



World Health
Organization

REGIONAL OFFICE FOR
Europe



The way forward – scaling up action to prevent and control major communicable diseases



WHO STRATEGIC OBJECTIVE 2: To combat HIV/AIDS,
tuberculosis and malaria

“Emerging and re-emerging communicable diseases remain a priority area of concern in many countries of the Region”

Zsuzsanna Jakab, WHO Regional Director for Europe



Introduction

The low and middle-income countries in the WHO European Region often face the double challenge of strengthening health systems while also bearing the heaviest burden of many communicable and non communicable diseases. Vulnerable populations, including migrants and people who inject drugs, within countries throughout the Region are similarly burdened by limited access to quality health services in combination with greater vulnerability to ill health. The consequences are evident in the geographic and, in many cases, societal distribution of various communicable diseases, including HIV/AIDS, tuberculosis (TB), malaria, viral hepatitis and sexually transmitted infections.

WHO/Europe develops norms and standards, guidance and public health tools to help countries implement effective disease prevention and control programmes and address their risk factors.

Some progress has been made in the past decade, for example in regaining malaria-free status for a number of Member States, and reducing mother-to-child transmission of HIV. However, scaled up efforts, aimed at monitoring the spread of disease, protecting vulnerable groups and providing universal access to quality care and treatment, are needed to retain this momentum and make a lasting difference.

The following programmes are concerned with major communicable diseases affecting the European Region:

- » HIV/AIDS, SEXUALLY TRANSMITTED INFECTIONS AND VIRAL HEPATITIS
- » TUBERCULOSIS AND MULTIDRUG-RESISTANT TUBERCULOSIS
- » MALARIA

Executive summary

HIV/AIDS

Whereas a peak in new cases seems to have been reached in the rest of the world, the number of new HIV cases reported annually continues to rise in the eastern European and central Asian countries of the WHO European Region. As HIV in Europe disproportionally affects populations that are often socially marginalized and people whose behaviour is socially stigmatized or illegal, HIV prevention and treatment are to a large extent not reaching the individuals at highest risk. WHO/Europe works with partners to achieve universal access in all Member States to effective, affordable and equitable HIV prevention, treatment and care services.

Tuberculosis and multidrug-resistant tuberculosis

While the incidence of tuberculosis (TB) is declining in the European Region as a whole, this decline is slowest in the 18 high-priority countries for TB (countries of eastern Europe, including Baltic states, central Asia, Bulgaria, Romania and Turkey), which together account for 88% of the TB burden in the entire Region. Moreover, poor adherence to evidence-based TB control practices and lack of patient-centred approaches in many of these countries is generating high levels of multidrug and extensively drug-resistant TB. WHO/Europe supports countries in implementation of the Stop TB Strategy, and together with its partners is developing a Consolidated Action Plan to Prevent and Combat M/XDR-TB in Europe for 2011-2015.

Malaria

Intensive anti-malaria interventions have led to a substantial reduction in the number of reported malaria cases since the last serious outbreaks took place in parts of the Region in the 1990s. Locally acquired malaria cases are now reported in only 5 out of the 53 Member States of the Region. Based on this improved context, a new strategy was adopted in 2005 to interrupt malaria transmission by 2015 and eliminate the disease within the Region. In areas and countries where malaria has already been eliminated, priority is given to maintaining the malaria-free status. A shortage of national expertise and competence to guide elimination programmes and the challenge of ensuring sustainable funding are continuing concerns.

Viral hepatitis

Hepatitis affects millions of people in the WHO European Region, but goes largely unseen and in many cases untreated, leading potentially to serious health complications. The disease is especially prevalent among people who inject drugs, often in combination with HIV. Hepatitis is now recognized as a global health problem and WHO/Europe has been spearheading efforts to collect prevalence data and introduce routine immunizations.

Sexually transmitted infections

Rates of syphilis remain high in some countries of the Region that are struggling with weak and fragmented health systems, among other challenges. At the same time, sexually transmitted infections (STIs) are also increasing in certain subpopulations in western European countries. WHO/Europe's approach to controlling STIs in Europe focuses on reducing STI transmission, eliminating congenital syphilis and improving sexual health. To achieve these goals, greater management and control efforts are needed throughout the Region as well as surveillance systems to monitor the spread of the various STIs and the emergence of antimicrobial-resistant strains of gonorrhoea.

HIV/AIDS



While the rest of the world has been observing annual decreases in the number of new HIV cases, the number of people living with HIV has tripled in the eastern European and central Asian countries of the WHO European Region since 2000, contributing to an increase in the yearly rate of new HIV cases by almost 30% between 2004 and 2009.

The burden of HIV is distributed unevenly not only across countries in the European Region but also among population groups, affecting most seriously populations that are socially marginalized and whose behaviour is socially stigmatized or illegal. These “key populations” include people who inject drugs and their sexual partners, men who have sex with men, sex workers, prisoners and migrants. They often face structural barriers to HIV services, such as criminalization of behaviours, stigma, discrimination, rules and regulations within and outside the health care system, that sometimes restrict the

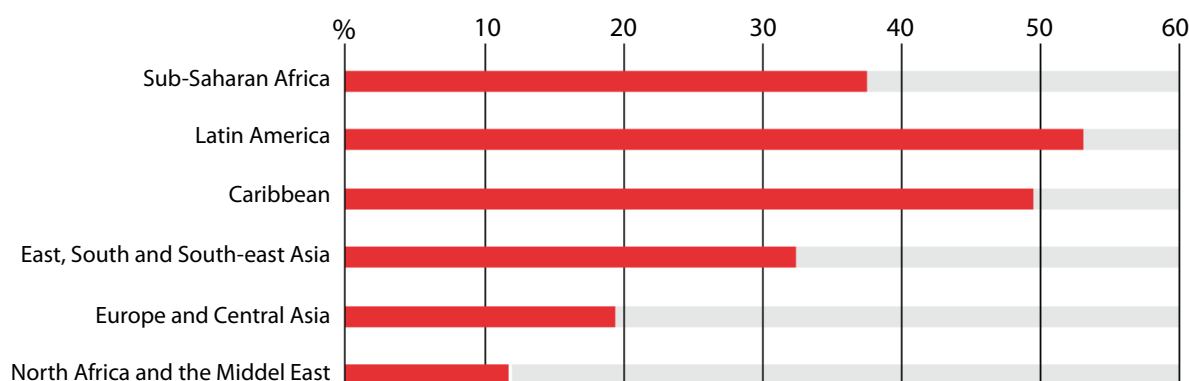
introduction of evidence-informed interventions. HIV prevention investments are to a large extent not focused on people at highest risk and in some countries effective and evidence-informed harm reduction measures for people who inject drugs remain at a small scale or are not implemented at all. Many people living with HIV are not aware that they have been infected due to limited access to and low uptake of HIV testing and counselling services.

