which these countries might work together on health policy development issues. This resulted in the WHO publication "Neighbours in the Balkans: Initiating dialogue for Health", the WHO Regional Office for Europe, National School of Public Health, Athens, Greece (11). A year later another formal WHO consultation showed initial indications on their expectations related to the inclusion of health on the Stability Pact actions (Report of WHO

meeting of Senior Government Officials of Countries of South-East Europe on Implementing the Priority Environmental Health Actions in Partnership, Skopje, The former Yugoslav Republic of Macedonia, 13–15 December 1999) (59). Recently, some of the Member States in the South-East European Region have both, informally and formally, expressed that they would welcome WHO support in health activities relevant to the Stability Pact process and their future EU association.

Second, the external evaluation of the WHO EUROHEALTH programme in 1999 underpinned the priority areas for country work in 2000–2005, emphasizing that, amongst other priorities, WHO needs to strengthen its partnership with other international organizations that are operating and are influential in the European Member States.

A third development at the Regional Office is the adoption of a new strategy “Matching services to new needs” by the 51 Member States of WHO’s European Region at the 50th Regional Committee in September 2000 (7). The strategy gives new directions for the future country work of the WHO Regional Office for Europe with its Member States in the Region that is to be implemented over the next years. The document focuses on the mechanism of strengthening international partnerships for health as an essential strategic principle of WHO’s work with the countries. In addition to “the accession to membership of the European Union”, the WHO Country Strategy foresees the grouping of certain countries within the Stability Pact as a possible example of mechanism to strengthen partnerships for health.

4.4 Implications of the Stability Pact process on health in SEE countries

In 1989 radical political changes took place in the countries of central and eastern Europe and the former Soviet Union. The most dramatic was the situation in South-East Europe (SEE) with the disruption of former Yugoslavia, subsequent war conflicts, thousands of people being killed and millions displaced, and total economical collapse of the countries. This led to deterioration of the health in the countries with re-emerging diseases and dissolved public health systems in the region.

After the end of the Kosovo war, the Stability Pact (SP) was established as a new conflict prevention instrument (Cologne, 1999) for the region. Its objective is to secure a regional dimension to the region development in the context of peace, democracy, economic growth, prosperity and external and internal security.

Health could play an important role as a catalyst to the overall peace and development process. Therefore, health needs to be better positioned within the SP development agenda. For WHO and the SEE countries the SP process is a unique opportunity to boost public health and health development in SEE.

On the other hand, should health be excluded from the Stability Pact initiatives and projects, should reform of the health care and public health services be delayed and should access of all citizens from the region, including the most vulnerable and marginalized groups of population, to high quality health services not be provided, the process of stabilization could be undesirably fragile and unstable. It is, therefore, in the interest of all, governments, health sector and professionals, citizens and the international society, that health strategies, objectives and actions are set up and implemented at both national and regional (intercountry) levels from the very beginning of the reconstruction, stabilization and development process.

The South-East European countries are a diverse group of countries. Although each country has its specific challenges, there are also common trends implying that countries might benefit from

common health status and health system observation and in sharing this information in the context of the Stability Pact and the association in the European Union.

The health data and recent international comparative analysis of health in the region, performed jointly between WHO Regional Office for Europe, the National Public Health School of Greece, and the SEE countries (11), show that the health gap between the SEE countries and Western Europe is continuing to widen. The further ageing of the people of SEE is accompanied by low birth rates and higher morbidity and mortality. The lower health rates are due to cardiovascular diseases, external causes, cancer and diabetes, which are related to unhealthy lifestyles and deficiencies in disease prevention. Many of the early deaths are avoidable, and some risk factors could be modified through medical management and/or changes in individual behaviour and or tackling the environmental factors. Some of the common issues are:

- Combating infectious diseases, particularly tuberculosis, STDs and AIDS;
- Improving child, maternal, and reproductive health;
- Reducing the burden of mental health problems;
- Development of well-functioning, effective and affordable primary and secondary health care systems;
- Improving the quality of services provided;
- Reducing the burden of lifestyle diseases by reducing tobacco and alcohol consumption, improving nutrition, introducing health promotion; and
- Improving the environmental health infrastructure and enforcement, including food safety, etc.

The countries are designing comprehensive health promotion and disease prevention programmes and action plans (Health strategies, Food and Nutrition Action Plans, National Environmental Health Action Plans, etc.) using the multisectoral integrative approach advocated by WHO and also building up on the provisions of the EU Amsterdam Treaty for streamlining health into all other sectors policies, strategies and developmental plans. The countries are, however, far from implementation and are requiring international collaboration and support.

The work of the Regional Office health information units has shown that international comparisons are a very useful and powerful way of helping countries to pinpoint areas for public health action. Comparative information is an essential prerequisite to aid policy and decision-making at all levels. Cooperation among the SEE countries through health information sharing and comparison, networking, stronger health-promoting actions (e.g. CINDI project, Healthy Cities, Health Promoting Schools, etc.) through collaborative efforts to fight the re-emerging communicable and sexually transmitted diseases, through continuing international research in the region, etc. could substantially contribute to improvements in health in addition to the efforts of national and local health authorities and systems.

Since the beginning of the 1990s the health sectors in all the South-East European countries faced the challenge of introducing radical and major reforms in the existing health systems. The main focus is on reforming the health care services, introducing new health insurance systems, introducing the family doctors/general practitioners as the backbone of the future primary health care, updating the health legislation, retraining medical professionals, etc. As in other countries, the challenge is how to bridge up the gap that persists between the priorities of health care reforms on the one hand and the broader issues of public health on the other.

There is, therefore, an urgent need for international solidarity to be expressed in operational terms to protect public health in the area and further more to restore healthy living conditions.

4.5 Health Objectives and Strategies of the Stability Pact Social Cohesion Initiative

Support to and technical collaboration for health development and empowerment of national and local authorities to take over the self-sustained future of their countries health sectors could be the main objective of WHO work. The regional perspective and dimension in collaboration should be stimulated, so that the concerted health actions would contribute to the SP process, to good neighbourliness and peace to the region.

The objective would be that in the next five years the health sectors in each of the SEE countries would be fully operational on their own, in the framework of EU future integration, and based on their own economic capacities. This is could be the goal for WHO's technical cooperation in the region. In this respect, better results could be achieved when working in cooperation with all other partners of the Stability Pact. WHO, as a partner of the SP process, will bring in the knowledge, expertise, experiences and resources, which are already in place.

Moving from almost entirely national support to a mix of well-coordinated and complementary national support and of an international (intercountry) programme and action will make a difference. That will bring an added value. The strategy to launch intercountry activities would also fully comply with the SP concept and intervention approaches.

Based on the initial studies and investigations, a regional health action plan for support was designed on Health Policy/Strategy development and implementation with two main strategic pylons related to the reforms of the health systems.

- **Reform of health care services:** This could be the most important stability factor that will result in implementing the main principles and values of health care such as access and equity, as well as in stabilizing the national budgets, etc. This reform is basically a national action. There will be an added value if WHO would support countries to establish a forum of the ministers of health to exchange experiences, etc. The SP might also provide means for the forum.
- **Reform of the public health services:** This could be the second strategic area. That is an extremely important element for building up the civil societies. These services are the backbones of the countries' enforcement systems. They are the key elements to introduce modern law and order, to involve citizens, etc. It is also related to the most sensitive question/issue of the border barriers to free movement of people and goods which under the SP should be resolved as Priority No. 1. Therefore, the international rules and recommendations, particularly those of the EU and WTO, should be incorporated in the practice of these inspections. Establishment of close collaboration between the services of the SP, as well as with the neighbouring and all EU countries should be stimulated. Modern public health concept and methodologies need to be introduced as an everyday practice.

4.6 The WHO Regional Office for Europe's approaches in support to SEE in partnership with the Council of Europe

In the light of the progress, accomplishments and future strategy of the Stability Pact process, and following the agreement reached between Dr Marc Danzon (WHO Regional Director for

Europe) and Mrs Gabriella Bataini (CoE-DG III) during their recent meeting in January 2001. Extensive discussions were held between WHO and Council of Europe (CoE) representatives with the objective to work out a concrete proposal of a joint action plan for SEE.

The collaboration between WHO and CoE followed three parallel lines of activities:

- The WHO Regional Office for Europe's support to SEE Member States within its regular activities (country collaboration strategy, MTP 2002–2003 and onwards and humanitarian assistance) as well as through the establishment of Forum of Ministers of Health and convening their first meeting on 31 August–1 September 2001 in Dubrovnik, Croatia at the kind proposal of the Minister of Health to host it.
- The Stability Pact Social Cohesion Initiative process, objectives and dynamics of work where the two organizations will come up with mutually supportive and/or joint ideas, statements, proposals, visions, actions, etc.
- The Council of Europe Strategic Health Review and establishment of South-East European Health Network.

4.7 WHO's role in the Stability Pact Initiative for Social Cohesion

As stated above, WHO became the leading partner for the health agenda of the Stability Pact Working Table II Initiative for Social Cohesion. Its roles are:

- | |
|---|
| <ul style="list-style-type: none">• A <u>leader</u> of a regional action plan for health development in SEE• An <u>adviser</u> to the SP Working Table II on health and in selecting the appropriate projects that will lead to the quickest and best end results• A <u>promoter</u> for investment projects through our counterparts in the region |
|---|

4.8 Joint CoE/WHO actions for SEE

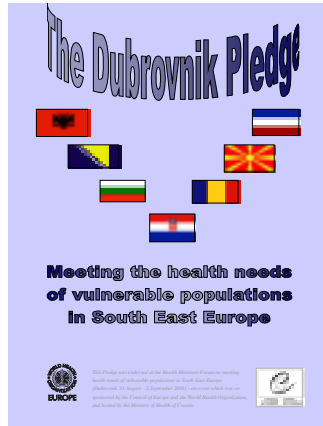
To effectively use the human and financial potentials, to increase the impact of work in the SEE countries, to improve the visibility of health and the health sectors in the SEE Region and, finally, to better fit into the Stability Pact tight dynamics of work, the Regional Office and the Council of Europe jointly established an ad hoc South-East European Network at the highest policy-maker level with six roles, functions and activities in 2001:

- to steer the strategic health thematic review;
- to steer the finalization of the SP/SCI action plan and preparation of health project proposals;
- to define the indicators for selection of health project proposals;
- to steer the preparatory process for a Health Ministers' Forum;
- to promote the health actions of the SP/SCI at the national level and to advocate for political support to the SCAP, including the health actions with the country National SP Coordinators, ministries of foreign affairs and ministries of finance;
- to steer and monitor the SP/SCAP implementation process.

5. Progress and Achievements

5.1 Progress in 2001

5.1.1 The Health Ministers' Forum for South-East Europe (SEE)



The Health Ministers' Forum for South-East Europe organized by WHO and the Council of Europe, and hosted by the Ministry of Health of Croatia, met in Dubrovnik from 31 August to 2 September 2001 to discuss improving the health of SEE populations. The *Dubrovnik Pledge*, signed by all seven Ministers of Health, now provides political commitment to work in partnership on specific strategies to meet the urgent needs of vulnerable groups in the subregion. Four of seven projects (capacity building, communicable diseases, food safety and nutrition and mental health) are now funded by the international community. At the request of the SEE countries and the international community, WHO has accepted to take the lead coordinating role over the next two years for these health development actions in SEE within the CE Stability Pact framework.

Following the ministerial endorsement of the forum document "The Dubrovnik Pledge", the Council of Europe and the WHO Regional Office for Europe jointly commenced preparation for the next two-year action in supporting the SEE countries to implement their own commitments. The work has been carried out in parallel with, as well as in the framework of, the Social Cohesion Initiative of the Stability Pact Working Table II for Reconstruction and Economic Development in South-East Europe (SEE).

5.1.2 Political outcomes in 2001

In 2001, the intensive implementation of activities by SEE Member States through the SEE Health Network (established in the frameworks of the Council of Europe's and the Regional Office's strategies and programmes of work and the Social Cohesion Initiative of the Stability Pact Process for South-East Europe), resulted in:

1. *Health*, being an important determinant of social and economic progress and as such, is positioned on the *Stability Pact's (SP) agenda for development*, through the SP's Social Cohesion Initiative of Working Table II for Reconstruction and Economic Development in SEE. The Social Cohesion Initiative Action Plan clearly presents both, the health standing within the SP framework as well as its objectives, strategies, implementation mechanisms and concrete areas for immediate and long-term interventions/actions/projects.
2. The Regional Office and the Council of Europe being recognized as a *partner, adviser and leader for health SP/SCI process* and being actively involved in all SP/SCI working group meetings.
3. The Regional Office *strengthening its partnership* with the Council of Europe and its Development Bank and establishing a series of joint actions to support health development in the SEE region.
4. The Regional Office and the Council of Europe *jointly supporting* the SEE countries to unite their efforts to develop health in their region and, to this end, establish *an ad hoc SEE Health Network* to analyze current access to health by vulnerable populations in the SEE countries and to define and agree on common health priorities for regional action.

5. The Regional Office and the CoE *facilitating collaboration amongst the SEE countries* through a number of meetings: Sofia, April 2001; Bucharest, June 2001; and the Health Ministers Forum held in Dubrovnik, September 2001. This process culminated in *signing the Dubrovnik Pledge – the first political commitment document for regional health development action*, owned by the Ministers of Health of the SEE Member States.
6. *Seven regional project proposals* being designed and finalized on seven high priority topics for the region as identified and endorsed by the SEE Ministers of Health.
7. To date, three out of the seven projects are confirmed to receive technical and initial financial support from donor countries as follows: (a) Project on *surveillance of communicable diseases* (approximately US \$250 000 from France; to be executed by CD/EURO); (b) Project on *mental health* (US \$500 000 from Greece; negotiations are in place with Italy (€100 000; Sweden and Germany for their involvement and funding); and (c) Project on *food safety and security* (US \$150 000 pledged by Greece; Italy: €100 000).
8. The Council of Europe and WHO Regional Office for Europe pledged their technical and financial support to a continued initiative in health in 2002–2003.

5.1.3 Lessons learned

- Understanding the cultural dimension of our partners abolishes many hurdles;
- Give ownership of work back to the country while providing it with unbiased expertise and motivation to build self-confidence;
- Work in broader strategic lines as entry points for introducing health, i.e. “peace and health”; “poverty and health”; “economic development and health”;
- Focus on policy and politics and look for the spin-off effects of implementation from other sources better than us;
- Partnerships should have well-defined interests, values, policies and capacities;
- Working as a team proved to be possible; building up on the capacities, skills and mutual genuine interest and contribution of all WHO is the key to any success.

5.2 Plan for 2002–2003

In view of the above developments, there are unique opportunities to continue to boost public health and health developments in SEE. The Council of Europe’s strategies and policies on social cohesion, health and vulnerability, the Regional Office’s country strategy, the EU’s new public health strategy, and the EU *Acquis*, provide important reference points in this respect.

