World Health Organization
REGIONAL OFFICE FOR Europe

Prevention and control of noncommunicable diseases in the European Region: a progress report

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Abstract

Noncommunicable diseases continue to be the leading cause of morbidity and mortality in the European Region. Member States have made significant progress in implementation of prevention and control activities in keeping with the mandates set forth by the Health 2020 and the Action Plan for Implementation of the European Strategy for Prevention and Control of Noncommunicable Diseases 2012-2016. This report aims to demonstrate achievements made in the various proposed action areas, reporting the activities already undertaken and future plans, through presentation of data for the region derived from WHO's NCD Country Capacity Survey 2013. While the report reveals gaps and challenges faced in the achievement of desired objectives, it also highlights examples of innovation in contextualization of interventions within various countries in the region. These, in addition to the impressive progress documented herein, are intended to challenge Member States to scale up efforts to eliminate the needless loss of life and productivity caused by NCDs within the region.

Keywords

Chronic disease
Health information systems
Health Management and Planning
Health policy
Public policy
Primary prevention

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Sylvie Stachenko and Frederiek Mantingh compiled the publication, with Gauden Galea, Director of the Division of Noncommunicable Diseases, providing overall coordination and support.

Abbreviations

CSEC	central and south-eastern European countries, including Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, the former Yugoslav Republic of Macedonia
EU	European Union
HBSC	Health Behaviour in School-aged Children
NCD	noncommunicable disease
NIS	newly independent states
STEPS	WHO STEPwise approach to surveillance

Foreword

In 2011, the WHO Regional Office for Europe, through a highly consultative and inclusive process, developed and subsequently adopted the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016. This Action Plan, derived from the European Strategy, focuses on priority action areas and interventions for the five years, identifying specific action areas and deliverables to which Member States, WHO and partners committed themselves.

This was done against the backdrop of the development of the new European health policy, Health 2020, which responds to the changing context in Europe, aiming to address the health inequities within and between countries, the impact of globalization and new technologies, the ageing population, concerns about the financial sustainability of health systems, the changing role of citizens and, importantly, the particularly alarming growth of NCDs. Health 2020 also highlights the deep connections between NCDs and sustainable economic and social development and the importance of effective collaboration across the whole government to advance Health in All Policies. As such, it emphasizes the need to strengthen our governance structures and institutional capacities to accelerate action.

This publication reports on the progress made by Member States in carrying out the Action Plan, as shown by the results for the European Region of the WHO Global NCD Country Capacity Survey undertaken in 2013. The publication endeavours to show the progress made by Member States in the various proposed action areas, reporting the activities already undertaken and future plans. The report not only highlights gains made in accordance with the proposed elements of the Action Plan but also details successes and innovations by various Member States in customizing their approaches to implementing strategies for preventing and controlling NCDs. It also shows progress in how the national information systems are aligned with the Global Monitoring Framework and the Health 2020 indicators and therefore better poised to monitor NCD outcomes, risk factors, the underlying determinants, and priority interventions.

The report highlights the opportunities and challenges faced in implementing the Action Plan. In particular, the European Region faces growing differences in tobacco use between and within countries. A large number of countries have not yet implemented the requirements of the WHO Framework Convention on Tobacco Control regarding the packaging and labeling of tobacco products. In this regard it will be critical over the next few years to accelerate our efforts to achieve full implementation of the WHO Framework Convention on Tobacco Control throughout the Region.

It is clear that health promotion and NCD prevention are essential for long term sustainability of health systems and a productive population. In this regard, Member States have been a great collaborating force in the fight against NCDs, and WHO values this continued cooperation. Our other partners within and outside the United Nations family, including nongovernmental organizations, are also important. We will need to sustain the priority accorded by the global and national stakeholders to reduce the burden of NCDs as a means of enhancing human, social and economic development across the whole of government and society and to ensure that due consideration is given to NCDs during the discussions on the post-2015 development agenda.

Despite all the progress made, efforts are still required in scaling up activities and interventions. NCDs threaten to destroy the fabric of our Region, and we therefore urge policy-makers and stakeholders to draw inspiration from the positive account of this report and to feel motivated to go the extra mile to overcome the challenges.

Zsuzsanna Jakab
WHO Regional Director for Europe

Executive summary

This is a mid-term report on progress made by Member States in the WHO European Region in relation to the Action Plan for the implementation of the European Strategy on the Prevention and Control of Noncommunicable Diseases (NCDs) 2012–2016. It combines the results of the 2013 WHO NCD Country Capacity Survey with more detailed descriptions of responses, highlights and innovative practices in the Region beyond what the Survey captures, thus creating a comprehensive profile of how Member States, the Regional Office and other national and international agencies are progressing with preventing and controlling NCDs in the Region.

Chapter 1 introduces the context within which Member States and the Regional Office are responding: the burden of NCDs; the health inequities within and between countries; the socioeconomic determinants of NCDs and risk factors and the intersectoral action needed; NCDs and sustainable development and the post-2015 agenda; and the current policy frameworks, both regional and global, that offer guidance for preventing and controlling NCDs.

Chapter 2 summarizes selected results submitted by Member States in the European Region to the 2013 WHO Global NCD Country Capacity Survey. Several of the results are compared with those from the previous Survey in 2010, and others are plotted with data going back to 2000–2001 for trend analysis. The response rate to the 2013 Survey was 96% among Member States.

What the Survey shows is that, despite the economic challenges facing the Region, and in some countries full national crises, 74% of reporting countries have policies that integrate several NCDs and their risk factors, an increase since 2010. Similarly, more countries have disease- and risk factor–specific policies with dedicated human resources and budgets.

Progress with surveillance of NCD risk factors has been considerable since 2010. More than 80% of countries across the Region report studies or surveys among adults on exposure to key risk factors, with newly independent states (NIS)[1] demonstrating the most progress in this regard since 2010. With civil and vital statistics registries, almost all countries have data by age and sex, and 74% can disaggregate the data by sociodemographic factors.

Ninety per cent of countries report that risk factors are being addressed by other than health ministries, and 54% have formal multisectoral mechanisms to coordinate policies relevant to NCDs. Partnerships with international organizations and United Nations agencies have increased by 13% since 2010, and among CSEC countries, these and the private sector have become more prominent as stakeholders in national initiatives.

Almost all countries in the Region (from 93% to 100% in the subregions) tax tobacco and alcohol. A few have instituted taxes on unhealthy foods. More than half of the countries in the Region implement policies to limit the marketing of foods and non-alcoholic beverages to children; some enforce the policies by law and others rely on voluntary compliance with government oversight.

Almost all primary care health systems in the Region (94–96%) provide primary prevention, detect risk factors and manage risk factors and NCDs. Since 2010, the most progress has been made in integrating home-based care, self-help and self-care into primary care. Policies and action plans that integrate early detection, treatment and care across the major NCDs and conditions increased by about 10% between 2010 and 2013; the basic technologies for early detection and diagnosis are almost universally available in the Region; and more than 80% of countries have essential medicines for NCDs. High-technology procedures for treating NCDs are increasingly available, but with notable differences by subregion.

Chapter 3 contains the current responses of Member States and the WHO Regional Office for Europe to NCDs, risk factors and determinants, mapped to the four priority areas in the European Region Strategy: governance and capacity-building; monitoring and surveillance; promoting health and preventing disease through health

[1] Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

in all policies; and strengthening health systems and building capacity to further the prevention of NCDs and risk factors and improve the care of people with NCDs. To facilitate action in the priority areas, the Regional Office's engagement of Member States individually or in subregional or common interest groups has been ongoing and multifaceted. With technical support and tools, countries have participated in in-depth situation analysis, review missions, policy dialogues, training seminars and workshops, some of which have been operationalized through biennial collaborative agreements, with a concentration in the subregions in the eastern part of the Region. The Regional Office has also assisted in leveraging existing institutional, policy and professional platforms, partnerships and collaborations to engage other organizations and agencies in Member States or subregions.

Advancing the implementation of the Action Plan specific to diet are five action networks that have continued support from the Regional Office and Member States (for salt reduction, obesity and inequalities, school nutrition, hospital nutrition and marketing of foods to children). In addition, the Regional Office houses a database on national and subnational policies on nutrition, obesity and physical activity and has established a childhood obesity surveillance initiative with 19 countries.

Since the 2010 Parma Declaration on Environment and Health, reinforced in 2013 by the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020, the Region has mobilized increasingly on environmental determinants and primary prevention of NCDs. The focus is on robust policies in areas such as urban development, active transport, food safety, nutrition and healthy settings. Specific to promoting physical activity, the Regional Office is working under the Transport, Health and Environment Pan-European Programme, participating in networks, supporting workshops and developing databases, guides and tools, intending to create a critical mass of technical and policy experience. In addition, Member States are implementing multilateral environment agreements to foster international collaboration and oversight to address the environmental issues that cross borders.

The Regional Office is assisting Member States and organizations in implementing the interventions described in the Action Plan with an emphasis on cardiometabolic risk assessment and has organized policy dialogues to mobilize the strengthening of health systems regarding NCDs with countries in the subregions in the eastern part of the Region.

Chapter 4 has the highlights and innovative practices of Member States that are addressing risk factors key to NCDs – excessive alcohol consumption, poor diet, lack of physical activity and tobacco use. Several countries have been particularly innovative in how to reduce and control the consumption of alcohol, including regulating volume discounts, introducing a minimum unit price for alcohol and test purchasing.

Chapter 5 focuses on the barriers and opportunities for health systems. A collaboration between the Regional Office and the Harvard School of Public Health delivered a background paper on common health system challenges and opportunities to improve NCD outcomes. The background paper informed a guide for decision makers for self-assessment and planning. The latter has been field tested in five countries.

1. Introduction

1.1. Burden of NCDs

Noncommunicable diseases (NCDs) are the leading causes of death worldwide; more people die from NCDs than from all other causes combined *(1)*. Among the WHO regions, the European Region has the highest burden of NCDs *(2)*: cardiovascular disease, cancer, respiratory diseases and diabetes (the four major NCDs) together account for 77% of the burden of disease and almost 86% of premature mortality *(3)*.

Premature death (before age 60 years) or living long term with an NCD or related disability has socioeconomic consequences and constitutes a double burden to sustainable social and economic development *(4)*. Reduced income and early retirement caused by NCDs can lead individuals and households into poverty. At the societal level, in addition to surging health care costs are increased demands for social care and welfare support as well as the burdens of the impact of absenteeism from school or work, decreased productivity and employee turnover *(5)*.

If the epidemic of NCDs is not halted, mortality from NCDs is predicted to increase – from 8.1 million deaths annually in 2004 to 8.6 million in 2015 *(4)*. Premature mortality can be prevented: estimates indicate that at least 80% of all heart disease, stroke and type 2 diabetes and at least one third of cancer cases are avoidable *(2)*. Early death can be partly countered by effective action dealing with four key behavioural risk factors: unhealthy diet, physical inactivity, tobacco use, the harmful use of alcohol and, in particular, the social determinants of these risk factors *(4)*.

The harmful use of alcohol and tobacco are the top modifiable risk factors in the European Region. Not only does the Region have the highest alcohol intake in the world and a per capita consumption twice as high as the world average, but consumption is increasing in lower- and middle-income countries that have had relatively lower rates *(4)*. The prevalence of smoking has generally stabilized or is decreasing in most western European countries and in some countries in the eastern part of the Region, but the prevalence among women is increasing slightly *(6)*.

Poor diet, overweight and obesity contribute to a large proportion of NCDs, including cardiovascular diseases and cancer, the two main killers in the WHO European Region. NCDs are associated with a cluster of common risk factors influenced by diet and physical activity, notably high blood pressure, high blood cholesterol, overweight and obesity, unhealthy diets and physical inactivity. These are exacerbated by a range of various lifestyle and demographic changes. Excess consumption of saturated fat and *trans*-fat, high intake of sugar and salt and low consumption of fresh vegetables and fruits are the leading risk factors for the burden of diet-related NCDs in the Region.

Overweight affects 30–80% of adults in the countries in the Region *(7, 8)*. More than 20% of children and adolescents are overweight, and one third of these are obese. The trend in obesity is especially alarming among children and adolescents. The annual rate of increase in the prevalence of childhood obesity has been growing steadily, and the current rate is 10 times that in the 1970s. This contributes to the obesity epidemic among adults and creates a growing health challenge for the next generation. After infancy, unhealthy diets, too little physical exercise and obesity are often linked to each other and to a far more common cluster of risk factors among people with low income versus higher income *(7)*.

1.2. Inequity within and between countries in the Region related to NCDs

Gaining health: the European Strategy for the Prevention and Control of Noncommunicable Disease (5) highlights the growth in health inequities found in many countries in the WHO European Region and states the following *(3, 5)*.

> There is an uneven distribution of conditions and their causes throughout the population, with higher concentration among the poor and vulnerable. People in low socioeconomic groups have at least twice the risk of serious illness and premature death as those in high socioeconomic groups. Inequalities in health between people with higher and lower educational level, occupational class and income level have been found in all European countries where measured. The increasing concentration of risk factors in the lower socioeconomic groups is leading to a widening gap in future health outcomes.

Where health does improve, people with higher socioeconomic status gain more than those with lower status. For example, the mortality rates among people with higher socioeconomic status decline proportionally more rapidly than among those less well off, particularly for cardiovascular diseases *(5)*.

NCDs also contribute to the widening health gap between countries in the Region. As populations age, the burden of the NCD epidemic will rise incrementally, with annual mortality caused by NCD predicted to increase all over the world; low- and middle-income countries expected to be the hardest hit *(1)*. Across countries in the Region, the range between the highest and lowest predicted life expectancy is 17 years for men and 12 years for women *(9)*. An even more conspicuous difference is in the risk of death for 30-year-old men across the Region: in countries with a high adult mortality rate in the eastern part of the Region, the risk of dying before the age 45 years is five times greater than in the western part. For women, this gradient is also significant but almost 50% smaller *(4)*.

The differences in mortality rates from NCDs in higher- versus lower-income countries are larger today than they were a few decades ago in some cases. Nevertheless, the trends shown in Fig. 1 suggest that, in lower-income countries, mortality rates have declined rapidly since 2005, surpassing the average rate of decline for the whole Region, and almost enough to counteract the rise in the early 1990s in the aftermath of independence and recession. The gains in life expectancy in these countries come from a combination of increased prosperity, increased investment in health services, and to some extent from change in behaviour as people shift more towards lifestyles more common in western Europe. The success in these countries is exemplary and worth documenting and calls for more focus in the coming years of the NCD Action Plan *(3)* to support and secure the progress being made.

Better health for the populations of the Region can be achieved. Taking a whole-of-society approach and investing to prevent and control the main NCDs can reduce the NCD burden of the Region and preventable morbidity, disability and death *(5)*. Adopting cost-effective, evidence-informed and potent strategies that support the most vulnerable people and overall address the health gradients across the spectrum of socioeconomic groups can achieve actual health benefits within resource-constrained settings *(2)*.

How changes in socioeconomic factors affect health outcomes is evident in countries in the midst of the current economic crisis. In Spain, for example, the number of people displaying mental health disorders (who attended primary care) has increased significantly, particularly the prevalence of mood, anxiety, somatoform and alcohol-related disorders, with the rise in prevalence of major depression being the highest. Researchers have estimated that at least half the increase in mental health disorders can be attributed to the combined risks of individual or family unemployment and difficulty in making mortgage payments. In Greece, between January and May 2011, economic hardship caused a 40% rise in suicide compared with the same period in 2010. In Portugal, there is concern about the 40% of people older than 65 years who live alone and are unable to keep their homes adequately heated during winter *(10)*.

The opposite was found in Iceland, where a national survey of health and well-being showed that people's happiness was barely affected by that country's eco-

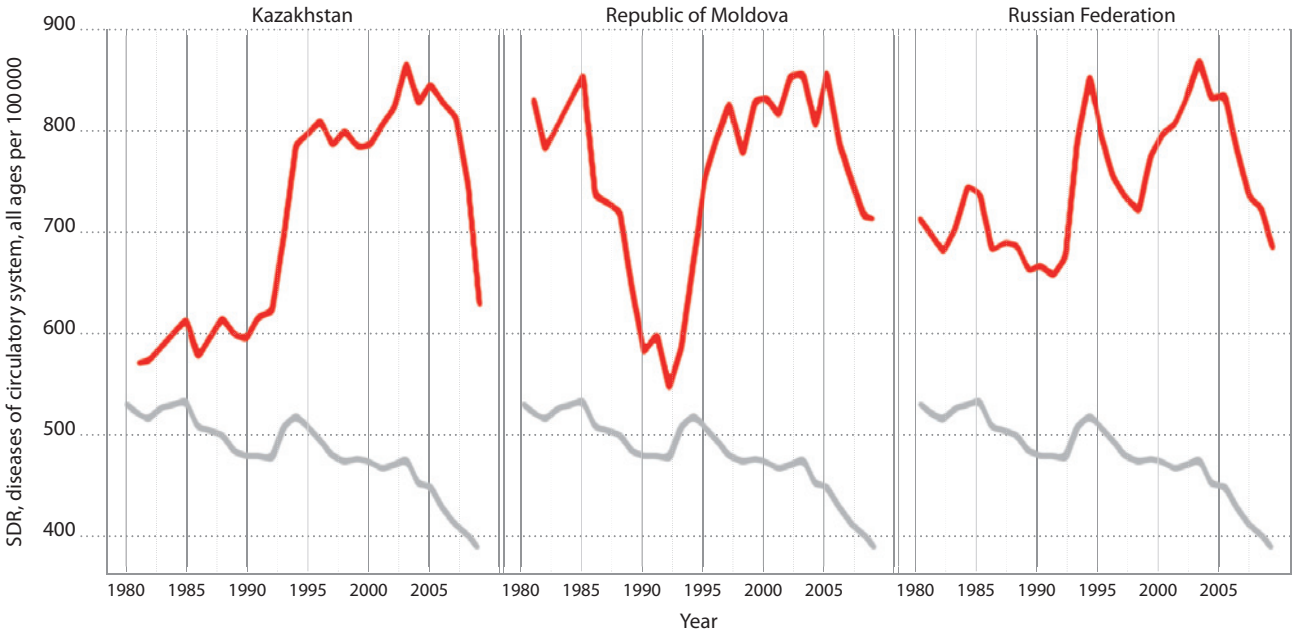
nomic crisis. A few socioeconomic determinants were significant in this experience. For one, Iceland invested in social protection and coupled this with active measures to keep people at work. When Icelanders began cooking more at home, the income of the country's fishing fleet rose. And since Iceland retained its restrictive policies on alcohol, no increase in alcohol-related incidents was observed. Finally, the Icelandic people drew on strong reserves of social capital and therefore felt united in the crisis *(10)*.

