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Action plan for the prevention and control of noncommunicable diseases in the WHO European Region

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Action plan for the prevention and control of noncommunicable diseases in the WHO European Region

The proposed Action plan for the prevention and control of noncommunicable diseases in the WHO European Region continues and updates the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016. Taking account of new evidence, exciting developments, existing commitments and progress of Member States, the Action plan focuses on priority action areas and interventions for the next 10 years (2016–2025) in order to achieve regional and global targets to reduce premature mortality, reduce the disease burden, improve the quality of life and make healthy life expectancy more equitable.

The Action plan has been developed through a consultative process, guided by technical experts. Its formulation incorporates the Health 2020 policy framework, follow-up to the United Nations high-level meetings on noncommunicable diseases in 2011 and 2014, and implications of the recently adopted Sustainable Development Goals.

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark Telephone: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eugovernance@who.int Web: http://www.euro.who.int/en/who-we-are/governance

Conceptual overview and main elements

Vision

A health-promoting Europe free of preventable noncommunicable disease (NCD), premature death and avoidable disability

Goal

The goal of the Action plan for the prevention and control of noncommunicable diseases in the WHO European Region is to avoid premature death and significantly reduce the disease burden from NCD by taking integrated action, improving the quality of life and making healthy life expectancy more equitable within and between Member States.

Objectives

- To take integrated action on risk factors and their underlying determinants across sectors
- To strengthen health systems for improved prevention and control of NCDs

Strategic approach

A comprehensive approach that systematically integrates policy and action to reduce inequalities in health and tackles NCDs by simultaneously:
(1) promoting population-level health promotion and disease prevention programmes;
(2) actively targeting groups and individuals at high risk; and
(3) maximizing population coverage with effective treatment and care.

Targets

Achievement of global and European targets on relative reduction of premature mortality from four NCDs of: 1.5% annually by 2020 (Health 2020); 25% by 2025 (global NCD monitoring framework); and one third by 2030 (Sustainable Development Goals) (baseline 2010).

Focus and supporting areas

Priority action areas
- Governance
- Surveillance, monitoring and evaluation, and research
- Prevention and health promotion
- Health systems

Priority interventions: population-level
- Promoting healthy consumption via fiscal and marketing policies: tobacco, alcohol, food
- Product reformulation and improvement: salt, fats and sugars
- Salt reduction
- Promoting active living and mobility
- Promoting clean air

Priority interventions: individual-level
- Cardio-metabolic risk assessment and management
- Early detection and treatment of major NCDs
- Vaccination and relevant communicable disease control

Supporting interventions
- Promoting oral health and musculoskeletal health
- Promoting mental health
- Promoting health in specific settings

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Introduction

1. The aspirational vision of the Action plan for the prevention and control of noncommunicable diseases in the WHO European Region is a health-promoting Europe free of preventable noncommunicable disease (NCD), premature death[1] and avoidable disability.

2. Can this vision be achieved? Certainly, the main causes of premature death and avoidable disability in the WHO European Region are known, as are effective interventions to prevent and control many of them. Two thirds of premature deaths in the Region are caused by four major NCDs (cardiovascular disease (CVD), diabetes, cancers and chronic respiratory disease) and by tackling major risk factors (such as tobacco and alcohol use, unhealthy diets, physical inactivity, hypertension, obesity and environmental factors), at least 80% of all heart disease, stroke and diabetes and 40% of cancer could be prevented. In Europe, some leading causes of years lived with disability (such as musculoskeletal disorders, mental disorders and dementia, injuries and oral disease) share many common risk factors and underlying determinants with the main NCDs.

3. Moreover, in the decade since the endorsement of the WHO European Strategy for the Prevention and Control of Noncommunicable Diseases *(1)*, and of the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 *(2)* five years later, the mandate for action on NCDs has been further strengthened. The United Nations high-level political declaration on NCDs in 2011 *(3)* was followed by the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and the global monitoring framework agreed at the Sixty-sixth World Health Assembly in 2013 *(4)*, and a set of time-bound commitments agreed at the second United Nations high-level meeting in 2014 for reporting by 2018. Reduction of NCD-related premature mortality is also included as a specific target within the Sustainable Development Goals and within the monitoring framework of the WHO European health policy framework, Health 2020.

4. Meeting these agreed international and regional targets for the reduction of premature mortality from NCDs in Europe could be possible on the evidence of trends described in the European health report 2015 with regard to achieving the Health 2020 target *(5)*. CVD death rates continue to decline, the clear downward trend on smoking continues and alcohol intake is steadily decreasing. Steep declines achieved in some countries provide opportunities for other countries to learn from their success. In addition, the NCD project under the new geographically dispersed office in the Russian Federation is initiating action in 23 countries and represents a major increase in capacity for the Region.

5. This overall European picture masks significant differences, however, within and between countries and population groups. Some of the global targets are at risk of not being achieved at the regional level, such as that for tobacco use, although some countries have demonstrated that the target is possible with sufficient determination. For

[1] Premature death is defined as occurring among adults aged 30–69 years.

the target related to obesity, the Regional Office for Europe estimates that the Region will fail to reach the target and this may be further hindered by slow progress on increasing physical activity. An acceleration of effort would be needed in countries with a high NCD mortality rate.