The Council of Europe and WHO continued their support to South Eastern European countries in 2002–2003 with a two-pronged aim:

1. To provide a framework within which health related initiatives jointly implemented by SEE Member States can develop. Through an overall role of coordination, guidance and technical assistance, this includes support to implementing SEE commitments under the *Dubrovnik Pledge namely*; the agreed and funded projects on communicable diseases surveillance, mental health, and food safety and security; fund-raising efforts with external partners and donors for SEE regional health efforts will be also necessary; and
2. Continuous support to sustain health on the agenda of the Stability Pact, including exploring the potential for mobilizing partners for the health component of the Stability

Pact agenda, and for sustaining the CoE and the Regional Office's roles of an important leaders, advisers, promoters and partners in the SP/SCI process.

5.3 Progress in 2002

In 2002 the Stability Pact Social Cohesion Initiative, and along with it both the joint CoE/WHO multicountry Public Health Initiative for SEE and the regional projects with initial funding entered the implementation phase. All efforts, actions and progress were focused around the following groups of activities:

5.3.1 Establishing coordination mechanisms

A number of coordinating mechanisms, such as setting up a WHO Task Force and a joint CoE/WHO coordinating group, continue their work since 2001.

However, the most important one is the SEE Health Network, whose existence was extended in 2002–2003 and which continued its work by acting as the Steering Committee for implementing the Dubrovnik Pledge. The SEE Health Network is composed of senior governmental officials nominated by SEE Ministers of Health. In September and October two other countries, namely the Republic of Moldova and Slovenia, joined the network, the latter one in the capacity of a donor country offering its technical expertise and experience as well as co-financing of some activities.

5.3.2 SEE Health Network (Steering Committee) meetings

To secure regular monitoring of progress, sustaining of commitments, successful delivery at both regional and country levels and planning immediate, medium and long term developments, the SEE Health Network will convene two meetings yearly.

The SEE Health Network held its Fourth Meeting in Hillerød, Denmark on 26–28 May 2002 (meeting report available as a separate working document with the SEE Health Network Secretariat at request). The adoption and signing of two Decisions on Implementing Components One of the projects on Community Mental Health and Communicable Diseases Surveillance respectively were its most essential and important outcomes.

In addition to the above, the SEE countries representatives agreed on the mandate and functions of the Health Network, as well as on a set of basic principles to be applied during the whole implementation process.

5.3.3 Projects implementation

As presented above, three of the seven projects were confirmed to receive technical and initial financial support from donor countries as follows:

3. Project on *surveillance of communicable diseases* (approximately €270 000 from France; to be executed by CDS Program of the Regional Office);
4. Project on *community mental health* (€500 000 from Greece; €105 000 from Italy; US \$112 000 as WHO contribution to the projects through the specific allocations for activities in the country Biannual Collaborative Agreements (BCAs); negotiations are ongoing with Sweden and Germany for their involvement and funding);
5. Project on *food safety and security* (€150 000 pledged by Greece; €105 000 from Italy and the Regional Office contribution of US \$68 000).

Following an inception period of approximately six months duration to fully progress the projects first components and prepare them for successful implementation within the frame of the available resources, the implementation process was launched as of June 2002. A detailed presentation of progress in implementing the above three projects is presented in Annex 3.

5.3.4 Exercising WHO's and CoE's lead, advisory and advocacy role

Both, the CoE and the Regional Office representatives participated in the Stability Pact/Social Cohesion Initiative Working Group meetings, the first one for year 2002 held in Paris in January, and the second one to be conducted in Thessalonika on 14–15 December 2002.

5.3.5 Advocacy

The participants in the Fourth Meeting of the SEE Health Network agreed that strong public relations and advocacy strategy and action are needed with the objectives of promoting the initiative, its achievements and developments, of mobilizing new partnerships and resources and informing the public at large. The following types of actions were considered to be essential for a good communication campaign:

- WHO website page for the initiative
- News bulletin
- Other publication
- Establishment of SEE electronic communication facility

However, only a limited number of actions were taken in this respect. There are two main reasons that pose obstacle to a starting and successfully accomplishing the advocacy function. On the one side, they are related to the very limited human resources within CoE and WHO which are acting as Secretariat for the initiative. On the other side, the two organizations' requirements, rules and procedures are very demanding to ensure high quality of materials and communication that even further increases the need of highly qualified professionals' involvement. Other options need to be explored and solutions found at the forthcoming Fifth Meeting of the SEE Health Network.

5.3.6 Monitoring, reporting and evaluation

The SEE countries recognize that monitoring progress is a key instrument for managing progress towards the individual and common goals of the overall health initiative in follow-up to the Dubrovnik Pledge of the Ministers of Health. The monitoring reports are an open and transparent means to describe the practical response, over time, of the SEE countries to the commitments made to social sector reform, and more generally the broader objectives of transition, and to provide a set of information to the donor countries and international organizations to balance interventions and select adequate policy reforms

At the recent 5th Meeting of the SEE Health Network, the National Political Health Coordinators agreed in general that the monitoring report format as proposed by the Stability Pact Secretariat will be used for health action monitoring, subject to further specification in consultation with the SEE Health Network by end of June 2002. The members of the SEE Health Network agreed to provide by the end of September 2002 the baseline information on the status of the three projects to be implemented in each country. It was recommended that a small drafting group prepare the SEE regional baseline report on health, based on summary regional reports for each of the three project topics.

6. Food and Nutrition Action Plan

Dr Aileen Robertson, Regional Adviser for Nutrition and Food Security, WHO Regional Office for Europe

Dr Robertson pointed out that the basic idea for this workshop is to collect feedback from the participants on the project proposal from the Brijuni meeting (September 2002) entitled: “Developing and Strengthening Food and Nutrition Strategies to Prevent Cardiovascular Diseases in South-East Europe” as well as develop it further. She mentioned that this meeting provides the opportunity to change and develop whatever is lacking in national nutrition policies and to strengthen collaboration on international level.

Dr Robertson focused on one very important component of this workshop and that was the hard work involved in solving health related problems. She also referred to the large amount of money that is spent in SEE countries for health care and technologies and to the relatively small investments in the area of public health and prevention.

The participants were reminded about the WHO First Action Plan for Food and Nutrition Policy for the WHO European Region 2000–2005. The Action Plan promotes, on the basis of current scientific evidence, strategies which reduce levels of noncommunicable diseases, protect health of adults and children and assist Member States in developing the most effective systems needed to deal with food and nutrition issues. Dr Robertson pointed out that in European countries there are high death rates and premature mortality for both genders from CHD and CVD. There is also a high prevalence of hypertension and obesity in European and SEE countries.

It was explained that the nutrition strategy based on a life-cycle approach is very important for the prevention of premature mortality. Nutrition policy development has to be intersectoral and has to ensure the three strategies are complementary through collaboration between different sectors. The coordination mechanisms between national, regional and local level are vital and also the implementation of the WHO EURO Regional Committee Resolution 59 from 14 September 2000. According to World Health Report 2002, preliminary results of analysis are showing that at the top of the global burden of diseases are high blood pressure, raised serum cholesterol, tobacco, obesity and low fruit and vegetable intake.

Afterwards there was video presentation – “Health in Europe: The Impact of Food and Nutrition on Public Health”

7. Project Proposal: Developing and Strengthening Food and Nutrition Strategies to Prevent Cardiovascular Diseases in South-East Europe.

Dr Maria Haralanova and Dr Aileen Robertson opened the discussion about the project proposal from the Brijuni meeting in Croatia. (September 2002). (Draft project presented in Annex 4.)

Dr Ljiljana Trajković (Yugoslavia), Dr Gabor Zajkas (Hungary) and Professor Gordana Ristić (Yugoslavia) commented that morbidity and mortality levels due to cardiovascular diseases (CVD) are increasing. Participants agreed that CVD is the first leading cause of mortality in their countries and that the prevention of CVD through better nutrition policies is needed.

Dr Haralanova commented that health has to be on the Stability Pact agenda and that in comparison with EU averages, the SEE Region has a large and increasing gap. She also referred

to the project and reminded participants that all donating agencies would like to see results in a short time. There was also a question as to who the potential donors might be and what their interests in this project proposal are. Dr Haralanova proposed that this project could be divided into a number of components or modules, each one being designed as a completed project itself and which could easily be submitted to different funds. It is very important to have quick outcomes that can be presented to the donors, but no quick outcome can be expected from the prevention of CVD.

Dr Antoinette Kaic-Rak (WHO, Croatia) suggested the title for the project, “Prevention of Nutrition Related Diseases”. She also agreed with Dr Maria Haralanova regarding the possibility of creating modules that can be easily submitted to different donors.

Dr Aida Filipovic-Hadziomeragic (Bosnia and Herzegovina) agreed that the previous title of the project sounds too medical and that it should have more of a public health component in it.

Professor Antonia Trichopoulou commented that it is very important not to miss the opportunity and suggested that CVD diseases should be taken out of the title. She proposed that the title of the project could be “Nutrition Surveillance” or “Better Nutrition and Better Health”.

8. Conclusions of workshop groups and discussion

The participants were divided into three groups to discuss the project proposal from the Brijuni meeting (Croatia, September 2002) entitled “Developing and Strengthening Food and Nutrition Strategies to Prevent Cardiovascular Diseases in South-East Europe”.

Suggestions from the first group regarding the project proposal

The first group suggested the new title of the project proposal, “Healthy South-East Europe Through Improvement of Diet and Nutrition.”

Regarding subtask A, they proposed to stress the nutrition part of the National Food and Nutrition Action Plan (including Food Security).

Considering subtask B, a new title of subtask B was proposed, “A situation analysis of the dietary risk factors contributing to the prevalence of diet-related health problems”. Other ways of implementing subtask B were suggested, i.e. dietary habits assessment on population level (DAFNE), dietary habits assessment of vulnerable groups and identification of the specific dietary risk factors including their monitoring.

Regarding subtask C, the new title was also proposed, “Training of Primary Health Care Professionals in Diet Related Problems”. The objectives of this subtask will be the training of trainers and dissemination of knowledge.

For the subtask D, the importance of the introduction of nutrition education during childhood (mothers, children, adolescents) was stressed.

Considering subtask E, it was mentioned that it is very important to recruit local communities into implementing nutrition policy.

Suggestions from the second group regarding the project proposal

The second group suggested several other titles of the Project Proposal: “Better Nutrition for Better Health”, “Developing and Strengthening Food and Nutrition Strategies to prevent CVD” or “Healthier Nutrition to a Healthier Heart”.

Regarding the subtask A, they proposed strengthening and developing national policy and strategy and developing/strengthening the Food and Nutrition Action Plan. They proposed an initial workshop of seven countries with participation of two persons from each country and also a workshop in each of the seven countries in order to set up objectives or a preparation draft version of their Food and Nutrition Action Plan.

They stressed that any suggestions for the subtask B will depend on funds.

Regarding subtask C, they suggested an initial two-day course on the role of diet in the prevention of CVD organized for 7 countries and local level seminars in order to educate educators in the country.

Considering subtask E, it was mentioned that it is very important to stimulate social mobilization and to include NGO's.

Suggestions from the third group regarding the project proposal

The third group suggested several other titles of the project proposal, “Food and Nutrition Strategies for Health Promotion”, “Food and Nutrition Strategies to Prevent Diet Related Diseases” and “Better Nutrition to Better Health.”

They proposed that the objectives of the project should also include prevention of diet-related diseases and promotion of the health.

Regarding subtask A, they recommended that the objectives be simplified and reduced to 5 objectives, since some of them are repetitive.

Considering subtask B, and survey methods it was suggested to substitute with the DAFNE data instead.

For subtask C, they suggested that in the summary, the risk communication courses should also be included. Regarding the objectives they proposed adding a third one, “Analytical description on risk assessment and communication courses”.

For subtask D, it was stressed that objectives 4 and 5 be united into one objective, since they are repetitive.

Considering subtask E, it was mentioned that the objectives should also include healthy diet.

Discussion

Assistant Professor Antoinette Kaic-Rak proposed some budget suggestions for the whole project and subtasks.

Professor Stefka Petrova referred to the modules and discussed which of them should be submitted to which donors. She reminded participants that all agreed that premature mortality

from CVD is high in the SEE Region. The project should identify some short-term goals. Professor Petrova believed it would be better for donors that the project is divided into smaller components.

Dr Robertson reminded participants of the agreement that all countries had agreed to participate.

9. The Data Food Networking Project (DAFNE)

Professor Antonia Trichopoulou, Temporary Adviser, University of Athens Medical School, Dept. of Hygiene and Epidemiology, WHO Collaborating Centre for Nutrition

Professor Antonia Trichopoulou presented the DAFNE project and “The use of household budget survey data for assessing food disparities within and between population”.

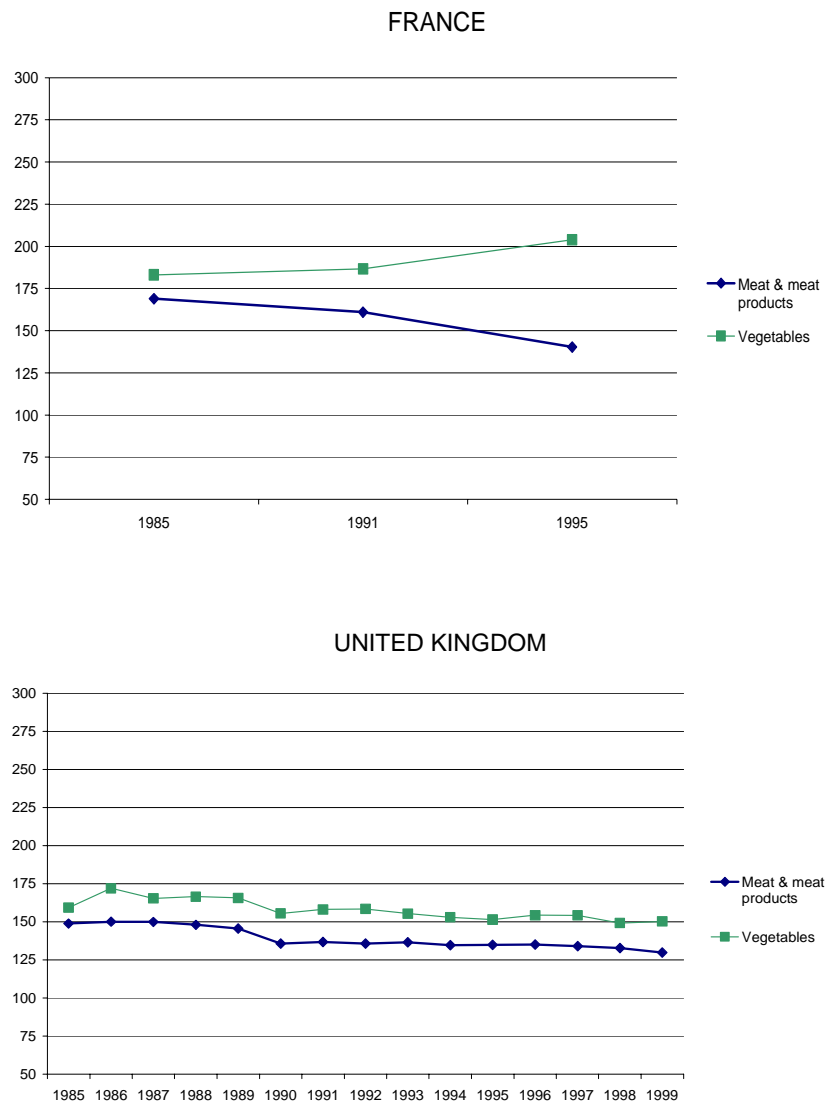
The objective of the Data Food Networking Project is to develop a European databank to be regularly updated of comparable food and socioeconomic information as a tool for monitoring trends in food habits in Europe.