These examples confirm that health is intrinsically correlated with socioeconomic determinants, notably (un)employment, financial status and a social network. Health inequities arise from inequities in power, money and resources that influence the everyday conditions in which people are born, grow, live, work and age. The most effective actions to bring about greater health equity (given the strong social gradient associated with disability, morbidity and premature mortality from NCDs) are those that create or consolidate societal cohesion and mutual responsibility *(9)*.

1.3. Intersectoral action on NCDs

Policies that aim for equitable economic growth and prosperity, education, working environments and access to health care and that intend to tackle poverty and unemployment are most likely to produce significant health gains *(5)*. Collaboration between health and non-health sectors as well as cross-societal efforts are needed to implement such population-wide policies. In addressing the social inequalities in health, these efforts should not be regarded as isolated interventions but rather as integral to social and economic policies *(5)*. Examples of intersectoral action on preventing NCDs proving to be effective include alcohol and tobacco. Purposely combining a fiscal instrument (taxes) with other reinforcing actions such as bans on advertising is cost-effective and

Fig. 1. Mortality from diseases of the circulatory system in three countries: Kazakhstan, the Republic of Moldova and the Russian Federation compared with the average trend for the whole WHO European Region (grey lines), 1980 to the latest available year



has generated significant impact *(4)*. New similar interventions are being employed in the Region and are discussed further in this report.

However, despite ample evidence that intersectoral action can effectively address risk factors and prevent NCDs, NCDs are often not identified as a global or national health priority worldwide *(1)*. The *Global status report on noncommunicable diseases 2010 (1)* states the following.

> Incomplete understanding and persistent misconceptions continue to impede action. Although the majority of NCD-related deaths, particularly premature deaths, occur in low- and middle-income countries, a perception persists that NCDs afflict mainly the wealthy. Other barriers include the point of view of NCDs as problems solely resulting from harmful individual behaviours and lifestyle choices, often linked to victim "blaming". The influence of socioeconomic circumstances on risk and vulnerability to NCDs and the impact of health-damaging policies are not always fully understood; they are often underestimated by some policy-makers, especially in non-health sectors, who may not fully appreciate the essential influence of public policies related to tobacco, nutrition, physical inactivity and the harmful use of alcohol on reducing behaviours and risk factors that lead to NCDs.

Currently, most governments in the European Region reserve limited fractions of their countries' health budgets for promoting health and preventing disease (about 3% in OECD countries), and many of these countries do not have a method for accounting for the determinants of socioeconomic inequalities *(2)*. Overcoming such omissions requires modifying how policy-makers understand the correlation between NCDs, their risk factors and the importance of intersectoral action.

1.4. NCDs and the sustainable development and post-2015 agenda

The need to address the NCD epidemic remains strong. Better outcomes regarding NCDs are a precondition for, an outcome of and an indicator of all three dimensions of sustainable development: economic development, environmental sustainability and social inclusion. Nevertheless, low-income countries are not meeting Millennium Development Goal targets for health and development and also lack the capacity to manage the current burden of NCDs, not to mention the increase predicted as populations age. The burden of NCDs will similarly increase to unmanageable proportions in high-income countries if it is not adequately and promptly addressed *(1, 11)*.

During the UNDESA/WHO Regional High-level Consultation on NCDs in Oslo, Norway on 25–26 November 2010 *(4)*, participants from low- and middle-income countries emphasized the need to receive support (through aid and expertise) from high-income countries to strengthen national capacity to address NCDs, even though NCDs are not included in the current Millennium Development Goals. Since then, in several declarations, reports and documents, countries have acknowledged that NCDs constitute one of the major challenges for sustainable development in the 21st century and that addressing them is a priority for social development and for investment in people *(11)*. For this reason, the *Report of the High-Level Panel of Eminent Persons on the Post 2015-Development Agenda (12)* recommends that reducing the burden of priority NCDs should be put on the agenda as part of the goal of ensuring healthy lives.

Achieving progress in the common purpose of preventing and controlling NCDs requires collaboration in the broadest sense – from people and organizations across society in every country. This implicates governments, nongovernmental organizations civil society, the private sector, science and academe, health professionals, communities – and every individual *(2)*.

1.5. Current framework for preventing and controlling NCDs

The adoption in 2000 of the Global Strategy for the Prevention and Control of Noncommunicable Diseases *(13)* initiated the building of an NCD framework. Since then, several World Health Assembly resolutions have been adopted or endorsed that support the key components of the Global Strategy. The NCD framework consists of: the WHO Framework Convention on Tobacco Control (resolution WHA56.1) *(14)*; the Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17) *(15)*; the Global Monitoring Framework for Noncommunicable Diseases (decision EUR/RC62.1) *(16)*; the Global Strategy to Reduce the Harmful Use of Alcohol (resolution WHA63.13) *(17)*; sustainable health financing structures and universal coverage (resolution WHA64.9) *(18)*; the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (resolution WHA61.21) *(19)*; the Moscow Declaration of the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control (resolution WHA64.11) *(20)*; the Outcome of the World Conference on Social Determinants of Health (resolution WHA65.8) *(21)*; the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (United Nations General Assembly resolution 66/2) *(22)*; the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (resolution WHA66.10) *(23)*; and regional mandates, of which the last example is the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 *(24)*.

Based on the above mandates, WHO embarked on a WHO Global NCD Country Capacity Survey in 2013, a follow-up to a similar survey undertaken in 2010. It assesses progress made and challenges encountered by individual Member States in implementing the proposed policies, measures and interventions to prevent and control NCDs.

2. Progress in the four priority areas of the European NCD Action Plan

This chapter presents selected results from the 2013 WHO Global NCD Country Capacity Survey of countries in the WHO European Region. As such, it serves as a mid-term status report on countries' progress in carrying out the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 *(3)*. The results are organized around the four priority areas of the Action Plan and point to remaining gaps and challenges to carrying it out.

The response rate to the 2013 Survey for the European Region was 96%. Annexes 1 and 2 list the countries and country groups that responded to both the 2010 and 2013 surveys.

2.1. Governance for NCDs: alliances and networks

Health 2020 – the European policy for health and well-being – identifies better governance for health as one of its two strategic objectives *(2)*. It recognizes that governments can be successful in improving health and well-being if they promote comprehensive action involving the health and non-health sectors, public and private actors and citizens "through both whole-of-government and whole-of-society approaches" *(25)*. The development of national NCD strategies and action plans provides a clear mandate for comprehensive and integrated action to tackle NCDs, acknowledging that many determinants of NCDs lie outside the health sector.

The increasing global crisis in NCDs is a barrier to development goals, including poverty reduction, health equity, economic stability and human security *(26)*. This is not only critical in middle- and low-income countries as it becomes more and more evident that policy responses to current challenges (such as the economic crisis) have added effects on population health beyond the direct impact of economic and social determinants *(27, 28)*. Sustainable social and economic development requires high-level political commitment and investment in preventing and controlling NCDs, including integrating specific NCD considerations into larger national policy and development frameworks *(11)*. Indeed, the policies directed at economic performance, poverty reduction, social policy and health are so closely linked that it has been proposed that the magnitude of health inequities is a marker for how well governments meet the needs of their citizens *(29)*.

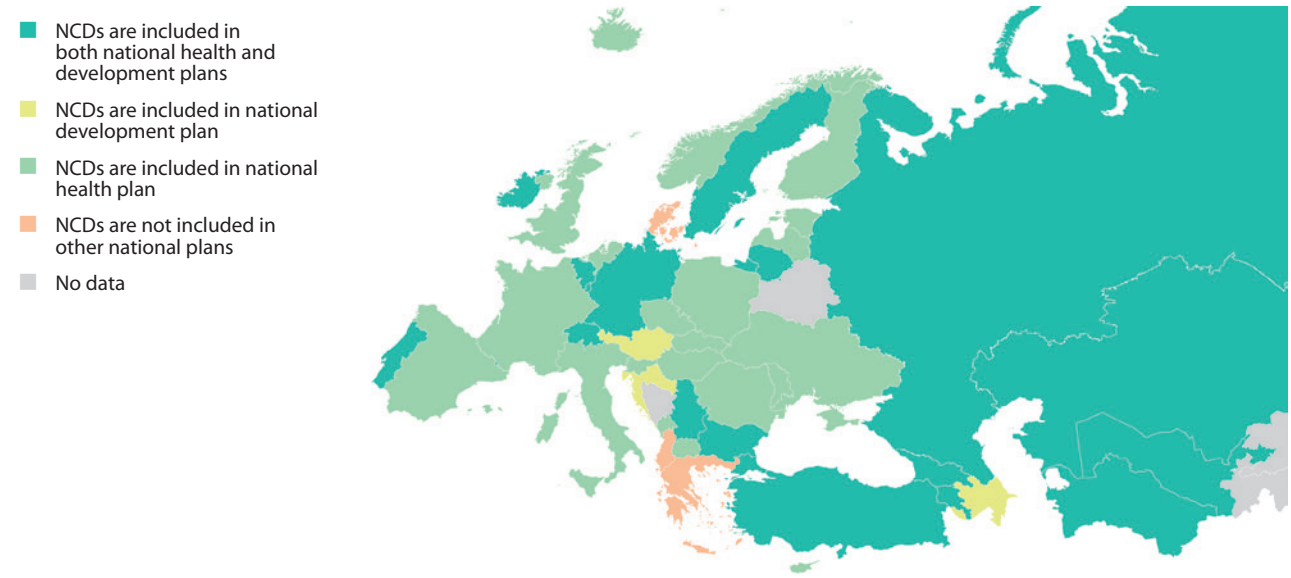
Nevertheless, NCDs (Fig. 2) are still not part of the development agenda in most countries; in the European Region, about 43% of countries include NCDs in their national development plans. In the health sector, including NCDs is more established, with 88% of countries including NCDs in their national health plans.

2.1.1. Number of national NCD strategies and action plans

Substantial progress has been made in preventing and controlling NCDs in the WHO European Region. As Fig. 3 and 4 demonstrate, the presence of national integrated NCD policies and strategies has increased from 67% in 2010 to 74% in 2013. Half the existing policies are operational. In 2013, only 11 countries in the Region (versus 17 countries in 2010) report not having a national NCD policy, strategy or action plan that integrates several NCDs and their risk factors.

The European Union (EU) subregion has the largest proportion of countries with operational strategies, and NIS have the smallest proportion. In 2013, 20% of the countries in the European Region have strategies or ac-

Fig. 2. Integration of NCDs into national health and development plans, 2012–2013



tion plans under development. The subregions with the greatest number of countries reporting strategies under development are NIS (44%) followed by CSEC countries (20%) and the EU (11%).

2.1.2. Multisectoral mechanisms to coordinate NCD policies

Almost all countries that reported having a national NCD policy, strategy or action plan indicated that it involved multiple stakeholders. As recommended in Health 2020 *(2)*, working together across the sectors and ministries is a key mechanism to coordinate NCD prevention and control and to enable coherence, efficiency and intersectoral problem-solving *(3)*. In this regard, multistakeholder and multisectoral approaches should be established not only in the development stage but also in implementing such policies.

Across the European Region, 90% of the countries have NCDs addressed by other than health ministries, such as the ministry responsible for sport, education, family or agriculture.

This situation underlines positive momentum towards better governance for health. However, the establishment of formal multisectoral mechanisms across ministries and sectors to coordinate NCD policies is lagging behind.

In 2013, slightly more than half (54%) of the countries have established formal multisectoral mechanisms to coordinate NCD policies. However, many are still under development. Less than half the countries thus reported having operational multisectoral mechanisms to coordinate NCD policies, which constitutes an important step towards adopting a health in all policies approach.

2.1.3. Partnerships and collaboration for implementation

Many countries (87%) in the Region reported multisectoral action or having established partnerships and collaboration in implementing NCD-related policies.

Fig. 5 highlights the mechanisms for multisectoral action for implementing NCD-related activities. Within the Region, the most common are interdepartmental or ministerial committees (76%), followed by interdisciplinary committees (71%) and joint task forces (57%). Other mechanisms mentioned are partnerships with the European Commission, international agencies, industry or national coalitions.

In 86% of the countries reporting mechanisms for partnerships and collaborations, key stakeholders are other ministries (other than health), and to the same extent also academe and research centres. These collaborations appear to be relatively stable over time. Equally frequent

Fig. 3. Status of a national integrated policy, strategy or action plan on NCDs, 2009–2010

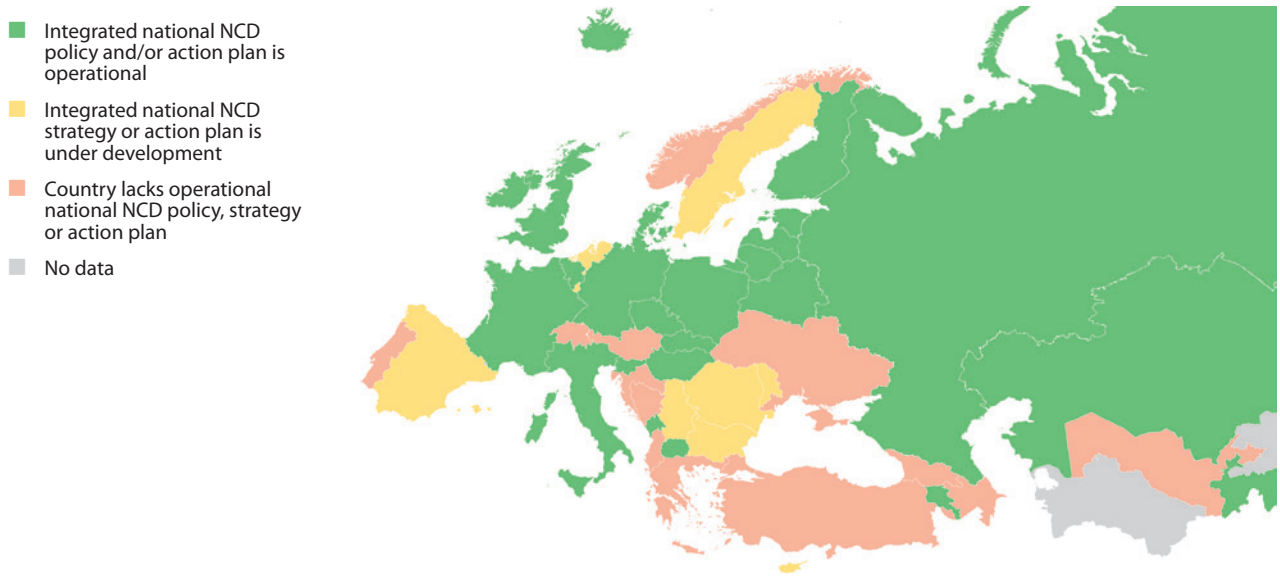
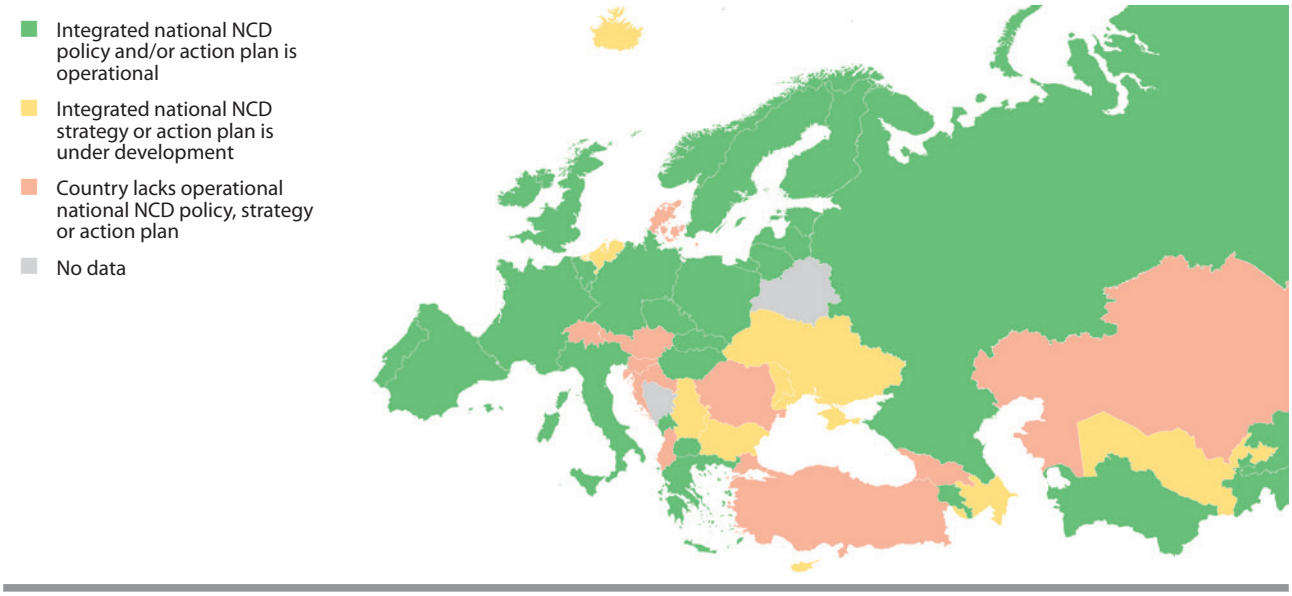


Fig. 4. Status of a national integrated policy, strategy or action plan on NCDs, 2012–2013



are collaborations with nongovernmental organizations, community-based organizations and civil society, although the trend is very slightly decreasing. During the past three years, the private sector became one of the key stakeholders in 73% of the CSEC countries, although it diminished in importance in the other country groups.

Further, since 2010, partnerships with international organizations and United Nations agencies increased by 13% across the Region, which makes them key stakeholders in all country groups. This reflects in part the leadership role that WHO and other global players have taken in preventing and controlling NCDs. Generally, CSEC is the subregion with the most established partnerships and the most positive trends in partnerships during the past three years.

The content areas covered by such collaborations around implementing NCD activities are diverse. The most important are tobacco and diabetes (covered in 87% and 85%

of the countries respectively) followed by chronic respiratory disease, unhealthy diet, overweight and obesity, harmful alcohol use and physical activity. A total of 61% of countries report collaborations with a comprehensive NCD focus.

