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Progress reports

This document contains consolidated progress reports on:

A. implementation of the European Action Plan for HIV/AIDS 2012–2015;
B. renewed commitment to elimination of measles and rubella and prevention of congenital rubella syndrome by 2015 and sustained support for polio-free status in the WHO European Region;
C. malaria elimination in the WHO European Region;
D. the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016;
E. the WHO European Declaration and Action Plan on the Health of Children and Young People with Intellectual Disabilities and their Families;
F. implementation of the Strategy and action plan for healthy ageing in Europe, 2012–2020;
G. the health-related Millennium Development Goals in the WHO European Region;
H. implementation of the European strategic action plan on antibiotic resistance.

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Category 1. Communicable diseases

A. Final progress report on implementation of the European Action Plan for HIV/AIDS 2012–2015 (resolution EUR/RC61/R8)

Introduction and background

1. In 2011, the 61st session of the Regional Committee for Europe adopted the European Action Plan for HIV/AIDS 2012–2015 *(1)* in resolution EUR/R61/R8, which requested the Regional Director to report on its implementation at the 64th and 66th sessions of the Regional Committee, in 2014 and 2016, respectively. This report, which should be read in conjunction with the Action Plan, describes progress made on the implementation of the Plan from 2012 to 2015 and identifies the challenges that remain.

Situation analysis

2. While global investments in the HIV response are paying off and new HIV infections and HIV-related deaths are declining globally, significant HIV transmission continues in the WHO European Region. A 23% increase in the annual number of people newly diagnosed with HIV during the four years since the European Action Plan was developed (2010–2014) emphasizes the continuing public health challenge of HIV in the Region. This change is largely driven by the high and increasing number of new cases in eastern Europe and central Asia, where population groups at highest risk of HIV infection often do not receive the comprehensive HIV services they need. More than 142 000 people were newly diagnosed with HIV in 2014, the highest number ever reported in one year: 77% of new cases were in the east[1] (43.2 per 100 000 population), with the Russian Federation accounting for almost 80% of cases; 19% in the west (6.4 per 100 000); and 3% in the centre (2.6 per 100 000) *(2)*.

3. The epidemic is concentrated in populations at higher risk of HIV infection – people who inject drugs, men who have sex with men, sex workers, prisoners and migrants – and their sexual partners – with considerable variation in epidemic patterns and trends across the European Region. HIV transmission linked to heterosexual sex is the main reported mode of HIV transmission in the east, although emerging evidence suggests that a substantial proportion of men reported as heterosexually infected may in fact be men who have sex with men or injecting drug users *(3)*. Transmission through injecting drug use remains low in western and central Europe and is declining in the

[1] Country groupings follow those used in the joint WHO/European Centre for Disease Prevention and Control annual reports on HIV/AIDS surveillance in Europe, which are based on epidemiological considerations. The eastern part of the Region (“the east”) comprises: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan; the central part of the Region (“the centre”) comprises: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, the former Yugoslav Republic of Macedonia and Turkey; and the western part of the Region (“the west”) comprises: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland and the United Kingdom.

majority of countries in the east. However, HIV transmission related to injecting drug use continues to dominate in the Russian Federation and accounts for almost half of all new HIV diagnoses with a known mode of transmission in the east.[2] HIV transmission through sex between men predominates in the west and centre of Europe and is increasing across the entire Region.

4. In 2014, migrants[3] represented 31% of people newly diagnosed with HIV in the Region: 22% were non-European migrants (people originating from outside Europe) and 9% were European migrants (people originating from a European country other than the reporting country). New diagnoses among non-European migrants decreased by 41% but increased by 48% among European migrants between 2005 and 2014 *(2)*.

5. In some countries, up to half of the people living with HIV remain unaware of their infection. Among those diagnosed, late diagnosis remains a challenge. In 2014, 48% of people newly diagnosed had a CD4 cell count < 350 per mm^3 of blood, with significant variation across countries (27–77%) and across transmission mode and with no change since 2010.

6. The number of people receiving antiretroviral therapy (ART) in the European Region continued to increase, reaching about 1 million in 2015 – a trend that has been observed across all countries. The sharpest increase was evident in the east, where the number of people on ART increased by 187%: from 112 100 in 2010 to 321 800 in 2015 *(4)*. In the western part of the Region, ART coverage[4] was high, averaging around 75%. However, in the east only 21% of people living with HIV were receiving ART in 2015, which is well below the global average of 46% *(5)*.

7. Partly as a result of the factors described above, the annual number of AIDS diagnoses increased by 49% in 2014 compared with 2010 while estimated AIDS-related deaths increased by 24% between 2010 and 2015 in the eastern part of the Region.

8. The burden of coinfections for people living with HIV in the European Region remains high with 8% of notified tuberculosis cases being HIV-positive in 2014 – a percentage that is increasing in the east and declining in the west *(6)*. The total number of HIV-positive people coinfected with tuberculosis increased by 43% in the Region between 2005 and 2014. While tuberculosis remained the most common AIDS-indicative disease in the east in 2014 *(2)*, tuberculosis-related deaths among people living with HIV decreased by 34% between 2004 and 2013. Of the estimated 2.3 million people living with HIV who are coinfected with hepatitis C virus globally, 27% live in eastern Europe and central Asia. An estimated 83% of HIV-positive people who inject drugs in the east and 70% in the west and centre are coinfected with hepatitis C *(7)*.

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[2] For those cases with a presumed mode of transmission recorded.
[3] Measured as the percentage of people originating from outside the reporting country.
[4] Measured as the percentage of people living with HIV (diagnosed and undiagnosed and regardless of CD4 cell count) receiving ART.

Achievements and challenges

9. In 2011, Member States endorsed the first ever European Action Plan for HIV/AIDS 2012–2015 as an urgent call for action to respond to the public health challenge of HIV in the European Region. The Action Plan had three overall regional goals:

- to halt and begin to reverse the spread of HIV in Europe by 2015;
- to achieve universal access to comprehensive HIV prevention, treatment, care and support by 2015; and
- to contribute to the attainment of Millennium Development Goal 6 and other health-related Millennium Development Goals. While the third of these goals has been partially met *(8)*, the first two are yet to be achieved.

Strategic direction 1: optimize HIV prevention, diagnosis, treatment and care outcomes

10. During the past four years, the Regional Office has worked with Member States to review, adapt and adopt national policies and practices in accordance with WHO recommendations and with an emphasis on HIV testing, comprehensive HIV care and treatment (including screening and treatment of coinfections), harm reduction services and prevention of mother-to-child transmission (MTCT).

11. HIV testing services are increasingly available, accessible and affordable in the European Region, both in health care settings and in the community; however, community-based testing services and the use of rapid testing remain limited in the east. The quality and ethical standards of testing services vary and some countries do not adhere to standards of voluntary informed consent, confidentiality and/or prompt linkage to appropriate treatment, care and support.

12. The percentage of key populations at higher risk of HIV infection who were tested remained below the European target of 90% by 2015, with average testing rates ranging from 40–60% in 2014: the lowest rate across the Region was among men who have sex with men and in eastern Europe and central Asia among people who inject drugs, while the highest rate across the Region was among sex workers and in western and central Europe among people who inject drugs *(8)*. This was despite the increase in the overall numbers of people being tested, which confirms that HIV testing strategies are not sufficiently targeted at key populations.

13. The Regional Office supported Member States to expand access to high quality, evidence- and human rights-based HIV testing services by translating and disseminating the Consolidated guidelines on HIV testing services *(9)*, publishing a regional HIV policy framework on Scaling up HIV testing and counselling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support *(10)*, supporting several pan-European HIV testing initiatives and related conferences, and providing technical assistance to Member States.

14. The Action Plan's regional target to reduce new HIV infections acquired through injecting drug use by 50% was achieved in eight countries when measured using case

surveillance data (2010–2014) while in nine countries the reduction was 40–50%. Another 16 countries reported ≤ 2 cases annually during the four-year period.

15. The majority of countries in the European Region have implemented recommended interventions to prevent and treat HIV among people who inject drugs *(11)*. While this has resulted in low levels of injecting drug user-related HIV transmission in parts of the Region, coverage and availability of certain components are limited or unavailable in some countries: opioid substitution therapy was unavailable in five countries and needle and syringe programmes were unavailable in four.

16. In 2014, more than 745 000 people were receiving opioid substitution therapy in 46 countries. Yet only 3% of these were in the east, a 50% increase from 2010, despite the high burden of drug use. Coverage among people in need of such therapy ranged from less than 1% to 81% across countries but remained below 5% in all except three countries in the east.

17. The Regional Office, in collaboration with key partners, supported Member States in preventing new infections among people who inject drugs by:

- convening workshops and publishing guidance on implementing and scaling up opioid substitution therapy;
- convening a regional technical consultation on prevention of HIV in injecting drug users in central Asia;
- designating a new WHO Collaborating Centre for Harm Reduction[5] to develop capacity and provide technical support to promote high quality, evidence-based approaches to drug use; and
- undertaking research on improving access to harm reduction, treatment and care for injecting drug users and identifying structural barriers and environmental risk factors.

18. The Action Plan's regional target to reduce new HIV infections acquired through sexual transmission by 50% was achieved by only two countries while eight countries achieved reductions of 20% or more between 2010 and 2014. Condom use varied among key populations: in 2014, it was highest among sex workers (90%), lower among men who have sex with men (72% in the east; 60% in the west and centre) and lowest among people who inject drugs (42% in the east; 47% in the west and centre) *(8)*.

19. The Regional Office supported Member States in preventing sexual transmission of HIV and sexually transmitted infections (STIs) by translating and disseminating Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations *(12)*, policy briefs on pre-exposure prophylaxis of HIV infection, WHO guidelines on prevention and treatment of HIV and other STIs among men who have sex with men and transgender people *(13)*, and guidelines on laboratory diagnosis of STIs, and by providing technical assistance to Member States.

20. Significant progress was achieved and sustained in the prevention of MTCT of HIV. Dual elimination of MTCT of HIV and congenital syphilis remains a regional

[5] Public Health Institute, Faculty of Medicine, Vilnius University, Lithuania.

priority with several countries preparing formally to validate elimination based on WHO global validation criteria *(14)*.

21. The European Region maintained high coverage of antiretroviral medicines for pregnant women living with HIV (92%) to prevent MTCT (76–95%), of early infant diagnosis (70% in 2014) and of HIV testing and counselling for pregnant women (75% in 2013). The majority of countries in the east moved to the WHO-recommended option B+[6] for prevention of MTCT. Despite this progress, challenges to eliminating MTCT of HIV and congenital syphilis persist in some key populations.

22. The Regional Office supported Member States in eliminating MTCT of HIV and congenital syphilis by:

- promoting WHO recommendations and facilitating integration of HIV and syphilis prevention with maternal and child health services; and
- implementing two regional consultations to review progress and support capacity-building to validate dual elimination of MTCT of HIV and congenital syphilis, and conducting several country missions in collaboration with partners.[7]

23. Member States made progress in delivering HIV treatment and care to people living with HIV. Increasing numbers of people are initiated and retained on ART. However, global and regional expansions are unevenly distributed with only 21% of people living with HIV in the east receiving ART.

24. Member States are implementing the WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection *(15)*: seven countries in the centre and east have changed their national ART initiation criterion to "treat all" regardless of disease stage, or planned to do so in 2016, and seven countries have implemented a criterion of < 500 CD4 cells per mm^3. The majority of people on ART in the east received a WHO-recommended first-line regimen; fixed-dose combinations of antiretroviral drugs were widely used and viral load and CD4 cell count testing were available, although some countries face challenges with regard to routine viral load monitoring for all patients.

25. The Regional Office supported Member States in ensuring universal access to treatment and care for people living with HIV by:

- translating and disseminating WHO guidelines and recommendations and convening regional technical consultations to support implementation of the guidelines;
- designating a new WHO Collaborating Centre on HIV and Viral Hepatitis[8] to support the Regional Office in providing technical assistance to countries; and

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[6] Option B+ refers to the approach in which all pregnant and breastfeeding women living with HIV receive ART regardless of CD4 cell count or clinical stage, both for their own health and to prevent vertical HIV transmission, and for additional HIV prevention benefits.

[7] UNAIDS, the United Nations Children's Fund (UNICEF), the United Nations Population Fund, the European Centre for Disease Prevention and Control, the United Nations Office on Drugs and Crime, the United States Centers for Disease Control and Prevention, WHO collaborating centres, civil society, academia and others.

- providing technical assistance to countries eligible for funding through the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to prepare concept notes, to evaluate national HIV programmes and to address specific issues with regard to optimization of ART regimens, development of ART scale-up plans, adaptation of country policy to reflect the new WHO recommendations, and updating normative guidelines.

26. Although only 0.2% of new HIV cases were acquired in health care settings in 2014, new health care-related infections increased in the eastern part of the Region. While Member States are implementing quality-assured HIV screening of all donated blood, health care-related HIV outbreaks must be better prevented and controlled.

Strategic direction 2: leverage broader health outcomes through HIV responses

27. There has been some progress in integrating health services delivery for HIV, tuberculosis, hepatitis, STIs, drug dependence and other conditions. For example, HIV testing among notified tuberculosis patients reached 89% in 2014 and 59% of HIV-positive tuberculosis patients received ART. A few countries in the east also integrated delivery of opioid substitution therapy in ART settings and integrated this therapy in tuberculosis clinics. All countries with high burdens of HIV and tuberculosis were implementing the 12-point policy package on collaborative tuberculosis/HIV activities.

28. However, significant improvement is still needed to ensure comprehensive people-centred care and to reduce the number of people that are not retained in care. Screening for viral hepatitis is recommended as part of comprehensive HIV care, yet only one third of people in the east enrolled in HIV care were screened for hepatitis B and C in 2014; this situation has not changed since 2010.

29. The Regional Office supported collaborative activities and integration of programmes by:

- supporting integrated tuberculosis services for people who use drugs by publishing a guidance manual in collaboration with the Eurasian Harm Reduction Network and the European Commission;
- promoting dual HIV and hepatitis testing, including through the European HIV and hepatitis testing week campaign, and integration of HIV and hepatitis services through development of interlinked action plans for the health sector response to HIV and viral hepatitis; and
- publishing articles and documents addressing barriers to and facilitators of treatment for HIV, hepatitis C and tuberculosis, and strengthening links between prison health and public health services.

Strategic direction 3: build strong and sustainable systems

30. Member States made progress to various extents towards building strong, sustainable health systems. The vast majority of countries reported having a

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[8] Centre for Health and Infectious Disease Research, Department of Infectious Diseases, University of Copenhagen, Denmark.

multisectoral strategy to respond to HIV infection and most countries in the centre and east had an officially recognized national multisectoral AIDS coordination body.

31. Several countries opened new ART sites in remote areas or decentralized services to reach key populations, including migrants, through mobile clinics.

32. Donor dependence and a lack of sustainable national financing for the HIV response remain a challenge in the east, where many countries benefited from support provided by the Global Fund. However, governments are assuming stronger leadership: six countries doubled domestic public spending on HIV between 2009 and 2014 *(8)* and four are now fully responsible for funding their ART programmes. Funding for prevention programmes aimed at key populations, including harm reduction programmes, remains heavily dependent on funding through the Global Fund.

33. Stock-outs of antiretroviral drugs remained a concern in the east although the number of facilities that reported a stock-out was low and decreasing: five stock-outs of at least one required antiretroviral drug were reported for 2012 and two for 2014.

34. The Regional Office directly supported building strong, sustainable systems by:

- promoting and providing technical assistance for the decentralization of HIV treatment and care services;
- supporting an initiative for improving the quality of HIV prevention in Europe with the German Federal Centre for Health Education and AIDS Action Europe; and
- strengthening human resource capacities by developing an online training course on the clinical management of HIV, in English and Russian, in collaboration with the WHO Collaborating Centre on HIV and Viral Hepatitis and the European AIDS Clinical Society.

35. The Regional Office continued to strengthen strategic information systems for surveillance, monitoring and evaluation of HIV in Europe by:

- coordinating regional surveillance jointly with the European Centre for Disease Prevention and Control, with annual data collection and surveillance report publications being the key outcomes: in 2014, 50 Member States (94%) submitted data;
- organizing biennial HIV surveillance network meetings jointly with the European Centre for Disease Prevention and Control for all WHO Member States in the European Region;
- contributing to the annual Global AIDS Response Progress Reporting through a joint interagency process[9] with harmonized indicators, and to the publication of regular progress reports on the health sector response to HIV;
- translating and disseminating the Consolidated strategic information guidelines for HIV in the health sector *(16)* to support prioritized collection and analysis of HIV strategic information to guide the health sector response to HIV;[10]

[9] With UNAIDS, UNICEF and the European Centre for Disease Prevention and Control.