6. Furthermore, the ambition for Europe could be even greater given its vision, specificities and capabilities. With the Region still recovering from economic crisis and with an ageing population, the need for a good start in life, a healthy workforce and improved quality of life in older age is more important than ever. As premature mortality is reduced, people live longer with disabilities that often result from chronic diseases. Multimorbidity is increasingly common, with an estimated 65% of people over 65 years of age affected, requiring more complex and patient-centred care models. While an emphasis on eliminating premature mortality and morbidity is appropriate overall, the future burden on populations will be increasingly at old age. People aged 70 years or older should be ensured more disability-free years compared with generations of previous decades and the gender gap for years spent in good health should be addressed. Synergistic work between existing strategies and action plans can bring mutual benefits, supported by the overall Health 2020 strategic objectives of improving health for all and reducing inequalities, and improving leadership and participatory governance for health.

7. This Action plan for the prevention and control of noncommunicable diseases in the WHO European Region will continue and update its predecessor. First, it provides an opportunity to reiterate and re-emphasize key messages to sustain action within the European Region in an integrated way, drawing together action on governance, surveillance, prevention and health systems. Secondly, it allows a clear focus on what is needed to achieve the nine global targets within the Region, serving as a tactical and operational strategy, and could support countries in meeting their own time-bound commitments and relevant national targets. Thirdly, and in the context of Health 2020 and European specificities, disease burden and interests, it allows a European perspective in interpreting how things might be done, furthering ambition. Finally, it benefits from new insights, research and evidence. Preparation of the Action plan benefited from the expertise of a senior advisory group, technical discussions with representatives of Member States, the advice of the Twenty-third Standing Committee of the Regional Committee for Europe, new evidence on the status of NCD control in Europe and current developments in the field.

8. The vision, goal, objectives, strategic approach, guiding principles and key messages for this Action plan continue from the previous Strategy and Action Plan. These are presented in the Conceptual overview for ease of reference.

Scope

9. This Action plan is consistent with the European Strategy for the Prevention and Control of Noncommunicable Diseases and will continue to drive work that is already bearing fruit in many countries.

10. Nevertheless, there is a need to strengthen efforts on strategic issues and interventions to ensure delivery of the agreed international and regional targets on premature mortality from NCDs within the time frames. There is also a need to consider new developments in knowledge and policy. In short:

- the importance of tobacco control for the prevention of NCDs should be recognized and emphasized; and
- the leading cause of premature mortality within the European Region is CVD, which requires focusing on population-level and targeted approaches to tobacco control; reduction of consumption of salt, saturated fat and *trans* fatty acids (*trans* fats); hypertension control; and, particularly in eastern Europe, alcohol control.

11. Also, achieving the broader vision on avoidable disability, given its leading causes, will require synergies between relevant action plans and strategies and a particular focus on a broader set of risk factors and determinants, particularly unhealthy diets, physical inactivity, overweight/obesity and air pollution, as well as early detection and management of disease.

12. Given this, the pre-existing priority action areas and interventions of the Action Plan 2012–2016 have been updated, restructured, re-emphasized and expanded as needed and to address any identified gaps. The links with existing commitments and targets are identified in Annex 2 of document EUR/RC66/Inf.Doc./2.

13. In the sections that follow, four priority action areas are described. These are strategic drivers, broad in scope and closely aligned with the objectives of the Global Action Plan on NCDs and achievement of the four time-bound commitments adopted by ministers within the United Nations outcome document on NCDs in 2014 *(6)*.

14. The priority action areas are followed by eight priority interventions covering primary and secondary prevention which are structured according to population-level and individual-level interventions. These draw on “best buys” for NCD prevention and control, aiming to implement a set of cost-effective, evidence-based interventions in the European Region *(4,7)*. There follow two supporting interventions which are broader in focus and cross-cutting. All 10 of these interventions are actions for Member States that will be supported by the Regional Office for Europe, as described in the final section.

Priority action areas

Governance

15. Through Health 2020, governments can achieve real improvements in health by working across government to fulfil two linked strategic objectives: improving health for all and reducing inequalities, and improving leadership and participatory governance for health. The underlying determinants of NCDs and their shared risk factors mean that multisectoral, whole-of-government and whole-of-society responses are required to prevent and control them. NCD-related health gains frequently require the influence of public policy in sectors such as trade, taxation, agriculture, education, environment and transport. Intersectoral action can be complex and challenging but there is now knowledge and experience as to which institutional processes promote intersectoral

policy practice and two strong examples are the WHO Framework Convention on Tobacco Control (WHO FCTC) and the European Environment and Health Process *(8)*.

