The briefs rigorous peer review process that examined both the science and policy leading experts were recruited as authors and production involved a the series. Given countries’ demand for evidence and health intelligence, consider means and strategies for innovation in their health systems. This but synthesize available research evidence in delivering a message on evidence.

Albania, Tajikistan, Turkey and the Russian Federation

control and patient safety. The overview includes also five joint projects in prison health, injuries prevention, influenza pandemic and other epidemic health security, and one project in each of the areas of alcohol-related harm, health information, indicators and data; two on mental health and two on

Overview of 28 joint projects that WHO/Europe and the European Commission presents an

• How can European health systems support investment in and the implementation of population health strategies?
• How can the impact of health technology assessments be enhanced?
• Where are the patients in decision-making about their own care?
• How can the settings used to provide care to older people be balanced?
• When do vertical (stand-alone) programmes have a place in health systems?
• How can chronic disease management programmes operate across care settings and providers?
• How can the migration of health service professionals be managed to reduce any negative effects on supply?
• How can optimal skill mix be effectively implemented and why?
• Do lifelong learning and revalidation ensure that physicians are fit to practice?

For more information, contact Dr Carson Permanand, Technical Officer, health Intelligence Services at WHO/ Europe (tel: +45 39 17 16 29; e-mail: mpg@euro.who.int) or see the WHO/Europe web site (http://www.euro.who.int/HEN/policybrief).

Upfront

European Commission–WHO/Europe joint projects
presents an overview of 28 joint projects that WHO/Europe and the European Commission have had since 2006. Some have been completed; others are under way or were just launched. Eight of these projects are in the area of environment and health; four – on obesity, diet, nutrition and physical activity; four – on health information, indicators and data; two on mental health and two on health security; and one project in each of the areas of alcohol-related harm, prison health, injuries prevention, influenza pandemic and other epidemic preparedness planning, equity in health – health systems, emergency medical services and pharmaceuticals. A separate feature presents a project on infection control and patient safety. The overview includes also five joint projects in Albania, Tajikistan, Turkey and the Russian Federation (read more on pp 4–9).

Insight

Perspective
How serious is commitment to young people’s health?

Around and about
Reform in public health – Improving environment and health

En route
Improving Patient Safety in Europe

Spotlight
Child injuries can and must be prevented

Crossroads
Sustainable, healthy transport can help address the economic crisis

The Czech Republic – Presidency of the Council of the EU
More than half of the countries had started to report partially disaggregating data, to meet it completely. Since 2006, more countries have started to report partially disaggregating data, especially for sex and age, but social class and population groups with accessibility.

Information systems
The European strategy outlines the crucial importance of ensuring that national decision-makers have easy access to in-depth, disaggregated and comparable data. National databases for child and adolescent health exist in half of the countries and are partially available in most of the others. These databases have not been reviewed since the adoption of the European strategy, even though WHO/Europe provided a tool for this task. Collecting disaggregated data remains a big challenge. Almost no country reported being able to meet it completely. Since 2006, more countries had started to report partially disaggregating data, especially for sex and age, but social class and ethnicity were still poorly detected.

International declarations and conventions
The European strategy aims to support countries in meeting the Millennium Development Goals (MDGs) and their obligations under the Convention of the Rights of the Child. The MDGs contributed to a national strategy for young people’s health in more than a third of the responding countries, and the Convention contributed to strategy in almost three fourths. Again, situations vary between countries.

Some recommendations
WHO/Europe sums up concrete action points, and commits:

• putting more emphasis on establishing national multisectoral taskforces;
• assisting countries in fundraising, since they have made very few budgetary allocations for child and adolescent health;
• providing guidance on involving young people in the development of national strategies;
• providing advice and support in moving from assessing needs to addressing them;
• increasing the use of the European strategy’s information tool;
• emphasizing the importance of disaggregated data;
• increasing effort to integrate the MDGs in national strategies: showing how the European strategy overlaps with and contributes to achieving the MDGs.

The broad, questionnaire-based survey was supplemented by in-depth, qualitative research that was carried out in parallel in Albania, Armenia, Hungary, Scotland (United Kingdom) and Uzbekistan, which revealed the real issues countries are confronting.

The results of both the survey and the case studies can further help all WHO European Member States understand national experience in translating the European strategy for child and adolescent health and development into a form suitable to their contexts. Countries have a heavy duty – to deal responsibly with this evidence – but, as the European strategy affirms, “the potential reward is beyond price”.

How serious is commitment to young people’s health?

WHO/Europe reports on a Region-wide evaluation
Back in 2005, the Member States in the WHO European Region set the ambitious goal of enabling children and adolescents to realize their full potential for health and development, and to reduce their burden of avoidable disease and mortality. Countries and WHO/Europe jointly endorsed the European strategy for child and adolescent health and development. Accompanied by a toolkit, it was designed to give practical help by providing a framework for national policy-makers and planners at all levels, and in all sectors.

Evidence shows that what works to improve child and adolescent health should be better and more widely used. Europe would see better health of young people, if all countries could replicate conditions in the most privileged parts of it and if the worst-off families within countries enjoyed the same conditions as the most affluent. The strategy affirmed that, while action now could maximize the same conditions as the most affluent. The strategy affirmed that, while action now could maximize the same conditions as the most affluent.

The follow-up
Conditions across the Region are so diverse that any meaningful implementation of the strategy can only happen at country, if not subnational, level through well-targeted national policies. WHO/Europe therefore asked countries whether the adoption of a European strategy could or did change anything. An evaluation of the strategy’s implementation was launched in 2006 and repeated in 2008, to show:
• what changes, if any, countries made as a result of the strategy;
• whether these changes had any concrete early outcomes;
• how countries implemented the strategy, if they did so.

The 23 countries that responded to the survey comprise a broad and representative sample of the different parts of the WHO European Region; half are European Union (EU) members. WHO/Europe initiated, guided, implemented, summarized and presented the results of the evaluation, acting as an observer, while national health authorities led the whole process. Countries now have in their hands a broad neutral picture, with information that is comparable across the Region.

Main findings
Political commitment and policies
More than half of the countries had started to develop or review a national strategy for child and adolescent health, but only a few said this was a result of the European strategy. Few countries had separate strategies in place; most included child and adolescent health in a range of national strategies. Almost two thirds had multisectoral taskforces to deal with young people’s health, but there is no hard evidence these were set up because of the European strategy. In comparison to 2006, however, the number of countries that had direct budgetary allocation for child and adolescent health doubled, although less than a fifth of all countries made such allocations.

Guiding principles
The European strategy outlines four core principles that should form the foundation of any national strategy: a life-course approach, equity, intersectoral action and participation. Young people were involved in the review or development of the national strategy in more than a third of countries, and nongovernmental organizations (NGOs), in half. In addition, countries widely embraced the principle of dealing with different age groups, with three out of four explicitly addressing age differences.

While less than half recognized or measured gaps in access to preventive and curative services in 2006, two thirds did so in 2008. Countries clearly indicated that they had started to tackle accessibility gaps as an equity issue and as a direct result of the European strategy. Even more important, countries became more skilful in correlating differences across age and population groups with accessibility.