The NCD Action Plan *(3)* proposed health promotion activities in settings such as schools and workplaces as a means of promoting intersectoral links between NCDs and action for more healthy and resilient environments. The Health 2020 framework points out that effective action in settings such as cities can be an effective subnational way to facilitate empowerment processes and to tackle health inequities *(2, 29)*. Fig. 6 shows the percentage of countries that reported settings being covered by their partnerships.

Most countries' partnerships focus on schools or cities. With schools, almost all countries in the CSEC and EU groups have established collaborations.

Empowerment of citizens and communities is an essential part of the NCD Action Plan and Health 2020. Although many countries report that they have established partnerships with nongovernmental organizations, community-based organizations and civil society, there has been no increase here since 2010.

Fig. 5. Percentage of countries in the European Union having various mechanisms in partnerships and collaborations for implementing NCD-related activities, 2012–2013

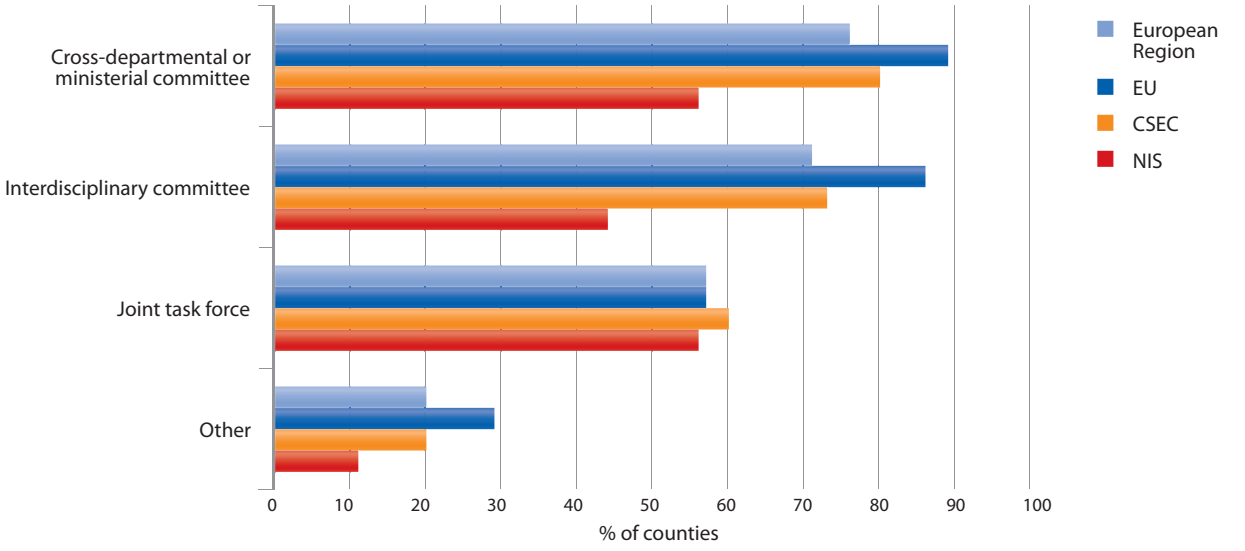
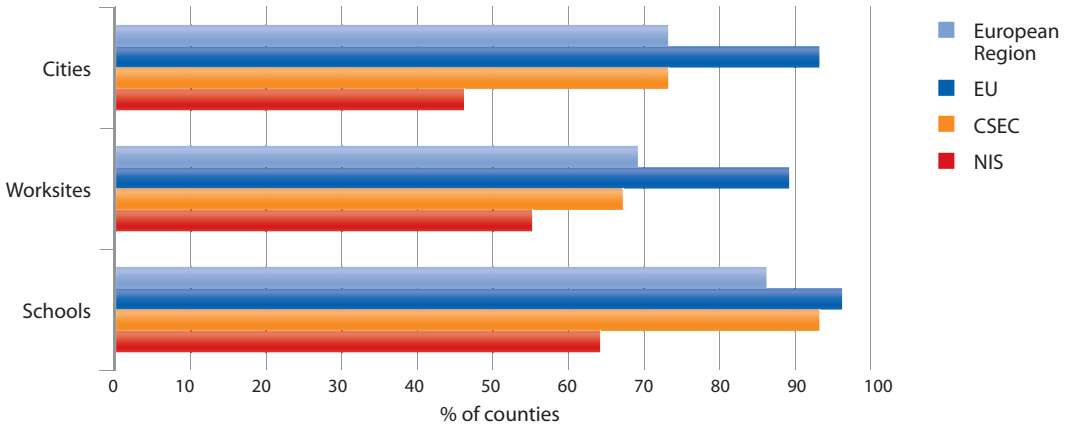


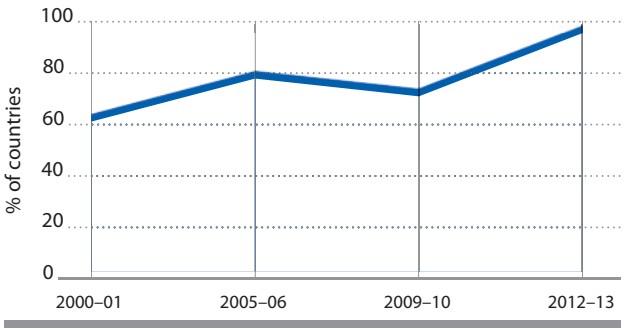
Fig. 6. Percentage of countries in country groups in the European Region with partnerships and collaborations that cover specific settings, 2012–2013



2.1.4. Capacity and budget for implementing NCD policies

The infrastructure of health ministries to deal with NCDs has improved considerably: in 2013, 97% of countries in the Region report having a unit, branch or department for preventing and controlling NCDs within the health ministries, an increase of 20 percentage points compared with 2010 and 30 percentage points compared with 2000. The increase between 2010 and 2013 has been steeper than in previous periods (Fig. 7).

Fig. 7. Percentage of countries in the European Region having a unit, branch or department for preventing and controlling NCDs within the health ministry, 2000–2013



The scope of responsibilities and areas covered by NCD departments has grown since 2010, as has the availability of specific NCD budgets in most country groups. Countries increasingly have specific resources for NCD-related primary prevention and health promotion, early detection and screening, treatment and surveillance.

Likewise, the human resource capacity of the ministries has improved. Except for the CSEC, the percentages of countries having at least one full-time staff member working on NCDs has improved compared with 2010, ranging from 67% in CSEC countries to 86% in EU countries.

Fig. 8 shows the responsibilities and areas covered by NCD units, branches or departments in the health ministries. The trend is positive in all country subgroups, with the coverage for all responsibilities and areas increasing by about 20 percentage points compared with 2010. Capacity-building and rehabilitation services have not been assessed in 2010 and particularly the latter is less covered than the other areas in 2013.

Despite the economic crisis in Europe, there is a positive trend in the number of countries that have a specific budget for implementing action for preventing and controlling NCDs. Almost all countries have a specific budget for NCD primary prevention and health promotion, ranging across the subregions from 88% to 100%. For early detection and screening, the range is 75–100%; for health care and treatment 93–100%; and surveillance 75–100%. Primary and secondary prevention and NCD surveillance activities received the lowest coverage and lack funding in NIS.

The most important source of funding NCD prevention and control originates from central government revenue followed by health insurance (Table 1). In addition, the role of international donors and earmarked taxes in funding NCD prevention and control is increasing.

2.2. Strengthening surveillance, monitoring and evaluation

Surveillance data are critical for developing targeted interventions, monitoring progress in preventing and controlling NCDs and informing and evaluating strategies and policies.

2.2.1. Health information systems

During the past three years, there has been considerable progress with surveillance of NCD risk factors. The Survey has shown that many countries in the Region are relatively well equipped to monitor and evaluate their national NCD action plans with indicators proposed in the Global Monitoring Framework for Noncommunicable Diseases *(16)*, and they can also report progress towards Health 2020 objectives and targets *(2)*.

In the large majority of countries in the Region (90% in 2013), the health ministry is responsible for monitoring and evaluating the actions taken to prevent and control NCDs. Most of these ministries have an office, department or division to carry out surveillance activities, but this responsibility is often shared across several areas within the ministry. In 16% of

Fig. 8. Percentage of countries in the European Region having a unit, branch or department for NCDs covering the following responsibilities and areas by country group, 2012–2013

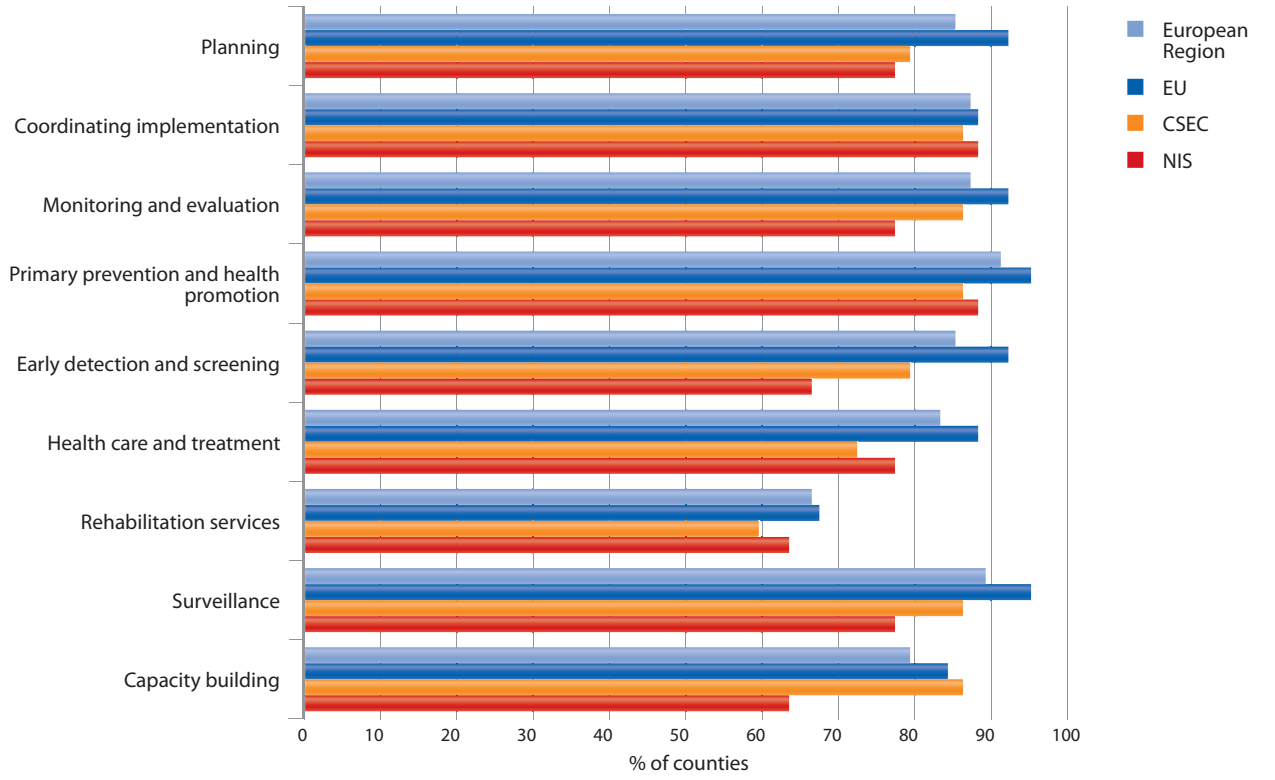


Table 1. Percentage of countries in the European Region reporting the following major sources of funding for NCD activities and functions, 2012–2013, with differences in percentage points from 2009–2010 in parentheses

	European Region	CSEC	EU	NIS
Central government revenue	98 (+8)	100 (±0)	96 (+3)	100 (+11)
Health insurance	71 (+10)	80 (–13)	79 (+12)	44 (±0)
International donors	47 (+6)	73 (+13)	39 (+9)	89 (±0)
Earmarked taxes on alcohol, tobacco, etc.	37 (+4)	53 (+13)	37 (±0)	33 (±0)

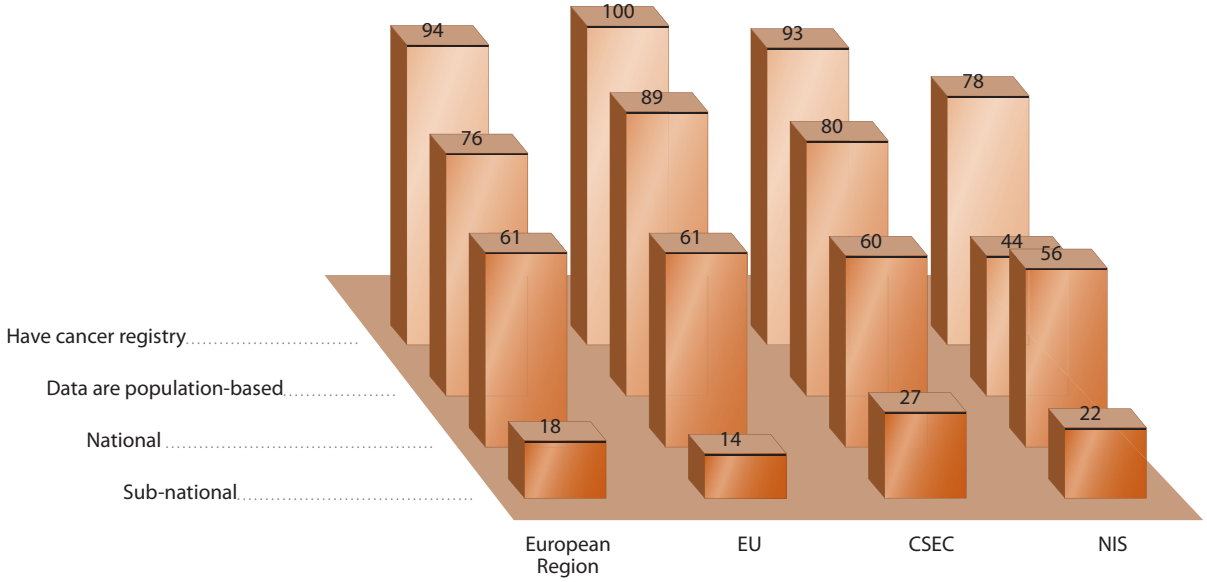
countries in the Region, an external agency, a non-governmental organization or statistical organization coordinates the responsibility for NCD surveillance, with this percentage higher in CSEC (30%) and EU countries (25%).

All countries in the European Region have civil or vital statistics registration systems, and all national health information systems routinely collect mortality data by cause of death. Almost all the countries can disaggregate these data by age (100%) and sex (98%). A total of 74% of the countries can disaggregate the data in civil registries by sociodemographic factors.

2.2.2. Cancer registries

Almost all countries in the European Region have a cancer registry. However, some NIS are lagging behind (Fig. 9). Generally, most registries are national in scope, and 76% of countries in the Region collect data on a population basis – ranging from 89% in the EU and 44% of NIS. There has been good progress in recent years, as the number of countries collecting population-based cancer data is increasing. Moreover, there has been an increase in the number of NIS and CSEC countries reporting the existence of subregional cancer registries, which have the potential to be scaled up to the national level.

Fig. 9. Percentage of countries in the European Region with a cancer registry, 2012–2013



2.2.3. Surveillance of risk factors

Progress has been made throughout the Region in the capacity for risk factor surveillance. Although surveillance for some risk factors could be improved, the EU countries have surveillance systems that cover almost all NCD risk factors in 2013. Fig. 10 provides an overview of risk factor surveys by country group and risk factor covered. Although NIS is lagging behind other subregions, these countries have made very good progress in the past years.

Between 2010 and 2013, there was progress in the monitoring of most risk factors included in the Global Monitoring Framework for Noncommunicable Diseases (Fig. 11). Almost all countries in the Region assess overweight and tobacco use. Sodium intake is being monitored by 56% of countries but only a few use the gold standard of 24-hour urine excretion survey, although the situation is improving fast. However, salt has only recently been added to the list of risk factors in the Global Monitoring Framework for Noncommunicable Diseases *(16)*. Blood lipid assessment has progressed during the past three years and is now available in more than 80% of countries.

In some ways, the WHO European Region is leading globally. The Regional Office established the WHO Childhood Obesity Surveillance Initiative (COSI) in 19 countries in the Region, 4 more have already adopted it and 12 more are expected during its next round. The system aims to routinely measure trends in overweight and obesity in primary school children (6–9 years old) to understand the progress of the epidemic in overweight and obesity in this population group and to permit intercountry comparisons within the European Region.

In addition, there has been progress since 2010 in the number of countries reporting surveillance systems covering biological risk factors (Table 2). In more than half of

Table 2. Percentage of countries in the European Region having studies or surveys with measured risk factors, 2012–2013, with differences in percentage points from 2010 in parentheses

	European Region	CSEC	EU	NIS
Hypertension or elevated blood pressure	61 (+8)	68 (+7)	57 (+16)	89 (+11)
Diabetes or elevated blood glucose	53 (+8)	53 (±0)	50 (+9)	67 (+23)
Overweight and obesity	55 (+4)	40 (±0)	50 (+17)	100 (+33)
Abnormal blood lipids	55 (+12)	60 (+7)	61 (+17)	56 (+23)
Salt or sodium intake	26	20	36	9

the countries, monitoring systems include actual measurements of blood pressure, blood glucose, overweight, and blood lipids. Salt intake is self-monitored in more than half the countries. Particularly notable are the efforts of NIS, which demonstrate the greatest improvement in risk factor surveillance covering physical measurements.