16. Ultimately, Health 2020 is about political choices for health *(9)*. Too frequently in the Europe of today, economic, trade and industrial considerations can appear to dominate the agenda and override health interests. Trade agreements which have been drawn up without adequate consideration of their health impact risk unravelling hard-won gains: policy coherence between trade/economic policy and nutrition/health policy is needed. Furthermore, industry is (re-)emerging as a force of opposition to progress in tobacco and alcohol control and is impeding progress in dietary improvement; in some countries, three quarters of the salt eaten is pre-added by the food industry, baby food can contain up to 30% free sugars, and saturated and *trans* fats are far too common in the European Region. Often, the health debate is framed as a matter of personal choice for individuals rather than a whole-of-society responsibility.

17. NCDs have significant negative impacts on human and social development. The adoption of the Sustainable Development Goals (SDGs) provides an imperative for mobilizing efforts to address determinants across sectors, since most of the 17 SDGs address social, economic and environmental determinants of health for which many sectors other than health have primary responsibility *(10)*. The United Nations political declaration called on WHO and all other relevant parts of the United Nations system to work together in a coordinated manner to support national efforts to prevent and control NCDs and to mitigate their impact. United Nations country teams have been asked to work with government counterparts to integrate NCDs into United Nations Development Assistance Framework design and implementation processes and are encouraged to scale up their capacities to support governments in implementing these priority actions and in establishing NCD coordination mechanisms within countries *(11)*.

Surveillance, monitoring and evaluation, and research

18. The report on progress to the third United Nations high-level meeting on NCDs in 2018 will monitor whether Member States have a functioning system for generating reliable cause-specific mortality data on a routine basis, and check that Member States have an integrated risk factors WHO STEPS survey or comprehensive health examination survey every five years. WHO STEPS surveys are planned for 11 Member States during 2016–2017, including among the highest NCD-burden countries. NCD surveillance and monitoring should be built into national health information systems and, for many countries, fit-for-purpose data systems need to be established. Harmonization of surveillance within European Union countries is under way, for example, through the European Health Examination Survey initiative. Specific risk factors surveys are being expanded and strengthened across Europe: at least 25 countries across the Region participate in the WHO European Childhood Surveillance Initiative.

19. The NCD global monitoring framework and Health 2020 track a number of targets and indicators, some of which are common to both. The European health report 2015 has highlighted shortcomings in measuring well-being, and health systems frequently do not monitor what really matters to patients, such as patient-reported

outcome measures. Measures of healthy life expectancy, or disability-free years, are likely to be particularly useful in an ageing Europe but health information systems may not adequately capture the causes of disability or related data. The European Health Information Initiative is committed to improving the information that underpins policy through a single system. Better harmonization of indicators and case definitions are needed, and are likely to benefit from further collaboration between the Regional Office and the European Union. The disaggregation of data, at least by sex and age, should be strengthened to highlight changing trends and inequalities between and across groups and to support coordinated action.

20. Innovations in data collection, including new analytic and predictive techniques, need to be harnessed. Many new sources of data have been generated by the revolution in information technology with potential use in understanding population health determinants, notwithstanding issues of data quality, security and information governance. Implementation of electronic health records may support the quality of health management along the continuum of care in health systems and facilitate performance monitoring.

21. The timely collection and use of data such as health care quality indicators can help drive improvement. For targets related to disease management and health services, there is little substantial evidence to set a baseline with confidence. Striking variations in NCD health care and its costs have been highlighted within and between countries, for example, in the probability of being hospitalized with diabetes or of surviving a heart attack *(12).* Such variations also exist among socioeconomic groups: differences between men and women in the probability of surviving a heart attack illustrate the importance of looking at gender norms and values and gender bias in health systems.

22. Evaluation and implementation research with dissemination of findings can maximize learning. Evidence can be unclear and confusing for policy-makers and better connections between experts and policy-makers could ensure that findings are accessible. To be effective, a comprehensive NCD surveillance will need to overcome the challenge of integrating and analysing information from sources beyond the traditional disease and risk factors and of communicating key issues to policy-makers in a more user-friendly, actionable way.

Prevention and health promotion

23. Common behavioural risk factors (tobacco and alcohol use, unhealthy diets, and physical inactivity) remain the predominant entry point. Upstream measures work, and there is an economic evidence base for investment in effective policies that reduce risk factors in the population *(13)*. This would benefit the four main diseases (CVD, diabetes, chronic respiratory disease and cancer) targeted in the Global Action Plan on NCDs as well as other noncommunicable conditions of particular concern in the European Region in terms of disease burden and quality of life, such as mental health disorders, musculoskeletal conditions and oral health, and violence and injuries.

24. Much more can be done to reduce major risk factors in the European Region. Although certain risk factors are trending in the right direction (tobacco and alcohol), the trends are uneven (by gender or socioeconomic group, for example) or too slow on a

regional basis to achieve the relevant targets. Alcohol is the leading risk factor for the disease burden in eastern Europe, associated with alarming injury and violence rates and fluctuations in CVD mortality, and the European Region overall leads in harmful drinking globally, particularly among youth. In addition, nearly three quarters of young people do not reach WHO recommendations for physical activity. Projections for prevalence of overweight and obesity are a concern in both children and adults, with a worrying pace of increase in southern and eastern Europe in particular, while the marketing of energy dense foods, rich in salt, sugar and saturated fats, is widespread. Behavioural risk factors disproportionately affect people with mental health problems. Frequently, tobacco use is highest, and tobacco control poorest, among the lower-income countries of the Region; tobacco use is highest among those of lowest income within all countries. All four risk factors are covered by recent strategies and plans adopted by the Regional Committee for Europe *(14–17)*: implementation and ongoing evaluation are key.