As a result, those who are most in need of treatment are the least likely to receive it. Whereas many countries, especially in the western part of the Region, show the highest ART coverage rates in the world, and although the access has been increasing over the years. On average, access to life-saving antiretroviral therapy (ART) in the WHO European Region is among the worst globally. Only 19% of the estimated number of adults in need of ART were receiving it in the Region’s low- and middle-income countries as of December 2009.

Figure 1. ART coverage in low and middle income countries

Source: WHO, UNAIDS & UNICEF (2010) Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2010. Geneva, World Health Organization, 2010

Population adjusted averages for ART coverage in low-and middle-income countries by geographical region in 2009.



“Europe and Central Asia” in the table above includes: Albania, Armenia, Azerbaijan, Belarus, Bulgaria, Croatia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Tajikistan, Turkey, Ukraine and Uzbekistan.

The WHO Regional Office for Europe continues to support a health system approach in tackling the HIV epidemic, keeping with the 2001 United Nations Declaration of commitment on HIV/AIDS, which calls for universal access to effective, affordable and equitable HIV prevention, treatment and care services.

Challenges

➤➤ HIV infection negatively impacts the control and health outcomes of other communicable diseases. Tuberculosis and the end-stage liver diseases caused by the viral hepatitis C infection are among the leading causes of death of people living with HIV in the Region.

➤➤ The increasing number of new HIV cases in parts of the Region, absence of cure and high-cost, lifelong treatment and care pose a considerable resource burden on health systems. With the ageing of the HIV-positive population and their increasing longevity due to ART, there is a growing prevalence of noncommunicable co-morbidities including cancers, neuro-degenerative and other chronic conditions and diseases, increasing the need and the demand for complex medical case management, care and end-of-life services for people living with HIV. In the near future, HIV infection may rank as one of the most costly chronic diseases.

➤➤ Many prevention, treatment and care programmes in eastern European and central Asian (EECA) countries are dependent on external international funding, which makes them vulnerable to changing funding priorities and unsustainable in the longer term. Prevention efforts for at risk populations remain seriously underfunded in some EECA countries.

➤➤ Fading political commitment and mobilization of resources coupled with fragmentation of health systems, the absence of common goals and systematic planning, and poor coordination between services and sectors represent obstacles to address HIV. Other health system aspects such as retention and adequate utilization of the available health workforce, low salaries, insufficient capacities and motivation of health care workers also inhibit an effective response in some countries.

What the WHO Regional Office for Europe is doing

Normative guidance

WHO/Europe provides the Region with important normative guidance on how to respond effectively to HIV/AIDS. These policies, strategies and other tools are based on public health approaches and evidence from operational research in pursuit of established targets, such as the MDGs and universal access to HIV prevention, treatment and care. Through the development of global and regional guidance, including clinical protocols, WHO/Europe has accelerated the scaling up of HIV prevention in vulnerable key populations and the treatment and care of HIV and co-infections. WHO/Europe also increasingly assumes a leading role in global efforts to develop instruments for quality improvement and quality assurance in HIV service provision.

Quality HIV testing and counselling (HTC) services are an essential component of an effective response. WHO/Europe developed a Regional HTC policy framework that outlines ten main principles for scaling up HTC services, particularly for at-risk and vulnerable populations.



Policy and technical support

WHO/Europe provides policy and technical support to countries to expand gender-sensitive prevention, treatment and care interventions for HIV. This assistance can focus on national or regional HIV strategies and policies. WHO evaluation missions to Member States take a comprehensive approach that utilizes expertise from other WHO programmes and divisions and involves collaboration with external experts, civil society and partner organizations. Specific objectives include integrated training and service delivery; wider service-provider networks; strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, and drug-dependence treatment services.

WHO/Europe also provides technical assistance to countries applying for support from the Global Fund to Fight AIDS, TB and Malaria (the Global Fund), mainly by revising and providing recommendations on components related to health system strengthening and HIV treatment and care.

In eastern Europe, the HIV epidemic remains especially concentrated among people who inject drugs. Under technical leadership of WHO/Europe, a joint WHO, UNODC and UNAIDS guide was developed in 2008 for countries to set targets for universal access to HIV prevention, treatment and care for this key population.



Surveillance, monitoring and evaluation

WHO/Europe is working to strengthen and expand global, regional and national systems for surveillance, monitoring and evaluation. These systems provide essential data to keep track of progress towards targets, allocation of resources for HIV/AIDS control, the impact of control efforts and the evolution of drug resistance. WHO/Europe promotes the increasing use of this strategic information in policy development. In pursuit of this objective, the Regional Office:

- o undertakes surveillance on HIV/AIDS in Europe for all Member States and releases annual reports on the acquired data in collaboration with ECDC;
- o monitors and reports annually on progress in scaling up HIV prevention, treatment and care in the health sector, in collaboration with UNAIDS and UNICEF, and in the context of the 2001 Declaration of Commitment on HIV/AIDS;
- o provides training on HIV surveillance;
- o consolidates and revises regional HIV/AIDS monitoring and evaluation indicators in collaboration with ECDC, UNAIDS and UNICEF;
- o performs HIV/AIDS modelling and estimation work in collaboration with regional partners.

Research

WHO/Europe promotes and facilitates ethical research and development of new diagnostic, prevention and treatment technologies for HIV. This research, which is increasingly led by scientists from developing countries, contributes to the development of new intervention tools and strategies to meet priority needs for the HIV prevention, treatment and care. WHO/Europe also conducts operational research and advises Member States on the implementation of new evidence.

Advocacy, community engagement and fundraising

The response to HIV epidemic requires commitment at all levels and sustainable funding. WHO/Europe engages communities and affected persons in development and implementation of policies and interventions, while also helping to sustain political commitment and the mobilization of resources through advocacy and the nurturing of HIV partnerships at country and regional levels.

Prevention of HIV mother-to-child HIV transmission (PMTCT) – a success story

A number of Member States in the WHO European Region have virtually achieved the elimination of mother-to-child HIV transmission, well in advance of the global goal set for 2015. Overall in the Region only 4-7% of infants born to mothers living with HIV acquired the infection in 2009 (the elimination target is set to less than 2%), representing the lowest rate among WHO regions globally, and an almost five-fold decrease since 2000.

This achievement would not have been possible without the strong support and commitment of governments and the bold decision made in 2004 by WHO/Europe and its partners to set targets and make recommendations for PMTCT that exceeded global recommendations of the time. Their vision was based on trust in the capacities, structures and advantages of the Member States' health systems, especially maternal and child health services. In 2006 WHO/Europe developed a clinical protocol on PMTCT with recommendations on the most important preventive measures, such as ARV medications during pregnancy, elective caesarean section, ARVs for infants and replacement feeding.