Fig. 10. Percentage of countries in the European Region having national or provincial studies or surveys of adults on specific risk factors, by country group, 2012–2013

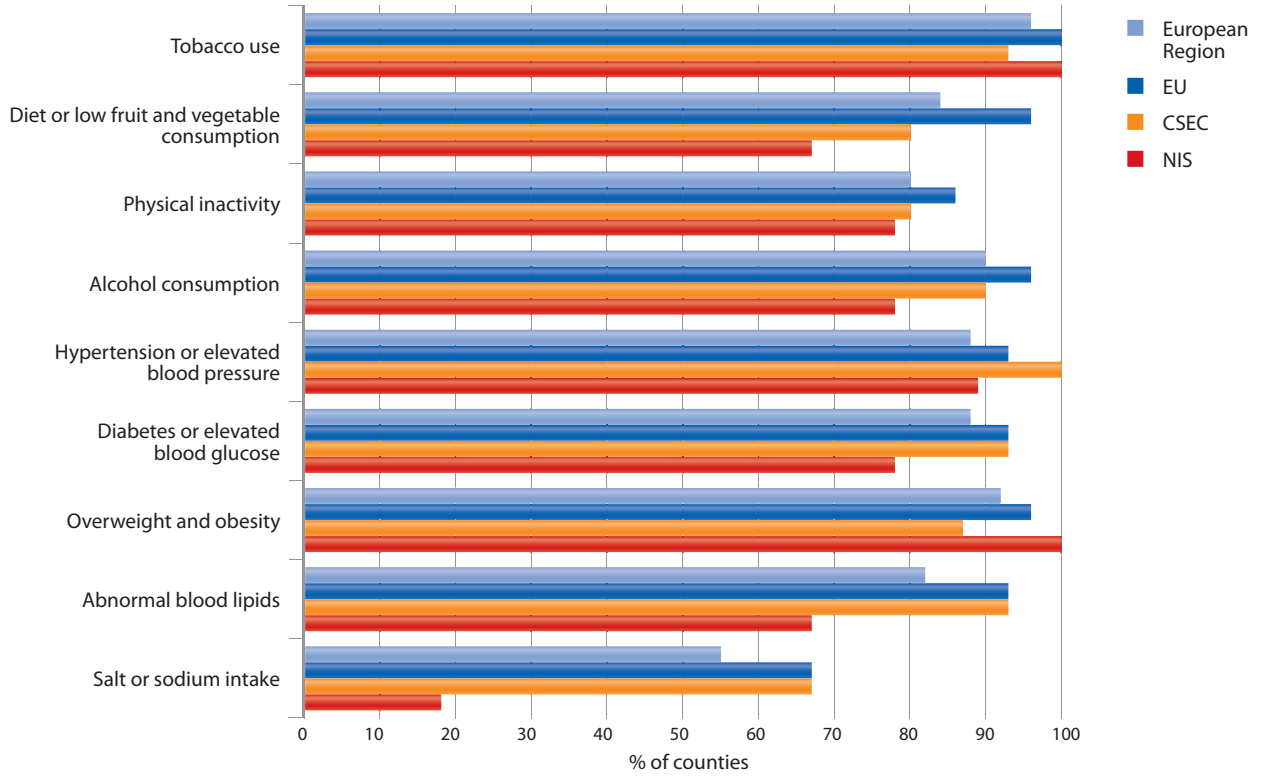
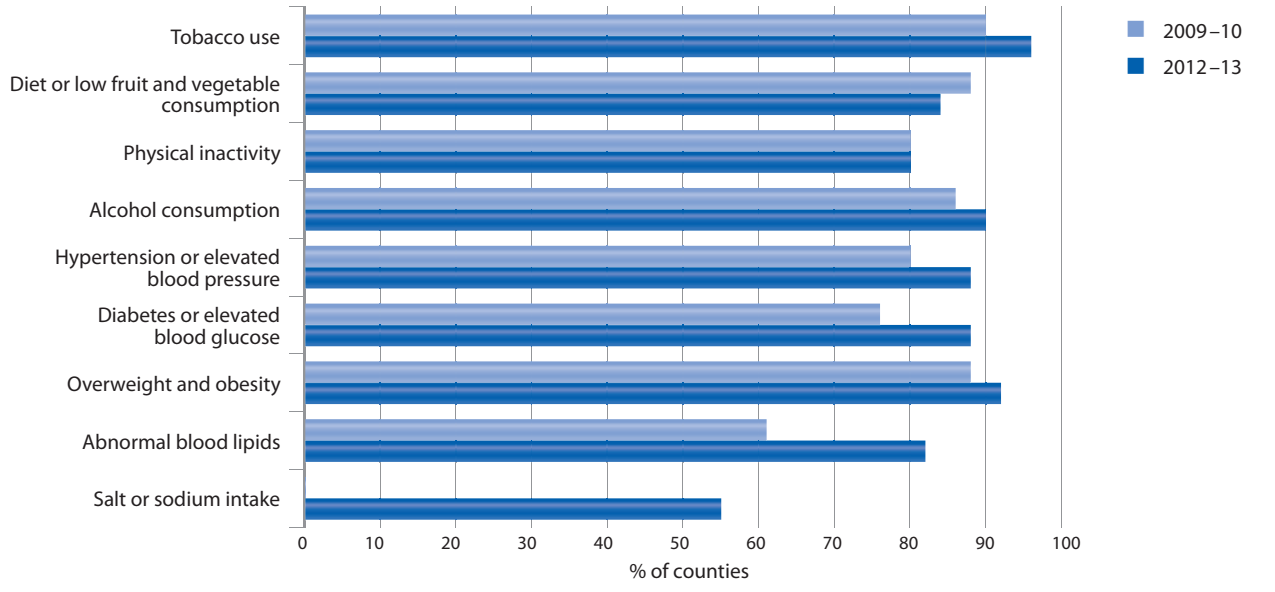


Fig. 11. Percentage of countries in the European Region having national or provincial studies or surveys of adults on specific risk factors for NCDs, 2009–2010 and 2012–2013



2.3. Promoting health and preventing disease

2.3.1. Primary prevention: policies, strategies and action plans for major NCDs and risk factors

Integrated NCD strategies and/or action plans exist in 74% of the countries in the European Region. As the total number of countries establishing an integrated national NCD policy has progressed significantly in recent years, so has the number of risk factors addressed by such plans. Fig. 12 shows the risk factors addressed by integrated national NCD policies, strategies and action plans. NIS show the greatest proportion of countries establishing integrated action plans addressing all four major risk factors.

Along with the increase in integrated national NCD policies and action plans, the number of countries that combine early detection, treatment and care for cancer, cardiovascular diseases, diabetes, chronic respiratory diseases and overweight and obesity has also increased by about 10% between 2010 and 2013. NIS have reported the most progress and the highest coverage with such integrated NCD control policies.

Beyond the integrated NCD strategies and plans, many countries have disease- and risk factor–specific policies, strategies and action plans in the Region. These specific policies have increased in number during the past decade in all country groups, but with a steeper increase between 2010 and 2013 (Fig. 13).

The most frequent vertical policies and action plans target the prevention and control of cancer (about 90% of the countries), followed bycardiovascular diseases and diabetes (Fig. 14). The most frequently addressed risk factors for NCDs are tobacco use, unhealthy diet and alcohol (Fig. 14). Specific national policies related to chronic respiratory diseases exist in about one quarter of the countries in the Region.

Most NCD-related national policies, plans or strategies in countries are operational and provide a good foundation for integrated policies and action plans to prevent and control NCDs.

2.3.2. Fiscal policies

The European NCD Action Plan *(3)* proposes that countries use fiscal policies to effectively influence health-related behaviour *(30)*. In 2010, 80% of the countries reported implementing fiscal interventions to influence behaviour change (such as taxation on alcohol, tobacco products and beverages with high sugar content).

In 2013, almost all countries in the European Region tax alcohol and tobacco, ranging from 93% to 100% of countries in the subregional groups. However, most other fiscal interventions that promote health have rarely been used in the Region. Taxation on food and non-alcoholic beverages high in sugar content is used almost exclusively

Fig. 12. Percentage of countries in the European Region having a national integrated policy, strategy or action plan on NCDs addressing specific risk factors, by country group, 2012–2013

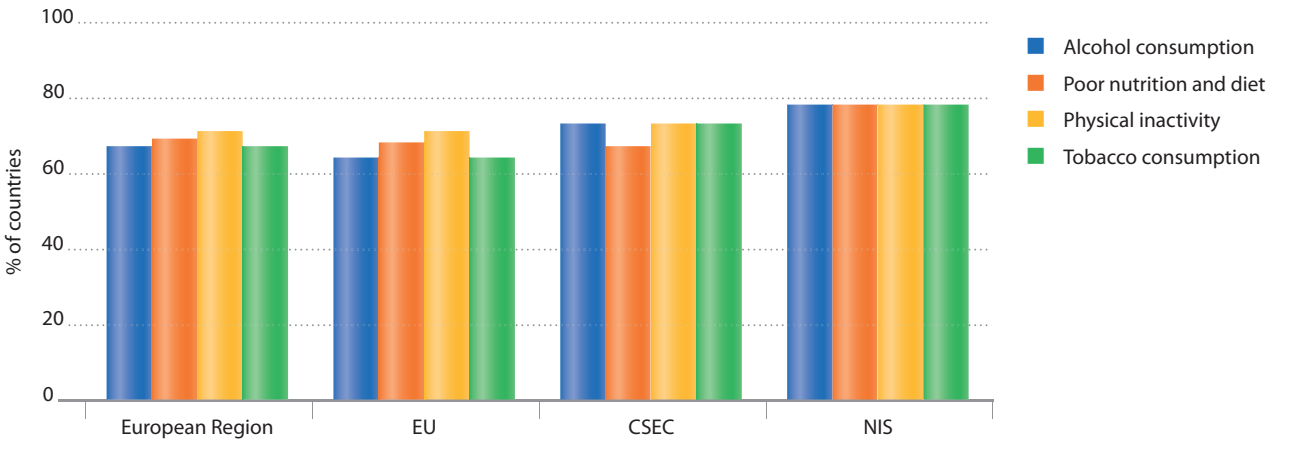
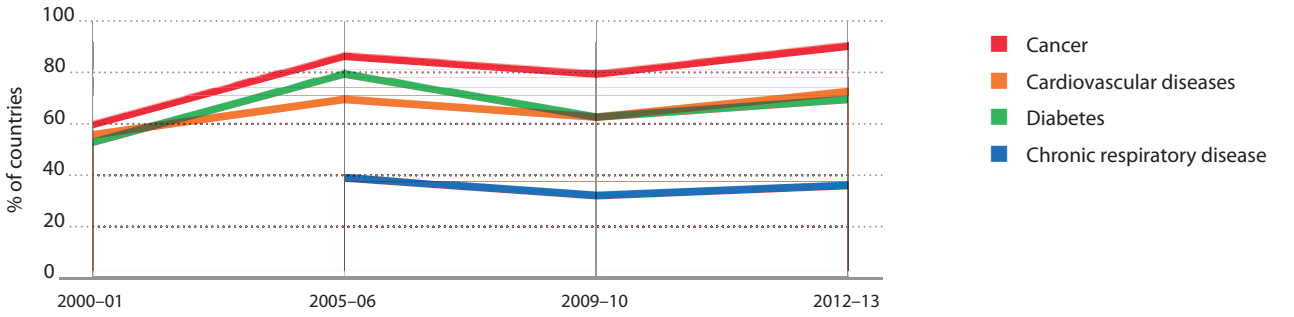


Fig. 13. Percentage of countries in the European Region having a specific national policy, strategy or action plan for preventing and controlling major diseases, 2000–2013



in the Nordic countries. Other fiscal interventions such as taxes on foods high in fat, price subsidies for healthy foods and taxation incentives to promote physical activity are rarely implemented (<10% of countries reporting).

The major motivation for fiscal intervention in the Region is raising general revenue (58%); second is the intention to influence health behaviour, reported by 38% of countries. In 32% of countries in the Region, earmarked taxes have also been a source of funding for NCD-related activities.

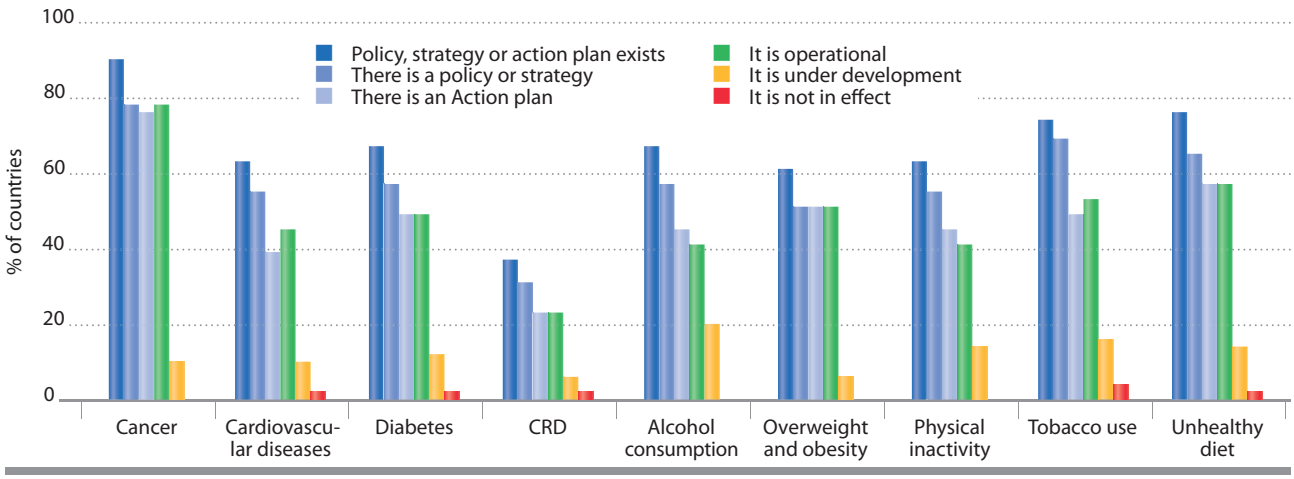
2.3.3. Interventions to regulate marketing, salt and trans-fat

The Action Plan for the implementation of the European Strategy for Prevention and Control of Noncommunicable Diseases also proposes interventions that reduce the exposure of children to marketing of foods high in fat, sugar and salt. The Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 has strengthened these efforts recently and provided a strong mandate for action to create healthy food and drink environments. Signatory countries declare that they will take "decisive action to reduce food marketing pressure to children with regard to foods high in energy, saturated fats, *trans*-fatty acids, free sugars or salt" *(24)*.

More than half the countries in the Region implement policies to address the marketing of foods and non-alcoholic beverages to children, most of them in northern Europe. These policies are both legally enforced or implemented by voluntary processes that encompass a strong role of the state. Many of the EU and CSEC countries have established legal frameworks on marketing.

Only 18% of the countries target marketing in web-based media and 20% target sports events. However, the marketing efforts of the food industry are now directed towards social media and based on the Internet.

Fig. 14. Percentage of countries in the European Region with specific national policies, plans, or strategies for preventing and controlling major diseases and risk factors and their stage of implementation, 2012–2013



More than half of the countries in the Region implement policies to reduce population salt consumption. Leading in such efforts are the EU countries followed by CSEC countries.

Interventions limiting saturated fatty acids and virtually eliminating *trans*-fats are the least well established in the Region, although four countries have a complete legal ban on *trans*-fats (less than 1%), and others have intakes lower than 1% in the overall diet using self-regulatory measures, such as the Netherlands and the United Kingdom. However, several authors argue that, in countries with self-regulatory approaches, people with low income have higher intakes of *trans*-fats given the lower prices of foods rich in *trans*-fat. Others found enormous differences across European capitals looking at the same categories of foods and brands, meaning that industry and restaurant chains incorporate the needed changes more thoroughly when legal frameworks are in place. Interventions limiting saturated fatty acids and eliminating industrially produced *trans*-fats (such as partially hydrogenated vegetable oil) are the least well established in the Region. In some subregions, only 10% of the countries promote such interventions. The percentage is higher in the EU countries (32%). Fig. 15 summarizes these findings and their mechanisms of enforcement.

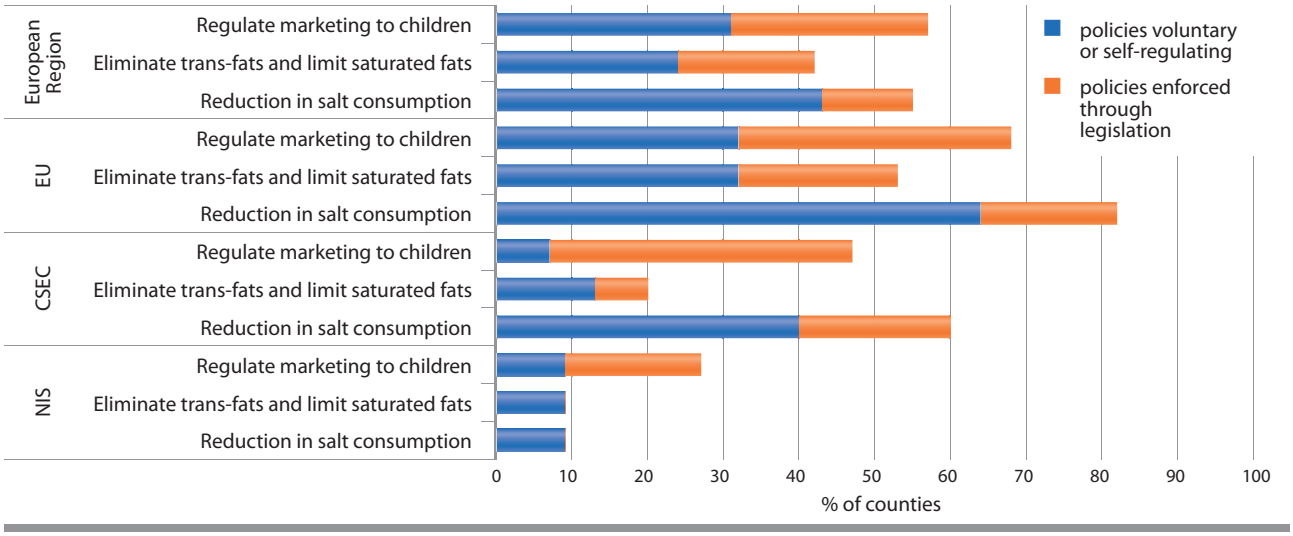
2.4. Reorienting health services towards preventing NCDs and providing care for people with NCDs

The challenges for health care systems in the 21st century are mounting. It has been emphasized that, given the regional economic downturn, the required health system reforms should not be neglected. There has been increasing emphasis on coordinated service delivery systems based on primary and community care linked with social care and health in all policies focused on risk factors related to NCDs.

Similar to the 2010 survey, countries report that NCDs are well integrated into their primary health care systems. Almost all primary health care systems in the Region (94–96%) provide primary prevention, risk factor detection and risk factor and disease management. The most progress reported during the past three years has been the integration of home-based care, self-help and self-care into national health systems. Countries less frequently report rehabilitation services (Fig. 16).