25. New insights have emerged on the contribution of social, economic, gender and environmental determinants to the development and disease course of NCDs *(18,19)*. These influences start even prior to conception, and extend from early life and through the life-course. Factors such as a body mass index above 25 kg/m^2 and smoking in late pregnancy are strongly related to the risk that infants will be overweight or obese as older children. Children who suffer adverse childhood experiences, such as child maltreatment, are three times more likely to be smokers, 10 times more likely to be problem drinkers and less likely to be physically active, for instance, putting them at risk of becoming overweight or obese or of developing cancer, heart disease and chronic respiratory disease in later life *(20,21)*. Enabling more people to lead active and healthy lives will allow them to remain active in society longer and will limit the strain on health and social care systems. It requires investment in a broad range of policies across the life-course and better prevention and management of NCDs at earlier stages of life, starting even in the preconception period and during pregnancy. One fifth of all deaths in the European Region, particularly from cardiovascular and respiratory diseases and cancers, are attributable to environmental exposures, such as air pollution, and chemical and physical agents *(22)*. The SDGs represent a new entry point for promoting health in all policies but this will require further political commitment and action.

Health systems

26. Ensuring an adequate level of public financing for health systems is essential for progress towards universal health coverage but this fluctuated or fell for many European countries from 2010 to 2013 both as a share of gross domestic product and per person, while on average out-of-pocket expenditure as a proportion of total expenditure on health remained unchanged. The main driver of out-of-pocket expenditure is usually medicines, and in many European health systems, weak pharmaceutical policies and inappropriate use of medicines are leading causes of inefficiency. Furthermore, the emergence of high-cost, high-impact treatments means that even affluent countries have to strategize how to handle non-sustainable escalating costs and resulting disparities.

27. A people-centred health system has been described as one that provides high-quality, comprehensive and coordinated services in an equitable manner, and involves people as partners in decision-making *(23)*. The expectations of patients are changing

and they expect health services to be delivered in more convenient and value-driven ways. The chronic and long-term nature of many noncommunicable diseases and conditions, the multiple morbidities and risk factors carried by individuals, and the increasing number of data points required to make clinical decisions, needing real-time integration, present particular challenges. Furthermore, as countries with high life expectancy increasingly feel the challenge of old age with multimorbidities, a move towards more integrated medical and social care is needed. The European Union-funded Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle has a specific focus on multimorbidity and identifying appropriate care models.

28. There is increasing recognition that both population-level interventions and improvements in health care are likely to be major contributors to the declining mortality rates in many countries *(24)*. Such care takes place in different settings, including the home, and needs integrated health services delivery: this is in line with the needs of the people and the populations served, ensuring that the processes of selecting, designing, organizing, managing and improving services optimize its performance *(25)*. It is supported by broader health systems functions and requires health literacy of the population, new ways of training, deploying and managing the health workforce *(26)*, better management and appropriate use of medicines, health technologies that are affordable and of assured quality, and stronger health information. Action on NCDs will be supported by strengthened public health capacities and services *(27)*. The health sector provides an opportunity for health promotion and disease prevention but this requires staff to be trained in NCD prevention.

29. By early 2016, 12 countries had been assessed for health systems barriers and opportunities for achieving better NCD outcomes and follow-up had been initiated. These indicate a need for transformative action. Issues highlighted include attention to the needs of working-age men who are largely excluded (or self-excluded) from effective clinical prevention and a scale-up of the total risk approach to cardiovascular and diabetes management.

Priority interventions (population-level)

Promoting healthy consumption via fiscal and marketing policies

Goal

30. To use fiscal policies and marketing controls to full effect to influence demand, access and affordability for tobacco, alcohol and foods and drinks high in saturated fats, *trans* fats, salt and sugar.

Rationale

31. Powerful instruments such as the WHO FCTC and the 2014 European Union Tobacco Products Directive are not being used to their full potential and, within Europe, there is a relatively low level of implementation overall, with few countries doing so comprehensively. Nevertheless, there are successful examples to be shared such as on plain packaging. Policies can reduce alcohol use, with the greatest gains for younger and heavier drinkers and those exposed to the heavy drinking of others *(28)*. The impact

of marketing, including online social media, on the use of alcohol should be fully recognized, particularly for young people, and systems for managing alcohol marketing such as regulatory frameworks can reduce exposure for the benefit of public health. Voluntary agreements are often ineffective and regulation or legislation is often needed *(29)*. Through skilful and successful marketing and modifying product design features, the tobacco and alcohol industries have created a fast growing market for female and underage smokers and drinkers *(30)*. Pervasive marketing to children and adolescents of food and drinks high in energy, saturated fats, *trans* fats, sugar and/or salt, twinned with increasing their availability and affordability, contribute to malnutrition and the rising levels of overweight and obesity. Initiatives to promote the availability and affordability of fruits and vegetables or whole grain products are needed. Beverages containing alcohol also contribute to total energy intake and weight gain. Combinations of actions, for example, in the areas of tobacco and alcohol control or which address several issues simultaneously, are often more cost effective than relying on one action alone. Nevertheless, the levying of taxes to influence individual choices on tobacco and alcohol use, as well as the consumption of food, is consistently seen as a cost-effective intervention to promote better behavioural choices *(13)*. If earmarked, such tax income could be used to finance public health programmes.