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Acknowledgments
This issue of The BRIDGE was prepared with the contributions, ideas, comments and support of the following staff of WHO/Europe: Vivian Barnekow, Mary Stewart Burgher, Ana Paula Coutinho, François Decaillet, Maria Haralanova, Jonathan North, Willy Palm, Govin Permanand, Matthias Wismar, Francesca Racciopi, Cristiana Salvi, Dinesh Sethi, Alena Šteflová, Nicoletta di Tanno, Viv Taylor Gee.

For more information, contact Ms Vivian Barnekow, Technical Officer, Country Policies and Systems at WHO/Europe (tel.: +45 39 17 14 10; e-mail: vbr@euro.who.int), or see the WHO/Europe web site (http://www.euro.who.int/childhealtdev/strategy/20060919_1).
Reform of public health – improving environment and health

Around and about

After nearly two decades of health system reform in countries in eastern Europe, the Caucasus and central Asia, public health is finally receiving much needed attention. The WHO European Ministerial Conference on Health Systems (Tallinn, Estonia, June 2008) and the preparations for the Fifth Conference on Environment and Health (Parma, Italy, 2010), have given additional impetus to this process. At a policy dialogue in Bishkek, Kyrgyzstan, in November 2008, representatives of the newly independent states (NIS) discussed the options for SANEPIDs (sanitary–epidemiology services) with experts from WHO/Europe and the European Observatory on Health Systems and Policies. The focus was on options for reforming these public health services, which traditionally have played a central role in addressing and regulating health and environmental threats. The Kyrgyz Ministry of Health therefore generously hosted this workshop, supported by the Ministry of Health of Finland.

The concerns

In spite of improvements in life expectancy, inequalities in population health still exist in the WHO European Region, between and within countries. There are significant gaps between the health status of people in the European Union (EU) and that of populations in eastern Europe, the Caucasus and central Asia. In particular, the NIS face a high burden of disease, with environmental factors and disasters posing a high risk for health and causing food- and water-borne infections, respiratory diseases, injuries and other health problems. These problems can be alleviated through well-targeted public health interventions and well-functioning monitoring systems. SANEPID services must adapt to cope with the current, emerging and future public health challenges. This requires modernizing the SANEPID services in the NIS and developing well-targeted and effective public health interventions and monitoring systems.

The issues discussed

- What are the challenges in promoting population health and preventing disease in the NIS? How does the current health system and the SANEPID system address them?
- How are SANEPIDs positioned in the broader public health decision-making framework? What level of autonomy do they have and what accountability mechanisms are in place?
- What is at stake in the reform of the SANEPID systems?
- How relevant are the stewardship and governance of the health sector in ensuring appropriate coordination across national, regional and local levels?
- What intermediate objectives in terms of access, quality and sustainability of public health services can be set to strengthen SANEPID services?
- How could SANEPID services be better integrated into the overall health system and primary care services? How can sufficient and sustainable funding be ensured?
- Which options exist to improve the training and continuous professional development of SANEPID and public health professionals?
- What tools can be used to improve and monitor the quality of SANEPID services?

The way forward

Several NIS are already in the process of SANEPID reform, while others have just begun. The policy dialogue took stock of the reform processes and achievements so far and identified potential weaknesses and areas for improvement. The NIS identified the reform of SANEPID services as a shared priority, as part of their preparations for the Fifth Ministerial Conference on Environment and Health. The Bishkek meeting was the first in a series of events to respond to their request to WHO/Europe for policy guidance and technical support in these reforms. In the light of international experience and trends, the participants discussed policy options for future reforms, helping to clarify and address the specific interests and needs of the NIS.

Some recommendations

- Build the SANEPID reform on existing strengths and assets, especially in areas that still need strengthening.
- Introduce changes in the roles, functions and organizational models of public health institutional networks.
- Upgrade and harmonize the national legislation, regulations, norms and standards in various public health areas in accordance with the international standards and based on proven country experiences of other European states.
- Improve health promotion and disease prevention, especially through multisectoral collaboration and increased advocacy in other sectors.
- Introduce risk assessment, management and communication practice in health protection, to enable better identification, prevention and control of the risk factors.
- Ensure data collection, collation and dissemination.

Support in health systems performance analysis was one of the key requests to WHO/Europe and other relevant intergovernmental organizations. The NIS were keen to analyse the level and quality of performance of their national health systems, checking whether and how they can deliver accessible, affordable and high-quality public health services. They would also welcome case studies from the WHO European Region and examples of self-assessment tools and of questionnaires on environment and health policy that could serve as best practice.

The participants in Bishkek decided to report back on progress at their second meeting, to be held in March 2009 in Dushanbe, Tajikistan.

For more information, contact Dr Maria Haralanova, Regional Adviser, Public Health Services at WHO/Europe (e-mail: mah@euro.who.int), or see the WHO/Europe web site (http://www.euro.who.int/EEHC/conferences/20081107_2) or see the WHO/Europe web site (http://www.euro.who.int/hp/publichealth).
European Commission–WHO/Europe joint projects

The BRIDGE presents a partial overview of joint projects implemented by WHO/Europe and the European Commission (EC) during the last three years. It provides a general idea of the levels of funding and areas of cooperation between the two organizations.