Primary care counselling of people at risk, notably because of unhealthy lifestyles, can be one of the most effective ways of changing behaviour and curbing obesity

Fig. 15. Percentage of countries in the European Union implementing the following specific health promotion activities or initiatives, by country group, 2012–2013



and NCDs, especially if advice is delivered collectively by different groups of health professionals. It may generate 10 times larger gains in disability-adjusted life-years (DALYs) over the long term than interventions such as food labelling or occupational health and 2–4 times larger gains in life-years, with greater savings in health expenditure than most interventions. A counselling intervention can generate an annual gain of 1 additional year of life expectancy per 12 individuals in a population. However, counselling individuals at risk in primary care is also expensive, and the costs can exceed the health expenditure savings by a large margin.

In addition to services provided by primary health care, home- and community-based care is available for people in the advanced or terminal stages of NCDs in 75% of countries across the Region. The Nordic countries are leading in providing such services, whereas only one third of NIS can provide home care for people in the terminal stages of NCDs.

2.4.1. Availability and implementation of evidence-informed guidelines

Preventing and managing NCDs requires systematic and integrated approaches. This applies not only to primary prevention but also to managing secondary prevention and NCD care, in which multidisciplinary teams intervene both simultaneously and consecutively *(32)*. WHO has been advocating the development of evidence-informed guidelines for the major NCDs to strengthen health care systems to address NCDs *(11)*.

In accordance with the recommendations in the NCD Action Plan, many countries have developed evidence-informed guidelines and standards for the integrated management of the major NCDs, but they have been fully implemented to a lesser degree (Fig. 17). The most commonly approved guidelines address diabetes. Implementing guidelines for managing cardiovascular diseases and cancer remains a challenge across the Region.

2.4.2. Capacity for early detection, diagnosis and monitoring

The European NCD Action Plan recommends that evidence-informed cancer screening tests be carried out in primary care followed by appropriate treatment *(32–35)*. Guidelines on preventing and managing cardiovascular diseases *(36, 37)* and the NCD Action Plan *(3)* encourage the use of total cardiometabolic risk estimation as a potential tool for guiding the management of people with NCDs.

The 2013 Survey shows that the basic technologies for early detection, diagnosis and monitoring of cancer are available in 80% or more of the countries. Breast cancer screening by palpation is the most commonly reported technology available in both public and private primary health care settings, followed by cervical cytology and faecal occult blood test, available in 80% of the health care settings in both the public and private sectors. Mam-

Fig. 16. Percentage of countries in the European Region integrating NCDs into the primary health care system, 2009–2010 and 2012–2013

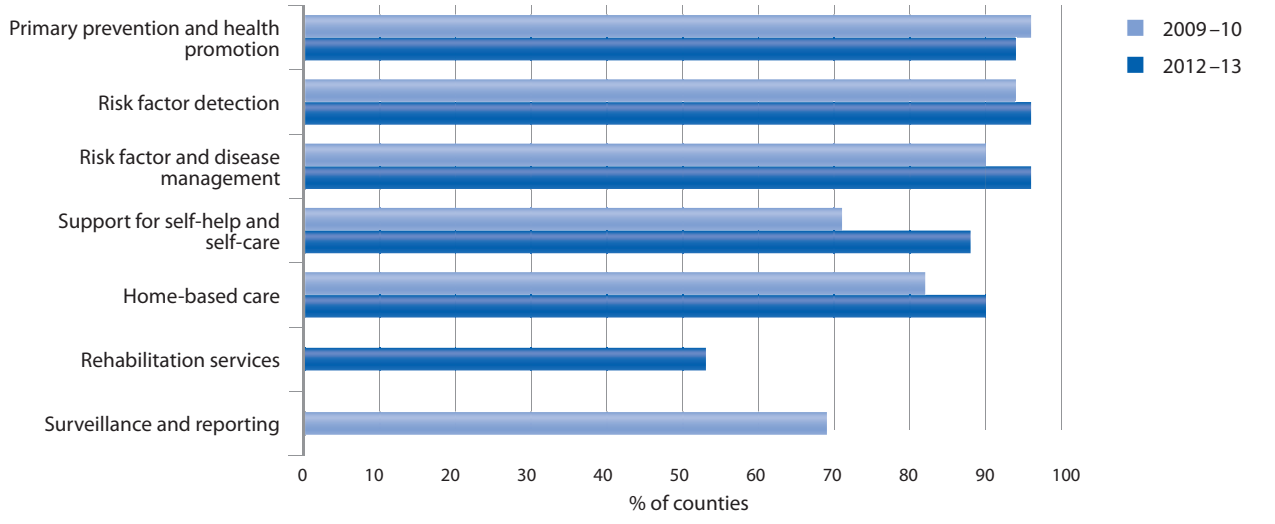
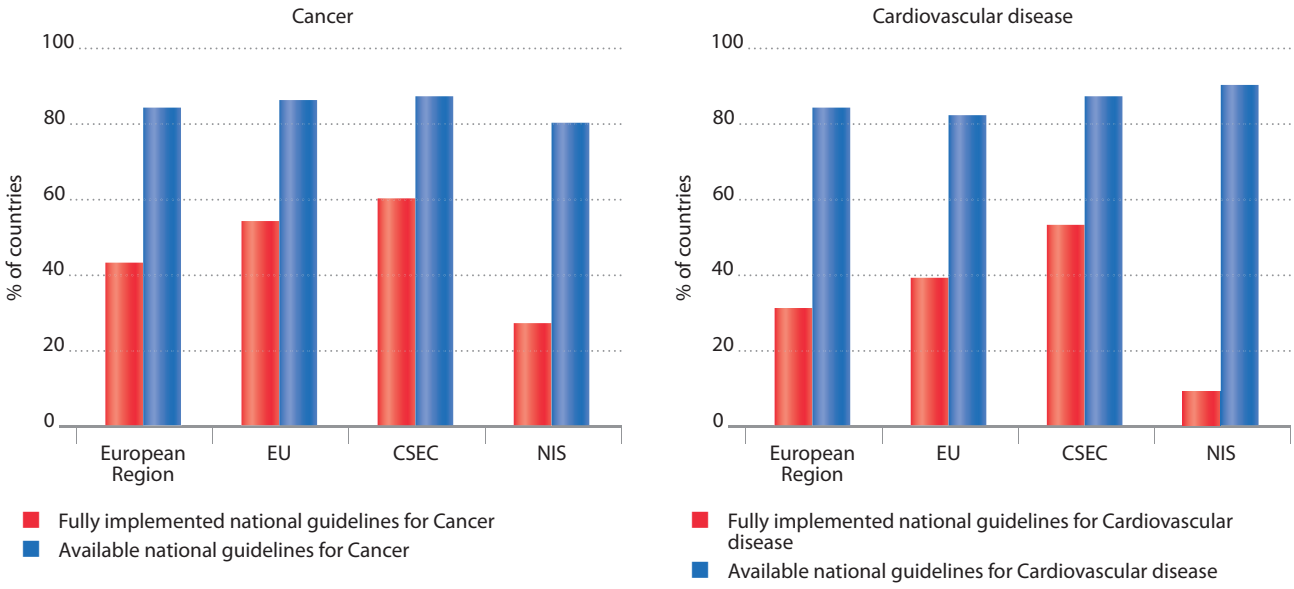


Fig. 17. Percentage of countries in the European Region having government-approved, evidence-informed national guidelines available for managing cardiovascular diseases and cancer and their implementation



mography is available in 70% of the countries in both the public and private sectors.

Interventions such as blood pressure measurement and total cholesterol measurement are widely available in both the public and private sectors. Likewise, there is good coverage of blood glucose measurement for managing and controlling diabetes as well as oral glucose tolerance and glycated haemoglobin testing (the latter being slightly better covered in the private sector).

Although many of the fairly basic technologies necessary for managing risk factors and preventing and diagnosing NCDs are almost universally available in primary health care, efforts to expand the coverage for cancer screening are still needed.

The WHO Model Essential Medicines List provides an internationally recognizable set of selected medicines to help countries choose how to treat their priority health needs. About three quarters of the countries in the European Region have devised their own list of essential medicines.

More than 80% of the countries have available essential medicines to treat NCDs. Insulin, metformin, thiazide diuretics, angiotensin-converting enzyme inhibitors, calcium-channel blockers, statins and bronchodilators are available in more than 90% of countries, and they appear in most national lists of essential medicines. Although the overall trend in essential medicines availability is increasing, only 25% of countries provide nicotine replacement therapy, and it is also less often present on national lists of essential medicines.

The percentage of countries having relatively high-technology procedures available for treating NCDs, such as renal replacements, radiotherapy and chemotherapy, is increasing. Nevertheless, availability differs greatly by subregion: coronary bypass or stenting is almost universally available in the Nordic, EU and CSEC countries, but only 25–30% of NIS can provide such procedures in their public health systems.

2.4.3. Gaps and challenges remaining

Although the number of countries in the Region with established national NCD policies, both integrated NCD policies and those that are disease- or risk factor–specific, has grown since 2010, NCDs need more firm high-level anchoring in national development agendas and health plans across the Region.

The formal structures and processes that produce the coherence and collaboration needed to make multisectoral mechanisms effective already exist in half the countries in the Region. These need to be better promoted and disseminated, as reinforced in the 2013

Helsinki Statement on Health in All Policies *(38)* and in Health 2020 *(2)*.

The role of nongovernmental organizations and civil society and the forms and mechanisms of their involvement to prevent and control NCDs are still unclear even though they are integral players in the whole-of-society approach to tackling health inequities *(29)*. Although the Survey does not provide insight into the mechanisms and processes of established collaborations or their effectiveness, the more detailed frameworks of the health in all policies and governance for health in the 21st-century approaches can provide guidance for countries to advance the processes and mechanisms needed for better governance for health *(25, 39)*.

Countries are successfully disaggregating cause-specific mortality data by age and sex, but disaggregating these data by social strata remains a challenge. Nevertheless, breaking down socioeconomic determinants of health is essential for identifying populations at higher risk in the pursuit of health equity.

The progress made with the surveillance of NCD risk factors is encouraging, but the monitoring of salt intake and measurement of blood lipids is lagging behind. Countries should examine the protocols and resources needed to add these elements to surveillance strategies.

Within health care, the availability of early detection technologies for NCDs can still be improved. Similarly, countries need to apply more concerted efforts to improve the development, implementation and impact of evidence-informed guidelines for the integrated management of NCDs. However, advancing the integration of NCDs in primary care should go hand in hand with efforts to establish universally accessible health care.

The potential of fiscal interventions to direct people towards healthier behaviour has not yet been fully exploited or researched. Apart from taxes on tobacco and alcohol, few countries are taxing unhealthy foods, such as those high in fat, salt and sugar, or offering price subsidies for healthy foods or tax incentives to promote physical activity.

3. Current responses in the European Region

3.1. Governance and capacity-building

The European NCD Action Plan *(3)* calls on WHO to facilitate and support the development of national plans for preventing and controlling NCDs, to build capacity for preventing and controlling NCDs and to develop proposals for cooperation on NCDs between international organizations.

In recent years, the Regional Office has supported many countries in developing NCD strategies and plans. A case worth highlighting in this case is the project of the Government of the Russian Federation for strengthening health systems for preventing and controlling NCDs. Within this project, four countries received intensive support from WHO in preparing NCD strategies and policies and in strengthening their integrated surveillance systems. The support entailed situational analysis, stakeholder consultations, drafting and possible adoption of national NCD strategies, action plans and policies and conducting WHO STEPwise approach to surveillance (STEPS) surveys. In addition, workshops on implementing the package of essential NCD interventions for primary care were also organized within the scope of this project.

The Regional Office can report strengthening collaboration with other United Nations agencies, the European Commission, nongovernmental organizations and academe. An example of this is the Programme of Action for Cancer Therapy (PACT), in which WHO, in collaboration with the International Atomic Energy Agency, has been helping Member States to optimize their investment in preventing and controlling cancer by assessing their cancer programmes and making recommendations. Although several imPACT review missions have been organized since the agreement on the European NCD Action Plan, the collaboration is further strengthened by the development and implementation of follow-up projects in which the implementation of the recommendations of the imPACT review missions has been supported in selected countries.

The situation analyses performed as part of the project supported by the Russian Federation stressed the urgency of building capacity for preventing and controlling NCDs. In this regard, a course in Russian is being prepared with the support of the Government of the Russian Federation and the First Moscow State Medical University. Other capacity-building courses that have been implemented the past years include the Flagship Course on Health System Strengthening with a special focus on NCDs, in which more than 50 health professionals participated, and the international seminar on the public health aspects of NCDs, in which six countries in the European Region were represented.

In response to the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016, the Regional Office developed and implemented measures and evaluated policy action in diet and physical activity. As a result, technical support was provided to Member States in developing governance models through country-specific action plans incorporating strategies that strongly address diet- and nutrition-related diseases. In Vienna in July 2013, the Regional Office organized a European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020 *(24)*. The Conference addressed policy options on nutrition and was the first to examine nutrition and diet in the Region in the context of Health 2020.

The Regional Office has continued to support countries with biennial collaborative agreements (22 Member States) that include activities to eliminate *trans*-fat from the diet, salt reduction initiatives, childhood obesity surveillance, capacity-building in nutrition and policy analysis. Important reports on the situation for salt and marketing of food to children were prepared, and the Regional Office also issued a thorough evaluation of the Norwegian Nutrition Policy *(40-42)*.

A very extensive set of 53 nutrition country profiles was also prepared and made available for Member States.

3.2. Monitoring and surveillance

The European NCD Action Plan *(3)* mentions the following.

> Surveillance data are crucial for developing targeted action, monitoring progress and success of counteracting NCDs and informing and evaluating strategies and policies. They should be tailored to the needs of countries while being coordinated at international level through common protocols, indicator definitions, analytical tools and databases that allow for international trend comparisons. In addition, it is stressed that monitoring and evaluation of NCDs and risk factors has to be integrated into general health information systems, in order to support linkages and sustainability and to allow longer-term measurement of the impact, and distribution of the impact, of interventions on NCDs.

The European NCD Action Plan calls for WHO to develop and implement a framework for evaluation of the European NCD Action Plan and to support the development of an integrated NCD information system.

After the United Nations General Assembly adopted the Political Declaration *(22)*, WHO developed a global monitoring framework for tracking progress in preventing and controlling major NCDs and their risk factors. The framework comprises 9 voluntary targets and 25 indicators and was adopted by Member States at the World Health Assembly in May 2013 *(16)*. The NCD indicators and targets in Health 2020 have been aligned with this global framework, with adjustments to take account of the fact that the European cut-off date is 2020 whereas that for global targets is 2025 *(2)*.

The indicators and voluntary global NCD targets of the Global Monitoring Framework for Noncommunicable Diseases and the targets and indicators for Health 2020 cover the whole spectrum of surveillance as outlined in the European NCD Action Plan. It responds to data on mortality and morbidity, data on risk factors and data on a national system response, and both frameworks will therefore track the implementation of the European NCD Action Plan.

Extensive consultation processes have been put in place towards developing the Global Monitoring Framework for Noncommunicable Diseases and the targets and indicators for Health 2020. To maximize the input of the European Member States in developing the global monitoring framework, the WHO Regional Office for Europe held a regional technical consultation on NCD surveillance, monitoring and evaluation hosted by the Government of Norway. At this meeting, Region-specific feedback and proposals were made on the feasibility and implications of the proposed framework. In addition, as mandated by the World Health Assembly in May 2012, a web-based Regional consultation was organized on the draft global monitoring framework on NCDs.

In response to recent policy and strategy developments in the area of surveillance, the National Institute for Health Development in Estonia hosted a technical meeting on the use of big data and social media for the surveillance of NCDs. This meeting aimed to explore the potential of novel data sources that could supplement the traditional means of NCD data collection *(43)*.

Several countries in the Region have strengthened their health information systems, with improvements in routine and ad hoc data collection on NCDs. Increasingly, WHO's STEPwise approach to surveillance has been the tool of choice in the European Region. This is a simple, standardized method for collecting, analysing and disseminating data on the main NCD risk factors. Monitoring and surveillance of NCDs related to diet and physical activity has been an important focus of the Regional Office's work since it unveiled the WHO European information system on nutrition, obesity and physical activity (NOPA), and it has been continuously updated and reinforced since then. Created in collaboration with health ministries in countries and with the support from the European Commission, NOPA includes details of more than 300 national and subnational policies in the European Region. COSI, established as a standardized European surveillance system, has been expanded to include 21 countries involving nearly 200 000 children in the European Region. This tool is already one of the most powerful obesity surveillance mechanisms in the world.

3.3. Health in all policies

As follow-up to the United Nations Political Declaration *(22)*, the United Nations Secretary-General released a report on options for strengthening and facilitating multisectoral action for the prevention and control of NCDs through effective partnership, contained in United Nations General Assembly document A/67/373 *(44)*. The report reviews existing partnerships in this area, lessons learned and successful approaches and proposes models for global partnerships to prevent and control NCDs. The options presented here are consistent with the governance and whole-of-government elements of the European Health 2020 policy.

One of the goals of the European NCD Action Plan 2012–2016 *(3)* is to "use fiscal policies and marketing controls to full effect to influence demand for tobacco, alcohol and foods high in saturated fats, *trans*-fats, salt and sugar".

Member States of the WHO European Region are involved in nutrient profiling initiatives to test different models to be used, for example, in food procurement for schools and hospitals. A total of 21 countries, for the first time, now include restrictions on marketing food to children in their strategies. Finally, several countries have initiated policies to protect public health through pricing policies, through increased taxation on "unhealthy" foods and considering subsidizing healthy foods such as fruit and vegetables.

The impact of pricing on tobacco and alcohol use is well established, and the WHO European Region has extensive experience in these areas. During the past two years, many studies have explored the impact of price policies (including taxation and subsidies) on food supplies. Denmark implemented (and later repealed) a tax on saturated fat. Hungary implemented a tax on a range of food products defined as unhealthy by law. France instituted a tax on certain sugary foods. When evidence was available, these taxes were shown to influence consumer behaviour, and this may have public health effects. Studies are still underway in these countries.

The WHO Regional Office for Europe has developed a package of supporting documents on fiscal policies *(30)*, which were used in a training seminar held on 24–26 September 2012 in Lithuania. Health decision-makers from Albania, Bulgaria, Croatia, Estonia, Hungary, Lithuania, Poland, Slovakia and Ukraine were offered an opportunity to understand the different aspects of using pricing policy to control NCDs and the principles of intersectoral action. The participating countries developed plans for advocacy and possible action in this promising field.

To support implementation of the NCD Action Plan, the Regional Office and Member States have been working with its five action networks, consisting of and led by countries committed to implementing specific actions on salt reduction (27 Member States), obesity and inequalities (13 Member States), school nutrition (18 Member States), the marketing of food to children (21 Member States) and hospital nutrition (10 Member States).