The revised 2010 WHO global recommendations on PMTCT took the European experience into account and leveraged interventions and targets to those set by the European Region in 2004.

>> *What additional progress can be achieved with greater resources?*

Though the HIV epidemic continues to increase at an alarming rate and treatment is not keeping pace with the rate of new infections, **countries in the WHO European Region are in a position to radically change the situation by seizing opportunities for action.**

WHO/Europe is proposing to lead a more effective response to HIV across the region and has developed a European Action Plan for 2012 to 2015. This Action Plan is guided by the global vision and goals outlined in UNAIDS and WHO global strategies. But, specific objectives, targets and areas of intervention have been tailored specifically for the European context.

WHO/Europe has taken a participatory and inclusive approach to developing the Action Plan. Contributions are invited from Member States, civil society, donor and development agencies, nongovernmental organizations, multilateral agencies, scientific and technical institutions, networks, the private sector, and leaders and experts in HIV and related programmes.

Global vision and goals

The global vision, articulated in the UNAIDS strategy for 2011–2015 is zero new infections, zero AIDS-related deaths and zero discrimination in a world where people living with HIV are able to live long, healthy lives.

The global goals are:

- *to achieve universal access to comprehensive HIV prevention, treatment and care.*
- *to contribute to the achievement of MDG 6 focused on combating HIV, malaria and other diseases.*
- *to contribute to the achievement of other health-related MDGs.*

The plan envisages four strategic directions for action. The first is **improving the outcomes of HIV prevention, diagnosis, treatment and care**. Specifically, this involves reducing late diagnosis; eliminating new HIV infections among people who inject drugs; reducing sexual transmission of HIV among men who have sex with men and sex workers; eliminating mother to child transmission; and ensuring universal access to care and treatment for people living with HIV.

- > There is sufficient experience, deriving from projects and interventions implemented throughout the WHO European Region, to support effective policies and interventions. In particular, it is recognized that further scaling up of prevention interventions targeting high-risk groups is an essential direction to take in order to control the epidemic.

The second strategic direction involves producing **better health outcomes as a result of HIV programmes**. Specifically, this involves reducing the number of people living with HIV dying of TB; supporting countries to make available comprehensive programmes for people who use drugs and increasing linkages to services focused on sexual and reproductive health (SRH) and maternal, child and adolescent health (MCH), decreasing burden of HIV and viral hepatitis infection and the burden of noncommunicable and chronic disease in people living with HIV.

- > Integration models and linkages with other health programmes show encouraging results. For example, rapid progress in addressing mother-to-child HIV transmission has been made in the Region, particularly through the integration of HIV prevention with maternal and child health services. Further development of integration models and linkages with other health programmes such as TB, drug dependence, viral hepatitis and chronic diseases will strengthen the overall success of each individual programme.

The third involves establishing **strong and sustainable systems** including for surveillance, monitoring and evaluation; delivery of services; medicines and diagnostics; quality improvement; health financing; and governance and partnerships.

- > The costs of prevention, treatment and care commodities and services have decreased substantially over the last five years and the possibility of additional price reductions and cost-efficiency savings must be further explored. In times of fiscal constraints it is imperative to ensure that available resources are invested appropriately in cost-effective programmes, for example to increase the availability of generic medicines. Countries should continue to be guided by the aims of achieving affordability, increasing cost effectiveness and reducing economic barriers to prevention, treatment and care.

The fourth involves **addressing the social determinants of health** including laws and regulations; intersectoral actions and partnerships; stigma and discrimination; and strengthening community systems.

- > Laws and regulations representing obstacles to an effective response to HIV have been addressed in many countries of the WHO European Region. Same-sex relations have been decriminalized in all except two countries and laws to address HIV-related discrimination in the workplace as well as travel restrictions have been revised to protect people living with HIV. Aligning national legislation and policies with internationally recognized standards, further enforcement of protective laws and increased efforts to protect the human rights of most-at-risk populations will strengthen the response to the HIV epidemic.
- > A truly patient-centred approach to diseases such as HIV or TB needs to be shaped by the patient. Civil society is being consulted more often and their involvement in HIV policy formulation and decision-making has increased significantly in most countries of the Region. This direction should be continued and strengthened throughout the entire WHO European Region.

With additional human and financial resources, WHO/Europe can expand and strengthen its leadership and contribution in each of these areas.

FOCUS COUNTRIES: WHO/Europe supports all Member States in responding to the HIV epidemic, with a special emphasis on eastern Europe and central Asia.



Tuberculosis and multidrug-resistant tuberculosis

WHO estimates that tuberculosis (TB), a contagious airborne disease caused mainly by *Mycobacterium tuberculosis*, infects one third of the world's population and is therefore a serious threat to individuals and public health. In the WHO European Region alone, TB makes 42 people ill and kills 7 patients every hour. While the Region comprises only 5.6% of newly detected and relapsed TB cases in the world, it reported 329 391 new episodes of TB and 46 241 deaths from TB in 2009. The 18 high-priority countries for TB (countries of eastern Europe, including Baltic countries, central Asia, Bulgaria, Romania and Turkey) together account for 88% of the TB burden in the entire Region.

Poor economies and weak public health approaches are the main causes of the higher rate of TB in the most affected countries, but vulnerable groups in every country, such as people living with HIV or in prisons, are particularly at risk. HIV infection is the greatest single risk factor for developing tuberculosis ever identified. It is estimated that one third of the 40 million people living with HIV worldwide are coinfecting with TB. Without proper treatment, approximately 90% of those living with HIV die within months of contracting TB.

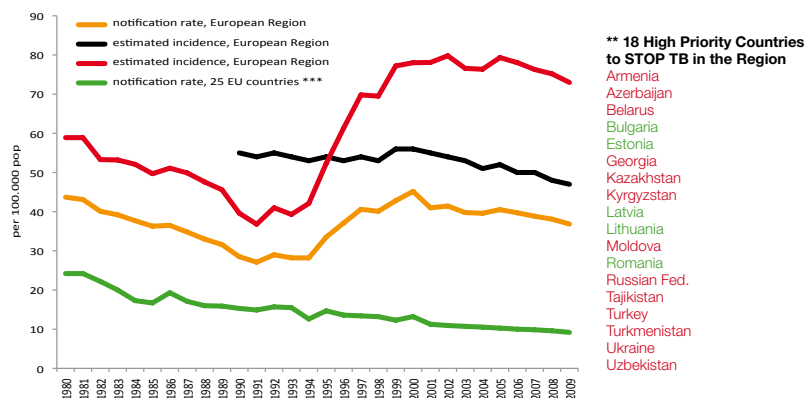
The WHO European Region is on track in achieving the Millennium Development Goal 6, target 8, which includes halting by 2015 and beginning to reverse the incidence of major diseases including tuberculosis. Incidence of TB has been slowly declining and is within reach of the 2015 goal, but mortality from TB must further decline from 7.0 (5.1-8.8) per 100 000 population in 2008 to 5.0 (3.9-9.5) by 2015. TB death rates increases from west to east across the European Region.

