# A Specialist for the left kidney and a Specialist for the right kidney:

**A preliminary assessment of health promotion and communication capacity in eight CEE/CIS countries**

*For UNICEF internal use only*

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# Contents

# Executive Summary

Investments in health promotion and health communication - strategies at the very heart of health systems reform - are evidence-based, multi-disciplinary and integrated approaches to public health that are cost-effective, drive improved population health and can make exponential contributions to social and economic progress.[1]

The 1986 *Ottawa Charter* on Health Promotion argues that health promotion underpins all modern public health strategies. Reinforcing effective health promotion are five key strategic actions that when employed in combination, drive improved health outcomes. These are: developing healthy public policy; creating supportive environments; strengthening community action; developing skills; and reorienting health services. Engendering a health literate society where families and individuals are engaged on health issues and empowered to make informed decisions must inform all efforts towards improving public health.

The European Commissions White Paper – *Together for Health: A Strategic Focus for the EU: 2008 – 2013* endorses an expanded role for health promotion within current health systems reform, and the engagement of communities as active agents for change. The Second Programme of Community Action in the Field of Health for 2008 – 2013 - informed by the White Paper – is intended, in the word of the Commission to:

***...complement, support and add value to the policies of the Member States and contribute to increased solidarity and prosperity in the European Union by protecting and promoting human health and safety and by improving public health***

To date, however, in Eastern Europe and Central Asia relatively few resources have been directed towards preventative health strategies, health promotion and building capacity for public health interventions, despite a growing recognition among development partners of the importance of these key elements for an effective health system. Instead reform efforts have focused on decentralization, reforming health financing systems, and improvements to primary health care services (see section 5 for more detail). Public health services, which prior to the transition were resourced through central level public funds, have, if anything, been undermined by reforms to financing systems and decentralization that have left public health authorities, especially at the sub-national level, under-resourced and unable to maintain basic services. In some countries, declining immunization coverage is a case in point.[2]

Now more than ever there is an urgent need for development partners to increase their financial commitment towards health promotion and to lobby CEE/CIS governments to increase budget allocations for public health interventions. However, without parallel efforts to provide coordinated technical assistance and to leverage shifts in the bureaucratic and professional cultures that prevail in post-Semashko health sectors, expanded budget allocations alone will be not be sufficient to enable reform and improve population health.

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[1] See section 2 for a more detailed description of how health promotion and communication for public health can contribute to health systems reform.

[2] For more details see (2008), Rathwell, Goldstein and Chauvin *Health Sector Reform in the CEE/CIS and its Effects on Immunisation as a Basic Primary Health Care Interventions: Lessons Learned and Recommendations for Action* – a study recently commissioned by UNICEF RO for CEE/CIS Health Section

In the CEE/CIS the health status of children mirrors the widening east-west gap seen in the health status of adults. Despite official data indicating overall improvements, children's health indicators show large disparities – within countries and between countries – in relation to their socio-economic position, age, gender, ethnicity and geographical location. From a human rights perspective these inequalities are unacceptable and overwhelmingly affect the countries, societies, communities, families and children with the fewest resources to cope. Even in the better off of the CEE/CIS countries, the poorer members of society carry a disproportionate burden of preventable disease and ill health – a situation that has been compounded by the transition to free market economies and the subsequent unravelling of access to social services which has undermined safety nets for the most socially and economically marginalized including the Roma, the elderly, disabled people, adolescents and children.

Increasing levels of disease and ill health and the inadequacy of government responses are resulting in a complex web of problems that threatens social stability and economic progress. The three main causes of mortality in the CEE/CIS region are cardiovascular diseases, accidents (usually related to alcohol abuse) and cancers caused by poor diets, smoking and alcohol abuse. High levels of adult morbidity and mortality also impact profoundly on a society's capacity ensure that all children are able to realise rights to survival, development and protection. In addition, children are suffering, needlessly, from many preventable threats to their health that include respiratory illness, physical abuse, and the risks posed by intravenous drug use and other risky behaviours linked to underlying socio-economic determinants including poverty, disempowerment and unemployment.

Communicable diseases such as drug-resistant tuberculosis and sexually transmitted infections are placing health sectors already reeling from the effects of transition under huge strain. Escalating levels of HIV infection and the threat posed by the H5N1 Avian Influenza virus add a new urgency to the need for health communications and health systems reform in the CEE/CIS. Reservoirs of communicable diseases are present within the region and pose very real threats to regional public health security. Clearly, preventing diseases and promoting good health are not only in the national interest, but also in the interest of all 27 EU members and neighbouring countries.

The excessive burden of non-communicable disease and the widespread prevalence of communicable disease and other threats to public health (such as environmental degradation) can only be addressed in the CEE/CIS through multi-disciplinary approaches to health promotion, improvements in health sector governance and the implementation and development of appropriate regulatory frameworks. These are cost-effective interventions and public goods.

Although none of the eight countries visited for this assessment have any dedicated budget for health promotion beyond operational costs (salaries, office supplies etc.), most EU15 countries allocate between 2 and 3 per cent of total health expenditures towards preventative health strategies and health promotion. While many public health policy makers argue that an allocation of 2 to 3 per cent is not sufficient, it is still much much more than in the CEE/CIS and therefore should represent a *minimum* budgetary target for CEE/CIS governments. Furthermore, wealthier members of the EU have higher levels of Gross Domestic Product and allocate a bigger share of GDP to the health sector – in this context, 2 or 3 per cent of total health expenditures can represent a lot of money for preventative health strategies, especially considering that EU15 countries also have a lower incidence of preventable disease than most CEE/CIS countries. In real terms, and relative to

national income and the inordinately high levels of preventable diseases in the CEE/CIS, this suggests that CEE/CIS countries and their development partners must find ways to significantly increase budgetary allocations for health promotion. In fact, given the potential benefits of a scaled up role for preventative health services, relative to the limited resources available, an allocation well above 2 to 3 percent of total health expenditures, if efficiently directed, may well prove to be efficacious and a prudent use of resources.

Most cost benefit analysis that considers the efficacy of health promotion has tended to focus on benefits at the individual level, perhaps as a consequence of the difficulties inherent in calculating the many cross sectoral benefits of health promotion interventions. However, there is wide consensus (among those who adhere to modern premises of what constitutes public health) that promoting health and all that this implies (see section 2) is enormously beneficial in many complex and interrelated ways to the point that these benefits are accepted and repeatedly promoted and endorsed within international forums and by the European and global public health community.

Regardless of the math, there is no argument – health promotion is hugely cost effective relative to curative services - to be successful health promotion requires good technical and institutional infrastructure rather than large capital investments on physical infrastructure or equipment. Furthermore, recent experiences in the Ukraine have again demonstrably proven that not only are health promotion and communication cost effective in their own right, but also that other cost-effective public health interventions such as immunisation campaigns are dependent for their success on effective health promotion and communication strategies. In short, investing in health promotion represents money extremely well spent – for example, over recent years Australian public health authorities estimate to have saved at least two dollars for every dollar spent on programmes that promote tobacco cessation. This is not taking into account the wider social and economic benefits of falling levels of tobacco related mortality.

The historical evolution of western medicine is characterised by a reverence for bio-medical approaches to population health which has lead to situations where the efficacy of health systems is in some ways undermined by professional cultures that short-sightedly applaud bio-medical science and specialisation at the expense of lower cost interventions that can, over time, benefit *all* of society. Developments in bio-medical science have also, in parallel, engendered expansions in medically related commercial interests and multinational companies that supply health sectors with drugs, equipment and physical infrastructure. These interests employ many varied strategies to solicit the collusion of bio-medical practitioners and have vested interests in maintaining the status quo, or at least orientating health sector development in such a way as to not adversely threaten profits. However, while there is no doubt that advances in medical science have benefited children and adults all over the world, increased investments in health promotion will not only improve population health and result in better prospects for sustainable social and economic development, but will also reduce dependence on curative services and associated costs. This is particularly salient for the CEE/CIS countries where financial, technical and human resources are limited and as such governments and partners simply cannot afford to continue to allow health systems the luxury of orientating themselves disporportionately around curative services at the expense of public health.

This assessment has determined that although there are a limited (but not insignificant) number of individuals with the skills, intellectual breadth and commitment to make a significant contribution to health systems reform through

promoting health and facilitating effective communications in support of improved public health outcomes (within health systems and across sectors), they are not supported institutionally and are without most of the technical and financial resources they require to do this work. Further investments in training and education are essential but so also are investments that ensure that those with appropriate skills are enabled to drive health systems reform, and improved public health outcomes.

Other key findings of this assessment include:

- Many public health initiatives and almost all health promotion programmes are externally driven, and implemented in parallel to the day to day concerns of health sectors. This is sometimes also true of both public health policy development, and when it occurs, the implementation of public health policy.

- Beyond the need for health promotion for improved public health outcomes, there is a need to communicate to support health systems reform. Communication mechanisms between the various elements/departments within health sectors are rudimentary and communications between ministries in relation to public health objectives is almost non-existent. Approaches to system reform are often disconnected and there is a need to establish an enabling environment within health sectors for the communication of both the elements of health systems reform (including health promotion), and attendant processes.

- While support for health promotion is improving in some countries, health systems reform is still retarded by an overly demarcated and hierarchical professional culture that institutionally devalues modern notions of public health and denies a significant role for health promotion within reform processes.

- External assistance for health sector reform lacks coordination and does not adequately address the relationship between health systems reform and the reforms to public administration necessary to enable sector-wide health systems reform. Multilateral agencies and other development partners tend to institutionally pursue and promote their own priorities at the expense of more coordinated approaches that build an enabling environment. However, the increasing emphasis on the need for the reform of public health services demonstrated by, for example, cross sectoral interventions in support of Avian Influenza and HIV/AIDS prevention, have created awareness within health sectors that institutional reform is achievable and that modern approaches to public health service delivery are effective.

- Health promotion and communication lie at the very heart of systems reform and UNICEF is well positioned in the European context to leverage and facilitate a coordinated and strategic approach to addressing capacity deficits in this regard.

This assessment argues that the momentum achieved through support to Avian Influenza prevention and to health promotion efforts more generally (for example, with regard to bread fortification, exclusive breastfeeding, HIV/AIDS prevention, and general hygiene promotion) should not be allowed to wane. UNICEF - employing its kudos as a communications facilitator - should look to ways to leverage an increasing focus on the value of health promotion as an integral part of health systems reform, among partners and within governments. Key to ensuring sustainability will be corralling external support for emerging cohorts of public health professionals in

order that they can develop and nurture a nuclei for reform within health systems; lobby decision makers for expanded commitments to health promotion and public health; communicate reform processes, and indeed the value of communications in general, across the health sector and the arms of government; and provide, in collaboration with appropriate partners, technical leadership for health promotion interventions. In this context, development partners should explore opportunities to better channel support through public health authorities with the explicit intent of finding new modalities for external assistance that better support skills transfer, and cultivate institutional capacity development. As noted in a 2004 study commissioned by the European Observatory on Health Systems entitled Health *Systems in Transition: Learning from Experience*:

***One of the greatest challenges has been and continues to be the empowerment of those involved, so that the message that change is possible is conveyed and so that practitioners can develop a real sense of ownership of quality initiatives***

Leveraging and facilitating a scale up of external support for health promotion capacity development, and for improvements in the way that governments in the CEE/CIS approach internal and external communications, presents a very tangible opportunity for UNICEF to bolster, even accelerate, existing reform efforts. Using the full extent of communications modalities and approaches as an additional entry point – a Trojan horse – will allow UNICEF to improve traction in an increasingly diffuse and complicated social development context, and ultimately, in doing so, advance the child rights agenda through improving public health outcomes. In the light of UNICEFs recent work in support of Avian Influenza prevention and preparedness it has become clearer to UNICEF, governments and development partners that UNICEF has significant capacity as a communications agency. However, the assistance that UNICEF and partners provide must be reoriented, however painfully, to ensure that opportunities for sustainable capacity development are maximized.[3]

[3] Notwithstanding the views of the author of this report, it is the overarching and primary intention of this assessment to provide the basis for a lively and fruitful in-house discussion about how UNICEF might better orient its communications expertise in support of capacity development for improved health outcomes, and regional public health security.

# 1. Introduction

## Scope and Objectives

This report is based on an assessment of public health promotion and communication capacity in eight CEE/CIS countries that has comprised of a desk review and field work visits to Serbia, Moldova, Ukraine, Turkey, Uzbekistan, Tajikistan, Albania and Romania. The purpose of the assessment has been to broadly consider the capacity of health ministries in the above mentioned countries to: do health promotion work in support of improved public health outcomes; consider the capacity of health ministries/governments to do communications work in relation to Avian Influenza and pandemic influenza prevention and preparedness; and, to look at the role that communications might play as a change agent and driver of health sector reform. A consideration of these issues is justified not only by the inordinate burden of communicable and non communicable disease in the CEE/CIS, but also in the context of the considerable resources that have been invested over the last few years by UNICEF in support of Avian Influenza prevention and preparedness, and in support of communication initiatives targeted at improving public health outcomes, especially as they relate to children and women. It is also intended that this assessment will illuminate some options through which UNICEF and partners might build on these experiences and subsequently better support government communications efforts in support of public health and social development objectives.

Shortly after the emergence of Avian Influenza as a global threat UNICEF was designated as the lead UN agency responsible for assisting governments to do communications work for Avian Influenza prevention, and later on for Avian Influenza and pandemic/human Influenza preparedness. Partly as a consequence of these activities, and the funding that has been available to facilitate this work, the role that communication plays in the social development cycle, and as a part of UNICEFs work in general, is back on the organizations radar, both at headquarters and at the CEE/CIS regional office. What has been known as the *programme communication* function of UNICEF has been stimulated and revitalized through this work and questions are now emerging about what can be learnt from these experiences and what possible opportunities there are to step up UNICEF's role as a communications catalyst and facilitator for a range of communication initiatives, within governments and between partners, in support of social development objectives.

For these reasons, this assessment was designed to look at both government capacity to do communications in support of Avian Influenza prevention and human/pandemic preparedness, as well as the broader capacity of government health ministries to do communication work in support of public health. UNICEFs work in relation to Avian Influenza prevention and preparedness has frequently meshed with other programme communication objectives, particularly in the context of the institutional infrastructure and linkages utilized, and with regard to the working level partnerships that UNICEF and governments employ and nurture on a day to day basis to meet country programme and national social development objectives. For these reasons it was decided to use UNICEF's work in support of AI prevention as an entry point for a broader consideration of government capacity to employ strategic communications for Avian Influenza prevention, and for health promotion and communication.

## Methodology and Limitations

To inform this assessment a questionnaire targeted at assessing government health promotion and communication capacity and Avian Influenza prevention and preparedness was developed from a tool recommended by UNICEF headquarters in New York. The tool used is a questionnaire developed for an assessment of health promotion capacity in the Western Pacific. The questionnaire, piloted in several Pacific countries in 2006, was designed by the Public Health Department at La Trobe University in Melbourne, Australia, in collaboration with the WHO Regional Office for the Western Pacific. Although not ideally suited to the transitional health systems in the CEE/CIS region, this questionnaire was considered the best tool available for a broad assessment of health promotion and communication capacity. Before being distributed the questionnaire was revised and commented on by the Regional Health Advisor for the CEE/CIS and the Regional Communications Advisor.

The questionnaire was distributed to all CEE/CIS Country Offices; however, as a result of the heavy work load frequently experienced by programme staff at the country level, the questionnaire was completed by only 10 of the countries in the UNICEF CEE/CIS region. Of the 10 Country Offices that did complete the questionnaire, eight countries were also the subject of county visits in support of the overall assessment. For this reason it was decided that this assessment should focus on these eight countries, rather than as originally planned the region as a whole. However, for a number of reasons that will be addressed later on, including the fact that all bar one of the countries in the UNICEF CEE/CIS region inherited a soviet style centrally administered health system, the findings of this assessment can be considered as broadly indicative of a range of problems and opportunities that face health systems, and of their overall capacity to do health promotion and communications work in the CEE/CIS.

Specific guidelines for the completion of this questionnaire were forwarded to all country offices but these guidelines were adhered to haphazardly. Specifically, country office staff members were requested to complete the questionnaires in collaboration with ministry of health counterparts but time constraints and the lack of lead time available for this work resulted in some of the questionnaires being completed by country office staff prior to country visits, or during the country visits. Nevertheless, it is arguable that the answers provided have been less subjective as a consequence; in fact it became evident that the questionnaires completed by UNICEF staff offered in most cases a more objective assessment than those that were completed in collaboration with ministry of health counterparts who were inclined to offer a more upbeat, but not necessarily accurate, assessment.

In any case, the questionnaire was intended as a subjective tool and has not provided results that can be considered as empirically sourced or indisputable. However, the questionnaire provided a very useful and consistent framework for discussions with UNICEF country office staff and government counterparts that has resulted in some clearly observable trends and a good range of anecdotal evidence. To inform this assessment, discussions were held with UNICEF country office Staff (Communications Officers, Health Programme Officers, Deputy Representatives, Representatives and consultants working in communications and health related areas); representatives from the European Union and its agencies, representatives from the US Agency for International Development, the World Bank, UN Systems Agencies, particularly WHO and UNFPA; from private and publicly owned media agencies; as well as government counterparts from national Avian Influenza prevention coordinating bodies, health ministries, institutes for public health, and, where they exist, health promotion departments or centres within these institutes.

This assessment can be considered as preliminary for a number of reasons, none the least being the limitations inherent in a sole researcher attempting to carry out an assessment of such wide reaching objectives within a relatively short time frame. Other limitations include: the short period of time allocated for project planning and design; the relatively brief (approximately 2 days) amount of time spent in each country and the limited opportunities for follow up, cross referencing and more wide ranging discussions that this allowed; the diversity of the sometimes contradictory information that was provided; the fact that some of the information provided is unverifiable; and, that at times confusion and inconsistency was in evidence among UNICEF staff and government counterparts vis-à-vis some of the key issues that are the subject of the assessment. For example, modern concepts of what 'health promotion' actually entails are not *consistently* understood in the CEE/CIS, either by government counterparts or by UNICEF staff. For the former, health promotion work is often termed as 'propaganda' within the mantra of post soviet health systems, and for the latter; health promotion is broadly perceived of as being related to the *programme communication* functions of UNICEF which are detached from the more far reaching and reformist notions of health promotion (as set out in the global framework established by the 1986 Ottawa Charter and updated by its successor, the 2005 Bangkok Charter). For UNICEF and its staff *programme communication* has since the 1990s been a supportive addendum to mainstream development programming and consequently some of the links between programme communications (or communication in support of social development programmes) and what is currently recognised to constitute modern health promotion work, have been missed.

There have been no previous attempts by UNICEF or WHO to map government health promotion and communication capacity in the CEE/CIS region and therefore this assessment has been constrained by the lack of a body of existing evidence that could guide planning and implementation. As far as could be ascertained, the only other assessment that has looked at similar issues in the CEE/CIS region was completed in 2005/06 as part of a broader capacity building project administered by the Euro Health Network and funded by the European Commission. This project entitled *Building Capacity for Public Health and Health Promotion in Central and Eastern Europe* included a broad assessment of health promotion capacity in 11 central and eastern European countries, one of which (Romania) is also covered by this study. The assessment conducted by the Euro Health Network used a similar methodology in as much as they utilised a questionnaire and in-country discussions to explore capacity. However, the Euro Health Networks assessment benefited from being better resourced to conduct country level assessments in a more detailed manner, which afforded assessments of health promotion capacity at the sub-national level, and extended interpersonal interactions between the research and project implementation team and government agents that facilitated a more in-depth analysis than that which has been possible within the scope of this assessment.

Nevertheless, despite the limitations described and the perhaps somewhat cursory nature of the findings presented, some clear patterns do emerge, as do some quite salient options for UNICEF vis-à-vis taking this work further at both the country and regional levels.

## Report structure

This report comprises of a main narrative text and a set of annexes. These annexes include: 1) the terms of reference for this assessment which were distributed to UNICEF country offices prior to country visits; 2) eight individual country reports

which, bearing in mind inconsistencies in the information available and/or offered by informants (for example, comparisons with EU averages and health sector expenditure data), attempt to set out in a consistent fashion the key information garnered as it relates to the capacity of these individual countries to do health promotion work, and with regard to communications in support of Avian Influenza and pandemic influenza prevention and preparedness; 3) the text from the Ottawa Charter on Health Promotion; 4) a glossary of key terms relating to Avian Influenza prevention and preparedness (defined by the author of this report) and to health promotion and health promotion capacity (adapted from terms defined in the supporting documents that accompany the capacity mapping tool developed by La Trobe University and WHO); and, 5) a set of links to key resources and further reading.

The narrative part of this report draws out the clear patterns that have emerged over the course of the assessment and discusses the future role that communications might play within CEE/CIS health systems and as a part of UNICEFs contribution to the social development agenda. Section 2 of this report briefly looks at what health promotion and communication embody; the elements of health promotion and communications capacity; and, responsibilities and accountabilities in regard to the effective development and employment of these elements. Section 3 discusses how the transition has impacted on health systems. Section 4 presents the responses to the questionnaire for the eight CEE/CIS countries covered by the assessment and discusses these responses in the broader context of the discussions held with informants and the information presented in the Country Information Reports. Finally, Section 5 of the narrative considers: a) the reform of public health systems and international development assistance; b) current development policy directions and partnership opportunities; and, c) some practical options as to how UNICEF might advocate for assistance to health ministries that builds capacity for employing communication and communicative modalities as a means to improve public health outcomes, strengthen preparedness in the face of emerging public health threats, and catalyse social development per se.[4]

[4] The narrative part of this report does not assess in any detail the burden of disease in the CEE/CIS region or the situation with regard to Avian Influenza. These issues are adequately covered in a range of other documents, some of which are referred to in annex 5. The country reports (annex 2) do however attempt to look at the leading causes of morbidity and trends in relation to child mortality for each of the eight countries. In addition, it is not the intention of this assessment to review UNICEFs communications work in support of Avian Influenza prevention or health promotion initiatives.

# 2. Background – Health Promotion and Communication, Capacity Mapping and Responsibilities

## What is Health Promotion and Health Communication?

While behaviour change communication and programme communication are critically important strategies through which public health outcomes can be achieved, it is important to recognize that health promotion represents a much broader and more ambitious set of concepts. Health promotion lies at the very core of what public health is understood to represent, that is: *the organized response by society to protect and promote health, and to prevent illness, injury and disability*.

Health promotion began to gain acceptance worldwide following the launch of the *Ottawa Charter for Health Promotion* (see annex 3) at the First International Health Promotion Conference, held in Ottawa, Canada in 1986 and organized by Health and Welfare Canada and the Canadian Public Health Association, in collaboration with the WHO. The Ottawa Charter which resulted from deliberations and discussion at this conference builds upon the *Health for All* strategy and the *Alma Ata Declaration,* and formally introduced into a debate that had been largely dominated by biomedical approaches, a focus on health and its determinants.

The Ottawa Charter, reinforced by a series of WHO supported international conferences on health promotion, defines health promotion as – *'the process of enabling people to increase control over the determinants of health and thereby improve their health. To reach a state of physical, mental and social well-being an individual or group must be able to identify and realise aspirations, to satisfy needs and to change or cope with the environment'*

The Ottawa Charter describes five key action areas for promoting health that when employed in combination, drive improved health outcomes. These action areas are:

1. Developing healthy public policy
2. Creating supportive environments
3. Strengthening community action
4. Developing personal skills
5. Reorienting health services

Underpinning these action areas are five key principals that must guide health promotion strategies. These are:

***Health promotion is context driven:***
Promoting health requires good knowledge about the interface between health and its determinants and social epidemiological skills for analyzing socio-economic, gender and ethnic gaps in health and disease patterns in populations.

***Health promotion integrates the three dimensions of WHOs definition of health:***
Promoting health requires addressing the multi-dimensional nature of good health: physical, social and mental.

***Health promotion underpins the responsibility of the state in promoting health:***

All levels of government have responsibility and accountability for protecting, maintaining and improving the health of citizens and as such must include health promotion as a major component in all undertakings.

***Health promotion champions good health as a public good***
Good health benefits the society as a whole and fosters social and economic development.

***Participation is a core principle of promoting health***
The participation of individuals and communities in improving and controlling the conditions for health is a core principle for promoting health. Improved health literacy brought about by health education will result in people being better equipped to contribute to participatory processes that support health promotion.

***Good health, the product of health promotion, is a human right***
The right to health is related to human rights as expressed in international human rights covenants including the Convention on the Rights of the Child.

## What is Health Communication?

Health communication has two main pillars: the use of, and access to, communications mediums (for example, television, radio, newspapers and other mediums that are often referred to as information, education and communication materials such as brochures and leaflets) to convey health promotion and preventative health messages; and, communication strategies that are employed to influence the decisions of individuals, groups, organizations, and communities to support health promotion and good health. Health communication should therefore enable health promotion and can include a range of activities, including;

- Advocating for health promotion and preventative health strategies within government and across sectors
- Educating individuals, organizations and decision makers about the value and good sense of health promotion, for example, through cost benefit analysis and media campaigns that target public awareness
- Lobbying for increased resource allocation in support of preventative health strategies
- Communicating health systems reform within government and the central role that health promotion must play in health systems reforms
- Collating, evaluating and disseminating information to support health systems reform and modern approaches to improving health outcomes

In many ways communicating for health, or health communication, is an integral part, or even pre-condition, for effective health promotion and in this sense the concepts of health promotion and health promotion capacity should be considered as concepts that also embrace health communication work and capacity. However, for practical reasons, health communication deserves to be demarcated because in doing so a role can be defined for advocates and coalitions who – within the context of governance, public administration reform, social development and the efforts of multilateral agencies and donors – can fulfil important roles, including, lobbying for health promotion and other elements of reform that are in the interests of public health and as such, society as a whole. Health communication therefore refers to both the means by which good health is promoted; and, the means by which health promotion is itself explicated and promoted.

## What is Health Promotion and Communication Capacity?

Health promotion capacity refers to the various pre-conditions for effective health promotion, including actions that bring about changes in social, economic, cultural and physical conditions, and actions that strengthen the understanding and skills of individuals and groups in ways that support their efforts to achieve and maintain health. A system that is conducive for effective health promotion brings together these various elements and can be depicted as having four key domains. These are:

- Governance
- The policy environment
- Systems infrastructure and resources
- Programmes and services

Good governance and political leadership is the key to effective health promotion. Within this domain the following conditions are required: a firm mandate and authority supporting health promotion and its role in health systems reform; strategic vision and leadership; links, relationships and *communication between* and within institutions and organizations; and, processes that make it possible for stakeholders, including the public, to take part in dialogues and decision making processes that relate to determining priorities and courses of action.

Fundamental to the implementation of effective action but not a substitute for effective action, as is sometimes the case, is a supportive policy environment. A supportive policy environment implies not only good policies but programmes and plans that determine: which issues will receive priority; responsibilities and accountabilities; the distribution and allocation of resources; and, expected results.

Essential to effective action is the availability of adequate resources. A skilled workforce, connected organizations and bureaucratic mechanisms, accessible data and information, *communication systems* and of course adequate funding are all prerequisites for effective health promotion.

A framework of programmes and services operating within and outside of the health system is needed to support the policies and plans that direct action, and requires responsibilities and accountabilities to be allocated for impact and results.

**NB:** While community capacity is a key dimension of overall national capacity for health promotion, it is beyond the scope of this assessment to address this complex topic. Attention could be given to community capacity as a part of country level capacity assessments.

***Health communication capacity*** cuts across all of these areas and is a central function that binds these elements together. The capacity of governments, actors and coalitions within governments to do health communications is what ensures that these resources and elements are attained and combined in a productive way that produces results.

## Roles and Responsibilities

Governments, health ministries and other stakeholders have complimentary roles and responsibilities with regard to facilitating and executing health promotion and communications work, including communications work in support of Avian Influenza prevention.

Stakeholders (including for the CEE/CIS region: multilateral agencies; bilateral donors; multilateral donors such as the European Union, the World Bank and the Asian Development Bank; non government organisations; civil society organizations; and communities) have a vital role to play in supporting national governments and health ministries to do health promotion and communications work. Communities and civil society have a particularly important role to play in assessing health determinants and setting national and local priorities. Non government organisations can also assist in these tasks as well as deliver health promotion and other health services in situations where their activities are tolerated, and/or health sector capacity is limited. Development partners can provide support that might include helping to establish institutional mechanisms that drive health promotion and communications; leveraging and/or providing resources; and providing assistance in relation to research into health determinants, planning, funding, implementing, monitoring, evaluating and advocating. The challenge for health ministries and development partners interested in advancing the health promotion and communications agenda is identifying which institutions, organizations and individuals are interested and committed, and determining how alliances can be formed and maximized for capacity development, and ultimately improved health outcomes.

However, health ministries and frequently departments, institutions or even working coalitions within health ministries have the primary role to play in advocating at the highest level for increased investments in health promotion and for health promotion capacity development within the health sector. This involves promoting the economic and social value of health promotion and the cost benefits that accrue. In countries where modern health promotion strategies are well established, health ministries have responsibility for ensuring that the necessary infrastructure and knowledge is available and adequately resourced and developed to enable effective health promotion work. In countries were capacity is known to be limited there is a need to promote the value of conducting in-depth *national level* assessments of the capacity of health systems to do health promotion work and to ensure that meaningful links are established between capacity needs and capacity development strategies.

# 3. Background – Health Systems in Transition

The years since the break up of the Soviet Union have brought enormous political and socioeconomic change and health sectors have not been spared the effects. All bar one of the countries that are the subject of this report (Turkey), and indeed 21 out of the 22 countries within the CEE/CIS region have since the 1990s, transitioned from centrally planned command driven economic and political systems to open market economies. Former Soviet satellite states Serbia (part of the former Yugoslavia), Moldova, Ukraine, Uzbekistan, Tajikistan, and Albania all inherited Soviet style centrally controlled Semashko health systems. Romania which was not a Soviet satellite but nevertheless was ruled, prior to transition, by a series of communist governments, also inherited a health system that was largely based on the Semashko model, although contains elements of other models such as the Bismarck health system model. While Turkey is the only country a part of this assessment that does not have a health system based on the Semashko model, it shares many features common to the health care systems of the post transition countries, perhaps as a consequence of being governed for a long time like a communist country and being surrounded by communist countries. These include a high degree of medical specialisation (particularly in Istanbul and Ankara); inefficient service delivery; a lack of adequate preventative services; a lack of accountability and transparency; and an inadequate allocation of resources to public health strategies, including health promotion.

The public health system established in the Soviet Union in the 1920s and 1930s did have some important achievements, in part because of the high *political* priority afforded to population health, something which, unfortunately, is largely absent today. The seriousness with which the threat of disease was regarded is illustrated by Lenin's pronouncement in respect of typhus that *"If communism does not destroy the louse then the louse will destroy communism"*. Many of the older health ministry staff interviewed for this assessment described efforts towards health education work in Soviet times and how for many countries with post-Semashko health systems physicians and other health workers were, and still are, required, within their professional terms of reference, to devote some 30 per cent of their time to health education. However, since the transition, these functions, while still existing on paper, have all but ceased to be implemented as a consequence of the diminishing resources that transitional health systems have endured in the face of the free market capitalism that has undermined the structure, rationale and processes of bureaucracies inherited from the Soviet system. This is not to suggest that modern notions of health promotion were understood, but rather that at least the health system was able to independently implement preventative strategies, however elementary they may have been, and that the system worked much better than it does now because it was designed to function under the auspices of a centrally planned communist system.