Standard procedures for data collection includes:

1. **General information:** household identification number, trimester of participation.
2. **Nutritional information:** food code, total food expenditure, expenditure per food item, amounts per food item.
3. Socioeconomic information:
 - degree of urbanization of household (urban, rural, semi-urban)
 - name of geographical area where the household is situated
 - household size
 - household composition
 - age and gender of household head and members
 - relationship of household members with the household head
 - household disposable income (net income)
 - household total expenditure
 - occupation/employment status/economic activity of household head and members
 - education of household head and members
 - income of household head
 - medical expenses data

An overview of time trends in France and United Kingdom is provided in Figure 1 below. In France, vegetable consumption is increasing while meat consumption is decreasing, but in the United Kingdom both are decreasing.

Figure 1. Time trends



Professor Antonia Trichopoulou pointed out that in all countries included in DAFNE there is an increase in soft drink consumption. It would seem that in addition to animal fat consumption, this increase in soft drink consumption is a contributing factor to obesity. (See Annex 5 – DAFNE information.)

All the above-mentioned information can be downloaded from the DAFNE website www.nut.uoa.gr.

She welcomed the participants to the DAFNE project and gave instructions to participants on how to join to the DAFNE project.

10. Next Steps – Nutrition Counterpart meeting in Greece, February 2003

Professor Antonia Trichopoulou reminded participants that the WHO Consultation on “Development of the First Food and Nutrition Action for the WHO European Region” will be organized from 28 February to 2 March 2003 in Athens, Greece. This also opens up the possibility of assessing how WHO Member States are proceeding and to exchange information on the progress made in the South-East European Region.

11. Conclusion and Closing Remarks

- At the end of the workshop, the representatives of the SEE countries of the Stability Pact agreed to participate in the presented project: “Developing and Strengthening Food and Nutrition Strategies – South-East Europe” that will be submitted to CARDS and other possible donors for funding.
- Professor Antonia Trichopoulou expressed the hope of meeting the participants in Athens in February 2003 and she also wished for more progress in the development of Food and Nutrition Action Plans. Participants were urged to explore by 27 February 2003 their country’s willingness to join the DAFNE project; thus an application to EC programmes could be drafted, agreed and submitted for funding.
- Dr Aileen Robertson agreed that former Yugoslav Republic of Macedonia take over the leading role and coordination of the nutrition project proposal.
- Professor Vladimir Kendrovski, representative for The former Yugoslav Republic of Macedonia agreed and accepted coordination of the project; a timetable of immediate follow-up action leading towards the February 2003 meeting was agreed (Annex 6).
- Dr Robertson thanked the participants for taking part in this important workshop and expressed hope to have more constructive meetings in the future.

PROGRAMME

Tuesday, 12 November 2002

08.30 **Registration**

09.00–09.30 **Opening session**

- Welcome address by WHO
- Introduction of participants
- Adoption of scope and purpose, agenda and programme
*Dr Maria Haralanova, Technical Officer, Strategic Country Support,
WHO Regional Office for Europe*

09.30–10.00 **Stability Pact Initiative, Joint WHO/CoE Multicountry Public Health Initiative for SEE and the EU CARDS Programme (Community Assistance for Reconstruction, Democratisation and Stabilization)**
Dr Maria Haralanova

10.00–10.30 **Food and Nutrition Action Plan**
Dr Aileen Robertson, Regional Adviser for Nutrition and Food Security, WHO Regional Office for Europe

10.30–11.00 Coffee Break

11.00–13.00 **Project Proposal: Developing and Strengthening Food and Nutrition Strategies to Prevent Cardiovascular Diseases in South East Europe**
Dr Maria Haralanova and Dr Aileen Robertson

13.00–14.30 Lunch

14.30–16.00 **Project Proposal: Developing and Strengthening Food and Nutrition Strategies to Prevent Cardiovascular Diseases in South-East Europe (Continued)**

16.00–16.30 Coffee Break

16.30–17.00 **Future Plans and Direction**

Annex 2

LIST OF PARTICIPANTS

Albania

Dr Marita Afezolli
NEHAP Coordinator
Ministry of Health
Department of Primary Health Care
Rr. B. Curri, Tirana
E-mail: maritas@albnet.net

Bosnia and Herzegovina

Dr Aida Filipovic-Hadziomeragic
Institute of Public Health FB&H
Titova 9, 71000
Sarajevo
Tel. No.: +387 33664643 Ex 107
Fax No.: +387 33 220 548
E-mail: ahadziomeragic@hotmail.com

Dr Dragana Stoisavljevic
Public Health Institute Republika Srpska
Jovana Ductia 1,
Banjaluka
Tel. No.: +387 51 216 509
Fax No.: +387 51 216 510
E-mail: dada.bl@inecco.net

Dr Nijaz Uzunovic
Chief Sanitary Inspector
Ministry of Health
Federation of Bosnia and Herzegovina
Marsala Tita 9
71000 Sarajevo
Tel. No.: +387 33 220 536
Fax No.: +387 33 664 245
E-mail kab.moh@bih.net.ba

Bulgaria

Professor Stefka Petrova
Head Department of Nutrition
National Centre of Hygiene, Medical
Ecology and Nutrition
15 Dimitar Nestorov Street,
1431 Sofia
Tel. No.: +359 2 5812505
Fax No.: +359 2 9581277
E-mail: s.petrova@nchmen.government.bg

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Dr Svetlana Tcherkezova
Chief Expert, Food Safety
State Health Control Administration
Ministry of Health
5 Sveta Nedelja Sq.
Sofia
Tel. No.: +359 2 9301 212
E-mail: dzpdsk@mh.government.bg
E-mail: tcherkezova@yahoo.com

Croatia

Dr Zrinka Petrovic (Rapporteur)
Croatian Institute of Public Health
Rockefellerova 7,
10,000 Zagreb
E-mail: hzzhz-fp@zg.tel.hr

Hungary

Dr Maria Szabo
Deputy Director
National Institute of Food Hygiene and Nutrition
Gyali u. 3/a
H-1097 Budapest
Tel No.: +36 1 216-9027
Fax No.: +36 1 215-1545
E-mail: H527sza@ella.hu

Dr Gabor Zajkas
Deputy Director
OKK-OETI
Gyali ut 3/a,
1097 Budapest
Tel. No.: +3612155613
Fax No.: +3612151545
Email: h11447zaj@ella.hu

Republic of Moldova

Professor Nicolae I. Opopol
Scientific Director
National Centre of Preventive Medicine
67A, G. Asachi Str.
Chisinau MD 2028
Office: +373 273 58 22
Fax: +373 272 97 25
Home: +373 2 323 261
E-mail: nopopol@mednet.md

Dr Ana Volneanski
Deputy Director
National Centre for Preventative Medicine
67a Gheorghe Asachi Street
MD 2028 Chisinau
Tel. No.: +373 2 72 96 52
Fax No.: +373 2 72 97 25
E-mail: avolneanski@mednet.md

Romania

Dr Camelia Parvan
Head
Institute of Public Health
Ministry of Health
Food Hygiene Department
Str. Dr Leonte 1-3
76256 Bucharest
Tel. No.: +40 1 638 4010
Fax No.: +40 1 312 3426
E-mail: cparvan@ispb.ro

The former Yugoslav Republic of Macedonia

Professor Vladimir Kendrovski
Specialist of Hygiene and
Republic Institute for Health Protection
Environmental Health
ul. 50 Divizija 6,
91000 Skopje
Tel. No.: +389 2 125 044
Fax No.: +389 2 223 354
E-mail: kendrovski@yahoo.com

Yugoslavia

Professor Gordana Ristić
Institute of Hygiene and Medical Ecology
Department of Food and Nutrition
Medical Faculty,
Bozidara Adzije 7
11000 Belgrade
Tel. No.: + 381 11 682 852
E-mail: risticg@eunet.yu

Dr Djordje Stojiljkovic
Director
Federal Institute of Public Health
Omladinskih Brigada 1
11000 Belgrade
Tel. No.: +381 11 311 28 16
Fax No.: +381 11 311 20 80
E-mail: mvu@who.org.yu

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Dr Ljiljana Trajkovic-Pavlovic

Institute of Public Health

1 Omladinskih brigada

11070 New Belgrade

Tel. No.: +381 11 311 2 816

E-mail: yuhealth@ptt.yu

Temporary Advisers

Professor Antonia Trichopoulou

University of Athens Medical School

Department of Hygiene and Epidemiology

WHO Collaborating Centre for Nutrition

Mikras Asias 75

GR-11527 Goudi- Athens

Greece

Tel. No.: +301 0746 2073

Fax No.: +3010 748 8902

E-mail: antonia@nut.uoa.gr

Representatives of other organizations

Council of Europe

Dr Piotr Mierzewski

Directorate General III

Social Cohesion, Department of Health

Council of Europe

Avenue De L'Europe

F-67075 Strasbourg Cedex

France

Tel. No.: +33 3 88413004

Fax No.: +33 3 88412726

E-mail: piotr.mierzewski@coe.int

World Health Organization

Regional Office for Europe

Dr Maria Haralanova

Project Manager

Strategic Country Support Programme

Division of Country Support

WHO Regional Office for Europe

Scherfigsvej 8

2100 Copenhagen Ø, Denmark

Tel. No.: +45 39 171513

E-mail: mah@who.dk

Dr Antoinette Kaic-Rak
WHO Liaison Officer
WHO Liaison Office
Ilica 207, Building A, 1st Floor
10000 Zagreb, Croatia
Tel. No.: +385 1 613705523
E-mail: a.kaic-rak@who.hr

Dr Luigi Migliorini
Head
WHO Office for Humanitarian Assistance,
Bulevar mira 8
11000 Belgrade, Yugoslavia
Fax/Phone: +381 11 660735
E-mail: secretariat@who.org.yu

Dr Aileen Robertson
Regional Adviser for Nutrition
Nutrition and Food Security Programme
World Health Organization
Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel. No.: +45 39 17 1362
Fax No.: +45 39 171854
E-mail: aro@who.dk

PROGRESS REPORT ON HEALTH DEVELOPMENT ACTION FOR SOUTH-EAST EUROPE IN 2002

**6th Meeting of the Working Group of the
Stability Pact Social Cohesion Initiative**
Thessalonica, Greece
13–14 December 2002

Introduction

Health, as an integral determinant of social cohesion and a major factor for investment and development, is essential to lasting peace, stability and economic development. Accordingly, health was included in the Stability Pact agenda in 2000 as part of the Initiative for Social Cohesion. The Action Plan for Social Cohesion, endorsed by the partners in the Stability Pact Working Table II on Reconstruction and Economic Development in Tirana, Albania on 23 May 2001 defined the medium-term objectives, intervention strategies and implementation mechanisms for health and served as the basis for actions in 2002–2003.

Political commitment: The Dubrovnik Pledge

The Dubrovnik Pledge on “Meeting the Needs of Vulnerable Populations in South East Europe” was signed in September 2001 at the Health Ministers’ Forum for South-East Europe. The signatories were the ministers of health for Albania, Bosnia and Herzegovina, Bulgaria, Croatia, The Former Yugoslav Republic of Macedonia, Romania, and Yugoslavia. This unprecedented political agreement for cooperation and action for health was the first political document making commitments on regional health development, on working in partnership on specific strategies to meet the urgent needs of vulnerable groups in the sub-region. Seven regional project proposals were designed, three of which (in mental health, food safety and surveillance of communicable diseases) are being implemented. The Governments of Greece, France, Italy, Switzerland and Slovenia, support the projects both technically and financially. The Council of Europe Development Bank provided support, though a loan to the Government of Croatia on reconstruction and modernization of the A. Stampar School of Public Health, to further enhance the process of building up capacities for public health in the region.

Leadership, Ownership and Coordination: The SEE Health Network

The South East Europe Health Network was established in Sofia in April 2001 by the seven above-mentioned SEE countries, the main beneficiaries of the Stability Pact process. It was consequently joined in 2002 by the Republic of Moldova and by three neighbouring and donor countries: Greece, Hungary and Slovenia. The network is the main political body to provide and sustain ownership and leadership of the countries in the region in implementing concerted action in the defined areas of mutual interest. Amongst all, its role and objective is to promote and facilitate actions and to coordinate and evaluate the implementation of the Dubrovnik Pledge and all regional projects within its framework.

Joint CoE/WHO support

The above developments provide unique opportunities to continue boosting public health and health developments in SEE. The CoE’s strategies and policies on social cohesion, health and vulnerability, WHO EURO’s country strategy, the EU’s new public health strategy, and the EU *Acquis*, provide important reference points in this respect.

The CoE and WHO continued their support to South Eastern European countries in 2002–2003 with a two-pronged aim to provide:

- (a) a framework within which health related initiatives jointly implemented by SEE countries can develop through an overall role of coordination, guidance and technical assistance; this also includes support to implementing SEE commitments under the *Dubrovnik Pledge* and the agreed and funded projects on communicable diseases surveillance, mental health, and food safety and security, and continuous efforts to build up partnerships and fundraise with external partners and donors for SEE regional health efforts, and
- (b) Continuous support to sustain health on the agenda of the Stability Pact, including exploring the potential for mobilizing partners for the health component of the Stability Pact agenda.

Progress in 2002

In 2002 the Stability Pact Social Cohesion Initiative, and along with it both the joint CoE/WHO multicountry Public Health Initiative for SEE and the regional projects with initial funding, entered the implementation phase. All efforts, actions and progress were focused around the following groups of activities:

Sustaining Political Commitment and Leadership. Strengthening Coordination Mechanisms

As launched by Ministers of Health at their first forum in Dubrovnik in 2001, a strong sense of regional ownership and leadership, as well as equal responsibilities, commitments and involvement of all SEE countries at both political and technical levels were further endorsed and sustained in 2002. This approach was even further strengthened through the process of implementing concrete activities in the health sector.

A number of mechanisms were established or were sustained since 2001 to that effect. The most important amongst all is the continuation of work of the SEE Health Network. Its existence was extended in 2002–2003. Furthermore, as stated above, in September and October two other countries, namely the Republic of Moldova and Slovenia, joined the network, the latter one in the capacity of a donor country offering its technical expertise and experience as well as co-financing of some activities.

At the political level, the mandate, role, functions and way of working of the network were further specified. To date, it is the political body of the Ministers of Health of the SEE countries, which acts as a Steering Committee for implementing the Dubrovnik Pledge. Its mandate and functions were endorsed (see Box 1), as well as twelve principles to be applied during the whole implementation process (see Box 2.)