<table>
<thead>
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<th>Topic</th>
<th>Objectives</th>
<th>Results</th>
<th>Duration (status), target groups, EC partner</th>
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<tbody>
<tr>
<td>Nutrition and physical activity</td>
<td>Monitoring progress on improving nutrition and physical activity and preventing obesity in the EU</td>
<td>An assessment tool will be developed to evaluate the stage of policy development and the quality of the action taken in various key areas (e.g., healthy and sustainable food supply, advertising and appropriate marketing practices, product reformulation, labelling of food products, surveillance systems, physical activity promotion and built environment). The seven work packages address: surveillance of nutritional status, dietary habits and physical activity patterns, national policies and actions, regional and local initiatives, database establishment and management, support to national policy intelligence, coordination and management and dissemination.</td>
<td>Duration: January 2008 – December 2010 (underway) Targets: the 27 common EU–WHO Member States plus some others in the WHO European Region Partner: DG SANCO</td>
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<td>Nutrition</td>
<td>European Micronutrient Recommendations Aligned (EURRECA) Network of Excellence</td>
<td>EURRECA has been established; information about existing nutrient recommendations and dietary data is being collected. The project: • promotes standardization of methodologies for nutrient intake status and requirements; • identifies micronutrients critical for the health of certain population groups; • develops comprehensive, innovative and consumer-friendly nutrient recommendations; • addresses individual differences within population groups and works to increase consumer understanding; and • will guide the development of country-specific food-based dietary guidelines.</td>
<td>Duration: five years, starting in January 2007 (underway) Targets: the 27 common EU – WHO Member States and some others in the WHO European Region Partners: Directorate-General for Research (DG RESEARCH) (Sixth Framework Programme – FP6), academic institutions, private entities, national agencies, consumer groups</td>
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<tr>
<td>Prevention of obesity in Europe – Consortium for the prevention of obesity through effective nutrition and physical activity actions: EURO-PREVOB</td>
<td>A multidisciplinary team (nutrition and physical activity research, public health, economics, epidemiology and health policy) examines in depth subregional needs, mapping the lifestyle and environmental risk factors for obesity and part, current, and planned policies to address it.</td>
<td>A wide range of complementary medium- to long-term activities such as: • developing a common information system; • establishing expert groups; • producing targeted reviews of the literature; • analysing policy, including identifying the opportunities and limitations of policy transfer to and among EU countries; and • sharing and disseminating information and good practice through consultations, conferences and other forms of policy engagement.</td>
<td>Duration: five years, starting in 2007 (underway) Targets: the 27 common EU – WHO Member States and some others in the WHO European Region Partner: DG-RESEARCH (FP6)</td>
</tr>
<tr>
<td>Mental health</td>
<td>Benchmarking status of mental health and monitoring progress towards milestones of the Mental Health Declaration for Europe</td>
<td>Work on the project involved national counterparts of participating countries. The project aimed to identify the status of mental health activities across the WHO European Region, 42 countries submitted data. An evaluation instrument assessed mental health in Member States. In partnership with WHO country offices, national counterparts, WHO headquarters and EC, WHO/Europe collected, analysed and delivered information to countries, which now have better capacity for: • benchmarking against milestones and points in an action plan to indicate needs for development activities across Europe; • monitoring progress against milestones; and • developing the evidence base on the mental health status at the European level.</td>
<td>Duration: project completed in December 2007 Targets: the 27 common EU–WHO Member States and 10 others (accession, EFTA and EEA countries) in the WHO European Region Partner: DG SANCO</td>
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<tr>
<td>Mental health</td>
<td>WHO/EC partnership project on user empowerment and advocacy in mental health solutions</td>
<td>1. identifying standards and indicators for mental health advocacy and empowerment; 2. identifying examples of good practice and gaps in user and carer empowerment; 3. supporting governments and local actors in empowering users and carers, and creating an environment for collaboration; 4. promoting the mainstreaming of good practice in empowerment and advocacy: involving people with mental health problems and their family members in promoting mental well-being and preventing mental disorders.</td>
<td>Duration: three years, starting in April 2008 (underway); Target: the 27 common EU–WHO Member States and accession, EFTA and EEA countries in the WHO European Region; Partner: DG SANCO</td>
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<tr>
<td>Alcohol-related harm</td>
<td>Coordinating implementation of measures under WHO/Europe’s framework for alcohol policy and the EC communication on an EU strategy to reduce alcohol-related harm.</td>
<td>Data are being collected, as the project aims to boost action where the EC and WHO/Europe add value to and complement each other’s work. Current actions include updating and expanding the WHO European alcohol information system and ensuring its compatibility with the EC database on alcohol. Preparations are underway to analyse the EC communication and the WHO framework and to summarize the evidence for the effectiveness of interventions to reduce alcohol-related harm in countries. WHO/Europe is developing the guidelines for national health action plans on alcohol. Alcoholic beverages will be presented at a meeting on alcoholic policy during the Swedish EU Presidency in 2009.</td>
<td>Duration: January 2008 – December 2009 (underway); Target: the 27 common EU–WHO Member States; Partner: DG SANCO</td>
</tr>
<tr>
<td>Prison health</td>
<td>Database for prison health profiles</td>
<td>Health in prisons: a WHO guide to how to implement.</td>
<td>Duration: three years, completed in August 2008; Target: the 27 common EU–WHO Member States, plus EU-candidate countries and others in the WHO European Region; Partners: DG SANCO, EMCDDA</td>
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<tr>
<td>Injury prevention</td>
<td>Supporting the EU and its Member States in implementing recent policies developed by EU Council and the WHO Regional Committee for Europe.</td>
<td>National experts in health systems and injuries will be given the resources and tools to develop and implement national policies and action plans, and monitor their relevance to the two key documents. Sharing experience among countries increases their capacities to develop action plans. Main developments: - a joint WHO/DG SANCO workshop on strengthening the public health response to violence and injuries; - a project web site that disseminates information on the project through the newsletters of the WHO European violence and injury prevention programme and the European Association for Injury Prevention and Safety Promotion (EuroSafe); - a web-based inventory of national plans and policies for violence and injury prevention, and relevant national initiatives and activities as a resource for national focal people, with their involvement; - a working group of national focal points, advising on the development of a web-based instrument.</td>
<td>Duration: March 2007 – March 2009 (underway); Target: the 27 common EU–WHO Member States; Partner: DG SANCO</td>
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<tr>
<td>Preparedness planning for an influenza pandemic and other epidemics</td>
<td>Strengthening national preparedness and planning for an influenza pandemic and other epidemics.</td>
<td>A set of indicators was developed for monitoring pandemic preparedness planning, self-assessment and training by countries; a core set will be used for monitoring at the regional level. Indicators were pilot-tested in the Russian Federation (7 regions). Preliminary work in elaborating these indicators allowed that they feed into a dynamic database for the production of country profiles. Joint EC/European Centre for Disease Prevention and Control (ECDC)/WHO workshops: with representatives from both EU and non-EU countries supported by the project stock-taking of all Member States’ plans, which are in different stages of development, and with varying degrees of completeness.</td>
<td>Duration: April 2006 – March 2008 (completed); Target: the EU 27 and neighbouring countries; Partners: DG SANCO, ECDC, public health institutes and academic institutions from the Croatia, France, Germany, Greece, Italy, Poland, Sweden and United Kingdom</td>
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<tr>
<td>Equity in health – Health systems</td>
<td>Assessing inequalities in the performance of health systems, and sharing information about their social determinants.</td>
<td>The deliverables include a geographical information system and maps of national health systems, and examples of best practice and sources are being selected. Some recent activities include: - development of the methodology for selection of indicators, and exploration of the availability of data from sources other than the Eurostat databases; - a special advisory meeting on critical questions and to test the content, format and uptake strategy for the published resource. Key outcomes include classification of the audience, identification of additional examples and recommendation to use a qualitative (grounded theory) approach to develop the publication and resource. A synthesis based on 10 examples was then drafted.</td>
<td>Duration: April 2007 – April 2010 (underway); Target: the 27 EU–WHO Member States and accession, EFTA and EEA countries, in the broader context of the WHO/European Region (including some western Balkan countries); Partner: DG SANCO, Eurostat</td>
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<tr>