- supporting the development of national HIV estimates through workshops with UNAIDS and in collaboration with the European Centre for Disease Prevention and Control; and
- providing technical assistance and capacity-building in HIV surveillance and monitoring and evaluation systems, including through the WHO Collaborating Centre for HIV Strategic Information in Zagreb, Croatia.

Strategic direction 4: reduce vulnerability and remove structural barriers to accessing services

36. Most Member States have made progress in reducing vulnerability, for example, by explicitly protecting or reflecting human rights in national HIV policies or strategies, implementing programmes to reduce HIV-related stigma and discrimination and involving civil society in formulating national policies. However, progress varied across the Region and was least apparent in the east.

37. A third of countries reported that some of their legislation or policies presented obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations.

38. The Regional Office supported the work of several regional civil society networks[11] through the provision of technical and financial support, information exchange and inclusion in regional and national processes and technical consultations.

39. Civil society organizations are increasingly involved in the provision of prevention services, community-based rapid HIV testing and linkage to HIV care, but could provide much stronger support in these areas in many settings. National HIV budget spending on activities implemented by civil society varied across the Region and was highest in the west, lower in the centre and lowest in the east.

40. The Regional Office supported countries in reducing vulnerability and removing structural barriers by:

- advocating against legislation, policies and practices that are barriers to accessing prevention and treatment and that marginalize and criminalize key populations;
- supporting the development and implementation of policies and practices that promote social support to vulnerable groups to strengthen ART retention and minimize loss of patients along the HIV continuum of care;
- contributing to a systematic review to identify and synthesize prevalence estimates and risk factors among people who inject drugs, which found that contact with law enforcement agencies and the legal environment are associated with risk for HIV infection; and

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[10] The 90-90-90 targets are that by 2020, 90% of people living with HIV know their HIV status; 90% of diagnosed people living with HIV receive ART; and 90% of people on ART achieve viral suppression. This translates into a target of 81% of people living with HIV receiving ART.

[11] For example, the Eurasian Harm Reduction Network, the Eurasian Coalition on Male Health, the International Treatment Preparedness Coalition in eastern Europe and central Asia, the Eastern Partnership Civil Society Forum, the European AIDS Treatment Group, AIDS Action Europe, and the East Europe & Central Asia Union of People Living With HIV/AIDS.

- providing technical guidance and advocacy to expand community-based HIV testing and the use of rapid testing, and opposing mandatory HIV testing.

The way forward

41. A global vision of ending AIDS as a public health threat by 2030 is supported by all Member States as part of the 2030 Agenda for Sustainable Development and the multisectoral UNAIDS 2016–2021 Strategy *(17)*, which highlights the importance of securing gains through accelerated action before 2021.

42. Critical challenges in reaching the 90-90-90 targets include: addressing the high number of people living with undiagnosed HIV infection or who are diagnosed late; the low coverage with ART; and inadequate monitoring of treatment outcomes in the east.

43. Scaling up comprehensive HIV prevention and testing services that are aligned with WHO recommendations and targeted at key populations at higher risk of HIV infection, notably people who inject drugs and men who have sex with men, is critical. Coverage of opioid substitution therapy and needle and syringe programmes should be further scaled up, particularly in the east. Uninfected people at substantial risk should be offered oral pre-exposure prophylaxis to prevent HIV infection.

44. Overcoming the social and legal stigma and discrimination related to men who have sex with men, people who inject drugs and sex workers is critical as it impedes prevention and treatment efforts in many settings, particularly in the east.

45. Structural barriers to accessing integrated services for HIV and comorbidities (tuberculosis, hepatitis, drug dependence, STIs) should be removed and community-based services that reach key populations scaled up.

46. Strong governance, political leadership and partnerships between civil society, state actors and the private sector are essential for an efficient response based on sustainable domestic funding to cover national HIV programmes.

47. Various economic, political, organizational, social and other challenges that affect the HIV response in many countries should be taken into consideration when formulating approaches to end the AIDS epidemic by 2030.

48. Innovative responses are critical to decreasing the rate of new infections, to increasing the number of people receiving HIV treatment and achieving viral suppression, and to reducing the number of AIDS-related deaths. The HIV epidemic in the European Region is currently moving at a faster pace than the programmes established to address it. Change is required in order to meet the global and regional targets.

Action plan for the health sector response to HIV in the WHO European Region

49. The Sixty-ninth World Health Assembly adopted a new global health sector strategy on HIV, for the period 2016–2021, in resolution WHA69.22 in May 2016 *(5)*,

which is aligned with broader strategic frameworks, such as the Sustainable Development Goals and the UNAIDS Strategy 2016–2021 *(17)*.

50. A new draft Action plan for the health sector response to HIV in the WHO European Region (document EUR/RC66/9) has been developed to contextualize the international response to the unique epidemiological, social and political context of the European Region.

51. The Action plan calls for urgent action by Member States to address the growing HIV epidemic in the European Region and is being submitted for consideration by the 66th session of the Regional Committee for Europe.

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B. Progress report on renewed commitment to elimination of measles and rubella and prevention of congenital rubella syndrome by 2015 and sustained support for polio-free status in the WHO European Region (resolution EUR/RC60/R12)

Introduction and background

1. This report summarizes progress towards achieving the measles and rubella elimination goal and the specific target of achieving the goal by 2015 in the WHO European Region (resolution EUR/RC60/R12). During the past five years, significant progress has been made towards realizing this regional goal. Measles and rubella transmission has been interrupted in a number of Member States through rigorous, routine two-dose combined measles and rubella vaccine programmes for children. However, despite these efforts, the European Regional Verification Commission for Measles and Rubella Elimination concluded at its meeting in October 2015 that the goal of measles and rubella elimination by 2015 in the WHO European Region has not been met.

2. In 2005, the 55th session of the WHO Regional Committee for Europe endorsed resolution EUR/RC55/R7 on strengthening national immunization systems through measles and rubella elimination and prevention of congenital rubella infection in the WHO European Region *(1)*, with a target date of 2010.

3. In 2008, in its follow-up report on child and adolescent health strategies, including immunization, to the 58th session of the Regional Committee for Europe, the WHO Regional Office for Europe reported on progress achieved towards measles and rubella elimination in the European Region *(2)*.

4. In 2010, the 60th session of the Regional Committee for Europe adopted resolution EUR/RC60/R12 *(3)*, which moved the target date for measles and rubella elimination from 2010 to 2015, and urged Member States to renew their commitment and to ensure that the required resources were made available to accelerate actions to eliminate measles and rubella and prevent congenital rubella syndrome, while continuing to implement current strategies to maintain the European Region's poliomyelitis-free status.

5. The Regional Office for Europe matched the commitment for renewed action by developing the Package for Accelerated Action: 2013–2015 *(4)* for measles and rubella elimination in the Region, upgrading and refining WHO's support to countries in meeting these goals. The Package for Accelerated Action was developed through a consultative and inclusive process guided by the Decade of Vaccines Global Vaccine Action Plan 2011–2020 *(5)*, which was adopted by the Sixty-fifth World Health Assembly in May 2012.

6. In January 2012, the European Regional Verification Commission for Measles and Rubella Elimination (RVC) was established by the Regional Office for Europe. The RVC is an independent expert body with the mission of verifying the elimination of measles and rubella in the European Region. Since its first meeting in 2012, the RVC has held three meetings to determine the status of measles and rubella elimination in the

Region. The RVC issued status reports for 2010–2012 *(6)*, 2013 *(7)* and 2014 *(8)*. The elimination status of a country is based on reports and additional documents prepared and submitted by the National Verification Committee. These reports include information on measles and rubella epidemiology, vaccination coverage, immunization programmes, surveillance performance, and molecular epidemiology, together with additional information to support the National Verification Committee statement on measles and rubella elimination status for a specific time period. The Regional Office serves as the secretariat to the RVC.

7. In 2014, through extensive consultation with countries and partners, a European vaccine action plan was drafted to complement, regionally interpret and adapt the Global Vaccine Action Plan 2011–2020 (GVAP) in harmony with Health 2020 and other key regional health strategies and polices. The European Vaccine Action Plan 2015–2020 (EVAP) *(9)* was unanimously adopted at the 64th session of the WHO Regional Committee for Europe in September 2014. In endorsing EVAP, countries recommitted to the elimination of measles and rubella (EVAP goal 2) through the strategic objectives and actions thereunder and pledged their political commitment to achieving this goal.

Work carried out and achievements made towards elimination

8. Elimination is defined as the interruption of endemic disease in a defined geographical area for ≥ 12 months in the presence of a well-performing surveillance system through high levels of population immunity achieved by sustainable, high-quality routine and supplementary immunization activities. Verification of elimination takes place after maintained and documented interruption of endemic measles or rubella virus transmission for 36 months.

9. The Regional Office for Europe intensified its efforts in supporting countries to attain the elimination goal. Apart from the development of the Package for Accelerated Action for measles and rubella elimination, the Regional Office regularly monitors the situation with these diseases and prioritizes countries for support. It has provided technical assistance directly to a number of countries through dedicated missions and has assisted with the implementation of tailoring immunization programmes and the development of communication materials and in the undertaking of supplementary immunization activities.

10. In 2014, the Regional Office for Europe developed the Framework for the Verification Process in the WHO European Region *(10)*, which describes in detail the steps to be taken to document and verify the elimination of measles and rubella to support Member States in achieving elimination status. Annual status reports submitted by national verification committees are then reviewed and elimination status is assessed by the RVC.

11. At its most recent meeting in October 2015, the RVC recommended that national public health authorities and national verification committees of countries with endemic measles and/or rubella transmission reconfirm their commitment to the regional goal and to achieving elimination as soon as possible. The RVC also strongly recommended that all national verification committees implement country-specific recommendations

made by the RVC, and that the health authorities of the three countries (Albania, Monaco and San Marino) that did not submit annual status reports establish a National Verification Committee and submit such reports.

12. An extraordinary meeting of the European Technical Advisory Group of Experts on Immunization (ETAGE) dedicated to measles and rubella elimination took place in Copenhagen, Denmark, in January 2015. ETAGE endorsed an RVC proposal to modify the verification process. The suggested modification to the verification process included grouping countries according to their level of achievement towards elimination and verifying elimination at the country level. These modifications, including the awarding of certificates for elimination to countries that have interrupted indigenous transmission of measles and rubella for more than 36 months, have the following benefits.

- It allows programme support to be focused where it is most needed.
- The traffic light format used to assess the level of achievement highlights risks.
- The format allows simple messaging to Member States and partners to highlight progress, better performing countries and areas where help is most needed.
- The ranking encourages Member States to maintain or improve their status.
- Verifying elimination at the country level will promote and highlight national achievements.

Situation analysis

13. The number of reported measles cases for 2015 increased to 30 762 compared with the previous year, when 16 156 cases were reported. This was the result of outbreaks in some countries that started in 2014 and continued into 2015, while in other countries measles transmission intensified *(11,12)*.

14. Of the 10 630 cases that had data on age, 43% occurred in adults aged 20 years and older – an age distribution similar to that in recent years.

15. Of the total cases reported for 2015, 88% of cases (n = 27 085) were reported by four countries: Kyrgyzstan (17 779; 58%), Bosnia and Herzegovina (4583; 15%), Germany (2383; 8%) and Kazakhstan (2340; 8%). Kyrgyzstan also had the highest incidence (2993.1 per million inhabitants) in the Region.

16. Rubella continues to be reported in fewer countries than measles is. The number of reported cases in the Region for 2015 (n = 2368) is 64% lower than that reported for 2014 (n = 6607). This is attributed to the 66% decline in reported rubella cases in Poland, from 5899 in 2014 to 2029 cases in 2015. Although most cases were reported in children, cases among teenagers and young adults were also reported largely as a consequence of the relatively recent introduction of universal rubella vaccine into the immunization programme.

17. Since 2013, supplementary immunization activities were conducted in countries such as Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Turkey and the United Kingdom in response to large-scale measles outbreaks.

18. The RVC assessed the measles and rubella elimination status of 50 countries for the period 2010–2014 and concluded the following.

(a) For measles, 21 countries have eliminated the disease, two countries have interrupted transmission for ≥ 24 months and nine countries have interrupted transmission for ≥ 12 months. Eighteen countries remain endemic for measles.

(b) For rubella, 20 countries have eliminated the disease, three countries have interrupted transmission for ≥ 24 months and nine countries have interrupted transmission for ≥ 12 months. Eighteen countries remain endemic for rubella.

(c) No conclusion could be reached for three countries due to the lack of annual status update reports.

19. With one exception, 71 of the 72 WHO measles and rubella reference laboratories in the European Region are accredited. Member States have included laboratory data from public, private or commercial laboratories outside the WHO laboratory network in their surveillance and other relevant reports, including those of the National Verification Commission. While there is evidence of the proficiency of many of these laboratories, the lack of information on these laboratories in several countries remains of great concern.

20. With a few exceptions, all countries are now submitting genomic sequence information on measles cases to the Measles Nucleotide Surveillance (MeaNS) database *(13)*. The predominant genotypes reported for 2014 include several lineages of D8, considered to be the dominant genotype in the European Region; B3 lineages, frequently associated with importations from countries in South-East Asia and the Western Pacific; and a relatively low incidence of D4 isolates. In contrast, few countries are submitting genomic sequence information on rubella cases to the Rubella Nucleotide Surveillance (RubeNS) website *(14)*. Rubella genotypes reported for 2014 include 2B and 1E.

Challenges

21. Some countries are reluctant to undertake campaigns to close immunity gaps due to the poor acceptance of mass immunization by health authorities and the general public, and to the lack of dedicated financial resources, political commitment and secure vaccine supplies.

22. Identifying and addressing significant gaps in population immunity while maintaining high routine vaccination coverage poses a challenge in many countries. Countries with outbreaks affecting mostly older age groups have additional challenges in the absence of policies and technical capacities to systematically address the vaccination needs of adults.

23. Epidemiological and laboratory components of surveillance are not optimal in many countries. In addition, delays in reporting and receipt of incomplete data at the regional level persist. This hinders appropriate evaluation of the status of measles and rubella in the European Region and timely recognition of outbreaks that may require support to be managed.

24. Not all countries respond adequately to outbreaks, thereby allowing extension of transmission for periods of more than a year in some cases. Improvements are also needed in active case-finding and contact-tracing. Ensuring timely and adequate responses to outbreaks is crucial to limit the duration of transmission of these diseases.

25. While the majority of parents and health-care workers have a positive attitude to vaccines, an increasing number of people have become complacent. The latter often delay vaccinating their children or do not feel the need to have their children vaccinated for diseases that are not perceived as a threat to their children's health. This paradoxical effect is due to successful immunization programmes across the European Region in drastically reducing the occurrence of vaccine-preventable diseases. There is therefore a constant need to provide health-care workers and the general public with high-quality evidence-based information on vaccination to improve their understanding of its associated benefits and risks. Reliable scientific sources and experts, supported by well-informed and trained public leaders and champions, are necessary to ensure pro-vaccination attitudes through advocacy and messaging.

The way forward

26. Eliminating measles and rubella is a core goal of EVAP and an important tool in global efforts to improve health and reduce inequalities (Sustainable Development Goals 3 and 10, respectively). Elimination will depend largely on gaining political commitment, achieving high vaccination coverage and closing immunity gaps, as well as ensuring high-quality, case-based surveillance.

27. National implementation of the following strategies to which countries committed in 2010 remains valid and warrants sustained attention:

(a) achieve and sustain high coverage (≥ 95%) with two doses of measles and at least one dose of rubella vaccine through high-quality routine immunization services;

(b) provide measles and rubella vaccination opportunities, including supplementary immunization activities, to all population groups at risk for and susceptible to measles and/or rubella;

(c) strengthen surveillance systems through rigorous case investigation and laboratory confirmation of suspected sporadic cases and outbreaks; specifically, timely detection, investigation and comprehensive outbreak response, and improvement of rubella and congenital rubella syndrome surveillance with an increase in the level of reporting of rubella genetic sequence data; and

(d) improve the availability of high-quality, evidence-based information for health professionals and the public on the benefits and risks associated with immunization against measles and rubella.

28. By assessing the elimination status and ranking Member States, the Regional Office for Europe and partners are able to refine and tailor support to countries most at need. Since January 2015, the Regional Office for Europe has developed annual mobilization plans, with specific country activities and priorities outlined, and firm milestones by which to measure progress at the country level.

29. National authorities should invest in improving their public communications related to immunization and to advocating for strengthening immunization programmes. This includes activities and initiatives:

(a) to drive demand for routine and supplementary immunization activities;

(b) to adequately address vaccine safety concerns and crises;

(c) to strengthen disease outbreak communication capacity; and

(d) to bolster advocacy platforms through both traditional and social media.