Actions

32. Actions in this area that cross-reference with existing action plans include:

- ratify the WHO FCTC, if not already done, and strengthen its implementation in a comprehensive way, including establishing long-term, coherent tax policies that monitor, increase or adjust tax rates on all tobacco products on a regular basis, and undertake a comprehensive ban on all tobacco advertising, promotion and sponsorship *(14)*;
- as part of a comprehensive approach to alcohol control, countries should have pricing policies to reduce the affordability of alcohol and systems to prevent inappropriate and irresponsible advertising and marketing that targets children and young people *(17)* in place; and
- adopt strong measures that reduce the overall impact on children and adults of all forms of marketing (including online) of foods high in energy, saturated fats, *trans* fats, free sugars and/or salt *(31)*, and consider and implement a range of economic tools that could discourage the consumption of such foods and improve the affordability and availability of a healthy diet, including, where appropriate, taxes on sugar-sweetened beverages *(16)*.

Product reformulation and improvement: salt, fats and sugars

Goal

33. To reformulate food products so that *trans* fats and saturated fats are replaced with unsaturated fats, and salt and sugar are reduced, without adding harmful alternatives.

Rationale

34. Excess intake of saturated fat (> 10% total energy intake) has been associated with increased risk of CVD. In many countries, a large majority of the population do not meet targets for saturated fats and *trans* fats, particularly those of low socioeconomic status. Increased intake of *trans* fats contributes to unfavourable lipid and lipoprotein profiles and increases the risk of CVD incidence and mortality more than any other source of dietary energy. Experience from countries in the European Region show that measures directed along the food supply chain, particularly at producers, processors, retailers and caterers, can bring about significant reductions in target nutrients in the full range of products, contributing to reductions in population-level consumption. Phasing *trans* fats out of food supplies through statutory limits is feasible but needs to avoid a concomitant increase in saturated fats in food products. Reformulation of food products to remove saturated fats, without substitution for refined carbohydrates such as sugar, would bring additional benefits.

35. Consumption of sugar, usually found in manufactured products, such as sugar-sweetened beverages, is linked with weight gain and a higher risk of overweight/obesity, as well as the risk of dental caries. It may also increase the risk of developing type 2 diabetes. WHO recommends that intake of free sugars should not exceed 10% of total energy intake, and suggests that a further reduction of the intake of free sugars to below 5% of total energy intake would have additional health benefits *(32)*. Apart from the fiscal and marketing policies referred to above, targeting foods and beverages that are high in free sugars and reducing their intake can be achieved through a range of public health interventions, such as food and nutrition labelling, consumer education and the development of a strategy to reformulate food products, in particular, processed foods that are high in free sugars.

36. Processed foods are a major source of salt in the diet. Product reformulation is one component of a salt reduction strategy, which is covered in more detail in the next section.

Actions

37. Actions in this area that cross-reference with existing WHO action plans include:

- develop and implement national policies to balance saturated and unsaturated fats within food products, and ban (or virtually eliminate) *trans* fats from the food supply, within the context of improvements to overall nutritional quality of food products *(16)*;
- explore opportunities and take concrete action such as regulatory measures to advance the reduction of free sugars in processed foods and beverages; and
- mainstream product improvement and reformulation supported by improvement in interpretative front-of-pack labelling.

Salt reduction

Goal

38. To reduce salt intake in the diet in line with WHO guidance.

Rationale

39. Increased salt/sodium intake is associated with increased blood pressure; sodium reduction is associated with decreases in CVD risk. Yet many countries far exceed the WHO recommendation of less than 5 grams of salt (2000 milligrams of sodium) per day, and the goal of a 30% reduction of intake by 2025 constitutes a major challenge. Globally, the absolute rate of CVD mortality attributable to sodium consumption of more than 2 grams daily was highest in central Asia and eastern and central Europe, approximately five times the rate in western Europe for adults under 70 years *(33)*. Reducing salt intake in communities is possible and is one of the most cost-effective and affordable public health interventions. Integrated salt reduction programmes can have a strong impact: their success depends on monitoring, stakeholder engagement and government leadership in establishing benchmarks and targets. Other population-level public health measures such as salt fluoridation for prevention of dental caries or iodization of salt to prevent iodine-deficiency disorders do not conflict with salt reduction measures. Policies are compatible but as sodium intake decreases, iodization levels in salt may require adjustment to ensure that the most vulnerable, such as pregnant women, infants and young children, receive the iodine they need.

Actions

40. Actions in this area that cross-reference with existing action plans include:

- develop, extend and evaluate salt reduction strategies to continue progress across food product categories and market segments *(16)*.