The rates of multidrug-resistant TB (MDR-TB) throughout the Region remain very alarming. Of 440 000 estimated MDR-TB patients in the world, 81 000 MDR-TB prevalent cases are estimated to be in WHO European Region (20% of the global burden). The top fifteen countries with highest rates of MDR-TB among previously treated TB cases, are in WHO European Region.

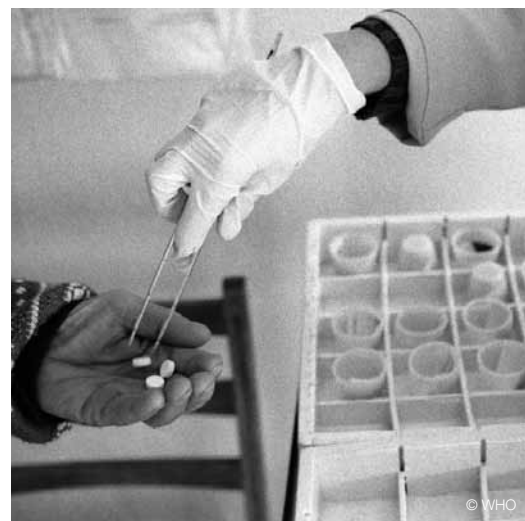
The proportion of MDR -TB among new TB cases and previously treated TB patients in 2009 was 11.1% and 36.7% respectively. Many countries in the Region have reported extensively drug-resistant TB (XDR-TB). Emergence of M/XDR-TB is a sign of failure of health systems and a lack of addressing social determinants of TB along with inequities in access to health services. In 2009, only 34.2% of estimated MDR -TB cases were notified due to low availability of bacteriological culture and drug susceptibility testing or molecular methodologies and only 36.4% of estimated MDR-TB cases received adequate treatment with quality second-line drugs.

The Berlin Declaration on Tuberculosis endorsed in 2007 by all Member States of the European Region calls for a strong commitment and action to fight against TB and properly address M/XDR-TB. Adequate interventions require proper national planning and effective implementation, comprehensive approaches in and across countries, and strong support from national and international partners. Timely prevention, diagnosis and treatment can control the spread of infection.

TB notification* and estimated incidence rates, the WHO European Region, 1980-2009



* Notified (TB cases) = new cases + relapses
 *** excluding Bulgaria and Romania that became EU in 2007
 Source: TB surveillance in Europe, report 2009



Challenges

➤ Diagnostic, prevention and treatment tools for TB control are extremely outdated. The only vaccine currently available against TB is Bacille Calmette Guérin (BCG), which was first used in 1921. BCG has limited efficacy for protection against the disease and cannot be administered for people living with HIV. The most effective drugs for treatment of TB were discovered in the 1950s. Agents introduced since that time often have more adverse side effects. Better control of TB in the Region thus requires the development of new and better drugs, diagnostics and vaccines in addition to more accessible and efficient TB services.

➤ Poor adherence to TB control practices is generating high levels of M/XDR-TB – resulting in poor health outcomes and putting an extensive additional burden on health systems.

➤ Drug-resistance makes TB difficult to cure. The Region has the lowest treatment success rate in the world compared to other WHO regions – only a little over 70% of new TB cases in 2009.

➤ Other challenges in the Region:

- o increasing rates of TB/HIV co-infection;
- o poorly developed health systems or health systems under reform, leading to ineffective TB control;
- o insufficient attention to social determinants of health and other social issues related to TB patients (homelessness, unemployment, alcohol- and drug-dependency, migration);
- o weak laboratory infrastructure and performance;

- o weak infection control;
- o poor TB control in prisons; and
- o insufficient community care and civil society involvement in planning, implementation and monitoring and evaluation of policies and programmes.

What the WHO Regional Office for Europe is doing

WHO/Europe works with its many partners to improve the monitoring and surveillance of TB in the WHO European Region; and to develop guidelines and protocols on TB diagnosis, treatment, prevention and care for programme managers, policy-makers, nongovernmental organizations, technical and financial partners and health personnel.

Specific actions

- o In response to the increasing threat from M/XDR-TB and the necessity of consolidating and scaling-up the response, WHO/Europe is implementing a Special Project on M/XDR-TB and developed a Regional Action Plan to Prevent and Combat M/XDR-TB in Europe for 2011-2015. The Plan calls for consolidated and coordinated action to reverse the spread of drug-resistant tuberculosis by scaling up the response in all Member States.
- o WHO/Europe provides technical assistance to countries applying for support from the Global Fund mainly by revising and providing recommendations on components related to TB, MDR-TB, TB/HIV and health system strengthening.

- o Through a technical assistance mechanism called the 'Collaborative on TB training and education', WHO/Europe and partners ensure coordination and synergy in updating TB-related training material.
- o WHO/Europe and its partners have assisted Member States in pursuing the integration of targeted disease-specific programmes into existing health system structures and services. National TB programmes have been reviewed, paying special attention to their linkages with health systems and aiming to streamline national TB plans and financing with national health strategies.

Recommendations of the review of the national TB programme in Tajikistan in 2009 were considered in the formulation of the country's national health strategy. International TB funding mechanisms, such as the Global Fund, have been applied to promote integrated laboratory technologies, national drug management, national surveillance, integrated TB and HIV interventions for co-infected patients, and delivery of TB services at primary level.

Regional and global collaboration

Berlin Declaration

WHO/Europe facilitated a European Ministerial Forum "All against Tuberculosis" held in October 2007 in Berlin, Germany, to accelerate progress towards achieving the global targets for TB control in the WHO European Region. A declaration that was endorsed in this Forum outlines priorities and actions to be taken. WHO/Europe is introducing a monitoring framework to measure the progress in implementation of the declaration.

Beijing Call for Action on TB

Ministers from 27 high M/XDR-TB burden countries of the world met in Beijing, China, in April 2009 to urgently address the alarming threat of MDR-TB. Their concern was reflected in a Call for Action on M/XDR-TB to help strengthen health agendas and ensure that urgent and necessary commitments for actions and funding are made to prevent this impending epidemic.

M/XDR-TB Action Plan for Europe

The Regional Consolidated Action Plan to Prevent and Combat M/XDR-TB 2011-2015. It is a roadmap to strengthen and intensify efforts to address the alarming problem of drug resistant TB in the Region. The Plan is prepared through a region-wide consultation with experts, patients and communities affected by the disease.