30. The barriers to vaccine demand are complex and context specific. They include social, cultural and other behavioural determinants. Programmes must therefore monitor and assess general public and subgroup attitudes, knowledge and behaviour more frequently to inform and tailor programme delivery and response. Success in countering anti-vaccination sentiment and safety concerns will depend on overcoming these barriers.

31. The European Immunization Week campaign and accompanying platforms, including the online Immunize Europe Forum *(15)* launched in April 2015, should continue to be promoted regionally and nationally. European Immunization Week continues to successfully serve the purpose of increasing vaccination coverage by raising awareness of the importance of immunization among parents and caregivers, health-care professionals, policy- and decision-makers and the media.

Conclusions

32. The verification process has clearly demonstrated that many countries in the European Region have eliminated measles and rubella; some have interrupted transmission to a certain degree, while others are still endemic for these diseases.

33. The incidence of measles and rubella in the European Region has decreased since 2013 and, today, more countries than ever before have interrupted indigenous transmission. It is also encouraging to conclude that a sense of urgency to eliminate both diseases was demonstrated in 2014 and 2015 through actions to respond to outbreaks, to strengthen country resilience and preparedness, and to actively close immunity gaps.

34. Elimination of both measles and rubella is within reach. A refined verification process that promotes elimination at the country level, coupled with intensified efforts by health authorities and the agencies and partners mandated to support them, presents the European Region with a very real opportunity to achieve the elimination of measles and rubella.

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Introduction and background

1. The perception that countries in the WHO European Region are free from malaria has changed rapidly over recent decades. In the early 1990s, the residual reservoir of malaria infection, political and socioeconomic issues, mass population migration and extensive development projects, together with the fact that malaria prevention and control activities had almost been discontinued, led to conditions that were favourable for malaria transmission. As a result, large-scale epidemics broke out in central Asia, the Caucasus countries and Turkey, and in 1995, some 90 712 malaria cases were officially reported in the European Region. During that time, Azerbaijan, Tajikistan and Turkey suffered explosive and extensive epidemics, while Armenia, Kyrgyzstan and Turkmenistan faced outbreaks on a smaller scale.

2. The WHO Regional Office for Europe has been committed to responding vigorously to the burden of malaria, and by 1999 had developed a regional strategy to roll back malaria *(1)* in affected countries in the European Region. The strategy's aim was to reduce the impact of the disease on the health of the population as far as could be achieved using available financial and human resources and existing control technologies and tools. The specific objectives were:

(a) to prevent mortality due to malaria;

(b) to halve the incidence of malaria;

(c) to contain malaria epidemics; and

(d) to maintain the malaria-free status in countries where malaria had been eradicated.

3. In 2002, the 52nd session of the Regional Committee for Europe adopted resolution EUR/RC52/R10 on scaling up the response to malaria in the WHO European Region *(2)*. The resolution urged Member States in the Region that were confronting the resurgence of malaria to take all possible measures to consolidate the results achieved and further reduce the malaria burden.

4. By 2005, the malaria resurgence had been contained and incidence of the disease had been reduced to such an extent that the goal of interruption of transmission had become feasible throughout the Region. In order to underpin the new efforts towards malaria elimination, the Tashkent Declaration, entitled "The move from malaria control to elimination" *(3)*, was adopted by all malaria-affected countries in the WHO European Region.

5. The Tashkent Declaration provided a political base that helped the Regional Office to launch its new Regional Strategy: from Malaria Control to Elimination in the WHO European Region 2006–2015, which aimed to interrupt the transmission of Plasmodium falciparum malaria in central Asia by 2010 and to eliminate the disease in the European Region by 2015 *(4)*.

6. In 2006, in the Follow-up to action taken at previous sessions of the Regional Committee for Europe (document EUR/RC56/12) *(5)*, the Regional Office reported on progress made in implementing resolution EUR/RC52/R10 and informed the Regional Committee about the adoption of the Tashkent Declaration and the new Regional Strategy.

7. In 2012, the Regional Committee adopted Health 2020, the European policy for health and well-being (resolution EUR/RC62/R4) *(6)*, a value- and evidence-based health policy framework for health and well-being for the European Region. Eliminating malaria from the Region by 2015 was defined as a key Health 2020 objective *(7)*.

8. In 2014, taking into consideration the successful implementation of the Regional Strategy: from Malaria Control to Elimination in the WHO European Region 2006–2015, and responding to the needs of countries that had become malaria-free, the Regional Office developed the Regional Framework for Prevention of Malaria Reintroduction and Certification of Malaria Elimination 2014–2020 *(8)* in order to help health policy-makers and managers of malaria programmes to plan, organize and implement measures to prevent malaria reintroduction and ensure certification of malaria elimination.

9. The WHO certification process has been completed in Turkmenistan and Armenia, which were declared malaria-free in 2010 *(9)* and 2011 *(10)*, respectively. In 2014, the certification process for malaria elimination was initiated in Kyrgyzstan. In 2016, Uzbekistan formally applied to the Regional Office requesting technical assistance to prepare for certification.

10. In 2015, the European Region was the first WHO region in the world to achieve interruption of indigenous malaria transmission: the number of indigenous cases fell from 90 172 in 1995 to zero in 2015.

Actions taken and progress made

11. Over the past decade, the Regional Office has provided technical assistance to all affected countries to help to develop and revise national malaria control and elimination strategies and national guidelines on surveillance, vector control, malaria diagnosis and treatment, epidemic preparedness and operational research.

12. Regular country visits by WHO staff and consultants have played a significant role in assessing and monitoring the malaria situation. Their recommendations have helped to redirect national programmes, when necessary.

13. To promote the sharing of experiences in malaria elimination among countries and regions – in particular between the European and Eastern Mediterranean regions – regional malaria programme manager meetings were held in Ashgabat, Turkmenistan, in 2007 *(11)*, and in Dushanbe, Tajikistan, in 2015.

14. The Regional Office has developed and published a number of guiding documents, including Practical Guidelines on Malaria Surveillance in the European Region Countries Faced with Re-Emerging Malaria (2006), Guidelines on Vector-

Control Measures (2006, 2007, 2008), Practical Guidelines on Malaria Elimination in Countries of the WHO European Region (2010), Operational Framework on Integrated Vector Management (2012), Training Module for Entomologists on Malaria Vectors and Vector-Control (2012), all of which are intended to help health professionals in malaria-affected countries in the Region with regard to planning, organizing, implementing and evaluating national elimination programmes and to preparing for certification of malaria elimination.

15. The Regional Office has paid special attention to strengthening the capacities of national malaria programme staff. Over recent years, several in-country training events have been conducted on various aspects of malaria control and elimination: malaria surveillance – Moscow, Russian Federation (2012, 2013, 2014); vector control – Almaty, Kazakhstan (2012), Dushanbe, Tajikistan (2014); malaria elimination – Baku, Azerbaijan (2013); prevention of malaria reintroduction – Ashgabat, Turkmenistan (2013), Batumi, Georgia (2015).

16. In the context of malaria elimination, particular emphasis is given to situations in which there is a risk of the spread of malaria between countries and regions. The main objectives of cross-border collaboration are:

(a) to establish operational modalities for regular exchanges of information on malaria, particularly in border areas;

(b) to synchronize action plans for coordinated implementation of malaria elimination activities in border areas;

(c) to ensure early notification of any changes in the epidemiological situation related to malaria in border areas;

(d) to coordinate mobilization of additional resources to support the countries' malaria elimination efforts; and

(e) to take actions to create greater awareness of the successes of malaria elimination programmes.

17. In order to tackle the issue of malaria elimination in border areas, the Regional Office has initiated and supported cross-border collaboration within the Region and across regions, notably with the Eastern Mediterranean Region. A series of meetings on the issue have been held in Dushanbe, Tajikistan (2006), Antalya, Turkey (2009), Baku, Azerbaijan (2009), and Bishkek, Kyrgyzstan (2010).

18. Joint statements on cross-border collaboration have been signed between Azerbaijan and Georgia (2009) *(12)*; Turkmenistan and Afghanistan (2009) *(13)*; Tajikistan and Afghanistan (2010) *(14)*; and Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan (2010) *(15)*. Practical modalities and joint plans for elimination and prevention of the reintroduction of malaria in bordering areas have been discussed and developed during operational meetings with participating countries.

19. The achievements and impact of cross-border collaboration between Azerbaijan and Georgia on malaria elimination were included as an example of a success story in the *World malaria report 2010 (16)*.

20. To discuss and agree on a strategy and implementation mechanisms for increased coordination of malaria elimination, the prevention of malaria reintroduction, and leishmaniasis control in Afghanistan and Tajikistan, with special emphasis on border areas, an Intercountry Coordination Meeting was conducted in Dushanbe, Tajikistan, on 24–25 May 2016. The meeting was attended by national programme managers and programme managers from border provinces of both countries. Following intensive discussions, a joint plan on cross-border collaboration between Afghanistan and Tajikistan was developed and agreed.

21. In 2010, the Demonstrating and Scaling up Sustainable Alternatives to DDT[1] for the Control of Vector-borne Diseases in Southern Caucasus (Georgia) and Central Asia (Kyrgyzstan and Tajikistan) 2010–2014 project was funded and implemented by the Global Environment Facility, the United Nations Environment Programme, Green Cross International, the WHO Regional Office for Europe, Milieukontakt International and national governments. The rationale for the project was the need to reduce countries' reliance on persistent insecticides in the public health sector, and the need to introduce and promote appropriate vector control alternatives in an integrated manner, in order to maintain malaria-free status and prevent the re-establishment of malaria and other vector-borne diseases. The following key messages were developed based on the outcomes of pilot field studies on the use of different vector-control options.

- A combination of non-chemical vector control alternatives to DDT and other persistent insecticides applied in an integrated manner has almost the same entomological effect as indoor residual spraying, can suit local ecological and epidemiological conditions, can be ecologically sound and can ensure maximum cost–effectiveness and sustainability, while at the same time avoiding potential issues of building insecticide resistance.
- The results obtained have created solid evidence for the benefits of non-chemical vector control alternatives applied in an integrated manner. That evidence can facilitate decision-making processes and ensure support and prioritization in the allocation of resources for such measures.

22. The Regional Office has provided technical assistance to Member States for developing proposals for submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria and for their implementation. Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan received and successfully implemented Global Fund grants for malaria.

23. In order to update scientific knowledge on malaria, the Regional Office for Europe has initiated a regional programme on operational research related to malaria entomology and vector control, which was successfully implemented with the assistance of research institutions and partners in affected countries in central Asia and the south Caucasus. The objectives of the research are closely tied to the specific situation and problems identified within a single country or with a group of neighbouring countries. The identification and geographical distribution of Anopheles mosquitoes, prevalence of sibling species and their role in malaria transmission, and the taxonomy, biology and ecology of malaria vectors are of particular interest in the Region.

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[1] DDT refers to the synthetic insecticide dichlorodiphenyltrichloroethane.

24. The Regional Framework for Prevention of Malaria Reintroduction and Certification of Malaria Elimination 2014–2020 was developed and made available to Member States to assist health policy-makers and managers of malaria programmes in planning, organizing and implementing measures to prevent malaria reintroduction and ensure certification of malaria elimination. The Framework outlines the key issues related to possible resurgence of malaria in the post-elimination period, the goals and objectives of malaria programmes, and key approaches and measures to prevent malaria reintroduction, as well as scientific, operational, organizational and methodological aspects of the process for certifying countries malaria-free.

Challenges

25. Although the interruption of indigenous transmission of malaria has been achieved in the European Region, that achievement remains fragile. Lessons learned from the past highlight that the Region remains under continued threat of malaria reintroduction.

26. The unexpected resurgence of malaria in Greece in 2010, which was directly linked with the influx of migrants, was a stark example of this. By the end of 2013, transmission had been interrupted owing to intensified control efforts, and no indigenous cases were reported in Greece in 2014. In addition, several countries in the European Region – in particular Tajikistan and Turkey – are at a higher risk of reintroduction of malaria owing to large influxes of refugees and population movements from countries such as Afghanistan and the Syrian Arab Republic.

27. This continued risk requires sustained political commitment, high vigilance and continued investment in health systems strengthening to ensure that any resurgence can be rapidly contained.

The way forward

28. The Regional Office for Europe will continue working with Member States to assist with prevention of malaria reintroduction and maintenance of their malaria-free status, as well as to issue WHO certification of malaria elimination.

29. To reaffirm the commitment of Member States to maintaining a malaria-free status and preventing the re-establishment of malaria, a high-level consultation on prevention of malaria reintroduction in the WHO European Region took place in Ashgabat, Turkmenistan, on 21–22 July 2016.

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Annex C1. Definitions for malaria elimination programmes

1. Malaria elimination is the interruption of local mosquito-borne malaria transmission. It does not require the elimination of disease vectors or a complete absence of reported malaria cases in the country: imported malaria cases will continue to be detected due to international travel, and may on occasion lead to the occurrence of introduced cases in which the infection is a first generation of local transmission subsequent to an imported case *(1)*.

2. In the elimination phase, all malaria infections are important, as they may lead to onward transmission. Therefore, all instances of detected parasitaemia (including gametocytaemia only) are considered a "malaria case", regardless of the presence or absence of clinical symptoms *(2)*.

3. Malaria case definitions for elimination programmes *(2)*:

Autochthonous: A case locally acquired by mosquito-borne transmission, that is, an indigenous or introduced case (also called "locally transmitted").

Imported: A case the origin of which can be traced to a known malarious area outside the country in which the case was diagnosed.

Indigenous: Any case contracted locally (that is, within national boundaries), without strong evidence of a direct link to an imported case. These include delayed first attacks of *P. vivax* malaria due to locally acquired parasites with a long incubation period.

Induced: A case the origin of which can be traced to a blood transfusion or other form of parenteral inoculation but not to normal transmission by a mosquito.

Introduced: A case contracted locally, with strong epidemiological evidence linking it directly to a known imported case (first generation from an imported case, that is, the mosquito was infected from a case classified as imported).

4. Countries that have had no locally transmitted malaria cases for three consecutive years and have the surveillance systems to prove it can apply to WHO for certification of achievement of malaria elimination. This involves a review of national documentation and field visits to recent transmission foci to establish that the evidence that there has been no malaria transmission is credible, that the national surveillance system would be able to detect local transmission should it occur and that a funded programme for prevention of reintroduction is in place *(2)*.

5. Vigilance is a function of the public health service during the programme for prevention of reintroduction of transmission, consisting of watchfulness for any occurrence of malaria in an area in which it did not exist or from which it had been eliminated and application of the necessary measures against it. During the phase of prevention of reintroduction, the intense surveillance operations required for eliminating transmission will be scaled down and will be replaced by vigilance *(2)*.

6. Re-establishment of transmission is the renewed presence of a constant measurable incidence of cases and mosquito-borne transmission in an area over a succession of years. An indication of the possible re-establishment of transmission would be the occurrence of three or more introduced and/or indigenous malaria infections in the same geographical focus, for two consecutive years for *P. falciparum* and for three consecutive years for *P. vivax (2).*

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Category 2. Noncommunicable diseases

D. Final progress report on the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (resolution EUR/RC61/R3)

Introduction and background

1. In 2006, the European Strategy for the Prevention and Control of Noncommunicable Diseases was prepared and approved by Member States of the WHO European Region. In 2011, the WHO Regional Office developed the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016, which was approved in resolution EUR/RC61/R3 by the Regional Committee for Europe at its 61st session. The aim of the Action Plan was to promote increased action among Member States towards achieving global and regional targets to reduce premature mortality due to the main noncommunicable diseases (NCDs).

2. This document provides an account of the progress made on the Action Plan and towards achieving the global and regional targets on prevention and control of NCDs in the European Region during the 2012–2016 period.

Key policy and strategic developments

3. NCDs have gained global recognition as a major public health threat. In 2013, NCDs accounted for 86% of all deaths in the European Region. Cardiovascular disease (CVD), cancer, chronic respiratory disease (CRD) and diabetes are considered key NCDs and have been the focus of intensified interventions. These NCDs have a high impact on health and human development as leading causes of premature mortality among people during the most productive ages of life – from 30 to 69 years – causing 67% of all deaths in this age range. The relevance and visibility of NCDs has been strengthened with their inclusion as a determinant of health in national development and health agendas.

4. This rise in visibility combined with new knowledge of determinants and evidence for effective interventions had prompted the Regional Office for Europe to develop the European Strategy for the Prevention and Control of NCDs *(1)*, which was endorsed by resolution EUR/RC56/R2 at the 56th session of the Regional Committee in 2006, and efforts were strengthened in 2011 with the adoption of the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 *(2)* by the 61st session of the Regional Committee.

5. In 2011, world governments met at the United Nations and delivered a political declaration to address NCDs *(3)*. As a result, WHO was charged with developing the Global Action Plan for the Prevention and Control of NCDs 2013–2020 *(4)* and its global monitoring framework (GMF) *(5)*. The GMF sets out nine global targets for

2025, together with health impacts, risk factors and health systems responses, and 25 indicators to monitor progress.