Promoting active living and mobility

Goal

41. To promote increased physical activity and reduced sedentary behaviour through health system and environmental modifications.

Rationale

42. Physical activity has positive effects on mental health, and promotes lung health and musculoskeletal health throughout life. It also reduces risk of CVD, diabetes, certain cancers and memory disorders, and has an important role in management of chronic conditions and weight control. A higher level of physical activity is likely to provide additional health benefits both for adults and for children and can be promoted through a range of settings and across the lifespan. Mobility is essential to physical function and independence. Lack of exercise is thought to be a significant risk factor for sarcopenia and osteoporosis, and promotion of physical activity among older people can maintain health, agility and functional independence and contribute to falls prevention. Nevertheless, levels of physical activity, use of public transport and road safety are

determined by gender norms, roles and values. The poor physical health frequently found among people with mental health disorders is due in part to behavioural risk factors, such as smoking, physical inactivity, poor diet and alcohol use.

43. Certain health conditions, such as musculoskeletal or respiratory, can limit physical activity and exercise. The value of exercise-based cardiac rehabilitation programmes has already been mentioned (see Priority interventions). Exercise-based rehabilitation is also an important component of the management of chronic obstructive pulmonary disease (COPD), heart failure and musculoskeletal conditions, and is beneficial in improving health-related quality of life and exercise capacity and reduces the risk of hospital admissions.

44. Increasing physical activity as part of daily life means redesigning home, kindergarten, school, workplace and community environments to facilitate healthy behaviour, particularly walking and cycling for transport. Public spaces and neighbourhoods favourable to physical activity, as well as policies to improve road safety, and the availability, affordability and attractiveness of public transport, are more likely to lead to active mobility.

Actions

45. Proposed actions include:

- maximize exercise-based rehabilitation programmes for those conditions that will benefit from them; and
- ensure that physical activity interventions take into consideration the specific needs and opportunities of different groups across their lives.

46. Actions in this area that cross-reference with existing action plans include:

- integrate physical activity into prevention, treatment and rehabilitation, and enable people with limitations to mobility to maximize their physical activity and reach their potential *(15)*;
- lifestyle modification in education and treatment programmes for people with mental health problems *(34)*;
- provide advice about physical activity in all health and social care settings for older people *(35)*;
- improve access to physical activity facilities and offers, particularly for vulnerable groups *(15)*;
- provide children with access to safe environments that promote walking and cycling to kindergartens and schools, and in which to play and undertake daily physical activity *(34,36,37)*;
- promote increased physical activity of older people and persons with disabilities through community environments and social activities and provide living spaces and neighbourhoods that facilitate their mobility and autonomy *(34,35)*; and
- promote physical activity at all ages, to be facilitated through the planning and design of appropriate settlements, housing, health care institutions, mobility plans and transport infrastructure *(36)*.

Promoting clean air

Goal

47. Promoting clean air by reducing outdoor and indoor air pollution will assist in addressing NCDs, including CVD, chronic and acute respiratory disease, and cancers.

Rationale

48. Air pollution is the single most important environmental health risk in the European Region and it contributes to the burden of disease from stroke, heart disease, lung cancer and both chronic and acute respiratory diseases, including asthma. An estimated 80% of outdoor air pollution-related premature deaths were due to ischaemic heart disease and strokes, while 14% of deaths were due to COPD or acute lower respiratory infections; and 6% of deaths were due to lung cancer. More than 80% of the population (in countries for which air quality data is available) is exposed annually to levels of particulate matter above the WHO air quality guidelines. In addition to outdoor air pollution, indoor smoke from tobacco and cooking stoves using biomass fuels and coal, as well as exposure to dampness and mould-related problems, are serious health risks. Most outdoor air pollution is beyond the control of individuals and the health sector alone and requires action by municipality, national and international policy-makers in sectors such as transport, industry, power generation, waste management, buildings and agriculture. Cleaner transport and heating, energy-efficient housing, urban planning and better municipal waste management are examples of policies and investments that would reduce key sources of outdoor air pollution. Reducing emissions from household coal and biomass energy systems, as well as environmental exposure to tobacco smoke, will reduce indoor air pollution. Interventions to reduce air pollution frequently have co-benefits for reducing exposure to other NCD risk factors, such as promoting modes of active transport, including walking and cycling.

Actions

49. Actions in this area that cross-reference with existing action plans, resolutions and conventions, requiring a strong stewardship role of the health sector in working across different sectors and levels of government, include:

- support the regional implementation of World Health Assembly resolution WHA68.8 on health and the environment, addressing the health impact of air pollution;
- continue and enhance efforts to promote the ratification and implementation of the 1979 Geneva Convention on Long-range Transboundary Air Pollution;
- develop appropriate policies that prevent and reduce tobacco consumption, exposure to tobacco smoke and nicotine addiction, with particular attention to young people, non-smokers and vulnerable groups *(14,37)*;
- continue and enhance efforts to decrease and monitor the incidence of acute and chronic respiratory diseases through reduction of exposure to particulate matter and its precursors, especially from industry, transport and domestic combustion, as well as ground-level ozone and other gaseous pollutants, in line with WHO's air quality guidelines *(36)*; and

- develop appropriate cross-sectoral policies and regulations capable of making a strategic difference in order to reduce indoor pollution, and provide incentives and opportunities to ensure that citizens have access to sustainable, clean and healthy energy solutions in homes and public places *(36)*.