Box 1. SEE HEALTH NETWORK: Functions

- To promote the implementation of the Dubrovnik Pledge of Ministers of Health from South East Europe “Meeting the Health Needs of Vulnerable Populations in South East Europe”
- To act as the prime mover in obtaining and sharing experience of implementation at all levels within Member States
- To assist the Council of Europe, WHO Regional Office for Europe and the Stability Pact Initiative for Social Cohesion in defining high-priority areas for international action
- To stimulate and participate in international cooperation
- To steer, monitor and evaluate the implementation of regional projects for health development in SEE
- When requested by countries, to facilitate and support the development of health development actions plans, including technical assistance in analysis of the economic, social and health implications of particular policy options, and to promote and assist in building up partnerships and mobilization of resources
- To promote and facilitate strengthening the intersectoral coordination at national level and other governmental sectors involvement and support to health actions
- To cooperate with bodies and partners involved in the Stability Pact process for SEE through its Initiative for Social Cohesion, in order to promote actions addressing health issues in, or to their close linkage with, action programmes for social cohesion
- To provide advice and recommendations on health issues of the South East European region to other international organizations and donors ready to support the countries in implementing reforms in different health sectors
- To assist in the identification of emerging health issues that require collaborative actions or their study
- To foster the exchange and dissemination of information

Box 2. SEE HEALTH NETWORK: Principles of Collaboration

- **SEE countries ownership**
- **Partnership approach**
- **Equal involvement of SEE countries**
- **Equal distribution of activities and resources**
- **Sustainability** (This implies SEE Ministries of Health commitment and continuous support to the projects implementation at the national level, capacity building and mobilization of resources for further expansion)
- **Complementarity and continuity** (This implies building up on ongoing plans/projects/investments and on WHO BCA)
- **Up to 30% of funds allocation to management**
- **Rotation of Member States in organizing the intercountry activities**
- **Decentralization of resources**
- **Transparency and accountability**
- **Projects management by multicountry project Steering Committees**
- **Regular reporting by projects Steering Committees to the SEE Health Network**

To maintain the high political level and to be able to exercise a decision-making role in the region in the framework of the Stability Pact senior governmental officials as their countries' representatives.

In addition to representation at the political level, a pool of the countries' best technical experts in the areas of communicable diseases surveillance, food safety and nutrition and mental health was established through a formal and thorough selection and nomination process.

To date, the SEE Health Network, at both political and technical levels, comprises of eleven countries (including eight beneficiaries and three donor and neighbouring ones) and four major international organizations. It has over 100 members whose names, functions, positions and full addresses are presented in a separate document. A team of over 15 leading senior international experts and professionals from the Council of Europe and WHO Regional Office for Europe works to provide technical expertise and support.

To secure regular monitoring of progress, sustained commitments, successful delivery at both regional and country levels and planning the immediate, medium and long term developments, the SEE Health Network convenes two meetings annually. In 2002 the following meetings took place.:

- 4th Meeting in Hillerød, Denmark. 26–28 May 2002
- 5th Meeting in Belgrade, Yugoslavia, 14–16 November 2002

Meeting reports are available as separate working documents with the SEE Health Network Secretariat upon request.

Projects implementation

As stated above, three of the seven projects received technical and initial financial support from donor countries as follows:

1. Project on *surveillance of communicable diseases* (approx. €270 000 from France);
2. Project on community *mental health* (€500 000 from Greece; €105 000 from Italy; US \$112 000 as WHO contribution to the projects through the specific allocations for activities in the country Biennial Collaborative Agreements (BCAs); negotiations are ongoing with SWE and DEU for their involvement and funding);
3. Project on *food safety and security* (€150 000 pledged by Greece; €105 000 from Italy, and WHO EURO contribution of US \$68 000).

The most valuable outcome of the work of the SEE Health Network was the adoption and signing of two Decisions on Implementing Components One of the projects on Community Mental Health and Communicable Diseases Surveillance. These documents represent both political and technical agreement of the SEE countries on the projects concrete objectives, outputs and deliverables at both regional and national levels, logical frame of activities, implementation plan, managerial set-up and detailed budget breakdowns which were worked out during an intensive inception period (first half of 2002) and through a tough consultation process. A third Decision document on Component One of the Food Safety and Nutrition project is in the process of finalization.

Following an inception period of approximately six months' duration to fully progress the projects' first components and prepare them for successful implementation within the frame of the available resources, the implementation process was launched as of June 2002. A detailed presentation of progress in implementing each one of the three projects is presented in Annex 1. However, there are number of common characteristics that need to

be specifically highlighted due to their importance for both the health and social cohesion development process. Amongst all, the most important ones are:

- Full agreement of the countries to the projects concept, long-term and immediate specific objectives, deliverables, approaches and mechanisms despite the existing differences in reforming and developing the respective technical areas; this is due to the shared understanding on the need for and added value of applying a regional approach and harmonizing policies, legislations and practices among the countries of the region themselves and with the EU Acquis Communautaire in the broader European integration process
- A well structured and systematic common approach is agreed and applied in all three projects in implementation at the intercountry level, while the content of deliverables and activities at national level is tailored to the countries' specific needs
- The commitment to sharing experiences, to mutual support and to benefiting mostly from the local (in the region) expertise in addition to the valuable role and input of international experts when needed
- The spirit of openness, transparency and accountability in both the dialogue and actions
- The high level of decentralization of resources as well as the establishment of organizational and managerial mechanisms to secure the primary ownership and responsibility of the countries for their own needs and actions

Monitoring, reporting and evaluation

The SEE countries recognized that monitoring progress is a key instrument for managing progress towards the individual and common goals of the overall health initiative in follow-up to the Dubrovnik Pledge of the Ministers of Health. The monitoring reports are an open and transparent means to describe the practical response, over time, of the SEE countries to the commitments made to social sector reform, and more generally the broader objectives of transition, and to provide a set of information to the donor countries and international organizations to balance interventions and select adequate policy reforms.

At the 4th Meeting in Hillerød, the National Political Health Coordinators agreed in general that the monitoring report format as proposed by the Stability Pact Secretariat will be used for health action monitoring, subject to further specification in consultation with the SEE Health Network in each one of the technical areas of work.

The process of reporting, monitoring and evaluation is being accomplished through the established managerial and coordination mechanisms at all levels. At the national level, the progress on implementation is reported by the respective technical experts to the Ministers of Health through the National Political Health Coordinators. At the intercountry (regional) level, each project leading country reports on the progress, problems, solutions and immediate follow-up to the project Steering Committee, and thereafter to the SEE Health Network.

At its 5th Meeting in Belgrade, the SEE Health Network discussed the baseline information on the status of policies, legislation and services in the three project technical areas of work. Thus, the following main conclusions were made and/or confirmed:

1. The health care systems in the countries of the Southeast European Region (SEE) are currently undergoing rapid changes. In all SEE countries, within the frame of overall health reforms many developments are taking place in the areas of CD Surveillance, Food Control and Mental Health Services, through either domestic or external support.

2. The eight SEE countries are at different level of development of the health reform process in general and in each one of the three particular areas, varying from more or less completed legislative reform to a non-existing one
3. Despite the differences, two main conclusions are still valid, namely:
 - The gap in the status of health and health systems between the SEE countries on the one hand and the EU and CEE averages on the other hand continues to widen
 - Within each one of the SEE countries, the gap between the overall health care systems reforms and public health is still wide
4. Despite the different level of development in each individual country, there are still issues, problems and shortcomings, which are common to all as follows.

In the area of Communicable Diseases Surveillance

- The status of infectious diseases is characterized by: (i) a still low HIV/AIDS epidemic but with high rates of risky behaviours and in high risk groups; (ii) reemerging of old communicable diseases such as tuberculosis; and (iii) experiencing an increase number of new diseases such as Tularemia or CCHF.
- As health care reforms, being the main focus of efforts and resources of health authorities, suffer of sufficient coordination with other important elements of public health, the surveillance and control of communicable diseases has deteriorated to a certain extent.
- The existing systems are rigid and not responding to new health threats in a timely, complete and representative way; they are still centralized ones where data collection is a statistical exercise that does not stimulate field action and measure implementation; there is lack of reporting and missing responses.
- The above characteristics make the systems difficult to outreach vulnerable groups.

The above commonalities provided a sound basis to formulating three objectives to be achieved by the region

- Building institutional and human capacities to develop successful action and problem oriented countries surveillance network;
- Strengthening the national surveillance systems;
- Integration of national surveillance systems through a subregional network in SE Europe which in the future will be prepared to integrate into the wider European Union system.

In the area of Food Safety

- The existing Food Legislation still needs major drafting/adjusting of general food laws in at least half of the countries, full harmonization of the secondary legislation with the EU Acquis in most of them with few exceptions, preparation of codes of practices in all and introducing a totally new approach to law enforcement to secure compliance with laws, norms and standards in reality. The existing food control services (in most cases comprising of minimum three institutions in each country) do not have clear cut responsibilities which are overlapping and duplicating each other; Flexible control procedures are needed including crossing from control of final products to control of processes; Inspectors in the food control systems need training in HACCP control while staff in the emerging private agriculture and food sector lacks specific training

- Food Control Laboratories need modernization of equipment, introducing new methods, training of laboratory personnel, quality assurance systems and proficiency testing, as well as revision of accreditation schemes Food Monitoring and Surveillance systems need updating according to EC regulations and specific needs as well as building up capacities in risk assessment, management and communication ***In the area of Nutrition***
- Cardiovascular diseases are the main cause of premature mortality in the whole region; Epidemiological data on morbidity and mortality show the highest prevalence in comparison to the EU and CEE averages
- The traditional diet is compromised due to economic situation and vulnerable population groups are exposed most; There is a dramatic need for changing dietary habits
- All the SEE countries need developing and strengthening Food and Nutrition Strategies to prevent and control cardiovascular diseases in the region
- There is a lack of database on dietary intake and modernization of epidemiological databases is needed including identification of common parameters to be monitored
- A major change might happen only through appropriate wide scale education of the general practitioners, the public and the individuals as well as involving of civil sector and local communities

In the area of Mental Health

- Lack of interest and political commitment by national authorities who fail to recognize mental health as one of the key national priorities in the area of health;
- Insufficient mental health policies and legislation in the SEE countries;
- Inadequate enforcement of the existing mental health policies and legislation;
- Lack of financial resources;
- Difficulties in ensuring continuity of reform processes due to frequent changes in the relevant government bodies;
- Lack of knowledge and skills required for successful fundraising activities;
- Lack of comprehensive data regarding the spread and severity of mental health problems in the population;
- Lack of standardized systems for reporting, monitoring and evaluation of different mental health programs;
- Insufficient participation of NGOs and other relevant sectors in the implementation process.

Advocacy:

The 4th Meeting of the SEE Health Network agreed that a strong public relation and advocacy strategy and action is needed with the objectives of promoting the initiative, its achievements and developments, of mobilizing new partnerships and resources and informing the public at large. The following types of actions were considered to be essential for a good communication campaign:

- WHO web site page for the initiative
- News bulletin
- Other publication

- Establishment of SEE electronic communication facility

However, only a limited number of actions were taken in this respect. There are two main obstacles to starting and successfully accomplishing the advocacy function. One is related to the limited human resources within the Council of Europe and WHO who act as Secretariat of the Network. The second one is related to the very demanding rules and procedures of the two organizations' to ensure high quality of materials and communication that increases even further the need for highly qualified professionals' involvement. Other options were explored and solutions found at the recent 5th Meeting of the SEE Health Network.

Outlook for the Up-Coming Period

Successful implementation and outputs delivery of the three projects, launched under the ISC Action Plan in 2002, as well as the monitoring through the country and regional reports will be the basis of the immediate future work. A detailed timetable of 22 regional activities for 2003 is presented in Annex 2. Mobilization of partners and securing resources for further expansion and completion of these three projects, as initially planned, will be a must in 2003.

Revision of the remaining four projects formulated in the framework of the Dubrovnik Pledge to more practical and realistic versions with clear objective, deliverables and resources will be another direction of work, which might bring to better opportunities for establishing partnerships and eventually gaining interest and support for launching their implementation too.

Refining and strengthening the work within the technical areas of work and defining viable implementation methodologies will be in the focus.

Using planned European Fora in 2003, such as the forthcoming Conference on Mental Health and Stigma to take place in February in Greece within the Greek Presidency of the European Union, the forthcoming European Conference of Ministers of Health on Health, Dignity and Human Rights to take place in June in Oslo, Norway and the forthcoming fifty-third Session of the WHO Regional Committee for Europe will be key milestones for maintaining the political support of SEE Ministers of Health for the ISC related activities in health.

The link between macroeconomics and progress in the area of health, especially in the current transition process, will be in the more general attention of the SEE Health Network as it recognizes that poverty reduction and human development hinge on this linkage. The SEE countries will search for support to their efforts to alleviate and effectively address issues related to poverty and health, and in particular, to increasing the capacity of health systems to undertake effective action for the promotion of health and poverty reduction.

Annex 1

FUNDING COMMITMENTS AND PLEDGES FOR HEALTH
IMPLEMENTATION STATUS AS AT 03 DECEMBER 2002

Specific Strategy/ Topic of Project:	Donors/Pledges: As at 25 April 02	Project Justification & Objectives	Expected Outputs & Deadlines	Progress Status	Other Potential Partners
1	2	3	4	5	6
<p>Intensifying social cohesion by strengthening community mental health service</p> <p>Involves all 7 SEE countries.</p> <p>Estimated budget (in Euros): 2.280.000</p>	<p>Greece (Euros 500 000) Italy (Euros 105 000) WHO (US \$112 000 for country specific actions through the signed BCAs)</p>	<p><i>Justification:</i> Mental health has deteriorated significantly in South-East Europe, complicated by the severity and complexity of factors including: wars and post-war trauma, unemployment; poverty; migration; political upheaval; increasing homelessness; and substance abuse, and particularly in socially vulnerable and economically disadvantaged groups.</p> <p><i>Objective:</i> to improve mental health and psychological wellbeing through development of operational community mental health services as a cornerstone of the mental health care reform process for strengthening social cohesion in the Region.</p>	<p>By September 2003 each SEE will deliver:</p> <ul style="list-style-type: none"> • Assessment of mental health status based on an agreed methodology • Formulation or revision of mental health policy • National mental health action plan (new or revised) • Draft mental health law (either new or amendments) • Assessment of Mental Health Services <p><i>By end of 2003–2004</i> (upon availability of further funding through domestic and external resources)</p> <ul style="list-style-type: none"> • Community mental health services to be established • Establishment of regional training curricula for mental health professionals, PHC professionals and social workers 	<p>Inception phase completed</p> <p>9 June, Athens, 1st Inaugural Meeting of the Project Steering Committee</p> <p>As of 10 June – Implementation phase for Component one (policy and legislation) started</p> <p>Regional Project Office and Country project offices being established</p> <p>Slovenia joins the project as a full partner and pledged \$25,000 for 2002</p> <p>First technical workshop on Mental Health Policies and Legislation took place in Ljubljana on 2–7 November</p> <p>Legal agreements between GRE and the 7 beneficiary countries in process of signing.</p> <p>Workplan prepared.</p>	<p>Germany – in process of discussion</p> <p>Sweden – in process of discussion</p> <p>Hungary – in process of discussion</p> <p>Slovenia – formally joined the project as of October 02; funded and hosted the first technical workshop; similar contribution in 2003</p> <p>EC/DGSanco – no contacts yet</p> <p>EC/CARDS – project to be submitted for eventual co-funding</p>