6. In 2014, the United Nations convened a high-level meeting to reaffirm Member States' pledges on the GMF targets. Four time-bound commitments, in line with the European Action Plan, were agreed to accelerate work in: governance; surveillance and monitoring; action on risk factors and determinants; and strengthening health systems to provide better health care and management *(6)*.

7. In 2010, the Regional Office for Europe had developed a new policy framework for health, Health 2020, for the European Region. Its targets aim to lessen premature mortality, reduce inequity in health, enhance health and well-being, and strengthen health systems to improve universal access to health care. By including NCDs among its targets, Health 2020 has been a catalysing force for enhancing the work towards the prevention and control of NCDs in the Region *(7)*.

8. In 2015, the United Nations adopted a new mandate, the 2030 Agenda for Sustainable Development and 17 Sustainable Development Goals, including a specific goal to ensure healthy lives and promote well-being with a number of targets that are expected to increase the momentum already achieved on NCD prevention and control *(8)*.

Progress and achievements

9. The key goal of the Action Plan was reducing the premature and avoidable burden from NCDs, which could be achieved by focusing on two objectives: taking integrated action on risk factors and their determinants across sectors; and strengthening health systems for improved prevention and control of NCDs. The Action Plan was organized into four priority action areas, five priority interventions and two sets of supporting interventions.

Trends of premature death and disease burden

10. Target 1 of the GMF aims to achieve a 25% relative premature mortality reduction from the main NCDs among persons 30–69 years of age by 2025. Trends in the European Region showed a 24.6% decrease (or nearly 1.5% per year) between 1995 and 2010. Projections to 2025 suggest that, if conditions remain similar, a reduction of 40.4% could be achieved. Furthermore, trends show convergence of countries towards improvement, with faster gains among those with the highest mortality levels, for both males and females.

11. Despite this positive situation, large inequalities in the probability of dying from NCDs persist among countries, with a threefold difference between the highest (27%) and lowest levels (9%). A twofold difference between males (23%) and females (12%) also indicates important gender inequalities. Although European women live eight years longer than European men, they spend a greater share of life in poor health, largely due to NCDs. This calls for adjusting interventions to local situations and focusing on vulnerable groups.

12. The relative importance of the causes of NCD determines priorities for action. Today, CVDs remain the most important causes of premature and avoidable mortality in the European Region with 50% of deaths, followed by cancer (43%), CRDs (6%) and diabetes (6%). There is a gradient of higher CVD mortality from eastern to western countries in the Region to a level at which CVD rates approach cancer levels. This suggests that cause of death differences allow opportunities for faster gains in some countries in times of crises, and potential challenges in achieving lower CVD mortality levels.

13. As with CVD, cancer patterns are changing in relation to types of cancer and risk factors. Lung cancer is still the leading cause among males but the rate is slowly decreasing in most countries, coinciding with lower tobacco smoking prevalence; there is a contrasting situation among women. Also, mortality due to breast cancer, the most frequent among women, decreased more rapidly, while incidence continues to be high. This suggests increased survival and that early diagnosis, enhanced treatment and disease management are making a difference for some causes of cancer at different health-care system levels.

Governance of NCDs: policies, planning and oversight

14. One challenge to addressing NCDs is that their socioeconomic determinants lie in sectors beyond health. Also, the organization of health programmes in the past addressed diseases separately and only now recognizes the commonality of key NCD risk factors.

15. In 2015, 45 countries of the European Region reported having an integrated national action plan for prevention and control of NCDs compared to 34 in 2010. Also, 17 Member States are currently working with the Regional Office on renewing their NCD plans or preparing implementation plans. Also, in line with United Nations commitments, 24 countries have established national targets but more work is needed.

16. The link between NCDs and development has been recognized by the Member States committed to addressing these diseases as a priority in national multisectoral development plans. Since 2014, all countries with completed United Nations Development Assistance Frameworks for the period ending 2019/2020 have included NCDs in the Framework agreement.

Strengthening NCD surveillance

17. Surveillance and monitoring are essential for targeted action, measuring progress and providing the basis for accountability of different sectors.

18. According to the 2015 global WHO survey on country capacity and response to NCDs, 41 European countries reportedly have vital statistics systems, allowing monitoring for premature NCD mortality and inequalities disaggregated by age and sex but less often for other equity considerations. Death registration is high (> 80%) and only a few countries require additional improvement. Today, the main concerns are data reliability and timeliness.

19. Also, 49 countries in the Region reported having a cancer registry, key for incidence monitoring, but only 29 of the registries are population-based and their functionality varies considerably from recording cases with limited information on histological stages to full monitoring. The Regional Office provides technical support to improve registries, information systems and the capacity of staff.

20. To tackle demands for surveillance, new tools are implemented in the European Region, including for different populations (for example, the WHO European Childhood Obesity Surveillance Initiative (COSI), Health Behaviour in School-aged Children (HBSC) studies and WHO integrated risk factors survey (STEPS)); for risk factors (for example, the Global Adult Tobacco Survey (GATS), the European Information System on Alcohol and Health (EISAH), the Nutrition, Obesity and Physical Activity database (NOPA) and STEPS); and for health systems response (STEPS, the Service Availability and Readiness Assessment (SARA) and the Better NCD Outcomes: challenges and opportunities for health systems country assessment series). STEPS and similar surveys integrating NCD risk factors are used in most countries, increasing efficiency of surveillance.

21. Other less traditional but promising formats based on "big data" approaches are currently being explored (for example, electronic health records, social media, digital trails and mobile information technologies and devices) as complementary tools for different surveillance issues (such as policy implementation and acceptance, biometrics and other measurements) that have not been collected broadly or in a near real-time manner.

Priority interventions: promoting healthy consumption to reduce risk factors in the population

22. Implementation of the Action Plan emphasized the importance of limiting the effects of common NCD risk factors in the population, particularly harmful alcohol consumption, tobacco use, unhealthy diet and obesity *(9)*.

Harmful use of alcohol

23. WHO estimated that 13.3% of mortality in the European Region is attributable to alcohol consumption, ranging by country from 2% to 35%. Target 2 of the GMF seeks to achieve at least a 10% relative reduction in the harmful use of alcohol by 2025.

24. In 2014, the estimated adult per capita consumption was 10.68 litres of pure alcohol for countries in the Region, a 3.9% reduction since 2010. The prevalence of heavy drinking (> 60 g) was 11.0%, with a twofold difference between men (15.8%) and women (6.3%). Increasing consumption among adolescents is also a concern: the HBSC 2013/2014 survey *(10)* found that 3% to 32% of 15-year-old boys reported drinking alcohol at least once a week, while the same was true for 2% to 29% of girls of that age. WHO has also estimated that 30% of 15–19-year-olds were heavy drinkers in 2010 *(11)*. Altogether, these findings indicate that more attention is needed to reduce the high levels of alcohol consumption observed in the Region *(12,13)*.

25. The European action plan to reduce the harmful use of alcohol 2012–2020 *(14)* proposed policy options to achieve the GMF target. As a result, stricter regulatory

alcohol policies to reduce access were introduced. The number of countries with a blood alcohol concentration limit of 0.5 g/L for drivers increased and random breath-testing is now used by 46 Member States, compared to 27 in 2010. Legislation on age limits for off-premise sales of alcoholic beverages and to prevent illegal production of alcoholic beverages has also increased.

26. The number of countries with marketing policies to reduce consumption or affordability with legally binding regulations of countries on alcohol advertising increased from 42 to 47, while the number of countries requiring health warnings on alcohol advertising also increased. More countries adjusted for inflation the level of taxation for alcoholic beverages and conducted national awareness-raising activities.

27. These findings highlight the need for continued and increased efforts to reduce the harmful use of alcohol using evidence-based population-level intervention strategies.

Reducing tobacco use

28. The European Region has the highest prevalence of tobacco smoking among adults globally (28%) and one of the highest prevalences for adolescents. Target 5 of the GMF aims to achieve a 30% relative reduction in the prevalence of current tobacco use in persons aged 15 years and over by 2025.

29. In 2013, WHO estimated that 38% of men and 19% women aged 15 years and above smoked tobacco in the European Region, the gender prevalence gap now being smaller in many countries. Projections to 2025 indicate that the prevalence will be 31% among males and 16% among females, achieving a relative reduction of 22% and 25%, respectively, meaning that the Region needs to accelerate its control efforts.

30. Tobacco use among adolescents is increasing and in some countries prevalence is similar to that among adults. The HBSC 2013/2014 survey *(10)* showed that weekly smoking decreased for 15-year-old boys and remained similar among girls, while a half of those reported smoking for the first time at age 13 or younger. These trends mimic the observed adult gender ones and reflect a need to target females with measures to counter their increasingly higher smoking rates.

31. The WHO Framework Convention on Tobacco Control and its Protocol to Eliminate Illicit Trade in Tobacco Products *(15)* are key drivers and powerful legal instruments against the tobacco epidemic. Fifty countries of the European Region adopted and became parties to the Convention, including its implementation guidelines, policy options and decisions. However, implementation of the WHO Framework Convention has been less than satisfactory as only 25 countries introduced taxes to limit access to tobacco products, 9 banned smoking in public places, and only 7 offer cessation programmes. In 2015, to reconfirm their commitment, Ministers of Health from the European Region signed up to a roadmap of actions leading to a tobacco-free life *(16)*.

Reducing obesity

32. Excess body weight among adults 18 years and over is responsible for approximately 35% of ischaemic heart disease, 55% of hypertension and some 80% of type 2 diabetes.

33. Overweight and obesity prevalence in the European population increased yearly, challenging the achievement of Target 7 of the GMF on halting the rise of diabetes and obesity. WHO estimated that 59% of the adult population in the European Region was overweight in 2014, an increase of 3.5% since 2010. Generally, men were slightly more overweight (62.6%) than women (54.9%) in 2014, but women were more frequently obese. Projections to 2030 estimate that most countries will have a prevalence of over 50%, leading to higher disease and disability risk and increasing strain on health systems and society.

34. According to COSI results, trends show a third of children aged 6–9 years being overweight or obese. Also, 15% to 39% of 11-year-old boys in the HBSC 2013/2014 survey reported being overweight or obese, while the same was true for 9% to 32% of girls.

35. Recognizing that many different factors and life-course stages underlie these trends, governments have renewed their commitments to tackle obesity and have taken steps following the endorsement of the European Food and Nutrition Action Plan 2015–2020 *(17)* in resolution EUR/RC64/R7 and the Physical Activity Strategy for the WHO European Region 2016–2025 *(18)* in resolution EUR/RC65/R3, by the 64th and 65th sessions of the Regional Committee for Europe in 2014 and 2015, respectively.

36. Specific policy actions recommended in the Food and Nutrition Action Plan have been adopted. For example, 27 countries developed marketing food policies, including tighter restrictions on the marketing of foods high in saturated fat, free sugars and salt to children. Additionally, 26 countries developed policies to limit fats in food, through reformulation. Others initiated promotion of clear and easy-to-understand labelling on the front of food packages or strict standards for the nutritional quality of foods available in schools.

Priority interventions: cardio-metabolic assessment and management and early cancer detection

Policies, guidelines and protocols for NCD assessments and management

37. Countries of the European Region have invested efforts to develop and increase NCD policies, strategies or plans or update and implement them. In view of that, countries with specific integrated disease policies for NCDs increased from 34 in 2010 to 45 in 2015 but of those that developed policies, fewer have fully implemented them and made them operational. Countries also reported developing disease-specific policies with cancer-related ones being the most commonly available (46 countries) while 38 countries had such policies for diabetes, 33 for CVD, and only 17 were dealing with CRD.

38. Thirty-four Member States reported having national NCD evidence-based guidelines and protocols for the assessment of risk and for behavioural and pharmacological interventions, which are essential for improving cost-effectiveness of health care management, but a third of countries were still under approval. In addition, 43 countries reported specific tools for cancer, 38 for CVD and 24 for diabetes.

Assessment and management of cardio-metabolic risk factors

39. Assessment and management of NCD cardio-metabolic risk factors and early pre-clinical detection are essential to limit the risk of CVD, diabetes or cancer events, and their progression into severe forms, disability or death. Efforts in the European Region were directed towards implementing early disease detection, integrated risk assessment, treatment and management, emphasizing primary health care approaches.

40. Target 6 of the GMF proposes a 25% reduction or containment of the prevalence of raised blood pressure, according to national circumstances, by 2025. Prevalence of raised blood pressure estimates for the European Region showed a 7% reduction from 25.1% in 2010 to 23.3% in 2014, with twofold differences among countries (ranging from 15.2% to 31.7%) and also between males and females. Recent STEPS surveys showed that between 22% and 80% of people with raised blood pressure were not currently under medication to control it.

41. Raised blood sugar is a risk factor for diabetes and CVD, which, jointly with obesity, allows monitoring Target 7 of the GMF. The estimated prevalence for high blood sugar in the European Region was 9.4% in 2008, which is near the global average. There were differences between European countries, ranging from a low of 5.1% to a high of 12.2%. The prevalence among males was 10.2% and that of females 8.7%, a pattern observed at country level as well.

42. The joint presence of these biological and other risk factors synergistically increases the risk of CVD events. This recognition prompted the development and use of CVD high risk scoring, taking into account different regional or country exposure profiles and cultural and socioeconomic backgrounds. Currently, WHO is contributing to the development effort of country-specific scoring charts and their implementation in Member States.

43. The aim of Target 8 of the GMF is that at least 50% of eligible people receive drug therapy and counselling to prevent heart attacks and strokes. STEPS surveys found that about one in five adults aged 40–64 years had high risk. Nevertheless, 50% or more of these persons received drug therapy or counselling, illustrating the usefulness of risk scoring and targeting of interventions according to need.

44. To further improve overall management of CVD risk factors and disease in the different settings, WHO has developed a package of essential NCD interventions (PEN), with a focus on integrated NCD management, including monitoring and evaluation. Starting with situational analyses and identification of issues and priorities for intervention, implementation to improve access to diagnosis and treatment in primary health care with increased management efficiency is currently under way in several countries in the Region.

45. Cancer mortality in the European Region is decreasing at a slower rate than CVD. However, new cases are often diagnosed at advanced stages in many countries, indicating poor early detection. The 2015 CCS found 40 countries reporting availability of policies including early cancer diagnosis, treatment and care; 40 reported having essential medicines (for example, oral morphine) at primary health-care level, while 34 have community care for people with advanced cancer. Also, 47 countries reported

screening programmes for breast and cervical cancer and 37 for colon cancer, but two thirds or fewer of such reports were population-based.

46. Target 9 of the GMF aims at an 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCDs. In addition to cancer screening, hepatitis B immunization for prevention of liver cancer is widely spread in the Region, with coverage levels > 85% among one-year-olds in most countries. Immunization programmes against human papilloma virus for preventing cervical cancer was also reported by 30 countries.

Strengthening health systems to address NCDs

47. Strengthening health systems to address NCDs and the underlying determinants through people-centred primary health care and universal health coverage throughout the life-course is essential to achieving the GMF targets and United Nations commitments.

48. To move towards universal health coverage and improve health system effectiveness, some barriers and opportunities need to be identified and proposals to overcome and implement them should be made. WHO initiated a process for country assessments, including the generation of score cards, which enable assessing key barriers and generating a list of context-specific priorities and recommendations for improvement. To date, 14 countries from different parts of the European Region have undertaken such an assessment and are implementing specific and innovative policies.

Supporting interventions

Improving environment and settings

49. Environmental and occupational exposures account for a significant part of the NCD burden. Attention to the socioeconomic environments and settings in which people grow, play, live and age contribute to common approaches for addressing the main NCD risk factors and determinants.

50. Target 3 of the GMF aims to reduce by at least 10% the prevalence of insufficient physical activity by 2025. Estimates of physical inactivity prevalence among adults in countries of the European Region ranged between a low of 10.1% to a high of 38.6% in males and from 11.7% to 47.2% in females, in 2010. The Region also showed decreasing levels among older children and adolescents aged 11–17 years, with country levels ranging from 65.6% to 91.0% among males and between 79.6% and 91.2% among females.

51. By altering physical environments, it is possible to encourage physical activity as part of everyday life through active transport (for example, commuting by bicycle, walking) and increased leisure-time activity. Physical activity is also influenced by urban environments and transport policies, which can promote cycling and walking for transport by developing safe infrastructure, as well as fostering the establishment of accessible green spaces for leisure-time physical activity and encouraging behaviour modification. Different priority policies are included in the Physical Activity Strategy for the WHO European Region 2016–2025.