<td>Health security</td>
<td>Supporting health security and preparedness planning in countries covered by the EU European Neighbourhood Policy (ENP)</td>
<td>Major gaps in data and evidence on the overall preparedness of ENP countries for public health emergencies needed to be filled. The project enhanced the ability of selected ENP countries to respond to health threats and emergencies of international concern. A standardized tool was developed to assess priority risks, the status of preparedness plans and their interoperability across countries. Knowledge about preparedness capacity is well developed within the EU, but scarce and limited in neighbouring countries. The lead agency for international health crisis response, WHO, is committed to bringing best practice to non-EU countries.</td>
<td>Duration: March 2007 – August 2008, with a six-month no-cost extension (completed)</td>
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<tr>
<td>Health security</td>
<td>Supporting health-system preparedness planning and crisis management in EU accession and ENP countries</td>
<td>The new project includes two components: disaster preparedness and emergency medical services (EMS) – thus combining two previous EC–WHO projects. The project aims to help improve the target countries' preparedness for public health emergencies. It assesses national capacities to respond to public health crises and to implement the IHR. It also promotes a multisectoral approach, to ensure the interoperability of existing public health emergency plans. Project officers were selected and a group of national counterparts was created: people authorized by health ministries to collaborate on the project. All countries completed a questionnaire and reported the results. A web-based tool was developed and a full list of education institutions on emergency care developed. Missions visited some selected countries. The counterparts proposed the establishment of an EU inter-ministerial panel on emergency care.</td>
<td>Duration: 2008–2010 (underway)</td>
</tr>
<tr>
<td>Emergency medical services (EMS)</td>
<td>Assessing the preparedness of EMS in EU Member States, in the framework of existing national structures for crisis management</td>
<td>Project officers were selected and a group of national counterparts was created: people authorized by health ministries to collaborate on the project. All countries completed a questionnaire and reported the results. A web-based tool was developed and a full list of education institutions on emergency care developed. Missions visited some selected countries. The counterparts proposed the establishment of an EU inter-ministerial panel on emergency care.</td>
<td>Duration: March 2007 – July 2008 (completed)</td>
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<tr>
<td>Pharmaceuticals</td>
<td>Pharmaceutical pricing and reimbursement information</td>
<td>The project improved the understanding of EMS and their links to national crisis management systems. 25 country profiles describing countries’ pharmaceutical policies according to a standard format, completed by Member States (with other profiles still in draft form). A comparative analysis of pharmaceutical pricing and reimbursement in the EU based on key indicators. A web site and SharePoint site with project participants and a large conference (2007). The network now comprises more than 20 partners and more than 20 observers from EU Member States, Albania, Canada, Norway and Turkey.</td>
<td>Duration: project ended in 2008 (completed)</td>
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<tr>
<td>Health indicators and monitoring</td>
<td>ECHIM: European Community Health Indicators</td>
<td>Using the Health for All indicators, the project group initiated their implementation in Member States to help establish a health monitoring system for Europe. To further support the outcome of this project, the selected indicators had been proposed to be used by the EC in a policy document on health in all policies in the EU. Although the project ended in June 2008, the group has submitted a proposal for joint action with Member States aiming to continue the work.</td>
<td>Duration: completed in June 2008</td>
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<tr>
<td>Health information</td>
<td>EU GLOREH: global report on health status in the EU</td>
<td>WHO Europe actively participates in the project, ensuring that data from the Health for All database were widely used. WHO Europe also helped to prepare, review and edit the section of the health status report (via the European Observatory on Health Systems and Policies). In May 2008, all these contributions were submitted.</td>
<td>Duration: 2005–2008</td>
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<tr>
<td>Public health information system</td>
<td>EUPHIS: European Union Public Health Information System</td>
<td>The whole EU platform is still under construction. The participation of WHO ensured that WHO European data were used and duplication of work avoided. Likewise, elements and experience from the EU approach are also being used in the presentation of WHO information. The outcome of this project links to the ECHIM as an electronic platform for presenting, analysing and synthesizing health indicators and related summaries for policy-making in the EU.</td>
<td>Duration: four years, completed June 2008</td>
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<tr>
<td>Hospital data</td>
<td>HDPS: Hospital Data Project, Phase 2</td>
<td>Although it was initially planned to use data collected by WHO, the participants subsequently agreed to commence data collection directly from the EU Member States, rather than relying on the data annually collected by WHO. The project collected a list of core procedures conducted by hospitals, allowing the making of more detailed performance analyses in the hospital sector, an attempt that can be expanded to other WHO European Member States in the future. With a similar approach, the project considered health procedures to identify health services’ usage and practice patterns. It proposed standards to be used in the common WHO–EU Member States.</td>
<td>Duration: November 2005 – October 2008 (completed)</td>
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<tr>
<td>Environment and health</td>
<td>Implementing the Budapest Declaration: supporting national policy development to address the health impacts of the environment on children and future generations in Europe</td>
<td>National policy workshops assist national policy-makers to build an institutional framework that will ensure action on the environmental and health risk factors that affect children's health. Environment and health performance reviews overall 11 to be made by spring 2009 present the environment and health situation in countries, using a uniform methodology. Case studies from 18 countries review the relevance of their policies to CEHAPE. Online summaries will allow sharing experience with action to reduce environmental risks to children's health.</td>
<td>Duration: June 2006 – June 2009 (underway) Targets: 27 EU–WHO Member States, 3 accession countries and 3 EFTA countries in the WHO European Region</td>
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<tr>
<td>Environment and health</td>
<td>Improving public health responses to heat-waves</td>
<td>WHO Europe published heat-health action plans and advocacy materials, and activated an online heat-risk tool. 10 countries have developed heat-health action plans, and 17 – heat-health warning systems. Products include: an agreement on core elements of a heat-wave health action plan, ten-day heat-wave forecasts at European district level, time series heat-wave analysis for nine cities, testing of a heat-wave definition and the development of a large country network and an advisory committee; a monograph and a technical summary.</td>
<td>Duration: 2005–2007 (completed) Partners: the common 27 EU–WHO Member States, plus EU candidate and accession countries in the WHO European Region</td>
</tr>
<tr>
<td>Environment and health</td>
<td>Establishment of environment and health information system supporting policy-making in Europe</td>
<td>The resulting European Environment and Health Information System is based on a set of indicators developed and updated by the Environment and Health Information Systems (ENHIS) project co-funded by DG SANCO, uses health impact assessment methods and contributes to the European Community Health Indicators system. Some project outcomes: a web-based information platform and an indicator-based assessment report on children’s health and the environment. These are now acknowledged as part of the information base on health in the EU.</td>
<td>Duration: completed in December 2007 Targets: new EU Member States (post-2004) and EU accession countries</td>
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<tr>
<td>Environment and health</td>
<td>Health and Environment Network</td>
<td>The aim is to review, exploit and disseminate knowledge on environmental health issues based on research and practices, for wider use by relevant stakeholders. The main result so far is the methodology for evaluating the quality of knowledge and identifying gaps in scientific understanding of the causal relationship between environmental health stressors and health effects. Future deliverables will include the results achieved by applying the methodology developed to the four environment and health action plans (HEAP) priority diseases.</td>
<td>Duration: 2006–2009 (underway) Partners: DG RESEARCH, National Institute on Air Quality (NILU), Norway (coordinator)</td>
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<tr>
<td>Environment and health</td>
<td>Integrated risk assessment of environmental factors</td>
<td>The project aims to develop a framework for integrated assessment of the health effects associated with various environmental stresses, exposure pathways and policy areas. The results to date include a report conceptualising the issues of uncertainty and quality in health risk assessment, and setting them in the context of the policy-making process. A three-day training workshop on uncertainty and quality for risk assessors was carried out, expected to lead to a series of uncertainty and quality assessments, including risk assessments of: waste management policies; practices on agriculture, transportation and home energy efficiency; and chemicals in consumer products.</td>