In all former communist countries, as a consequence of market forces, the size and influence of government has decreased significantly. Although this is a predictable, even necessary, consequence of the transition, rapidly growing, almost Wild West (or Wild East) free market forces have unravelled the positive attributes of the Soviet modelled social sectors. Ways of doing business have been revolutionised but outmoded public administrations have struggled to remain viable and sustain service delivery, especially for those who have not benefited from increasing wealth – the socially marginalised, ethnic minorities, and the elderly and children from within these groups.

The extensive but obtuse and rudimentary health systems inherited from the Soviet era were, and to lesser extent still are, typified by an oversupply of doctors and curative specialists; a large and inefficient hospital sector; a rigid demarcation between professional groups; and, an inappropriate mix of skills. In addition, the command and control nature of Soviet inspired systems, which many initially thought might of paved the way for health systems reform, has actually hampered efforts as those in positions of leadership – usually specialists – have been reluctant to delegate decision making to small but emerging cohorts of multi-skilled professionals trained in public health and/or strategic planning. Within Soviet style health systems and the hierarchical medical culture that has prevailed, practicing public health was seen as being of low status where as curative specialisation was the path to reverence, status and career success. The legacy of these pervasive values and of a political system that maligned independent thinking continues to retard reform in post Semashko health systems. Even in Western health systems where public health has been a topic of debate for some time, and has had an increasing level of influence on health policy reform, doctors, particularly specialist doctors, can have a tendency to conduct themselves is if they are in some way ordained and therefore irreproachable – a professional culture that has arguably been consistently exploited by multinational pharmaceuticals.

Before 1990, responsibility for public health and preventative services in most CEE/CIS countries was vested in the highly centralised Sanitary-Epidemiological (Sanepid) services and focused on a traditional and limited core of activities haphazardly related to modern public health practices. Perhaps the most tangible achievement of the Sanepid system was its contribution to vaccination programmes, child health and communicable disease control. However, the Sanepid system was relatively ineffective in combating problems such as environmental pollution, occupational health and non-communicable diseases. The system was also unable to produce quality information that might have allowed public health specialists to assess health determinants and public health needs, or to respond to emerging patterns of ill health. Finally, apart from didactic health education programmes in schools, the Sanepid system was ill-equipped to engage with the public to promote health or leverage behavioural change.

Public health services did undergo a series of changes during the 1990s including the decentralisation of services, a patchy reform of primary health care services, and the reconfiguring of the Sanitary-Epidemiological services into Institutes for Public Health. However, these were not system wide reforms and when coupled with a decline in funding for the Sanepid services, led to deterioration in the quality of functions that were previously successful such as communicable disease control.

Health promotion has of late been ascribed the status of a core public health priority, on paper at least, but preventative strategies have been largely externally driven focusing on drug users, HIV/AIDS, more recently Avian Influenza prevention, and other issues that often reflect the public health priorities of international agencies such as UNICEF and UNFPA, bilateral donors and NGOs working in the sector. There is also a relative lack of cross-sectoral engagement in support of public health which is a consequence of ministerial and departmental territorialism and a medical culture that posits population health as being achieved through curative rather than preventative services. In addition, there are explicit problems with adopting and enforcing public health legislation that creates conflict with key interest groups like, for example, the tobacco industry which has been known, in collusion with senior politicians, to obstruct the introduction of advertising bans and tax increases on tobacco products. Another example is the endorsement of anti-vaccination campaigns in the Ukraine by senior health sector officials who are suspected of being

on the payroll of homeopathic companies purporting to offer the public ‘less harmful’ alternatives.

Currently health systems in most CEE/CIS countries are unable to cope with the complex challenges faced. As noted in the introduction, these challenges include: the inordinately high burden of non-communicable diseases such as cancer and heart disease caused by poor diets and rising levels of alcohol and tobacco consumption; infections diseases that are returning in much more complex guises, such as HIV/AIDS, sexually transmitted infections and drug resistant tuberculosis; and, emerging public health threats like Avian Influenza and its potential to mutate into a human influenza virus. Unless efforts by the international community to support the few beleaguered government health sector staff with the commitment and skills to drive reform processes are significantly ramped up, the longer term prospects for improved health outcomes and sustainable social and economic development will be undermined.

# 4. Results from the Capacity Mapping Questionnaire and Some Key Issues for Discussion

## Preface

As mentioned in the introduction to this report, this assessment of health promotion and communication capacity is a preliminary assessment that has not benefited from a body of prior work that could have informed the assessment. The questionnaire used – the results of which are presented below – was considered by UNICEF headquarters to be the most appropriate tool available to inform an assessment such as this. However, in practice the questionnaire proved much more functional as a framework to guide in-country discussions with health sector counterparts than it has as a tool that could elicit data that is any way quantifiable. The 1 to 6 capacity scale (see below) that represents a range of situations which start from a point where an element of capacity is not at all developed and move to a point where capacity is fully developed and functioning well is open to arbitrary responses and subjective reasoning. Consequently, some of the initial responses have been modified on the basis of anecdotal evidence relayed by informants during the course of the country visits and internal cross referencing. In this context responses along the 1 to 6 capacity scale are best considered as indicative. If this assessment should lead to country level health promotion and communication capacity assessments, which is one possible follow up strategy recommended by this report, then it would be prudent if this questionnaire were collectively revised to better reflect realities on the ground.

Also presented in this section is a range of contextualised anecdotal evidence that was garnered throughout the course of in-country discussions. This evidence, while not entirely verifiable, nevertheless supports in a relatively consistent fashion the general pattern of results that have emerged. In any case, it was never the intention that this assessment should provide solid empirical data but rather determine clear trends and raise questions about how UNICEF might better direct communications support to governments in the CEE/CIS. Overall the questionnaire has greatly assisted the realisation of these objectives, regardless that some of the fields of inquiry seem in hindsight, perhaps a tad out of context - this is in part reflected by the depth of responses obtained for some fields of inquiry and the relative lack of information available for others which in itself is indicative of the fact that some elements of health promotion capacity are so underdeveloped that there simply is little that can be said about them. A revised questionnaire might benefit from a structure that implicitly recognises that some elements of capacity are clearly absent or extremely limited and as such places more emphasis on lines of inquiry that would reveal in more detail the characteristics of elements that are present. However, given that the elements of capacity delineated below are considered as integral to health promotion capacity, the very absence of some capacities needs to be noted.

The discussions below attempt to consider evidence from the eight countries that are the subject of the assessment as being indicative of *regional* trends vis-à-vis health promotion and communication capacity. For more detailed country level information please refer to the individual Country Information Reports that are presented as Annex 2. These Country Information Reports are structured around the clusters of inquiry which are the main focus of the questionnaire and also contain additional summary information on the burden of disease, child mortality trends, health sector expenditure as percentage of Gross Domestic Product and development assistance in the health sector.

## National Mandate for Health Promotion

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| MoH has a mandate for health promotion that is expressed through policy legislation and national budgetary allocations | 5 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| MoH has a department dedicated to health promotion | 6 | 4 | 2 | 3 | 4 | 5 | 5 | 4 |

In all of the eight countries visited health promotion is to some degree mandated as a public health priority in health policy, which can include public health strategies, national action plans or presidential decrees relating to health reform. However, while these policies are in some countries supported by legislation, the budget allocations for public health or health promotion are indeterminate. In fact only Turkey and Romania have specific budget allocations for health promotion programmes but informants were unable to suggest the amount of funds allocated. Were countries do have budget allocations for health promotion departments, or other bodies with health promotion functions, they usually only cover operational costs such as salaries. This is largely due to the fact that most health promotion initiatives are externally driven and funded by bilateral donors and multilateral agencies. Examples of national policies that express mandates for health promotion are listed below.

- ***Serbia*** has a Strategy and Action Plan for Health Care Reform prepared in early 2003 following the adoption of the Health Policy of Serbia and the development of the Serbian Health Vision. This Strategy and Action Plan addresses public health in some detail.

- ***Moldova*** has a 2007 to 2011 National Health Promotion Strategy. This strategy is unfunded and has little support outside of the Moldovan Institute for Public Health.

- ***Turkey*** has a 2003 National Health Strategy which addresses public health.

- ***Uzbekistan*** has recently developed, with assistance from the World Bank, a National Public Health Strategy for 2008 to 2012. A national level steering committee is planned to coordinate implementation.

- ***Tajikistan*** has a National Health for All strategy that was developed with assistance from the WHO in 1995 but has remained largely policy on paper.

- ***Albania*** has a Public Health Strategy that was developed in 2003 by the World Bank and the UK Health Education Authority. This strategy has never been allocated funding and consequently remains unimplemented.

- ***Romania*** also has a Public Health Strategy developed with the assistance of the World Bank but it so far remains without an accompanying action plan or a budget line.

In Ukraine the health ministry is so beleaguered by political flux that policy development has been severely compromised.

Even though for most countries health promotion is addressed within national policy the development of this policy is often externally driven, as has been the case with World Bank assisted Public Health Strategies in Uzbekistan, Albania and Romania. Often international consultants are recruited by agencies to develop policy in consultation with health ministry officials but consultative processes are sometimes inadequate or jettisoned as a consequence of external pressures to complete the work. For example, in Romania an informant who had previously been the Chief of the Department for Communicable Diseases at the time the Public Health Strategy was being drafted claimed that she was not consulted at any time during the development of the draft. That being said, pressure from international development partners does have a positive impact on policy development although more needs to be done to enable implementation and engage with partners in policy development.

Specific departments for health promotion, where they do exist, usually fall under the auspices of Institutes for Public Health. Serbia has a *relatively* effective National Centre for Health Promotion with regional branches; Moldova has a national network of Centres for Preventative Medicine that have responsibility for health promotion; Ukraine health ministry officials would like to establish a department for health promotion to coordinate work that is always externally driven and ad hoc but have no resources or political backing to do so; Turkey plans to establish, in 2008, a Department for the Promotion of Health Development under the control of the General Directorate of Primary Health Care and apparently has a budget to do so; Uzbekistan has a Unit for Health Promotion and Education under the auspices of the Institute for Public Health but it, and the Institute, suffer from a chronic lack of resources and skilled personnel; Tajikistan has a Health Lifestyles Department which was established to assist with the implementation of externally funded projects; Albania has a Health Promotion Department also under the auspices of the Institute for Public Health but it has no funding beyond the minimal levels required to pay salaries; and Romania has a plan to establish a health promotion programme under the National Agency for Health Programmes and apparently a budget line has been allocated for this purpose.

During the course of this assessment it became clear that even when there is a department or unit with specific responsibility for health promotion this department is often bypassed when health promotion strategies are implemented. For example, national HIV/AIDS coordinating bodies have been engaged in some countries to implement health promotion initiatives in support of HIV/AIDS prevention, rather than this work being implemented through health promotion agencies within public health institutes. Another problem is that the health promotion departments have often been established as a result of external pressure. This can also be said of the reconfiguring of the Sanepid services into Institutes for Public Health which occurred partly as a consequence of donor frustration at the lack of health sector capacity to design and implement public health initiatives. In Tajikistan a National Centre for Health Promotion was established in 1999 at the behest of WHO which at the time was more vigorously advocating for a cross-sectoral and coordinated approach to health promotion. This department is now defunct. It is worth noting that within the Semashko medical bureaucracy a department can constitute merely two or three people and an office without any resources or strategic plan. The establishment of

departments in this context can represent, for example, the ambitions of individuals or a group of individuals, rather than a dedicated attempt to pursue a set of objectives or a strategy.

Ownership is therefore an issue of some concern and it is clear that health ministry counterparts often feel that projects and initiatives reflect the priorities of external partners rather than priorities determined by government. Universal Salt Iodisation, important as it is, was noted in Uzbekistan as being perceived as a UNICEF concern.

## Strategic Vision and Leadership

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| **Vision statement –** MoH and/or government expresses the role of health promotion in achieving the vision for improved population health in s strategic vision statement | 4 | n/a | 4 | n/a | 3 | 3 | 2 | 3 |
| **Endorsement of equity in health** – MoH and/or national government endorses equity in health as a major priority within the strategic vision statement | 5 | 5 | 4 | 5 | 5 | 5 | 5 | 5 |
| **Political leadership** – There is visible and convincing political leadership for health promotion | 4 | 2 | 1 | 4 | 2 | 4 | 3 | 4 |
| **Professional leadership –** There is visible and convincing professional leadership for health promotion | 5 | 3 | 1 | 3 | 3 | 4 | 3 | 5 |
| **Technical leadership –** There is visible and convincing technical leadership for health promotion at all levels | 5 | 4 | 1 | 3 | 2 | 3 | 4 | 4 |

A vision statement that articulates the role of health promotion implies a fairly sophisticated and modern understanding of the positive role that health promotion plays in improving health outcomes, and more broadly in support of social and economic development. Countries visited do not articulate such a vision beyond references to the importance of health promotion in national health policies, strategies and programmes.

Equity in health is widely endorsed in the CEE/CIS region as a consequence of inherited Soviet values that have always posited equity as important, even if in reality inequity is on the rise, including in relation to access to services. WHO policy drives such as the *Health for All* initiative have also ensured that notions of equity are paid due attention in policy documentation.

In terms of professional and technical leadership, which are for the purposes of this assessment sufficiently related to be grouped together, there is evidence that some health sector personnel advocate for health promotion and have the technical skills to articulate concepts of health promotion within the health sector. Some health sector personnel have received training in public health and health promotion but these personnel generally lack the authority, within the prevailing medical hierarchy, to assert a major influence on health systems policy or budget allocations. As noted previously in this report, there is a culture of medical specialisation within the CEE/CIS countries and most personnel in senior positions within the health sector are specialist doctors who hail from a conservative tradition of curative medicine and have had only limited exposure to modern concepts of public health. Even when authority figures within the health sector have developed an acceptance of the value of modern public health services they are often reluctant to promote the reorientation of services in such a way that would render their own expertise and world view less relevant. Within the inherited soviet political and bureaucratic legacy there is a tendency to pursue personal aggrandisement as a means for self preservation and supplementary income generation. This culture obstructs free, fair and productive flows of information.

Many health ministers in the CEE/CIS are former doctors, often specialised doctors. These ministers are, like specialised doctors in positions of authority, often reluctant or unable to provide the political leadership that can shift the orientation of health services. Interestingly, in countries such as Albania and Romania where the health ministers are both former economists and are therefore perhaps better able to understand the cost benefits of preventative health strategies, it would appear that health promotion is being afforded a much higher priority. In Romania the health minister is reportedly fed up with resources being unproductively expended on curative approaches to non-communicable diseases with no visible results and has recently called for a strong strategic focus on health promotion and preventative strategies. In Albania, where the Health Promotion Department within Institute of Health has no real authority or capacity to make decisions independent of the Ministry of Health, the Minister instructed the Ministry to establish a post for a health promotion focal point within the Ministry. This person is tasked with establishing a data base of past health promotion initiatives and with considering possible strategic approaches to raising the profile of health promotion as a key priority for action within the health sector. Other examples of positive movement include a reported recent proclamation by the President of Uzbekistan that ways must be found to ensure that all doctors and nurse develop health promotion capacities; and the consistent focus on public health that has been demonstrated by the Serbian Health Minister who is widely respected as a leader who has overseen significant health sector reform since 2000.

On a less positive note some UNICEF staff commented that proclamations about the importance of health promotion in Tajikistan, for example, can be somewhat hollow and are not backed up by budget and other resource allocations. Similarly, many countries in the region are signatories to regulatory instruments such as the WHO Framework Convention on Tobacco Control, but in reality do little to curb tobacco consumption.

However, in some of the countries visited there is a sense that the level of political leadership for health promotion is gaining ground as cumulative frustration with medical specialisation and ongoing external advocacy for preventative health strategies are gaining traction and slowly creating a momentum for change. However, this momentum lacks focus and those who are best positioned to advocate for change are not supported by development partners in a manner that is altogether

sustainable. There is still a long way to go and upstream strategies to educate leaders about the social, economic, health and cost benefits of preventative strategies are urgently needed.

As an example of how important and effective political will can be in leveraging change it was noted that unlike all other CEE/CIS countries visited for this assessment, Albania has introduced a total ban on smoking in restaurants and bars. This development reportedly occurred as a consequence of an order introduced by the former Albanian prime minister who is an ex-smoker and has obviously enjoyed first hand the benefits of smoking cessation.

## Institutional Links and Relationships at the System Level

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| There are formal mechanisms in place to support the institutional links and relationships required for effective health promotion | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| - between the MoH and national radio and television networks | 4 | 3 | 3 | 4 | 4 | 5 | 4 | 4 |
| - between the MoH and other sectors | 2 | 4 | 4 | 4 | 3 | 4 | 4 | 4 |
| - between MoH and the national Parliament/Legislature (upstream communications to the political level) | 4 | 4 | 4 | 5 | 4 | 4 | 5 | 4 |
| - between MoH and donor sectors (e.g. UN system agencies, WB, EU) | 5 | 5 | 4 | 4 | 5 | 4 | 5 | 5 |

This field of inquiry relates to health communication, or communication in support of health promotion – responses above reflect the embryonic state of cross sectoral approaches within governments in the eight countries visited.

In terms of formal mechanisms being in place to support health promotion all countries stated that these were only partially in place. Formal mechanisms in this context can include inter-departmental committees that are not working under the constant threat of being dissolved as a part of a political shakedown or arbitrary reorientation of priorities as seems to often occur in the Ukraine; or, other mechanisms that facilitate inter-departmental communication and information sharing in support of health promotion. Generally formal mechanisms are not in place to support inter-ministerial or inter-departmental cooperation and what cooperation does occur is ad hoc and often associated with externally driven work around issues such as Avian Influenza prevention. In Albania, for example, informants reported that there are a lack of regular information exchanges between the Institute of Public Health

and the Ministry of Health and that there is little collaboration between departments on health promotion concerns – departments within the health sector have been known to bypass the Health Promotion Department within the Institute of Public Health and plan their own campaigns as part of externally funded projects that are under their particular jurisdiction. Despite best intentions, health promotion departments or agencies, where they exist, often lack the authority to properly coordinate all the health promotion activities that occur or to assert their technical authority.

In terms of inter-ministerial communication the situation is even worse with territorialism and the competition for resources obstructing progress. In countries like Serbia and Ukraine where governments are comprised of an ever-shifting coalition of political parties and individual ministries can become dominated by one political party or another, inter-ministerial communication is often perceived as being, as one informant put it, 'the work of the devil'. Ironically, two of the poorest and most aid dependent countries visited for this assessment – Uzbekistan and Tajikistan – reportedly have relatively good mechanisms in place for inter-sectoral and inter-ministerial communication, perhaps because governments in these two countries are single party governments and relatively stable, and also because of the high levels of donor and agency engagement in the health sector which acts, sometimes unintentionally and sometimes intentionally, as a driver for communication in support of health systems reform.

Generally in post Semashko health systems inter-departmental and inter-ministerial communication has been driven by external engagement on issues such as HIV/AIDS, mother and child health and Avian Influenza Prevention. For example, collaborations between the Ministry of Education and the Ministry of Health have been noted to occur in relation to the WHO Health Promoting Schools Network and in relation to the significant resources that have been expended in support of Avian Influenza prevention. One of the important achievements resulting from external assistance directed in support of Avian Influenza prevention has been the establishment of multi-sectoral task forces and support to improved collaborations between agriculture and health ministries, although in some countries where funding for this work is drying up, these collaborations are starting to unravel.

Donor coordination and cooperation between external partners and the Ministry of Health are key overarching issues that have arisen out of this assessment and will inform some of the recommendations that are offered in the conclusion. However, for the meantime it is worth noting that it is clearly felt among both UNICEF staff and health ministry staff that there is much room for improvement. Despite commitments that have been made to support national development priorities in articles such as the Paris Declaration on Aid Effectiveness, donors and agencies in the rush to expedite funds, continue to push their own priorities and in doing so can undermine sustainability and capacity development. Clearly much good work is done and much experience is shared but opportunities for a more systemised approach to capacity development and priority setting are not always maximised.

Informal cooperation between development practitioners, and between donor, agency and health ministry staff – often supported by strong inter-personal relationships – is in many cases excellent and frequently supports the achievement of positive and improving social sector outcomes. However, the same can not always be said about how the regional and global priorities of bilateral donors and multilateral agencies play out on the ground. Overlap, duplication, bypassing, and a lack of consultation between actors working in the health sector are frequent occurrences. Especially when resources for a particular public health concern are

abundant, as has been evidenced with efforts in support of Avian Influenza and HIV/AIDS prevention, confusion is rife about who is doing what and who should be doing what.

By way of example, an Avian Influenza prevention desktop simulation exercise was recently (January 2008) organised for government counterparts in Tirana, Albania by FAO headquarters in Rome, WHO headquarters in Geneva and USAID in Washington. Although, the division of labour for UN Systems Agencies clearly demarcates responsibility for communications issues to UNICEF, UNICEF was not consulted either at the regional or country level in regard to preparations for this simulation exercise. Perhaps as a consequence, communications exercises were not given adequate attention within the exercises undertaken. Externally funded health promotion initiatives are also often badly coordinated and implemented in ad hoc manner which does little to build government capacity – one health ministry informant in Romania suggested that health ministries in the CEE/CIS pay little attention to conducting health promotion campaigns because UNICEF, UNFPA and others seem so eager and happy to do it for them.

## Policy and Planning (Participation)

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | **Not developed** | **Not developed but need for increased capacity recognized** | **In early stage of development** | **Partially developed** | **Fully developed** | **Fully developed and functioning well** | **Not available/relevant/ no answer** |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| **Non-government organizations –** mechanisms are in place to involve non-government organizations (incl. civil society) in health promotion planning and policy development | **2** | **3** | **4** | **2** | **3** | **3** | **4** | **4** |
| **Donors –** mechanisms are in place to guide donor involvement in health promotion planning and policy development | **3** | **5** | **4** | **2** | **5** | **5** | **5** | **5** |
| **Private sector –** mechanisms are in place to guide private sector involvement in health promotion planning and policy development | **2** | **3** | **2** | **2** | **3** | **3** | **4** | **4** |

As has been discussed already health policy and public health and health promotion policy, where it exists, is largely externally driven or at least externally advised. This is reflected in the second part of this field of inquiry which indicated that mechanisms to guide donor involvement in policy development and planning are for most countries fully developed, although the key word *guide* may not have been adequately taken into consideration by respondents. Serbia and Turkey which have arguably the strongest and most autonomous health sectors out of the eight countries considered, and therefore the most independent processes for policy development – both have recorded responses that show a lower level of donor involvement. Ukraine, although having a weak health sector, has suffered from

limited donor involvement as a consequence of the political instability that has impacted on governance in the Ukraine since the 2004/05 Orange Revolution.

The engagement, through consultation, of the non-government sector and/or civil society in policy development is negligible. Ukraine, Albania and Romania all have reported that this function is partially developed but no evidence was offered to support these claims.

In terms of mechanisms to guide private sector involvement in health promotion policy and planning, efforts are at best embryonic. Efforts to moderate negative private sector influence on public health are also weak. Health sector informants and staff from development agencies interviewed for this assessment all reported that health ministries are aware that the private sector needs to be better regulated and controlled but given the relatively limited influence and size of the public sector, in relation to the burgeoning private sector, it is difficult to see how this will be achieved. If anything, parts of the private sector are undermining public health in some CEE/CIS countries by, for example, aggressively promoting alcohol and tobacco consumption, often in collusion with politicians, and by enticing talented and educated personnel away from public sector jobs. One informant noted that in the post Soviet milieu rising, often politically well connected oligarchs are now admired and there continues to be a widespread culture of corruption. Ethics and notions of civic responsibility are luxuries that few can afford.

However, as economic growth stabilises in some CEE/CIS countries and people start to look more to governments to meet their needs, increasing opportunities for public / private partnerships may become available.

## Policy and Planning (Process)

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| **Intersectoral policy and planning –** MoH has mechanisms in place for developing health promotion policy and plans across sectors | 2 | 2 | 1 | 2 | 3 | 3 | 3 | 3 |
| **Implementation –** MoH has mechanisms that oversee and/or evaluate policy implementation | 3 | 2 | 3 | 2 | 3 | 3 | 3 | 3 |
| **Accountability and transparency –** MoH has mechanisms in place that assure accountability and transparency of decision making in relation to health promotion | 3 | 3 | 3 | 3 | 2 | 3 | 3 | 3 |
| **Support –** MoH builds a constituency for health promotion among all relevant stakeholders | 4 | 2 | 2 | 2 | 3 | 3 | 3 | 3 |
| **Use of evidence –** relevant evidence (data) of high quality is always gathered and used for priority setting, policy development and planning | 5 | 3 | 3 | 5 | 2 | 3 | 3 | 2 |

The above field of inquiry 'Policy and Planning (Process)' reveals the depth of capacity deficits in regard to public health and health promotion policy development. Intersectoral policy development and planning does not really occur and if does occur it is in an ad hoc manner. The implementation of policy, when it is implemented at all, is generally only evaluated through comparing results from surveys such as demographic and health surveys and the UNICEF MICS. Accountability and transparency are improving but remain largely absent from public health systems in the countries visited, let alone in relation to health promotion decision making. There are of course elements of health systems that are transparent but information is offered up in goodwill or out of professional courtesy rather than because there are mechanisms in place that ensure that this happens. Likewise, there are constituencies for health promotion such as the informal multisectoral working group for health communications that was formed in Romania, but these constituencies are not instigated at the behest of Health ministries but instead manifest as a consequence of the professionalism of their core membership.

In regard to the use of evidence, there is more of a professional culture of collecting evidence than of using it and when data is obtained, the capacities required to make use of that data in a productive way are often not in place. When capacities are in place the people that can put data to good use mostly don't have the resources or incentives to do so. Both Serbia and Turkey reported a well developed use of evidence for policy development which may reflect the fact that health sectors in

Serbia and Turkey are better resourced than health sectors in the other six countries the subject of this assessment.

## Legislation and Regulations

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| Legislation and regulations are enacted at a national level to address current priority health issues | 4 | 2 | 4 | 4 | 4 | 4 | 4 | 4 |
| MoH implements and evaluates actions in accordance with international instruments or other obligations that have a bearing on health promotion | 5 | 4 | 4 | 4 | 4 | 4 | 5 | 4 |

In all of the eight countries visited, attempts to establish legislation and regulations and to adhere with international instruments are underway but these efforts partially reflect international concerns, and laws and regulations are not always enforced.

In ***Serbia*** legislation and regulations that address priority health issues are in place (for pharmaceuticals, communicable diseases and sanitary inspection) at the national level and Serbia is signatory to international instruments such as the International Code on the Marketing of Breast Milk Substitutes (adopted in 2005) and international protocols on tobacco control.

In ***Moldova*** regulatory and legislative frameworks are not in place for the health sector and evaluation systems are rudimentary at best. The pharmaceutical sector is also largely unregulated which has lead to the proliferation of a large black market for drugs.

In the ***Ukraine,*** where there seems to be a fondness for lawmaking, there are many regulatory frameworks and much legislation is in place but implementation is usually absent or partial, monitoring and evaluation is also amiss and many legal instruments remain only declarations on paper that are enacted to comply with international pressure.

In ***Turkey*** efforts at regulation are highly fragmented. While legislation is in place (often to align with EU regulations and pre-accession requirements) and is in some cases pending (for example, the Code on Breast Milk Marketing) there is no comprehensive regulatory framework that properly supports preventative health initiatives or health promotion. Legislation is not always enforced and there are only limited attempts to evaluate the impact of legislation and regulatory instruments. The WHO Framework Convention on Tobacco Control was ratified in 2004 but it is unlikely that smoking will outlawed in bars and restaurants until the end of 2009.

In ***Uzbekistan*** the 1996 Law on Health Protection outlines the areas subject to regulation in the health sector.

In ***Tajikistan*** the Government has enacted a range of legislations to support health service delivery and regulate the sector but implementation is a problem. Laws that have been enacted include: the 1993 Law on the Donation of Blood and its Components; 1993 Law on HIV/AIDS Prevention; the 1997 Law on Health Protection of the Population; the 1997 Law on Health for All to 2005; the 1998 National Programme for Health Care Reform; and the 2000 Law on Universal Salt Iodization.

In ***Albania*** laws and regulations that have been enacted include: the Code on Breast Milk Substitutes that was recently upgraded to the status of national law, WHO protocols on the promotion of tobacco, and provisions to ensure that all patients receive free inpatient care. However, monitoring and evaluation systems are rudimentary or not in place and the enforcement of legal standards is an issue of concern. For example, despite a law stipulating free inpatient care for all, informal payments at all levels of the health system are common.

In ***Romania*** health legislation is complex and changes frequently. There are however programmes in place that may lead to a more supportive legislative environment in the near future, including: the National Strategy on Iodine Deficiency Disorder Elimination, the National HIV/AIDS Strategy, the National Strategy on Drug Use; the National Strategy on Tobacco Control and the National Strategy on Breast Feeding Promotion.

## Health Sector Policies and Plans

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| Contemporary health promotion philosophy and practice are embedded in National health sector policies and plans | 4 | 4 | 4 | 3 | 2 | 4 | 4 | 4 |
| MoH implements national health sector policy and plans | 4 | 3 | 4 | 4 | 4 | 4 | 4 | 4 |
| MoH evaluates the implementation of national health sector policy and plans | 4 | 2 | 4 | 2 | 3 | 4 | 3 | 4 |
| Results of evaluations supplied to national parliament | 5 | 2 | 4 | 2 | 3 | 4 | 2 | 3 |

In countries that have developed a national public health strategy or national health promotion strategy, modern notions of health promotions are articulated because these strategies have in the most been developed by, or with the assistance of, external experts that are contracted by international partners. However, policies and strategies rarely address health promotion as a cross sectoral concern that has salience for other ministries and as has been noted, policy implementation is weak, or incomplete. Similarly, the evaluation of policy implementation is rudimentary and usually does not extend beyond comparing the results of national level surveys such as demographic and health surveys and the UNICEF MICS. Resources are limited and evaluation is thus often considered as a non-essential function of the health sector. Health promotion activities are also, as has been noted, largely externally

drive so an evaluation of these activities is considered, when it is considered at all, the responsibility of the implementing agency. Agencies such as UNICEF that implement health promotion initiatives, perhaps in support of national health objectives, do not always conduct evaluation exercises and when they do they are often conducted independently with limited government involvement. Health systems in all countries visited for this assessment, perhaps with the exception of Serbia, are too undeveloped and antiquated, and too under resourced, to adopt systems that allow for the ongoing evaluation of health policy. When evaluations do get done they are done on an ad-hoc basis and usually to inform new programmes that have potential for external funding.

In terms of supplying results of evaluations upstream to the national parliament or to decision makers, particularly as they relate to the efficacy or cost effectiveness of health promotion initiatives, this is indeed important work. However, personnel with the appropriate mix of skills and strategic capacity are generally not mandated to do this work. Cost benefit analysis does occasionally get done in relation to preventative health strategies as has been the case in Turkey where the motivation has been to solicit a budget for a national health promotion programme. However, none of the countries visited seem to explicitly recognize the importance of developing mechanisms and capacity within the health sector for lobbying decision makers in a strategic and consistent manner.

## Policies and Plans in Sectors other than Health

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| National policies and plans in sectors other than health acknowledge public health implications | 3 | 2 | 3 | 2 | 3 | 3 | 4 | 4 |

Among health sector personnel that do have an understanding of the cross-sectoral nature of health promotion and public health there is recognition of the need to communicate the importance of health promotion and foster the internalization of public health concerns within ministries other than health. However, personnel and departments involved with the design and implementation of health promotion and public health strategies are usually preoccupied with the considerable efforts required just to implement policies and programmes within the health sector, let alone establish and maintain mechanisms for cross sectoral communication. Perhaps more importantly, public health personnel are not really mandated to advance the health promotion agenda across sectors and institutional mechanisms that could facilitate a better awareness of the need to address public health in non health sector policy are generally not in place.