Challenges

52. The following challenges are pending or new issues, without any specific order of priority.

- There is a persistent and important inequality gradient of premature mortality, main risk factors and determinants among countries, especially related to CVD among men, which needs further attention and stronger action. Addressing this need may help many countries to meet the NCD targets.
- The limited decrease in cancer mortality, including main avoidable causes and changing sex patterns, as well as the insufficient implementation of early diagnosis suggests the need to strengthen cancer registry information and early diagnoses and treatment.
- The level of several risk factors remains high and there has been limited change in many countries, despite recognition of their importance. Adoption of specific policies is needed to accelerate the implementation of proposed "best buys" (high-impact cost-effective interventions to improve NCD prevention and control).
- Improving health systems functions, including early diagnoses, care and monitoring of quality outcomes, initiated with involvement of different WHO technical areas, has been a successful effort and should be continued.
- Enhanced monitoring and surveillance of NCDs and health systems indicators will be needed to assess progress in specific areas of the global and European strategies to prevent and control NCDs. To date emphasis has been placed on premature mortality reduction, but other health outcomes such as decreased disability, healthy life expectancy and improved well-being could be considered in the future as targets and indicators of progress.
- Air quality and climate change are known determinants of health and are closely related to NCDs, particularly CVD and CRD, and have a strong impact on populations. Air pollution is increasingly affecting more people living in cities and next to major highways. Monitoring of transport density, air quality and their relation with health will be required. However, accurate and reliable measurement of CRD in the population, and assessment and improved health care management also need to be improved in the European Region.

53. Given the current unfinished agenda on NCDs and the new demands to streamline and increase action, the newly proposed Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2016–2025 may provide an opportunity to address some of these and other emerging issues.

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E. Progress report on implementing the WHO European Declaration and Action Plan on the Health of Children and Young People with Intellectual Disabilities and their Families (resolution EUR/RC61/R5)

Background and introduction

1. The European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families[1] was adopted at the High-level Conference on Better health, better lives: children and young people with intellectual disabilities and their families held in Bucharest, Romania, in November 2010. The Declaration, which includes an action plan, was endorsed in resolution EUR/RC61/R5 by the 61st session of the Regional Committee for Europe in September 2011. This report summarizes the progress made by the Regional Office for Europe towards achieving the objectives of the Declaration through the five actions identified in resolution EUR/RC61/R5.

2. Between 1–3% of children can be expected to have an intellectual disability. At least 300 000 children in the WHO European Region live in segregated residential institutions. It is difficult to ascertain the precise number of children with intellectual disabilities in these institutions, as the institutions typically host children with other types of disability (physical and/or sensory) and children who were abandoned or placed in care for social reasons. It is estimated, however, that at least 80% of children in institutions have some degree of developmental delay or intellectual disability. Long-term placement in an institutional setting can further aggravate an existing intellectual disability or can result in serious developmental delays in children who initially were not intellectually disabled.

3. The High-level Conference was convened to heighten awareness of the large number of children with intellectual disabilities living in institutions and to propose, for endorsement by participating countries, objectives and actions that would improve the independence, inclusion and opportunities of these children, in accordance with the United Nations Convention on the Rights of People with Disabilities and the United Nations Convention on the Rights of the Child.

4. Ten priority areas for action that would enable young people with intellectual disabilities and their families to live healthy and full lives were identified in the Declaration and highlighted in resolution EUR/RC61/R5:

- protect children and young people with intellectual disabilities from harm and abuse;
- enable children and young people to grow up in a family environment;
- transfer care from institutions to the community;
- identify the needs of each child and young person;

[1] Document EUR/51298/17/6.

- ensure that good quality mental and physical health care is coordinated and sustained;
- safeguard the health and well-being of family carers;
- empower children and young people with intellectual disabilities to contribute to decision-making about their lives;
- build workforce capacity and commitment;
- collect essential information about needs and services and assure service quality; and
- invest to provide equal opportunities and achieve the best outcomes.

5. Resolution EUR/RC61/R5 requests the Regional Director for Europe "to ensure that adequate priority and resources are given to activities and programmes to fulfil the requirements of the Declaration and the Action Plan, according to WHO's mandate, by:

(a) exercising leadership concerning the role and functioning of health systems in accordance with all relevant European and global standards and policies, in order to meet the needs of children and young people with intellectual disabilities and their families;

(b) providing technical support to Member States in order to promote quality in service provision and to establish sustainable capacity;

(c) supporting research initiatives that will result in ethical and evidence-based policy and practice;

(d) monitoring the health status of children and young people with intellectual disabilities and their families and assessing progress towards the implementation of this Declaration and Action Plan;

(e) engaging in partnership with UNICEF, the European Commission and the Council of Europe and other intergovernmental and nongovernmental organizations where joint action can facilitate implementation …".

6. This report presents the progress made by the Regional Office towards achieving these five aims by 2020.

Achievements, progress and challenges

Exercising leadership concerning the role and functioning of health systems in accordance with all relevant European and global standards and policies, in order to meet the needs of children and young people with intellectual disabilities and their families

7. Within the framework of the Convention on the Rights of People with Disabilities and Health 2020, the health of children with intellectual disabilities is linked to inequities and is an intersectoral issue affected by a wide range of policies across government. The Regional Office for Europe has exercised leadership in the role and functioning of health systems relevant to the needs of children and young people with intellectual disabilities and their families by integrating the work of programmes contributing to this objective.

8. Investing in Children: the European Child and Adolescent Health Strategy 2015–2020, [2] adopted in resolution EUR/RC64/R6 by the 64th session of the Regional Committee in September 2014, addresses mental disorders and disabilities in young people and is based on the principle of adopting a life-course, evidence-informed, rights-based approach with strong partnerships and intersectoral collaboration. This Strategy is highly relevant for developing policies that enable children and adolescents in the European Region to realize their full potential for health, development and well-being.

9. Investing in Children: the European Child Maltreatment Prevention Action Plan 2015–2020,[3] also adopted in resolution EUR/RC64/R6, is equally important for addressing the needs of children and young people with intellectual disabilities. The European Child Maltreatment Prevention Action Plan, which is closely aligned with the European Child and Adolescent Health Strategy, points out that children with disabilities or behavioural problems and children in institutional care, such as orphanages, may be at increased risk for maltreatment. The objectives of the Action Plan complement the priority actions of the "better health for better lives" initiative; joint work on implementation of the Strategy and the Action Plan, including surveillance, is under way.

10. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.8, which calls on Member States to give appropriate recognition to the specific needs of individuals affected by autism spectrum disorders and other developmental disorders, and requests WHO to collaborate with Member States and partner agencies in order to provide support. Autism is specifically included within the scope of intellectual disabilities, as defined in the Declaration, since about 75% of people with autism have an intellectual disability and many are placed in the same institutions. The urgency for needs assessments and the provision of evidence-based specialist interventions are issues on which WHO will focus in the next stage of implementation.

Providing technical support to Member States in order to promote quality in service provision and to establish sustainable capacity

11. The Regional Office for Europe has supported the elaboration of health strategies and the implementation of services by analysing the effectiveness of national mental health systems. Most of these are being delivered within the scope of biennial collaborative agreements (BCAs) with Member States, some at the special request of ministries. In 2012–2013, the national mental health programme was included in 24 BCAs, and in 2014–2015 and 2016–2017, in 26 BCAs; most BCAs request support with policies related to deinstitutionalization and the development of community-based services. Several countries (Albania, Armenia, Bulgaria, the Czech Republic, Georgia, Hungary, Kyrgyzstan, Republic of Moldova, Romania, Tajikistan, Turkey, Turkmenistan and Ukraine) have requested the Regional Office to make country assessments, including on the status of institutions, and to develop recommendations.

12. Some countries have shown progress. The number of places in institutions declined considerably in Bulgaria, Republic of Moldova and Romania. All countries

[2] Document EUR/RC64/12.
[3] Document EUR/RC64/13.

requesting support were engaged in reforms. Some consistent challenges were identified. The reduction in bed numbers means a shift of responsibility from national to local government, which is not always able to handle the budget implications. Community services are for the most part inadequate and the workforce is insufficiently prepared. Stigma and discrimination still hinder full integration in the community.

13. In Turkey, the Regional Office was invited to implement a large project on promoting people with disabilities, with a special focus on people with mental disabilities, which was defined as a combination of people with intellectual disabilities and long-term mental disorders. The project, co-funded by the European Commission, started in 2011 and the first phase was completed in 2014. This project included young people. The Regional Office ensured the coordination for the development of services for people with disabilities through effective collaboration among ministries, institutions, local authorities, universities, United Nations agencies, nongovernmental organizations, civil society, community leaders and the private sector. The project successfully supported the Turkish Government to reduce the number of institutions and establish some 75 community centres and more than 40 Houses of Hope (small residential homes for disabled people) across the country.

Supporting research initiatives that will result in ethical and evidence-based policy and practice

14. Some research was initiated in partnership with WHO. The Lumos Foundation completed the Turning Words into Action project in 2014. This pilot project, funded by the European Commission, aimed to find ways to implement the actions identified in the European Declaration on Children and Young People with Intellectual Disabilities and their Families. The European Commission fully endorsed the Declaration and its priorities, and recognized deinstitutionalization and the rights of children and young people with intellectual disabilities as areas of concern. The project involved children and young people with intellectual disabilities, their parents, policy-makers, and health and educational professionals. The project was conducted in Bulgaria, the Czech Republic and Serbia. These countries were selected due to the challenges they face regarding the numbers of institutionalized children, the significant differences in terms of culture and economic development, and the fact that prior to the project none of the three countries had a structure in place for the meaningful inclusion of the voices of children with intellectual disabilities in the policy-making process.

15. The project concluded that the inclusion of children with intellectual disabilities in the design of policies and activities concerning them is vital, as is the commitment of all involved parties to understand and adjust to the needs and capacities of these children. For participatory decision-making to become sustainable and embedded in societies, a supportive and inclusive social environment and firm political commitment are essential.

Monitoring the health status of children and young people with intellectual disabilities and their families and assessing progress towards the implementation of this Declaration and Action Plan

16. WHO is planning an updated review of the status of children and young people with intellectual disabilities and their families in 2016–2017, within the context of the

survey of institutions for adults with mental disabilities in the European Region, which was started in 2015. Although this project addresses the number and quality of institutions for adults with intellectual disabilities and long-term mental disorders, it has established a network that can also provide information on institutional places for young people within the mandate under resolution EUR/RC61/R5. The Regional Office will provide the resources required for project implementation.

Engaging in partnership with UNICEF, the European Commission and the Council of Europe and other intergovernmental and nongovernmental organizations where joint action can facilitate implementation

17. Since co-organizing the High-level Conference in Bucharest in 2010, a close partnership with UNICEF has been maintained. Both parties meet regularly with representatives of the European Commission, and consult on progress on deinstitutionalization. The Regional Office advises the European Commission on the status in European Union countries, and has supported requests from Member States to that body for resources.

18. The Regional Office is also in regular contact with the European Representative of the United Nations Human Rights Committee on issues related to rights and institutionalization. The Regional Office has participated in Council of Europe meetings addressing disability.

19. The Regional Office continues to engage in partnerships with nongovernmental organizations and expert centres active in this field, such as the Lumos Foundation. The Mental Health Foundation and the Picker Institute in the United Kingdom have supported quality assessments and staff training. WHO collaborating centres, including Verona and Trieste in Italy, Queen Mary's in London, the United Kingdom, and the Serbsky Center in Moscow and the Bekhterev Psychoneurological Research Institute in Saint Petersburg, the Russian Federation, have supported the assessments of institutions. The South-eastern Europe Health Network has discussed progress on the reduction of numbers of institutions and the development of community capacity.

20. The Regional Office convened a meeting of European professional associations active in this field and decided on a statement of intent, addressing joint challenges in service delivery and workforce development, and agreed to carry out a European workforce survey, to be coordinated by the Regional Office.

Category 3: Promoting health through the life-course

F. Interim progress report on implementation of the Strategy and action plan for healthy ageing in Europe, 2012–2020 (resolution EUR/RC62/R6)

Background and introduction

1. In September 2012, the 62nd session of the WHO Regional Committee for Europe adopted the Strategy and action plan for healthy ageing in Europe, 2012–2020 (document EUR/RC62/10 Rev.1). The Strategy and action plan set out four priority areas for action, five priority interventions, and three supporting interventions for promoting healthy ageing – an increasingly important aspect of health and well-being – in the context of the rapidly ageing population in the WHO European Region. This interim report outlines the progress made with regard to the implementation of the Strategy and action plan for consideration by the 66th session of the Regional Committee, as requested in resolution EUR/RC62/R6.

2. Healthy ageing is a cross-divisional issue involving several programmes within the WHO Regional Office for Europe. At the country level, policy initiatives for healthy ageing are often intersectoral, requiring cooperation between government departments to build partnerships and coalitions with a broad range of stakeholders. From this perspective, work on ageing and health in the European Region is in line with key aspects of the Health 2020 vision.

3. Given the increasingly ageing population throughout the European Region, the concern for active and healthy ageing remains high on policy agendas in European countries. Since the adoption of the Strategy and action plan, most Member States have taken measures to promote healthy and active ageing, through independent policies or as part of a broader national strategy or action plan for ageing, either by amending existing policies or taking new initiatives. An increasing number of Member States (eight to date) have requested support from the Regional Office with regard to policy design and implementation for healthy ageing, through biennial collaborative agreements.

4. Since 2012, the Regional Office for Europe has been providing support to Member States by:

- undertaking a review of their national situation (for example, the former Yugoslav Republic of Macedonia);
- designing comprehensive national plans for active and healthy ageing (Slovenia); and
- assisting with the development of policies in specific fields, in the context of overall policy reforms, most notably, by establishing or reforming long-term care systems (Czech Republic, Republic of Moldova, Slovakia, Slovenia and Turkey) and improving the coordination and integration of services for older people (Serbia).

5. Another major aspect of the Regional Office's work has been to update and expand the WHO framework and toolkit on age-friendly environments that is now broadly used by Member States in the European Region at various levels of government.

Strategic priority areas for action and priority interventions

6. Healthy ageing over the life-course is key to reaching Health 2020 targets: recent gains in life expectancy in Member States of the European Region are, in part, the result of better health and lower mortality among the oldest age groups, as documented in the Global Burden of Disease database *(1)*. Strategies and policies for healthy ageing over the life-course were therefore high on the agenda of the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020, which was held in Minsk, Belarus, in October 2015.

7. Greater investment in healthy ageing over the life-course is essential to addressing the large and growing disparities in the health and well-being of older people, both within and between Member States. These inequalities are addressed in two publications:

- Tackling health inequalities among older people in Europe as presented in the Review of social determinants and the health divide in the WHO European Region: final report *(2)* and the ongoing work of the Regional Office on age-friendly environments; and
- a report on health and quality of life of older inhabitants of the Pomurje region, which outlines evidence for policy provided by a study on health disparities among older people living in Pomurje, a rural area in Slovenia.

8. Gender aspects of healthy ageing are being addressed in many ways, including by improving public support for long-term care provided by family caregivers, and improving coverage and quality of care provided to older people with functional limitations. Women are predominant in both groups. These and other aspects are discussed in *Beyond the mortality advantage: investigating women's health in Europe (3)*, a report published by the Regional Office in 2016.

9. *Ageing and sexual health*, issue No. 77 of *Entre Nous – the European magazine for sexual and reproductive health (4)*, addresses a broad spectrum of aspects of ageing and sexual health, from specific medical challenges to wider social trends that recognize that sexuality and sexual health are an intrinsic part of health and well-being in older age. Several articles in this edition consider how gains in lifespan can be transformed into better health and well-being, including sexual health in older age groups, and touch upon the most intimate aspects of healthy ageing.

10. Since 2012, a number of core public health aspects under the priority and supporting interventions of the Strategy and action plan for healthy ageing have been mainstreamed into new action plans at the regional level, including the European Mental Health Action Plan 2013–2020 (document EUR/RC63/11), the European Food and Nutrition Action Plan 2015–2020 (document EUR/RC64/14), the Physical activity strategy for the WHO European Region 2016–2025 (document EUR/RC65/9), and the Action plan for the prevention and control of noncommunicable diseases in the WHO

European Region (document EUR/RC66/11), which is submitted for consideration by the 66th session of the Regional Committee.

11. There is also growing recognition in the European Region that greater attention should be paid to the needs of specific groups of potentially vulnerable older people. Policy recommendations on healthy ageing among Roma populations have been discussed in a two-day workshop held in Pécs, Hungary, in 2014, which culminated in the adoption of the Pécs Declaration on Healthy Ageing of Roma Communities. Participants in the workshop concluded that, given the fact that health inequities between Roma and non-Roma are most accentuated in old age, healthy ageing for the older Roma population needs greater attention in research and policy, including to mitigate specific problems older members of the Roma community face with regard to access to age-appropriate health services and social support.