1	2	3	4	5	6
<p>Strengthening surveillance and control of communicable diseases</p> <p>Involves all 7 SEE countries.</p> <p>Estimated budget (in Euros): 1.100.000</p> <p>Others:</p> <ul style="list-style-type: none"> HIV/AIDS project in Bulgaria TB project for ROM 	<p>France (EUROS 270 000)</p> <ul style="list-style-type: none"> WHO (US \$68 000 for country specific actions through the signed BCAs) <p>France (EUROS 140 000)</p> <p>France (EUROS 130 000)</p>	<p><i>Justification:</i> Communicable diseases continue to pose a threat for SEE with many old diseases reappearing and new infections emerging due to lack of funding and of coordinated activities, privatisation of health services which make them unaffordable to vulnerable population, a lack of systematic reporting, appropriate investigation of infectious disease outbreaks and response, and, finally, a rigid, poorly financed and outdated surveillance practices</p> <p><i>Objective:</i> To strengthen the national Communicable Diseases Surveillance and Response through enhancing sub-regional collaboration and integration of surveillance</p>	<p><i>By end of 2003</i> (based on available resources):</p> <ul style="list-style-type: none"> Assessment of national CDS systems, including laboratories (by multicountry teams from the region) Action plans for strengthening and adapting the CDS Systems Harmonization of definitions, regulations and information systems Integration of national surveillance systems through a sub-regional network. in SEE Establishment of Regional Internet based database on communicable diseases Capacity building in areas of laboratory support, information systems, and applied epidemiological methods 	<p>Inception phase completed</p> <p>Implementation in progress</p> <p>First Meeting of CDS National Counterparts, Vloara, ALB, 28-30 August 02</p> <p>Second Meeting of CDS National Counterparts on Definitions and Legislation, Bucharest, Romania, 21-24 November 2002</p> <p>Workplan for 2003 agreed.</p>	<p>EC, DG Sanco – no contacts</p> <p><u>EC/CARDS – project to be submitted for eventual co-funding</u></p> <p>EUROAIDS, ECHO – operating in YUG, FUM and ALB</p> <p>CIDA – negotiations to be held</p> <p>UNICEF – to be explored</p> <p>Switzerland – to be explored</p> <p>Hungary- expected to join</p> <p>Slovenia – formally joined the project as of October 02</p>
<p>Strengthening institutional capacity and intersectoral collaboration for access to affordable and safe food products</p> <p>Involves all 7 SEE countries.</p> <p>Estimated budget (in Euros): 1 500 000</p>	<ul style="list-style-type: none"> Greece (EUROS 150 000) Italy (EUROS 100 000) WHO (US \$68 000 for country specific actions through the signed BCAs) WHO (US \$50 000 for intercountry public health action on developing Food and Nutrition Action Plans) 	<p><i>Justification:</i> The countries of the Sub-region are all in transition characterised by economic decline, rising poverty, declining health status due to unhealthy lifestyles and poor nutrition and lack of access to sufficient, safe food. Policy development with focus particularly on vulnerable groups, including refugees and internally displaced persons. Networking in the region will facilitate shared learning experiences and cross border collaboration on these issues</p> <p><i>Objective:</i> To strengthen the food safety and nutrition policies, legislation, infrastructures and services' regional network</p>	<p><i>By mid 2003:</i></p> <ul style="list-style-type: none"> Country profiles prepared National Food and Nutrition Policies and Action Plans developed. Food laws (new or amendments) Secondary food legislation Codes of practices developed A sub-regional inter-country framework for collaboration and partnership established and sustained. Sub-regional and national level workshops held to capacity build policy and decision-makers <p><i>By mid 2003:</i> National projects identified and taken forward to improve food safety services throughout the region</p>	<p>Italian contribution awaited</p> <p>Greek contribution under discussion</p> <p>Draft Decision on Component One prepared and in second round of consultation</p> <p>First Meeting on FS legislation held on 12-13 November, Belgrade, Yugoslavia</p> <p>Workplan for 2003 prepared.</p>	<p>FAO – negotiation in progress</p> <p>EC/DG SANCO – no contacts</p> <p><u>EC/CARDS – project to be submitted for eventual co-funding</u></p> <p>Hungary- expected to join the project</p> <p>Slovenia – formally joined the project as of October 02</p>

<p>Capacity building for increasing the access to appropriate, affordable and high-quality health care services</p> <p>Estimated budget (in Euros): 2 950 000</p>	<ul style="list-style-type: none"> Council of Europe Development Bank (EUROs 2.8 million loan to Croatia) 	<p>Justification: The current health situation in South East Europe necessitates improved sub-regional and inter-country collaboration in the area of public health in order to unify actions to resolve common needs in the region. These needs include: capacity building for basic, post-graduate and continuing education in public health, and quality assurance circles.</p> <p>Objective: To assist and support individual countries to improve education and training for national based public health policies with the eventual objective of establishing a network of schools of public health within the region.</p>	<p><i>By end of 2003:</i></p> <ul style="list-style-type: none"> Reconstruction and modernization of Andrija Stampar School of Public Health, CRO 	<p>Utilization of funds for accompanying measures to CEB loan for CRO started in September 2002</p> <p>First meeting of Regional Working Group on Curricula development, Zagreb, 26–28 September 2002</p> <p>First Draft Curricula on two master courses reported to the 5th SEE Health Network Meeting, 14–16 November 2002, Belgrade</p> <p>Second meeting of the Regional Working Group to be held on in January 2003</p> <p>Exploring possibilities for funding of the original regional project</p>	<p>ASPHER</p> <p>Germany – partnership established with SEE Public Health Network funded by a DEU</p> <p>Hungary – to be explored</p> <p>Slovenia – formally joined the project as of October 02</p> <p>EC/CARDS – project to be submitted for <u>eventual co-funding</u></p> <p>European Observatory on Health Care Systems NGOs</p>
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Annex 2

TIMETABLE OF REGIONAL MEETINGS AND EVENTS IN 2003

Month	Week	No	Event	Venue	Organizer	Area of work
January						
	IV	1.	2nd Technical Workshop on review of Mental Health Services in SEE	Ohrid, FYM	RPO FYM	MNH
February						
	III	2.	3rd Technical Workshop on Review of Mental Health Policies and Legislation. Country reports. Recommendations to Governments	V. Tarnovo BUL	RPO BUL	MNH
	III	3.	2nd Meeting of the Steering Committee for the SEE MNH Project	V. Tarnovo BUL	RPO BUL	MNH
	III	4.	4th Meeting of the Executive Committee for the SEE MNH Project	V. Tarnovo BUL	RPO BUL	MNH
	IV (27)	5.	SEE Meeting on Nutrition Surveillance (DAFNE Project),	Athens, GRE	GRE WHO/NUT	NUT
	IV	6.	2nd Technical Workshop and Training in Food Safety Policies and Legislation (5 days)	Belgrade YUG	WHO/FOS YUG	FS
March						
	II	7.	Inter-country assessment mission to review strengths and weakness of surveillance systems (Bulgaria)	BUL	ALB WHO/CDS	CDS
April						
	III	8.	4th SEE Workshop on International Recommendation and experiences in MNH Policy and Legislation; Introducing EU standards	Sarajevo, BIH	RPO BIH	
		9.	Inter-country assessment of laboratory capacities	To be defined	WHO ALB SEE	CDS
		10.	Training on applied epidemiology and management of surveillance systems in Cooperation with IVS and EPIET	Zagreb CRO	WHO	CDS
April						
	III	11.	5th Meeting of the Executive Committee for the SEE MNH Project	Sarajevo BIH	RPO	MNH
May						
	IV	12.	6th Meeting of SEE Health Network	Sarajevo BIH	WHO CoE	Health & Social Cohesion
		13.	Training on geographical information systems in coordination with WHO-HQ, Skopje	Skopje, FYM	WHO FYM	CDS
June						
	III	14.	5th SEE Workshop on review of Mental Health Services in SEE; Recommendations to Governments	Tirana ALB	RPO ALB	

- | | | | | |
|-----|--|---------------|------------------------------|-----|
| 15. | 6th Meeting of the Executive Committee for the SEE MNH Project | Tirana
ALB | RPO | MNH |
| 16. | Training on data management and information systems for communicable disease reporting in coordination with WHO Lyon Collaborating Centre | | WHO
WHO CC
Lyon
FRA | CDS |

July

August

September

- | | | | | | |
|----|-----|--|------------------|------------|-----|
| IV | 17. | 6th SEE Workshop on Regional Dimension of Mental Health Policies and Legislation | Split
CRO | RPO
CRO | MNH |
| IV | 17. | 3rd Meeting of the Steering Committee for the SEE MNH Project | Split
CRO | RPO | MNH |
| IV | 18. | 7th Meeting of the Executive Committee for the SEE MNH Project | Split
CRO | RPO | MNH |
| IV | 19. | Publication of SEE Regional and Country Reports on Mental Health Services | Sarajevo,
BIH | RPO | MNH |

October

- | | | | | | |
|----|-----|---|----------------|------------|----------------------------------|
| IV | 20. | 7th Meeting of SEE Health Network: Review of Progress | Tirana,
ALB | CoE
WHO | Health and
Social
Cohesion |
|----|-----|---|----------------|------------|----------------------------------|

November

- | | | | | | |
|---------------|-----|---|----------------|------------|-----|
| II
(14-16) | 21. | Training on second generation surveillance for HIV-AIDS, 14–16 November 2002, Zagreb | Zagreb,
CRO | WHO
CRO | CDS |
|---------------|-----|---|----------------|------------|-----|

December

Annex 4

PROJECT PROPOSAL: DEVELOPING AND STRENGTHENING FOOD AND NUTRITION STRATEGIES TO PREVENT CARDIOVASCULAR DISEASES IN SOUTH-EAST EUROPE

Project Information

Project Title: Developing and Strengthening Food and Nutrition Strategies to prevent cardiovascular diseases in South East Europe

Organization:

Croatia, in collaboration with Bulgaria and Bosnia and Herzegovina, will oversee coordination on a rotational basis.

Mailing Address:

Rockefellerova 7, 10 000 Croatia

Telephone/fax:

Phone: +385 1 46 83 001

Fax: +385 1 46 83 002

Contact Person:

Assistant Professor Antoinette Kaic-Rak, MD

Geographical focus:

South Eastern European Countries – Albania, Bosnia and Herzegovina, Bulgaria, Croatia, The former Yugoslav Republic of Macedonia, Romania, and Yugoslavia.

Amount requested:

US \$1 700 000

Partners involved:

WHO, FAO, Council of Europe, Slovenia and Greece

Category:

- // 1. Institutional Strengthening and Policy Development
- /X/ 2. Health Civil Society Building
- // 3. Combating War Consequences on Health
- // 4. Regional projects
- // 5. Support to priority national and regional projects

Date: 18 September 2002

Project Summary

Keywords:

Obesity

Cardiovascular diseases

Diet-related diseases and Public Health

Primary Health Care

Maternal and young child health

Social Cohesion

This project will help to develop and strengthen strategies to prevent cardiovascular diseases and promote public health and social cohesion in South Eastern Europe. These strategies include six main strands: a) to strengthen information systems, especially to highlight the needs of the most vulnerable; b) develop a comprehensive and integrated food and nutrition policy targeted at the most vulnerable; c) design cost-effective intervention programs for the most vulnerable; d) strengthen the capacity of health professionals to practice primary prevention of cardiovascular diseases; e) strengthen the capacity of maternal and child care services to promote health and prevent death from cardiovascular diseases in adult life; and f) improve public participation and the ability of civil society to improve social cohesion. These strands will be developed simultaneously by seven countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, The former Yugoslav Republic of Macedonia, Romania, and Yugoslavia) through a new intercountry network of national experts from each country.

Anticipated lifetime of project:

10 years

Summary of first two years:

During the first two years a situation analysis will be carried out in each country separately and the results compared with their neighbours and EU countries. Following this the information collected will be used to develop a comprehensive and integrated food and nutrition policy for each country. Each country will have to form a “Food and Nutrition Council”, or similar mechanism, which will consist of a wide-range of inter-sectoral stakeholders, from health, agriculture, education, private sector and civil society. This independent body will be responsible for developing the food and nutrition policy. While this consultative process is being carried out individually in each country, simultaneously “training of trainers” on prevention of cardiovascular diseases can be carried out for staff in primary health care, maternal and child health and in the public health and sani-epidemiology services. This can be carried out jointly for the seven countries to ensure a core of national experts who will then have the responsibility of translating the training materials into the local languages and then disseminating the post-graduate training at a national level in each country. Each country will have to develop its own language specific materials for health education and media activity. Similarly national NGOs will have to be established but the initial core concepts involved can be developed by networks involving all the countries in the Region. Working together will provide added value and shared learning experiences of lessons learnt from each other.

Anticipated results:

First two years:

1. Development of a comprehensive and integrated Food and Nutrition Policy in each of the seven countries.
2. A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases for each country.

3. Comparative analysis of the different dietary risk factors in each country compared with EU countries.
4. Trained trainers in primary health care who can improve the practice of primary prevention of cardiovascular diseases.
5. Trained trainers to strengthen the capacity of maternal and child care services to promote health and prevent death from cardiovascular diseases in adult life.
6. Improve public participation and the ability of civil society to improve social cohesion through the development of media campaigns, health education materials and the establishment of NGOs

Total project:

- Reduction in prevalence of cardiovascular diseases and premature mortality
- Reduction in medicines needed to treat cardiovascular diseases
- Increased local job opportunities through the promotion of locally produced, processed and retailed healthy foods to help prevent cardiovascular diseases
- Improved social cohesion between urban and rural communities through the promotion of locally produced healthy foods retailed through local farmers markets.
- Improved trading of healthy food between neighbouring countries and SE Europe

Assumptions:

- Political commitment for the project
- Funding is received from donors
- Indicators of success:

Short-term:

1. Development of a national comprehensive and integrated Food and Nutrition Policy in each of the seven countries.
2. A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases in each country.
3. A report comparing the dietary risk factors in each country with those in the EU Countries.
4. Ten trained trainers in primary health care in each country who can improve the practice of primary prevention of cardiovascular diseases.
5. Ten trained trainers to strengthen the capacity of maternal and child care in each country to promote health and prevent death from cardiovascular diseases in adult life.
6. Development of one media campaign in each country, health education materials and the establishment of one NGO in each country.

Long-term:

- A 20% reduction in prevalence of cardiovascular diseases and premature mortality.
- A 30% reduction in medicines needed to treat cardiovascular diseases.
- A 10% decrease in unemployment.

- A stabilization of the numbers of people living in the rural areas with less moving to urban areas to seek jobs.
- An increased number of local farmers markets.
- An increase in trading of food between neighbouring countries and SE Europe.
- Improved quality of life, security, peace and stability in the region through food and nutrition policy.