As noted previously there have been topical collaborations between health and education ministries in support of mother and child health and healthy lifestyles but these collaborations have been externally driven. Nevertheless, the importance of establishing and supporting the capacity of health systems to advocate for the incorporation of health promotion concerns within non health sector public policy cannot be emphasized enough.

## System Infrastructure – Workforce

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| **Workforce development –** Training to develop health promotion competencies is part of the basic curriculum for all health workers and health professionals | 4 | 3 | 2 | 2 | 2 | 2 | 3 | 2 |
| **Workforce development –** Ongoing opportunities are provided for professional development in relation to health promotion | 3 | 2 | 2 | 3 | 2 | 3 | 3 | 2 |
| **Workforce policy –** A national health promotion workforce strategy guides the development and deployment of health promotion competencies | 1 | 1 | 2 | 1 | 2 | 3 | 3 | 3 |
| **Workforce development –** Other government workers outside of the health sector are provided with training on health promotion | 3 | 2 | 2 | 1 | 1 | 2 | 2 | 2 |
| **Workforce development –** Workforce development facilitates multi-disciplinary teamwork | 1 | 2 | 1 | 1 | 2 | 3 | 2 | 2 |

This field of inquiry elicited responses and provoked discussions that have pointed to some of the most significant problems facing health systems in the eight countries visited; and to the severe lack of development with regard to the mainstreaming of health promotion across health sectors and in regard to training and education opportunities. As can be seen from the response above workforce development and workforce policy as it relates to health promotion and the development and deployment of health promotion capacities are areas where much work needs to be done.

Discussions in country about workforce issues also revealed profound concerns that impact on the performance of the health sector and its capacity to do health promotion work. Probably the most salient of these concerns are the inadequate salaries that health sector employees receive which have led to out of pocket payments for services becoming the norm across health systems in the CEE/CIS region. Particularly in relation to salaries received in the burgeoning private sectors of CEE/CIS countries, public sector salaries have simply not been able to keep pace which has exacerbated corruption and forced health professionals to seek supplementary sources of income. In none of the countries visited did health sector salaries exceed 300 Euros per month and in countries like Uzbekistan and Tajikistan, salaries are as low as 50 US Dollars per month. In the Ukraine it is common for one health sector staff member to officially occupy two positions so that they can receive

two salaries – a situation that is unofficially sanctioned by the Ministry of Health. Even though low salaries have been recognized as an issue that is impeding health sector reform, and have been increased several times in many countries in the CEE/CIS, these salaries are still paltry, relative to private sector income generation opportunities, and inadequate to meet ever rising living costs in countries where societies are increasingly polarized into those that have money and those that don't – in Moldova, for example, salaries for civil servants are about one tenth of private sector salaries even though they have doubled over the last two years.

The rising level of opportunities for employment among private health services and for income generation in the private sector is draining personnel, especially better educated and qualified personnel, away from the public health system. In addition, as borders in Europe become more porous and demand increases for foreign health sector personnel within the EU member states that are experiencing high levels of economic prosperity, additional pressure is placed on health systems among the poorer EU members and neighbouring countries. International agencies, which pay professional health sector staff at much higher rates (often 5 times or more as much as they would receive working within their governments) also tend to lure better qualified personnel away from the public health sector. This is particularly the case in regard to physicians who have advanced training in public health. These personnel are in particularly short supply and in high demand.

Another unintentional problem that relates to capacity development strategies employed by international agencies is the sponsoring of government health sector staff to attend international training sessions and / or post graduate courses in public health. While this is of course a valuable endeavour it often results in newly trained health sector staff taking their newly acquired skills out of the public sector and either finding better paid employment within the private sector, within international agencies, or abroad, which tends to defeat the broader purposes of sponsoring trainings in the first place. Skills do circulate around but the state of health systems in many CEE/CIS countries is too dire for them to be able to sustain services when skilled personnel are exiting the health sector in pursuit of more reasonable levels of income - it is not only opportunism that compels public health professionals to leave the health system but economic necessity and a desire for a better future for them and their families. These issues, particularly in the CEE/CIS where government salaries are so inadequate, require much more collective consideration by the UN systems agencies and other development partners.

In relation to health promotion, many health sector informants noted that are simply no incentives for physicians and other health sector personnel to carry out health promotion work. Out of pocket payments for services are rife but hard up members of the public are, for example, not going to supplement doctor's incomes for being informed about health problems they may or not develop in the future. The current financial situation that many health sector personnel face often precludes activities that have no potential to supplement incomes in favour of activities that do have income generation potential, such as acting as an intermediary or broker between pharmaceutical companies looking to expand markets, and patients. In all of the countries visited for this assessment corruption in the health sector is identified as a major problem and political influence and seniority are often perceived as providing opportunities to increase income generation, or get rich. When there are conflicts of interest in relation to, for example, tobacco control or drug licensing, the private sector has been known to undermine the health system through informal payments to politicians and others that have an influence on the health sector and its regulatory frameworks. In some countries such as the Ukraine, there is evidence that the private sector is colluding with corrupt health sector officials to exploit weaknesses in the

public health system and marketing and promoting harmful or untested alternatives to tested public health strategies such as immunization programmes for children. As one concerned official in the Ukraine suggested – 'businesses are being built on health ignorance'.

In regard to reforms that have taken place in health financing systems, doctors are in some countries remunerated on the basis of the number of patients treated rather than on a qualitative basis. All of these issues have a profound impact on equity and many informants noted how the quality of care, even access to care, relates directly to capacity to pay.

As noted in the introduction, a consideration of sub national capacity is beyond the scope of this report. However it is worth pointing out that in all countries visited the performance of sub-national health sector staff is curtailed by limited incomes and resources. Some countries reported that personnel from regional and/or district health authorities have little incentive to turn up for work let alone to do health promotion. In Tajikistan, for example, it was reported that Rayon and Oblast level staff with public health and health promotion responsibilities often turn up for work on only one day of the week, although apparently attendance improves when there is an externally funded project to implement.

Another factor that is impacting on the capacity of health systems to implement reform and to build sustainable public health interventions is the political flux that typifies many countries in the CEE/CIS region, particularly Ukraine, Serbia and Romania, and impacts on programme and project sustainability. In Serbia there have been three deputy prime ministers in the last two years which has led to the creation and dissolution of three task forces for Avian Influenza prevention. In the Ukraine ministerial power shifts are frequent which tends to result in a constant politically motivated reassigning of senior managers in the health sector – 18,000 government workers have reportedly been shifted around the Ukrainian public sector since the Orange revolution in 2004/05. In Romania, the Bucharest branch of the Institute for Public Health has had six different directors in two years and there are concerns that the currently reformist health minister will loose his job when elections are held in November 2008 which, it is felt, will jeopardize the success of the newly approved and budgeted National Health Promotion Programme that the minister has vigorously supported and advocated for.

The general destabilization of bureaucracies that has resulted from the transition to free market economies has not allowed emerging programmes and initiatives, or indeed health systems, to develop the kind of bureaucratic resilience that is common in many other countries. In Thailand, for example, where the bureaucracy is institutionally resilient, there was a military coup in 2006 but this coup had negligible impact on the delivery of services for the year preceding the reinstallation of a democratically elected government. In many countries around the world political power equates to opportunities for wealth accumulation but in some CEE/CIS countries that are experiencing transition but still clinging to Soviet political traditions, political uncertainty and change also present opportunities for individuals to sure up their positions within government, to forge alliances, reward political support and reduce or annul the influence of opponents and dissenters.

## System Infrastructure – Specialist Health Promotion Expertise

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| A specialist health promotion faculty undertakes teaching and research functions | 4 | 3 | 4 | 3 | 3 | 2 | 3 | 1 |
| A specialist health promotion faculty resources the health promotion workforce | 4 | 2 | 2 | 2 | 3 | 2 | 2 | 1 |

All of the eight countries visited have some arrangements for the training of health professional in public health, although specialist training in health promotion is generally unavailable.

In ***Serbia*** training in public health is provided through the Institute for Social Medicine and the Belgrade School of Public Health which was established with support from the European Commission in 2005. The Masters Degree in Public Health offered by the school offers two or three units that relate to health promotion.

In ***Moldova*** the SOROS Foundation - a non-profit philanthropic organisation - founded a School of Public Health and Management in 2005 and offers a masters degree program. SOROS and the government also co-fund scholarships for students at the school.

In the ***Ukraine*** a national school of public health – the Mohyla Academy School of Public Health - has been established at the National University of Kiev and its first students graduated in 2004. The school, in partnership with the School of Public Health at the University of Maastricht in the Netherlands, runs a two year masters program that offers significant professional training on public health, preventative health and health promotion. The Ministry of Health in the Ukraine has no capacity to effectively absorb or support graduates from these schools.

In ***Turkey*** there is a National School of Public Health in Ankara which operates under the auspices of the Ministry of Health and offers specialised training in public health with a focus on management, coordination and financing. Health promotion is not a major focus of this school and of the five departments none is dedicated to health promotion.

In ***Uzbekistan*** the former Second Tashkent State Medical Institute initiated the introduction of a unified public health programme in line with international standards in 2000 and in 2001 established the Department of Public Health and Health Management. The Department has developed an integrated public health training programme at graduate level and offers the degree of Master of Public Health.

In ***Tajikistan*** efforts are underway to establish a health promotion department at the Tajik Medical Institute of Postgraduate Training, but as it stands students are currently sent overseas for training in health promotion and public health. The

government of Japan supports approximately 10 students a year to attend 2 week health promotion training courses at the Institute for Health Services in Kazakhstan.

In ***Albania*** opportunities for training in public health and especially health promotion are limited. It is possible to study for a masters degree in public health at the State University but the focus is on reproductive health and no specific attention is paid to health promotion or communication issues.

In ***Romania*** it is also possible to study for a masters degree in public health at the State University and some minor specialization in health promotion is available.

As is evident from the information presented above, efforts to improve public health training are emerging. The establishment of public health schools and departments within universities as well as initiatives targeting the training of health sector staff in health promotion and public health are vital and are leading to a slow but steady establishment of cohorts of health sector personnel who have the capacity to think and plan public health strategies and to lobby and advocate for health systems reform which necessarily includes a much greater focus on preventative health strategies and health promotion. However, currently the major concern is that health sectors with their prevailing cultures of curative specialisation may be unable to absorb public health graduates or offer adequate incentives to ensure their active participation in health sector reform.

For the eight countries visited, the number of personnel with training in public health is limited and therefore it is extremely difficult for these personnel to exert a significant influence on prevailing medical mores, or to play an active role in advocating for change and a greater role for health promotion. In Romania, where the level of capacity for health promotion is higher than most of the other countries visited except perhaps Serbia, there are only an estimated 100 personnel in the health sector nationwide who have some training in public health. These 100 people have responsibility to address the public health needs of some 22 million people.

Linkages between public health training facilities and the broader health system, in terms of providing examples of best practice and technical leadership, were not considered in any depth by this assessment. However, given that the structure, available resources, and orientation of health systems in most CEE/CIS countries are not really conducive to reform and the scaling up of preventative health strategies, it can be safely posited that the contribution made by these facilities is limited and underexploited. If, as is one of the recommendations of this report, emerging cohorts of public health professionals are supported to conduct in-depth assessments of country level health promotion and communication capacity then it would be prudent to ensure that these assessments cover the interface between public health training institutes / facilities and health systems, as well as potentials for collaboration and mechanisms for information sharing.

## System Infrastructure – Financing and Funding

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| There is a financing system for health promotion that can assure adequate funding for health promotion | 4 | 2 | 1 | 2 | 2 | 2 | 1 | 4 |
| The budgetary timeframe enables medium and long-term planning for health promotion | 3 | 2 | 2 | 2 | n/a | 3 | 1 | 2 |
| Processes for funding allocations to health promotion are based on criteria that are publicly known | 1 | 2 | 1 | 2 | n/a | 2 | 1 | 2 |
| Health promotion authorities are able to make autonomous decisions about funding health promotion that are unconstrained by funding sources | 1 | 2 | 1 | 2 | n/a | 3 | 1 | 3 |

As can be seen from the responses above, in all of the eight countries visited for this assessment, the capacity of health systems and of agencies and institutions that have responsibility for health promotion to conduct budgetary analysis, to fund health promotion work, to plan for health promotion work and to make autonomous decisions is limited, or non-existent. Where there are departments or arrangements for health promotion work within health systems, funding is usually only available for operational costs such as salaries and office maintenance. In Uzbekistan, for example, the World Bank has noted that 70 per cent of health sector expenditures are spent on recurrent costs, a situation that is mirrored in most CEE/CIS countries that are dependent on official development assistance.

As noted previously, almost all health promotion work is externally resourced. Out of the eight countries visited only informants in Romania, Turkey and Serbia claimed that there was a budget line dedicated to health promotion work, beyond operational costs. None of the health system informants from any of the countries visited was able to suggest how much money might be allocated from health sector budgets or what percentage of total health sector expenditure is allocated to preventative health.

Ironically, absorptive capacity is an issue in some countries. In Romania where taxes on tobacco products have recently been introduced, the Ministry of Health has been unable to determine where new additional revenues should be allocated. Similarly in Moldova the government is reported to currently have a US 130 million dollar budget surplus which remains unallocated. Rivalry and competition between health ministries and the partially reformed health insurance funds are also known to impede an efficient and/or targeted allocation of resources. As one health ministry official noted in Serbia – ‘it is sometimes more difficult to direct funds than to obtain them’

In terms of the criteria by which funding decisions are made and the public availability of information pertaining to resource allocations within health systems and the amount of resources allocated, all of the eight countries report a lack of transparency. Media representatives interviewed for this assessment all reported that health ministries are universally cagey about funding allocations and their justification.

NB: Some data on overall patterns in health sector financing are presented in the individual country reports (Annex 2).

## System Infrastructure – Program Delivery Systems

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| **Program delivery infrastructure –** organizations are in place to deliver health promotion | 5 | 4 | 3 | 5 | 3 | 4 | 4 | 4 |
| **-** between preventive and curative services and the public health system | 3 | 2 | 1 | 3 | 4 | 4 | 3 | 2 |
| **-** between communities and the public health system | 2 | 2 | 1 | 3 | 3 | 4 | 3 | 2 |
| Health promotion strategies are integrated into the practice of clinical services | 4 | 3 | 4 | 2 | 4 | 4 | 4 | 2 |

This field of inquiry has been partly addressed in previous responses and in discussions about the institutional infrastructure available to support health promotion work. To quickly reiterate, all of the eight countries have some arrangements for health promotion, including through the Institutes for Public Health and in some cases through health promotion agencies within the institutes. However, as is clear, these institutional arrangements are embryonic, chronically under resourced, understaffed and neglected within an inefficient, overly specialized and risk-averse professional culture.

Efforts have been made since the transition in all of the eight countries visited to reform primary health care services and these efforts have included an increased emphasis on preventative health. An assessment of the efficacy of primary health care services is beyond the scope of this report but the general lack of resources available for health care at the sub-national level and the human resources deficiencies that are clearly evident suggest that there is much room for improvement. However underutilised opportunities to link curative and preventative services are nevertheless present.

The hierarchical structure of post Semashko health systems is conducive to the establishment of efficient logistical arrangements for the distribution of health promotion strategies as has been demonstrated in some countries through the national distribution of information, education and communications materials in support of Avian Influenza prevention. The developing network of primary health care

centres that is evident in most countries also continues to presents significant opportunities for a scale up of health promotion work and an improvement in the linkages between national health promotion initiatives and the primary care system. One informant noted that in Moldova antenatal care coverage is excellent, as it was in Soviet times, and that antenatal care offers an excellent, but so far unexploited, entry point for health promotion activities at all levels.

The engagement of communities, women, children and adolescents in health promotion work is extremely limited in all of the countries visited and also offers significant opportunities not only for improving health outcomes, but for empowering communities and individuals to become active participants in local development, and with regard to increasing control over their own health.

## Health Information Systems – Data Collection and Analysis

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| The health information system periodically (more than once a year) tracks and reports on population health status | 5 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| The health information system periodically (more than once a year) tracks and reports on child health status | 5 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| The health information system periodically (more than once a year) tracks and reports on health determinants | 4 | 4 | 1 | 3 | 4 | 4 | 3 | 2 |

On one level the primary determinants of ill health (bad diet, smoking, alcoholism, lack of access to clean water for some population groups, environmental pollution, drug abuse etc.) are well understood in the CEE/CIS region and considering the many pressing priorities facing CEE/CIS health systems it may be that developing sophisticated methods for the tracking of determinants may prove an injudicious use of available resources. In addition, development partners such as UNICEF, which routinely conducts Multi-indicator Cluster Surveys, and others, including UNFPA and USAID, support the implementation of demographic and reproductive health surveys, which for the short term, is probably adequate for some countries, especially the countries with extremely limited resources for preventative health. However, these surveys do not uniformly reach marginalized populations and do not always uncover the more complex socio-economic determinants of ill health. As always, an efficacious balance needs to be struck between research and implementation – it is not necessary to know everything to take positive action, and research and experimentation on the types of health promotion initiatives that may have a positive impact on public health could prove a more efficient use of available resources.

Within the Semashko model, epidemiology was a respected specialization and as such the capacity of post Semashko health systems to *collect* data is not too bad (see the individual country reports for more detail). However, some health sector informants, especially from the emerging sub-set of public health professionals, report that data is often collected for the sake of collecting data rather than for the purpose of informing preventative health strategies. This is not to say that data is not used to support policy development and programme design, but rather that the level of data collection activity does not equate with either data analysis capacity or strategic planning capacity. Data analysis capacity, from a public health perspective, was widely reported as quite limited in most of the countries visited.

## Health Information Systems – Knowledge Management

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| Relevant data relating to health promotion planning and programs are documented, systematically published and widely available | 2 | 3 | 3 | 2 | 2 | 2 | 3 | 2 |

In the preface to this section of the report it was noted that some of the questions contained within the mapping tool were somewhat out of context. The question above is one of those questions. However, this question did generate some interesting discussion about knowledge management more generally.

Clear and well-structured mechanisms ensuring public access to health sector policy, reports, programme documentation and budgetary allocations are not in place in any of the countries visited. Some of the countries visited have established internet web sites for health ministries but these websites, on examination, often have missing elements. For example, links to what are supposed to be public documents or platforms that detail policy reveal web pages reporting that they are still under construction and in other cases links are inoperative. Public transparency was never a part of the Soviet style of management and the health system requires the establishment of a whole new set of facilitating frameworks and structures to enhance the availability of information. Generally, outside of the capitals, access to the internet for health sector staff is limited in some countries and in some situations even the computers needed to access the internet are in short supply. In Tajikistan the recently established Healthy Lifestyles Department has no internet access, even in the capital Dushanbe.

Access to public health journals and other technical resources that might assist with health promotion work is also very limited outside of the major centres. Even at the national level, access to regional public health bodies that could supply information on best practice and other technical resources that support public health is limited. Two of the six branches of the Institute for Public Health (Bucharest and one regional branch) in Romania are now members of the European Commission supported Euro Health Network which supports public health capacity building efforts and disseminates information on approaches to preventative health, and in relation to

health promotion and other public health concerns. This is viewed as an important achievement by members of the Bucharest branch of the Institute for Public Health.

Another important concern is the absence of mechanisms within the central level of health sectors in Moldova, Ukraine, Uzbekistan, Tajikistan, and to lesser extent Serbia, Romania, Albania and Turkey, to absorb international experience and to determine how that experience might be adapted to suit local circumstances. This is not to say that there are not personnel who can do this work but rather that they are not mandated and / or resourced to do so in a manner that could benefit programme and strategy design.

## Health Information Systems – Communication Channels

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| Delivery channels (e.g. access to TV broadcast time) for health communication can be accessed at minimal cost | 5 | 3 | 2 | 2 | 4 | 5 | 4 | 5 |
| The delivery channels used for health promotion facilitate access to all population groups | 4 | 3 | 2 | 3 | 4 | 4 | 4 | 5 |
| Relationships between the media and MoH are conducive for effective health promotion efforts | 3 | 4 | 2 | 3 | 2 | 2 | 3 | 4 |
| A national coalition is resourced and supported to communicate the importance of health promotion across sectors and within MoH | 3 | 2 | 2 | 2 | 2 | 2 | 3 | 4 |

Government relations with broadcasters in the eight countries visited for this assessment depend on many variables including the level of private sector participation in the mass media. In Moldova, Uzbekistan, Tajikistan and Albania where broadcasters and the press remain largely under state influence; relations can be strained but relatively productive. Air time can theoretically be accessed at minimal cost or for free, although apparently in Moldova the state TV station has requested payments for airtime because the government has failed to meet its funding obligations. In Uzbekistan airtime is also available on state TV and radio but a Ministerial Order is required to access this airtime and when airtime is secured, announcements are broadcast at times when few people are watching or listening. In Albania all TV and radio stations are required by law to provide free airtime for government under difficult or extreme circumstances. Generally speaking, governments in these countries have more influence and control over the content of television and radio announcements that are broadcast in support of Avian Influenza prevention or other public health situations that require the dissemination of public announcements.

Informants from some of the countries visited reported that in crisis situations there is good cooperation between public authorities, and that Avian Influenza prevention

messages broadcast by health ministries are generally clear and informative. Even in countries where large parts of the media are privately owned, informants have reported that although announcements in relation to Avian Influenza were sensationalist to start with, they became more informative and balanced after briefings from the ministries of agriculture and health.

For Serbia, Ukraine, Turkey and Romania where large sections of the broadcast and print media are privately owned the situation is more complex with informants from the media and government officials generally having more negative views about each other. This was particularly evident at the last session of a UNICEF sponsored crisis communication workshop in Serbia where media representatives and health ministry officials were required to play out various scenarios that tested their capacity to handle situations were crisis communications strategies are required. At this session it was quite clear that both media and health ministry counterparts had such disparaging views about each other that productive relations were obstructed. Nevertheless, governments in these countries can access air time and informants from both sides noted that the more important the message that needs to be conveyed the more accommodating the media tend to be. Anecdotal evidence suggests that tensions and animosity can be put aside in trying circumstances. For example, a 2007 hepatitis outbreak in Serbia was reportedly responded to in a timely manner with media outlets reporting on how health authorities handled their response, including the hospitalization and isolation of patients; press conferences where epidemiologists explained the outbreak and its causes; and hourly media updates. In Romania, health ministry informants report that media agencies cooperated well with public authorities in regard to providing public information relating to a 2007 heat wave that posed severe risks to the elderly and infirm.

However, in terms of the communications components of emergency preparedness both media and government informants seem to be unsure whether or not arrangements would be adequate to ensure the widespread and effective dissemination of balanced and quality information. The UNICEF sponsored crisis communications workshops that were convened for government and media representatives addressed many of the issues that need to be considered by government and media representatives but also revealed that more needs to be done to improve communications and relations between governments and the media. Some of the deficits identified throughout the course of these workshops and more generally by media and government informants include:

- The absence of standing agreements for airtime in the event of pandemic
- The failure of the responsible authorities to disseminate and socialize Avian Influenza prevention and preparedness plans and communications strategies to media and within government – when questioned, the Press Officer at the Ministry of Emergencies in the Ukraine revealed that he had never heard of the Ukrainian Governments Avian Influenza prevention and preparedness plan
- The lack of background information on Avian Influenza and its prevention disseminated in advance to media manager and content editors
- The lack of any mechanisms to address surges in media interest and the relative inexperience of press officers in some health ministries – it was noted by one informant that often press officers are often friends or close associates of the Minister and that spokespersons for key issues are identified arbitrarily, are inexperienced and/or lack professional training
- The lack of preparation with regard to pre-testing messaging for the five separate pandemic phases and the lack of any socialization of messaging, where it exists, among media managers

- The lack of government transparency, the failure of health ministries to initiate communication with journalists, and the difficulties faced by journalists trying to obtain information from health authorities, especially in relation to health financing or sensitive topics like drug procurement – governments are generally considered by media informants as reactive not proactive
- The tendency of health ministries to report on issues that make them look good rather than more difficult issues such as health systems reform or corruption – in difficult circumstances, such as in relation to an Avian Influenza outbreak, journalists in Romania claimed that the Ministry of Health only releases information when they have the situation under control
- The lack of balance between private and public sector media providers – public sector media providers tend to be more pro-government and where as private sector media often sensationalize, confront and embarrass government
- The tendency of media agencies to not adequately inform themselves about public health concerns, to embellish situations in the interests of improving ratings or circulation, and to occasionally disseminate inaccurate information – press monitoring in the Ukraine revealed the dissemination of much inaccurate information in relation to vaccination campaigns
- The lack of specialist health journalists in media agencies – in Ukraine politics apparently dominates the media to the point where it is almost, as one informant remarked – 'a national sport'. Frequently, coverage of health issues is delegated to junior or cadet reporters
- The lack of structured and informal meetings between press agencies within government and media partners, and the difficulty public authorities can face in trying to access media managers – when meetings do occur it is usually at the behest of development agencies with a communications focus

In terms of relations between the media and health ministries providing a supportive environment for communicating about health and health promotion, the situation is mixed and it is difficult to draw firm conclusions, short of saying that the role of the media relations in support of communication and health promotion needs to be better understood and articulated by health ministries and national authorities. While media agencies have an ethical responsibility to provide balanced and informative news to the public, it is primarily the role of government to regulate media providers and work towards ensuring better collaborations. Some reported positive aspects that could be built upon include:

- In some countries there are weekly and monthly newspapers that exclusively deal with health related issues and some mainstream newspapers regularly deal with public health issues. This is in some ways a legacy from Soviet times when health related issues were widely discussed in State owned media although some informants noted how content is often regurgitated from overseas publications
- In Serbia the widespread printing of important health related contacts (for example, in relation to HIV/AIDS, hepatitis and breastfeeding) within national newspapers
- In Tajikistan, weekly radio shows that address primary health care reform
- In Moldova, weekly radio programmes that deal with health related issues
- Nascent efforts on the part of health ministries to develop public relations and communications strategies demonstrates an increasing recognition of the important role that media can play in advancing public health agendas

## Avian Influenza Prevention and Human Influenza / Pandemic Influenza Preparedness

| CODE | 1 | 2 | 3 | 4 | 5 | 6 | (N/A) |
|---|---|---|---|---|---|---|---|
| | Not developed | Not developed but need for increased capacity recognized | In early stage of development | Partially developed | Fully developed | Fully developed and functioning well | Not available/relevant/ no answer |

| | Serbia | Moldova | Ukraine | Turkey | Uzbekistan | Tajikistan | Albania | Romania |
|---|---|---|---|---|---|---|---|---|
| An national Avian Influenza Prevention Plan is in Place | 5 | 5 | 4 | 5 | 5 | 5 | 5 | 5 |
| - has a communications strategy | 5 | 5 | 3 | 4 | 5 | 5 | 4 | 4 |
| - is tested and updated | 5 | 4 | 2 | 4 | 3 | 4 | 4 | 3 |
| A national Pandemic/Human Influenza preparedness plan is in place | 5 | 4 | 2 | 5 | 4 | 4 | 5 | 4 |
| - has a communication strategy | 4 | 4 | 2 | 3 | 3 | 3 | 5 | 3 |
| - is tested and updated | 2 | 2 | 2 | 3 | 2 | 3 | 2 | 2 |

Since the threat of Avian Influenza and its possible mutation into a human influenza virus emerged a few years ago, considerable resources have been expended by bilateral donors and multilateral agencies, most notably the Government of Japan and the United States Agency for International Development, UNICEF, the FAO, WHO, UNDP, the World Bank and the European Union, in support of Avian Influenza prevention and human and pandemic preparedness. As a consequence there have been considerable achievements and awareness of Avian Influenza and the possible risks that it poses is high, particularly among people that have access to electronic media (television and radio) which is most people in the CEE/CIS region. As one Moldovan official remarked – 'everyone knows about Avian Influenza because there is money for Avian Influenza'.[5]

All of the eight countries visited have cross-sectoral Avian Influenza prevention plans in place and in Turkey their national plan for Avian Influenza is combined with contingency plans for pandemic influenza and human influenza outbreaks. In Serbia and Albania pandemic and human influenza preparedness plans are separate but completed documents and in all other countries they are at various stages of development.

Of all of the eight countries visited, Turkey, Serbia, Moldova and Albania claim that their Avian Influenza prevention plans are to some degree updated and tested through simulation exercise supported by the WHO, FAO and USAID. With regard to pandemic influenza and human influenza preparedness no country out of the eight visited claims to have a contingency or preparedness plan that is actually operational.

[5] For a detailed synopsis of country level activities in support of Avian Influenza prevention and preparedness see the individual country reports presented in Annex 2 of this report.

Nevertheless, some important lessons have been learnt particularly with regard to cross sectoral coordination and communication. At the behest of the UN Systems Agencies, particularly UNDP, and other development partners, governments in the CEE/CIS region have been urged to establish national level coordinating bodies for Avian Influenza prevention and in some cases, pandemic and human influenza preparedness. These coordinating bodies, frequently known as task forces or national committees, have been established under the auspices of national level authorities and chaired by senior decision makers including, for many CEE/CIS countries, deputy prime ministers. The primary achievement of these bodies, apart from coordinating prevention and preparedness work, has been to demonstrate that not only is inter-ministerial collaboration possible but that it can produce results. As Avian Influenza is an avian virus there was initially considerable rivalry between Agriculture and Health ministries who were in many countries both vying for supremacy with regard to influence over an area that promised a prestigious profile and influence over considerable donor resources. However, given that both the human and animal health components of Avian Influenza prevention are vital to effective control strategies, health and agriculture ministries have been compelled to cooperate by donors and external partners who have repeatedly emphasized the importance of intersectoral cooperation.

Another achievement is the capacity that has been developed with regard to the implementation of communication strategies in support of Avian Influenza prevention. UNICEF as the UN agency charged with supporting communications work has had a major role in facilitating the design and implementation of communications strategies and while this is not an assessment of UNICEFs work in support of Avian Influenza prevention; some developments relate directly to the themes of this assessment and do require some analysis.

In particular, UNICEF has lead the establishment of cross sectoral communications working groups that have overseen: the development of communications strategies; the implementation and design of knowledge attitude and practice surveys that have informed the design of communication materials for Avian Influenza prevention; the roll out of crisis communication workshops that address government and media relations; and, the pre-testing and rollout of information, education and communication materials in support of avian influenza prevention, including television and radio public service announcements, brochures, flyers and the development of interpersonal communications modalities such as soliciting the services of religious and community leaders, youth and community organizations. In Ukraine (which is the only country to complete a follow up knowledge attitude and practice survey completed subsequent to the rollout of the Avian Influenza prevention communications strategy) a second knowledge attitude and practice survey clearly demonstrated that awareness of Avian Influenza has increased. All of this work, while often driven by UNICEF in-country, has nevertheless demonstrated to partners the range of tools available for preventative health and health promotion strategies that enhance public health security.