Green Light Committee for Europe

WHO/Europe in collaboration with the Stop TB Partnership is establishing an expert committee to scale up MDR-TB response. This independent committee will provide advice to Member States and donors, including the Global Fund, on measures to improve MDR-TB prevention, control and care. WHO/Europe has already assisted and facilitated the process of development of national MDR-TB response plans in 15 high MDR-TB burden countries.

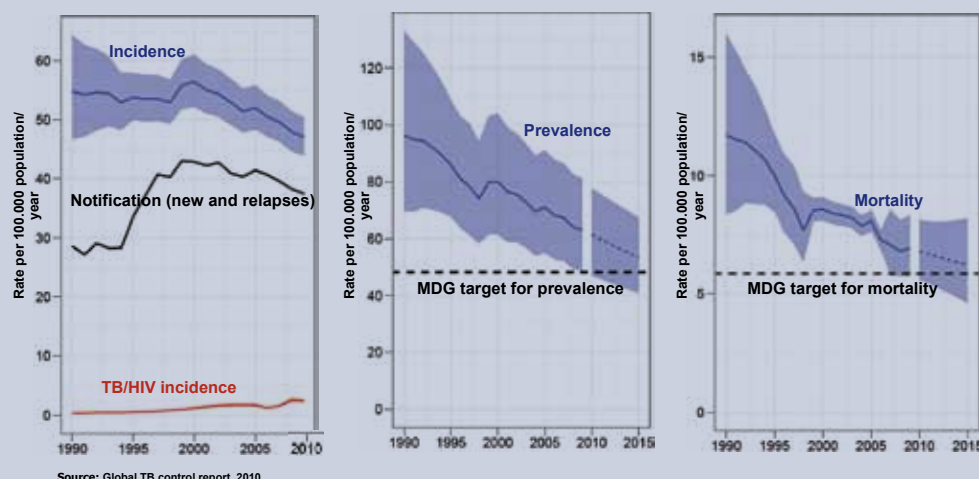


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>> *What additional progress can be achieved with more resources?*

The Member States need to scale up actions to reach the MDG 6 TB control targets and respond urgently to the M/XDR-TB emergence. Most Member States and particularly the high TB priority countries that carry more than 80% of burden of the disease in WHO European Region need intensified technical assistance in the following areas.

MDG 6: Tuberculosis Estimated incidence, prevalence and mortality, WHO European Region, 1990-2008



Strengthening health systems With greater resources, WHO/Europe could assist Member States in documenting and expanding the best models of care with patient-centred approaches making TB services more accessible and efficient, and integrate them into general health services.

Improving quality assured diagnosis Further resources are needed to intensify technical assistance by introducing new diagnostic technologies, and strengthen the network of supranational TB reference laboratory in Europe.

Evidence-based interventions and policy guidance WHO/Europe in collaboration with the Member States could intensify its assistance to the Member States in documenting the most effective and feasible interventions and develop and adopt evidence-informed policy guidelines and strategies.

Human resources capacity building In terms of human resource development, the WHO collaborating centres and knowledge hubs need further funding and intensive support to improve their services to the Member States and improve knowledge management and exchange of experiences. This is particularly needed for M/XDR-TB diagnosis and treatment and implementation of TB/HIV collaborative activities.

Promoting research and development New and better ways to fight TB are crucial for rapid and effective prevention and control the disease. More resources will be needed for TB-related research and to convert scientific discoveries into new and better drugs, diagnostics and vaccines.

Fostering Partnership and coordination WHO/Europe is in a key position to promote coordination and collaboration between the Member States. With further resources, European institutes and twinning of TB control and prevention programmes could be formalized and nurtured. Improved coordination among partners in terms of quality technical assistance and sustainable development could only be made possible through improved partnership.

FOCUS COUNTRIES: WHO/Europe supports all Member States for TB Control, although emphasis is on 18 high TB priority countries where they carry more than 80% burden of TB in the Region (eastern Europe, including Baltic countries, central Asia, Bulgaria, Romania and Turkey).

Malaria

At present malaria is endemic in 109 countries and territories in tropical and subtropical zones around the world with intensities of transmission that range from very low to extremely high. By the beginning of the 1960s, malaria had been nearly eliminated in all countries of the WHO European Region, with the exception of some areas in Azerbaijan, Tajikistan and Turkey, where malaria transmission remained in residual foci.

The perception that the Region is free from malaria has changed rapidly over the past decades. Starting in the early 1980s, the number of countries affected by locally acquired malaria increased from 3 to 10. At the beginning of the 1990s, the residual reservoir of malaria infection, aggravated by political and socioeconomic situations, mass population migration, extensive development projects, and almost discontinued activities on malaria prevention and control constituted conditions favourable for malaria transmission. As a result, large-scale epidemics broke out in central Asia and the Trans-Caucasian countries, and a total of 90 712 autochthonous cases of malaria were officially reported in the Region in 1995. Azerbaijan, Tajikistan and Turkey suffered explosive and extensive epidemics, while Armenia, Kyrgyzstan and Turkmenistan faced outbreaks on a smaller scale.

Intensive anti-malaria interventions undertaken since 1995 have led to a substantial reduction in the number of reported malaria cases (90 712 cases in 1995 and only 176 in 2010).

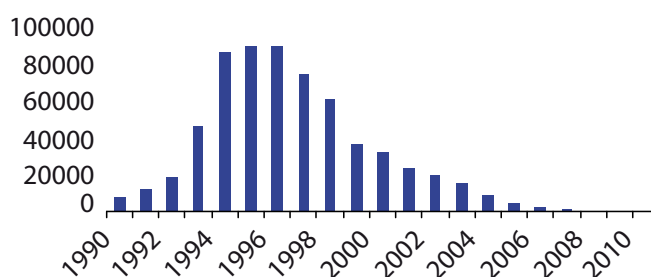
At present, locally acquired malaria cases are still reported in 5 out of the 53 Member States of the Region: Azerbaijan, Kyrgyzstan, Tajikistan, Turkey and Uzbekistan.

Each successful milestone in the reduction of a disease allows for establishment of new and more demanding objectives along with the path to achieving these goals.



The demonstrated feasibility of malaria elimination in the past, the visible impact of anti-malaria interventions at present, the strong political commitment to proceed with malaria elimination at national level, and the availability of effective control technologies and tools facilitated the decision taken in 2005 to undertake a new elimination effort in the Region as endorsed in the *Tashkent Declaration: The Move from Malaria Control to Elimination in the WHO European Region*.

Number of autochthonous malaria cases in the Region, 1990-2010 (Source: CISID)





The ultimate goal of the new strategy is to interrupt malaria transmission by 2015 and eliminate the disease within the Region. In areas and countries where malaria has already been eliminated, priority is given to maintaining the malaria-free status.