During the past 10 years, the population of the United Kingdom has registered a significant decrease in salt intake, brought about by sound policies that include stakeholder engagement, reformulation and community interventions. This is one of the success stories of the European Salt Action Network, now led by Switzerland, and the Network is seeking to replicate this among its other 22 members. Other countries, including Estonia, Finland, Montenegro, Portugal, Slovenia, Spain and Turkey, have developed policies and showing leadership in this field.

Norway leads the 21-member European Marketing Network, the aim of which is to reduce marketing pressure on children. Norway has prepared a regulatory framework to reduce children's exposure to foods that are high in fat, sugar and salt. It has also taken a series of actions, including nutrient profiling and stakeholder dialogue, with strong leadership from the health sector. Many countries in the Network are preparing approaches that are appropriate to their national contexts.

Many intersectoral projects in the field of NCDs were presented at Europe Day during the Eighth Global Conference on Health Promotion held in Helsinki, Finland on 10–14 June 2013, on the theme of health in all policies. The Helsinki Statement on Health in All Policies *(38)* lends strong support to efforts to prevent and control NCDs in the European Region.

3.4. Promoting health in settings and active mobility

The Action Plan for the implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases (2012–2016) *(3)* recognizes the important link between environmental determinants and primary prevention of NCDs. This corresponds with the 2010 Parma Declaration on Environment and Health *(45)*, in which European ministries of health and environment made a commitment to act on the key environment and health challenges of our time, including "… the burden of noncommunicable diseases, in particular to the extent that it can be reduced through adequate policies in areas such as urban development, transport, food safety and nutrition and living and working environments …".

The Action Plan not only recognizes that environmental hazards represent a major risk factor for noncommunicable diseases: for example, recent evidence indicates that more than 20% of coronary heart disease cases are attributable to living in proximity to polluted roads in 10 European cities *(3)*. Importantly, It also acknowledges that the environment, including the settings in which people live, study and work, can provide excellent opportunities to promote health, notably through multisectoral policies and interventions that involve such sectors as the urban, transport, education and employment sectors. In particular, the Action Plan identifies the following supporting interventions:

- promoting active mobility, with the goal of promoting increased physical activity by modifying the urban environment; and
- promoting health in settings, with the goal of improving health and well-being by making schools and workplace settings more supportive of health.

This section provides an overview of progress achieved in implementing the actions recommended in the Action Plan, focusing on intercountry developments that have occurred since its adoption, and identifies areas requiring further attention.

3.4.1 Promoting active mobility

Transport and urban planning policies play a paramount role in determining environmental exposure to transport-related air pollution and noise and in providing conditions which can enable or suppress daily physical activity, particularly through cycling and walking for transport and leisure. The Action Plan recommends the following actions.

Develop and implement national transport, health and environment action plans

The Regional Office, working under the Transport, Health and Environment Pan-European Programme (THE PEP) *(47)*, a multisectoral policy framework that brings together the ministries responsible for transport, health and environment, has developed a manual for developing national transport, health and environment action plans through a highly inclusive approach. The manual has been extensively discussed with Member States and is enriched by a collection of inspiring case studies. The manual will be launched during the Fourth High Level Meeting on Transport, Environment and Health, which will take place in Paris, France in April 2014.

Participate in regional networks, share experience, identify and transfer evidence on the effectiveness of transport and urban planning interventions in reducing the risk of NCDs

THE PEP workshop series

As part of a series of thematic workshops *(48)* organized under the framework of THE PEP, a Workshop on Sustainable Development of Urban Transport Challenges and Opportunities took place in Moscow, Russian Federation in June 2012 and a Workshop on Green and Health Friendly Sustainable Mobility: Focus on Urban Central Asia in Almaty, Kazakhstan in September 2013. These workshops brought together experts and policy-makers from various parts of the European Region and from the transport, environment and health sector, providing Member States with a multisectoral platform for networking and exchanging information, knowledge and practices. In addition, two symposia addressed to the Member States participating in the THE PEP Steering Committee discussed "Green and health-friendly mobility for sustainable urban life" in 2012 and "Healthy urban mobility for all: walking and cycling in cities" in 2013.

Initiatives supporting networking for promoting physical activity, including through active mobility

Projects supported by the European Commission provided other important networking opportunities that promoted the dissemination of relevant scientific evidence and interactions between scientists, practitioners and policy-makers from various sectors. These allowed for further consolidation and development of the European Network for the Promotion of Health-enhancing Physical Activity (HEPA Europe) *(49)* through the project Promoting networking and action on healthy and equitable environments for physical activity (PHAN) *(50)*, as well as the establishment of a HEPA Europe–EU Contact Group to maximize synergy and exchange between the existing HEPA Europe network and the activities of the EU as part of the project Promoting networking, exchange and greater synergy between sport and health enhancing physical activity sectors (NET-SPORT-HEALTH) *(51)*. In particular, annual meetings of HEPA Europe, which presently counts some 130 member institutions, were held in Amsterdam, the Netherlands in 2011 *(52)*, Cardiff, United Kingdom in October 2012 *(53)* and Helsinki, Finland in October 2013 *(54)*. The topics included themes related to promoting active mobility.

Develop and apply databases, guidance and tools for estimating transport-related health effects, including in economic terms

Health Economic Assessment Tool (HEAT) for Cycling and Walking *(55)*

HEAT is an online resource that estimates the economic savings resulting from reducing mortality as a consequence of regular cycling and/or walking. It is based on the best available evidence, with parameters that can be adapted to fit specific situations. The tool, which was developed in the context of THE PEP, is freely available and is supported by a method and user guide that has been translated into Finnish, French, German, Polish and Spanish *(56)*. Webinars have been organized during 2012 and 2013 to provide free online training to interested users. In addition, direct support has been provided to cities in the WHO European Healthy Cities Network that were interested in applying the tool in the context of the PHAN project, co-funded by the Health Programme of the European Union (Box 1).

Blueprint to promote physical activity to young people

In the context of the PHAN project, and drawing on the direct input and contribution provided by representatives of youth organizations and the collaboration with HEPA Europe, *Young and physically active: a blueprint for making physical activity appealing to youth* was launched in English, German, French and Russian *(57)*. It is intended to be a resource for physical-activity promoters, with a focus on supportive urban environments and settings where children and young people live, study and play. The blueprint was launched during the first meeting of the European Environment and Health Youth Coalition, held in Florence, Italy in October 2012.

Guidance on promoting physical activity among disadvantaged groups

In addition, in the context of the PHAN project and in collaboration with HEPA Europe, principles for action were identified for promoting physical activity among

Box 1. Health Economic Assessment Tool (HEAT) for Cycling and Walking

In 2006, the Austrian Federal Ministry of Agriculture, Forestry, Environment and Water Management introduced the Masterplan for Cycling, a national strategy to promote cycling. The stated goal was to double the share of cycling as a mode of transport in Austria from 5% to 10% by 2015. Calculations made with HEAT for cycling estimate that this level of cycling saves 412 lives every year owing to regular physical activity. The corresponding average annual savings for Austria from this reduced mortality alone are estimated to amount to €405 million. These estimates helped secure further political support for the Masterplan and highlighted the health and economic dimension of benefits of cycling beyond environmental and transport management. As such, it is a good example of evidence-informed action outside the health sector, working upstream and improving the efficiency of the use of public resources.

socially disadvantaged groups, with a focus on the role of healthy environments. A policy summary is available in English, French and German *(58)*. Based on a review of evidence, case studies and national policies, the publication offers suggestions for national and local action and policies to support physical activity in these groups and identifies gaps in evidence to be addressed by future research.

Develop and implement tools to integrate health into transport decisions

Integrating health into transport decisions remains a key objective of THE PEP. In addition to developing resources such as the manual for national transport, environment and health action plans and tools such as HEAT and the WHO European NOPA information system, a promising entry point is provided by supporting the development of critical assessments of transport policies, with views of understanding their possible health implications or health co-benefits from investing in transport policies that benefit both environment and health. This appears especially relevant at a time when most countries consider green economy policies as a means to overcome the economic downturn. The publication *Health co-benefits of climate change mitigation – transport sector: health in the green economy (59)* considers the evidence regarding health co-benefits, and risks, of climate change mitigation strategies for transport, as reviewed by the Intergovernmental Panel on Climate Change. It concludes that transport systems that give priority to active transport and rapid transit systems, along with better urban land use, can also help improve access for vulnerable groups, including children, older people, people with disabilities, and lower wage earners, enhancing health equity. A new and promising line of work is also presented by understanding the possible economic implications of investing in green and healthy transport, in terms of opportunities for creating new jobs. Within the context of THE PEP, a new partnership has been launched to investigate these opportunities and their economic significance more closely *(60)*.

3.4.2 Promoting health in settings

Many settings provide an important entry point for NCD prevention and health promotion programmes, especially schools and workplaces.

Engage with relevant networks in strengthening countries' capacity, health-promoting settings and primary prevention of NCDs

Promoting health in settings poses the challenge of engaging actors and partners from different sectors and with different agendas. Nevertheless, existing and new partnerships can be forged and enhanced by recognizing opportunities for joint action on areas of common interest. For example, trade unions and other workers' associations may be attracted by the possibility of improving working conditions while promoting health. Civil society, especially young people, can see opportunities to lead and be empowered to act, particularly in the settings where they live, study and work. The European Environment and Health Youth Coalition is an example of a new international nongovernmental organization of young people initiated by the commitment taken by Member States at the Fifth Ministerial Conference on Environment and Health in Parma, Italy to promote and support a "meaningful" engagement of youth in implementing the Parma Commitments. At the institutional level, the convergence of interests in promoting health-enhancing physical activity has resulted in a new partnership between the WHO Regional Office for Europe and the Directorate-General on Education and Culture of the European Commission.

It is well recognized that health promotion in schools is a powerful tool for preventing NCDs later in life. However, the situation in the Region, notably regarding overweight and obesity, threatens to wipe out gains in other dimensions of NCDs. The figures resulting from COSI, round 2 (2009/2010), show that, on average, one in every three children aged 6–9 years was overweight or obese. The prevalence of overweight (including obesity) ranged from 24% to 57% among boys and from 21% to 50% among girls. In addition, 9–31% of boys and 6–21% of girls were obese. The figures resulting from the Health Behaviour in School-aged Children (HBSC) study from 2009/2010 in the WHO European Region showed a prevalence of overweight and obesity between 11% and 33% for children aged 11 years, between 12% and 27% for children aged 13 years and between 10% and 23% for children aged 15 years. The HBSC study showed that a higher prevalence of overweight is associated with lower socioeconomic status in some countries, which may be related to a more obesogenic environment (with limited access to healthy foods and fewer opportunities to engage in physical activity) in lower-affluence settings.

Nevertheless, the Regional Office, Member States and other stakeholders, such as research organizations, have been working together to achieve health gains in school settings. Within an informal school network supported by the Regional Office, an international analysis emphasizing middle- and high-income countries was conducted along with information on monitoring, evaluation and other research to demonstrate how school meals affect health, attainment, food sourcing, procurement and finances in the context of interactions between the evidence base and policy decisions. It was agreed that school food and nutrition can provide a cohesive core for improving health, education and agriculture if: (1) the policy is appropriately framed and includes robust monitoring and evaluation; and (2) all stakeholders are adequately engaged in the process. Further promising intervention programmes at the municipal level to tackle childhood overweight and obesity have been identified in the Region.

Develop policy, legislation and governance tools targeting work-related NCDs at the national, local and workplace levels in accordance with WHO guidance and ensure that employers comply with relevant rules and regulations

The relationship between workers' health and well-being, their performance at work and issues such as work organization and productivity is known, but awareness of the importance of these issues is not yet widespread across many organizations in the European Region (Box 2).

Implement existing mandates and commitments to a healthier environment in a manner that reduces exposure to risk of NCDsMember States can take advantage of many opportunities to make progress in preventing NCDs by strengthening their participation in existing mandates and commitments, such as the European environment and health process in particular, and advocating the implementation of relevant multilateral environmental agreements.

Parma Declaration on Environment and Health

Adopted in 2010 by the Fifth Ministerial Conference on Environment and Health, the Parma Declaration on Environment and Health *(45)* identifies " … the burden of noncommunicable diseases, in particular to the extent that it can be reduced through adequate policies in areas such as urban development, transport, food safety and nutrition and living and working environments …" as one of the key environmental and health challenges of our time and seeks commitment from Member States to act on these. The Parma Declaration provides Member States with a clear framework for action, aiming at achieving regional priority goals.

In particular, regional priority goal 2 on addressing obesity and injuries through safe environments, physical activity and healthy diets, regional priority goal 3 on preventing disease through improved outdoor and indoor air quality and regional priority goal 4 on preventing disease arising from chemical, biological and physical environments identify specific actions that have a strong potential to reduce respiratory and cardiovascular diseases, overweight and obesity and cancer. In addition, the Parma Declaration *(45)* sets time-bound targets, including those aiming at:

- providing each child by 2020 with access to healthy and safe environments and settings of daily life in which they can walk and cycle to kindergartens and schools and to green spaces in which to play and undertake physical activity;
- ensuring smoke-free indoor environments by 2015, in line with the WHO Framework Convention on Tobacco Control;
- identifying and, to the extent possible, eliminating exposure to harmful substances and preparations, focusing on pregnant and breastfeeding women and places where children live, learn and play, by 2015; and
- developing national programmes for eliminating asbestos-related diseases, by 2015.

Importantly, the Parma Declaration has also given the WHO the mandate to develop a system for monitoring and reporting on progress towards achieving these targets through a set of indicators that constitute the backbone of the European Environment and Health Information System (ENHIS) *(61)*.

Implementing multilateral environmental agreements and programmes

Health ministries have a major role to play in advocating and supporting the enforcement of existing multilateral environmental agreements, including, for EU countries, relevant EU directives, such as those related to air quality, noise and chemical substances and preparations. Multilateral environmental agreements set a negotiated and

Box 2. Promoting health and well-being at work through empowerment strategies in a health care organization in Italy

A large not-for-profit cooperative organization in Italy has 1367 health care workers employed in the rehabilitative care facilities situated in five provinces and serving the needs of a wide range of user groups, including older people, people with disabilities, children and adolescents, people with mental health problems and/or substance abuse and people at risk of marginalization and exclusion.

This five-year project has the full support and active participation of top management and actively involves all 1367 workers in an action research model project that fosters empowerment and responsibility. The declared values and aims of the project are to facilitate the processes that operate to become a more person-centred organization, not only more patient-centred but also more worker-centred since administrators, managers and health care workers are also people with needs. Effectively satisfying the needs of the service users requires considering the needs and the protection and promotion of the health and well-being of all the workers as pivotal determinants of their professional effectiveness.

Protecting and promoting health and ensuring the personal and professional growth of the workers are seen as part of a win-win project to improve quality for all the stakeholders.

The project involves all the stakeholders as active protagonists of an action research. The personnel of the Institute for the Person Centered Approach operate in the role of consultants and project facilitators, providing training, facilitating encounter groups and support groups and assisting in assessing needs and collecting and evaluating data. The main features comprise work groups dedicated to assessing needs and setting priorities within:

- health and well-being needs
- needs related to professional training and continuing education
- promoting quality in the provision of services
- changing and improving organization
- monitoring and evaluation
- discussion groups for the patients' family members
- training and continuing education groups.

Each health worker team participates for five years in a yearly 40-hour training programme on health promotion at the workplace covering the following topics: basic concepts of health promotion at work, stress prevention and management, effective communication, conflict prevention and conflict resolution, effective teamwork, work–life balance, healthy lifestyles, effective coping and resilience, learning from mistakes, best practices in health promotion at work, the phases of a workplace health promotion project, how to design and carry out an action research project, how to design and evaluate questionnaires on needs and on evaluation, the theory and practice of the person-centred and patient-centred approach and how to promote a solid working alliance with patients and their families. The yearly 40-hour training sessions are organized in a comfortable facility outside the workplace.

Source: personal communication, Alberto Zucconi, Institute for the Person Centered Approach (Istituto dell'Approccio Centrato sulla Persona, IACP), Rome, Italy.

democratic level playing field to address environmental issues that affect the entire population across geographical and political borders and socioeconomic groups and foster international collaboration and oversight. Importantly, multilateral environmental agreements represent a highly cost-effective opportunity to attain the Parma targets, especially with respect to primary prevention of NCDs. For this reason, the European Environment and Health Ministerial Board, which is the political driving force of the European environment and health process, decided to call on all Member States to strengthen their participation in and advancing implementation of the following multilateral environmental agreements and policies in July 2013:

- the 1979 Convention on Long-range Transboundary Air Pollution and its Protocols;
- the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes;
- the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade;
- the Minamata Convention on Mercury; and
- THE PEP.

3.5. Strengthening health systems and building capacity

A project for strengthening health systems for preventing and controlling NCDs has started in Armenia, Kyrgyzstan, Tajikistan and Uzbekistan. These countries are receiving intensive support from WHO in preparing NCD strategies and policies and in strengthening their integrated surveillance systems. These four countries have conducted an initial assessment, organized national multistakeholder consultations and drafted and possibly adopted national NCD strategies, action plans and policies and are conducting STEPS surveys. To follow up the regional meeting on primary care and NCDs, workshops on implementing the package of essential NCD interventions for primary care were organized in Tajikistan in December 2012 and in Uzbekistan in June 2013. The Government of the Russian Federation supported these comprehensive initiatives.

Within PACT, WHO, in collaboration with the International Atomic Energy Agency, is helping Member States to optimize their investment in preventing and controlling cancer by assessing their cancer programmes and making recommendations. During 2012–2013, missions are being organized to Armenia, Montenegro, Republic of Moldova, Romania and Tajikistan. The Regional Office supported the preparation of a palliative care plan in Ukraine in September 2012 and the second annual "Walking for the Cure" event in Turkey in November 2012, to promote awareness of breast cancer.

On 25 and 26 January 2012, the Regional Office organized a meeting in Amsterdam, Netherlands, on how strengthening primary care can contribute to preventing and controlling NCDs. The objective was to assist Member States and organizations in implementing the primary care action and interventions described in the European NCD Action Plan 2012–2016, focusing on cardiometabolic risk assessment.

A policy dialogue on strengthening public health services for improving the prevention and control of NCD was organized on 27–29 June 2012 in Astana, Kazakhstan with the participation of Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Ukraine and Uzbekistan. A draft of the new global action plan for the preventing and controlling NCDs was presented, and participants commented and shared their ideas.