The communications working groups, established at UNICEFs behest, have included representatives from health, agriculture and education ministries, as well as national emergency coordinating bodies, media representatives, private sector stakeholders, non government organisations and other development partners. These working groups have demonstrated, through practice, the cross sectoral nature of communications work and the value that cross sectoral collaboration can add to communications and health promotion work. Unfortunately these groups have become dependent on resources being available for Avian Influenza prevention and as available resources dwindle in some CEE/CIS countries the role and relevance of

these groups has started to diminish. In countries such as Romania and Albania these communications working groups have had more wide ranging responsibilities that have crossed into areas such as general hygiene promotion which has lead some partners to consider how the functional life of these coalitions can be extended. In other countries such as Moldova and Tajikistan, the only purpose of the communications working groups has been to oversee and support communications work in support of Avian Influenza prevention. As such, they are at risk of faltering when the supply of money for communications materials starts to dry up. In many ways development partners have focused too much on Avian Influenza prevention at the expense of solidifying the institutional arrangements that enable and support Avian Influenza prevention, and could perhaps, by extension, support health promotion and communications work more generally. Health ministry informants working in public health in some of the countries visited noted that communication efforts in support of Avian Influenza prevention and preparedness have strengthened capacity for health promotion and communications work in general.

## Conclusions

Within the parlance of post-colonial development efforts, capacity and capacity development are frequently perceived of as pertaining to the capacity of individuals to carry out specific functions, and efforts to improve the capacity of individuals to carry out these functions. This paradigm has shifted over recent year to include other elements of capacity that provide an enabling environment for individual capacity, such as resources, stewardship, sustainability and institutional strengthening. However the notion that capacity building relates more to educating individuals and improving their skills still permeates much development practice. This is evidenced in the disproportionate emphasis on training as a strategy for capacity development at the expense of more sustainable approaches that enable progress and reform in support of social development.

In the CEE/CIS there is the technical know-how, the skills and the vision to communicate and advocate in support of health promotion and public health. The real problem is that the people who have these qualities, limited in numbers as they are, lack the authority, resources and political support to drive reform and make their full contribution to national development objectives. Training, education and professional development are of course vitally important, but unless the people who receive training and education are supported by decision makers, development partners and the bureaucracies that they work in, opportunities for progress will be only partially exploited.

A period of rapid economic and social change has been witnessed in all CEE/CIS countries since the break up the Soviet Union and the sheer volatility and pace of this change has undermined efforts to build sustainable mechanisms within governments that can have a stabilising and productive influence on public sector reform. As a consequence of relative political, economic and social chaos development partners have had difficulty assisting governments to build such mechanisms and have been compelled to take a more project driven approach to social development – in some countries in the CEE/CIS, especially the Central Asian countries, the World Bank has felt compelled to neglect sector wide approaches to health system reform in favour of approaches that improve service delivery, principally because population health needs are so pressing.

However, this period of burgeoning expansion and change is arguably entering a more balanced phase where private sector growth will start to even out and the focus may shift towards meeting demands for better services. There is also a growing and perhaps even grudging awareness among the medical establishment that the old curative approaches to population health have failed over recent years and that new modalities for improving health outcomes are required. In this context UNICEF may be able to contribute towards assisting governments in the region to improve their capacity to communicate for improved health and for social development more generally.

# 5. Communication, Public Health and Capacity Development

Public health is a public good. While public health is sometimes reduced to its core components – preventing diseases, prolonging life, and improving the quality of life – it is really much better understood as the promotion of good health as a multidisciplinary cross sectoral concern that impacts on society in many positive ways that support social, cultural and economic wellbeing. In the broadest sense of what public health represents the core functions of public health and its outcomes are public goods, and within this discourse health promotion and the spectrum of communications work that enables health promotion to occur are both core functions of public health, and the overarching focus through which public health objectives are achieved.

Health promotion therefore refers to a set of tools that can promote, encourage and foster healthy practices within communities (for example, communicative media, interpersonal communications between health service providers and clients, legislation and regulations), and the promotion of the governmental, institutional, policy, and resource environment that enables the use of these tools in the interests of public health and developmental objectives.

Before considering what might be done to better support health communication and health promotion capacity an overview of the reform of public health services, the role of development assistance, and the current policy environment is necessary.

## *Reforming Public Health Services*

A comprehensive assessment of the range of health systems reform in the CEE/CIS region is beyond the scope of this assessment, as is a detailed analysis of the role external assistance has played in supporting reform. However, summaries of country level health systems reform efforts and the contribution that development partners are making towards these efforts are contained within the individual country reports presented in Annex 2.

This section of the report is an attempt to broadly consider how public health services have been affected by the transition and what will be required to strengthen public health services in coming years. Hopefully this discussion will pave the way for a consideration of how UNICEF might play a role in supporting these objectives.

There have been several changes to the delivery of public health services since the break up of the Soviet Union, some of them have been positive and others have conspired to retard the delivery of public health services. These changes are summarised below:

***Decentralisation***

In most CEE/CIS countries the subordination of sub-national health services to national level administrations has become less pronounced. Central level public health institutions have in the most remained under the control of health ministries, but in some countries local public health services have been incorporated into local government structures, or local governments have been given an increasing say in how these services set priorities and deliver services. This has had some positive results, including in some instances, public health services becoming more responsive to local needs, even if resources at the sub-national level are so diminished that service delivery is a major challenge. Decentralisation has also

resulted in the shifting of public health functions further away from the interest of health ministries which has resulted in a diminished profile for public health services. It has also been noted in some countries that routine immunisation services have been compromised by decentralisation processes which have lead to a diffusion of operational responsibility in a system where vaccine procurement and distribution has in the past benefited, logistically, from centralised control.

***Changes in funding systems and the impact of public health services***
In many countries, particularly the CIS countries, economic crisis have greatly reduced public sector funding and the impact on public health services has been greater than on curative services. Changes in financing systems have also impacted on the capacity of public health authorities to deliver services. Before 1990, health care systems in CEE/CIS were financed directly from state budgets but now they are financed primarily through national health insurance or privatised schemes that are largely independent of government. As a consequence much less money is directed towards public health agencies than was previously the case. This has resulted in a curtailing of services and situations where public health agencies have been forced, in some cases, to sell services such as laboratory analysis or even to sell facilities. Some public health functions can be incorporated within clinical services but functions such as surveillance, primary prevention and health promotion require public health agencies that are autonomously funded, ideally from a central budget.

***Reductions in the number of health systems staff***
Prior to 1990 public health services were well staffed in the CEE/CIS but following the transition staff numbers have reduced. Many of those who left, primarily because of falling real wages and uncertainty about the future of services, were among the more dynamic and better trained personnel.

***Environmental health***
Since 1990 the issue of environmental pollution has become a priority for some countries that have initiated training and research programmes, although environmental health impact assessments are yet to become standard practice. As an example of new approaches to environmental health the WHO have led National Environmental Health Action Plans that have been adopted by a number of CEE/CIS countries. These plans attempt to coordinate different sectors of the economy and government by formulating sustainable strategies for environmental health. Unfortunately, like much public policy in the CEE/CIS, these strategies remain largely policy on paper.

***Health information Systems***
Over recent years investments have been made to improve the quality of information systems and health monitoring tools, and many countries now have computerised systems for reporting the incidence of different diseases. Many of these data are forwarded to international data bases including the WHO European Health for ALL statistical databases and to UNICEFs Trans-MONEE database of health and socioeconomic indicators.

Data quality of course depends on the quality of primary data collection, and for some health issues and some countries this information is somewhat unreliable, and as has been previously noted, the use of data is limited by the lack of data analysis capacity especially in relation to the design of public health and health promotion policies and programmes.

In addition, communication between different agencies within the health sector that collect, maintain and analyse data is inadequate and health information systems are

not integrated with management systems (this notion was strongly felt by informants from the European Agency for Reconstruction and Development in Serbia).

***Attitudes towards public health and health promotion***
For many CEE/CIS countries the predominant view within the prevailing medical culture is that population health is a product of curative services. Policy makers and other senior health sector personnel may support health promotion as a strategy to combat chronic disease, substance abuse or con-communicable diseases such as Avian Influenza, especially if these efforts are externally funded, but few understand how actions taken in other sectors (for example, education, housing or environmental protection) have an impact on health. Similarly, not enough people are able to make the connections between improving population health and the successful development of a society. As a consequence, different sectors do not adequately consider the impact of their policy decisions on public health and it is extremely difficult to gain support for health related initiatives in other sectors. While public health documents in the CEE/CIS reveal some focus on preventative programmes they generally only consider work that needs to be done within the health sector.

***The lack of a multisectoral approach***
Even within recent initiatives set up to be multisectoral, such as Avian Influenza Prevention and Preparedness initiatives, collaborations between different sectors and institutions remains problematic and in many ways runs against the bureaucratic grain. Inter-departmental cooperation is also an area that requires attention and without improved *communication* between the various mechanisms/departments contained within health sectors it will be impossible to work towards modernising approaches to public health.

***The emergence of health promotion***
Health promotion strategies, albeit ad hoc, have gained ground in CEE/CIS countries as a core function of public health over recent years. However much more needs to be done to support health systems to institutionally internalise health promotion issues, scale up efforts and take greater responsibility for implementation. In general responsive health promotion strategies have received the most attention. Most countries have, for example, some sort of programme in place for HIV prevention and for harm reduction among intravenous drug users. Other examples include efforts towards Avian Influenza prevention, the promotion of exclusive breastfeeding, and bread fortification.

There have been attempts to introduce intersectoral approaches to health promotion, including through the Healthy Cities Network which has promoted community engagement and intersectoral collaboration at the municipal level and through the WHO led Health Promoting Schools Network which was funded by the European Union and implemented in most CEE countries. However, as has been noted, these initiatives are externally driven and project and programme based, and consequently have not created sustainable mechanisms within health systems that might continue to promote health promotion as a valid and cost effective strategy for improving population health. This lack of sustainable approaches to development assistance was pointed out as a hindrance to institutional capacity development by a number of health sector informants in all the eight countries visited.

***Policy directions for public health***[6]

A 2004 study that was commissioned by the European Observatory on Health Systems and entitled *Health Systems in Transition: Learning from Experience* notes that in early 1991, a consultation by the World Bank with the Czech Republic produced six core principles vital to the improvement of public health services. The European Observatory on Health Systems in Transition report argues, and this report concurs, that these six principles are still valid. These principles, described below, are: preserve the good (for example, communicable disease control, vaccination and maternal health programmes); attack the bad; reform institutions; develop training; safeguard and improve budgetary allocations for public health; and adopt a multidisciplinary and multisectoral approach. This report strongly advocates that an ambitious multidisciplinary and multisectoral approach to health promotion, as defined by the Ottawa Charter for Health Promotion, underpins and informs *all* of these principals.

***Preserve the good:*** Preserve, or rebuild, the capacity of public health services for communicable disease control, vaccination services and child and maternal health. Countries that preserve the effective parts of public health systems are better prepared to meet new challenges (such as HIV/AIDS and Avian Influenza prevention) than those that allow their public health systems to be compromised by human and financial resource deficiencies.

***Attack the bad:*** Focus resources where they are most needed and ensure that notions of equity in health policy are reflected in equitable service delivery that addresses the needs of the most marginalised and vulnerable populations.

***Train in public health:*** Public health schools have been established in many CEE/CIS countries but generally focus on health service management rather than on population health, prevention, health promotion and strategic planning. Much more needs to be done to improve the quality and orientation of public health training in the CEE/CIS and to improve access to this training in a sustainable manner.

***Protect the budget:*** Countries in the CEE/CIS need to be lobbied to recognise that health promotion and preventative services are public goods that should be financed from public funds and allocated resources that are commensurate to the wide ranging benefits that such services can potentially offer.

***Adopt interdisciplinary and intersectoral approaches:*** Causes of ill health are complex and relate to a range of human rights issues that are widely recognised as central to social and economic development. While health sector interventions can make a valuable contribution to improving population health, the problems of ill health and the hindrance to social and economic development that it causes can only be addressed by addressing the broader determinants of health, and by establishing and supporting institutional mechanisms that can promote the value and efficacy of preventative health services, upstream, downstream, within the health sector and across the arms of government.

***Institutional reform:*** Reforms need to occur from within health sectors but development partners can assist by enabling models of institutional reform that invigorate reform processes and can be brought to scale. Key to creating an

[6] This section of the report is partly indebted to a 2004 study that was commissioned by the European Observatory on Health Systems and is entitled 'Health Systems in Transition: Learning from Experience'. This report provides detailed analysis of health systems reforms that have taken place in CEE/CIS countries since the break up of the Soviet Union.

embryonic nucleus of reform within health sectors that works to drive whole-of-sector reform is finding ways to retain and support the bright and motivated personnel who have the intellectual breadth and the necessary mix of public health and strategic planning skills to catalyse broader change.

## The Policy Environment

Despite the potential contribution that a focus on strengthening public health services and health promotion can make to improving population health and social and economic development more broadly, they have received inadequate attention from development partners to date. Instead governments and development partners in the CEE/CIS region have focused primarily on reforming health financing systems and the strengthening and modernisation of primary health care services.

As has been noted several times in this report development assistance directed towards improving public health services has been largely ad hoc and project driven. While this approach has been in many ways a practical response to the state of institutional flux that has typified health sectors in the CEE/CIS since transition, it has not lead to the necessary improvements in institutional capacity that could catalyze the system wide reform required to improve health outcomes in a sustainable manner. This project based approach is indicative of systems of development assistance that reflect the priorities of donors and international agencies working in public sector reform, and service delivery. Despite the 2004 Paris Accord on Aid Effectiveness there is still some institutionally sourced resistance, perhaps embedded within the political and bureaucratic cultures of bilateral donors and multilateral agencies, to aligning their work more closely with national priorities or broader needs in regard to public sector reform.

Throughout the course of this assessment health ministry officials bemoaned the lack of coordinated approaches to development assistance in the health sector – as one UNICEF Representative noted *'development partners pay lip service to improved coordination but continue to push their own agenda's'*. Some examples from the field that illustrate deficits in the way assistance is delivered are described below:

- The World Bank is of course a bank and therefore its priority is lending money for physical infrastructure and equipment but in the case of loans for equipment for primary health care centres, it was reported that sometimes health sector personnel do not have the training to effectively utilize this equipment. The reverse situation has also been noted where trainings have been provided but on return to their own countries health sector personnel do not have access to the equipment they need to maintain and utilize their newly acquired skills. The World Bank also establishes project implementation units to oversee Bank funded health projects and to ensure compliance with Bank regulations. Personnel within these project implementation units are provided trainings and are often supported by highly skilled international consultants. These units arguably deny the broader health sector opportunities to gain first hand experience in programme implementation, financial management and procurement. In Tajikistan it was noted that the World Bank supported Project Management Unit (or implementation unit) was named the Health Reform Department primarily because the World Bank assistance project for the Tajik health sector is named the Health Reform Project, not because it had responsibility for promoting reform or considering how reform might be best advanced.

- In Romania, despite laws that determine that non government organisations and agencies must seek approval from public health authorities to commence development projects, it was reported that projects are often implemented without this approval. The European Union has also been known to place unhelpful pressure on governments in order to hurry the approval of development projects.

- In Serbia, and probably other countries in the CEE/CIS region, USAID has, perhaps inadvertently, undermined national government mechanisms by implementing emergency preparedness exercises and capacity development activities at the regional level that bypass national authorities and largely exclude them from capacity building activities.

- In regard to Avian Influenza prevention and preparedness which has been a priority for the World Bank, the European Union, USAID, FAO, UNDP, WHO and UNICEF, it was widely reported by health ministry informants that there is a need for a greatly improved coordination of external assistance. In the Ukraine where work on Avian Influenza work has been, for some donors, something of a litmus test preceding a scale up of external assistance, this work has reportedly been partly used to lobby for influence within government and to establish key contacts. In Serbia, where UNICEF staff report that there are too many actors confusing the situation in regard to Avian and pandemic influenza preparedness, and the Kosovo situation is still unresolved, some government informants reported that they suspect that emergency preparedness work has also functioned to facilitate a degree of external influence over government.

- UN agencies and UNICEF, within the contexts of Avian Influenza prevention and other programme communication work in support of, for example, bread fortification, mother and child health, universal salt iodisation, and exclusive breastfeeding, have been *filling* capacity deficits in health sectors rather than addressing these capacity deficits in a sustainable way. There are often considerable impediments to implementing communications work in a more sustainable manner that builds capacity but if UNICEF, as an international organisation that likes to think of itself as also being intergovernmental, is to continue to move beyond service provision and increase traction with governments in the CEE/CIS region then new modalities for cooperation should be explored.

However, returning to the reform of public health services and support for preventative services and health promotion, it is clear that these issues have been repeatedly singled out for attention, even if nobody seem to know quite how to go about assisting health sectors to scale up health promotion interventions, or to support the enabling environment that is required for health sectors to do this work. As a precursor to the recommendations that are contained in the following section of this report, a consideration of potentials for partnership is required.

***The UN System***

As a part of UN reform, UN agencies are compelled to look for areas to increase cooperation, and in this context scaling up communications work is a key area worthy of consideration. As is noted in the *Rome Consensus on Communication for Development*, adopted at the World Congress on Communications for Development in January 2007:

*Communications for Development is a social process based on dialogue using a broad range of tools and methods. It is also about seeking change at different levels including listening, building trust, sharing knowledge and skills, building policies, debating and learning for sustained and meaningful change. It is not public relations or corporate communications.*

In the context of the UN systems agencies commitment to the Rome Consensus and the requirement of UN Country Teams to develop strategies in support of communications for development, there should be room to leverage for an increased focus on health promotion and the communications work that can enable and drive health systems reform. Albania is one of the eight countries around the world that was selected in 2007 to pilot a One UN Programme where 80 per cent of all efforts must be channelled through a single joint UN programme. Albania is developing a joint UN communications strategy as a part of preparations for the signing of an agreement with the Government of Romania for the One UN Programme in 2008. This strategy which is regularly updated could in practice reflect communication for development strategies, such as those that are recommended by this report. In any case there are, across the UN System in the CEE/CIS, opportunities to better coordinate communications and development work that supports health sector reform, of which health promotion plays a key part.

The WHO supports health promotion as a cross sectoral activity that must be integrated across all health programmes. However, this support is not active in the CEE/CIS region where the WHO has a small presence and does not explicitly articulate the need to establish an enabling environment and driving force for health promotion. According to WHO informants there was a health promotion department at WHO Euro headquarters in Copenhagen but this function of the organization has since lost much of its influence. Apparently, WHO Euro, in accordance with the opinions of health ministers (often former senior doctors) from its 51 member states, decided to relegate health promotion to a supportive function within broader health programmes. As one WHO representative put it – 'this is a reductionist approach – they cut out the brain'

However, there is no doubt that the WHO and personnel within WHO take preventative health and health promotion seriously, and in this context there is a need to reinvigorate the debate about health promotion and to engage with WHO as a partner who can provide sanction and technical support for a stepped up role for public health professionals working to promote and communicate health within CEE/CIS health sectors. WHO also facilitates high level health sector ministerial events and conferences that could be employed to advocate upstream for the importance of communications and health promotion within health sector reform.

UNFPA have a small but effective presence in the CEE/CIS and their work on reproductive and maternal health is complimentary to UNICEFs support to health sectors and focus on children, adolescents and women. UNICEF is however by far the better resourced organization and is in this sense well positioned to cultivate a more productive working relationship with the UNFPA. In Albania, for example, UNFPA are providing the bulk of advice to the health sector for the planned Demographic and Health Survey which they inform could be modified to better ascertain health information needs among populations. However, communications work is not their recognized forte and as such UNICEF is perhaps best positioned to advise that issues that could inform health promotion are more adequately addressed. It is the opinion of this report that UNFPA have a lot to offer and that UNICEF should take the lead in forging more productive relations at the regional level - working level relationships between UNICEF and UNFPA are clearly very

good in some countries but would be improved if potential areas for cooperation were formalized at the regional level – this could include more guidance for collaborating on health sector communications and health promotion work.

***The World Bank***

The World Bank are big lenders for health systems reform in the CEE/CIS and conduct excellent analysis of public expenditures in health, budgetary allocations, policy development, and the state of health systems reform. These technical resources should be better utilised and need not be duplicated at the regional or country level.

World Bank public expenditure reviews and health sector project appraisal documents for CEE/CIS World Bank funded health projects all, without exception, point to the need for an increased focus on preventative health strategies. However, the lack of emphasis on inter-agency consultation that sometimes typifies the way Breton Woods Institutes operate, and the Banks function as primarily a lending institution that provides ad hoc technical assistance, is not really conducive to allowing a more active engagement with these issues. Nevertheless, it is likely that the Bank would be supportive of any new modalities that support the development of health sector institutional capacity and drive health sector reform.

***The European Union and the European Commission***

The European Union, the European Commission and its agencies are the key players in the CEE/CIS region. Various different policy instruments determine the parameters of potential EU assistance for non EU member countries. These include: Stabilization and Association Agreements for Western Balkan pre EU accession countries; Joint Inclusion Memorandums that address issues of social inclusion for all pre-accession countries; the Instrument for Pre-Accession that enables funding for EU accession candidate countries; the Regional Strategy Paper for Assistance to Central Asia; and, the EU Neighbourhood Policy. Unfortunately none of these policy instruments explicitly address potential support to health sectors or health sector reform and instead focus on issues such as justice sector reform, customs reform and border control, economic reform, security, and cross border trafficking. However, the EU negotiates all agreements for assistance with individual countries and assistance can be tempered by specific needs. The Instrument of pre-Accession may also present opportunities for discussion as there is purported focus on human resources development and institutional capacity building which may present opportunities for broader policy interpretations to evolve.

For the neighbourhood countries which includes all of the CIS countries, the EU have allocated some 1.18 Billion Euros for the period 2007 – 2013 which is administered by the European Neighbourhood and Partnership Instrument which succeeds the TACIS programme. Under this instrument which is described by the EU as being – *"a much more flexible, policy-driven instrument that is designed to target sustainable development and approximation to EU policies and standards"* Neighbourhood countries can be granted funds depending on their *'needs and absorptive capacity'* but within the broader parameters of the EU Neighbourhood Policy. However, given that public health is a significant priority for work with EU Member States (see below) and that health promotion has been singled out as a key area for increasing emphasis, it might be reasonable to assume that the EU would be open to discussions about how health systems reform might be better supported in the CIS countries. The issue of regional public health security, in the context of emerging communicable diseases such as Avian Influenza, could also be put forward as a focus for discussion between UN Systems Agencies and the European Union.

The situation in pre EU accession countries is also problematic and it is very difficult to divert attention towards social sector development and away from compliance with the *Acquis Communautaire* and its emphasis on 'hard' reforms. Similarly, informants in Turkey, Albania and Serbia (the pre-accession countries visited as a part of this assessment) all reported that opportunities contained within the Joint Inclusion Memorandum and the Instrument for Pre-Accession to garner support for social sector reform are limited. Nevertheless, the European Commission is a very large and complex organization and as such may be looking out for new partnership arrangements and new ways to support social and economic development. In this context, personal connections and face to face bilateral meetings should help to find interpretations to policy that enable support to communications for development work.

In relation to the EU member states the situation with regard to health systems development and the policy of the European Commission is clearer and there are substantial opportunities for extended collaborations that should be explored. The European Commissions Directorate for Health and Consumer Protection (DG SANCO) Second Programme of Community Action in the Field of Health for 2008 to 2013 came into force on 1 January 2008. This Programme follows the first Programme of Community Action (2003 to 2008) which financed over 300 projects and actions. The stated objectives of the Second Programme of Community Action in the Field of Health for 2008 to 2013 are:

1. Improve citizen's health security. The focus will be on health threats and health safety, for example, in relation to pharmaceuticals and providing information to patients, and developing EU and Member States' capacity to respond to health threats in relation to health emergency planning and preparedness measures.

2. Promoting health, including the reduction of health inequalities. The main focus will be on children and young people.

3. Generate and disseminate health information and knowledge through action on health indicators and through new ways of disseminating information to citizens including E-health and a focus on community added-value to exchange knowledge in areas relating to gender, children's health and rare diseases.

The Health Programme for 2008 to 2013 is in the words of the European Commission – *Intended to complement, support and add value to the policies of the Member States and contribute to increased solidarity and prosperity in the European Union by protecting and promoting human health and safety and by improving public health*

Total funds allocated for this programme are stated as 321.5 million Euros.

## *Recommendations for Discussion*

This assessment and the analysis presented in this report, embryonic as it is, must inevitably ask the question – what can UNICEF do in the CEE/CIS region to support health systems reform with the ultimate goal of improving health outcomes for children and women, thereby in the longer term bolstering economic and social development at both national and regional levels? Programme communications work in support of social development and recent communications efforts targeted at the prevention of Avian Influenza have again clearly demonstrated to UNICEF itself, to CEE/CIS governments and to development partners that UNICEF has significant capacity as a communications resource centre that can support national governments to build systems, to innovate for progress and to better understand and address the development challenges faced. Programme communication as it has been known, or communication for development, or the related field of health promotion – whatever we want to call it - can function as a significant entry point through which UNICEF can leverage, facilitate and convene a wide range of activities and processes that support social development objectives and the sustainable capacity of governments to address public health outcomes.

The development of communications materials (IEC) that can be used to promote health is a discrete set of functions within the wider discourse of health promotion. However, because governments and development partners recognise UNICEFs expertise as an agency that can support these specific functions and because UNICEF has the credibility to be able to lead initiatives in this area, UNICEF can thereby employ strategies for the development of these functions as a precursor and entry point to the facilitation of collaborative support for institutional mechanisms that could address a wide range of issues that affect health systems reform. UNICEF is relatively small player in the CEE/CIS and cannot alone address the broad ranging health promotion and intersectoral needs of CEE/CIS health systems but in supporting health sector communications work UNICEF can gain much needed traction and broaden its role as an enabler of reform.

The overarching and principal recommendation emanating from this assessment is that UNICEF must use its communication kudos to leverage change from within CEE/CIS health sectors. UNICEF must build on its past experience and reassert its communication expertise in a manner that builds capacity across the health system and creates models of good governance that can inspire and drive social sector reform. Communication is at the heart of good governance and UNICEFs communication capacity is best directed where it will have most impact, which is, within the multidisciplinary framework of health promotion.

A first step must be to reinvigorate discussions about the role of health promotion and communication for development with the organizations that have potential to contribute to collaborative partnerships that support across-government capacity development for health promotion and with regard to the communications processes that enable effective health promotion and wider systems reform. Before this occurs UNICEF must recognise at the regional level that its credibility as a communications facilitator currently presents in the CEE/CIS a very significant opportunity for the organisation to assert itself as an *intergovernmental* agency that can leverage change and assist governments to achieve public health objectives. This requires a dual focus on communications in support of institutional reform and on the rights of children to good health which cannot sensibly be divorced from the need to improve health systems and health outcomes in general.

Whatever UNICEF wants to call its communications work in the health sector communications in support of improved health outcomes forms a big part of UNICEFs work in the CEE/CIS. This needs to be acknowledged. However, it is the opinion of this report that too much, but not all, of this work is designed and executed in parallel with government health agencies rather than through meaningful collaborations with government agencies that build capacity. The focus needs to shift so that government counterparts have a greater role in the design and implementation of health promotion strategies and can as such apply these skills across the range of public health priorities they face. Providing financial and technical assistance for the development of communications media that promote health is the entry point and a beginning for what can be achieved.

Perhaps the most significant finding of this assessment relates to the excellent quality of relationships between UNICEF programme staff and health sector partners in many of the countries visited and how these relationships work to effect change. The other significant finding of this assessment is that there are emerging cohorts of serious, committed, hardworking and skilled public health professionals working within CEE/CIS health sectors, and that UNICEF and other development partners do not adequately support these cohorts to leverage progress and reform. These professionals are the future of health systems reform and if development partners allow them to become disillusioned by the lack of progress and the lack of systematic external support (as opposed to ad-hoc support) then changes to the delivery of health services will not accelerate at a rapid enough pace to meet the many public health problems faced in the CEE/CIS. A 2004 study commissioned by the European Observatory on Health Systems and entitled Health *Systems in Transition: Learning from Experience* noted in relation to public health reform in the CEE/CIS that:

***One of the greatest challenges has been and continues to be the empowerment of those involved, so that the message that change is possible is conveyed and so that practitioners can develop a real sense of ownership of quality initiatives***

Building upon the work of this assessment and laying the groundwork for discussions with the European Commission's Public Health Executive Agency and WHO Euro is essential. Supporting networks, leveraging for increased investments in public health, initiating and supporting national level assessments, and collecting, analysing and disseminating global communications for development and health promotion resources will all be best achieved in partnership with other agencies that have vested interests in health systems reform. However, before such discussions can take place it is essential that within the Regional Office for CEE/CIS a lively internal debate is initiated around the development of a distinctively regional approach to how UNICEF might better direct its communications expertise.

Beyond these preliminary steps and advocating for expanded investments in public health, including preventative health strategies, it is the strong conclusion of this report that UNICEF should work with other development partners to pilot supporting the establishment of national coalitions for health promotion and communications. These coalitions would ideally comprise of a core membership of key public health personnel from within CEE/CIS health sectors and representatives from development agencies. Engaging with civil society, the media, non government organisations and community representatives on a rotating basis these coalitions would have the dual function of advancing and implementing health promotion agendas and informing, in the most practical ways, health sector reform and development. As a starting point a small group of public health professionals could be identified to work in collaboration

with UNICEF and other interested development partners to carry out in depth assessments of health promotion capacity at the country level and to look at what communications activities and processes are required to support the intersectoral exchanges of information needed to ramp up reform and improve the efficacy of public health systems.

Possible options for pilot countries could include Romania which can probably access EU funding to support further initiatives under the Second Programme of Community Action in the Field of Health for 2008 to 2013 and/or other EU member states that face similar capacity deficits as those identified by this assessment. Romania also has an established intersectoral communications working group that has overseen health promotion work since 2000 and has already established many of the connections and linkages that would be need to be built for other coalitions. Other options for an initial pilot would be Albania where preparations for the One UN Programme that will be agreed to in 2008 may offer opportunities for inter-agency collaborations that support communications and health systems development. Another options might be Uzbekistan where a coordination committee has been established to oversee the implementation of the recent World Bank supported public health strategy, or Moldova which being a small country with a small population and a health system in urgent need of modernisation, may, by virtue of the relatively small size of the health system and its openness to reform, present a supported communications working group significant leverage opportunities.

Building on the most effective of the existing communications working groups that were established to support Avian Influenza prevention may also prove a viable option, especially for those working groups that have defined their objectives as relating not only to Avian Influenza prevention but to hygiene promotion more generally. In any case where to develop and support coalitions for health promotion and communications is a context based question and very much open to internal discussion.

Another context based issue is whether or not to formalise coalitions. In some countries a formalised structure established by, for example, ministerial decree may render such a coalition more effective and influential and would perhaps be the preferred option in countries where the bureaucracy is stable enough to sustain support. In other countries a formalised structure may leave a formalised coalition at the mercy of the types of politically motivated reorganisations of the health sector that continue to unravel reform efforts in the Ukraine. In Romania where the communications working group has worked effectively for several years and where the bureaucracy is also relatively unstable, the communications working group has been protected from political vagary by the very informality of its structure. Careful consideration of local conditions by key government actors and development partners would determine the best operational modality.