Since 2008, all malaria-affected countries of the Region have moved into the elimination phase and their national strategies on malaria have been revised to reflect the new elimination challenges. When a country has zero locally acquired malaria cases for at least three consecutive years, it can request WHO to certify its malaria-free status. Turkmenistan was certified free from malaria in October 2010, and notice on its malaria-free status will be given during the 64th World Health Assembly in May 2011. Armenia is working closely with WHO to attain the declared goal by the end of 2011. Transmission of autochthonous *P. falciparum* malaria was interrupted in Tajikistan in 2009, thus eliminating this type of malaria from the entire Region. There is a high expectation that the local transmission of *P. vivax* malaria has been interrupted in Georgia.

Challenges

Despite the visible achievements and relative calm of the present malaria situation in the Region, the established goals will not be reached without national malaria elimination programmes with a strong technical management structure capable of mobilizing sufficient

resources and implementing technically sound and effective measures adapted to national conditions and responding to local needs. A concern for the future of malaria elimination in the Region is the shortage of national expertise and competence to guide such programmes.

A main obstacle for national elimination programmes, when the number of malaria cases becomes very low, is the justification of their cost. New possibilities and approaches for additional resource mobilization should be widely explored at global, regional and national level.

What the WHO Regional Office for Europe is doing

The international and political attention that has been mobilized in recent years in malaria-affected countries is being translated into real commitments and action to eliminate malaria in the Region. In line with the aforementioned Tashkent Declaration, WHO/Europe works closely with all countries with the goal of eliminating malaria in the Region by 2015.

WHO/Europe provides strategic and normative guidance, technical assistance and back-up in planning, implementation, monitoring and evaluation of national malaria elimination programmes to ensure that they are implemented in accordance with global and regional WHO policies and strategies. Particular emphasis is given to situations in which there is a risk of malaria spreading between neighbouring countries within the European Region, and between the WHO European and Eastern Mediterranean Regions. WHO/Europe and the Global

Fund are heavily involved in providing technical guidance and financial assistance to promote and facilitate cross-border collaboration.

In close cooperation with the Regional Office, and with grants from the Global Fund, Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan are strengthening their national capacities to eliminate malaria. The governments of Armenia and Turkey are also providing full-scale assistance to help them implement their malaria elimination programmes.



>> *What additional progress can be achieved with more resources?*

WHO/Europe urges existing and potential partners to increase the level of financial assistance, in order to contribute to the attainment of the established objectives and goals. Extra funding will undoubtedly facilitate and accelerate the process of malaria elimination at national level. Successful malaria elimination will contribute to the strengthening of national health systems, as integration of targeted disease-specific programmes into their existing structures and services will allow them to achieve better and sustainable outcomes. Furthermore, elimination of malaria will help the affected countries realize future expectations in terms of industry, trade and tourism.

FOCUS COUNTRIES: Armenia, Azerbaijan, Georgia, Kyrgyzstan, Tajikistan, Turkey and Uzbekistan.

Viral hepatitis

Viral hepatitis is a largely neglected epidemic in the WHO European Region. An estimated 14 million people live with chronic hepatitis B, and an estimated 9 million people are infected with hepatitis C, but most are unaware that they are infected. Because it is often left untreated, chronic hepatitis is a major cause of liver cirrhosis and primary liver cancer. Hepatitis B is responsible for about 36 000 deaths per year in the Region, with hepatitis C responsible for around 86 000 deaths annually.

People who inject drugs are particularly vulnerable to hepatitis and, in some settings, almost all are infected with hepatitis C. As they are also more vulnerable to HIV infection, co-infection with both HIV and hepatitis is particularly common among those who inject drugs in the Region. Between 70-90% of injecting drug users living with HIV also have hepatitis C infection. With increasing availability of effective treatment for HIV, chronic, untreated viral hepatitis is increasingly a major cause of death among people living with HIV in the Region.

The spread of hepatitis can be prevented if countries adopt measures promoted by WHO. These include:

- universal newborn immunization against hepatitis B, in addition to vaccination against hepatitis A and B in specific high risk groups of population, determined according to the level of endemicity in a given country and as a supplement to comprehensive prevention and control efforts
- prevention of mother-to-child transmission of hepatitis B
- promotion of safer sexual behaviour to reduce the risk of infection
- reduction of harm related to injecting drug use
- provision of a safe blood supply
- prevention of transmission in health care settings.



In addition, access to diagnosis and timely treatment reduces sickness from viral hepatitis and reduce complications, including liver failure and primary liver cancer. This improves quality of life and reduces mortality.

Challenges

As a person with hepatitis may have no symptoms for a long time, the epidemic is largely hidden and was until recently not fully recognized as a public health problem in the Region. As a result:

- >> hepatitis surveillance is weak – the number of persons living with different forms of chronic hepatitis are not known accurately;
- >> the cost of diagnosis and treatment of hepatitis remains very high; and
- >> access to prevention and treatment services is limited in many countries of the Region, particularly in eastern European and central Asian countries.

What the WHO Regional Office for Europe is doing

In May 2010, the World Health Assembly adopted a resolution recognizing hepatitis as a global public health problem. Even prior to that, the WHO Regional Office for Europe had been spearheading the response to hepatitis in three key ways: by supporting hepatitis immunization programmes, providing technical guidance and arranging prevalence surveys.