<td>Duration: 2006–2010 (underway) Targets: the 27 EU–WHO Member States; the EU-candidate, accession and neighbouring countries in the WHO European region Partners: DG RESEARCH, Imperial College, United Kingdom (coordinator)</td>
</tr>
<tr>
<td>Environment and health</td>
<td>CIRCLE: Climate Change and Impact Research: the Mediterranean Environment</td>
<td>The expected results are: to predict and to quantify physical, social and health effects of climate change in the Mediterranean area; evaluate the consequences of climate change for the societies and economies; develop an integrated approach to understand the combined effects of climate change and identify adaptation and mitigation strategies. For the health line of the project, the expected results are: HIA in Turkey and Tunisia; analysis of heat waves and air pollution in five cities (Athens, Cairo, Istanbul, Jerusalem and Tunis) in collaboration with the WHO Regional Office for the Eastern Mediterranean risk maps of water- and vector-borne diseases; and development of strategies to adapt to climate change for Turkey and Tunisia.</td>
<td>Duration: 2007–2011 (underway) Targets: 27 EU–WHO Member States, plus candidate accession and neighbouring countries in the WHO European region Partners: DG RESEARCH</td>
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<tr>
<td>Environment and health</td>
<td>PAVE: developing and pilot-testing a service that will enable the EC to provide systematic policy advice on environment and health to European countries</td>
<td>This project includes the development of criteria and procedures that will be pilot-tested through four case studies on electromagnetic fields, climate change, nanotechnologies and urban planning. The project elaborates guiding principles and schemes that the EC can use to manage complex cases of high concern.</td>
<td>Duration: June 2007 – June 2009 (underway) Targets: the 27 EU–WHO Member States Partner: DG SANCO</td>
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<td>Environment and health</td>
<td>Climate, environment and health action plan and information system (CEHAPEIS)</td>
<td>One of the key objectives is to maintain the environment and health information system and expand its scope to enable monitoring and assessment of environmental health issues related to climate change.</td>
<td>Duration: two years, starting in March 2008 (underway) Targets: WHO European Member States Partner: DG SANCO</td>
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<tr>
<td>Topic and country</td>
<td>Objectives</td>
<td>Status of implementation and results</td>
<td>Duration (status), target groups, EC partner</td>
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The project strengthened the capacity of the Ministry of Health and Social Development to scale up antiretroviral treatment (ART) delivery and to improve blood safety in four pilot regions and at the federal level. It supported the Ministry in developing normative documents; ensured capacity building in ART and blood safety and provided equipment for training and blood safety. | Technical support: 7 prikazes and 13 clinical protocols on treatment and care of people living with HIV/AIDS (under a World Bank loan); translation and dissemination of 7 instruction papers on HIV/AIDS-related issues in all pilot regions.  
Materials for training in blood safety quality management for facilitators and trainees, educational materials on HIV/AIDS and palliative care for nurses and modules.  
Human resources development: 72 training courses on ART for 1665 AIDS centres’ specialists and 11 training courses on blood safety for 220 transfusion specialists; training on self-help principles; a national blood safety conference.  
Institution building: provision to regional blood transfusion services of centrifuges, refrigerators, blood separators and laminar boxes; information centres established and equipped with information technology, furniture and publications on AIDS-related topics.  
Dissemination: regular media briefings; designated health days to ensure the visibility of project activities; a workshop for health journalists and a national media contest “Donor of the Russian Federation”; and dissemination of EU/WHO standards and other material during several national conferences related to HIV/AIDS and blood transfusion safety.  
Targets: people living with HIV/AIDS, blood donors, patients in need of blood transfusion services, health care providers, instructors at medical and educational institutions, regional and federal government officials  
Partners: EC delegation in Moscow, Ministry of Health and Social Development, Federal AIDS Centre, Federal Blood Centre, regional AIDS centres; regional blood transfusion stations |
| Health care provision in the Russian Federation | Improvement of health care provision in the North Caucasus, Russian Federation  
The project aims to help strengthen the health care systems and infrastructure and training systems for health care personnel (including purchase and maintenance of equipment) in the Chechen Republic and the Republic of Ingushetia. | To build health workers’ capacities, 4181 health professionals were trained in 26 specialties. A WHO flagship course was held in spring 2008 to train health care workers in aspects of health system management, which will be part of all future WHO–financed training.  
Capacity building for dentists in the Republic of Ingushetia: certified training of 20 Ingush dentists.  
Network of health information and learning centres: establishment of three such centres and supply of equipment; set-up of seven others in the Chechen Republic.  
Publications: press releases on the project work, articles and health information booklets on maternal and child health and health promotion. | Duration: October 2006 – April 2010 (underway)  
Targets: Ministry of Health of the Chechen Republic, Ministry of Health of the Republic of Ingushetia, selected hospitals in the Chechen Republic and the school dental service in the Republic of Ingushetia, and other health personnel in both republics  
Partner: Delegation of the EC to Russia |
| Disaster preparedness and response in Tajikistan | Strengthening disaster preparedness, prevention and response activities at all levels of the health system  
WHO/Europe and the EC Disaster Preparedness ECHO (DIPECHO) programme work with the Ministry of Health to strengthen disaster preparedness in the health system. Recently, the Red Crescent Society of Tajikistan has been involved as an implementing partner. | WHO supports the Ministry of Health in developing a national health crisis management plan, and an action plan for its implementation. The draft was endorsed by the Ministry.  
In 2007–2008, the disaster preparedness capacity of 102 hospitals/health facilities in Tajikistan was assessed and mapped. A report with recommendations on improving this capacity was produced. The information gathered was further integrated into a geographical information system database for hospital capacity mapping.  
As to disaster mitigation, in 2007–2008, the seismic vulnerability of three key health facilities was assessed and recommendations made to improve their resilience.  
As to capacity building, five Red Crescent centres for disaster management training have been established in target regions. About 240 health workers have been trained in disaster management, 600 volunteers have taken part in awareness-raising activities, and information material is being produced and distributed to health facilities and schools. | Duration: March 2007 – July 2009 (underway)  
Target: Ministry of Health  
Partners: DIPECHO, Red Crescent Society of Tajikistan |
| Health security in Albania | Consolidation and integration of the veterinary and phytosanitary border inspection services  
The project aims to improve the movement of goods at border posts to benefit market development, and improve plant and animal health and consumer protection. The EC supports the WHO Country Office, Albania, in strengthening and consolidating food inspection services to meet EU and international standards (World Trade Organization). | The project has three main components, each linked to a result: equipment and supplies, training on working procedures and supplies for and training on communication systems.  
During the inception phase, the project team surveyed several times interviewed project beneficiaries and stakeholders at both central and field levels. Preliminary assessments were carried out and project intervention was evaluated. This resulted in a more detailed, comprehensive and accurate strategy for project implementation, including some readjustments to the original work plan. | Duration: ends October 2009 (underway)  
Target: veterinary and phytosanitary reforms in Albania, in view of EU accession  
Partner: EC Directorate-General for Enlargement, Community Assistance for Reconstruction, Development and Stabilisation (CARD) programme |
| Communicable disease surveillance and control in Turkey | Strengthening the epidemiological surveillance and control of communicable diseases (CDSC) system  
This project aimed to create a firm foundation for building a CDSC system meeting the requirements of the EU acquis and the HLR, broadly advocating the importance of the issue to public health and health security. | There is a general consensus among stakeholders that the project was a success, with two main achievements:  
- political ownership and establishment of a wider network of experts at the central level; a shift in thinking away from seeing surveillance as a purely technical task and towards a multisectoral, system building approach that is in line with best practice in the EU and  
- a large-scale upgrading of awareness and basic public health skills at different levels of the CDSC system and throughout Turkey, particularly including increased communication, exchange and understanding between laboratory and public health professionals.  
These achievements resulted in a legal regulation on CDSC, establishing administrative committees and transposing the basic acquis, and a detailed draft five-year national action plan that received approval in principle from the Ministry of Health. There is better analytical capacity in the field of CDSC at the national and provincial levels. | Duration: completed in March 2008 (the third phase of the project is expected to be initiated in the first quarter of 2009)  
Partner: Delegation of the EC to Turkey |
**IPSE**