Following on from in-country capacity assessments, national inter-sectoral coalitions could be established to provide technical oversight for health promotion, look for opportunities to build capacities that are identified as in need of attention, and carry out a range of other internally, but consultatively, determined communications functions that support health systems development. Below is a menu of possible functions that such a coalition could pursue in alignment with their own determinations as to what are the most salient priorities, and what is most achievable and or efficacious. National coalitions for health promotion and communications could consider the following actions as ongoing priorities:

- Providing technical oversight for all externally funded and government health promotion initiatives, ensuring that lessons learned are documented and that best practices are observed and disseminated
- Evaluating, or managing the evaluation of, health promotion initiatives
- Negotiating standing agreements with media agencies for airtime and cultivating productive working relations through regular meetings with media representatives
- Overseeing and organising the implementation of health promotion and media campaigns
- Functioning as an information clearing house that can absorb international best practice and disseminate technical resources throughout the health sector and at the sub-national level
- Preparing and research funding proposals for preventative health strategies and lobby major international development partners such as the EU and the World Bank to pay greater attention to preventative health and its role within the national context that the country level coalition works within
- Participating in and contributing to the work of regional public health coalitions such as the Paris based International Union for Health Promotion and Education and the Euro Health Network, and look to creating linkages with other national health promotion coalitions with similar objectives
- Looking for ways to reach marginalised groups with health promotion messages and to re-focus attention on achieving equity
- Looking for ways to improve the linkages between primary health care / clinical services and preventative health services – the excellent antenatal care available in many countries in the CEE/CIS offers a significant entry report for health promotion initiatives
- Liaising with, and supporting, other health sector departments with communications responsibilities
- Investigating, exploring and debating the merits of public health and health promotion training opportunities for health sector personnel
- Investigating and exploring the interface between health promotion/public health services and the technical resources that can be provided by national and overseas universities, and opportunities that may present for improved collaborations
- Instigating dialogues with communities about health determinants and possible approaches to health education and promotion
- Initiating and developing discussions with private sector entities that could contribute to public health and health promotion objectives – examining and reviewing the effectiveness of regulatory frameworks
- Considering ways to build upon initiatives that engage ***young people as active agents*** for health promotion in their communities through collaborations with education ministries and development partners actively engaged in educations systems reform – lessons learned from the WHO Health Promoting Schools Network would be a key resource
- Overseeing and informing externally funded research and analysis on budgetary allocations and public health policy development, perhaps with the assistance of rotating participation from policy think tanks, consultants or external agencies
- Lobbying decision makers to pay more attention to health promotion as a cost effective approach to improving public health outcomes and provide information (such as cost benefit analysis) upstream to national parliaments to secure expanded budgetary allocations
- Conducting cost benefit analysis relating to the efficacy of funding dedicated cross sectoral health promotion departments that have established mechanisms for promoting health across non-health sector policy

- Encouraging and driving an expanded focus on first interdepartmental but ultimately inter-ministerial approaches to public health
- Consultatively building donor oversight capacity as well as accountability and quality control mechanisms for government led public health reform projects so that donors become more confident about providing direct financial assistance to governments

To reiterate, this is a list of possible options which is meant to serve as a starting point for discussions about how to build capacity in sustainable ways, an issue that as one UNICEF Representative put it – 'needs to be brought back to life'. There is an urgent need for a qualitative shift in the way UNICEF goes about its work in the CEE/CIS and in this context there is a need to open discussions about what sort institutional infrastructure can be enabled to effectively absorb and administer technical and financial resources. The establishment of a national coalition for health promotion and communications for development, in effect a 'brain' within health sectors that influences processes from within is something that UNICEF has the technical resources to achieve, and the standing among development partners to leverage.

The establishment of communications working groups for Avian Influenza prevention has demonstrated that it is possible to develop new mechanisms, the challenge however is to build upon what has been learnt and see beyond the end of programme cycles. In this context creating incentives for sustaining the engagement of talented health sector personnel is one challenge that must be addressed. Another is garnering commitment among partners to ensure that a sufficient flow of resources is maintained to ensure the longer term viability of such a coalition. One way that UNICEF and / or other development partners could provide more sustainable financial support is by lobbying all donors that fund health related interventions in the CEE/CIS to allow a small percentage of allocations to be dedicated to health promotion and health communication capacity development.

Many of the actions listed above can be advanced by external partners with varying degrees of participation from government counterparts. However, finding ways to better resource and thereby encourage counterparts to take greater responsibility and to lead health system reform will be the key to longer-term sustainability. This means investing in a vitally important community of professionals who can leverage reform – *a community in the capital not the country*.

# 6. Annexes

## Annex 1: Assessment Terms of Reference

# UNICEF CEE/CIS Regional Assessment of Health Promotion and Communication Capacity

## Project Description and Terms of Reference

16 November 2007

***Internal UNICEF use only – not for circulation***

***Rationale***

In the context of the potentially pervasive threat of an AI/HI pandemic; the need to review the range of preparedness and prevention work that has already been undertaken; the lessons that can be learned from these endeavours; and, the need to look to ways to assist governments in the CEE/CIS region to build their capacity for pandemic preparedness and health promotion and communication in general, the UNICEF RO for CEE/CIS (Communication Section, in Partnership with the Health and Nutrition Section) plans to conduct and assessment of health communication capacity in the CEE/CIS region. Health promotion and communication capacities will be reviewed for all countries in the CEE/CIS region but special consideration will be given to Serbia, Ukraine, Moldova, Turkey, Uzbekistan, Tajikistan, Albania and Romania.

This assessment will provide useful insights into health promotion and communication capacity in the CEE/CIS region. In addition, the processes required at the country level to facilitate this assessment will be useful for government counterparts and programme staff.

***Engagement and human resources***

A consultant, Mr. Karl Spence, has been engaged to plan, manage, execute and finalize this research. Mr. Spence has had extensive experience as a social development researcher, project manager and evaluator. He can be contacted at kspence@unicef.org or by telephone on +41 (0) 22 909 5411 or +41798377541. All questions relating to logistics, content and process should be directed to Mr. Spence by e-mail, and, if necessary, followed up by phone.

Technical and managerial oversight will be provided by the Regional Chief of Communications Mr. John Budd, his deputy Mr. Mervyn Fletcher, the regional Health and Nutrition Chief Mr. Sanjiv Kumar and the regional Immunization Project Officer Mr. Dragoslav Popovic. At the country level the pro-active engagement of Communications and Health Programme officers and their technical inputs will be critical to the success of this endeavour.

***Project objectives***

The overarching objective is to conduct qualitative baseline research on health promotion and communication capacity in the CEE/CIS region within the resource limitations that present, and, specifically in relation to health communication for AI/HI

pandemic preparedness and prevention, and, generally, in relation to health communication and promotion systems within the region. AI/HI pandemic preparedness and prevention is an entry point and a key focus but will serve, along with other examples of health communication initiatives, as indicative of capacity deficits and needs.

The level of human and financial resources available for this project, the need to assess a broad range of regional capacity issues, and the methodological limitations of working within these constraints have determined the parameters of this research, as well as what is feasible and achievable.

While this assessment will result in very useful insights and qualitative analysis on national as well as regional level health promotion and communication capacity, CO level decisions will determine what future uses the regional assessment and associated processes will have at the national level - for example, this project may well stimulate processes that lead to comprehensive and systematic national level health promotion and communication capacity assessments facilitated by the MoH, in collaboration with UNICEF (guidelines are available).

By virtue of the regional assessment being a 'regional' assessment it requires a more generic set of research goals that facilitate comparisons, strategic planning and the identification of future needs. The regional assessment will also require responsiveness and flexibility to deal with country-specific contexts, and to address the varying needs of governments in the region.

***Processes***
To meet these objectives a number of processes and elements will inform the research. These are:

- A desk review of: available information relating to health communication and promotion capacity; health communication activities in support of AI prevention and preparedness; and of relevant strategic planning and policy documents.

- The development, dissemination and completion of a questionnaire that assess national health communication capacity. This questionnaire to be completed by Health Programme Officers, in collaboration with counterparts from MoH, will guide and inform in-country discussions and provide a road map for possible further in-country assessments and/or follow up. The questionnaire will also serve to stimulate government engagement in regard to issues of health promotion and communication capacity and ensure that partners are aware of the scope of the issues that need to be addressed.

  A questionnaire that assesses communication activities specifically for AI prevention and preparedness has already been distributed and completed by Communications officers in the region. The results of the broader health promotion and communication capacity assessment will expand on and compliment information that has already been collected on AI communication. In addition to guiding research, both these questionnaires will also help to establish a qualitative data set on which the final assessment report can be built. The questionnaire is a multiple choice questionnaire and should take Health Programme Staff and MoH counterparts about 2 to 3 hours to complete. Full instructions on how the utility value of this questionnaire can be maximised will be forwarded with the questionnaire on Monday 19 November.

- A series of in country meetings will be convened to expand on, and probe, issues that surface as a consequence of these questionnaires. These in-country meeting will also serve to assess how UNICEF and other development partners can assist in meeting government needs with regard to health promotion systems development.

  While CO level suggestions in regard to how in-country discussions are organized are welcome it will engender a more dependable and hence more comparative approach if the sequence and composition of meetings is broadly consistent for the eight countries chosen for in-depth analysis. For each two day visit conducted by the consultant the following meetings are proposed:

  1 Day one (AM): Meeting and discussions with Representative, Deputy Representative and the health and communication programme officers. COs may also, as appropriate, wish to invite other *non-government* partners from, for example, other UN agencies or the World Bank. COs may also determine that these partners are best met on a one to one basis or at a different time. The purpose of this preliminary meeting will be to clarify and expand on the range of salient issues in-house, and to fine tune arrangements and objectives for the subsequent meetings.

  2 Day one (PM): Meeting and discussion with 2 or 3 key informants from the national media (e.g. journalists, TV or radio producers, or media monitors). The intention of these meetings is to elicit information about the extent of media engagement with health promotion, and about the general situation vis a vis productive relations between the media and government that serve health communication objectives.

  3 Day two (AM/PM?): Meetings and discussions with key counterparts from the MoH, particularly staff who are involved with pandemic preparedness, health promotion and communication, system reform and policy development (ideally the partners that should be invited are those that are able to contribute most frankly to discussions - both the Communications and Health Officers should also attend these meetings). The exact mix of counterparts invited is of course best determined at CO level but it is recommended that the partners invited are at a relatively senior technical and managerial level and that nobody present is so senior that their presence will inhibit a frank and open exchange between other participants.

  4 In addition to these meetings, a meeting with either the Minister, vice-Minister, or at MoH Director level will contribute significantly towards improving knowledge in relation to issues of political commitment for system reform and/or the self-expressed needs of government.

***Timeframe***

It is expected that all desk-based and primary research will be completed by early February and the Assessment Report will be completed by the end of March.

***Project results***

This assessment will provide a comprehensive report that identifies key regional needs and trends in relation to health promotion and communication capacity. At a national level the assessment will aim to identify key deficits and needs and consider

options for health promotion and communication capacity development. This final report is also expected to inform funding proposals for capacity development that will be prepared in 2008. Other results that are dependent on variables which may or may not be surmountable (such as the level of in-country engagement and commitment to the assessment process) may include:

- An enhancement of government awareness of health promotion and communication capacity issues and their importance to the overall delivery of quality health services
- Opportunities to strengthen relationships between the media and the MoH
- The identification of key areas for further research
- The identification of priority areas for increased investments
- A better understanding of how health communication links to national pandemic and emergency preparedness

# Annex 2: Country Information Reports

## Serbia

**i) Health status:**

Population: around 10 million. GDP Per Capita (USD 7,700, 2007)

Serbia and Montenegro has low child mortality levels (U5MR was 14/1,000 live births in 2003) and routine immunization coverage near 90 per cent nationally. However, figures mask significant disparities. Disease related mortality is highest among children living in poverty and within marginalized groups such as Roma, among which immunization levels are the lowest.

A National Burden of Disease and Injury Study conducted in 2003 indicated that cardiovascular diseases, cancers and injuries are responsible for 80 per cent of the total mortality burden for both males and females.

**ii) Recent and current health sector reform efforts, national mandate / policies and political leadership:**

On paper, Serbia appears to have a well developed healthcare system with primary, secondary and tertiary care centres, however the system is inefficient and under funded. Progress towards reform has been slow.

Reform of the health sector is generally considered to have got underway in 2000 as Serbia started to recover economically from the effects of the conflict in Kosovo (economic downturn, war, sanctions, NATO bombing campaign). In 2002 representatives from the MoH, the HIF and the IPH participated in an exercise aimed at articulating the overall vision for the health sector. The government's vision statement agreed in August 2002 (the Serbian Health Vision) outlines a three tiered approach targeted at ensuring affordable and effective service. The statement also delineates other key strategic directions. These include: ensuring equality of access and financial coverage of services through the HIF for all citizens; priorities for basic health care will be determined in relation to the cost effectiveness of interventions and disease burdens; a high priority for preventative health and PHC services; an increased involvement of the private sector and non-profit sector; the development of supplementary and private health insurance; improved definition and separation of the roles of users, payers and providers; and, the promotion of the quality of services as a key strategy.

A working version of a Strategy and Action Plan for the Health Care Reform was prepared by the MoH in early 2003 following the earlier adoption of the Health Policy of Serbia and the development of the Serbian Health Vision. This Strategy is also based on the UN Millennium Development Goals, the WHO strategy 'Health for All in 21st century' and EU directives in the field of health. It covers topics such as health financing, public health development, health care system delivery, human resources development, health information system and health management, as well as the new role of the MoH.

In 2004 the MoH made a major policy commitment to move towards a preventative health care approach and developed, in consultation with the European Agency for Reconstruction, a project to improve preventative health services in Serbia (see below). Implementation began in September 2004.

In Serbia, Minister of Health, Tomica Milosavljevic, has been in his position since 2000 and is widely considered to be energetic and pro-reform. Prior to his tenure, systems were antiquated and the MoH would willingly accept any project offered by external partners. Achievements since 2000 have been significant and presently MoH largely sets the reform agenda. Health Sector reform is posited within the wider context of European Integration and the reform of the public administration.

**iii) Development Assistance and the health sector:**

Apart from some limited assistance (provision of medical equipment) that has been received from bilateral's (mainly Japan and China) the EU through the EAR and the WB are the main donors for the health sector. UNICEF has also played and active role.

**EU Assistance 2000 - 2007**
EU Emergency assistance following the Kosovo crisis included the purchase, maintenance and repair of key equipment, essential medicines and the refurbishment of health facilities. Capacity building efforts have included the modernization of medical services; assistance with the establishment of a blood transfusion system and pharmaceutical sector, including setting up a regulatory agency; the establishment of a school of public health in 2005; the development of a Health Information System; and support to improving preventive services in 25 Primary Care Centres. Support to institutional reform has included efforts aimed at improving the performance of public health laboratories; the national health insurance fund; the payment system in primary health care; and tertiary care services.

Future EU assistance will focus on: health care waste management; capacity building for tertiary care; support to the implementation of capitation payments in PHC; trainings for health service management; assistance to the preparation of Instrument for Pre-Accession programme 2007 – 2009 (emergency medical services, health technology assessment; and drug prevention strategy development)

The proclaimed objective of the World Bank are to build capacity to develop a sustainable, performance oriented health care system where providers are rewarded for quality and efficiency and where health insurance coverage ensures access to affordable and effective care. The WB project has two components: 1 - Health Services Restructuring – support for government efforts aimed at improving efficiency and quality, 2 – Health Finance, Policy and Management – aims to build the capacity of the government to develop, communicate, and effectively implement health financing mechanisms, health policy, and health sector regulation.

**UNICEF – Ongoing**
Technical assistance and financial support for MCH, breastfeeding, immunisation (cold chain strengthening, vehicles, procurement), especially for marginalised children, baby friendly hospitals, IMCI and USI, communication for AI prevention.

**iv) Tracking of determinants, and health data collection and analysis:**
Routine statistical reports are produced once a year and DevInfo health data is updated twice a year. The tracking and reporting of health determinants is less frequent with the last National Burden of Disease and Injury Study conducted in 2003. This study indicated that cardiovascular diseases, cancers and injuries are responsible for 80 per cent of total mortality burden for both males and females. Data are not systematically published or widely available. However, it is apparent that data (2005/06 MICS and National Health Surveys) are been considered in relation to policy development and planning – UNICEF presented MICS data to the Parliament in December 2007.

**v) Evidenced based policy development, implementation and regulatory frameworks:**
While the use of evidence is increasing, the MoH has no functional mechanism for developing health promotion policy and plans *across* sectors. Neither NGOs nor the private sector are actively engaged in policy development or planning. Efforts to evaluate the implementation of policies and plans are limited to MICS and National Health Surveys, and efforts to ensure accountability and transparency in decision making are nascent.

Legislation and regulations that address priority health issues are in place (for pharmaceuticals, communicable diseases and sanitary inspection) at the national level (to a lesser extent at the sub-national level) and Serbia is signatory to international instruments such as the International Code on the Marketing of Breast Milk Substitutes (adopted in 2005) and international protocols on tobacco control. Serbia is currently chair of the WHO regional committee.

Generally speaking reforms efforts are still evolving. Regulations and legislation have only recently been put in place and national plans have only recently been developed. As such it is difficult to evaluate implementation. The CO feels that MoH is making genuine effort to reform and improve accountability and transparency.

**vi) Infrastructure and program delivery for health promotion and some key issues:**
Partners have commented that there was and is no real culture of preventative care (incl. HP) in the Serbian health system; although since 2000 there have been substantial efforts to

redress this situation.

Public health and health promotion are the responsibility of the IPH in Serbia which has national offices and offices in each of the 23 regions – public health services still suffer from a medical culture which places emphasis on traditional hygiene and clinical approaches. The efficacy of the work of the IPHs at the sub-national level is unclear and it is thought communication between the 23 regions and the 160 municipalities is not good. Within the IPH there is a national Centre for Health Promotion which has personnel at the district level. The Centre consists of three departments and three national offices. These are: Department of Health Education; Community Mobilisation Department; Department of Health Promotion for Vulnerable Groups; Office for Tobacco Control; National HIV/AIDS Office; and Office of Non-Communicable Disease Prevention. In their own words the aim of the Centre for Health Promotion is to: "*promote community health, provide educational services in a multi-disciplinary and multi-sectoral approach, particularly concerning vulnerable groups with special needs"* Key activities include: Risk analysis and health promotion through PHCs; program coordination and evaluation; health promotion in schools; cooperation with mass media; prevention of communicable diseases and provision of public information; education and technical leadership.

The Health Promotion Centre draws attention to many major national and international health days.

Health promotion efforts, with assistance from external partners, have been expanded over recent years but generally speaking it is not clear how effective the Centre for Health Promotion is, especially at the sub-national level – there is a need for the centre to update approaches. The 2003 National Burden of Disease and Injury Study found that the public where generally unaware of health promotion initiatives, with the exception of HIV/AIDS which has been a focus of externally driven interventions. Links between communities and public health services are undeveloped and in need of strengthening and a further integration of health promotion activities into PHC services is needed. Reaching marginalised populations such as the Roma has proven especially difficult.
Examples of campaigns that have been conducted to date include campaigns that provide information on: HIV/AIDS, MCH, USI, health lifestyles and smoking cessation.

**vii) Workforce issues and training for public health and health promotion:**

Nationally some 246 people are employed by the IPH. Of these 115 have university degrees and of these, 60 apparently have some form of specialisation in public health (it is unlikely that many of these have received modern training in HP or PH but rather have training in, for example, communicable disease prevention or epidemiology). The Centre for HP employs 14 people 11 of whom have university degrees.

As with other arms of the public administration, salaries are extremely low (maximum E300 per month).

Training in public health is provided through the Institute for Social Medicine and the Belgrade School of Public Health which was established with EC support in 2005. The Masters Degree in PH offered by the school offers 2 or 3 units that directly relate to health promotion.

**viii) Institutional and cross sectoral linkages / donor coordination and private sector partnerships:**

There are donor coordination mechanisms in place to guide external inputs to the sector – how well it functions is unclear. Communication between the various parts of the MoH needs to be improved as does reporting on health related issues to the national parliament. Communication between the MoH and other ministries is limited although cooperation with the Ministry of Agriculture for AI prevention has steadily improved. There is also some limited cooperation with the Ministry of Education in order to engage teachers in HP strategies and campaigns.

Cooperation with NGOs is improving but still limited. The only example of cooperation with private sector cited is in relation to USI initiatives.

**ix) Health sector financing:**

Budgetary timeframes do not allow for medium and long term planning for health promotion.

Funding for health sector is not transparent and public health / health promotion authorities have little discretionary power and are unable to make autonomous decisions about budget allocations. Funding for health promotions is largely absorbed by salaries and basic operational costs – the costs of campaigns are met by external partners. Funding for public health / health promotion as a part of overall spending is unclear.

Overall spending in health sector as a percentage of GDP (2004/05) is around 8 per cent (EU 15 average 8.8). Of total expenditure on health 63 per cent is public expenditure (EU 15 average 90 per cent). NB: GDP is as for low to middle income in Serbia and the system suffers from inefficiency

**x) AI and pandemic preparedness - Status / achievements:**

A national Influenza Preparedness Plan (incorporates AI prevention and PI/HI preparedness) is in place and was communicated to health professionals through a series of workshops in 2005. Operational plans have been developed at the national and district level and guidelines for the implementation of preparedness plans have been adopted. Other achievements aided by external partners include: the preparation of AI prevention plan and IEC materials; facilities for patient isolations established; procurement and distribution of protection equipment; stockpiling of anti-viral drugs; government level coordinating body for AI prevention established with representation from MoH and MoA; assessment of preparedness in all districts in 2006; learning symposium on crisis communication in Belgrade 2007; mobile epidemiological teams trained for quick reactions; and roundtable discussions on crisis communications organised with media and health sector managers.

Preparedness for AI in the health and agricultural sectors and in Serbia as a whole is satisfactory; however preparedness for PI is unsatisfactory (by the admission of the intersectoral AI task force). Interestingly, the UN Pandemic Influenza Contingency planning website determines that Serbia is rated as 'more prepared' as opposed to 'medium' and 'less' prepared. The AI task force points out that while the general pandemic preparedness plan is a component of the National Influenza Preparedness Plan it is not an operational element of that plan. National AI Task force consider that it is essential that PI preparedness activities are stepped up and that an intersectoral pandemic preparedness task force is established.

At the national level there is an inter-sectoral coordinating body for AI preparedness (AI task force) but not for PI preparedness. AI Task Force is made up of representatives from MoA and MoH who are cooperating well. However, the task force has been somewhat destabilised by political changes - the task force is chaired by the Deputy Prime Minister and there have been three Deputy Prime Ministers in the last 2 years.

The AI task force acknowledge that there needs to be an improved understanding of the differences between preparing for AI and PI within government, especially in as much as that pandemic preparedness is a model that relates to threats from many communicable diseases

Currently the pandemic preparedness plan is largely a healthcare system response plan to the threat of an influenza pandemic in WHO Pandemic Alert Phases 3 and 4 and lacks the planning details and arrangements for national critical infrastructure to keep the society running during the Pandemic Alert Phases 5 and 6, subsequent pandemic waves. To redress this situation UNDP have submitted a proposal for USD500,000 to assist the Government of Serbia in developing a comprehensive national pandemic preparedness plan using the Whole-of-Society multisectoral approach. This plan will include the establishment of an intersectoral PI preparedness mechanism.

Generally it is felt that there are too many actors contributing to AI prevention and PI preparedness and not enough efforts to channel assistance through government. Despite this situation, and the fact that the AI task force is comprised of representatives from four different political parties, the national AI task force is thought to nevertheless be aware of its own strengths and weaknesses and its advice should be sought in relation to all AI and PI focused interventions.

Currently the Ministry of Defence and the Ministry of Interior are at loggerheads over who should take responsibility for general emergency coordination and it is thought that it is

unlikely that an inter-ministerial task force for PI preparedness will be established prior to the resolution of ongoing arguments about Kosovo. At the municipal level some municipalities have good emergency response systems in place which are supported by the USAID funded scopes project. For more detail see:

http://serbia-montenegro.usaid.gov/code/navigate.php?Id=210

**xi) Communications as a component of AI and pandemic preparedness:**

A KAP survey was done prior to the roll out of IEC AI prevention materials, however, directive for KAP came from RO and CO comments that there was inadequate time to incorporate from AI task force and other partners. Implementation was hurried.

At the time of writing there was a communication strategy in place for AI prevention but not for AI preparedness. However, UNICEF is in the process of assisting the government with this task and has developed a proposal for USD200,000 from USAID to support communication for pandemic preparedness (current status of this proposal is unknown). There is a UN Theme group for AI/PI which delineates WHO as responsible for outbreak communication. However, there is also some confusion over responsibility for communication – UNICEF as delegated as the lead agency for the development of AI preventative information but it seems UNDP are currently planning a workshop on crisis communication and the development of PSAs.

# Moldova

**i) Health status:**

Population: 4.32 million (under 15: 16.5 per cent), GDP Per Capita (USD 2,200, 2007)

Health indicators have improved but remain well below EU averages. Moldovan average life expectancy is 68 years, 12 years shorter than the average for EU countries. Life expectancy of Moldovan women is the lowest in the European region at 71.6 years. There is progress in several areas: for example, infant and maternal mortality has declined (IMR has fallen from 35/1000 in 1990 to 15/1000 in 2005).

Nevertheless, chronic diseases such as cardiovascular diseases cause double the share of avoidable mortality in the working age population as in the EU. The re-emergence of TB (TB incidence is thought to be 11 times higher than EU averages) and emergence of HIV/AIDS in the mid-1990s pose serious risks to the population; this has become a concern not only for Moldova but also to the EU, considering its Neighbourhood policies and programs. As the World Bank have noted: investments to improve the quality of health services would decrease avoidable mortality and disability and would, over the long-term, reduce poverty and enhance economic growth.

**ii) Recent and current health sector reform efforts, national mandate / policies and political leadership:**

The reform of the health care system in the Republic of Moldova has been slow. Following independence in 1991 the government tried to maintain the existing high levels of health care provision but the worsening economic climate undermined these efforts. Recent efforts aimed at health sector reform include; the establishment of regional health administrations with devolved responsibilities for financing, management and the planning of services; a reduction in the overcapacity of beds and staff in the hospital sector; and the integration of 'family' doctors into primary health care services. A new method for funding health care based on age-weighted capitation was introduced in 1999, and to partially offset the poor financial situation of the health care system, the government in 1999 introduced official fee-for-service payments. However, as the health care system continues to endure funding shortages many providers have begun to levy informal user charges. These charges place a heavy burden on health care consumers and, as for other countries in the region, result in inequitable access to and utilization of, health care, especially among less better off rural users.

The MoH has recently prepared a National Health Policy 2007-2021 with a five year implementation plan. The strategy builds on the achievements of ongoing reforms in the sector. The medium to long-term vision of the MoH can be summarized in terms of three pillars: to focus the MoH on health promotion, policy and regulatory functions; to improve the level of financing to the sector and the efficiency with which available resources are used, and third, to improve the quality and effectiveness of health services.

There is also a 2007 – 2011 National Health Promotion Strategy (or: National Programme for the Promotion of Healthy Lifestyles). This strategy was developed by the Moldovan Centre for Preventative Medicine (CPM) and partially evolved out of a 2003 – 2005 EU Health Promotion and Disease Prevention project. Approved by government in June 2007 the National Health Promotion Strategy will, according to the CPM, require at least USD 850,000 to implement. USD 550,000 is sought from external partners but the government has not been able to guarantee the remainder of funds, even though the Prime Minister has apparently identified HP as a key strategic priority. The CPM Deputy Director has approached the WHO and other donors for funding but no agreements have been reached.

**iii) Development Assistance and the health sector:**

The main donors/external actors currently contributing towards improvements in the health sector are the World Bank, the EU through the TACIS arrangements, DFID, WHO and UNICEF

The World Bank has a Health Services and Social Assistance project (2007 – 2011). The objective is to assist the government to increase access to quality health services with the aim of decreasing premature mortality and disability. The project has three components: 1) health

systems modernisation project which will, along with other partners, support the 2007 – 2021 National Health Strategy (capacity building for policy development, institutional financing and management); 2) social assistance and welfare components; and 3) institutional support component (provides logistical support for the working groups assisting in implementation of social sector reforms)

The EU Public Health Reform Project which is now completed is aimed to increase knowledge and skills among health managers; strengthen training institutions; improve planning and management procedures in 2 regions; develop models for health in formations systems at all levels, piloted in 2 regions; development of performance indicators in 2 regions; and raising community awareness of health reforms.

In areas that relate to the health sector DFID works to improve public administration and to support statistical analysis.

USAID works through INGOs (not government) to strengthen Decontrol and to prevent HIV/AIDS and hepatitis.

WHO has limited presence and funds small scale TAs worth up to USD 10,000

UNICEF work in Moldova includes advocacy for legislative reform that ensures women and children have free access to health services (especially prenatal, obstetric care and immunisation); trainings for health workers on PMTCT; immunisation; MCH and ECD; TV and radio campaigns in support of immunisation and AI prevention; USI initiatives; and HIV/AIDS VCT for young people. SIDA and UNICEF have campaigned and promoted awareness of the 4 key health risks for new born babies.

In addition, the Swiss Agency for International Development have implemented campaigns in 2006 to promote iron and folic acid for pregnant women – after a national TV campaign more than 70 per cent of women attending health care services requested these supplements.

**iv) Tracking of determinants, and health data collection and analysis:**

Data is collected annually at the central level by the Institute for the Management of Public Health Services. This data is collated for annual reports and in theory used to assist with strategic planning and policy development. Determinants are not systematically tracked.

Data and trends are made available within government but are not generally available to the public. Although the MoH website does contain a link to 'statistics' there is nothing available to download.

**v) Evidenced based policy development, implementation and regulatory frameworks:**

Clearly available data have been used to inform the development of the National Health Strategy and the Health Promotion Strategy but the implementation of these policies is extremely problematic, primarily because of the lack of financial, human and technical resources available.

Regulatory and legislative frameworks are largely not in place for the health sector in Moldova and evaluation systems are rudimentary. The pharmaceutical sector is also largely unregulated which has lead to a large black market for drugs in Moldova. The World Bank has argued that the MoH is trying to shift away from direct management of health care towards regulatory functions.

**vi) Infrastructure and program delivery for health promotion and some key issues:**

The MoH is responsible for general public health services while health promotion in Moldova is the responsibility of the National Scientific Practical Centre for Preventative Medicine (CPM for short). Within the CPM there is a department for health promotion which is currently staffed by 4 doctors (2 part timers) – this department is critically under funded. These doctors apparently have some training in Public Health. Within each of the 36 regional CPM's there is sometimes also a health promotion officer, although anecdotal evidence suggests that these posts are inactive. Apparently each regional office develops its own annual plan for HP that is in line with national priorities but the extent that these plans are funded and/or implemented is unclear. There is some attempt to evaluate each year through meetings in the capital but these meetings focus on the review of quantitative indicators (number of meetings held,

number of patients and their ailments, etc) not qualitative evaluative processes.

Current priorities for health promotion are for school level interventions that target alcohol and drug abuse and HIV/AIDS/STIs. Other priorities are family planning, mental health and hygiene promotion. CPM also has a plan to establish HP information centres in all regional office to support HP efforts, especially in schools.

Despite positive changes and a shifting emphasis towards preventative health, public health in Moldova remains, in practice, focused on the traditional functions of the old sanitary-epidemiological service, with an emphasis on control of communicable disease and environmental health. These activities are run as separate vertical programmes with their own structures apart from the health care delivery system (with the exception of immunization) and the regional health administrations. Generally there is no financial incentive for health promotion either for individual health workers or regional centres. Almost all health promotion activities in Moldova are undertaken with external funding and often at the behest of donors and/or multilateral agencies – that efforts are made by external partners to conduct HP activities is also, in the context of limited resources generally available to the sector, a disincentive to government allocating funds to HP initiatives.

Many opportunities to scale up HP activities in Moldova are being overlooked, including through the excellent antenatal care networks that exist.