Priority interventions (individual-level)

Cardio-metabolic risk assessment and management

Goal

50. To assess and lower absolute cardio-metabolic risk.

Rationale

51. There is scope for vast improvement in the detection and control of raised blood pressure and other risk factors in Europe: for example, health examination surveys show that only a fraction of those identified at high risk in the general population had been diagnosed and were being treated and/or well controlled. Multiple risk factors, such as tobacco use, high cholesterol and raised blood pressure, contribute to the atherosclerosis that causes CVD; and these risk factors interact, sometimes multiplicatively. Recent WHO STEPS surveys found that around one third of men and women have three or more risk factors. Emphasis should be placed on overall assessment of a number of risk factors for heart disease and stroke, rather than a single one, and the aim should be to reduce total risk. Those with known CVD (for example, following a heart attack or stroke), diabetes or impaired renal function or very high levels of individual risk factors are already at increased CVD risk and require management of all risk factors. For all other people, risk charts can be used to estimate total risk so that the focus for treatment is on those with high levels of total CVD risk rather than on those with mildly raised individual risk factors; apart from seeking to avoid "over-medicalization" of the population, this can also be a more efficient use of limited resources. In addition to identifying those at increased total risk, risk charts can serve as a communication tool to support patient understanding and adherence to risk management advice and treatment. Such a strategy can be largely based in primary health care. Opportunistic screening of individuals for risk factors when presenting in primary care is likely to be a more effective use of health service resources than general health check programmes *(38)*, although such a strategy needs to consider how best to engage those less likely to present routinely, such as the often "hidden men".

52. Cardiac rehabilitation programmes aid recovery from cardiac events such as heart attacks improve quality of life and reduce the likelihood of further illness *(39)*. Nevertheless, there is increasing evidence that even those already known to be at increased CVD risk are not being adequately followed up: only half of coronary patients receive advice to participate in a secondary prevention and/or rehabilitation programme, for instance, and risk factor control is often inadequate *(40)*. Optimal management of vascular risk factors may be even less likely for those recovering from a stroke but stroke rehabilitation programmes help to improve quality of life for stroke survivors. Nurses and allied health professionals and patient associations have a valuable

contribution to make in secondary prevention and rehabilitation, involving families in home-based care programmes.

Actions

53. Proposed actions include:

- strengthen the capacity of primary health care to prevent, assess and manage cardio-metabolic risk, including clinical guidelines, capacity-building, monitoring and evaluation, and patient-centred approaches;
- increase coverage and quality of cardio-metabolic management following assessment so that those found to have a total CVD risk above threshold receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes; and
- improve the quality and coverage of secondary prevention and rehabilitation following heart attacks and strokes.

54. Actions in this area that cross-reference with existing action plans include:

- establish sustainable, evidence-based, accredited tobacco cessation services and systems, with cost coverage; incorporate brief advice on tobacco cessation at all points throughout the health-care system; promote the integration of tobacco cessation treatment and smoking prevention in the training of all health professionals; provide targeted support for specific groups, including pregnant women, parents of young children, people with mental health conditions and patients with cardiac and respiratory disorders *(14)*;
- put in place appropriate systems, and provider training, so that early identification and brief advice programmes can be offered to at least 30% of the population at risk of hazardous or harmful alcohol consumption, including those who consult a provider about particular disease categories, such as hypertension *(17)*;
- reinforce health systems to promote healthy diets: improve capacity and training for primary health-care professionals on appropriate nutrition counselling and weight monitoring and management; improve capacity and training for professionals in nutrition and deliver high-quality nutrition services in health-care settings; promote healthy meals in health and social care institutions *(16)*; and
- integrate physical activity into prevention, treatment and rehabilitation: work towards making the promotion of physical activity by health professionals the norm, integrated into standard practice and a core competence for primary health-care professionals, and consider incentives and reimbursement of physical activity-based prevention or rehabilitation programmes by health insurance companies, where appropriate *(15)*.

Early detection and effective treatment of major NCDs

Goal

55. To reduce mortality from cervical, breast and colorectal cancers, and reduce the disease burden from other noncommunicable diseases and conditions.

Rationale

56. Many conditions fail to be detected early enough for effective treatment: 30–40% of cancer in eastern Europe is metastatic at diagnosis. Early detection of some cancers is possible either through raising awareness of the early signs and symptoms of disease among the general public and professionals, so that prompt referral for diagnosis and treatment can take place, and/or screening of asymptomatic individuals to detect pre-cancerous lesions or an early stage of cancer and referral for diagnosis and treatment. To minimize harm and increase effectiveness, cancer screening should take place where evidence of effectiveness exists, and within population-based, organized screening programmes with strong quality assurance mechanisms. There has been a proliferation of screening programmes, not all evidence-based, which can consume resources without changing population health outcomes. Additionally, commercial companies may promote screening tests of questionable value through direct-to-consumer marketing.