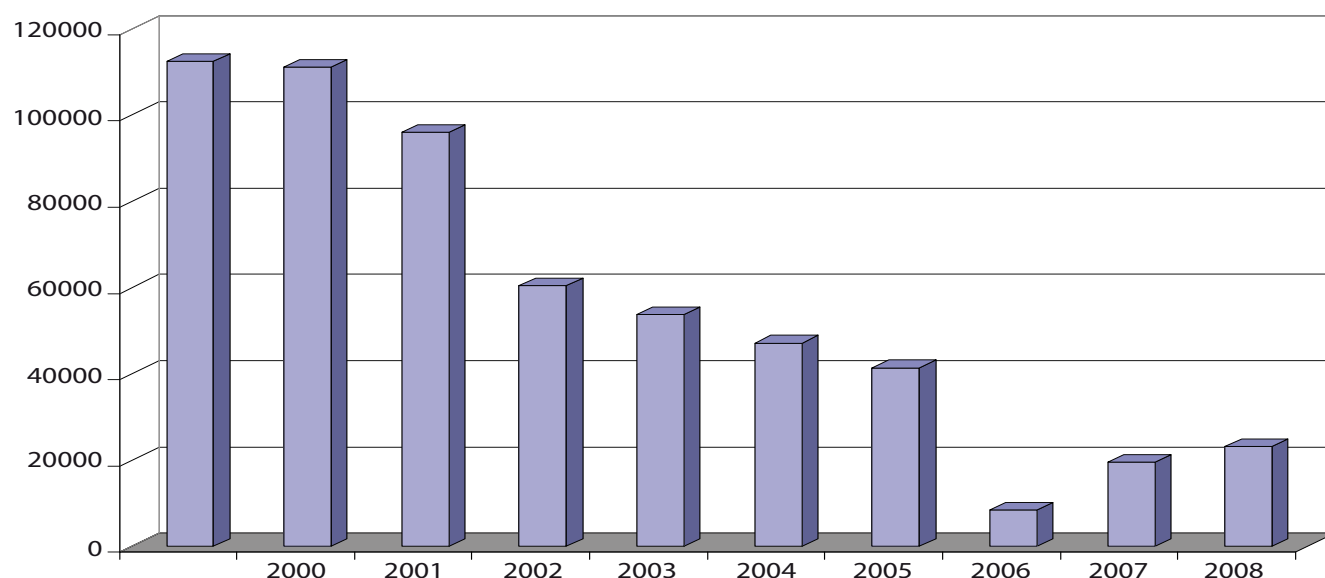
Immunization programmes

Throughout the Region, WHO has supported programmes that provide routine immunizations against hepatitis B to infants and children. As a result, the number of reported cases of acute hepatitis B has fallen dramatically over the last ten years. The project in Ukraine that extended hepatitis B vaccination to hard-to-reach populations is a good example of reaching out to those most at risk.

Reaching injecting drug users and men who have sex with men with hepatitis B vaccination: The example of Ukraine

In Ukraine, the WHO Regional Office for Europe suggested a model of hepatitis vaccination which would allow the existing programme to be expanded beyond infants only. In only six months, this new approach resulted in the vaccination of more than 700 injecting drug users and men who have sex with men in six regions of the country. As a result of this success, the programme is being expanded into a further seven regions with financial support from the International Health Alliance.

Acute hepatitis B reported cases, WHO European Region, 1999-2008



Technical guidance

The Regional Office provides Member States with important technical guidance on how to respond effectively to hepatitis. For example, clinical protocols have been developed on the management of hepatitis B and HIV co-infection, and the prevention of hepatitis A, B, C and other hepatotoxic factors in people living with HIV. These protocols are available in both English and Russian. They have been adapted for national use by countries and are being used as clinical guidance in daily practice across the Region.

The Regional Office for Europe has also played a pivotal role in the development of WHO's global guidance on programmatic issues related to prevention, screening, diagnosis and treatment of hepatitis in people who inject drugs.

Surveillance

WHO has supported efforts to increase the availability of information about hepatitis in the Region by arranging sentinel surveys of the prevalence of hepatitis B and C in populations at increased risk of infection in some countries.



>> *What additional progress can be achieved with more resources?*

With increased human and financial resources more could be done to strengthen the response to hepatitis in the Region. The Regional Office would specifically support countries in:

- > developing an overall regional strategy that uses a comprehensive integrated approach;
- > increasing political commitment in Member States to prevent and control chronic viral hepatitis;
- > assessing the current situation, defining appropriate policies and building national capacity;
- > strengthening hepatitis prevention by integrating into existing health systems and services, including blood transfusion services, immunization programmes, national cancer programmes, STI services, HIV services and specific programmes for injecting drug users;
- > enhancing hepatitis surveillance and early detection;
- > improving case management and access to diagnosis and treatment; and
- > cooperating with a broad network of regional and national organizations and bodies.

FOCUS COUNTRIES: WHO/Europe supports all Member States with special support and technical assistance to Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

Sexually transmitted infections

Sexually transmitted infections (STIs) remain a challenge to public health in the European Region. Though accurate information is not available from all countries, available data indicate that rates of some STIs remain high in some countries. For example, in 2007, the number of new cases of syphilis notified per 100,000 population was only 4.4 in countries across the European Union but was as high as 70.0 in some countries of eastern Europe. Emergence of antimicrobial-resistant strains of gonorrhoea is also of growing concern.

Some STIs also particularly affect certain sub-populations. For example, there has been an increase of some STIs among some men who have sex with men (MSM) in western Europe. There have been outbreaks of Lymphogranuloma Venereum in western Europe among MSM co-infected with HIV and other STIs. Genital Chlamydia is the leading STI in western Europe, particularly among young people. It causes short-term illness and can also cause long-term reproductive health problems. Migrant sex workers are particularly vulnerable to STIs and often have difficulty accessing services. Addressing STIs among these sub-populations means that issues such as stigma, discrimination and violence also have to be addressed.

There are particular challenges relating to STIs in some countries of eastern Europe and central Asia including weak policies and strategies, limited availability of data, weak and fragmented health systems, limited human resources, ineffective punitive practices, barriers to access for sub-populations and lack of effective monitoring. The availability and quality of information concerning STIs varies markedly across the region. As a result, data should be treated with caution. There is a need to improve STI surveillance across the region.



Challenges

WHO/Europe has established an approach for an effective response to STIs in Europe. This is structured around achieving three long-term goals, reducing STI transmission, eliminating congenital syphilis and improving sexual health. Key elements in achieving these goals include:

- >> Increasing the commitment of national governments, national and international development partners for prevention and control of STIs.
- >> Developing appropriate policies, strategies, programmes and initiatives related to STI prevention, control and care.
- >> Improving health systems by mobilizing and reallocating resources to ensure access to quality STI services to all who need them.
- >> Harnessing the strengths and capacities of all partners and institutions, including civil society and affected communities, in the design, planning, implementation and evaluation of STI programmes.

What the WHO Regional Office for Europe is doing

WHO/Europe has been leading the response to STIs in the Region in a number of ways. First, it has provided leadership on many issues related to STIs. These include identifying and promoting suitable policy options, setting norms and standards and promoting change. For example, WHO/Europe stimulated countries of eastern Europe and central Asia to modernize their approach to STIs. Recently WHO/Europe has initiated

the development of a Regional Strategic Framework for STI control and prevention. This framework fits with the approach outlined above and also reflects key international declarations and targets, such as the Millennium Development Goals.

Second, WHO/Europe is building the technical capacity to respond to STIs in the region.

Building technical capacity to respond to STIs: Some examples

WHO/Europe supports the development and delivery of a training module on STI surveillance through the WHO Collaborating Centre in Croatia. In addition to training, WHO/Europe provides technical assistance related to STI surveillance and supports the development of relevant tools, guidelines and training manuals. It also supports the integration of STI surveillance and the involvement of national STI specialists in HIV surveillance systems. WHO/Europe is collecting data on STIs in collaboration with UNICEF, which is stored in a Computerized Information System for Infectious Diseases (CISID).

WHO/Europe supports the integration of STIs into other programmes as part of a process of health systems strengthening. This has included:

- Workshops on promoting links with reproductive health and HIV;
- HIV strategic planning and care workshops such as those done in Armenia, Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan;
- High level policy meetings;
- Technical support missions covering STIs such as those done in Albania, Azerbaijan, Bulgaria, Estonia, Kazakhstan, Serbia and Uzbekistan; and
- Technical support on the use of the Global Fund grants including in Kyrgyzstan, Tajikistan and Uzbekistan.