**vii) Workforce issues and training for public health and health promotion:**

As for other transition countries a specialisation in PH and / or HP is considered low status within the medical profession. Salaries for government workers in the health sector, including physicians, are also extremely low – perhaps 10 per cent of what can be earned in the private sector. Out of pocket payments are common and there is no incentive for doctors to conduct health promotion work.

In terms of training available in PH and HP there is a medical university in Chisinau which has a public health department. The SOROS Foundation (non-profit / philanthropic) founded a School of Public Health and Management in 2005 and offers a masters degree program. SOROS and the Government also co-fund scholarships for students at the school. For more information see:

http://www.soros.md/programs/health/phhrdp/en.html

In addition, an EU 2003 - 2005 Health Promotion and Disease Prevention project developed training curricular in collaboration with the Medical University. Trainings for CPM staff have been conducted on HP and issues such as prevention of cervical cancer, tobacco control, and cardiovascular diseases...

**viii) Institutional and cross sectoral linkages / donor coordination and private sector partnerships:**

As government in Moldova is relatively stable and compact there are more opportunities for cross-sectoral communication than in, say, neighbouring Ukraine which is politically distraught. There is evidence of some cooperation between MoH and the MoE in relation to MCH initiatives and there has also been cooperation between MoH, MoJ and the Ministry of Public Administration in relation to TB control. Health sector donor coordination meetings are convened but health sector policy development and planning is generally donor driven. Private sector partnerships have also only been established through donor leveraging and are limited to arrangements relating to salt iodisation and breast milk substitutes. Generally formal mechanisms are not in place to support inter-ministerial or inter-departmental cooperation and what cooperation does occur is ad hoc and mostly associated with externally driven work around issues such as AI.

**ix)) Health sector financing:**

According the World Bank's 2007 Public Expenditure Review, spending on health, both public and private, has increased since the 1999 regional crisis. As a share of GDP, total health expenditures have increased from around 6.5 per cent of GDP in 2001 to 9.8 per cent in 2005. Public health expenditure increased from 2.8 to 4.3 per cent of GDP in the same period (all ministries, agencies and levels of government). The level of allocations directed at HP activities is indeterminate.

**x) AI and pandemic preparedness - status / achievements:**

There is a national AP prevention plan in place under the jurisdiction of the National Extraordinary Anti-epidemic Commission (national AI coordinating body or task force). This body is cross-sectoral and is comprised of representatives from the MoH, National Centre for Preventative Medicine, MoA, and the National Centre for Veterinary Diagnostic, Ministry of Internal Affairs, Ministry of Ecology and Natural Resources, State Customs Service, Ministry of Transport and the Ministry of Education and Youth. The plan was tested through desk top simulation exercises in August and September – CPM claim that plans have also been tested at the regional level. In terms of PI/HI preparedness there is a national PI/HI preparedness plan in place (driven and supported by the WHO) but it is untested and not operational. The National Extraordinary Anti-epidemic Commission has of late become relatively dysfunctional due to internal political shifts that have resulted in constant changes to the chain of command.

**xi) Communications as a component of AI and pandemic preparedness:**

IN 2006 UNICEF supported the development of a national AI prevention communication strategy for 2006 to 2008 that is currently slated for updating. This plan addresses AI prevention in details but only superficially addresses HI/PI preparedness. Under the National Extraordinary Anti-epidemic Commission there is a national communications working group which used to meet every three months – recently this group has ceased to operate as there have been no AI IEC materials for the group to approve. However, IEC materials were developed and distributed through the CPM networks and information campaigns are considered to have been informative and balanced. UNICEF, UNDP, USAID, the World Band and the EC have all, to some extent, been involved in communications for AI. Currently UNICEF is the implementing partner for the communications component of the World Banks AI project – as part of the agreement between UNICEF and the Bank, a strong focus will be capacity building within the CPM for health communication and HP.

Communication components have not been developed for HI/PI preparedness but UNICEF has initiated groundwork for a PI/HI communications framework.

## Ukraine

**i) Health status:**

**Population:** approximately 46.3 million (under 15: 14 per cent), GDP Per Capita $6900 (2007)

Ukraine has experienced a severe mortality crisis over recent years, with male life expectancy at birth falling by 4.4 years between 1990 and 1995 (women: −2.4 years). Death rates rose again after 1998, coinciding with the 1998 Russian economic crisis, with little subsequent indication of reversal. By 2002, male life expectancy had fallen to 62.2 years, about 2.5 years lower than it had been in 1980. For women, life expectancy was, at 73.7 years, also lower than in 1980 (74 years). Child health indicators have however improved with IMR and U5MR, 19/1000 and 26/1000, respectively, in 1990, to 13/1000 and 17/1000, respectively, in 2005. Maternal mortality, although falling, remains high at around 24 per 100,000 live births (approximately 5 times EU averages)

Fluctuations in life expectancy have largely been driven by changes in mortality from cardiovascular diseases and external causes of death (incl. intentional and unintentional injuries), affecting mainly young and middle aged men. Cancer and diabetes rates are also inordinately high and smoking accounts for a considerable part of the burden of disease, particularly among men. Another important factor is hazardous alcohol consumption.

Ukraine also has a fast growing HIV/AIDS epidemic that is fuelled by intravenous drug use, needle sharing and commercial sex work. This epidemic and rising incidence of TB have profound implications for children and youth.

**ii) Recent and current health sector reform efforts, national mandate / policies and political leadership:**

Like other countries in the CEE/CIS health sector reform has been slow. In Ukraine reform has been particularly hampered by political uncertainty although the Orange Revolution of 2004/2005 has paved the way for closer cooperation between Ukraine, the EU and bilateral donors. The first democratic elections ever were held in 2006 and the period following has been characterised by political instability, turf wars and power squabbles. The country is currently facing a number of structural challenges, including in the areas of economic reform, administrative reform and in terms of separating private interests from politics.

The basic principles of the health system have changed little since independence in 1991, and since independence, reform and efficacy in the health sector have been severely curtailed by the establishment of complex and fragmented legal frameworks with overlapping and ambiguous lines of accountability. These problems have been compounded by diminishing resources and inadequate investments. Health sector reform has also been complicated by failure to apply effective means of cost-containment or to increase efficiency, except for measures to reduce oversupply of hospital beds and health care staff. A complex interplay of factors, including political flux and government instability, has resulted in a drastic reduction in the quality of, and accessibility to, health care, with unofficial payments and other forms of health service charging having become widespread. In a recent move, the parliament has committed itself to introducing necessary legislative changes to implement reform, with reasonable expectation of success despite the numerous obstacles. Reform efforts that have taken place have focused, somewhat unsuccessfully, on developing primary care, attempts to replace the tax based system of health care financing with mandatory social health insurance and decentralising management functions.

As a 2007 joint report prepared by the Ukraine MoH, the World Bank and EC called "*Key Strategies for Development of the Health Sector in Ukraine"* points out:

During the years of Ukraine's existence as an independent state, no substantial changes have taken place in the structure and organization of the health care system. Just as before, the integrated command-driven system continues to be used in health care management, and because of this:

• there is no distinct division between the payer and the provider of medical services, nor are there contractual relations between them;
• there is no strategic planning and the institutional and personnel capacities are highly inadequate for efficient management of resources at macro and micro levels;
• the state and community health institutions continue to have the status of financial managers of the budget, with severely limited rights and incentives for making management and financial decisions that would allow more efficient use of resources;
• the policy of decentralization (both administrative and financial) is being applied inconsistently and inefficiently;
• the public (the medical community, in particular, and the population in general) has no impact on the development and adoption of political and management decisions.

The UNICEF Country Office reports that there is no visible political, technical, or professional leadership for health promotion or indeed public health issues in the Ukraine. Health promotion and equity are endorsed in policy documents and programmes including: the "Health of the Nation"; the National Plan on CRC Realisation; the National Reproductive Health Programme; and 2007 – 2013 National Healthy Child Programme. Likewise health promotion activities are mandated in a number of Ministerial Decrees and orders such as guiding documents (policies) on breast feeding promotion and neonatal care. However, HP activities are attached as having only a 'supportive' role and not strategic. Most mandated HP activities are not budgeted and are rarely implemented unless they are externally supported.

**iii) Development Assistance and the health sector:**

External support to the health sector in the Ukraine has been largely ad hoc and project based as a consequence of the political instability that has typified the period sine the Orange Revolution. This instability and the sheer scale and complexity of the problems faced act as a disincentive to a more comprehensive engagement on the part of large lenders and bilateral donors. Where as in other countries the World Bank has large health projects and lending arrangements in place, Ukraine has not been unable to meet Bank requirements for compliance and grants management. World Bank assistance is currently focused on HIV and TB prevention.

Donors to the health sector in the Ukraine have included, the UN system agencies, the EU, UK DFID Swedish SIDA, the Government of Japan, and USAID who are the biggest contributors and been engaged in the promotion of healthy lifestyles, maternal and infant and child health, family planning and reproductive health, HIV/AIDS and TB prevention.

Generally external assistance has revolved around the provision of TA rather than the large scale systems support that is evidenced in more stable countries in the region. However, in November 2007 the EU and the Government of Ukraine signed a cooperation agreement for some 4 million Euros in support of the reform of secondary medical care which will involve hospital reform in three pilot districts.
External assistance currently has little influence on the overall condition of the health care system and is thought to contribute to less than 1 pr cent of total health care spending.

UNICEF in Ukraine works: with the media for HIV prevention and with MoH for PMTCT; towards the establishment of youth friendly health services; towards improving vaccination coverage; towards the development of national Young Child Development programmes; and towards evidence based policy development.

**iv) Tracking of determinants, and health data collection and analysis:**

Key statistical data is collected the Centre for Medical statistics on a fairly regular basis as it has been since Soviet times. Both child and adult health indicators are monitored fairly regularly but systems that might utilise this data for policy / programme development and implementation are not in place or dysfunctional. Demographic or reproductive health surveys have not been completed for some years. UNICEF completed a MICS in 2005.

Data is not widely available or disseminated. There is MoH website but much information is missing.

**v) Evidenced based policy development, implementation and regulatory frameworks:**

Available data and international evidence are referred to for policy development but not in any systematic way (UNICEF CO say that evidence use is in early stage of development) – in

relation to HP there are no mechanisms in place to develop plans or policies, although when donor funds are available, intersectoral meetings are occasionally convened.

In terms of stakeholder engagement, the MoH has no mechanisms for the engagement of civil society or the private sector in policy development. With regard to implementation, the CO reports that data is used to assess implementation but qualitative evaluation is limited.

CO reports that Ukraine has many regulatory frameworks and legislation is in place but that implementation is usually absent or partial, monitoring and evaluation is absent and many remain just declarations on paper that are made to comply with international pressures.

**vi) Infrastructure and program delivery for health promotion and some key issues:**

The situation with regard to health systems infrastructure for PH and HP is particularly dire in Ukraine and many good intentions remain unmet. Public health remains based on the traditional functions of the state Sanitary and Epidemiological Service, whose main objectives are the control of communicable diseases and environmental protection. Its structure and functions have changed little since Ukraine's independence. New public health functions are being developed, especially in response to HIV/AIDS and TB. Family planning and reproductive health services have been strengthened through the successive implementation of two national programmes with the assistance of international donors, enabling the creation of a comprehensive family planning service. The service is headed by the Ukrainian State Family Planning Centre, followed by regional family planning centres and contraception consulting rooms and, at the primary care level, rural health posts. There was strong government support for the WHO "Health for all" (HFA) strategy demonstrated through the adoption in 2002 of the Health of the Nation for 2002 to 2011 programme that incorporates the promotion of healthy lifestyles as an essential activity to advance population health and envisages a package of multisectoral activities. So far no clear means for implementing this ambitious programme have become apparent.

There is state system of health centres left over from Soviet days that have had responsibility for health education and promotion but these centres face acute problems, including inadequate resources (for example, this often can mean no computers or internet access), staffing issues, inadequate capacity and a lack of incentives. Theoretically, physicians in all specialities and PHC doctors are responsible for HP and health education (doctors ToRs have not changed since Soviet days and still include references obligations to conduct HP and health education), but in reality little is achieved beyond ad hoc and personal interventions by individuals working in the system. Ultimately the severe financial crisis that the health sector has faced has severely curtailed health education and health promotion activity at all levels.

At the central level there is no dedicated department that oversees HP work in a cross sectoral manner and HP activities, when they are included, designed and implemented, are but components of programmes. HP activities are viewed by the Ministry itself as being externally driven. However, it is thought that staff within the MoH feel there is a strong need for a dedicated HP department and that there is an intention to lobby for such a department when it is clear who the next health minister will be (this was accurate as of November 2007) – frequent ministerial shifts and senior management changes are currently hampering progress across a range of areas within the ministry. MoH staff believes that this department should have cross-sectoral responsibilities for overseeing HP and various technical and external inputs. MoH informant also believes that external inputs relating to HP and preventative health need to be better coordinated. There is also a current call to create a role for the regional health centres as information and resource centres for health promotion.

**vii) Workforce issues and training for public health and health promotion:**

According to CO staff the situation vis a vis health promotion is worse than in Soviet times when professional obligations for physicians to conduct HP and health education activities were monitored. Even though the ToRs of health workers have not changed, health promotion competencies are paid little attention. While the need for increased capacity is recognised: training on HP is not part of basic curriculums; there are no opportunities for professional development; there is no workforce strategy relating to health promotion or even public health; and there are no attempts to educate other parts of the government workforce on HP issues.

A national school of public health (Mohyla Academy School of Public Health) has been established at the National University of Kyiv and its first students graduated in 2004. The school, in partnership with the School of Public Health at University of Maastricht in the Netherlands runs a two year masters program that offers significant professional training on public health, preventative health and health promotion. How this school and its graduates can contribute to health sector reform in Ukraine in the longer term is unclear. However, evidence suggests that as long as financial or professional incentives to practice preventative approaches and do health promotion are limited, and as long as the bureaucratic culture and infrastructure are not supportive of PH and HP approaches, then the contribution will be limited..

**viii) Institutional and cross sectoral linkages / donor coordination and private sector partnerships:**

Mechanisms for intersectoral collaboration in Ukraine are embryonic at best. At the level of the Cabinet of Ministers there may be some frameworks for multisectoral national programs and there intersectoral collaborations do occasionally occur within the framework of externally driven development projects.

CO informs that there is an urgent need to develop mechanisms to guide private sector involvement in health promotion and for the health sector in general – interactions between the MoH and the private sector are currently typified by conflicts of interest and corruption.

**ix)) Health sector financing:**

Expenditure on the health sector is inadequate and a key cause of the sectors lacklustre performance. Between 2002 and 2005, expenditure on the sector as a percentage of GDP increased from 3.4 to 3.7 per cent – average spending for the EU15 is 8.8 per cent of GDP.

Funding for health sector is not transparent and there are no specific allocations for public health or health promotion. Authorities have little discretionary power and are unable to make autonomous decisions about budget allocations. What little funding is available for health promotions is largely absorbed by salaries and basic operational costs – the costs of campaigns are met by external partners.

**x) AI and pandemic preparedness - status / achievements:**

The situation in regard to AI prevention and preparedness in the Ukraine is unclear and reflects on the general level of political chaos that typifies government in Ukraine, and the lack of coordination among donor partners. Apparently there is national AI prevention plan in place under the jurisdiction of the Cabinet of Ministers. There was also some sort of AI committee chaired by the Ministry of Emergencies that includes representation from the MoA, MoH and MoE – the status of this group is currently unknown – the Ministry of Emergencies, focused mostly on issues relating to Chernobyl, is considered reactive rather than pro-active in regard to AI prevention. When questioned, representatives from the Ministry of emergencies had not heard of the AI prevention plan. It is unclear but unlikely if there have been any efforts to test AI prevention plans although USAID, as is there custom, are working to build capacity for preparedness at the local level. There is no PI/HI preparedness plan in place.

**xi) Communications as a component of AI and pandemic preparedness:**

UNICEF, in cooperation with USAID and other donors, prepared a national AI communication strategy which was shared with all key government partners. Feed back was received but due to political tensions there has been (as of November 2007) no formal approval of this plan. There was also a committee formed to provide inputs to the communications strategy and to approve the strategy but this committee was abolished as a consequence of the political upheavals that occur regularly within the Government of Ukraine.

UNICEF and USAID nevertheless developed a range of IEC materials and a communication campaign. A second KAP survey conducted after the campaign indicated that there had been a significant improvement in general public knowledge about AI and AI prevention. Government efforts to provide information to the public about AI and AI prevention have been minimal.

# Turkey

**i) Health status:**

Population: around 71.15 million (under 15: 24.9 per cent), GDP Per Capita (USD 9,400, 2007)

Turkey has made progress in reducing child and maternal mortality rates since 1999 by as much as 40 per cent (U5MR between 1999 and 2005), However, mortality rates are still higher than any other country in Europe. For example, in 2005 the Infant Mortality Rate was recorded as 26/1000 where as for 2005 the EU average was 4.9, the CEE average was 11.3 and the CIS was 17.8. Maternal mortality has also fallen significantly but remains higher than other European countries. What improvements that have occurred have not been spread evenly and infant and under five mortality remains much higher in rural than urban areas. According to the 2003 Demographic and Health Survey, one fifth of mothers do not receive any antenatal care during their pregnancies. The share of mothers who do not receive any antenatal care increases to one third in rural areas. Vaccination coverage is also inequitable and skewed in favour of urban areas.

Considerable efforts will be needed to improve health status and health care delivery to standards that are comparable to EU15 and EU25 countries - the main causes of death among adults are heart disease and accidents (ages 25 to 44) and heart disease and smoking related respiratory disorders (ages 45 to 64)

**ii) Recent and current health sector reform efforts, national mandate / policies and political leadership:**

While Turkey is the only country that is a part of this eight country assessment that does not have a health system based on the Soviet Semashko model, it shares many features common to the health care systems of the post transition countries. These include a high degree of medical specialisation (particularly in Istanbul and Ankara), inefficient service delivery, a lack of adequate preventative services, a lack of accountability and transparency and an inadequate allocation of resources to public health and health promotion.

The Turkish health system is also highly complex and both overly centralised and fragmented.

Health policy-making and planning are divided and unevenly distributed between various stakeholders and as a norm; the provision of healthcare is linked to the financing institutions. There is no concept of a “national health service” and, according to some data, as much as a third of the population has no health insurance coverage.

The National Health Strategy “Transformations in Health” launched in 2003 aims to tackle all structural deficiencies in the Turkish health sector, including those relating to: universal health insurance; improving access and quality; the solid establishment of a primary care network; the role of the Minister of Health; changes to the legislative environment; the autonomy of healthcare facilities; capacity building and health professional training; the enhancing of patients’ rights; and the need for accountable health information systems.

In relation to health promotion, MoH informants indicated that strengthening preventative services and health promotion is the number one priority for the ministry in coming years. To this end the MoH plans to establish a cross-sectoral department of health promotion in early 2008 (see below for more detail). CO also informs that Government of Turkey has been pro-reform since it was elected in 2002 and the current Minister of Health is committed to an increased emphasis on public health. While, assessing progress towards reform in the health sector in Turkey is highly problematic, it is reasonable to assume that the inordinate complexity of the bureaucracy, and the lack of good communication between its many tentacles, has not aided reform processes.

**iii) Development Assistance and the health sector:**

Large donors such as the World Bank and the EU are not engaged so actively in funding sector wide reform as they are in other countries like Moldova or Serbia, mostly because Turkey is a middle to high income country, and because health sector problems relate more to technical and management issues than they do to resource shortages. As the World Bank have noted: “health outcomes in Turkey compare unfavourably with health outcomes in

countries that have similar or lower levels of GDP per capita and approximately the same share of public spending on health". As an EU candidate country assistance provided by the European Union to Turkey focuses on the Acquis Communautaire and not especially on social development. Most external assistance provided to the Turkish health sector is technical assistance provided by WHO and to a lesser extent UNICEF and other UN agencies.

WHO in particular support the ambitious MoH National Health Strategy by providing assistance with regard to: capacity building for stewardship capacity; policy development; the reform of primary health care; communicable disease surveillance; and human resource development. UNICEF provides assistance through its Early Childhood Care and Learning Program.

Both the World Bank and USAID have projects specifically targeted at AI prevention.

**iv) Tracking of determinants, and health data collection and analysis:**

The State Institute of Statistics (re-named Turkstat in 2006) collects data on a range of social, economic and cultural issues, including health, and provides data to users, including policy makers. Within the health sector, disease trends are tracked through doctors recording one of a 150 categories of diagnosis for every prescription issued. This data is reported back to the central level of the system but data gaps result from inadequate reporting in some rural areas.

Turkey completed its first Turkish Demographic and Health Survey (TDHS) in 1968 and has completed a similar survey every fiver years, the most recent being completed in 2003. The National School of Public Health in Ankara (see below) also tracks health determinants and conducts cost benefit analysis. The extent to which this information is incorporated into policy development or advocacy work is unclear.

**v) Evidenced based policy development, implementation and regulatory frameworks:**

Data from Turkstat and the TDHS are used to inform policy development. However, according to CO there are limited mechanisms to facilitate intersectoral policy and planning; to oversee or evaluate policy implementation; to incorporate health promotion concerns into other sectors; or to ensure the public dissemination of health data.

Like the Turkish health system itself, efforts at regulation are also highly fragmented. While legislation is in place (EU regulations) and is in some cases pending (Code on Breast Milk Marketing) there is no comprehensive regulatory framework that properly supports preventative health initiatives or health promotion; legislation often remains unimplemented; and there are no attempts to evaluate the implementation of legislation. For example, the WHO Framework Convention on Tobacco Control was ratified in 2004 but it is unlikely that smoking will outlawed in bars and restaurants until the end of 2009.

**vi) Infrastructure and program delivery for health promotion and some key issues:**

Within the MoH, the General Directorate of Primary Health Care has responsibility for public health programs. At the provincial level primary health care is provided through some 76,000 health centres, health posts, some 300 mother and child health and family planning centres and TB dispensaries.

Health centres are each staffed by a team consisting of a doctor, a nurse, a midwife, a health technician and an administrator. Their main responsibilities consists on preventing and treating communicable diseases, providing basic treatment, immunization, mother and child services, family planning, public health education and environmental health services. They are responsible for collecting health-related statistical data. Health posts report to health centres and are each staffed by a midwife.

Health centres and health posts are the only settings providing preventive care, health promotion and community-based health services.

Currently there is no dedicated department for health promotion at the national level and health promotion activities are attached to specific programmes. However, informants at the General Directorate of Primary Health Care informed that there is a plan and a budget to establish such a department within the MoH in 2008. This new department which will be called the Department for the Promotion of Health Development will not be an implementing

agency but will instead provide technical oversight and stewardship for HP activities conducted as a part of other programmes. Apparently the health minister is very committed and will ensure that the department has the resources and authority to do its work effectively. The new department will include three components: epidemiology, national control programmes and communication monitoring and evaluation. In the first four months of 2008 the Directorate for Primary Health Care plans to staff, equip and train the new health promotion department which will then prepare strategic plan for health promotion. This work is apparently an absolute priority for 2008/9. Other activities planned are for the new HP department to provide to provide training for trainers so that training teams can then train family physicians from 71 provincial health centres on HP approaches and best practices. The department will be staffed by public health specialists, communications specialists and psychologists and will explore new funding opportunities, including from external sources, once it is properly established.

The establishment of this new HP department must be viewed as vitally important for the Turkish health system where HP has received very little attention as a viable and cost-effective public health strategy. Similarly, preventative health care, which has a higher profile than HP, is also severely neglected. As the world bank have accurately noted:

"Better use of preventive health services among high risk groups (mothers and children) is the key to improving core health outcomes. Turkey's high levels of infant and under-5 mortality, as well as high maternal mortality, are directly related to the poor usage of preventive care" - according to the 2003 Demographic and Health Survey, 25 per cent of mothers do not receive any antenatal care during their pregnancies and the share of mothers who do not receive any antenatal care increases to 33 per cent in rural areas.

**vii) Workforce issues and training for public health and health promotion:**

. Between 1994 and 2004 the ratio of physicians and nurses grew significantly relative to population but is still considered inadequate relative to EU averages. Health care providers are also unequally distributed, with fewer providers operating in the East and Southeast regions as compared to the rest of the country. In terms of workforce development for health promotion there are no indications that training in health promotion is part of basic curriculum; that there is any workforce policy that guides the development of HP competencies; or, that there is any communication on the importance of HP directed at workers outside the health sector. Apparently there have been some opportunities for ad hoc professional development for health workers in the area of health promotion.

In terms of training there is a National School of Public Health in Ankara which operates under the auspices of the MoH and offers specialised training in public health (management, coordination, financing etc.). HP is not a major focus of this school and of the five main departments there is no department dedicated to HP. According to the DG for Primary Health Care some staff has been sent to attend courses at the Athens School of Public Health.

**viii) Institutional and cross sectoral linkages / donor coordination and private sector partnerships:**

The Turkish MoH has an extremely centralised administration and communication between levels and departments is bureaucratic and slow. There are some established links between the MoH, the media, other sectors and donors but generally the MoH is considered to function in a largely non-consultative fashion – according to the CO, UNICEF and the UN agencies are often excluded from MoH and government meetings and only invited when funding is sought. As donor activity in the health sector is limited relative to the size of the sector there is no pressing need for donor coordination. Efforts in support of AI prevention have perhaps been an exception to this.

**ix)) Health sector financing:**

According to the World Banks 2007 Public Expenditure Review, Turkey spent approximately 6.6 per cent of GDP on health, in 2004. (EU15 average is 8.8 per cent) Expenditure on health accounts for 13 per cent of the total government expenditure (17 per cent is the average for the EU15). The Bank also notes that in relation to the distribution of recurrent public expenditures by type of provider data from the Turkey National Health Accounts are only available for the years 1999 to 2000 only. These data show that in 2000, around 57 per cent of all recurrent expenditures were spent on curative care and 34 per cent on medical goods dispensed to outpatients. Only 5 percent was spent on prevention and public health services.

More recent data is not available.

As in many other countries in the CEE/CIS budgetary timeframes do not allow for medium and long term planning for health promotion. Funding for the health sector is not transparent and public health / health promotion authorities have little discretionary power and are unable to make autonomous decisions about budget allocations.

**x) AI and pandemic preparedness - status / achievements:**

Allot of time and money has been spent on AI prevention in Turkey by UNICEF, other UN Agencies, the World Bank, USAID and the EU. Not surprisingly, Turkey has made considerable progress, especially with regard to animal disease surveillance, laboratory screening for AI and in terms preparedness for AI outbreaks. However, there has also been a lot of confusion about who is doing what, and it is widely felt that there is a need for greater coordination among all active partners. Currently there are both national AI prevention plans and national PI/HI preparedness documents in place that have been tested and simulated at both the national and provincial level. In 2006 there was considerable rivalry between the health and agriculture sectors and some planning, preparedness, simulation and communication activities occurred in parallel – however, the EU and WB projects have managed to bridge health and agriculture sector prevention and preparedness activities and have combined relevant prevention and preparedness documents from both the Ministry of Agriculture and the MoH into a national AI/PI prevention and preparedness plan. This plan has been recently supported by seminars to raise awareness of the plan and by 2 national level contingency planning exercises. Preparedness planning is also in place at the provincial level but it is unclear how operational this planning is.

**xi) Communications as a component of AI and pandemic preparedness:**

Following initial AI outbreaks in Turkey there was much confusion about AI messaging and how to go about it. There was also contradictory messaging. For example, WHO were telling the public to kill infected chickens where as FAO who were concerned about indiscriminate culling and livelihood issues were advocating separation. UNICEF and partners initially established a communications working group to oversee the development of a communications strategy for initial AI prevention strategies but as the MoA and the world bank were generally not in attendance they refused to accept the communications strategy that was developed. UNICEF assisted with the development of a communications strategy that was accepted by MoH and NGO and private sector partners involved with the working group – the MoA ended up developing there own communications strategy. Initially many different messages (IEC materials, radio and TV PSAs) were being disseminated by different ministries, NGOs, agencies and the private sector. However, despite rivalries the inter-sectoral communications working group did to some extent manage to coordinate the many different inputs and ensure that messages reaching the public were informative and balanced.

Recently, in November 2007, the communications working group met to consider an updated communications strategy for the aforementioned recently developed multi-sectoral AI prevention and PI/HI preparedness plan.

## Uzbekistan

**i) Health status:**

Population: around 27.78 million (under 15: 32.4 per cent), GDP Per Capita (USD 2,200, 2007)

While the U5MR has reduced from 74/1000 in 1990 to 43/1000 in 2006 it is still far too high. MMR is also extremely high at 24/100,000 (5 times EU average). Links between the deteriorating conditions of children's and women's health and the quality of antenatal services, together with the low level of knowledge of families in managing pregnancy and detecting early childhood illness, are thought to be the cause. The official rate of infant mortality, although decreasing, is high compared to most former Soviet countries and would be higher still if internationally accepted definitions of live births were used and all child deaths were reported.

Adult life expectancy is low (estimated by the World Bank at around 67 years) and the leading causes of mortality are diseases of the circulatory system, cancer and TB. As with some other countries in the CEE/CIS the burden of these illnesses has increased since the transition. HIV/AIDS is also a growing problem that is impacting particularly on young people and is being fuelled by intravenous drug use and commercial sex.

**ii) Recent and current health sector reform efforts, national mandate / policies and political leadership:**

Health care reforms in Uzbekistan have been mostly geared towards the structural framework of the health system and the processes of health care delivery, and really only got underway in the mid 1990's. The focus of reforms to date have been: improving child and maternal health; promoting the privatisation of services to relieve the burden of having to fund a large health sector; improving the quality of health services (which has not specifically addressed health promotion); the strengthening of primary health care through World Bank funded 1998 to 2005 Project Health; and decentralisation to make the allocation of resources more responsive to local needs. Success has been mixed with some clear achievements and many challenges that still remain, including: achieving equity and improving access, utilisation and coverage; reducing dependency, inefficiency and duplication; improving quality and emphasising preventative health and health promotion; increasing access to medical information, training, and professional development, especially in relation to Public Health; and improving data collection, analysis and evidence based policy development.

The main policy documents underlying these reform efforts are the 1998 Presidential Decrees on Reform of the Health Care System; the 2003 Presidential Decree on Further Reform of the Health Care System (tertiary care) and the 1996 Law on Health Protection which encompasses: compliance with human rights norms; accessibility of services; the importance of prevention as a priority; and bridging the gap between medical science and practice. This law provides a legal basis for health sector reform and health policy development, although there is no overarching vision statement for national health policy. Issue specific health policy is implemented through decrees (Prikaz – prime ministerial decree Postanovlenic – cabinet of ministers decree, Ukaz – presidential decree), and most projects and reforms are sensitised to donor priorities.

In Uzbekistan, as in other former Soviet countries, preventative health practices and health promotion have been historically considered as having low status within the medical culture – specialised doctors enjoyed high status and only general practitioners (considered low skilled doctors) would do HP or engage with public health issues. However, since transition, exposure to international experiences such as the British model where everyone is able to access a GP, and various different cost benefit analysis on the value of preventative health strategies have won political support for a greater focus on public health and health promotion, even if entrenched values among the medical establishment have been less easy to shift. In Uzbekistan, the President has made proclamations about the importance of public health approaches and the Deputy Prime Minister has recently gone on the record to say that all doctors and nurses in Uzbekistan will soon have to develop some capacity for health promotion.

The Uzbekistan Institute for Public Health, in collaboration with the World Bank, has recently developed a draft National Public Health Strategy for 2008 to 2012 which places a strong emphasis on health promotion. The extent that this strategy is funded or actionable is currently unclear, although this strategy will be presented to the Parliament soon. Following approval a coordination group will be established under the Cabinet of Ministers – an initiative suggested by the Bank.