12. *Prisons and Health (5)*, published by the Regional Office for Europe in 2014, includes a chapter on evidence for health policy to improve the situation of older people in prison populations, who increasingly represent a vulnerable group, particularly those living with dementia, at high risk of not receiving adequate attention to their specific needs.

13. Although strategies for the prevention of falls is included in most national action plans and is addressed in the design of accessible urban space and in housing standards, it remains a challenge, not only for environments supportive to healthy ageing, but also for improving the quality of care provided in health and social care institutions. In Lithuania, a policy dialogue was held on a comprehensive approach to falls prevention, to support implementation of the national healthy ageing strategy.

14. With regard to quality of care standards for long-term care, progress has been made in several countries, including through local government initiatives to create health-promoting residential facilities for older people. There is, however, evidence that more could be done, for example, to prevent falls in institutional settings and by better adapting the built environment.

15. Ongoing work on quality of long-term care is being addressed in the Regional Office through cross-divisional cooperation between the Division of Noncommunicable Diseases and Promoting Health through the Life-course and the Division of Health Systems and Public Health and under Strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery (document EUR/RC66/15) as part of the Regional Office’s work on people-centered health and long-term health care systems.

16. One outcome of this work was the establishment of a patient pathway for people with dementia in Serbia in November 2015, to improve both quality and coordination of care, and ultimately the quality of life of older people. Such pathways constitute guidance for patients that highlights prevention, control and management of diseases, and supports patient trajectories in the health sector and in liaison with other sectors.

17. In the Czech Republic, a study was conducted on the future of long-term care, which analysed current care provision, including economic aspects of long-term care. The study supported a national policy dialogue on future long-term care reform. An

initial stocktake to facilitate similar policy dialogues and reform discussions are ongoing in Slovenia and Turkey.

18. The European Vaccine Action Plan 2015–2020 (document EUR/RC64/15) promotes a life-course approach to vaccination. For the 2015 winter season, a special advocacy and awareness-raising campaign was launched on influenza vaccination for older people. Greater awareness of the benefits of vaccination for older people is needed in order to reverse the recent decline in influenza vaccination rates (observed where data are available).

19. The *Global status report on violence prevention 2014 (6)*, and its supporting country profiles, published jointly by WHO, the United Nations Development Programme and the United Nations Office on Drugs and Crime, document the growing awareness of and political commitment to address elder maltreatment in the European Region. The report provides evidence based on a global survey on violence and injury prevention, which also constitutes a useful tool for future monitoring of progress in Europe for this action area.

20. The number of cities and communities that are basing their activities for creating more supportive, age-friendly environments on WHO guidance on age-friendly cities and environments continues to grow. Since 2012, this movement has received more direct government support at higher – including national – levels in several countries, such as Finland, France, Ireland and the United Kingdom. Local action has been acknowledged as central to efforts to address issues related to promoting physical activity among older people and to addressing loneliness and social isolation.

21. During Phase V (2009–2013) of the European Healthy Cities Network (EHCN) age-friendly policy development was one of the most frequently addressed policy issues at the municipal level. It has continued to be a priority area, as cities have expressed interest in maintaining cooperation with the Regional Office during Phase VI (2014–2018). Some 12 cities have joined forces to work with the Regional Office through the Healthy Ageing Task Force for mutual learning and to support the Regional Office in developing tools for age-friendly environments for use by other cities and communities.

22. Healthy ageing has also been discussed regularly during the annual meetings of the EHCN, which cover a broad range of topics, from policy issues such as social participation, physical activity and age-friendly built environment, to multilevel governance, monitoring, indicators and rapid assessment of progress on implementation.

23. The Regional Office's work with European cities and communities through the EHCN and the WHO Global Network of Age-Friendly Cities and Communities has provided essential input for *Age-friendly environments in Europe (7)*, which is the result of a joint project and cooperation between the Regional Office and the European Commission's Directorate-General for Employment, Social Affairs and Inclusion. This joint project, in which the Regional Office cooperated with the European Commission and other partners from 2013 to 2016, formed part of the Regional Office's commitment to joint action through the European Innovation Partnership on Active and Healthy Ageing.

24. During the Irish Presidency of the Council of the European Union (EU), the EU Summit on Active and Health Ageing was held in Dublin, Ireland, in June 2013, to discuss ways to implement policies for age-friendly environments through an international movement of cities and other local authorities using the WHO age-friendly cities publications as inspiration and guidance. The meeting culminated in the adoption, by cities and regional authorities, of the Dublin Declaration on Age-friendly Cities and Communities in Europe 2013, which acknowledges the role of the WHO Regional Office for Europe and its core policy frameworks for the future development of the supportive environments movement in Europe.

25. Policy support at the national level has focused on issues of long-term care reform, palliative care, quality and equity of access to health and long-term care services, and integrated health services delivery, all of which contribute to strategic area 3 (people-centred health and long-term care systems fit for ageing populations) of the Strategy and action plan for healthy ageing. This has been supported by joint work undertaken in cooperation between the Division of Noncommunicable Diseases and Promoting Health through the Life-course and the Division of Health Systems and Public Health.

26. In Slovenia, the Regional Office has been involved since the beginning of discussions about developing a new, comprehensive national strategy for active and healthy ageing. The project is being funded jointly by the European Commission's Directorate-General for Employment, Social Affairs and Inclusion, the Ministry of Labour, Family, Social Affairs and Equal Opportunities, and the Ministry of Health.

27. In recent years, investment in long-term care has increased in countries of the European Region, both through explicit long-term care policies and as part of overall health and social expenditure. Long-term care expenditure is one of the fastest growing health expenditure components, and this growth rate has suffered less in the aftermath of the 2008 financial crisis compared with overall spending on health.

28. The number of actions that specifically plan for or focus on improved care and better integration for people living with dementia is also increasing. Strong engagement in this policy area in the European Region in general was illustrated in the statements made by Member States during the First WHO Ministerial Conference on Global Action Against Dementia, which was organized by WHO with support from the Department of Health of the United Kingdom of Great Britain and Northern Ireland and the Organisation for Economic Co-operation and Development (OECD). The Regional Office will participate in the European Commission Joint Action on Dementia initiative.

29. The Regional Office's age-friendly environments in Europe framework for monitoring and evaluation of age-friendly environments is an important tool for supporting local authorities in strengthening the evidence base and research on healthy ageing. It brings together a wide range of research and practice experience from the fast growing movement of age-friendly cities and communities. As the *World report on ageing and health (8)* emphasizes, however, significant gaps remain in knowledge about trends in and underlying mechanisms for healthy ageing and independent living. These gaps must be bridged in order to support policy-making, and require close cooperation with partners, such as the European Commission, the United Nations Economic Commission for Europe (UNECE), OECD and the World Bank.

Outlook for 2017–2020

30. In the coming four years, work will focus on health workforce-related issues for ageing populations and on further strengthening cooperation with international organizations (in particular, the European Commission, OECD, UNECE, UNFPA and the World Bank) to promote healthy ageing, including cooperation on indicators, and among the three levels of WHO. This will include cooperation on the UNECE/European Commission Active Ageing Index, and under the UNECE monitoring of the Regional Implementation Strategy for the Madrid International Plan of Action on Ageing and its 2017 round of reporting.

31. The *World report on ageing and health (8)* and the new WHO Global Strategy and Action Plan on Ageing and Health *(9)*, to which the Regional Office has contributed, will help strengthen the coherence and relevance of work on healthy ageing with Member States.

32. The further development of targets and indicators at the global and regional levels during 2016 will support monitoring of the implementation of the Strategy and action plan for healthy ageing in Europe from 2017 to 2020. The emphasis of the Global Strategy and Action Plan on Ageing and Health on the need to establish long-term care systems in all countries is also in line with the future plans of the Regional Office to step up work in this area in cooperation with Member States.

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G. Final progress report towards the health-related Millennium Development Goals in the WHO European Region (resolution EUR/RC57/R2)

Background and introduction

1. The adoption of the United Nations Millennium Declaration (General Assembly resolution A/RES/55/2) in September 2000 and its formalization into the Millennium Development Goals (MDGs) represented a major achievement in terms of providing a framework for advancing development in an inclusive manner. The implementation of the framework, however, proved to be complex, and the lessons learned along the way informed the preparations and the negotiations for the post-2015 development agenda, as well as the final outcome document Transforming our World: the 2030 Agenda for Sustainable Development.

2. Since the adoption of the MDGs, health, a critical part of human well-being, has greatly improved throughout the WHO European Region, but not everywhere and not for everyone. Health inequalities persist within and between countries. The rapid growth of noncommunicable diseases, disabilities and mental disorders, environmental health risks and financial uncertainty, has placed new pressures on health and welfare systems. The difficulties faced by many countries in the eastern part of the European Region in attaining the health-related MDGs attest to that.

3. Much needs to be done to sustain the health gains that have been achieved so far and to ensure the highest attainable standard of health as one of the fundamental rights of every human being across countries and populations.

4. This requires addressing the unfinished business of the MDGs as well as the challenges posed by noncommunicable diseases, mental health and sexual and reproductive health; and ensuring universal health coverage. Health 2020 and the newly adopted 2030 Agenda for Sustainable Development, provide an excellent policy framework to improve health, reduce health inequalities and strengthen leadership and participatory governance for health in the European Region.

5. This report summarizes the progress towards achieving the health-related MDGs and specific targets in the WHO European Region (resolution EUR/RC57/R2).

Progress and achievements

Goal 4: reduce child mortality

6. A good start early in life makes it easier to protect and promote health in the later stages. Based on this, improving child and maternal health is a major focus of the work of the WHO Regional Office for Europe, as reconfirmed by Investing in children: the European Child and Adolescent Health Strategy 2015–2020 (document EUR/RC64/12), endorsed by the 64th session of the Regional Committee for Europe in resolution EUR/RC64/R6 in September 2014.

7. The European Child and Adolescent Health Strategy 2015–2020 seeks to collect data on older children and adolescents, and to study the environmental influences on children's health at all ages, including before birth. It pursues a vision in which children are visible and attended to, free of poverty, bonded with caring parents, exclusively breastfed in their first months and educated to equip them to be well-functioning members of society.

8. Although the European Region has made substantial progress in reducing infant and under-five mortality, disparities persist. The average under-five mortality rate for the Region decreased from 32 per 1000 live births in 1990 to an estimated (modelled) 11 per 1000 in 2015 with an annual reduction rate of 4.2% *(1)*. This corresponds to a reduction of almost two thirds, reaching the 2015 target. The average infant mortality rate for the Region decreased from 26 per 1000 live births in 1990 to 10 per 1000 in 2015 (modelled). In 2015, 26 countries in the Region had achieved MDG Target 4A (reduce by two-thirds, between 1990 and 2015, the under-five mortality rate).

9. Prematurity, low birth weight, congenital anomalies, birth asphyxia, birth trauma, and neonatal infections are among the leading causes of neonatal death; and acute respiratory infections, diarrhoeal diseases, noncommunicable diseases and injuries are among the leading causes of post-neonatal deaths in the European Region.

10. The Regional Office provides support for capacity-building of policy-makers, health managers and health-care providers for improving the quality of care. Evidence-based tools developed by WHO and its partners are adapted to the national context and used for assessment and improvement of quality of services for children in hospital and primary health care facilities. Support is also given to reformulate the educational curricula of health-care providers. In addition, WHO works with other United Nations agencies and partners to develop capacity-building tools that address inequities in progress towards Goals 4 and 5, with a particular focus on the Roma population.

11. Immunization has helped drive a remarkable reduction in child mortality in the European Region over the past decades, as a priority supported by the direction and guidance of Health 2020 and the European Vaccine Action Plan 2015–2020.

12. Great advances have been made in developing and introducing new vaccines and expanding the reach of immunization programmes to reduce both mortality and morbidity. More people than ever before are being vaccinated and access to and use of vaccines by all age groups is expanding. New and increasingly sophisticated vaccines have become available in the last decade, with WHO support, including pneumococcal conjugate vaccine (34 countries) and vaccines against infection with rotavirus (15 countries) and human papillomavirus (42 countries). This represents significant progress towards Goal 4.

13. However, while national immunization programmes are generally strong and national routine immunization coverage is high, the European Region has experienced outbreaks of vaccine preventable diseases over the past four years. As the Region enters 2016, the measles and rubella elimination target date of 2015 has been missed but there are signs of momentum – with renewed commitment and the majority of countries having interrupted indigenous transmission of both diseases.

Goal 5: improve maternal health

14. The average maternal mortality rate for the European Region decreased from 44 per 100 000 live births in 1990 to 16 per 100 000 in 2015 *(2)*. Despite this progress, the average decrease of 4% remained short of the 5.5% required to reach MDG Target 5A (reduce by three quarters, between 1990 and 2015, the maternal mortality ratio). The annual decrease is even less (3%) in countries of central Asian and the Caucasus. The average maternal mortality rate in countries in the European Union remains low; however, analysis of data on different social groups shows diversity within countries, and targeted interventions have been developed.

15. Reliable, comparable data on the prevalence of contraceptive use, unmet needs for family planning and the adolescent birth rate (MDG Target 5B indicators) are missing for many countries. The rates of use of modern, effective methods of contraception are alarmingly low in many countries of eastern Europe and central Asia. Low contraceptive use in eastern Europe, as well as a high degree of reliance on methods with relatively high user failure rates, is a cause of steady high abortion rates after a period of steep decline in the late 1990s and the early 2000s. In some countries, barriers to safe abortion lead to unsafe practices, resulting in maternal morbidity and even deaths.

16. The Regional Office for Europe supports the inclusion of reproductive, maternal and child health in national policies, within the health systems framework, and emphasizes equity in access to quality services. The strategy on women's health and well-being in the WHO European Region (document EUR/RC66/14)and the Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind (document EUR/RC66/13) are presented for consideration by Member States at the 66th session of the Regional Committee for Europe.

17. In addition, WHO works with other United Nations agencies and partners to develop capacity-building tools that address inequities in progress towards Goals 4 and 5, with a particular focus on the Roma population.

Goal 6: combat HIV/AIDS, malaria and other diseases

HIV/AIDS

18. More than 142 000 people were newly diagnosed with HIV infection in the European Region in 2014, representing a rate of 16.4 per 100 000 population and contributing to a cumulative total of more than 1.8 million people diagnosed since the beginning of reporting. This represents a 76% increase in new diagnoses of HIV infection compared to 2005, when almost 81 000 people were newly diagnosed. This trend is mainly driven by an increase in cases in eastern Europe and central Asia where the number of new diagnoses increased by 115% during the last decade. This is a marked difference compared to other WHO regions where the number of new HIV infections is generally decreasing. Of the 142 000 new diagnoses in 2014, 77% were from eastern Europe and central Asia.

19. A total of 16 037 people were newly diagnosed with AIDS in 2014, corresponding to a rate of 2.3 diagnoses per 100 000 population, with many more in eastern Europe

and central Asia (11 890 cases) than in western and central Europe (4147 cases). The majority of countries in eastern Europe and central Asia have reported sustained increases in the numbers of new AIDS diagnoses, with a 141% increase in 2014 over 2005. In western Europe, the number of people newly diagnosed with AIDS decreased by 63%.

20. Community-based HIV testing is increasingly accepted and widespread in the western part of the European Region, but remains a challenge in the east. The overall increase in the number of people tested in the Region does not reflect better coverage of those who need testing most in many settings, as average HIV testing rates among people who inject drugs, sex workers and men who have sex with men ranged from 40% to 60% – well below the European target of 90% for 2015. In addition, late detection remains a challenge, with 48% of people diagnosed at a late stage of infection[1] in 2014 having negative consequences for treatment effectiveness, AIDS incidence, mortality and onward transmission of HIV to other people.

21. Countries in the European Region have made progress in delivering treatment and care for patients with HIV infection. Antiretroviral treatment (ART) is widely available in the western part of the Region with coverage estimates averaging around 75% at the end of 2015 and has also become more accessible in eastern Europe and central Asia: 210 000 more people received ART in 2015 than in 2010, representing a 187% increase from 112 100 to 321 800 in just five years, while compared with 2005 there has been a twenty-fold increase from just 15 600 people receiving treatment. Yet, relative to the estimated 1.5 million people living with HIV (diagnosed and undiagnosed) in eastern Europe and central Asia, only 21% were receiving ART at the end of 2015.

22. The reduction in mother-to-child transmission of HIV is one of Europe's successes in its response to the HIV/AIDS epidemic. This mode of transmission accounted for less than 1% of new cases in 2014; the number of children infected in this way has decreased by 11% between 2005 and 2014, with 74% of mother-to-child transmitted cases in 2014 reported in the eastern part of the European Region. European countries continued to have the highest coverage globally of ART for HIV-infected pregnant women (estimated at75–95%) in low- and middle-income countries at the end of 2014).