Task Objectives:

Improved security and reconciliation in SE Europe through the prevention of cardiovascular diseases and promotion of public health

Subtasks:

1. Development of a comprehensive and integrated Food and Nutrition Policy.
2. A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases.
3. Trained trainers in primary health care who can improve the practice of primary prevention of cardiovascular diseases.
4. Trained trainers to strengthen the capacity of maternal and child care services to promote health and prevent death from cardiovascular diseases in adult life.
5. Improve public participation and the ability of civil society to improve social cohesion through the development of media campaigns, health education materials and the establishment of NGOs

Justification:

The overall task objective is to create an environment where public health, economic and social policy can be sustainable through the development of a national comprehensive and integrated food and nutrition policy in each of the seven countries in SE Europe.

This project is the result of the continuing cooperation between WHO/EURO and the countries in SE Europe. It has the purpose to provide support to the countries in SE Europe regarding development and strengthening of their food and nutrition policies.

Besides providing support to partners in government there will be special attention given to public participation and the development of civil society through the development of NGOs.

The project time frame is 24 months. The project design provides clear objectives in terms of expected products exposing the logic of how the project is expected to work indicating the human and financial resources and defining indicators by which progress can be monitored and evaluated.

This project will have a beneficiary influence on the process of EU accession so that dietary guidelines and other diet related recommendations are in line with those of the EU Member States.

Assistance will consist of advisory assistance, training and education, facilitating and coaching and provision of equipment and project funds. Each country will be provided with the assistance needed for creating optimal conditions for the implementing of their food and nutrition policies

In order to achieve an optimal networking in SE Europe positive experiences from participating

countries from neighbouring countries will be available and if appropriate qualified experts from neighbouring countries will provide assistance as local experts.

Summary description of subtasks:

1. Development of a comprehensive and integrated Food and Nutrition Policy for each country. All WHO Member States endorsed the World Declaration and Plan of Action for Nutrition at the International Conference on Nutrition in 1992. More recently the First Food and Nutrition Action Plan for European Region was endorsed by the 51 Member States in September 2000. WHO through its WHO country offices and nominated governmental national experts in food and nutrition can assist countries to develop their national policies based on the European Model. Similarly the European Commission is working on its draft Action Plan for food and nutrition policy which should be published during the Autumn of 2001.

An intersectoral "Food and Nutrition Council" or similar mechanism will be given the responsibility of developing this policy document through a broad consultative process.

2. A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases.

Nationally representative surveys will be carried out to determine the food and nutrient intake of vulnerable groups in relation to the population, including infant and young children and the adult population. Nationally representative surveys to determine nutritional health and nutritional status will also be carried out in vulnerable groups and compared with the population.

In order to carry out these surveys countries will require the provision of equipment (laboratory equipment), reagents, computers, software, and field equipment, including logistic support and communication equipment.

3. Trained trainers in primary health care who can improve the practice of primary prevention of cardiovascular diseases.

The training of trainer courses will enable each country to acquire new or more detailed knowledge and practice relating to the prevention of cardiovascular diseases. Some of these courses will be conducted at the beginning of the project during periods 4–6 months. Basically three persons from each country, experts in the field, (one from central government, one from local government and one from an academic institution) should be selected to participate. A set of guidelines and training manuals will be provided during the training courses. The participants will convene in the institution responsible for organizing the course. The teachers will be selected from EU Member States. During these courses personal as well as inter-country links for future collaboration will be established. WHO/EURO will identify the trainers from EU Member States.

4. Trained trainers to strengthen the capacity of maternal and child care services to promote health and prevent death from cardiovascular diseases in adult life.

The training of trainers courses will enable each country to acquire new or more detailed knowledge and practice relating to maternal and child care services to promote health and prevent death from cardiovascular diseases in adult life. Some of these courses will be conducted at the beginning of the project during periods 4–6 months. Basically three persons from each country, experts in the field, (one from central government, one from local government and one from an academic institution) should be selected to participate. A set of guidelines and training manuals will be provided during the training courses. The

participants will convene in the institution responsible for organizing the course. The teachers will be selected from EU Member States. During these courses personal as well as inter-country links for future collaboration will be established. WHO/EURO will identify the trainers from EU Member States.

5. Improve public participation and the ability of civil society to improve social cohesion through the development of media campaigns, health education materials and the establishment of NGOs

Workshop on public participation planning;

Work with existing NGOs in Europe – e.g. European Heart Network; EPHA (European Public Health Alliance) encouraging branches of these already existing networks to be formed in each of these seven countries.

Expected Results and Deliverables:

1. Development of a national comprehensive and integrated Food and Nutrition Policy in each of the seven countries.
2. A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases in each country.
3. A report comparing the dietary risk factors in each country with those in the EU Countries.
4. Ten trained trainers in primary health care in each country who can improve the practice of primary prevention of cardiovascular diseases.
5. Adaptation and translation of the national materials needed to improve the practice of primary prevention of cardiovascular diseases.
6. Ten trained trainers to strengthen the capacity of maternal and child care in each country to promote health and prevent death from cardiovascular diseases in adult life.
7. Adaptation and translation of the national materials needed to promote health and prevent death from cardiovascular diseases in adult life.
8. Development of one media campaign in each country.
9. Development of health education materials
10. The establishment of one NGO in each country.

Longer-term:

- A 20% reduction in prevalence of cardiovascular diseases and premature mortality.
- A 30% reduction in medicines needed to treat cardiovascular diseases.
- A 10% decrease in unemployment.
- A stabilization of the numbers of people living in the rural areas with less moving to urban areas to seek jobs.
- An increased number of local farmers markets.
- An increase in trading of food between neighbouring countries and SE Europe
- Improved quality of life, security, peace and stability in the region through food and nutrition security

Expert Input to the Whole Project:

Expert Category

Expert Input/Unit m-days

Senior experts	2
Project Officers	7
Project Assistants	7
WHO Country Offices	7
In-Country Experts	14
TOTAL:	37

Project Description

Introduction

Activities can be divided into two activity levels:

A superior level with WHO EURO as an overall coordinator and provider of support to all seven countries and,

A lower level where each of the seven governments develops and implements its own food and nutrition policy

Health

Before the nineteen nineties most of the countries in SE Europe were relatively developed with good gross national product figures. Like all socialist countries they had an extensive system of pension-disability insurances, child protection, social protection of vulnerable groups and the right to free health care and education. During the periods of conflict there has been mass migration of millions of people. Most move from rural areas and villages to larger towns. In social terms this phenomenon could be called “forced urban migration”. Approximately 80% of the population in BiH now live in cities. To illustrate how high this is – this is the same as the level of urbanization within the EU compared with nearer 60–70% urbanization in most countries in central and eastern Europe.

This rapid degree of urbanization has a negative impact on the earning opportunities. The income in many families in the Region is not enough to meet even the most basic needs such as the food required to satisfy current WHO dietary recommendations. This means that many of the families are suffering from food insecurity. Peace and reconciliation can never return until the situation improves and the population can be sure that their food supply is secure and not threatened by black markets, fighting or minefields.

In addition some countries generate large foreign trade deficits, caused by higher levels of imports compared with exports. For example in BiH 90 million liters of milk and milk-products were imported in 1998. Lack of production capacity and lack of job result in high unemployment levels. For example more than half the workforce in BiH was unemployed in 1999.

The populations living in SE Europe generally have an unhealthy lifestyle. In addition to smoking many lead sedentary lifestyles and this combined with unhealthy diets results in high levels of premature mortality from cardiovascular diseases. The food intake of the people in SE Europe before the 1990s was generally high. There was a high consumption of meat, and fatty, sweet and salty foods. This resulted in high levels of obesity and cardiovascular diseases such as stroke, raised blood pressure, diabetes and heart disease.

Indeed evidence exists to demonstrate that the prevalence of cardiovascular diseases decreased during the conflict in SE Europe, similar to the European experience during the Second World War. A study carried out on non-insulin dependant diabetics during the war in Sarajevo demonstrated a dramatic reduction from one half to one quarter of the diabetics suffering from high blood pressure and the amount of diabetic medicines needed decreased by one third. Clearly if these improvements could be repeated the resulting savings and economic improvement for health care services could be dramatic.

Due to the poor socioeconomic conditions there are signs that the population is forced to adopt unhealthy eating patterns. Eating cheaper sources of calories, which tend to have a higher fat, salt and sugar content, than foods that are low fat, salt and sugar. Fruit and vegetables contribute little calories. Therefore if money is scarce, families spend their limited resources to secure sufficient calories, or energy, for their families. This means that they may not be able to afford little or no fruit and vegetables. This contributes significantly to the high prevalence of cardiovascular diseases, especially in smokers.

There is no data describing what the populations actually eat and this information is needed to develop effective food and nutrition policies. This information should be obtained through dietary intake surveys. The weight and nutritional status of the population should also be assessed in order to assess the effectiveness of the public health measures. In addition the prevalence and dietary determinants of cardiovascular disease should be determined in order to assess the impact of this project.

Historical background

The agriculture and food production sectors suffered substantial damages during the last ten years. Farms were destroyed, equipment was damaged, livestock was slaughtered and arable land was neglected. This has resulted in some places in up to 80% of the population being dependent on imported food aid. In contrast much of the Region comprises of arable land (50% of BIH comprises agricultural land). This natural resource forms the basis of a thriving agriculture sector but its current neglect will lead to potential environmental degradation. The current level of cultivation is critical and barely meets the basic food needs of the population (food security). The World Bank has identified the agriculture sector as a key to rural development by providing jobs for both returnees and residents.

It is desirable to stimulate rural development for many reasons. The rural population that has settled in cities exerts an enormous pressure on the scarce number of jobs and the limited housing. The living costs in cities are much higher than in villages and most of the displaced people are unemployed, so that the competition for the limited social security funds is high. Moreover there is a risk of constant tension between the traditional urban and the incoming rural people. They represent either the resident population of the displaced population respectively. The term "urban frustration" is commonly used when referring to the tensions that exist in the cities of SE Europe.

Clearly it will not be possible for everyone to return to their pre-war residence or to completely reverse all the urbanization. Therefore in addition, employment must be created for the displaced and previously rural people now living in cities. New businesses related to urban and periurban horticulture and food processing, distribution and retail could be established in and around cities to make use of the existing skills. Health ministries need to collaborate with agriculture ministries to plan how to minimize health risks and maximize the natural resources, notably land, labour, in addition to local knowledge and skills. Revitalized agriculture and food businesses would benefit from competitive advantages in the markets of the EU and neighbouring countries. In addition many wild herbs and mushrooms can be found throughout SE Europe. Due to the

economic collapse and the fact that many industrial plants, which were the main source of pollution, have been forced to close, wild herbs and vegetables and fruits can be grown organically or at least without risk of contamination.

In contrast to the agriculture sector the health sector under the present socioeconomic conditions is unable to improve the health status of the population without improvements in food and nutrition security. Particularly where the expenditure on health services is low and largely dependent on foreign aid.

Consequently in order to improve the health status of the population policy makers in SE Europe must begin to seek other intersectoral strategies which will help to maintain the health of the population and so prevent them from getting sick. It is challenging for the health sector to develop intersectoral policies and usually much easier to just continue to work in the same old ways but this project is designed specifically to help the health sector learn how to develop intersectoral policies that promote public health. This approach will have a very positive impact on the peace by promoting reconciliation and stability with the Region. This project will be especially useful since it recommends that all the seven countries in SE Europe work together to develop their own national food and nutrition policies and action plans by working together through Regional networks. National food and nutrition security is vital for stability in SE Europe.

Background – Health and the Stability Pact Initiative for Social Cohesion

The overall task objective is to create an environment where public health, economic and social policy can be sustainable through the development of a national comprehensive and integrated food and nutrition policy in each of the seven countries in SE Europe. This could improve the social well being of the population in addition to creating new job opportunities and a healthier environment to live in. As an outcome of promoting local healthy food production better retailing and improved food and nutrition security, cardiovascular diseases can be prevented. New jobs could be created and the trade balance figures improved. In addition a durable peace and improved social cohesion could be built through the return and reconciliation of internally displaced persons and refugees who have the skills to produce food in the rural areas. There are many benefits to be gained from developing and implementing a food and nutrition policy. Many sectors have to be involved in addition to the health sector: agriculture, trade, food processing businesses, retail businesses, education sector, civil society and the general public. By promoting this intersectoral approach to food and nutrition policy development WHO can assist the countries in SE Europe to prevent cardiovascular diseases and promote public health. In other words growing, buying and eating the right kinds of foods can reduce the risk of cardiovascular diseases and simultaneously promote sustainable development while helping to repatriate displaced populations.

This will contribute to a durable peace in the Region.

Details of Subtasks

Subtask A: Development of a comprehensive and integrated Food and Nutrition Policy in each of the seven countries.

Summary:

One of the six main strands of the Project is development of a comprehensive and integrated food and nutrition policy targeted at the most vulnerable. Food and nutrition policies will incorporate priority objectives and strategies taking into account country specific needs and the

importance of implementing disease prevention programmes as well as having a continuing education for professionals but also for general population in the area of nutrition in order to ensure the adoption of proper diet as a healthy lifestyle. It will also consider modern eating habits with the aim of promoting healthy nutrition and hence contribute to the better health of nations.

Objectives:

Development of a comprehensive and integrated Food and Nutrition Policy.

National Food and Nutrition Policies will integrate nutritional objectives into national strategic policies and programmes related to improving nutritional status and health through:

- improvement of food quality and safety;
- continuous household food security through sustainable local and regional food production and retail;
- control of food borne diseases and contaminants;
- promotion of breastfeeding;
- adequate nutrition for socioeconomically deprived and nutritionally vulnerable;
- prevention and control of specific micronutrient deficiencies;
- promotion proper dietary habits and healthy lifestyles;
- monitoring the nutritional situation and status of population with special emphasis on nutritionally vulnerable segments of population.

Justification:

In order to achieve the implementation of goals of National Food and Nutrition Policies, which reflect the nation's commitment, it is necessary to secure a multisectoral cooperation with suitable political support, authority, infrastructure and legislation that will lead to improvement of quality of food and nutrition in all seven countries.

The development of national legislation and implementation of other appropriate measures aimed at improving food security, food safety, prevention of food borne diseases, elimination of specific micronutrient deficiencies, promotion of proper diets including breastfeeding and continuous monitoring of nutrition situation will establish a network involving all countries in the Region and thus provide added value through mutual learning experience.

Description:

- Initial workshop with representatives of seven countries (two persons from each country who will be in charge of drafting national Food and Nutrition Policies) plus WHO representative and senior project officers.
- Workshops in each of the seven countries: three day workshops will be organized in each of the seven countries with the objective of preparing draft versions of their Food and Nutrition Policies. Workshops should be attended by project officers, governments, NGOs, the food industry and consumers representatives. Realization of developments of national draft documents by the members of "Food and Nutrition Council" or a similar body.
- Roundtable discussion and consultation with different sectors via written suggestions and comments.
- Joint workshops for all countries – status report preparation

- Finalization of draft documents
- Submission of the documents to each country's governments/parliaments for adoption.