**Improving Patient Safety in Europe**

The three-year Improving Patient Safety in Europe (IPSE) project ended in June 2008. It was supported by an extensive partnership: the European Commission (EC), WHO/Europe, Claude Bernard University Lyon (the main partner), the European Centre for Disease Prevention and Control (ECDC), the European Society of Clinical Microbiology and Infectious Diseases (ESCMID), leading European public health institutes and networks supported by the European Union (EU).

**Who did what?**

Seven different work packages were implemented by different lead organizations, as follows:

- **Claude Bernard University Lyon**: European training for doctors and nurses in infection control, dissemination of the project’s results and project management;
- **WHO/Europe**: European standards and indicators for public health surveillance and technical guidance on the control of health-care-associated infections and antimicrobial resistance;
- **National Institute for Public Health and the Environment, Bilthoven**: event warning and rapid information exchange on nosocomial infections and antimicrobial resistance;
- **Scientific Institute of Public Health, Brussels**: technical support to sustain and extend the surveillance of nosocomial infections and the control of health-care-associated infections and antimicrobial resistance through the Hospital in Europe Link for Infection Control through Surveillance (HELICS);
- **Swedish Institute for Infectious Disease Control, Stockholm**: improving surveillance and control of antibiotic resistance in intensive care units;
- **Freiburg University Hospital**: providing complementary tools for the study and control of antimicrobial resistance in intensive care units; and
- **Regional Health Agency, Bologna**: feasibility study on surveillance of health-care-associated infections in European nursing homes.

**How did coordination work?**

National contact points were designated by each country to act as focal points on the project. A project management group comprised work package leaders and experts from other partner institutions. An expert advisory board of individuals responsible for and familiar with the practical and scientific challenges of the project, provided an external view of the progress of the project and proposed improvements in organization. The work on the different work packages was coordinated all along and IPSE network members continuously reviewed progress at annual plenary meetings in Vienna, Austria (2005 and 2006) and Lyon, France (2007 and 2008). The project used international and national conferences and congresses on infectious diseases and infection control to maintain contact among the network members and with a wider scientific community; at some of these events IPSE organized workshops.

**The final project conference** was held in Lyon, hosted by the lead partner.

**Raising standards of infection control in Europe**

The Directorate General for Health and Consumers (DG SANCO) of the EC launched a public consultation on strategies for improving patient safety by prevention and control of health-care-associated infections and increased standards of antimicrobial stewardship. It proposed that a consensus be explored for prevention and control standards and related performance indicators, as part of the IPSE project.

WHO/Europe was responsible for reviewing the existing guidelines, standards and indicators of infection control programmes in the EU and providing a manual of international standards for both health-care-associated infection and antimicrobial resistance.

**The concerns**

Health-care-associated infections affect an estimated 1 in 10 patients and lead to considerable illness, mortality and costs. These infections are not constrained by national borders and spread between countries; they are also expected to make up an increasing proportion of the overall disease burden in Europe. To improve control, consistent standards for monitoring and treatment should be used across the Region and European standards of infection control should be developed.

**Comparable data are lacking worldwide** on how health-care-associated infections contribute to mortality and longer hospital stays, and on their economic impact on individuals, health care systems and societies. Such information would empower health-system managers, policy-makers, public health specialists and health care workers to understand, prioritize, develop and implement solutions to competing health threats. Demonstrating the value of activities to control health-care-associated infections and antimicrobial resistance to both caregivers and health administrators is essential. It is most important, however, that health personnel perceive the value of such programmes, as changes in the behaviour of caregivers can actually improve the quality of patient care.

The project revealed the enormous differences between infection control programmes in the WHO European Region. Valid and consistent standards of infection control would allow a better and more systematic assessment of the economic impact of health-care-associated infections. The survey of national recommendations and indicators showed many differences between EU countries as well.

**The outcomes**

Countries now have a checklist for use by hospital management and a summary tool to check the level of infection control measures. A list of standards and recommended practices helps countries harmonize their standards by measuring the occurrence of infections and the control capabilities in this area, and enabling them to collect comparable information.

The widely disseminated standards and indicators for national and local control capabilities contribute to another project outcome: guidance on how to implement and improve infection control practices at national and hospital levels.

Training materials further support the use of this guidance. National governments can now assess the progress of each hospital by reviewing the information collected through the checklist.

A remarkable level of agreement on the standards and performance indicators was achieved, probably the most extensive international exercise ever performed in this field. In recognition, DG SANCO invited members of the IPSE group to join its core group in drafting a document for the Council of the EU on the prevention and control of health-care-associated infection.

**The challenge**

Despite the vast knowledge accumulated over past decades on infection control, a considerable gap still exists between theory and practice. Breaches in infection control practices facilitate the transmission of infection from patients to health care workers, other patients and attendants. Thus, during outbreaks, health care settings often become amplifiers of disease, with an impact on both hospital and community health.

Health-care-associated infection was the primary accelerator of severe acute respiratory syndrome (SARS) infections, accounting for 55–72% of probable cases. The emergence of life-threatening infections such as SARS and the risk of a new influenza pandemic highlight the urgent need for efficient and basic infection control practices such as improved hand hygiene. Clear and effective guidance on practicable measures to control the spread of infections is particularly important when an outbreak happens.

The emergence and spread of antimicrobial resistance is a major public health threat. Data are scarce on the outcomes of treatment of infections due to antimicrobial-resistant pathogens, in terms of attributable mortality, prolongation of hospital care and, above all, the economic consequences for individuals and health-care systems and societies. Further, because of the wide variety of health systems in Europe, comparing information from individual studies is difficult. Yet EU Member States and EU accession/candidate countries urgently need realistic estimates of the disease burden and the costs of infections caused by antimicrobial-resistant pathogens.

WHO/Europe continues to develop training materials on infection control measures, which are critical for preparing health care settings to control the spread of communicable diseases.
Child injuries can and must be prevented

FIVE OUT OF SIX CHILDHOOD DEATHS FROM INJURIES OCCUR IN POOR COUNTRIES, BUT A POOR CHILD LIVING IN AN AFFLUENT METROPOLIS CAN BE AT THE SAME RISK.