23. Great progress has also been achieved towards elimination of mother-to-child transmission of HIV and congenital syphilis, which is addressed in the European Region as dual elimination. Three countries (Armenia, Belarus, Republic of Moldova) have had elimination of MTCT of HIV and/or congenital syphilis successfully validated, and several more countries are preparing for validation based on WHO global validation criteria. Two regional technical consultations implemented in collaboration with key United Nations and other major partners in Astana, Kazakhstan, in 2015, as well as several validation readiness assessment missions accelerated movement towards achieving and validating elimination of mother-to-child transmission of HIV and congenital syphilis across the Region.

24. Much needs to be done to halt and reverse the spread of HIV/AIDS and work will continue as part of regional efforts to achieve Sustainable Development Goal 3 (good

[1] CD4 cell counts below 350 per ml blood at diagnosis.

health and well-being), in the recently adopted 2030 Agenda for Sustainable Development. Support and technical assistance will continue to be provided to Member States to adopt evidence-informed policies for treating and preventing HIV infection, particularly among key populations, and to implement harm reduction interventions and programmes for the prevention of sexual transmission in national HIV plans. In collaboration with Member States and partners, the Regional Office has developed a new Action plan for the health sector response to HIV in the WHO European Region which is presented for consideration by the 66th session of the WHO Regional Committee for Europe in September 2016. The Action plan guides the transformation of the health sector response required to reverse the HIV epidemic in the Region, and advocates for an accelerated HIV response by prioritizing high-impact, evidence-based, fast-track actions. The political commitment of Member States is crucial for successful implementation of the Action plan.

Malaria

25. The Tashkent Declaration "The Move from Malaria Control to Elimination", 2005 *(3)*, endorsed by ten malaria affected countries in the European Region, was a turning point in the process towards a malaria-free Europe. The Tashkent Declaration led the way to a new regional strategy for 2006–2015 that guided European affected countries to reduce the number of indigenous malaria cases to zero.

26. The European Region is the first in the world to have achieved interruption of indigenous malaria transmission. The number of indigenous malaria cases dropped from 90 712 in 1995, to zero cases in 2015, in line with the goal of the Tashkent Declaration to eliminate malaria from the Region by 2015. Turkmenistan attained malaria-free status in 2010, Armenia in 2011, and Kazakhstan in 2012. Certification of malaria elimination in Kyrgyzstan is expected to be completed by the end of 2016. Indigenous malaria transmission has also been interrupted in Azerbaijan, Georgia, Tajikistan, Turkey and Uzbekistan.

27. This achievement was made possible through a combination of strong political commitment, heightened detection and surveillance of malaria cases, integrated strategies for mosquito control with community involvement, cross-border collaboration, and communications to those at risk. Key partners substantially funded malaria elimination efforts in European countries.

28. The Regional framework for prevention of malaria reintroduction and certification of malaria elimination 2014–2020 *(4)* was developed and published. This Regional framework outlines the key ways to avoid the resurgence of malaria in countries where it has been eliminated and methodological aspects of the process of certifying countries free from malaria.

29. While zero indigenous cases were reported in 2015, there is still a possibility of cases with a long incubation period showing themselves in 2016.

30. This achievement is still fragile. Lessons from the past highlight the continual threat of malaria reintroduction, and this experience urges the need to maintain political commitment, keep up high vigilance and continue investing in strengthening health systems to ensure that any resurgence can be rapidly contained.

Tuberculosis

31. The target of halting the prevalence of and death associated with tuberculosis and reversing the incidence has been achieved only partially in the European Region. In 2014, the incidence and prevalence of tuberculosis were estimated, respectively, as 37 and 48 cases per 100 000 population *(5)*. Tuberculosis incidence has been falling at an average rate of 5.2% per year since 2005, which is the fastest decline in the world. The prevalence has been reduced by 28.4% compared to the targeted 50% reduction against the baseline of 1990, nevertheless, it has more than halved since 2000. Tuberculosis mortality in 2014 was estimated to be 3.7 deaths per 100 000 population, a 20% decline compared to 1990 and more than halved since 2000.

32. During the last five years more than 1 million tuberculosis patients, including 53 000 with multidrug-resistant tuberculosis (MDR-TB) have been cured, about 200 000 MDR-TB cases have been averted and more than 2.6 million lives have been saved *(6)*. Nevertheless, despite a constant decrease in burden and remarkable impact of the concerted regional interventions, the European Region did not fully meet Goal 6 targets.

33. The burden of tuberculosis in the European Region varies widely within and between countries, from two cases per 100 000 population in some Member States to over 150 cases per 100 000 in others. Even within countries, there is a wide variation, with tuberculosis rates above 100 per 100 000 population in some districts and capitals of western Europe. The major burden is borne by 18 high-priority countries, which have 83% of new tuberculosis cases, 92% of tuberculosis-related deaths, 88% of HIV co-infected tuberculosis patients and 99% of all MDR-TB cases.

34. In 2014, about half of the estimated 73 000 MDR-TB cases had been detected. The prevalence of MDR among new tuberculosis cases in the European Region was 18.4%, while the prevalence among previously treated tuberculosis cases was 46.2%. Although HIV/TB co-infection is not as prevalent as in some other WHO regions, the European Region is the only region with an increasing prevalence of HIV infection among tuberculosis patients, the percentage increased from 2.8% in 2007 to 8.0% in 2014.

35. In 2013, the European Region reached universal coverage with first- and second-line tuberculosis treatment. However, the treatment success rate in the last decade, among new and relapsed tuberculosis cases remained consistently low. In 2014, it was 76%, considerably below the 85% target. The treatment success rate among MDR-TB patients has also been decreasing, and for the first time in 2014, it went up as compared to 2013, from 46% to 49%.

36. The Regional Office continues to provide technical assistance to Member States in monitoring and assessing national interventions and improving tuberculosis drug management, infection control, laboratory networks, HIV/TB co-infection, advocacy and communication, surveillance and response, clinical management, recording and reporting, intersectoral collaboration, social determinants of tuberculosis and people-centered approaches to achieve universal access to tuberculosis care in line with Health 2020.

37. The year 2015 marked the end of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region. In order to continue to move forward and address the challenges to tuberculosis and M/XDR-TB prevention and care, the WHO Regional Office for Europe has developed the new Tuberculosis Action Plan for the WHO European Region 2016–2020. The new Action Plan, endorsed by Member States at the 65th session of the Regional Committee in September 2015, was based on lessons learned in the implementation of the seven areas of intervention of the Consolidated M/XDR-TB Action Plan 2011–2020, in line with the global End TB Strategy and Health 2020, the European policy for health and wellbeing *(7)*.

Neglected tropical diseases

38. EURO’s work in this area is mainly focused on emerging/re-emerging vector-borne diseases, such as Zika virus disease, dengue and chikungunya as well as leishmaniasis and soil-transmitted helminthiasis.

39. *Aedes albopictus*, the vector of dengue, has spread rapidly to more than 25 countries in the European Region. The threat of dengue outbreaks has therefore returned to Europe, after a lapse of 55 years. Local transmission of the virus was reported in Croatia and France in 2010, and imported cases were detected in several other European countries. A dengue outbreak on the island of Madeira (Portugal) in 2012 resulted in more than 2200 cases and importation of cases into 17 other European countries. The Regional Framework for Surveillance and Control of Invasive Mosquito Vectors and Re-emerging Vector-borne Diseases, adopted by the 63rd session of the Regional Committee in resolution EUR/RC63/R6, is used as a framework for actions to support Member States.

40. As of today, no mosquito-borne Zika virus transmission has been reported in the European Region. The Regional Office has developed the Interim Zika Risk Assessment for the Region, which highlights that while the overall level of likelihood for local Zika virus transmission and the subsequent risk for a widespread Zika virus outbreak is generally moderate to low across the Region, the risk varies at the country level. Several countries extending from the Mediterranean basin have a moderate likelihood of local Zika virus transmission due to established populations of *Aedes albopictus.* In addition, there are three geographical areas with established populations of *Aedes aegypti*, which subsequently have higher likelihood for local Zika virus transmission (Madeira Island (Portugal), Black Sea costal areas of Georgia and the Russian Federation).

41. Leishmaniasis is a neglected and poorly reported disease with an underestimated or undetermined burden in most countries of the European Region. The regional incidence of visceral leishmaniasis and cutaneous leishmaniasis is estimated at less than 2% of the global burden of leishmaniasis, according to the WHO recent estimate of leishmaniasis incidence. In 2014, the Strategic Framework for Leishmaniasis Control in the WHO European Region 2014–2020 was developed and published. The Strategic Framework outlines the regional goal and objectives to be achieved by 2020, and the recommended strategic approaches and priority interventions with special attention to: programme management, case detection and management, disease surveillance, control of reservoir hosts, integrated vector control, environmental management and personal protection, epidemic preparedness and response, operational research, capacity-

building, community participation and health education, cross-border cooperation, intersectoral collaboration, partnership action, and monitoring and evaluation.

42. Soil-transmitted helminthes, commonly known as intestinal worms are the most common parasitic infections worldwide, affecting the most deprived communities. Soil-transmitted helminthiases produce a wide range of symptoms that may affect people's working and learning capacities and impair physical and intellectual growth and development. WHO estimates that more than 4 million children in the European Region need preventive chemotherapy (1% of the global burden). A regional framework on control and prevention of soil-transmitted helminthes in the Region has been drafted with the vision to protect all children of the European Region from the negative impact of soil-transmitted helminthes. This draft regional framework is expected to be finalized and published in July 2016.

Target 7C: halve, by 2015, the proportion of the population without sustainable access to safe drinking-water and basic sanitation

43. In 2015, the majority of the population of the European Region had access to basic sources of drinking-water (98.5%) and sanitation facilities (93.1%), as defined by the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation *(8)*. However, these figures mask large gaps and disparities within the Region, within and between countries, between urban and rural areas and between high- and low-income groups.

44. The European Region failed to meet the sanitation target. More than 62 million people still lack access to functioning toilets and safe means to dispose of human faeces. Almost 1.7 million people in 11 countries practice open defecation – their faeces are disposed of in fields, forests, bushes, open bodies of water, beaches or other open spaces or disposed of with solid waste. These people without access to appropriate sanitation facilities are denied the opportunity to live in a healthy environment and deprived of the human right to adequate sanitation.

45. The European Region has met the target on drinking-water. Still, about 14 million people do not enjoy access to a basic drinking-water source, and 62 million still lack access to piped drinking-water on their premises. More than 4 million still rely on surface water from rivers, dams, canals, streams, lakes, ponds or irrigation channels as their primary water source, posing severe risks to health.

46. Significant inequalities exist in access to drinking-water and sanitation services; rural dwellers and the poor are the most disadvantaged. Seven out of ten people without access to a basic drinking-water source live in rural areas. In the Caucasus and central Asia, for example, 19% of the rural population lives in homes without access to a basic drinking-water source, as opposed to only 2% of urban dwellers. Even more significantly, 62% of the rural population lives in homes without access to piped water on the premises, whereas only 10% of town and city residents are similarly disadvantaged.

47. Data on access to services, such as water and sanitation, can distort and mask the true picture in terms of quality, quantity, functionality, reliability, continuity and affordability of the services delivered. For low- and middle-income countries of the

European Region, 10 diarrhoea deaths a day are estimated attributable to inadequate water, sanitation and hygiene (*9*). Therefore, more emphasis on accelerating safety and sustainability of services is needed. Significant health gains are expected when access transitions from "basic" to "systematically managed" water sources and sanitation facilities. The Regional Office encourages Member States to scale-up systematic risk management approaches, such as the water safety plan and the sanitation safety plan, in policy and practice.

48. The Protocol on Water and Health, referred to in the 2010 Parma Declaration on Environment and Health as the primary multilateral policy instrument to develop integrated policies in the water, sanitation and health domain in the European Region, has been ratified so far by 26 countries in the Region, representing 60% of its population. Under the Protocol framework, the Regional Office, together with its partners, supports Member States in setting national policy targets on reducing water-related diseases, strengthening safe management of water and sanitation services, establishing effective surveillance systems, and reducing persistent inequalities in access to water and sanitation services. The Protocol's provisions and principles fully align with the Sustainable Development Goals (SDGs) of the 2030 Agenda pertaining to water, sanitation and health and play a pivotal role in "translating" and operationalizing global commitments of the 2030 Agenda, specificallySDG3 and SDG6, into national targets and actions.

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Category 5: Preparedness, surveillance and response

H. Progress report on implementation of the European strategic action plan on antibiotic resistance (resolution EUR/RC61/R6)

Background and introduction

European strategic action plan on antibiotic resistance

1. At the 61st session of the Regional Committee for Europe in September 2011, the 53 Member States of the European Region adopted resolution EUR/RC61/R6 and the European strategic action plan on antibiotic resistance (document EUR/RC61/14), which contains seven strategic objectives, intended to comprehensively address the complex factors related to bacterial resistance:

(a) strengthen national multisectoral coordination for the containment of antibiotic resistance;

(b) strengthen surveillance of antibiotic resistance;

(c) promote strategies for the rational use of antibiotics and strengthen surveillance of antibiotic consumption;

(d) strengthen infection control and surveillance of antibiotic resistance in health care settings;

(e) prevent and control the development and spread of antibiotic resistance in the veterinary and agricultural sectors;

(f) promote innovation and research on new drugs and technology; and

(g) improve awareness, patient safety and partnership.

2. To promote the implementation of the European strategic action plan on antibiotic resistance, resolution EUR/RC61/R6 urges Member States:

(a) to secure the political commitment and resources necessary to implement the strategic action plan;

(b) to analyse the national situation of antimicrobial resistance and antibiotic use in a comprehensive approach covering the community, health care settings and food and animal production

(c) to support the development of national systems for surveillance and monitoring of antibiotic resistance and consumption;

(d) to initiate and formalize national, intersectoral, all-inclusive coordinating mechanisms;

(e) to review and ensure adherence to national recommendations for infection control in health care settings;

(f) to develop cooperation with the pharmaceutical industry, academia and other relevant sectors to address research and development of new antibiotics and diagnostic tools to contain antibiotic resistance; and

(g) to support national campaigns to raise awareness of the causes of antibiotic resistance.

3. Resolution EUR/RC61/R6 requests the Regional Director to continue to provide leadership, tools, guidance and technical support to Member States in assessing their current situations with regard to antibiotic resistance, antibiotic consumption and their capacity to develop and implement national action plans.

Global action on antibiotic resistance

4. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.25 on antimicrobial resistance (AMR), requesting the Director-General to develop a draft global action plan to combat AMR, including antibiotic resistance, and to submit the draft to the Sixty-eighth World Health Assembly, through the Executive Board.

5. During the drafting of the global action plan, the Secretariat had intense and extensive consultations with the Strategic and Technical Advisory Group on Antimicrobial Resistance (STAG-AMR), international organizations such as the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE), Member States and other relevant stakeholders. In addition, the work of the Secretariat was supported by high-level technical and political conferences, hosted by the Netherlands, Norway and Sweden, on:

(a) the importance of a One Health approach (The Hague, Netherlands, 25–26 June 2014);

(b) the responsible use of antibiotics (Oslo, Norway, 13–14 November 2014); and

(c) global surveillance capacity, systems and standards (Stockholm, Sweden, 2–3 December 2014).

6. Through the Secretariat's work on AMR, which involves all three levels of the Organization, two important reports were published: *Antimicrobial resistance: global report on surveillance 2014* (April 2014) and *Worldwide country situation analysis: response to antimicrobial resistance* (April 2015). These reports provide an overview of the current level of global capacity to respond to the threat of AMR and the needs that must be addressed by the Global action plan.

7. In May 2015, the Sixty-eighth World Health Assembly, in resolution WHA68.7, endorsed the Global action plan on antimicrobial resistance (document A68/20). The Global action plan on antimicrobial resistance, which includes antibiotic resistance – the most urgent drug resistance trend, sets out five strategic objectives:

(a) to improve awareness and understanding of AMR;

(b) to strengthen knowledge through surveillance and research;

(c) to reduce the incidence of infection;

(d) to optimize the use of antimicrobial agents; and

(e) to ensure sustainable investment in countering AMR.

8. The Global action plan urges Member States to have in place, by the time of the Seventieth World Health Assembly in May 2017, comprehensive national action plans on AMR that are in line with the Global action plan. These national action plans should reflect the following principles:

(a) whole-of-society engagement, including a One Health approach;

(b) prevention first;

(c) access;

(d) sustainability; and

(e) incremental targets for implementation.

Action taken and progress made

Implementation of the European strategic action plan on antibiotic resistance

9. Although it precedes the Global action plan by four years, the objectives of the European strategic action plan on antibiotic resistance adopted in 2011 are fully aligned with those of the Global action plan. The ongoing implementation of the European strategic action plan therefore paves the way for Member States in the Region in implementing the Global action plan. The efforts of the Regional Office for Europe and partners have guided and inspired global activities and initiatives in support of the development and implementation of the Global action plan.