WHO/Europe supports initiatives to improve the quality of STI policies and practices including:

- Technical assistance to adapt international STI case management guidelines for example in Armenia, Georgia, Republic of Moldova, Ukraine and Uzbekistan;
- Supporting the review of national STI programmes such as those done in Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan;
- Technical assistance to build laboratory capacity;
- Support to the promotion of STI case management such as those done in the former Yugoslav Republic of Macedonia, Turkmenistan and Uzbekistan with missions planned to Kyrgyzstan and Tajikistan;
- Support in translating key documents into Russian language;
- Review of national STI policies such as those done in Croatia and Turkmenistan; and
- Monitoring progress in STI control and prevention such as those done in Armenia, Azerbaijan, Georgia, Kyrgyzstan, Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

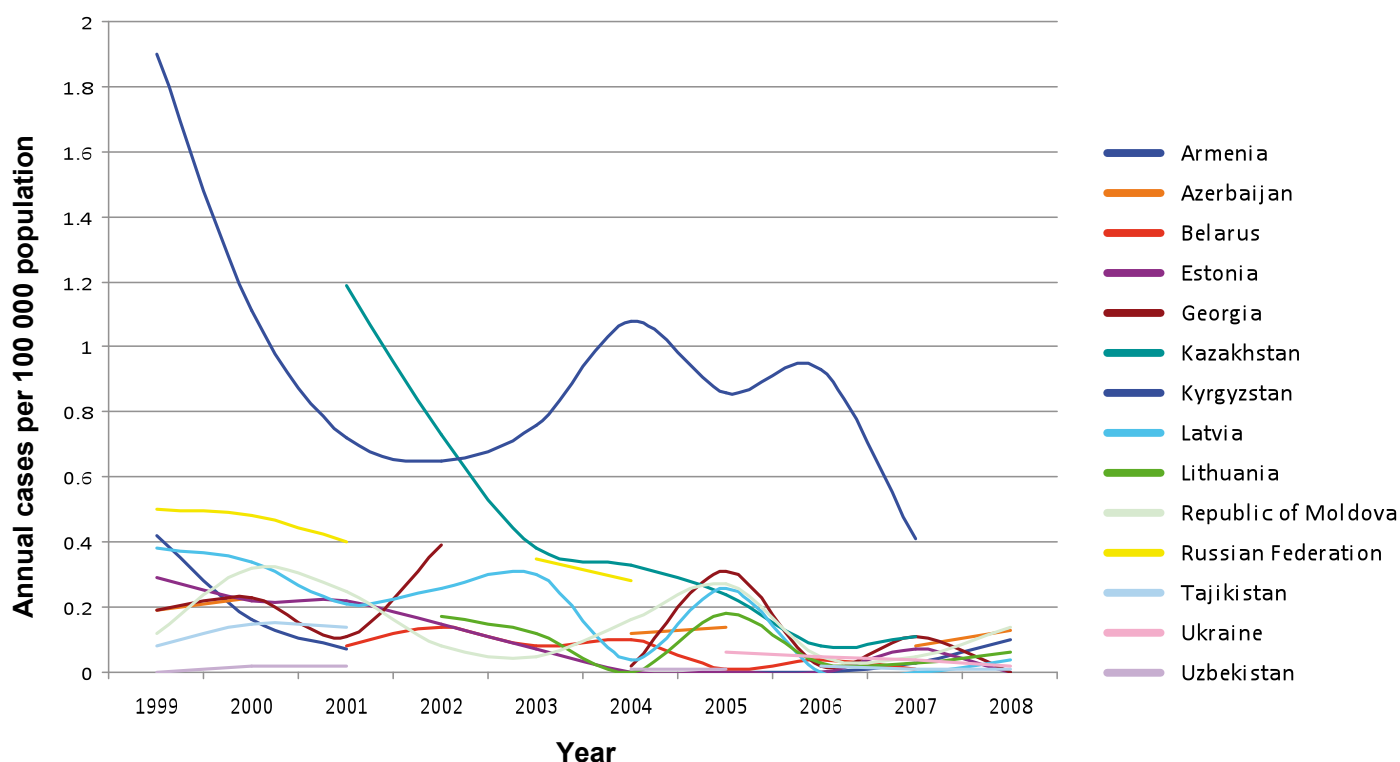
Third, WHO/Europe has been successful in supporting initiatives to eliminate congenital syphilis in Europe.

Fourth, WHO has addressed the challenge of emerging antimicrobial resistance among strains of gonorrhoea by establishing a Collaborating Centre with Örebro University Hospital, in Sweden. This collaboration focuses on expanding the Gonococcal Antimicrobial Surveillance Programme (GASP) across the eastern part of the region. It also aims to strengthen overall STI laboratory diagnosis in the countries of that part of the region.

Finally, WHO/Europe has been collaborating with the International Union against STIs in development of guidance documents relating to STIs management or jointly organizing workshops and scientific sessions at international STIs congresses.



Congenital syphilis rate per 100,000 population, in selected countries



>> *What additional progress can be achieved with more resources?*

With additional human and financial resources, WHO/Europe would support activities aimed to improve STIs prevention, management and control in 15 focus countries. These activities would include:

- > Further efforts to eliminate congenital syphilis.
- > Improving STI surveillance and to expand the network of laboratories in eastern Europe able to monitor antimicrobial-resistant strains of gonorrhoea.
- > Improving STIs services for key populations, such as young people, sex workers, men who have sex with men and migrants. This would include developing innovative approaches to prevention and care for both STIs and HIV. It would also involve making services more available.
- > Improving Chlamydia control programmes among young people, particularly in eastern Europe and central Asia.

In addition, WHO/Europe would like to support efforts to integrate STIs management into broader health systems including through:

- > Ensuring that social, behavioural, political and economic dimensions of STIs control and prevention are reflected in national policies, strategies and practices
- > Promoting links between STIs and other programmes notably HIV and reproductive health.
- > Promoting wide-scale partnership and collaboration, including with civil society, affected communities and the private sector.
- > Strengthening surveillance systems that collect information needed for countries to respond effectively to both HIV and STIs.

FOCUS COUNTRIES: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

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WHO's Strategic objectives

With a specific focus on inequalities, social determinants of health and health in all policies, 2020 provides a European platform for achieving the 11 Strategic Objectives which frame the work of WHO in the European Region.

Briefings are available in each of the Strategic Objective areas:

1. Reduce the health, social and economic burden of communicable diseases
2. **Combat HIV/AIDS, tuberculosis and malaria**
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment
4. Reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.
6. Promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex
7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches
8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
9. Improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.
10. Improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research
11. Ensure improved access, quality and use of medical products and technologies.

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