The largest gap in implementation of the European NCD Action Plan 2012–2016 has been direct technical support to Member States on disease management approaches. Under the Region's sustainability plan, an investment is being made to recruit specialists in this field, and this will be one of the two main objectives of the Regional Office's new geographically dispersed office on NCDs, which is currently being established.

Four in-depth country assessments were conducted towards the end of 2012 in Armenia, Kyrgyzstan, Tajikistan and Uzbekistan, with the aim of developing national strategies, action plans and policies on NCDs. These assessments showed that health sector decision-makers require training on NCDs. Although training courses on the

subject are frequently organized, access to programmes in Russian is limited. A course in Russian is being prepared, with the support of the Government of the Russian Federation and the First Moscow State Medical University, and the first group was trained in February 2014.

A collaboration led by the Regional Office and including the Harvard School of Public Health will deliver two products: a review of the barriers in health systems to preventing and controlling NCDs and a guide for decision-makers for self-assessment and planning. The latter is already being used for multidisciplinary assessments in five countries: Hungary, Kyrgyzstan, Republic of Moldova, Tajikistan and Turkey.

In the context of health system collaboration, more than 50 health professionals from Albania, Armenia, Azerbaijan, Bulgaria, Kazakhstan, Republic of Moldova, Romania, Russian Federation, Serbia, Spain, Tajikistan, Turkey, Ukraine and Uzbekistan participated in the annual Flagship Course on Health System Strengthening, held in Barcelona, Spain from 25 September to 3 October 2012, and the special focus that year was on NCDs.

Representatives of Georgia, Kyrgyzstan, Montenegro, the Republic of Moldova, the Russian Federation and Uzbekistan participated in international seminars on the public health aspects of NCDs on 7–12 May 2012 in Geneva, Switzerland and 3–8 June 2013 in Lausanne, Switzerland.

4. Highlights of innovative practices for addressing NCDs in the European Region

There have been interesting developments in preventive and control measures and interventions, particularly around the four major risk factors in the European Region. This chapter aims to present novel and innovative measures adopted by various countries in establishing and implementing measures to counteract the major risk factors. They not only offer groundbreaking ideas but should also serve as inspiration for preventing and controlling NCDs.

4.1. Alcohol

Pricing policies

All countries reported that excise duty is levied on spirits, and all but one country (Kyrgyzstan) reported that excise duty is levied on beer.[1] However, 11 countries do not have an excise duty on wine. Twelve countries reported that the level of excise duty is regularly adjusted for inflation. Alcoholic beverages are subject to value-added tax above 0% except for two countries (Andorra and Azerbaijan), with the rates varying from 8% to 30%[2] (Table 3).

A few countries reported using price measures other than taxation. At the end of 2011, Germany, Sweden and Uzbekistan prohibited below-cost selling (selling for a price less than the production cost), and Finland, Iceland and Sweden prohibited volume discounts (such as two-for-one offers) (Box 3).

Table 3. Price and tax measures related to alcohol in countries in the European Region

Price and tax measures	Number of countries (n = 53)
Value-added tax on alcoholic beverages of 0%	2
Value-added tax on alcoholic beverages of 8–12%	2
Value-added tax on alcoholic beverages of 15–20%	30
Value-added tax on alcoholic beverages of 21–25%	14
Value-added tax on alcoholic beverages of 26–30%	3
Level of excise duty adjusted for inflation	12
Ban on below-cost selling	3
Ban on volume discounts	3
Additional levy on specific products	5
Requirement to offer non-alcoholic beverages at a lower price	4
Other price measures to discourage underage drinking or high-volume drinking	1

[1] No information provided for Uzbekistan.

[2] No information provided for Kazakhstan.

Box 3. Regulation of volume discounts in Finland

Before 2008, the pricing of alcoholic beverages was not specifically regulated in Finland. Competition in the beer market, which is outside the government monopoly, has been fierce. Because of price competition, one can of beer often cost €1 but a 12-pack cost only €9. Before weekends and public holidays, big supermarkets had only one advertisement to attract customers: "Only today – a 12-pack of beer €7". Restaurants also had special discounts; for example, during "happy hours", one beer or cocktail would cost only half the normal price.

Volume discounts and happy hours were considered to promote excessive drinking. The Constitution did not allow the government to override the pricing decisions of private shops, markets and restaurants. Restrictions on sales below cost were not feasible, as costs vary and can be manipulated. Some amendments were possible, however. In 2008, a ban on volume discounts was introduced. It is now forbidden to offer several packages or servings of alcoholic beverages at a reduced joint price. Mass-media advertising for short-term discount prices or happy hours was also banned: the price may only be advertised if it stays the same for at least two months. Both bans apply to shops, markets and restaurants.

After volume discounts were prohibited, shops did not raise the price of 12-packs. Instead, they were forced by law to reduce the price of one can to equal the price of one can in the 12-pack. After discount advertising was restricted, shops extended special prices to last two or three months. The introduction of these bans illustrates the advantages and disadvantages of market regulation. The reaction of producers and retailers to regulating the pricing of multipacks led to the price of one beer being reduced by over 40%, allowing, for example, young people to buy more cans for the little money they have. The wildest discounts and loss leaders have practically disappeared but, in general, discount prices have now been extended to last two months.

The lesson is that taxation is the most rational way of regulating alcohol prices. The government has now raised alcohol excise duties four times in four years: all prices (both normal and discounted) have gone up, tax income has increased by €400 million and the total consumption of alcohol has decreased by 8%.

Source: personal communication, Ismo Tuominen, Department for Promotion of Welfare and Health, Ministry of Social Affairs and Health, Finland.

Five countries reported that they made an additional levy on specific products, such as alcopops and other ready-to-drink mixtures (Table 3).

Five countries (Belarus, Kyrgyzstan, Republic of Moldova, Russian Federation and Ukraine) reported imposing a minimum retail price on alcoholic beverages. In the United Kingdom (Scotland), legislation has been passed introducing a minimum pricing policy (Box 4).

Availability of alcohol

As of February 2013, all countries have a legal age limit for on- and off-premise sales of alcoholic beverages. On-premise sales means sales in, for example, a café, pub, bar or restaurant, and off-premise sales means sales to be taken away from, for example, a shop or supermarket.

The minimum age ranges from 16 to 20 years, with 18 years as the most common age (Fig. 18 and 19).

Test purchasing as a method of monitoring and fostering compliance with age limits is a fairly recent addition to the portfolio of law enforcement methods. Box 5 gives information on Switzerland's experience with using test purchasing.

Box 4. Scotland passes legislation to introduce a minimum unit price for alcohol

In 2012, the Scottish Parliament passed legislation to set a minimum unit price for alcohol of £0.50 (€0.60). This sets a floor price below which a given quantity of pure alcohol cannot be sold (1 unit = 10 ml or 8 g). The government of the United Kingdom has since announced that it also intends to introduce a minimum unit price for England and Wales. As the price of alcohol falls, consumption rises and, consequently, so does alcohol-related harm. In the United Kingdom as a whole, both the affordability and availability of alcohol have increased in recent years, particularly driven by off-premise sales.

In the United Kingdom (Scotland), alcohol consumption has risen by 10% since 1994; in 2011, 11.2 litres of pure alcohol were sold for every adult. This rise in consumption has been associated with an increase in alcohol-related harm. Since the 1980s, alcohol-related hospital admissions have quadrupled and alcohol-related deaths have more than doubled, with chronic liver cirrhosis mortality rates being among the highest in western Europe. A minimum unit price is part of Scotland's strategy introduced in 2009, with more than 40 measures at both the population and the individual level in accordance with those recommended by WHO as effective alcohol policy. Econometric modelling of a minimum unit price shows that consumption would fall more among heavy drinkers, since they tend to drink more inexpensive alcohol. It would affect moderate drinkers little. Emerging research findings on the minimum pricing systems in Canada show the first empirical evidence of the effectiveness of a minimum unit price.

One study found that a 10% increase in minimum prices reduced overall consumption by an estimated 8.4%. The effects of minimum pricing are also seen at the level of overall consumption because heavy drinkers account for a large part of all alcohol consumed. Another study showed that a 10% increase in the average minimum price for all alcoholic beverages was associated with an estimated 32% reduction in deaths wholly attributable to alcohol. The minimum unit price effectively targets the individuals who will benefit most from reducing consumption.

Source: personal communication, Lesley Graham, Information Services Division, NHS National Services, Scotland.

Fig. 18. Minimum age limits for on-premise sale of beer, wine and spirits in the European Region, by number of countries (n = 53)

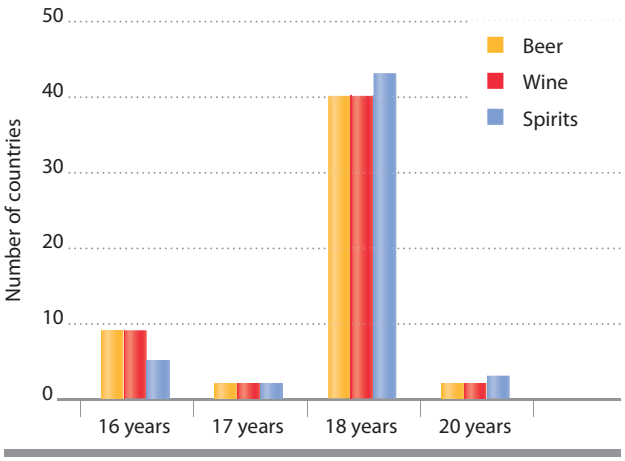
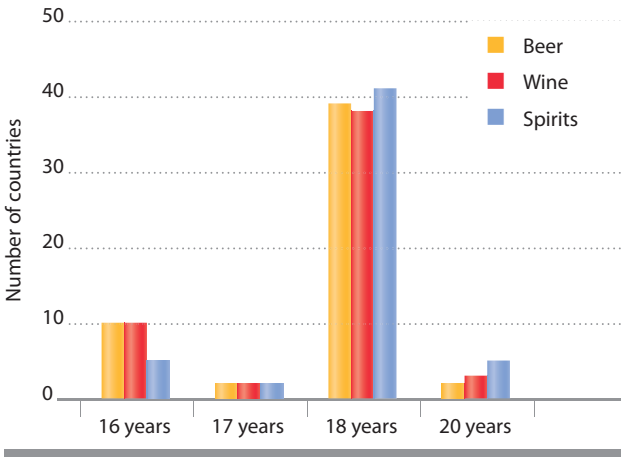


Fig. 19. Minimum age limits for off-premise sale of beer, wine and spirits in the European Region, by number of countries (n = 53)



Box 5. Mystery shopping and test purchasing in Switzerland

Mystery shopping or test purchasing is a method used to check whether the sellers or servers of alcoholic beverages comply with legal age limits. Young people actually or seemingly below the minimum age attempt to buy alcoholic beverages and report whether or not proof of age was requested.

In 2008, the Federal Office of Public Health and the Swiss Alcohol Board developed a guide on mystery shopping for alcohol to foster standardization of practices and data and to ensure that the procedure is legal and ethical *(62)*. The guide is targeted at cantons, communes, nongovernmental organizations and companies and provides them with checklists, templates of agreements and model letters to participants and parents.

Cantons, cities or municipalities or companies generally mandate local nongovernmental organizations to hire and train adolescents (usually between 14–17 years old) to visit supermarkets, restaurants, service station shops and so on and try to buy alcoholic beverages. This method has been applied and evaluated in Switzerland for more than 10 years.

Test purchases were started in one canton in 2000. In 2011, test purchasing was regularly carried out in 25 out of the 26 cantons.

The annual number of test purchases rose from 85 in 2000 to 5518 in 2011, and the percentage of successful purchases dropped from 83% to 30%.

In 2000, only 3.5% of the mystery shoppers were asked to show identification, whereas in 2010, almost 80% were asked their age or had to identify themselves.

Source: personal communication, Monika Rüegg, Federal Office of Public Health, Public Health Directorate, Switzerland.

4.2. Nutrition and physical activity

The WHO European Ministerial Conference on Nutrition and Noncommunicable Diseases in the Context of Health 2020 adopted the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 in July 2013 *(24)*. The WHO Regional Committee for Europe later endorsed the Vienna Declaration. It called on Member States to consider the policy options presented as a foundation for building or strengthening national policies on nutrition and physical activity; to promote an evidence-based approach that includes all levels of government and involves all stakeholders; to ensure appropriate governance for implementing action towards preventing conditions related to poor nutrition and physical inactivity and to build intersectoral alliances and networks and foster citizen empowerment; to promote access to and the affordability of healthy nutrition and physical activity as a means to reduce inequalities; and to strengthen national capacity for health systems to respond to health issues related to nutrition and physical activity. In the context of Health 2020, a mandate was entrusted to develop a European action plan on food and nutrition and a physical activity strategy.

Several social innovative examples focusing on diet and physical activity can be identified in the Region and shared as experiments by countries that lead the way in health promotion and protection.

- **Unique surveillance and survey tools**: an example of a consolidated surveillance system is COSI. COSI established a standardized European surveillance system focusing on childhood obesity and has expanded to include 23 countries in 2013 where data can be

disaggregated by socioeconomic status *(63)*. Another example of cross-national surveillance collaboration between the countries in the European Region is the HBSC study, which examines the physical and mental health of children and teenagers, including perceptions and behaviour related to diet and physical activity. These surveys, carried out using standardized validated protocols, facilitate comparability between Member States.

- **Improve early nutrition to prevent later NCDs**: the compelling body of evidence indicates that factors such as breastfeeding and appropriate complementary feeding practices may presents an ideal window of opportunity for preventing obesity and other NCDs. The Regional Office together with WHO headquarters has worked with Member States compiling evidence of the links between early nutrition and NCDs and the influence of such factors as baby food marketing on these outcomes. Extra effort has been put into collecting and standardizing survey tools to evaluate breastfeeding and complementary feeding practices, given the striking disparity in methods in the Region.

- **Regular moderate intensity physical activity** – such as walking, cycling or participating in sports – has significant benefits for health and is part of healthy lifestyles. This can be promoted by green spaces, public transport, cycle paths etc. The contribution of WHO in this area has been relevant, including issuing *Steps to health: a framework for action in the WHO European Region* (64). Further, WHO has been developing tools, notably a Physical Activity Toolkit (ACT) to provide practical approaches and strategies that can be implemented by a wide range of stakeholders and for different economic realities and population sizes. ACT stands for active workplaces, children and schools and transport and environment. Finally, the Regional Office is working together with its collaborating institutions in developing a new tool to promote spontaneous physical activity among children by engaging in a process to develop a walkability index for children *(65)*.

- **Settings** – workplace initiatives, schools (health-promoting schools and nutrition-friendly schools); health-promoting hospitals and baby-friendly hospitals; healthy cities; health-promoting universities; kindergartens; and facilities for older people.

- **Economic tools**, such as a combination of subsidies and/or taxes, have been implemented as food and nutrition policy tools at the national level *(66)*. Five countries have tested the use of food taxes with a public health aim with encouraging results, and 25 countries are using subsidized vegetable and fruit schemes and school meals as a means to promote children's health and promote equity (67).

- **Member State action networks** were established to promote experience sharing in such areas as reformulation in salt and fat, stakeholder interaction and restrictions on the marketing of foods and non-alcoholic beverages for children as well as school initiatives *(68)*. A good example of this was the establishment, under the WHO framework, of the European Salt Action Network, involving 27 Member States. This Member State action network set up by Member States' own initiative was the result of a sense of urgency and underachievement in nutrition. Until recently, the majority of the population had failed to meet the WHO targets for intake of salt, saturated fat and *trans*-fatty acids and sugar as well as the recommendations for vegetable and fruit intake. Despite progress in reducing *trans*-fatty acid consumption in recent years, popular foods with high amounts of *trans*-fat are easily available in the eastern part of the Region, and there are special concerns about high intake among people who are most vulnerable *(69)*. The action networks have definitely brought these themes to the agenda, and in many cases they have been instrumental in generating global action (such as the WHO Member States Action Network on Reducing Marketing Pressure on Children *(70, 71)*.

- **The Regional Office and Member States have been working together towards developing a single-nutrient profiling model** that can clearly indicate which food products should be reformulated by providing a standard against which reformulation can be measured. For example, nutrient profiling can help guide reformulation leading to the reduction of the consumption of free sugar present in sugar-sweetened beverages.

Box 6. European countries and food taxation

Denmark was the first country in the world to introduce a tax on a natural component of many foods. The fat tax amounted to €2.15 per kilogram of saturated fat. The tax came into force on 1 October 2011, and even though evidence indicates that the tax reduced the consumption of saturated fat, it was abolished again on 1 January 2013. The main reason was concern about border trade and competitiveness. The tax collected the predicted revenue, reduced saturated fat intake by 6% and was shown not to be socially regressive according to preliminary data.

Finland has a long history of taxation on unhealthy food products, with their taxation on sweets and soft drinks initially being in place from 1926 to 1999. However, in 2000 the sweets component was abolished, with the soft drink component remaining. In late 2010, Finland's parliament reinstated the sweets tax, with the tax now applying to sweets, ice cream and chocolate. The taxes are primarily levied to generate revenue for government purposes, but the potential health and consumption effects are acknowledged. The tax rates were increased in 2012.

Hungary has a high average per capita salt consumption, and about two thirds of the adult population is obese. Hungary therefore introduced a public health product tax. The tax was introduced in 2011, aimed at products for which healthier alternatives were available. It has a specific health objective to promote both healthier food consumption by individuals and product reformulation by manufacturers. The revenue generated from the tax is allocated for health promotion purposes. The tax is levied on soft drinks, energy drinks, confectionery, salted snacks, condiments, flavoured alcohol and fruit jams. It was initially broader, including fast food, chips and bakery products, but industry was able to lobby for exemptions in these areas.

In France a tax was levied on sugar-sweetened and diet soft drinks in January 2012. It is levied on French manufacturers, importers and food outlets serving prepared drinks with added sugar. It is primarily a revenue-raising tax but is aligned with the goals of reducing overweight and obesity, particularly obesity among children and adolescents.

4.3. Tobacco

Tobacco packaging and labelling

All parties to the WHO Framework Convention on Tobacco Control are obligated to adopt, within a three-year period after entry into force, requirements regarding the packaging and labeling of tobacco products (Article 11). The guidelines for implementing this article within the WHO Framework Convention on Tobacco Control were developed to support the parties.