10. At the Regional Office, implementation of the European strategic action plan is coordinated among several technical programmes with their respective networks of technical partners to ensure that progress is made on the implementation of all seven strategic objectives. Joint missions and workshops are organized to provide comprehensive support to Member States.

11. On 24–27 February 2015, the Regional Office organized a multicountry AMR workshop with a focus on sharing experiences and methodologies on rational use of antibiotics and antimicrobial stewardship in hospital settings, surveillance of antimicrobial resistance and use, and promoting AMR awareness. The workshop was well attended with participation from 75 representatives of 17 countries (Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Ukraine and Uzbekistan), 29 international faculty representing 17 organizations in 10 countries, and WHO staff and consultants. This workshop was a follow-up to workshops held in Bilthoven, the Netherlands (2013) and Tbilisi, Georgia (2014).

12. In order to meet the increasing demand from Member States for technical support on national AMR coordination, surveillance and laboratory diagnostics, the Regional Office for Europe and partners have organized training-of-trainers courses, in June and September 2015, designed to prepare technical experts for AMR assignments in these areas. This activity increased the ability of the Regional Office to provide tailored assistance to Member States in implementing the European strategic action plan on

antibiotic resistance, while ensuring adherence to commonly accepted approaches and standards.

13. This report highlights recent activities and achievements of the Regional Office and partners in implementing the seven strategic objectives of the European strategic action plan on antibiotic resistance and the support provided by the Regional Office towards the development and implementation of the Global action plan on antimicrobial resistance.

Strategic objective 1: strengthen national multisectoral coordination for the containment of antibiotic resistance

14. The Regional Office has undertaken efforts to assess the current situation in Member States in addressing the challenges raised by AMR, focusing on all areas identified in the European strategic action plan on antibiotic resistance. For this purpose, teams composed of WHO staff and external experts from the National Institute for Public Health and the Environment (RIVM) of the Netherlands and the European Society of Clinical Microbiology and Infectious Diseases (ESCMID), visited Member States to discuss the current status of the AMR response with nominated focal points and other relevant national stakeholders in the human and veterinary health sectors, including site visits to laboratories and health care facilities.

15. Between 2013 and 2016, in-country situation analyses have been performed in Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

16. Stakeholder meetings organized during follow-up missions to countries have been used to introduce the concept of intersectoral coordination for AMR, and to convene groups of relevant stakeholders, with a special focus on adopting the One Health approach, to facilitate the creation of an intersectoral coordination mechanism, national networks and AMR action plans. In order to facilitate this process, WHO headquarters, in close collaboration with the regional offices, developed a package of supportive tools and templates, which were shared with seven Member States (Albania, Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan and Uzbekistan) in the Regional Workshop on Development and Implementation of National Antimicrobial Resistance Action Plans, held in Istanbul, Turkey, on 15–17 March 2016, organized jointly with FAO and OIE.

17. To date, 15 Member States and Kosovo[1] have developed a national AMR action plan. Since the adoption of the European strategic action plan in 2011, a number of additional countries, including Albania, Armenia, Belarus, Georgia, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan and Uzbekistan, have established or are in the process of formalizing an intersectoral coordination mechanism and developing a national action plan. The Secretariat provides technical support and access to experts for the development and advancement of national plans and related governance structures.

[1] Kosovo (in accordance with Security Council resolution 1244 (1999)).

Strategic objective 2: strengthen surveillance of antibiotic resistance

18. Surveillance of antibiotic resistance is considered the backbone of both the European strategic action plan and the Global action plan. Many countries in the Region that are not members of the European Union do not systematically collect and share data on antibiotic resistance. Therefore, the Regional Office, together with RIVM and ESCMID, established the Central Asian and Eastern European Surveillance of Antimicrobial Resistance (CAESAR) network in 2012 to assist countries in setting up and/or strengthening national AMR surveillance. These efforts will also contribute to the newly established WHO Global Antimicrobial Resistance Surveillance System that was launched in October 2015 in Copenhagen, Denmark, to support a standardized approach to the collection, analysis and sharing of data on AMR at the global level.

19. The CAESAR network focuses on countries that are not part of the European Antimicrobial Resistance Surveillance Network (EARS-Net), which is hosted by the European Centre for Disease Prevention and Control (ECDC). In close collaboration with the ECDC and using compatible methodology, CAESAR complements surveillance conducted in the European Union to complete the regional picture. Currently, Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan, as well as Kosovo,[1] are engaged in the CAESAR network at various stages of development and participation.

20. Since 2013, the Secretariat and partners have organized a CAESAR network meeting each year during the European Conference on Clinical Microbiology and Infectious Diseases organized by ESCMID, where all national AMR focal points from the countries involved in CAESAR are invited to discuss AMR trends, network progress, external quality assurance results, and specific issues and challenges related to AMR surveillance. In 2015, the Secretariat provided grants to Belarus, Bosnia and Herzegovina, Montenegro, Serbia, the former Yugoslav Republic of Macedonia and Turkey to organize national AMR surveillance meetings to set up or strengthen their national AMR surveillance system networks.

21. The Secretariat published the first CAESAR annual report on the occasion of the first World Antibiotic Awareness Week (WAAW) in November 2015, with data from Belarus, Serbia, Switzerland, the former Yugoslav Republic of Macedonia and Turkey. Since then, the Russian Federation, as well as Kosovo,[1] have submitted AMR data to the CAESAR database. The second CAESAR annual report will be published during WAAW in November 2016, and will include three-year AMR data and an overview of progress made by countries in setting up their own national AMR surveillance systems.

22. The efforts of the CAESAR network to improve laboratory quality include annual external quality assessments (since 2013), publishing the CAESAR surveillance manual (2015), training courses on laboratory quality management, and national workshops and meetings to set up and strengthen national AMR reference laboratories to perform their tasks.

23. In 2015, 13 countries/areas with a total of 250 laboratories participated in the CAESAR external quality assessment of antimicrobial susceptibility testing. In

September 2015, the Secretariat provided a training course on laboratory quality management to participants from the national AMR reference laboratories of Armenia, Georgia, Republic of Moldova, Russian Federation, Tajikistan and Turkey, together with prospective mentors who should provide follow-up support.

24. The Secretariat organized national workshops and meetings in Albania, Armenia, Belarus, Georgia, Montenegro, Republic of Moldova, Tajikistan and Uzbekistan to set up and strengthen national AMR reference laboratories to perform their tasks, including implementation of international guidelines on antimicrobial susceptibility testing and quality control in laboratories.

25. In April 2015, a pilot of the proof-of-principle (PoP) study on antimicrobial resistance routine diagnostics was initiated in Georgia. The PoP study is designed to introduce sustainable routine sampling practice into a country to improve patient treatment (antibiotic stewardship) and enable national AMR surveillance. In November 2015, the Secretariat and partners organized a multicountry meeting to introduce countries to the principles of the PoP study and prepare for the start of the study.

26. The Regional Office and partners will continue to work towards including all remaining countries, because a harmonized, coordinated surveillance network in all countries of the European Region is crucial to protecting health from emerging cross-border AMR threats.

Strategic objective 3: promote strategies for rational use of antibiotics, and strengthen surveillance of antibiotic consumption

27. Work to consolidate data collection on antimicrobial consumption has continued in Member States in the European Region. Eighteen non-European Union Member States (Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Ukraine and Uzbekistan) and Kosovo[1] have provided data for 2012, 2013 and 2014. Analyses of the data are being conducted by the Secretariat.

28. The Secretariat has worked to support the antimicrobial medicines consumption (AMC) network through regular meetings at the country level and at network meetings of all participating countries, one of which was held in Copenhagen, Denmark, in November 2015; the next AMC network meeting is scheduled for September 2016. The discussions focus on country-specific factors that might explain trends and patterns of antimicrobial utilization observed. The Secretariat is working to support countries in moving beyond estimates of total consumption of antimicrobial agents to more detailed analyses of the data disaggregated by medicine class, medicine type and setting of use where possible.

29. To ensure sustainability of the AMC network over time, a small steering group has been established, comprising Regional Office staff, external experts and a rotating membership of participating countries, to guide activities and programme planning for the network. Ensuring visibility of the work is crucial to sustaining the network and increasing the use of data at the country level. The Secretariat is supporting publication of the results of the analyses of antimicrobial consumption data in peer-reviewed

journals. In addition, the Secretariat is working with countries to facilitate in-country dissemination workshops where the antimicrobial consumption data are shared with decision-makers and interested stakeholders.

30. The collection of data on antimicrobial medicines consumption is a key commitment under the Global action plan on AMR. The work of the European Region's AMC network is being used to inform global models for data collection. The Secretariat has participated in meetings convened by WHO headquarters to discuss data collection tools, present the results of AMC network activities and to share experiences with other WHO regional offices on developing sustainable regional networks.

31. Quantitative estimates of AMC are important. However, the interpretation of the data relies on country-specific information of the pharmaceutical market and access to medicines. In addition, qualitative studies are needed to understand why health care professionals recommend specific antimicrobials and consumers' and patients' understanding of the role of these medicines in managing their health. The Secretariat has facilitated collaboration between researchers at the University of Copenhagen and a number of national focal points for the AMC network, who are using interview studies to better understand the use of antimicrobials by doctors, pharmacists and patients. It is anticipated that this work will be extended to other countries participating in the AMC network.

32. The Secretariat continues to support countries in activities relating to responsible use of antimicrobials. Evidence generated by AMC network activities and other studies underpins work in the development of interventions to improve the responsible use of these agents.

Strategic objective 4: strengthen infection control and surveillance of antibiotic resistance in health care settings

33. One of the guiding principles of the Global action plan is "prevention first". Antimicrobials are often used to mask poor infection prevention and control. Country situation analyses in the European Region have shown that there is an alarming need to implement infection prevention and control principles in health care facilities. In supporting the drafting of national AMR action plans, the Secretariat actively promotes the inclusion of infection prevention and control measures, such as advocating vaccines, providing specific recommendations, and engaging in both multicountry and tailored country-level follow-up activities.

34. The Regional Office provides financial and technical support for capacity-building workshops in clinical microbiology and antibiotic stewardship, with the participation of specialists in infectious diseases, intensive care and other relevant medical disciplines. The regional workshops held in Tbilisi, Georgia (July 2014), Copenhagen, Denmark (February 2015) and Istanbul, Turkey (October 2015) also offered introductory training modules on antibiotic stewardship and good clinical practice for clinicians.

35. The Secretariat supported 50 clinicians from the former Yugoslav Republic of Macedonia to obtain continuous medical education credit for an open-source, online course (developed by the University of Stanford, United States of America) on

optimizing antibiotic practice. This was followed by a meeting at the Medical University in Skopje, where representatives of the Secretariat, accompanied by an external expert on antibiotic stewardship, witnessed the presentation of the results from the online course. The course is currently under review for the development of targeted training materials benefitting additional Member States in 2016.

36. At the request of the National Board of Health in Estonia to improve hospital capacity to respond to highly infectious diseases, including those caused by multidrug-resistant bacteria, the Secretariat organized a table-top simulation exercise in April 2016. The exercise explored current practices and identified best practices and opportunities for improvement, to inform the development of both hospital- and country-level strategies for reducing health care-associated infections and AMR.

37. In the absence of a dedicated programme on infection prevention and control at the Regional Office, much of the support is provided in close collaboration with WHO headquarters and experts of the Global Infection Prevention and Control Network. However, given the high demand from Member States to receive technical support, the capacity to respond to this need should be strengthened at the Regional Office.

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

38. The Secretariat continues to advocate for addressing AMR from a One Health perspective, including its relevance to food safety, and conducts activities at both the regional and country levels.

39. A five-day training course, focusing on laboratory diagnosis of *Salmonella* and *Campylobacter* and related AMR, took place in Albania in July 2015. This course brought together officials from the public health, veterinary and agricultural sectors and was funded by the WHO Advisory Group on Integrated Surveillance of Antimicrobial Resistance (AGISAR).

40. In Uzbekistan, a five-day, hands-on laboratory and epidemiology training course took place in November 2015 to build capacity in the central Asian republics on AMR from a food safety perspective, focusing on coordinated surveillance of AMR in the foodborne pathogens *Salmonella* and *Campylobacter*. The emphasis was on intersectoral cooperation and information sharing in line with Health 2020, the European policy framework on health and well-being. This training course brought together approximately 40 national professionals from Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, microbiologists as well as epidemiologists, from the public health, food safety and veterinary sectors.

41. Surveys on the occurrence of *Salmonella* and *Campylobacter* in humans and poultry and their AMR were conducted in Uzbekistan between January and May 2015, and in Albania between October 2015 and February 2016. The surveys revealed results that are in line with European Union countries and confirmed that the poultry food-chain is important for the transmission of resistant *Salmonella* and *Campylobacter* to humans in Albania and Uzbekistan, and that the usage of antibiotics in poultry production has an impact on resistance patterns.

42. The results from the aforementioned surveys in Albania and Uzbekistan were presented and discussed at intersectoral food safety/One Health workshops. A national workshop was held in Tashkent in May 2015 with support from WHO and FAO. A workshop for Albania and Kosovo[1] was held in Tirana in April 2016. Both workshops were opened by high-level representatives of the ministry of health and the ministry of agriculture of the respective countries, and brought together about 40 professionals from the public health, veterinary and agriculture sectors.

43. In Ankara, Turkey (May 2015) and Kiev, Ukraine (October 2015), two-day intersectoral food safety workshops were conducted, with sessions devoted to AMR from a One Health perspective. These brought together 50–100 national professionals from the public health, veterinary and agriculture sectors and stimulated discussions and engagement. The workshop in Turkey was held jointly with FAO and opened by high-level representatives of the Ministry of Health, the Ministry of Food, Agriculture and Livestock, and Hacettepe University. The Codex Alimentarius Commission, the ECDC and the European Food Safety Authority also contributed. The workshop in Kiev was opened by the Minister of Health of Ukraine.

44. The Secretariat is closely following the European Commission project “European Surveillance of Veterinary Antibiotic Consumption”, coordinated by the European Medicines Agency (EMA) for members of the European Union. The Regional Office plans to support the EMA in conducting similar surveys in some countries that are not members of the European Union.

Strategic objective 6: promote innovation and research on new drugs and technology

45. The Secretariat is a member of the stakeholder advisory board of the Joint Programming Initiative on Antimicrobial Resistance, which launched its strategic research agenda in April 2014.

46. The Secretariat is following developments involving new diagnostic methods and research on new drugs on a continuous basis. The Regional Director for Europe is a member of the jury of the Horizon Prize for better use of antibiotics, which will be awarded for a rapid test to identify, at the point of care, patients with upper respiratory tract infections that can be treated safely without antibiotics.

47. The Secretariat continues to engage with nongovernmental groups and networks, such as ReAct and Antibiotic Action, to promote innovation and develop new business models that stimulate research and discourage aggressive marketing of new antibiotics.

Strategic objective 7: improve awareness, patient safety and partnerships

48. Since 2012, the Regional Office has collaborated with ECDC and the European Commission to mark European Antibiotic Awareness Day (EAAD). The Secretariat has increased the number of participating countries by actively promoting the EAAD and preparing and distributing promotional materials. In 2014, the total number of countries marking the EAAD in the European Region reached 44.

49. In November 2015, the first ever WAAW was held. The WHO-led campaign received a great deal of attention worldwide and reached millions of people. In the

European Region, the WAAW built on the success of the EAAD and the long-standing collaboration between ECDC and the Regional Office. Even more European countries participated in the 2015 WAAW/EAAD and the Regional Office was able to provide financial support to campaigns in Armenia, Bulgaria, Czech Republic, Estonia, Georgia, Kazakhstan, Lithuania, Montenegro, Poland, Russian Federation, Serbia, Slovakia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan and Uzbekistan.

50. In preparation for the WAAW, a global survey was conducted, in which the Russian Federation and Serbia participated from the European Region. The survey revealed key gaps in the public understanding of the AMR problem and misconceptions about how and when to use antibiotics, highlighting the continuous need to raise awareness and educate the public, professionals, producers and politicians.

51. It is generally accepted that knowledge alone is not enough to change behaviour. Based on the successful publication, *Guide to tailoring immunization programmes*,[2] the Secretariat is preparing a Guide to tailoring AMR programmes, in collaboration with RIVM, which will provide Member States with tools to identify the audiences that contribute significantly to the issues around AMR and to design targeted strategies to bring about behaviour change, such as prudent antibiotic use and effective infection prevention and control. The Secretariat is working with Sweden and the United Kingdom to pilot the methodology and is planning to publish the guide in late 2016.

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[2] The guide to tailoring immunization programmes (TIP): increasing coverage of infant and child vaccination in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/health-topics/health-determinants/roma-health/publications/2013/guide-to-tailoring-immunization-programmes).