ISSUED IN DECEMBER 2008, THE EUROPEAN REPORT ON CHILD INJURY PREVENTION CALLS FOR ACTION TO REDUCE CHILDHOOD INJURIES AND GIVES EVIDENCE OF SUCCESSFUL MEASURES TO PROVIDE SAFER ENVIRONMENTS FOR CHILDREN. THIS REPORT GIVES THE EUROPEAN DIMENSION OF THE ISSUES PRESENTED IN THE JOINT WHO–UNITED NATIONS CHILDREN’S FUND (UNICEF) WORLD REPORT ON CHILD INJURY PREVENTION, LAUNCHED AT THE SAME TIME.

Figures that speak for themselves

Unintentional injuries – from road traffic crashes, drowning, poisoning, fires and falls – are the leading threat to children and teenagers in the WHO European Region. Injuries drain the resources of health systems. They also affect society and can damage families’ income and quality of life. Worldwide, unintentional injuries are responsible for the deaths of 830 000 children every year.

Inequalities

The burden from injuries is unequally distributed, falling most heavily on children living in the countries undergoing the greatest socioeconomic changes. There is up to an eightfold difference between the countries with the highest and lowest injury death rates in the Region. High inflation, unemployment, rising income inequality, social disintegration and high levels of poverty, exacerbated by some of the highest levels of alcohol consumption in the world, contributed to a peak in child injury mortality in the Commonwealth of Independent States (CIS) in the early 1990s. Today, while death rates for unintentional injury in these countries are declining, they are still three times those in the European Union (EU). Regardless of a country’s average income, poor children are at highest risk. Studies from Ireland, the Netherlands, Spain, Sweden and the United Kingdom demonstrate that children from less affluent areas suffer and die from injuries up to five times more often than their richer peers. One of the major risk factors is unsafe environments; poor children may be exposed to fast traffic, lack of safe areas to play and crowded homes with unsafe structures, such as stairs without rails or gates or windows without bars and locks. Poorer families may not be able to afford safety equipment, such as child restraints for cars, smoke alarms or cycle helmets. Supervision may be difficult in families with single parents, or affected by alcohol and drug abuse. Once injured, poorer children may have less access to high-quality medical and rehabilitation services.

10 key facts about unintentional injuries in children

1. Injuries are the leading cause of death in children and adolescents aged 5–19 years.
2. They cause 42 000 deaths each year in children and adolescents aged 0–19 years in the WHO European Region.
3. The leading causes of injury death are road traffic, drowning, poisoning, fires and falls.
4. Boys suffer three out of four injury deaths.
5. Five out of six injury deaths occur in poorer countries.
6. Death rates in poorer countries are three times those in richer ones.
7. Death rates within countries can vary up to ninefold.
8. Injuries cause a huge drain on health and other societal resources, including an estimated 5 million hospital admissions and 70 million visits to emergency departments annually in the European Region.
9. Reducing all countries’ mortality rates to the lowest national rates would prevent an estimated three out of four deaths from injury in the Region. The leading types of injury reflect this great potential for prevention. If all countries matched the lowest mortality rates in the Region, half of the lives lost to road traffic injuries and 9 out of 10 of those lost to drowning, poisoning, burns and falls could be saved each year.
10. Some of the interventions that save lives give very good value for money. For example, each euro invested in smoke alarms, child restraints or bicycle helmets, and poison control centres would yield estimated savings to society of €60, €29 and €7, respectively.

Why it matters

Child injuries are largely preventable. The successes of some European countries in reducing injury mortality show that most deaths can be averted. If all countries in the Region matched the performance of those with the lowest mortality, nearly three out of four child injury deaths could be prevented, and millions of children could avoid disability. The inequalities are both a threat and an opportunity. Experience from countries that started tackling injury prevention as a priority decades ago represents a resource for the whole European Region. They shifted from trying to change individuals’ behaviour to providing safe environments, thus assuming collective societal responsibility for preventing injuries. As a result, fatalities were substantially reduced, as were health inequalities. Many of the solutions are multisectoral and require that health equity in injuries be put at the forefront of social policy.

Health systems can play a central role in this new approach by documenting the burden, distilling the evidence of what works, prioritizing action and engaging other sectors in partnerships to develop action plans. Injuries prevention requires different approaches at each stage of children’s emotional, physical and brain development and in each context.

European report on child injury prevention

The report was launched at a press conference on 10 December 2008 in Rome, Italy. In the former Yugoslav Republic of Macedonia, a national launch of the European report was combined with a parliamentary hearing by the Commission for Equal Opportunities on 16 December in Skopje (co-organized with the WHO Country Office). The public hearing on protecting children from violence and injury was attended by more than 70 stakeholders in child safety, including parliamentarians, members of the Commission, NGOs and other stakeholders. The world and European reports on child injury prevention were presented to highlight the problem and was followed by presentations on violence and injury in children in the country.

The Russian translation of the report will be launched in Moscow, Russian Federation, in February. The event will be jointly organized by the WHO Country Office, the WHO/Europe violence and injuries prevention programme and the Ministry of Health and Social Development. Other launches will take place throughout 2009 in, for example, Belarus, the Czech Republic, Hungary, Kyrgyzstan, Lithuania, Slovakia and Uzbekistan. For further information, contact Dr Dinesh Sethi, Technical Officer, Noncommunicable Diseases and Environment at WHO/Europe (tel.: +39 06 4877751; e-mail: dineshsethi.euro.who.int), or see the WHO/Europe web site (http://www.euro.who.int/violenceinjury/injuries/20080827_1).
Can innovative transport policies create employment and economic opportunities for a healthier society? Policy-makers from ministries of transport, health and the environment across Europe considered this question when they gathered in Amsterdam, the Netherlands, in January 2009 at the High-Level Meeting on Transport, Health and Environment, hosted by the Government of the Netherlands. The meeting was organized by WHO/Europe and the United Nations Economic Commission for Europe (UNECE).

Looking for concrete solutions, the representatives of the three sectors adopted action points to address the key challenges to health, the economy and the environment. They are looking to the Transport, Health and Environment Pan-European Programme (THE PEP) as a platform to advocate and stimulate investment in energy-efficient and low-emission vehicles and technology, and environmentally friendly transport modes and infrastructure, particularly in urban settings. An objective is to make health and environmental considerations a more explicit criterion for decision-making on transport.

Experiences from countries demonstrated how sustainable transport can boost health, the environment and the economy. Investment in healthy and environmentally friendly transport – including clean and efficient public transport systems and infrastructure – can help reduce congestion, accidents and pollution, thereby contributing to healthier societies, sustainable wealth, and the fight against climate change. The inclusion of environment and health considerations in transport policies can bring Europe closer to achieving four priority goals:
- contributing to economic development and job creation by investing in environmentally friendly and healthy mobility;
- promoting more efficient transport systems;
- reducing emissions of transport-related greenhouse gases, air pollutants and noise; and
- promoting policies and action conducive to healthy and safe transport.