Major developments have taken place in the WHO European Region from 2007 to 2013. For example, the percentage of countries having medium-size warnings with all appropriate characteristics (or large warnings lacking some appropriate characteristics) increased from 6% in 2007 to 32% in 2013. Similarly, the proportion of countries requiring pictorial warnings increased from 8% in 2007 to 38% in 2013.

However, only two countries (4%) in the European Region have required large warnings with all appropriate characteristics, and this is significantly lower than in all other WHO regions. For example, 34% of countries in the WHO Region of the Americas have implemented strong requirements in tobacco packaging and labeling, 27% of countries in the WHO South-East Asia Region, 22% in the WHO Western Pacific Region and 13% in the WHO Eastern Mediterranean Region. A total of 9% of countries in the WHO African Region have required large warnings with all appropriate characteristics.

High-income countries generally provide more stringent regulations on tobacco packaging and labelling than low- and middle-income countries. For example, 81% of high-income countries have the obligation to display warnings on all tobacco products, whether manufactured domestically, imported or for duty-free sale versus only 55% of low- and middle-income countries. Likewise, 90% of high-income countries ban deceitful terms versus 77% of low- and middle-income countries.

Another drawback is that not all tobacco products are uniformly regulated. For example, only 13% of countries in the Region require pictorial warnings for smokeless tobacco versus 38% requiring pictorial warnings on cigarettes. Similarly, only 13% of countries require rotating health warnings on smokeless tobacco versus 89% of countries for cigarettes.

The European Commission's Tobacco Products Directive *(72)* includes an obligation to display health warnings on tobacco products and comply with prescribed requirements about their size, format and other characteristics, among other regulations. The ongoing revision of this Directive has been undertaken, with the proposal including an increase of the size of combined text and picture warnings, and this presents great potential and opportunities for advancement in the EU countries and beyond.

5. Health system challenges and opportunities

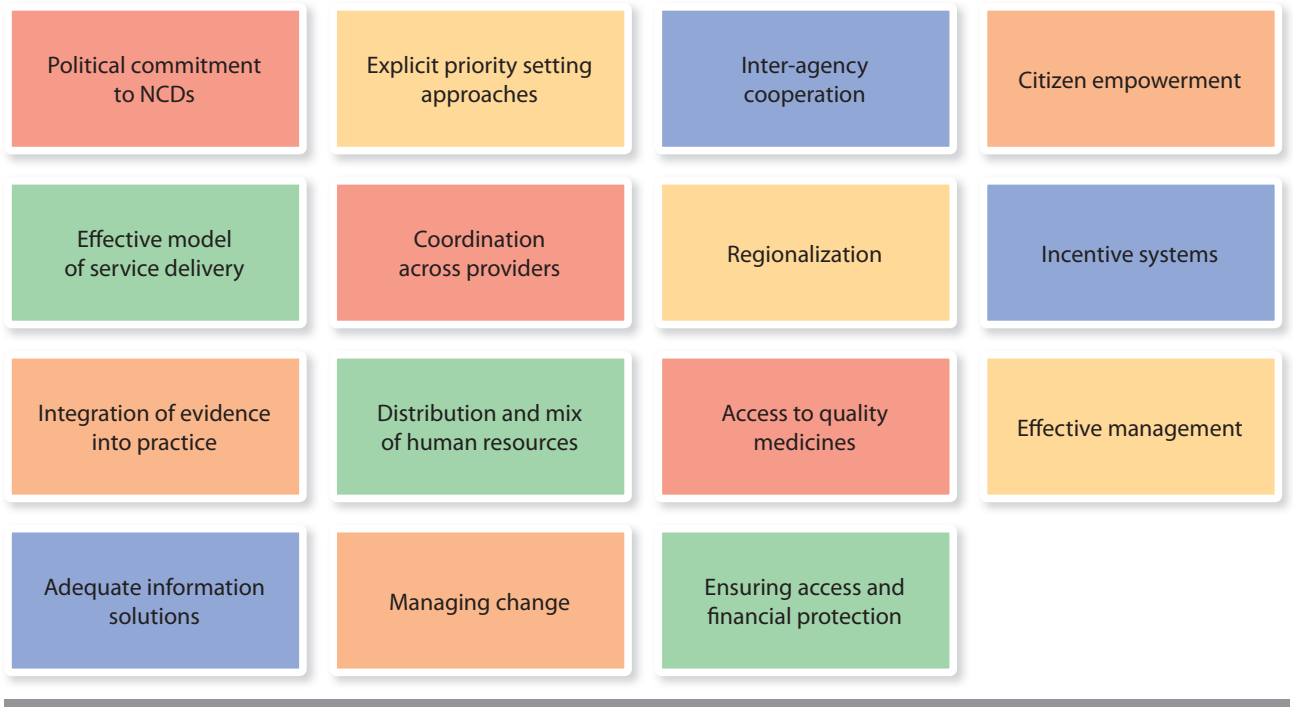
The Regional Office has embarked on a work programme to collaborate with Member States to strengthen their health system response in order to accelerate improvement in outcomes related to NCDs. The work programme was motivated by numerous calls for a "comprehensive health system response" to reducing the burden of NCDs. This new work programme launched in 2013 aims (i) to produce pragmatic and actionable policy recommendations at the country level in strengthening health systems that accelerate gains in key NCD outcomes; and (ii) to synthesize knowledge and experience around the Region on common health system challenges and promising approaches to addressing them. This new work programme of WHO is a joint effort by the Division of Health Systems and Public Health and the Division of Noncommunicable Diseases and Life-course.

Country assessments and follow-up engagement to develop a policy response are at the heart of this work programme. To facilitate solid country assessments and policy advice, the Regional Office has undertaken conceptual work and developed a country assessment guide. In 2013, several outputs have been developed and are at the stage of finalization.

Output 1: background paper

In collaboration with the Harvard School of Public Health, Marc J. Roberts and Mary Ann Stevenson developed a conceptual background paper: *Improving outcomes for noncommunicable diseases through health system strengthening (73)*. The background paper reviews the nature of NCDs, in particular cardiovascular disease and cancer, and outlines the health system requirements for effectively preventing, detecting and managing these conditions. The paper proposes 15 health system challenges that often prevent health systems from effectively carrying out these functions or conversely can be viewed as opportunities to accelerate health gain (Fig. 20).

Fig. 20. Fifteen important health system challenges and opportunities for NCDs



Output 2: country assessment guide

The country assessment guide provides a systematic approach to assessing the strengths and weaknesses of how countries' health systems respond to the NCD burden. The guide prompts assessment teams to start by analysing health system performance on key NCD outcomes and comment on the likelihood of meeting the 25 by 25 targets (including a 25% reduction in mortality from NCDs by 2025). The health outcome pattern is linked with coverage of the core population interventions and individual services, which map very closely to the best buys developed for the Global NCD Action Plan *(3)*. This is followed by in-depth exploration of the 15 health system challenges that prevent more extensive coverage of core NCD interventions and services as well as opportunities. The assessments explore innovations and good practices to enable cross-country learning. The assessments end with contextualized country-specific policy recommendations (Table 4).

Output 3: country assessments with follow-up policy development

In 2013, five countries have volunteered to field-test the approach and the assessment guide: Hungary, Kyrgyzstan, Republic of Moldova, Tajikistan and Turkey. Each assessment was preceded by extensive discussions of the country-specific objectives for the assessment and the role this assessment could play in further policy development. In most cases, the results of country assessments are to feed into national processes for defining comprehensive action plans on health system strengthening and/or NCDs. Processes for follow-up policy development in response to the assessment are in place. In all cases, the assessment teams reflected a multidisciplinary approach, with experts in public health, health services, financing, medicines and others as needed. A joint team of national and international experts led by WHO carried out the assessment.

Although far-reaching conclusions cannot be drawn from the example of five countries, there was remarkable consistency in the findings across the assessments conducted so far.

- Progress on cardiovascular diseases outcomes is promising in all countries, although it is fragile in some of the 12 countries of the former Soviet Union requiring sustained efforts to meet the 25 by 25 targets. In contrast, cancer mortality in all five countries requires considerable attention and enhanced effort to meet the 25 by 25 targets.
- The coverage of core population interventions (tobacco, alcohol and nutrition) is fairly limited, with some notable exceptions such as tobacco control in Turkey and innovative nutrition policies in Hungary. In all cases, implementing the best buys remains on the agenda.
- Similarly, the coverage of core individual interventions (such as comprehensive cardiovascular risk assessment and effective management of hypertension and diabetes) was significantly lower than the assessment teams expected, even in countries that have implemented deep health system reforms for 10–15 years.
- The main health system challenges that would enable the five countries make more rapid progress implementing population interventions included stronger interagency cooperation, greater political commitment,

Table 4. Summary of the structure of the country studies

Section	Objective
Part A. Health system performance on NCD outcomes	This section highlights the country's performance in improving NCD outcomes and the likelihood of meeting the global target of 25% reduction in mortality by 2025.
Part B. Scorecard for core population interventions and individual services	This section focuses on the coverage of core NCD intervention services and linking it to health behaviour and outcomes.
Part C. Health system challenges and opportunities	This section analyses the presence and extent of 15 common health system challenges and opportunities that undermine the delivery of core services.
Part D. Spotlight on health system innovations and good practices	This section highlights good practices and innovations in health systems with evidence of how they affect NCD-related core services and outcomes.
Part E. Policy recommendations	This section provides policy recommendations with priorities for the country to address health system barriers and can provide input into NCD and action plans for strengthening health systems.

more explicit priority-setting approaches, including for budget allocation processes, and improved surveillance and monitoring systems.

- The main health system challenges that would enable the five countries to make more rapid progress in implementing individual services included improving human resource policies, getting the service delivery model right, better aligning financial incentives and empowering the population.

Early lessons of the work programme, including some of the conceptual underpinnings and emerging lessons from the country assessments, were shared at the Health Systems for Health and Wealth in the Context of Health 2020 Meeting in Tallinn, at the Regional Flagship Course on Health System Strengthening with a Focus on NCDs, at the International anniversary conference marking 35 years of the Declaration of Alma Ata on primary health care on 6–7 November 2013 and at the WHO European Ministerial Conference on the Prevention and Control of Noncommunicable Diseases in the Context of Health 2020 in Turkmenistan.

The next steps involve more strengthening of health systems with a focus on NCD country assessments in 2014 and 2015 that will allow synthesizing lessons for the Region. In addition, short, crisp innovation case studies will be developed and published to spotlight specific good practices. Finally, several technical papers will be developed when Member States require more in-depth guidance and policy advice. The combination of these outputs will enable the development of a regional synthesis report with lessons learned and recommendations by the end of 2015.

Box 7. Health system strengthening focusing on NCD assessment in Turkey: a focus on social determinants

The NCD assessment as part of health system strengthening in Turkey included the four major NCDs (cardiovascular diseases, respiratory diseases, diabetes and cancer) and strongly focused on social determinants of health and equity. The assessment documented the impressive results Turkey's health system has achieved in the past decade in improving access and reducing the financial burden and consequently improving health outcomes, particularly for maternal and child health. Turkey has been hailed as a global best practice in tobacco control, and many other countries in the Region seek information on the experience. The assessment also noted that addressing the rapidly growing obesity problem is the next challenge among population interventions with stronger intersectoral collaboration and involving community outreach workers in nutrition behaviour change, counselling and peer support. For individual services, the next challenge is to fully integrate NCDs into the work of family doctors with clinical decision support aids, training, monitoring and incentives. Turkey intends to use the results of the assessment to develop a comprehensive plan for preventing and controlling NCDs that would act as an umbrella to existing plans and policies on various areas of NCD prevention and control.

6. Conclusion and reflections

The Survey results and detailed descriptions of Member States activities in this report are testament to the progress being made in implementing the Action Plan in all priority areas of the European NCD Action Plan. Member States are also aligning with the strategic objectives in Health 2020 – improving health for all to reduce health inequities while improving leadership and participatory governance – and their actions are consistent with the WHO Global Monitoring Framework for Noncommunicable Diseases.

Health 2020 positions health as an essential resource and asset for economic and social development – economic performance is linked to people's health along the life-course. With countries in the Region experiencing economic challenges or full national crises, the growing momentum in multisectoral involvement and governance in NCD and risk factor programming, the collaborative work within partnerships and networks and the willingness to learn from each other, continue to build capacity and be innovative are laudable.

Although the full recognition of how good health and health equity contribute to a country's socioeconomic fabric is lagging, an increasing number of Member States have included NCDs in their social and economic development plans.

NCDs need to be more firmly anchored in national development agendas and health plans across the Region. The multisectoral mechanisms that are effectively positioning NCDs and their risk factors and determinants on the agendas of other sectors need to be further promoted and disseminated. Various sectors need even more engagement: the actors who hold different agendas and reach various populations and communities. Identifying the opportunities for joint action in areas of common interest requires building on existing institutional, policy and professional platforms, thus raising the potential for recruiting political support and new capacity, resources and technical expertise from various disciplines. In addition, the roles of nongovernmental organizations and civil society need to be better defined so that they can be used optimally.

It is encouraging to note that Member States' surveillance coverage of the main types of risk behaviour and conditions is improving and provides a solid foundation for aligning with the Global Monitoring Framework for Noncommunicable Diseases. The eastern part of the Region is catching up with the EU countries in their surveillance of risk factors.

Regarding the priority of healthy consumption in the Action Plan, countries increasingly tend to limit the exposure of children to food and non-alcoholic beverage marketing, and more than 50% of Member States have established measures to limit marketing to children. Regarding dietary salt, measuring actual intake remains a barrier to effectively monitor the effects of any food reformulation or other population-level interventions. Nevertheless, protocols for measuring population-level intake are expected to evolve. Important innovations are emerging to control alcohol consumption, and with many products supplied by global producers and many marketing and promotion practices being common across countries, the lessons being learned may become increasingly transferable. With tobacco, only two countries in the Region require large warnings on packs with all appropriate characteristics, significantly lower than all other WHO regions, and tobacco products, particularly new products such as smokeless tobacco, are not yet uniformly regulated.

Health in all policies is being activated in a variety of settings to address NCDs, and several initiatives are engaging multiple players and institutions, especially in the urban planning, transport, education and employment sectors. It is encouraging to note the numerous initiatives across the Region that recognize the relationship between health and well-being and the environments where people live, work and take leisure, such as healthy schools, cities and workplaces; the growing emphasis on addressing risk factors for NCDs through multisectoral and multistakeholder

initiatives; and the multilateral environment agreements that are fostering coordinated action. As experience is gained with such novel initiatives, disseminating the lessons learned is essential.

Commitments to strengthening health systems are ongoing; better uptake of clinical practice guidelines remains a priority. In the eastern subregions of the Region, countries have participated in general policy dialogues on their public health services, and five countries field-tested a guide to self-assessment of specific barriers and the planning needed for better health system response to preventing and controlling NCDs at both the population and individual levels.

In summary, effectively preventing and controlling NCDs requires engaging actors and partners from various sectors who hold different agendas and reach different populations and communities. The challenge is to identify the opportunities for joint action in areas of common interest and come to understand the variety of policy instruments that are available that hold the best potential for traction in current political climates. This is being facilitated by capitalizing on existing institutional, policy and professional platforms, thus increasing the potential for recruiting political support and new capacity, resources and technical expertise from different disciplines and societal actors.

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Annex 1. Countries in the European Region responding to the WHO Global NCD Country Capacity Survey, 2010 and 2013

2010	2013
Albania	Albania
Andorra	Andorra
Armenia	Armenia
Austria	Austria
Azerbaijan	Azerbaijan
Belarus	
Belgium	Belgium
Bosnia and Herzegovina	
Bulgaria	Bulgaria
Croatia	Croatia
Cyprus	Cyprus
Czech Republic	Czech Republic
Denmark	Denmark
Estonia	Estonia
Finland	Finland
France	France
Georgia	Georgia
Germany	Germany
Greece	Greece
Hungary	Hungary
Iceland	Iceland
Ireland	Ireland
Israel	Israel
Italy	Italy
Kazakhstan	Kazakhstan

2010	2013
	Kyrgyzstan
Latvia	Latvia
Lithuania	Lithuania
Luxembourg	Luxembourg
Malta	Malta
Monaco	Monaco
Montenegro	Montenegro
Netherlands	Netherlands
Norway	Norway
Poland	Poland
Portugal	Portugal
Republic of Moldova	Republic of Moldova
Romania	Romania
Russian Federation	Russian Federation
San Marino	San Marino
Serbia	Serbia
Slovakia	Slovakia
Slovenia	Slovenia
Spain	Spain
Sweden	Sweden
Switzerland	Switzerland
Tajikistan	Tajikistan
The former Yugoslav Republic of Macedonia	The former Yugoslav Republic of Macedonia
Turkey	Turkey
	Turkmenistan
Ukraine	Ukraine
United Kingdom	United Kingdom
Uzbekistan	Uzbekistan

Annex 2. Countries in the European Region responding to the WHO Global NCD Country Capacity Survey by country group

European Region	EU	NIS	CSEC
Albania			Albania
Andorra			
Armenia		Armenia	
Austria	Austria		
Azerbaijan		Azerbaijan	
Belgium	Belgium		
Bulgaria	Bulgaria		
Croatia			Croatia
Cyprus	Cyprus		
Czech Republic	Czech Republic		
Denmark	Denmark		
Estonia	Estonia		
Finland	Finland		
France	France		
Georgia		Georgia	
Germany	Germany		
Greece	Greece		
Hungary	Hungary		Hungary
Iceland			
Ireland	Ireland		
Israel			
Italy	Italy		
Kazakhstan		Kazakhstan	
Kyrgyzstan		Kyrgyzstan	

European Region	EU	NIS	CSEC
Latvia	Latvia		Latvia
Lithuania	Lithuania		Lithuania
Luxembourg	Luxembourg		
Malta	Malta		
Monaco			
Montenegro			Montenegro
Netherlands	Netherlands		
Norway			
Poland	Poland		Poland
Portugal	Portugal		
Republic of Moldova		Republic of Moldova	
Romania	Romania		Romania
Russian Federation		Russian Federation	
San Marino			
Serbia			Serbia
Slovakia	Slovakia		Slovakia
Slovenia	Slovenia		Slovenia
Spain	Spain		
Sweden	Sweden		
Switzerland			
Tajikistan		Tajikistan	
The former Yugoslav Republic of Macedonia			The former Yugoslav Republic of Macedonia
Turkey			
Turkmenistan		Turkmenistan	
Ukraine		Ukraine	
United Kingdom	United Kingdom		
Uzbekistan		Uzbekistan	

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
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