Summary timetable:

Activities	Activity/Month											
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
Initial workshop with representatives of seven, WHO representative and senior project officer	x											
Organization of a three-day workshop in each of seven countries.		x										
Realization of developments of national draft documents			x	x								
Roundtable discussion and consultation with different sectors via written suggestions and comments					x	x	x	x				
Joint workshops for all countries – status report									x	x		
Finalization of draft documents											x	x
Submission of the documents to each country's governments/parliaments for adoption.												x
Preparation of report												x

Expected results and deliverables:

1. Development of a national comprehensive and integrated Food and Nutrition Policy in each of the seven countries.

External input:

Expert Category

Expert Input/Unit m-days

Senior experts – two persons: 7 countries x 5 days = 70 working days

Project Officers – 7 persons: 7 countries x 25 days = 105 working days

Project Assistants – 7 persons: 7 countries x 30 days = 210 working days

WHO Country Offices – 7 persons x 10 days = 70 working days

In-Country Experts – 2 persons from seven countries = 14 persons x 30 days = 420 days

TOTAL: 875 days

Subtask B: A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases.

Summary:

In all countries of the Region exists the obvious need for a multicentre collaborative epidemiological research in the field of nutrition as a complementary part of health monitoring programs needed in order to improve dietary habits and promote healthier life styles with the objective of preventing cardiovascular diseases, the leading cause of death and disability in all countries of the Region. In some countries of the Region for more than a decade there is a lack of relevant data or the data at the national level exist but there is regrettably a lack of internationally comparable data (among the countries of the Region and EU).

Thus there are unfortunately no available nationwide food consumption surveys providing nutrient intake data on the individual level.

Proposed base line survey will assess present situation concerning major dietary risk factors contributing to the high prevalence of cardiovascular diseases. The study will focus on dietary indicators selected on the basis of their relevance to the development of cardiovascular diseases.

Survey will focus on:

- dietary habits of adolescent and adult population
- Study will assess breastfeeding and complementary feeding practices of infants 0–2 years.

Objectives:

- To assess infant and young child feeding practices 0–2 years of age.
- To assess dietary habits and physical activity among in adolescent population.
- To assess dietary practices and physical activity among adult population, age 18–64 years.
- To collect data on the general knowledge and attitudes concerning the impact of nutrition on health.
- To determine the prevalence of obesity, especially among vulnerable groups (schoolchildren, middle age men).

Justification:

To enable governments to put in place standardized monitoring programmes which would contribute to the establishment of a national health monitoring systems that would allow measurement of health status, trends and determinants and thus help in facilitating planning by providing appropriate health information to make comparison and support in development of national health policies.

Description:

Initial coordination meeting for the country coordinators and representatives with WHO representative, senior project officers and WHO liaison officers.

SURVEY:

Methods:

For adolescents and adult population the minimum set of dietary indicators would include:

Foods: fruits, vegetables, fish, bread, fats.

Nutrients: energy intake, total fat (% of E), SFA (% of E), cholesterol, Na, Ethanol.

Biomarkers: for practical reasons it is recommended to collect only urine samples for determination of Na excretion (20% of sample).

Each of the seven countries will carry out:

- a minimal number of repeated non-consecutive 24-hour recall interviews which
- will allow calibration with other countries
- conduct FFQ in order to assess dietary habits (seasonal variations: winter/spring and summer/autumn seasons)
- apply questionnaires in order to assess knowledge and attitudes toward the nutrition as a risk or protective factor in development/prevention of cardiovascular diseases.

Food classification system: European Food Grouping System,

Food composition database: national food comp. Data bases or CRO FDB

Software: HRANA that enables composition at the raw edible ingredient level for fruits including fruit juices, vegetables excel. potatoes, fish and fats).

Infants and small children:

Questionnaire on breastfeeding and complementary feeding practices will be conducted in the presence of mothers or care givers of children.

Sample size should be representative of geographic distribution (rural/urban):

Infants and small children: 1000 – age 0–2 years – per country

Adolescents: 1000 – 7th and 8th grade elementary school children – per country

Adults: 1000 age and gender stratified random sample, age 18–64 years – per country

For presentation of data it is necessary to analyse data accordingly: mean, median, quartiles distribution, P5 and P95.

Training courses: 1-week seminars/training for interviewers (nurses, dieticians, nutrition students)

Intermittent coordinative meetings (sample size selection, preparation of questionnaires, field work status reports, statistical analyses planning and reports etc.).

Summary timetable:

Activities	Activity/Month											
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
Initial coordination meeting	x											
Sample size selection		x										
Software development			x	x	x							
Preparation of questionnaires		x	x									
Training courses for interviewers					x	x						
Field work						x	x	x	x	x		
Laboratory analysis							x	x	x	x	x	
Intermittent coordinative meetings			x		x		x		x		x	
Statistical analysis												x
Preparation of report												x

Expected results and deliverables:

1. A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases in each country.
2. A report comparing the dietary risk factors in each country with those in the EU Countries.

External input:

Expert Category

Expert Input / Unit m-days

Senior experts: 2 experts x 11 days x 7 countries = 144 days

Project Officers: 7 x 60 days = 420 days

Project Assistants: 7 x 70 days = 490 days

WHO Country Offices: 7 x 15 days = 105 days

In-Country Experts 7 countries x 5 national experts x 110 days = 3850 days

TOTAL: 5009 working days

Subtask C: Trained trainers in primary health care who can improve the practice of primary prevention of cardiovascular diseases.

Summary:

In order to strengthen capacity and upgrade professional competence of primary health care professionals with the main objectives of preventing cardiovascular diseases, main task will be approached at three different steps. Objective will be implemented through organized courses and seminars for trainers in primary health care who can improve the practice of primary prevention of cardiovascular diseases. Workshops, seminars and courses will be conducted in collaboration with EU experts.

Courses on risk assessment and public health measures topics aimed at prevention of cardiovascular diseases and health promotion will be organized at two levels, one for the invited

experts from seven countries as a coordinative meeting and three two days national/local level seminars intended for national experts and professionals from PHC and professionals in the field of public health.

Objectives:

- Upgrade professional competence and skills of primary health care professionals (paediatricians, school medicine doctors, family medicine doctors, epidemiologists, and public health experts) through acquiring knowledge and skills targeted to prevention of cardiovascular diseases and promotion of healthy nutrition and physical activity a personal choice in the countries of the Region.
- Decrease the mortality rates caused by cardiovascular diseases and premature mortality in longer term by 20%.

Justification:

Subproject “Trained trainers in primary health care who can improve the practice of primary prevention of cardiovascular diseases” will contribute to the share of knowledge and experience among experts of involved neighboring countries and will provide assistance to experts working on the local level. All activities and diet related materials would be in line with EU recommendations, which will also contribute to the process of EU accession of involved countries.

Description:

- Initial two day course “The Role of Diet in Prevention of CHD” will be organized for local experts in the field of epidemiology of noncommunicable diseases, representatives of ministry of health, and academic institutions). It is planned to invite 3–4 persons from each country.
- After the initial course it is foreseen to conduct three two-day local level seminars in each country.
- Mass media campaign

Summary timetable:

TRAINING OF TRAINERS:

Activity/Month

Activities	Months											
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
Initial two day course on the role of diet in prevention of CHD organized for participants of 7 countries	x											
3 x 2 day local level seminars x 7 countries			x	x	x							
Preparation of report						x						

Expected results and deliverables:

1. Ten trained trainers in primary health care in each country that can improve the practice of primary prevention of cardiovascular diseases.
2. Adaptation and translation of the national materials needed to improve the practice of primary prevention of cardiovascular diseases.

External input:

Expert Category

Expert Input/Unit m-days

Senior experts: 3 persons x 4 days, 2 persons x 7 days = 28 days

Project Officers: 7 countries/ 1 person x 11 days = 77 days

Project Assistants: 7 countries / 1 person x 15 days = 105 days

WHO Country Offices: 7 persons = 10 days = 70 days

In-Country Experts: 7 countries x 21 = 147 days

TOTAL: 427 days

Subtask D: Trained trainers to strengthen the capacity of maternal and child care services to promote health and prevent death from cardiovascular diseases in adult life.

Summary:

Courses on upgrading maternal and childcare services to promote health and prevent death from cardiovascular diseases in later life will primarily focus on primary health care professional's role in improving infant and young child nutrition practices in all seven countries to ensure the healthy start in life. This includes increased number of mothers who exclusively breastfeed their infants for at least six months and increased number of mothers who continue breastfeeding their infants until about two years or longer with timely and appropriate introduction of complementary feeding.

Objectives:

- To evaluate infant and young child feeding practices 0–2 years of age, regarding the breastfeeding and complementary feeding practices.
- To strengthen the Baby Friendly Hospital Initiative and maintain high standards and commitment among health workers.
- To increase access to antenatal care with special emphasis to education about breastfeeding and delivery care which supports breastfeeding.
- To increase health worker skills by upgrading professional competence of health workers who counsel and assist mothers and children on breastfeeding, complementary feeding, HIV and infant feeding and when necessary artificial feeding practices.
- To raise awareness of health workers toward their obligations related to the enforcement of the International Code of Marketing of Breast Milk Substitutes and national measures to give effect to it.

Justification:

This subproject will contribute to the realization of commitments and obligation of national governments to implement and ensure the fulfilment of the rights of children to the highest attainable standard of health and the right of women to full and unbiased information which will result in improving infant and young child feeding but also contribute to the prevention of cardiovascular diseases in later life.

Description:

- Two day course on maternal and child health care services will be organized as an initial course intended for country representatives in collaboration with WHO representative and EU experts. Invited participants (three from each country) will be recruited from local mother and child health care experts, representatives of central, local government and academic institutions.
- One day seminars at the national levels in collaboration with EU experts, WHO liaison officers and visiting neighbouring experts will be conducted in each country. It is foreseen to invite 15–20 local experts to each seminar.
- Preparation of education materials on breastfeeding practices (manuals for health care workers, pregnant women and mothers).

Summary timetable:

Activities	Activity/Month											
	Months											
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
Initial coordinative meeting for seven countries	x											
Preparation of educative material for participants		x	x	x								
Initial 2 day course on maternal and child health care services organized for participants of 7 countries						x						
Two one day seminars on MCH services for each of seven countries							x					
Preparation of report								x				

Expected results and deliverables:

1. Ten trained trainers to strengthen the capacity of maternal and child care in each country to promote health and prevent death from cardiovascular diseases in adult life.
2. Adaptation and translation of the national materials needed to promote health and prevent death from cardiovascular diseases in adult life.

External input:

Expert Category

Expert Input/Unit m-days

Senior experts: 2 x 18 days = 36 days

Project Officers: 7 x 4 days = 28 days

Project Assistants: 7x 8 days = 56 days

WHO Country Offices 7x 4 days = 28 days

Subtask E: Improve public participation and the ability of civil society to improve social cohesion through the development of media campaigns, health education materials and the establishment of NGOs

Summary:

Mass media campaign targeted to prevention of cardiovascular diseases and health promotion will be organized and implemented in all seven countries of the Region. Health messages will be conveyed to general population through TV, radio, health education materials, jumbo posters, and round table discussions open to general population, newspapers and magazines. In order to ensure support to mass media campaign and to provide assistance in managing and implementing such activities, NGO will be established.

Objective:

- Increase the awareness and knowledge of general population about the role of diet and physical activity in prevention of cardiovascular diseases.

Justification:

Acceptance of self-responsibility for personal health as well as acceptance of healthy life styles will be promoted as a personal choice.

The change in attitudes and behaviour will in longer-term result up to 30% reduction in medicines needed to treat cardiovascular diseases.

Public participation and the development of NGOs in the countries of Region will be stimulated.

Description:

Mass media campaign will comprise of following activities:

- TV spots: five television spots (four translated in all countries, one country specific)
- Radio messages: seven messages (five translated in all countries, two country specific)
- Newspapers and magazines: six advertisements/messages (five translated in all countries, one country specific)
- Jumbo posters: one diet, one BF, one physical activity (same for all countries, translated)
- Posters: three types of posters (same, translated in all countries of the Region)
- Health education material: one brochure on the role of diet in prevention of cardiovascular diseases, one brochure on breastfeeding promotion) – same material translated in all seven countries.
- Leaflets: lifestyles (diet, physical activity and smoking) as risk factors for development of cardiovascular diseases) and leaflet on promotion of breastfeeding (same only translated for all seven countries of the Region).
- Roundtable discussions: five topic specific, open public round table discussions in different regions of each country of the Region.
- Establishment of one NGO in each of the seven countries in the region responsible for organization and logistic service of the project will be encouraged to start as soon as the project is accepted.

Summary timetable:

	Activity/Month											
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
Mass media campaign												
NGO establishment	x											
TV spots				x	x							
Radio broadcasting			x	x	x	X	x	x	x	x	x	x
Newspapers advertisements		x	x	x	x	X	x	x	x	x	x	x
Jumbo posters						X	x	x				
Posters				x		X		x		x		
TV emissions			x		x		x		x		x	
Educative materials Leaflets, brochures			x			X		x				x
Round table discussions			x	x			x		x	x		
Preparation of report												x

Expected results and deliverables:

1. Development of one media campaign in each country.
2. Development of health education materials
3. The establishment of one NGO in each country.

External input:

Expert Category

Expert Input / Unit m-days

Senior experts: 2 persons x 10 days x 7 countries = 140 days

Project Officers: 7 countries/ 1 person x 11 days = 77 days

Project Assistants: 7 countries / 1 person x 15 days = 105 days

WHO Country Offices: 7 persons x 10 days = 70 days

In-Country Experts: 7 countries x 15persons x 24 days = 2520 days

TOTAL: 2912 days

Budget**Total budget requested: US \$1 700 000**

To be divided between five subtasks as follows:

Subtask A: Development of a comprehensive and integrated Food and Nutrition Policy in each of the seven countries
= US \$340 000

Subtask B: A situation analysis of the dietary risk factors contributing to the high prevalence of cardiovascular diseases
= US \$340 000

Subtask C: Trained trainers in primary health care who can improve the practice of primary prevention of cardiovascular diseases
= US \$340 000

Subtask D: Trained trainers to strengthen the capacity of maternal and child care services to promote health and prevent death from cardiovascular diseases in adult life
= US \$340 000

Subtask E: Improve public participation and the ability of civil society to improve social cohesion through the development of media campaigns, health education materials and the establishment of NGOs
= US \$340 000

Activity:	Percentage of allocated budget:
National activities	65%
Intercountry activities	25%
Steering Committee activities	10%

Coordination and management of national level activities will be in kind contribution of countries involved.