Innovative tools for transport and urban planners were launched:
- the THE PEP toolbox of good practice in sustainable urban transport;
- the health economic assessment tool (HEAT) for cycling; and
- guidance on how to quantify the health effects of cycling and walking.

These tools will help planners take account of health effects when estimating costs and integrate transport, environment and health considerations into policy-making.

Key achievements and the way forward
In 2002, a series of policy frameworks that were pursuing more sustainable and healthy transport converged in the THE PEP, jointly managed by WHO/Europe and UNECE.

Interventions for sustainable urban transport in the framework of THE PEP
- In the field of air pollution, technical and legal measures taken since 1990 have helped reduce some vehicle-exhaust emissions; since 2002, all petrol sold in the EU has been unleaded. An important legal instrument for reducing emissions into the air, including those from transport, is the UNECE Convention on Long-range Transboundary Air Pollution. In 2006, WHO issued new air quality guidelines, challenging countries around the world to improve air quality in their cities.
- The number of road deaths declined by 21% in the EU in 2000–2005, despite the considerable increase in traffic. In contrast, an increase in road traffic injuries accompanied the growth in motorization in the eastern part of the Region. Many countries have set ambitious road-safety targets and are monitoring their progress.
- Exposure to noise has been steadily decreasing, but the expected growth in traffic, is likely to offset this achievement. WHO/Europe is developing guidelines for night-time noise through a project in partnership with the EC and several countries. A holistic, integrated approach to reducing people’s exposure to noise is lacking, however, at the international level.
- Dwindling opportunities for physical activity increasingly challenge transport and health professionals to work together to make physical activity part of daily life and improve conditions for walking and cycling, whose potential to make up a bigger share of total transport still remains largely untapped in many countries.

For further information, see the web sites of THE PEP (http://www.thepep.org/en/welcome.html), WHO/Europe (http://www.euro.who.int/transport) and UNECE (http://www.unece.org/trans/welcome.html).

Did you know
In recent decades, the rapid growth of road transport in Europe, while supporting economic development and integration, has harmed health and the environment through congestion, road traffic crashes, and air and noise pollution, and by contributing to sedentary lifestyles and emissions of greenhouse gases.

- Traffic accidents kill around 100 000 people per year in the WHO European Region, and cause some 2.4 million injuries. People under 25 years of age suffer a third of these deaths.
- Air pollution is estimated to have cut an average of 8.6 months from the life of every person in the 25 Member States of the European Union (EU) (before the January 2007 EU enlargement), and emissions from road traffic account for a significant share of this burden.
- About 120 million people in the EU-15 Member States (before the May 2004 enlargement) – over 30% of the total population – are exposed to levels of road-traffic noise exceeding the standard.
- Physical inactivity is associated with 600 000 annual deaths in the Region, and 20–30% of adults are estimated to be obese.
- The contribution of the transport sector to total greenhouse-gas emissions increased from 17% in 1990 to 24% in 2006 in the 27 current EU Member States, and continues to grow. Road transport accounts for more than 70% of these emissions.
- Today, the road network occupies 93% of the total land area used in the EU for transport, while rail occupies only 4% and uses about 3.5 times less space per passenger-kilometre than cars.

The health and environmental consequences of transport affect most of the population, not just transport users.
Crossroads

On 1 January 2009, the Czech Republic took over the six-month rotating Presidency of the Council of the European Union (EU) from France. Sweden will hold the Presidency in the second half of 2009, and Spain and Belgium, in 2010. The Czech Presidency’s priorities are outlined broadly as the 3 Es: economy, energy and external relations. It intends to deal with the financial and economic crisis and to boost Europe’s energy security. In foreign policy, key issues include making contacts with the new administration of the United States of America and building up the EU’s partnership with its eastern neighbours (keeping the door open to the western Balkans).

The health priorities of the Czech Presidency are the following.

- **Patient safety and quality in health care** are high on the health agenda of the EU Member States. The Presidency intends to help identify and promote relevant infection-control policies, standards and preventive measures in European hospitals.

- A high-level conference in May 2009 will allow the 27 EU Member States to share experience, information, and best practice in the field of health systems and their financial sustainability. This work is indirectly linked to the work of the European Commission (EC) towards a communication on social protection in health and the reform of the health financing systems in developing countries.

- As to e-Health, the focus will be on telemedicine and the interoperability of information systems in health services.

- As to the pharmaceutical package, the focus is on improving pharmacovigilance systems across the EU; improving the distribution chain of pharmaceuticals and protecting it from infiltration by illegal or falsified pharmaceuticals; and providing better information. This is directly related to EC work on a pharmaceutical package.

- To ensure the quality and safety of donation and transplantation of organs, the aim is to produce guidelines on donation and transplantation and to define a framework and a common set of standards for storage, transportation and reporting. The Presidency also wants to help an EU directive to accompany the guidelines.

During its Presidency of the Council of the EU, the Czech Republic is organizing ministerial conferences and expert meetings. WHO/Europe is actively involved in the preparation of several. WHO/Europe has a 2008–2009 biennial collaborative agreement with the Czech Republic, focused on three main priorities: preventing noncommunicable diseases, improving access to and efficiency of health services, and strengthening health workforce availability and skills.

The trio’s health agenda

On 1 July 2008, the French, Czech and Swedish presidencies released their eighteen-month programme, in which the three presidencies commit actively to promote work in the public health area, with the following priorities:

- **Proposal for an EU directive on cross-border health care**, aiming to conclude the negotiations before the end of 2009. EU action can bring added value to patients and health systems alike, especially given people’s increasing mobility.

- **Patients’ safety** and the quality of health care as the focus of a future regulatory system, irrespective of whether it is the patient, the practitioner or the service that moves across the border.

- **Availability and safety of organs for donation and transplantation** in order to improve the quality of health care and the safety of patients.

- **e-health** and the transmission and sharing of health care information

- **Alcohol consumption and the use of tobacco products by children and adolescents**: The EU strategy on nutrition, overweight and obesity-related health issues will continue to be implemented, in the context of health promotion and disease prevention, which are at the core of public health policy in Europe.

- **Cross-border threat of communicable diseases** and other public health threats require enhanced coordination and cooperation across Europe. The three presidencies wish to increase political awareness of health threats and work towards strengthening EU systems in order to achieve efficient surveillance and response mechanisms linking national, EU and international institutions. The trio agenda also pursues the issue of antibiotic resistance.

- **Alzheimer’s disease**, with the ambition for the three presidencies to draw particular attention to by focusing EU efforts on enhancing the coordination of research, exchange of experiences relating to health care and solidarity with carers. Action should also be pursued on rare diseases.

- **Pharmaceuticals**, with the objective of improving the quality and security of pharmaceuticals, focusing on strengthening and rationalizing EU pharmacovigilance, limiting antibiotic resistance, combating counterfeit pharmaceuticals and improving information to patients.

- **Food safety**: finalize the revision of current EU legislation on food and nutritional labelling and on novel foods on the basis of European Commission proposals made in January and February 2008. Other cross-cutting health issues on which the trio hopes to move forward are the EU Common Agricultural Policy and it health check and a new EU action plan for the fight against counterfeiting (2009–2012).