**iii) Development Assistance and the health sector:**

The health sector in Uzbekistan is heavily dependent on financial and technical resources from external partners, particularly the World Bank and the Asian Development Bank, who are, and have been for some time, providing loans and technical assistance to the health sector in Uzbekistan. British DFID and Japanese JICA are also major donors to the Uzbekistan health sector. According to UNDP USD 144 Million of external funds were disbursed in the health sector between 2000 and 2005 and some USD 150 million will be disbursed between 2005 and 2010.

Currently the World Bank, through the Health Project II, are, for example, continuing to support reform of primary health care and improvements to the quality of services; the restructuring of the public health system; responses to communicable diseases such as AI, HIV/AIDS and TB; the improved management of pharmaceuticals; and human resources development.

The Asian Development Bank continues to support MCH and reproductive health programmes as well as a range of interventions aimed at systems reforms for management and financing.

USAID also implement their technical assistance program ZadravPlus which focuses on management training and capacity building for the sector.

Underneath the superstructure of World Bank and ADB support UN agencies provide technical assistance and project implementation services. Due to general government restrictions of civil liberties and civil society it has become very difficulty for NGOs to work in Uzbekistan and the bulk of small scale initiatives, such as local health promotion initiatives, are now carried out by *Mahalla* (government sanctioned local community groups) and/or local health workers.

The WHO has a very limited presence in Uzbekistan and provides small scale TAs when funding is available. UNICEF in Uzbekistan implements a Family Education Programme which includes interventions aimed at improving health knowledge in relation to promoting nutrition, early childhood care and breastfeeding; providing healthy lifestyles information for adolescents; promoting strategies for early childhood care and development; and providing training on health and development issues to home visiting nurses, doctors, local leaders, kindergarten teachers and community volunteers.

**iv) Tracking of determinants, and health data collection and analysis:**

Uzbekistan, like other transition countries, has inherited very complex data collection and analysis systems – data collection often seems to occur for its own sake rather than to inform policy or programme development. Despite efforts to reform data collection, the current system is fragmented, collects too many data that are poorly processed, and is disconnected from health needs, particularly public health needs. Recently however, the National Information Centre for Data collection was amalgamated with the Institute for Health (created in 2001) which may result in an improved use of data for practical purposes. Data collected by the Institute for Health is gathered from all public health care facilities and pooled at the central branch of the Institute in Tashkent.

Data is also collected by the Sanitary and Epidemiological Services which operates separately from the Institute of
Health system and is mainly concerned with data related to infectious diseases and hygiene. In addition, national programmes develop their own reporting systems for monitoring and evaluation purposes. Examples of such data collection systems are the TB Research Institute with its nationwide dispensary system, and the nationwide HIV/AIDS network. The Ministry of

Macroeconomics and Statistics requires separate reporting of health data (mortality, number of births etc.) through its provincial networks (Oblasts and Rayons).

All of these data collection systems operate independently of each other and it is not clear to what extent data-collection systems are coordinated or if data are pooled at the different levels. The Institute of Health is the primary data collection agency for the MoH; however, even though the Sanitary and Epidemiological Services is a part of the MoH, it still collects data independently from the MoH.

Based on the data collected, the Institute of Health produces a number of reports which are distributed to relevant agencies within the MoH. These reports are designed to facilitate decision and policy-making at national or oblast levels, with little attention paid to local (rayon and facility) levels. Data collection heavily focuses on quantitative indicators, related to the predominant use of data for planning and control purposes. The lack of analytical and statistical training for policy and decision makers, as well as within the Institute of Health, limits the usefulness of the data that is collected.

In terms of the tracking of determinants, and in order to obtain data that are not captured by the public data collection, the MoH and USAID have collaborated to produce Demographic and Health Surveys is 1996 and 2002.

**v) Evidenced based policy development, implementation and regulatory frameworks:**

As mentioned, capacity for data analysis is limited both within the MoH and among high level decision makers. Policy making is often externally driven (for example the recent Public Health Strategy developed by the World Bank and the Institute of Health). Even when evidence based policy is developed, implementation is often only partial, or just absent.

The 1996 Law on Health Protection outlines the areas subject to regulation in the health sector. The Cabinet of Ministers and the MoH are charged with competencies such as: defending the rights of individuals to health protection; developing the national health policy and ensuring its implementation; financing the health sector and programmes for the development of medical science; managing, coordinating and controlling the public health sector; controlling the sanitary-epidemiological status of the population; ensuring a unified system of statistical reporting in the health sector; and, defining the state guaranteed benefits package for vulnerable groups of the population.

Underneath the guiding structure of the Law on Health Protection and the 1998 Presidential Decree on reforming the Uzbek health sector there are, and have been, many initiatives to regulate in support of public health but existing regulatory structures tend to emphasize structures and process inputs (such as the number of primary health care units built or the number of personnel trained). An emphasis on outcomes is lacking, especially public health outcomes, which is considered to be compromising the achievement of the ultimate goals, set out by these documents, i.e.: quality, efficiency and access. UNICEF in Uzbekistan has after seven years of negotiation and bringing evidence to the table, only just succeeded in lobbying the government to legally ensure USI. Generally, if private sector profits might be compromised by regulation for public health then difficulties arise – Uzbekistan is not a signatory to the WHO global framework convention on tobacco control.

**vi) Infrastructure and program delivery for health promotion and some key issues:**

The Institute of Health (established in 2001) was envisaged to become the main agency for health promotion and education. The Institute has 14 oblast branches, and 159 rayon branches and 15 urban health centres. The Institute has four units: the Media Relations Unit, the Editors' Unit, the Unit for Health Promotion and Education, and the Unit for Health Information. The Unit for Health Promotion and Education also has sub-units on maternal and child health, promotion of healthy nutrition, prevention of harmful behaviour, promotion of healthy lifestyles and promotion of hygiene. However, government has generally failed to appoint enough skilled personnel or directors and partly as a result, the institute has become dependent on external funding and technical assistance for HP activities. The HP capacity of the Institute has also been hampered by amalgamation with the National Information Centre for data collection which has historically always enjoyed a higher status than the Institute. Subsequently, the Institute is now more clearly focused on statistical analysis than on health promotion. Nevertheless, the institute, with external assistance, developed some 29 different

brochures and 12 PSAs for AI/ HIV/ Drugs / TB and STIs last year; although CO informants expressed doubts about the capacity of the Institute to do this work alone or without external financial and technical inputs.

Many INGOs such as ZdravPlus, Project Hope and Central Asian Free Exchange, have been actively involved in health promotion. Currently an initiative with a focus on improving adolescent reproductive health and maternal education is being carried out by Project Hope and the USAID ZdravPlus has run four major campaigns in pilot oblasts, in cooperation with local health authorities and the regional units of the Institute of Health. The campaigns focused on anaemia, diarrhoea, pneumonia in children, and family planning and they incorporated a wide range of communication channels, including periodicals and social marketing via national television. An evaluation of these campaigns has shown that they were effective in instituting behavioural changes (Information leaflet produced by ZdravPlus). International agencies have also involved local NGOs, but recent government policies have restricted the work of NGOs to the extent that that the bulk of health promotion work must now be carried out through government organisms such as Mahalla groups (local community organizations) and through health local health workers. It remains to be seen how successful these new arrangements are. Certainly there is much attention currently being paid to health promotion in Uzbekistan as a valid strategy to reduce the considerable burden of diseases that the country faces but there is also a sense that the Institute of Health has neither the resources nor capacity to adequately address the challenges faced.

Most primary care providers are also nominally supposed to be engaging in some kind of promotional or educational activities (as envisaged by the MoH as part of the main functions of primary health care) but again it seems unlikely that there are adequate professional, bureaucratic and / or financial incentives to conduct these activities.

**vii) Workforce issues and training for public health and health promotion:**

Like other countries in the CEE/CIS region, training on HP is not part of basic curriculum's; there are very limited opportunities for professional development; there is no workforce strategy relating to health promotion or even public health; and there are no attempts to educate other parts of the government workforce on HP issues. Prior to 2000 there was no real modern (western) public health professional orientation in Uzbekistan. Before then, practitioners graduating from the Sanitary Epidemiological Department of the Tashkent State Medical Academy were seen as the professionals most closely fitting the description of public health professionals in the areas of epidemiology, health promotion and environmental health.

However, in 2000, the former Second Tashkent State Medical Institute initiated the introduction of a unified public health programme in line with international standards and in 2001 established the Department of Public Health and Health Management. The Department has developed an integrated public health training programme at graduate level and offers the degree of Master of Public Health. International agencies, such as the Open Society Institute, the Association for Schools of Public Health in the European Region, UK DFID, the USAID-funded ZdravPlus project and the American International Health Alliance played important roles in aligning the new programme with international standards and in developing local capacity. However, concerns remain that the health sector and its culture of specialisation may be unable to absorb public health graduates or offer adequate incentives to ensure their active participation in health sector reform – the Institute of Health only employs 3 public health graduates.

**viii) Institutional and cross sectoral linkages / donor coordination and private sector partnerships:**

Because there has been such heavy donor involvement in the Uzbek health sector there have been some sustained efforts towards inter-departmental and cross-sectoral coordination and communication (like there have been for HP) that may have rubbed off on the bureaucratic culture, although the MoH has over recent years become increasingly assertive about its perceived priorities. Mechanisms are in place to guide donor involvement and while agencies and bilateral's are driven by their own agenda's, efforts are still made to communicate.

As a part of health sector reform there has been a considerable emphasis on private sector development which has proven in some ways incompatible with Uzbekistan's centralised model of health care – market forces are often the determinants of resource allocation in the

private sector, the private sector is currently largely unregulated and private sector service delivery is generally not accessible to the poor and lower income groups. Wealthier patients are turning to the private sector for a perceived superior quality of care which is offering health workers opportunities for higher incomes than they might get within the public health sector. Some of these issues, regardless of continued public sector health care reform, may serve to undermine quality and equity.

**ix)) Health sector financing:**

According to the World Banks 2005 Public Expenditure Review, public expenditure on health has been falling as a share of GDP, as a share of total budget expenditures, in real terms and in per capita terms. Health sector spending (including externally-financed) was 2.5 percent of GDP in 2003, decreasing from 3.8 percent in 1995. Current expenditures have almost halved as a share of GDP since 1992. Investment in health care has been low, averaging 0.2 percent of GDP in 1995-2003, financed roughly equally by external loans and through the state budget. The World Bank have also noted that public expenditure on health as a proportion of GDP is higher in Uzbekistan than in neighbouring countries but per capita health expenditure is less than low income country averages; that the majority of health spending is out of pocket payments which has serious implications for the poor; that public expenditures do not redress inequities; that the budget continues to favour inpatient care, which benefits the rich and urban population; and that there is an urgent need for more investment in public health including preventative health and health promotion. It is unclear what proportion of resources are allocated towards public health initiatives and the CO informs that generally processes for funding allocations are not publicly known; that budgetary timeframes do not support adequate planning; and that there are no government allocations for health promotion beyond recurrent expenditures (e.g. salaries at the Institute of Health). At least 70 per cent of health expenditure is spent on recurrent costs and in this context it is clear why PH initiatives are almost always externally supported.

**x) AI and pandemic preparedness - status / achievements:**

In February 2006 the Government of Uzbekistan developed a comprehensive National Program for Avian Influenza Prevention and Control which has included AI prevention and preparedness plans and other regulatory documents. Prevention and preparedness is overseen by the National Commission for Emergencies under the Cabinet of Ministers and there is national AI task force that is chaired by MoH and MoA. There is also a National Influenza Centre within the MoH. Other achievements include the training of technical personnel in both the health and agriculture sectors; and funds have been invested for laboratory equipment, disinfection and surveillance.

In terms of other external assistance he US Defence Threat Reduction Agency (DTRA) has invested some USD 70 million to increase animal and human diagnostic capacity for several dangerous pathogens, including HI and AI. This investment has resulted in 6 completed laboratories (two for the MoH, two for the Veterinarian System, one for the Ministry of Defence, and one for the Institute of Especially Dangerous Diseases!). These laboratories have been fully refurbished and equipped with modern virology equipment. The US Centre for Disease Control has been active in Central Asia for a long time. The CDC provides training that complements the DTRA investments in laboratories and equipment operation. The FAO has been working on providing training and small equipment to veterinary services and has a significant amount available to continue providing training at regional level.

**xi) Communications as a component of AI and pandemic preparedness:**

A communications strategy was developed by UNICEF and endorsed by the MoH and a communications campaign was implemented by UNICEF and the ADB in consultation with the National Influenza Centre. This strategy included the implementation of a KAP survey; the development of IEC materials and PSAs; and conducting a five day crisis communication symposium for MoH and MoA spokespersons and media representatives. An AI communications working group is yet to be established.

UNICEF has recently submitted a proposal to the World Bank for the implementation of the communications component of the Bank's 2008 – 2010 AI and HI prevention and preparedness programme. This proposal details objectives that include: the establishment of an AI communications working group; the development of communications materials for all five stages of AI/PI preparedness; supplying ministries with pre-tested information that promotes awareness and can change behaviour; supporting communication training needs; and producing and disseminating PSAs through state owned and public media.

# Tajikistan

**i) Health status:**

Population: around 7.076 million (under 15: 35 per cent), GDP per capita USD 1,600, (2007)

Tajikistan is an extremely poor country that unlike many other transition countries has not experienced significant economic growth - average annual GDP growth rate in Tajikistan between 1990 and 2004 was minus 5.1 per cent, and between 1993 and 2003 (although GDP growth is currently positive) 7 per cent of the population was subsisting on less than USD $1 a day. The impact of this poverty, particularly for children, is extreme.
Comparing data from the 2000 and 2005 MICS indicates that child survival rates are improving – IMR fell from 89/1000 to 65/1000 and U5MR fell from 126/1000 to 79/1000 – but these rates are still exceedingly high, even for the CIS countries (MMR is also high) Chronic and acute malnutrition are also major problems as are limited access to safe drinking water and appropriate sanitation.

Adult life expectancy is low and as with other CEE/CIS countries the leading causes of mortality are diseases of the circulatory system, cancer and tuberculosis. Also like some other countries in the CEE/CIS, the burden of these illnesses has increased since the transition. HIV/AIDS is also a growing problem which is being fuelled by intravenous drug use and the proximity to regional heroin production. Water-borne diseases including malaria, typhoid and cholera are also major public health concerns that require urgent attention. Environmental degradation and pollution are also public heal risks and nutritional deficiencies are common – in the 1990's some 35 per cent of the population were considered iodine deficient, although since the passing of USI legislation in 2002 this situation has improved.

**ii) Recent and current health sector reform efforts, national mandate / policies and political leadership:**

Tajikistan's health system has many structural weaknesses, most of which are common to post Soviet and transition countries. Primary health care is under emphasized; the hospital network is larger than necessary; hospitals receive the biggest share of public financing but their services are too expensive for the poor; health workers are paid poorly and demand informal payments to compensate; and public health functions such as disease surveillance, human resource development and health promotion are carried out poorly, if at all. Significant capacity gaps in health policy, planning and management, both at the central level and at the oblast level are frequently reported. The magnitude of these gaps appears to be masked by the high level of donor-financed, and NGO activity (by all accounts, Tajikistan is more democratic than neighbouring Uzbekistan and NGO activity is tolerated),

The health policy environment in Tajikistan is disorganized. There is still limited agreement on an overall strategy for the health sector and the level of internal dialogue between key players such as the MoH, MoF and the President's Administration in particular is limited, leading to frequent policy inconsistency (policy directives are formed by presidential decree as they are in Uzbekistan). This confusion is mirrored by the pattern of donor activity, which is often characterized by weak coordination. Nevertheless, informants suggest that some clear policy direction has begun to emerge as a consequence of interactions between donors, agencies and the MoH. Currently the government appears committed to strengthening: primary health care services; policy development, planning and donor coordination capacity within the MoH; organisational and financial reforms; and capacity building for implementation. These priorities also reflect the key elements of the World Bank's current engagement with the Tajik health sector which is in itself highly indicative of the level of donor dependency within the health sector – there is no 'national' health policy in Tajikistan beyond the National Health for All strategy developed with assistance from WHO in 1995, and the underdevelopment of the health sector determines that high levels of external support that are required. By way of example, the World Bank considered lobbying the government for the introduction of a sector wide approach to health sector reform but decided against that option in 2005 because donor coordination is weak, but mostly because the government has no agreed health sector strategy. Likewise, given the dire state of the Tajik health sector and of health indicators, a focus on service delivery has taken precedence over systems reform.

In terns of policy and / or commitment to health promotion and public health there is

recognition of the importance of these issues within the Ministry but no real clarity on to how to progress – 2008 is the first year that the Government has allocated some of its own funds to the expanded programme on immunisation which is indicative of commitment but also of just how far the MoH has to go. There is a National Healthy Lifestyles Programme that is implemented by the Health Lifestyles Department within the MoH but the government hardly has the funds to pay salaries, let alone implement campaigns.

**iii) Development Assistance and the health sector:**

The health sector in Tajikistan is almost entirely dependent on financial and technical resources provided by external partners, particularly the World Bank and the Asian Development Bank who provide loans and technical assistance.

The World Bank through their active Community and Basic Health Project for Tajikistan aim to increase access to, utilization of, and patient satisfaction with health services in project supported areas, and to build capacity and efficiency at national, oblast and rayon levels in administering a basic package of health benefits and introducing financing reforms in primary health care. The projects components reflect the priorities identified by the World Bank and the Government for health sector reform (see above)

The Asian Development Bank through its active Health Sector Reform project aims to improve system efficiency and management capacity of the health sector; increase equitable access to and utilization of quality basic health services by women, children and the poor; and, support informed policy dialogue to pursue reform. The ADB also provides technical assistance for social sector development; policy dialogue and development; drug procurement strategy development.

UK DFID provides regional support to HIV/AIDS programmes, a part of which is the promotion of harm reduction activities for high-risk groups. The Government of Japan have funded a variety of initiatives through UNICEF including the expanded programme for immunisation and MCH initiatives. The Swiss Agency for Development SDC has a number of active projects including support for: the strengthening of health research capacity; community care and basic health services; policy dialogue and development; and family medicine services.

USAID, apart from the usual support to democracy building and good governance, have provided technical assistance for the TB DOTS (Directly Observed Treatment Short-course) program and piloted the implementation of a TB/HIV interaction model in Dushanbe. WHO, like most countries in the CEE/CIS has a limited operation in Tajikistan but provides technical assistance to the MoH and advice on best practices, regulation and other policy related matters. The UNFPA works on reproductive health issues and UNICEF supports initiatives that include integrated early childhood development, safe motherhood and neonatal care, nutrition components and immunization (incl. the procurement of vaccines).

**iv) Tracking of determinants, and health data collection and analysis:**

Data are collected through PHC centres but are not always reliable and underreporting and over reporting are common.
In some areas of the country it has been noted that the system has broken down completely. Most statistics are processed manually with some computer capability in the Medical Statistics Branch of the MoH.

In terms of the tracking of determinants a Demographic Survey was conducted in 2002 and UNICEF have conducted MICS in 2000 and 2005 – there is no systematic effort or capacity within the MoH to track or analyse health determinants.

**v) Evidenced based policy development, implementation and regulatory frameworks:**

As mentioned above the capacity of the MoH to independently develop evidence based policy and programmes is extremely limited. Likewise, the capacity for data analysis is limited both within the MoH and among high level decision makers. Policy making is externally driven and many directives and policy initiatives remain unimplemented as a consequence of a lack of internal drivers within the Ministry and a lack of resources.

The Government has enacted a range of legislations to support health service delivery and regulate the sector but without the means to implement policy and programmes there is not a great deal to regulate, especially considering that private sector engagement in the health

sector is limited. Laws that have been enacted include: the 1993 law on the donation of blood and its components; 1993 law on AIDS prevention; the 1997 law on health protection of the population; the 1997 law on 'Health for All to 2005"; the 1998 national programme for health care reform; and the 2000 law on universal salt iodisation.

**vi) Infrastructure and program delivery for health promotion and some key issues:**

Apparently a National Centre for Health Promotion was established in 1999 with technical assistance from the WHO but informants reveal that it no longer exists – it may have been a centre with no staff and no budget. Currently there is Health Lifestyles Department within the MoH that has branches in each oblast and rayon. These branches are attached to the PHC centres and are staffed by just 6 and 2 personnel respectively, although it was suggested that these staff often only work for 3 or 4 hours a week as they must find other ways to supplement their income. Also without an externally driven, donor funded project to implement there is little to do.

In theory all programmes implemented through the PHC centres are meant to have HP components but the human, financial and technical resources are not in place. Other organs within the MoH are also doing HP when it is part of an externally funded programme that is implemented outside of the jurisdiction of the Health Lifestyles Department. Informants from the Health Lifestyles Department argue that they should function as a resources centre for HP, provide technical oversight for HP activities and coordination services. However, again they are limited by a lack of resources and claim that they are even without internet connections. The Healthy Lifestyles Department Deputy Director also identified: the absence of a national HP strategy as a major obstacle; the strong need to improve market research and evaluation capacity; the need for a supportive regulatory environment and quality control; the need for a clearly defined mandate; and clearly allocated resources – apparently the government make much ado about the parallel importance of HP alongside health systems reform but allocate no resources from the state budget (except for salaries)

The Healthy Lifestyles Department is currently advocating for the establishment of an inter-departmental technical review group that could oversee the development of HP campaigns (in the context of HP activities being somewhat dispersed within the Ministries various departments and institutes). Apparently the Healthy Lifestyles Department have requested technical assistance from the WHO to establish and determine priorities and to coordinate donor involvement but are yet to receive a response. UNICEF have suggested a consultant be engaged to assist the Healthy Lifestyles Department with these tasks and to assist, in collaboration with the department, with the implementation of the communications component of the World Banks AI project that is UNICEF's responsibility (see below)

**vii) Workforce issues and training for public health and health promotion:**

Since the late 1990's many trained health professionals have left the health sector for better paid jobs in the private sector and with international agencies. Training remains highly specialised – physicians are trained in the Tajik State Medical University which still trains students with outdated Soviet methodologies. There is no dedicated faculty or department which specifically provides training on health promotion or public health related issues. According to CO staff, there are currently efforts underway to establish a health promotion department at the Tajik Medical Institute of Postgraduate Training, but as it stands students are sent overseas for training in health promotion and public health. The government of Japan currently supports approximately 10 students a year to attend 2 week health promotion training courses at the Institute for Health Services in Kazakhstan. .

**viii) Institutional and cross sectoral linkages / donor coordination and private sector partnerships:**

Similar to Uzbekistan, significant donor engagement in the health sector has necessitated a degree of inter-sectoral and inter-departmental coordination, especially in regard to externally funded programme implementation, although this is by no means the norm and rivalries and resource competition are common between ministries and departments. Donor coordination is also week although the Department of Health Reform recently submitted a proposal to GAVI which includes the establishment of a Health Council Unit to take care of donor coordination.

**ix)) Health sector financing:**

Since independence, according to the World Bank 2005 Public Expenditure Review, health spending has fallen both as a share of health spending in GDP and in terms of USD per capita. Although health spending slowly increased during the 2000 to 2002 period, health

spending in 2002 was only about one third of the 1995 level (3.1 percent of GDP). However, recent increases have been too small to have significant impacts on health care resource allocation and are not consistent with GDP growth.

With the exception of Georgia, Tajikistan has the lowest level of public spending on health among the CIS countries. Public spending on health dropped noticeably in 1995 and has remained roughly constant at about 1 per cent of GDP. Such a low level of public financing is not even sufficient to cover basic needs. Health services have been sustained by the additional resources of the private sector and donors. No resources seem to be specifically related to health promotion activities apart from salaries for staff within the Healthy Lifestyles Department.

**x) AI and pandemic preparedness - status / achievements:**

Tajikistan has developed a national Action Plan for the prevention of AI that is overseen by a National Steering Committee on AI which is chaired by the Deputy Prime Minister. This steering committee also includes: members from the Ministry of Agriculture and Environmental Protection; the World Bank's AI Project's Project Management Unit within the MoA; the MoH; the State Committee for Emergencies and Civil Defence; the State Committee on Youth and Sports Affairs; the Institute of Zoology and Parasitology; and the Food and Mouth Institute. To date simulation exercises have been limited to one exercise conducted at the district level with support from the World Bank, UNICEF, and FAO. There is, however, a plan to implement a major national level simulation exercise for AI preparedness in the near future.

As yet there is no completed plan for PI/HI Preparedness but informants indicate that efforts are underway to address these concerns.

Currently UNICEF, FAO, WHO, the World Bank and USAID are the government's most active partners for the prevention of AI. Commencing in 2006, the World Bank's AI prevention project is the largest contributor to joint efforts. This project comprises of four components: strategic communication; animal health; human health; and implementation support and monitoring and evaluation. As for Uzbekistan, UNICEF will, in collaboration with government, be the implementing partner for the strategic communication component which represents USD 600,000 of a total 2 million allocated. Interestingly, the communications component of the World Banks Uzbekistan AI project represents USD 200,000 of its total commitment because social advertising costs are reportedly lower in Uzbekistan than Tajikistan.

**xi) Communications as a component of AI and pandemic preparedness:**

A communications strategy was developed and a communications campaign was implemented by UNICEF in collaboration with a cross sectoral communications working group established by the MoH and UNICEF. This working group, which has been reportedly meeting once a week to oversee the development of the communication strategy and IEC materials based on the results of the first KAP survey (a second survey is planned for 2009), included representatives from all of the Ministries participating in the National AI Steering Committee as well as media representatives and representatives from donor and multilateral agencies. IEC materials developed included TV and radios PSAs, printed materials (leaflets and flyers) and material specifically developed for backyard poultry farmers. UNICEF also supported interpersonal communication through information sessions with community members in several high risk areas along the Afghan border.

UNICEF also supported a crisis communication workshop in 2007 which assisted government in recognising shortfalls in crisis communication. As a consequence of the symposium the government recognised the need to create press centres for all front line ministries and to establish a hotline for AI and other health related emergencies within the MoH.

# Albania

**i) Health status:**

Population: around 3.65 million (under 15: 24.1 per cent), GDP per capita USD 5,500, (2007)

According to the World Bank 2005 Public Expenditure Review, Albania has since transition recorded the highest economic growth of all the transition countries with real GDP growth averaging 7 per cent for the period 1999 to 2007, allowing Albania's per capita GDP to approach middle income country level. Poverty reduction has also been achieved – Living Standards Measurement Surveys in 2002 and 2005 record that absolute poverty fell by 6.8 per cent in the period between the surveys.

Albania's health outcomes compare favourably with those of other middle income countries but lag behind those of countries in the south-eastern Europe. All data sources show an improvement in Albania's key health outcome indicators over the past decade, but different data sources present a different picture. As probably is the case for many CEE/CIS countries, there is controversy about the prevalence of under-reporting and the general reliability of data.

However, despite discrepancies between official data and other data sources, the trend is generally positive – U5MR fell from 45/1000 in 1990 to 17/1000 in 2005.

In terms of the burden of disease – the threat of emerging communicable diseases like AI and HIV/AIDS and the ever present and increasing levels of non-communicable disease such as cancer and heart disease, place huge stress on a health system that is struggling to deliver adequate services.

**ii) Recent and current health sector reform efforts, national mandate / policies and political leadership:**

Like other transition countries, the health sector in Albania is heavily focused on secondary and hospital care, with insufficient emphasis on primary care, including primary and secondary preventive care, and health promotion. As the World Bank noted in their 2005 Public Expenditure Review: "....preventive care and health promotion will need to be substantially strengthened and will require higher resource allocations if Albania is to effectively address the growing incidence of non-communicable diseases in a cost-effective manner"

A series of reforms were initiated in the mid l990s, but limited progress has been made. These reforms included the decentralization o f primary care management to district public health directorates and integration of the former with public health functions, the privatization of the pharmaceutical sector and most dental care, and the establishment o f the Health Insurance Institute in view of a gradual change of the health financing system. Plans were also made to substantially upgrade the quality of the primary care system through physical investments and skills upgrading. The Kosovo crisis interrupted many of these initiatives, and limited progress has been made in most of the reform areas since then. Other challenges that have been faced include: severe budgetary constraints; damage to infrastructure and disruptions caused by political volatility and civil strife; and, an obstructive bureaucratic culture.

There is still a long way to go, especially with regard to preventative health care services and health promotion. Currently there is no functioning national level policy that addresses public health and health promotion in Albania except a Public Health Strategy that was developed in 2003 by the World Bank and the UK Health Education Authority. This strategy has never been allocated funding and consequently remains policy on paper.

There is however evidence that the MoH will increasingly address the need for an improved public health as they have recently established a liaison focal point for health promotion within the Ministry. Health promotion is nominally the responsibility of the Department of Health Promotion within the IPH but the MoH feels that there is need for a focal point to advocate and lobby for health promotion within the Ministry. To this end the newly appointed focal point

is tasked with developing a data base of past and present HP initiatives and an analysis of best practice.

The new Minister for the MoH was appointed in July 2007 and it is thought that he is interested in preventative health and HP strategies. The current Minister is a former business man and economist so he may be more open to cost-effective preventative health strategies than his predecessor who was, like many CEE/CIS health ministers, a medical specialist. There is also a sense that there is a renewed focus on HP within the IPH which plans to shortly publish a calendar of all international health days distributed to high-level decision makers, cabinet ministers and the media.

**iii) Development Assistance and the health sector:**

As Albania progresses towards EU membership resources have become increasing focused on reforms that are in line with EU accession requirements. As government becomes more preoccupied with complying with the *acquis* there is a risk that social sector reform will be paid less attention. External and donor funding of healthcare has already dropped from almost 9 percent of total sectoral funding in 2000 to around 2 percent in 2005.

In Albania, as in many other transition countries, the World Bank is the big player in the reform of the Health Sector. The World Banks current Health Systems Modernisation Project aims to: improve physical and financial access to quality primary health care services; to improve the effectiveness of the MoH and the HIF; to improve governance and management; and to improve the stewardship capacity of the MoH, the IPH and HIF.

EU assistance to Romania is focused on complying with conditions for EU accession and there is little leverage for support to the health sector.

USAID through its Investing in People Programme works in Albania to assist with the strengthening health reform efforts by helping to create a fully integrated primary health care system to respond to the basic health needs of the population. Services target reproductive health, family planning, HIV/AIDS/STIs and tuberculosis.

The United Nations agencies in Albania are currently working towards a 'One UN' joint programmes for Albania. By 2008 all the UN Agencies must devote 80 per cent of their efforts towards a joint programme and by 2010 one programme for all of the agencies will be in place.

UNICEF in Albania is contributing towards work in preparation for the One UN Programme and also has an Early Childhood Programmes that address safe motherhood; breastfeeding, immunisation, nutrition and the integrated management of childhood illnesses. UNICEF is also actively engaged in HIV/AIDS prevention.

**iv) Tracking of determinants, and health data collection and analysis:**

The IPH, reorganized in 1995 from the previous research institute in hygiene and epidemiology, is accountable to the MoH and is in theory responsible for collecting public health statistics, organizing health surveys, monitoring the environment, running immunisation campaigns, and collecting data on health status. It also offers advice on public health policy, provides technical support, and acts as a national research and training centre. The extent to which these functions are implemented is unclear and varies across the scope of the Institutes various responsibilities; however it is widely reported that the IPH lacks the resources to adequately complete its work.