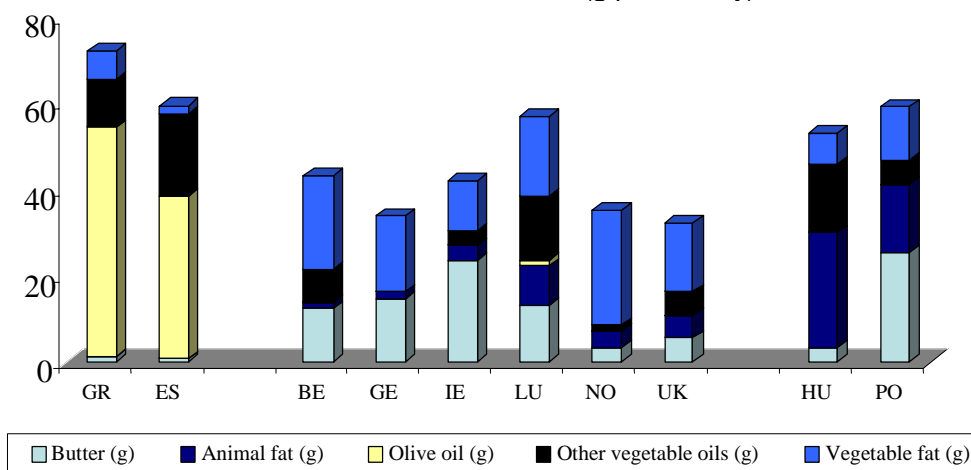
Annex 5

DAFNE INFORMATION

The DAFNE Networking Project includes:

Countries	Years of HBS data
Austria	In process
Belgium	1987/1988, 1996/1997, 1999
Finland	In process
France	1985, 1991, 1995
Germany	1988. In process
Greece	1981, 1987/1988, 1993/1994, 1998/1999
Hungary	1991
Ireland	1987, 1994, 1999
Italy	1990, 1993, 1996
Malta	1994
Norway	1986–1998, 1992–1994, 1996–1998
Poland	1988
Portugal	1989/1990, 1994/1995, In process
Spain	1980/1981, 1990/1991, 1998/1990
Sweden	In process
United Kingdom	1985–1999 (15 surveys)

. Results for average availability of total added lipids by type in the DAFNE countries (g/person/day)

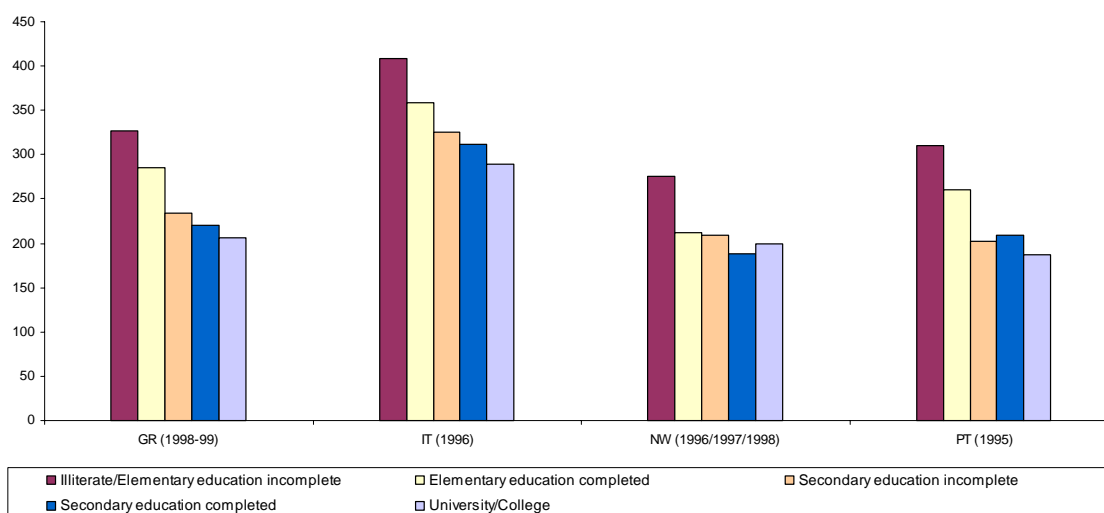


Results of DAFNE for consumption of vegetables and fruit according to WHO recommendations (expressed as percentage of low consumers)

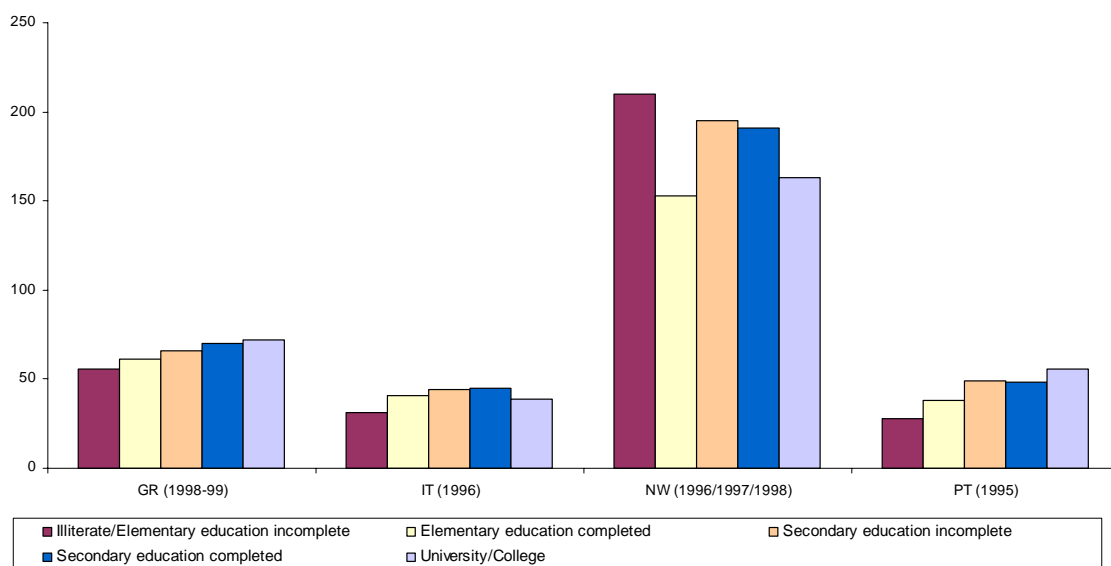
Countries	Fruit < 150 g/p/day	Vegetable < 250 g/p/day
Belgium	68	76
France	59	71
Germany	45	88
Greece	30	50
Hungary	66	76
Ireland	74	80
Italy	34	71
Luxembourg	41	83
Norway	69	93
Poland	81	75
Portugal	55	83
Spain	30	72
United Kingdom	70	78

Food availability by education

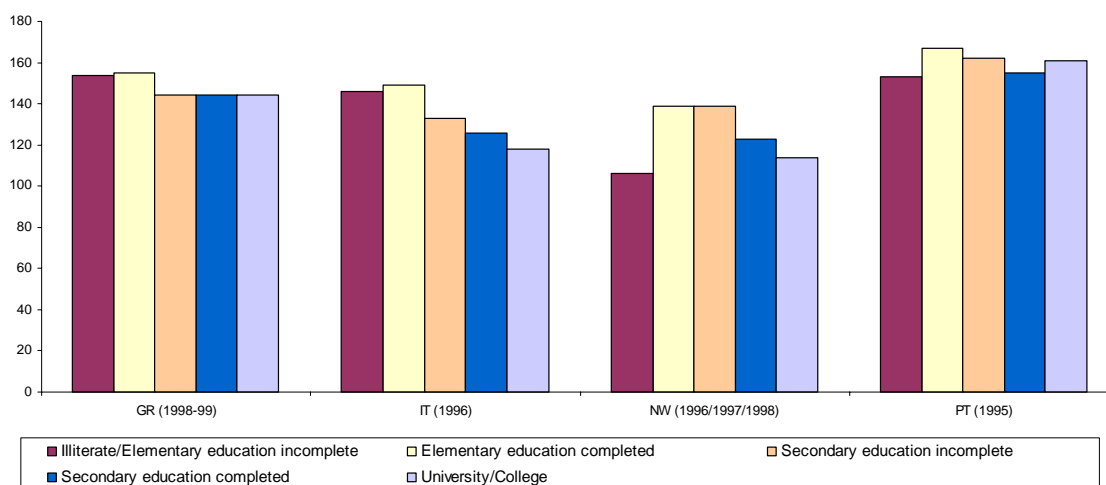
Mean availability of cereals by education level of household head (g/person/day)



Mean availability of soft drinks by education level of household head (mL/person/day)



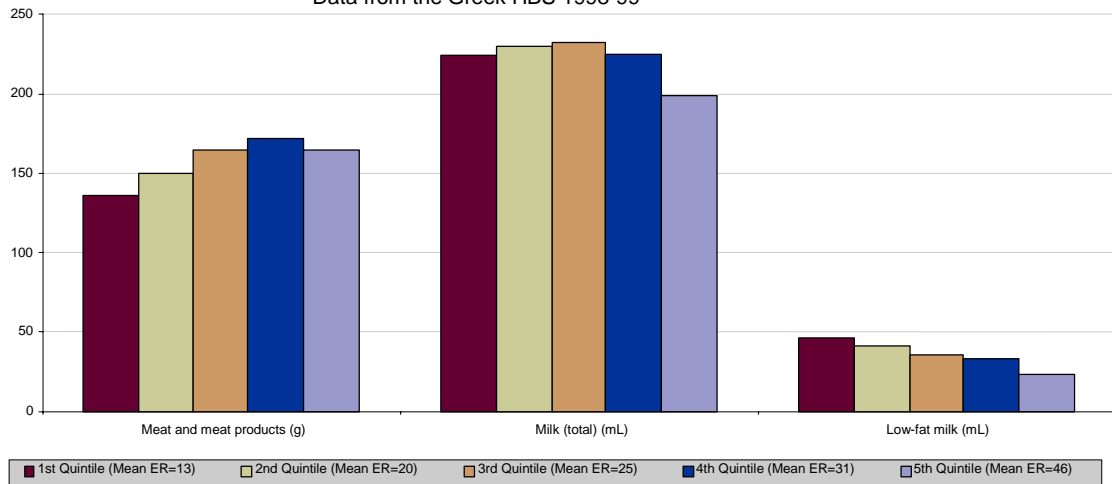
Mean availability of meat and meat products by education level of household head (g/person/day)



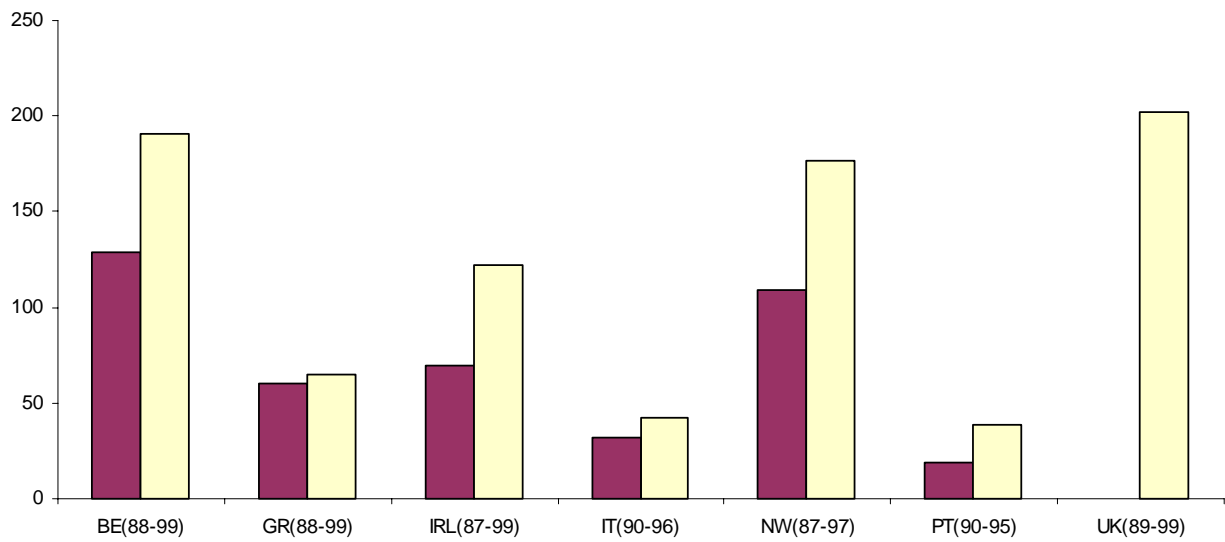
. The data for food expenditure

Mean availability of meat and meat products, milk (total) and low-fat milk by quintiles of the households' food expenditure ratio.

Data from the Greek HBS 1998-99



Mean availability (mL/person/day) of soft drinks by country and year.



Annex 6

TERMS OF REFERENCE OF AN INFORMAL REGIONAL WORKING GROUP AND PLAN OF ACTION OF ACTION

In follow-up to the discussions and agreements reached between the nominated Nutrition counterparts from the countries of South Eastern Europe at their recent First Technical Workshop on Food and Nutrition Policies and Legislation, Belgrade, 12–13 November 2002 an **Informal Regional Working Group on Nutrition (IRWGN)** is established to form a collaborative network with the objective to carry out activities in the field of nutrition for the South Eastern Europe Health Network within the framework of the Social Cohesion Initiative of the Stability Pact for SEE.

The **IRWGN** comprises of designated nutrition experts, officially nominated by the Ministries of Health of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, The former Yugoslav Republic of Macedonia, Republic of Moldova, Romania and Yugoslavia. Representatives of Greece, Hungary and Slovenia, in the capacity of neighboring and donor countries, will also participate. The former Yugoslav Republic of Macedonia will undertake the coordinating and leading role. List of members of the IRWGN is presented in Annex 1.

As a supportive body to the SEE Health Network, the IRWGN will work fully in line with the principles of work and collaboration agreed at the 4th Meeting of the SEE Health Network, Hillerød, 26–28 May 2002. It will have the following specific functions:

- Developing and fund-raising for regional project proposals within the Regional Programme “Developing and Strengthening Food and Nutrition Strategies to Prevent Cardiovascular Diseases in South East Europe”;
- Supporting the process of implementation of regional projects in the area of nutrition;
- Creating a sustainable network and working daily links between the SEE countries at all levels, including governmental, institutional and expert, as well as with all relevant international agencies involved in nutrition related activities in the region;
- Providing advise to the respective regulatory bodies in the SEE countries concerned in relations to decisions having essential significance for healthy diets, including on policies, strategies, risk assessment, monitoring and management;
- Establishing an appropriate set of nutritional indicators and information network for the SEE Regional;
- Promoting of nutrition policies and actions, raising awareness and mobilizing the general public and individuals.

The IRWGN will undertake the following immediate actions:

No	Deadline	Activity	Responsible Institution	Note
1.	01 Dec. 2002	Preparation and agreement on ToR and plan of action of the IRWGN	FYM WHO/NUT	
2.	10 Dec. 2002	Establishing communication lines for the network	FYM WHO/NUT	
3.	20 Dec. 2002	Revising the draft Regional Programme on Nutrition and CVDs for SEE	FYM SEE experts WHO/NUT	
4.	20 Dec. 2002	Information on legal and other conditions in SEE to join the DAFNE project of EU on Nutrition Surveillance	SEE FUM GRE WHO/NUT	
5.	20 Dec. 2002	Preparation of portfolio of draft bankable project proposals based on the programme modules (components)	FYM SEE experts WHO/NUT	
6.	20 Jan. 2003	Consultation with SEE MS on the revised programme and portfolio with project proposals	FYM SEE	
7.	30 Jan. 2003	Revision and finalization of programme and projects	FYM	
8.	30 Jan. 2003	Drafting Application to the EC DAFNE Project	GRE SEE WHO/NUT	
9.	15 Feb. 2003	Fund-raising strategy preparation	FYM SEE experts	
10.	27 Feb. 2003	SEE Meeting on Nutrition Surveillance (DAFNE Project), Athens	GRE WHO/NUT FYM	