Evidence is also collated at the regional and district levels by the Directorate of Public Health and Health Information Management Systems are being piloted in 5 districts. In addition, a Reproductive Health Survey was conducted in 2002, UNICEF conducted a MICS in 2005 and a Demographic and Health Survey is planned for 2008. Currently there is a steering committee established to guide the objectives of the DHS that is chaired by the deputy Minister of Health and comprises representatives from the UN agencies, the MoH and the IPH. Hopefully the results of the DHS will inform public health policy development for the next few years. In this context, UNFPA have argued, in support of health promotion interventions, that there should be an increased focus on health knowledge within the DHS structure.

**v) Evidenced based policy development, implementation and regulatory frameworks:**

It is clear that evidence is collected by the Albanian health system but it would seem that it is rarely used to develop effective public health policy and when it is, that policy is often only partially implemented, or in some cases not at all. Some mechanisms are in place to ensure the cross sectoral fertilisation of health policy through inter-departmental and inter-ministerial forums but the international community leverages most government action in this regard, and much still remains to be done, especially in terms of articulating some sort of actionable public health strategy. There are also concerns that international activity in the health sector weakens institutions as they become dependent on partners to take the lead – USI initiatives are, for example, viewed very much as a UNICEF concern.

The Government has enacted a range of legislations to support health service delivery and regulate the sector but much more is needed to better support preventative health measures and health promotion. Laws that have been enacted include: the code on breast milk substitutes that was recently upgraded to the status of national law, the WHO protocols on the promotion of tobacco, and provisions to ensure that all patients receive free inpatient care. However, monitoring and evaluation systems are often rudimentary or not in place and enforcement of legal standards is an issue. For example, despite a law stipulating free inpatient care for all, informal payments at all levels of the health system are common.

On a positive note, Albania has been more successful than some other countries in implementing the WHO protocols on tobacco marketing and has managed to nominally ban tobacco consumption in a wide range of locations, especially in the capital Tirana. Apparently the Prime Minister is an ex-smoker and vehemently against tobacco consumption which is indicative of the vital role that decision makers can play in supporting health promotion and public health endeavours.

**vi) Infrastructure and program delivery for health promotion and some key issues:**

The Department of Health Promotion within the IPH has responsibility for providing technical advice in support of health promotion activities and the Public Health Directorate and Primary Health Care Directorates, which have branches in all districts and take responsibility for the delivery of public health services, including health promotion and family medicine. Currently 12 regional Public Health Directorates have health promotion focal points.

The functions of the IPH and the HP department are still very much evolving as the health sector in Albania is slowly shifting from a curative and specialised approach to a focus on PHC and public health. Currently the IPH and the Department for HP are accountable to the MoH and have little autonomy as all decisions must be cleared by the MoH. However, with the new HP focal point positioned within the MoH it is thought that the HP Department may be able to assert more influence on decision making within the MoH. The MoH tends towards achieving short term objectives at the expense of long term PH strategies that address the high incidences of both communicable and non-communicable disease. Much, if not all, of the work that is done by the Health Promotion Department is externally driven and has included initiatives that target iodine deficiency disorders, HIV/AIDS prevention, road safety, family planning and Avian Influenza. Work done by the HP department varies in quality and often reflects the priorities of development partners rather the objectives of any integrated strategy for preventative health/health promotion.

**vii) Workforce issues and training for public health and health promotion:**

Physicians, nurses and others working on PH issues, especially at the district or regional level, often lack the motivation and the incentives to meet their public health responsibilities. HP and PH work also, as in other CEE/CIS countries, are considered as lacking status, which along with the low wages on offer conspires to ensure that the health sector has difficulty attracting and retaining public health professionals (the Health Promotion department has only 9 professional staff in the national office and the position of the head of the Department of HP is currently vacant as the previous director left for a better paid job with higher status in the MoH). The performance of the sector is also compromised by staffing changes that follow ministerial and political shifts (for example, when the new health minister was appointed in 2006). While, as in other post-Semashko systems, physicians are required to devote 30 per cent of their time to health promotion and preventative health, these obligations are largely ignored as health workers struggle to make a living and are compelled to devote their time to services that have the potential to generate external income through out of pocket payments.

Profiteering is also a problem with the health and justice sectors considered as the most corrupt in Albania.

In terms of training, opportunities for training in public health and especially health promotion are limited. It is possible to study for a master in public health at the state university which focuses on reproductive health. There is no specific focus on health promotion or communication issues. Albania also has a problem with the recognition of qualifications and the accreditation of physicians.

The CO reports that opportunities for health promotion training, professional development, and multi-disciplinary teamwork are limited. Health promotion is a part of a physicians ToR but no resources are dedicated for this purpose by national authorities.

**viii) Institutional and cross sectoral linkages / donor coordination and private sector partnerships:**

Theoretically institutional and cross sectoral linkages are established at all levels, between: MoH and its components; MoH and regional and district authorities; MoH and other ministries; and, between MoH, donors and multilaterals. In reality there still appears to be a lot of confusion and linkages are maintained by externally funded activities like AI prevention planning, rather than on established mechanisms for inter-sectoral collaboration. Informants report that there are a lack of regular information exchanges between the IPH and the MoH and that there is little collaboration between departments on health promotion concerns – departments within the MoH have been known to bypass the Health Promotion Department and plan their own campaigns as part of an externally funded project under their particular jurisdiction. Despite its best intentions, the Health Promotion department in the IPH lacks the authority to properly coordinate all health promotion activities that occur. The Deputy Director of the IPH in Tirana reports that there is a need for a multi-disciplinary approach to health promotion and public health that influences decision makers as well as health workers, suggesting that there is a mood for reform in this regard.

Donor coordination in Albania is better than average for the health sector because of the sectors dependency on external assistance (particularly World Bank loans) and the relatively small size of the country. Efforts towards joint programming are also well advanced among the UN agencies that are looking to the signing of a joint programme agreement in 2008.

**ix)) Health sector financing:**

Despite considerable increases in health sector spending over the past three years, Albania continues to allocate a below average share of public sector resources to the health sector. Health sector expenditures have increased from a low 7.2 per cent of government spending in 1999 to 9.3 per cent in 2005, therefore remaining below that of most European and transition countries. However, according to the World Bank, health sector expenditures have increased by 41 per cent in real terms over the past five years, with an increase in per capita spending of 37 per cent over the past three years. Almost 100 per cent of private sector spending on healthcare is out of pocket spending at the point of service. External and donor funding of healthcare has dropped from almost 9 per cent of total sectoral funding in 2000 to around 2 per cent in 2005.

While it is extremely difficult and often impossible to find expenditure data on specific government funded public health and health promotion programmes and projects, the World Bank in its 2006 Public Expenditure Review estimates that a maximum of 3.7 per cent of all public expenditure for the health sector were allocated to public health and preventative health programmes for 2002 to 2004. Considering the burden of communicable and non-communicable diseases this low spending seems to indicate, as it does in other countries, that government and the MoH are not taking preventative health seriously enough.

**x) AI and pandemic preparedness - status / achievements:**

Under the Prime Ministers office a national inter-sectoral task force for AI prevention and preparedness has been established, is chaired by the Ministry of Agriculture and attended by representatives from the MoH, the IPH and the Institute of Food Safety and Veterinary Science. Contingency plans exist for both AI prevention and pandemic preparedness and both these plans contain communications components. A national AI/PI preparedness workshop was held in the capital in January 2008 (see main report, section: .....for more detailed discussion about this workshop).

**xi) Communications as a component of AI and pandemic preparedness:**

As was the case in other countries that have experienced AI outbreaks, clear notions of what to do can be hard to come by – the Ministry of Agriculture wanted to protect poultry farmers and MoH wanted to promote healthy behaviours. Subsequently in 2006, at the behest of UNICEF and the MoH, an AI communications working group was established to provide technical oversight for AI related communications and to provide advice to the ministries. The communications working group is co-chaired by UNICEF and the IPH, and has representation from farmers groups, the Ministry of Education, the IPH, MoH, UNDP, USAID, FAO and WHO. The work of this group has included overseeing the development of strategic communications plans for AI prevention and preparedness; regional trainings for journalists on AI related issues; and, despite delays in decision making, overseeing the development, pre-testing and production of IEC materials and radio and TV PSAs. The working group has so far taken a broad spectrum approach to messaging that emphasises personal hygiene as a key preventative strategy.

UNICEFs work in support of communications for AI prevention and preparedness has been a part of a larger USAID project. Other achievements that have been supported by USAID through UNICEF and the AI communications working group include the development and implementation of a KAP survey on AI knowledge (a second KAP is planned for 2008) and the convening of a symposium for media and government representatives on crisis communication.

Currently near the end of its funding cycle the USAID communications component will be superseded by the World Bank's AI project which will also have a communications component. There were some discussions between UNICEF and the World Bank in regard to UNICEF being the implementing partner for the communications work but the WB decided to engage a contractor. However, the WB has agreed to ensure that the work undertaken builds on the work that has already been done, continues to take a broad spectrum approach to communications for disease control, and continues to engage the already established communications working group.

## Romania

**i) Health status:**

Population: around 22.3 million (under 15: 15.6 per cent), GDP per capita USD 11,100, (2007)

Since 2000 Romania has benefited substantially from economic growth that has averaged around 5 to 6 per cent annually. According to the World Bank, this period of growth in Romania since 2000 has caused a big decline in absolute poverty, from 35.9 per cent in 2000 to 13.8 per cent in 2006. Nevertheless, deep pockets of poverty remain in rural areas, the north east, among the least educated and among ethnic minorities.

There was a period in the 1990's when health indicators worsened but they have since improved steadily. Infant and maternal mortality have been reduced markedly and for 2004 were recorded as 17/1000 and 24/100,000, respectively. Infant mortality rates are below the average of countries with similar income levels, while maternal mortality is slightly above average. However, these rates are higher than every other country in the European Union, and among countries that are candidates for accession. It should also be noted that national averages also mask regional inequities and significant disparities in the regional distribution of public resources.

In terms of the burden of disease, cardiovascular diseases, respiratory illnesses and cancer are the leading causes of death which indicates that inadequate resources are being allocated towards public and preventative health initiatives. Communicable diseases are an ongoing problem for Romania which still has the highest rates of TB in Europe. Romania also has the highest incidence in Europe of other infectious diseases including syphilis, viral hepatitis and rubella. HIV/AIDS and other emerging threats are also major public health concerns.

**ii) Recent and current health sector reform efforts, national mandate / policies and political leadership:**

Romania was never a Soviet satellite state but did have a series of communist governments so the Romanian health care system was, and is, strongly influenced by the Semashko model but also has elements of the Bismarck system and has based reform of the HIF on German approaches. Reform of the health care system has been influenced by the World Bank (through primary heath care), Germany (health insurance system) and United Kingdom (through capitation approaches). Processes of decentralization, and moves to diversify the sources of funding started in the early 1990s and in 1997, the Health Insurance Law transformed the system from a Semashko state financed model to an insurance based system. Like any major reform, there have been problems and obstacles. Coordination of the process has been complicated, in part due to multiple actors and in part to staff turnovers and other change. Health legislation is complex and changes frequently, the country spent little on health in the 1990s and the social health insurance system has proven limited as a solution for increased funding due to collection problems. Other obstacles to reform have included, the governments focus on EU accession priorities at the expense of social sector investments, ongoing friction between the MoH and the HIF, and issues of transparency and absorptive capacity – recently introduced taxes on cigarettes have led to increased revenue for the MoH which it reportedly has had difficulty spending.

With regard to health promotion there is recognition that efforts must be significantly enhanced. The current health minister, a former economist, has reportedly witnessed increasing expenditure on curative approaches to non-communicable disease unproductively accompanied by increases in the incidence of these diseases. As a consequence the minister has determined that more resources should be targeted at preventative health strategies, including health promotion. To this end there is a plan to establish a health promotion programme within the soon to be established National Agency for Public Health, Health Programmes and Medical Assistance - a budget line has been allocated for this purpose which suggests that the MoH is serious about these issues. However, the exact amount budgeted is currently indeterminable and the new agency and health promotion programme (as of January 2008) are yet to be approved.

In terms of supportive policy, health promotion is in theory meant to be a part of the National Health Programme, but without coordination and advocacy at the central level it is difficult to gauge the efficacy of health promotion interventions that are undertaken by different organisms within the health sector. A public health strategy has been developed for 2008 to 2010 with the assistance of the World Bank but so far remains without an accompanying action plan or a budget line. This public health strategy will nevertheless be consulted at length and built upon to inform the creation of the new health promotion programme and a health promotion strategy. However, informants demonstrated concerns about the forthcoming election in November 2008 which well may result in the Minister ending up in a different job which could derail these ambitious plans – as in many other CEE/CIS countries, political instability and frequent staff movements within the health sector threaten the sustainability of public health initiatives and other reform processes.

**iii) Development Assistance and the health sector:**

As a consequence of Romania's EU candidate status in the lead up to Romania's full accession to the EU, there has over recent years been less of a focus on social sector reform and more focus on issues such as justice, human rights and good governance, which relate to compliance with the EU acquis. However since the granting of membership status in 2007. Romania is now eligible for assistance under the European Commissions Directorate for Health and Consumer Protection (DG SANCO) Second Programme of Community Action in the Field of Health for 2008 to 2013 (see section 5 "the policy environment' for more detail). For more detail on EU relations with Romania in general see the link below:

http://www.euractiv.com/en/enlargement/eu-romania-relations/article-129587

World Bank assistance to the Romanian health sector is focused through the Second Romania Health Sector Reform Project which helps to the health sector to provide more accessible services, of increased quality. The project has five components: rationalization and improvements to the system of maternity and neonatal care; integrated ambulance dispatch capability and upgrades for hospital emergency areas; improvements to the accessibility and quality of basic medical services in rural and small urban areas; support for the development of national health accounts and the preparation of proposals for rationalization and service development projects; and project implementation support. USAID withdrew from Romania following EU accession in 2007.

UNICEF in Romania supports the health sector through the Quality of health services Programme which has included awareness raising campaigns on the benefits of breastfeeding; assistance with the development of National Strategy Paper for Breastfeeding Promotion 2003-2012; support to the establishment of baby friendly hospitals; support for a national campaign on iodine deficiency disorders; and the roll out of a national Education in Romanian Schools project which has resulted in the distribution of some 8,000 manuals containing chapters on nutrition and iodine deficiency disorders.

**iv) Tracking of determinants, and health data collection and analysis:**

As in other countries whose health systems are based on the Semashko model there are mechanisms for collecting data at the national and sub-national level but there is also a general lack of analytical capacity to extrapolate trends and patterns or to consider determining factors. The last Demographic and Health Survey was completed by the National Institute of Statistics in 2001.

The tracking of health determinants is however recognized as a priority for the health sector and discussions have been held in relation to how to establish a national system to track health determinants. The health minister has also called for a national assessment of health determinants as part of the proposed new emphasis on public health.

**v) Evidenced based policy development, implementation and regulatory frameworks:**

As noted, efforts targeted at the tracking of health determinants are limited. The 2008 – 2010 Public Health Strategy clearly has drawn on available evidence, although an informant who had been the Chief of the Department for Communicable Diseases at the time the strategy was being drafted, claimed that she was not consulted at any time while the draft was being developed.

With regard to regulatory frameworks health legislation in Romania is complex and changes

frequently. There are however programmes in place that may lead to a more supportive legislative environment in the near future, including: the National Strategy on IDD Elimination, the National HIV/AIDS Strategy, the National Strategy on Drug Use; the National Strategy on Tobacco Control and the National Strategy on Breast Feeding Promotion.

**vi) Infrastructure and program delivery for health promotion and some key issues:**

The health sector in Romania suffers from a culture of specialisation and lacks standards and protocols, particularly in relation to public health and primary health care.

Currently the situation with regard to responsibility for, and delivery of, public health services is quite confusing. Technically the MoH, through the National Public Health Authority, is responsible for setting organizational and functional standards, developing and financing national public health programmes, collecting data and drawing up reports on population health status. The Ministry is also responsible for environmental health, through the IPH Bucharest (there are also 5 other autonomous IPH branches under the authority of the MoH which along with the IPH in Bucharest deliver HP and PH services at the sub-national level). District level Public Health Directorates are also responsible for addressing public health issues in their districts, and their expenses are financed by the MoH. Communicable diseases are the responsibility of the MoH, but treatment is covered by the HIF. Among others, there are screening programmes for cervical and breast cancer, radiological screening for TB and compulsory immunization. Until 1990, there was no family planning network in Romania; now there are eleven reference centres for reproductive health. In addition, health education, previously termed “sanitary education”, has been developed into a network for health promotion and education, and currently there are programmes of health promotion and education at national and district levels.
In Albania there have been many successful health promotion campaigns most of which have been externally driven. Campaigns have included interventions focused on HIV/AIDS, TB, USI and breastfeeding but there is an urgent need for a coordinated approach as initiatives are often duplicated, and follow up monitoring and evaluation is often ignored. Sustainability is also an issue as health workers have no incentives to maintain health promotion initiatives when external funding dwindles.

As mentioned above there is a plan to establish a National Agency for Public Health, Health Programmes and Medical Assistance and under this agency there will be a health promotion programme which will hopefully lead to improved coordination and less duplication. The proposed health promotion strategy that will support this programme will therefore include an assessment of past health promotion activities and how they have evolved, and will establish priorities based on health determinants and lessons learned. There is also a plan to establish National Centre for communication and information within the abovementioned National Agency although its relationship with the health promotion programme is currently unclear.

Around 1999/2000 an informal inter-ministerial health promotion and communications working group or network came into being. This group included most qualified public health personnel from the 6 IPHs and representatives from the UN Agencies, NGOs, the MoH, and the MoE. Journalists and media people also occasionally attend. This WG has provided technical advice to organisms within the MoH that have been required to develop health promotion components as a part of specific programmes, and has functioned to unofficially coordinate work on health promotion. Informants recognize that the experience of this working group must be fed into the plans and processes of institutional reform that will lead to the establishment of the National Health Promotion Programme. There has been some discussion about the health promotion / communications working group being formalized by Ministerial Decree, although it has been noted by some of its members that the reason the group has survived is because it has not been formalized. Being an informal network, the working group may be less at risk of being scuttled in a political power struggle or ministerial shake up.

Under the new structure the National Agency for Health Programmes, the Dept of Health Policy and the Public Health Authority, with advice from the Bucharest IPH and its regional networks, will cooperate to implement the proposed Health Promotion Strategy – however some key staff involved with these proposals have only been in their jobs for around a year and political instability is always a threat to the sustainability of interventions. Informants in the

Public Health Authority have also stated that technical assistance is urgently required for the development of the health promotion strategy. Informants also noted that the MoH needs to learn from experiences in other countries and to better coordinate, support and retain the technical expertise that is available in Romania – there are about 100 staff in the entire health sector with some training in public health and health promotion.

**vii) Workforce issues and training for public health and health promotion:**

CO and government informants report that generally only the people within the established health promotion networks in Romania understand the value and importance of preventative approaches and health promotion. There are no significant health promotion training opportunities for those employed in the health sector and opportunities for general professional development are limited. It is possible to study for a master's degree in public health at the State University and some minor specialization in health promotion is available. There is however, no specialist department for health promotion and the university does not supply technical expertise to the health sector in regard to health promotion.

**viii) Institutional and cross sectoral linkages / donor coordination and private sector partnerships:**

Linkages between the various arms of the health sector and between ministries are not well established, with exception of the cross-sectoral health promotion and communications working group mentioned above. Linkages are partially established and functioning between the MoH and other ministries and between the MoH and its regional bodies. Frequent staffing changes including the regular replacement of managers in the health and other government sectors does not help to create and environment conducive to strengthening institutional linkages – for example, the Bucharest branch of the IPH has reportedly had six directors in the last two years. On a more positive note, 2 out of 6 of the IPHs in Romania are members of the EC Euro Health Network for public health.

Donor coordination in the health sector is good but operates in an ad hoc rather than systemised fashion with partners being regularly summonsed to the Ministry for discussions. Efforts to engage with civil society and the private sector on public health related issues are at a very early stage of development.

**ix)) Health sector financing:**

Public spending on health has fluctuated between 3.4 and 4 per cent of GDP. For 2006 the budget allocation for health amounted to approximately 3.3 per cent of GDP. Public spending is expected to increase or at least remain steady at the current rate given the recent decision to earmark part of the excise tax revenues from alcohol and tobacco for the health sector.

While there is reportedly a budget line for the new Health Promotion Programme, there is no clear indication of how much funding will be allocated. It is impossible to ascertain past expenditure on public health and health promotion initiatives as many of them have been externally funded. Government funds for public health are generally absorbed by ongoing operational costs such as salaries.

**x) AI and pandemic preparedness - status / achievements:**

There is a National AI Task Force, chaired by the Ministry of Agriculture, under the jurisdiction of the National Committee for Emergencies, chaired by the Ministry of Interior and coordinated by the Prime Minister's office. The AI task force nominally has representation from MoH, MoA, Ministry of Administration and Interior, MoE, IPH, General Inspectorate for Emergency Situations, Ministry of Transport, Ministry of Defence, and Institute for Infectious Diseases. Non government participants include USAID, UNICEF, UNDP, WHO, World Bank and the EU (FAO has no presence in Romania). Informants report that it is more of a task force on paper than in reality.

An AI prevention plan is in place, but work is still underway on a national PI/HI pandemic preparedness plan. Simulations exercises have not been undertaken to date.

**xi) Communications as a component of AI and pandemic preparedness:**

The national HP working group that was discussed earlier has been substantially engaged with AI communications issues and has overseen the preparation of a communications strategy for the AI prevention plan. As of January 2008 this communications strategy was still being debated and had not as yet received approval from government.
Nevertheless, UNICEF and USAID, in consultation with the communications WG, prepared, pre-tested and disseminated a range of AI prevention materials including TV, radio and

newspaper PSAs; brochures and leaflets and through inter-personal channels such as puppet theatres for children (USAID regional strategy). Materials were only prepared for phase 1 and 2. Other achievements include trainings for journalists and the UNICEF supported symposium on crisis communication that was convened for government and media participants in November 2007.

Following Romania accession to the EU, USAID closed offices. As a consequence the World Bank is currently the major donor for AI prevention and preparedness planning. In this context informants have noted the importance of continuing to engage with the communications WG in relation to communications components and to ensure improvements in preparedness planning through simulation exercises.

# Annex 3: The Ottawa Charter for Health Promotion

## Ottawa Charter for Health Promotion, 1986

### Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

### Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

### Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

### Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

### Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

### Health Promotion Action Means

### Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy-makers as well.

## Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

## Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

## Develop personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare them for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

## Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

## Moving into the future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

## Commitment to health promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource, to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and wellbeing;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

## Call for international action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, health for all by the year 2000 will become a reality.

# Annex 4: Glossary of Key Terms

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| **Avian Influenza** | Highly pathogenic H5NI virus (Bird Flu virus) which infects birds and can infect humans |
| **Avian Influenza Prevention and Preparedness Plan** | National Avian Influenza prevention plan and/or preparedness plan developed by government, and for the CEE/CIS, usually with the strong support of UN systems agencies, the European Union, and often the World Bank and USAID. Some countries have separate plans for prevention and preparedness others combine these two functions. |
| **National Avian Influenza Task Force** | Can also be called National Avian Influenza Committee, Coordinating Body or something else. For the purpose of this report a National Avian Influenza Task force is an at least partially inter-sectoral body established (sometimes at the behest of development partners) to coordinate and oversee Avian Influenza prevention and sometimes also preparedness for pandemic human influenza |
| **Capacity building for health promotion** | Capacity building for health promotion refers to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over. |
| **Capacity mapping** | Capacity mapping is a structured process that involves identifying, describing and assessing critical components of capacity in a system (such as governance policy, infrastructure, resources) as well as attributes (such as problem solving and resource mobilisation), and the relationships between them. |
| **Avian Influenza Communications Strategy** | Avian Influenza Prevention Communications Strategies have been Prepared by UNICEF in collaboration with government counterparts and sometimes with the assistance of a cross-sectoral communications working group (see below). These plans detail the communications strategies that will be employed in support of Avian Influenza preparedness and roles and accountabilities in this regard. |
| **Avian Influenza Communications Working Group or: *Communications Working Group*** | Formed, usually after lobbying efforts by UNICEF, as a part of the above mentioned *Communications Strategy,* or before it in cases where the Communications Working Group has contributed to that strategy. These working groups are usually intersectoral and inter-ministerial and also include, to variable degrees and depending on local contexts, representation from UN systems agencies and other partners involved in AI prevention such as the World Bank and USAID. Public and private sector media agencies, NGOs, and industry groups (especially from the poultry industry) are sometimes also represented. A primary responsibility of these working groups has been to oversee the development of information, education and communication materials (see below) that are developed in support of AI prevention and transmission to humans, especially adults and children who may live or work in close proximity to potentially infected birds |
| **Constituency** | A constituency is a group of sectors or organisations from whom the government hopes to attract support. |
| **Contemporary health promotion philosophy and practice** | Policy makers, practitioners and others have a shared interest in keeping track of changing ideas, models and practices. In general, health promotion philosophy and practice that is 'contemporary' will be consistent with the principles of the Ottawa Charter for Health Promotion. |
| **Equity in health** | Equity in health refers to prevailing circumstances in which there are no systematic differences (potentially remediable) in one or more aspects of health across population groups (as they are defined socially, economically, demographically or geographically) |
| **Governance** | Governance primarily involves the policing of social relations, environmental<br>conditions, and the allocation of resources essential to well-being |

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|---|---|
| **Health education** | Health education is one of the common methods used in health promotion programs and has been defined as follows: 'Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health.' |
| **Health communication** | Health communication refers to the use of communication strategies to inform and influence the decisions of individuals, groups, organisations and communities that can protect and improve health. |
| **Health promotion** | Health promotion is a process that uses a combination of strategies to enable people to increase control over the determinants of their health, and in turn, to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Five strategies comprise the overall approach:<br><br>1. Build healthy public policy<br>2. Create supportive environments for health<br>3. Strengthen community actions<br>4. Develop personal skills<br>5. Reorient health services.<br><br>(Ottawa Charter for Health Promotion, WHO 1986) |
| **Health promotion programs and services** | Health promotion programs and services aim to enable people to increase control over the determinants of their health, and in turn, to improve their health. Their designs reflect the multi-strategy approach outlined in the Ottawa Charter for Health Promotion |
| **Health promotion capacity/ Capacity to promote health** | A country's capacity for health promotion relies on several domains being in place, and strong, effective and efficient relationships existing between these domains:<br>▪ Governance of the system: The governance and administrative structures and processes involved in priority setting and mobilising and coordinating the deployment of infrastructure and resources for planning, implementing, evaluating and researching health promotion programs and services<br>▪ Policy environment: The set of policies, legislation and plans that represents country population health priorities, how it will act on these priorities and how this work will be financed, implemented, monitored and evaluated<br>▪ System infrastructure and resources: The people, money, partnerships, and information and knowledge required to define, assess, analyse and act (through programs and services for instance) on health issues<br>▪ A framework of programs and services designed to bring about change in macro level and micro level determinants of health. |
| **Leadership** | Leadership (political, technical, professional) refers to the interpersonal influence over and above the influence that stems from a person's positional authority or legitimate power and has the effect of influencing the activities of others toward defined goals. |
| **National Pandemic Influenza Preparedness Plan** | A national preparedness plan that addresses national level preparedness for the 5 possible phases (as delineated by WHO) of an Influenza Pandemic. These plans are sometimes (as Turkey is planning) combined into a National Avian Influenza and Pandemic Preparedness Plan. Sub national or regional plans may also exist. |
| **Public health** | WHO in 1998 defined public health as the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society. |

## Annex 5: Links to Key Resources and Further Reading

### *European Observatory on Health Systems:*

For an excellent 2004 study commissioned by the European Observatory on Health Systems and entitled 'Health Systems in Transition: Learning from Experience' see link below. This report provides detailed analysis of health systems reforms that have taken place in CEE/CIS countries since the break up of the Soviet Union.

**http://www.euro.who.int/observatory/Publications/20040720_2**

For detailed analysis for many CEE/CIS health systems in transition see:

**http://www.euro.who.int/observatory/Hits/TopPage**

For the summaries go to:

**http://www.euro.who.int/observatory/Hits/20020525_2**

For the European Observatory on Health Systems homepage go to:

**http://www.euro.who.int/observatory**

### *The Euro Health Network*

The Euro Health Network is the network of health promotion and public health agencies in Europe. Their aim is to improve the health of European citizens by striving for a healthier Europe between and within countries. This is supported by coordinating the work of 31 national and regional agencies in Europe thereby constituting a valuable platform for information, advice, policy and advocacy on health issues in the EU

Below is a link to the report that details the Euro Health Networks 2005/06 Capacity Building for Public Health and Health Promotion Project:

**http://www.eurohealthnet.eu/index.php?option=com_frontpage&Itemid=1**

### *International Union for Health Promotion and Education*

Based in France, the International Union for Health Promotion and Education is the only global organisation entirely devoted to advancing public health through health promotion and health education.

**http://www.iuhpe.org/**

NB: The International Union for Health Promotion and Education will convene its 8th European Conference on Health Promotion and Health Education from 10 to 13 September 2008 in Turin, Italy.

## *The Importance of Health Investments for the CEE/CIS*

Link to an excellent 2007 report by the European Observatory on Health Systems and Policies entitled – *Health: a vital investment for economic development in Eastern Europe and Central Asia* – that details health determinants, health expenditures and the rationale for increased investments in the health sector.

**http://www.euro.who.int/document/e90569.pdf**

## *World Bank Resources*

For public expenditure reviews and project appraisal documents relating to health sector reforms see the World Bank sites for Europe and Central Asia. Follow links for individual countries, and then links to individual projects for appraisal documents, and links to documents and reports for public expenditure reviews.

**http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/0,,menuPK:258604~pagePK:158889~piPK:146815~theSitePK:258599,00.html**

For World Bank documents on development communications:

**http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTDEVCOMMENG/0,,contentMDK:21433084~menuPK:34000171~pagePK:34000187~piPK:34000160~theSitePK:423815,00.html**

## *European Union/Commission Resources*

On external relations in Europe and Central Asia see:

**http://ec.europa.eu/external_relations/ceeca/index.htm**

For the European Commission's Health and Consumer Protection Directorate and information on public health priorities for 2008 to 2013

**http://www.epha.org/a/2842**

For the Public Health Executive Agency:

**http://ec.europa.eu/phea/index_en.html**

NB: The European Commission's Health and Consumer Protection DG (DG SANCO) and the Public Health Executive Agency have clearly defined responsibilities. The Commission lays down the European Community policy in Public Health, liaises with Member States and sets out related priorities in the annual work programmes. The Public Health Executive Agency has overall technical and financial responsibility for implementation, launches calls for proposals and tenders, ensures efficiency in the management of awarded projects and tenders and is in charge of disseminating the results. The European Commission's Health and Consumer Protection Directorate and the Public Health Executive Agency collaborate closely in the execution of their tasks through meetings at both managerial and technical levels and through the

agency's reporting structure. National Focal Points have been nominated in a number of Member States and participating countries to act as national information relay points on the Public Health Programme and to provide local support to potential project applicants.

## *Health Promotion Portal of WHO*

**http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=health_promotion**

## *USAID in Europe in Central Asia*

**http://www.usaid.gov/locations/europe_eurasia/**

## *UN and Avian Influenza*

UN Portal on Avian Influenza

**http://un-influenza.org/**

On pandemic preparedness:

**http://www.hhs.gov/pandemicflu/plan/sup10.html**

Assessment of pandemic preparedness for Europe and Central Asia:

**http://www.un-pic.org/web/**