57. If resources and health systems are limited, and most cancers amenable to early detection are diagnosed in late stages, the establishment of an early diagnosis (rather than screening) programme may be the most feasible strategy to improve survival rates. Either way, early detection programmes should be supported with a range of provisions, including effective diagnostic and treatment pathways and monitoring and surveillance with population-based disease registries. There is no real value in screening and early detection, however, if diagnostic or treatment options are unavailable. WHO calls for at least 80% access to essential medicines by 2025 and concrete actions are needed, such as national diagnostic and treatment guidelines that are tailored to country resources and ensure equity of access to the highest national standards for all citizens.

58. Early recognition of the symptoms and signs of a heart attack or stroke and timely delivery of care along a critical pathway (the “chain of survival” or “chain of recovery”) can make a significant difference to outcomes. Partnerships between patient and professional associations, providers and planners of care and other relevant parties are crucial in a pre-hospital setting to define pathways and shorten the time between an episode and admission in a stroke unit or coronary unit. In stroke, where the patient is unable to alert, awareness campaigns are especially important for the recognition of symptoms. Involvement of emergency medical systems, with a public and known telephone number, is critical to achieve a short delivery to early advanced, evidence-based care such as thrombolysis, thrombectomy or percutaneous coronary intervention. Coordinated, multidisciplinary care in assessment, management and early rehabilitation can reduce mortality and prevent or limit disability.

59. Other noncommunicable diseases and conditions, such as diabetes mellitus, chronic respiratory disease and many musculoskeletal disorders, can also benefit from early detection and treatment in order to reduce morbidity, promote quality of life and reduce more costly care at later stages. For example, individuals identified as being at high risk of developing type 2 diabetes can be offered a quality-assured, evidence-based, intensive lifestyle-change programme to prevent or delay the onset of type 2 diabetes. Implementing a minimum set of essential NCD interventions, such as those within the WHO Package of Essential NCD interventions (WHO PEN) *(41)*, with appropriate referral, preventive, diagnostic and treatment pathways and access to essential medicines and technologies, can assist countries initiating universal health coverage reform and support health equity.

Actions

60. Proposed actions include:

- raise awareness of the risk factors, early signs and symptoms of cancer, diabetes and other major NCDs among health professionals and the general public, increase clinical competencies in early diagnosis and management, and have in place effective and rapid referral, diagnostic and treatment pathways for management of those detected;
- implement, where appropriate and evidence-based, population-based, organized and quality-assured screening programmes for cervical, breast and colorectal cancers according to the country context and where health systems can support effective outcomes;
- assess public and private facilities within primary care systems and, where necessary, improve the availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs;
- support the implementation of at least a minimum set of essential NCD interventions in primary care to increase coverage and equitability of basic care;
- promote early recognition of symptoms and signs of a heart attack or stroke in men and women and timely delivery of care along a critical pathway (the "chain of survival" or "chain of recovery"); and
- implement coordinated, multidisciplinary care in assessment, early management and early rehabilitation of heart attacks, strokes and other conditions, such as musculoskeletal, that would benefit from such care.

61. Actions in this area that cross-reference with existing action plans include:

- ensure provision in European health systems for the care of children and adolescents with chronic, long-term illness *(37)*; and
- improve access of people with mental disorders to physical health services such as CVD, diabetes, cancer and dental care such that the quality of the physical health care they receive is equal to that of the general population *(34)*.

Vaccination and relevant communicable disease control

Goal

62. To promote vaccination and relevant communicable disease control to prevent development of NCDs and/or their exacerbation, where the context and resources allow.

Rationale

63. Although commonly referred to as "noncommunicable" diseases, a number of this group of diseases originate from and/or are exacerbated by an infection or complicate treatment, which has implications for response. There are some shared causal pathways, such as undernutrition and poor sanitation; shared risk factors, such as tobacco, alcohol and poverty for NCDs and tuberculosis; and shared causative agents, such as untreated infections linked to cancers and some CVDs, for example, streptococcal disease and

rheumatic valvular disease. Several conditions, communicable and noncommunicable, can coexist in one person, which has consequences for health management. The presence of one condition can increase the likelihood of developing another condition, for example, alcohol use, smoking and diabetes each increase the risk of tuberculosis. The treatment of one condition can increase the risk for developing another condition, for example, antiretroviral therapy for HIV can increase the risk of developing metabolic syndrome. The presence of one condition can worsen the outcome of another, for example, comorbidity of tuberculosis and diabetes can worsen outcomes for both diseases *(42)*, and tobacco and alcohol use can impact negatively on HIV and/or tuberculosis treatment outcomes.

64. Some vaccine-preventable conditions are associated with the development of NCDs: the primary cause of cervical cancer is persistent or chronic infection with one or more of the high-risk (or oncogenic) types of human papilloma virus (HPV), a sexually transmitted infection; maternal rubella can lead to congenital heart disease in the infant; and, in some people, chronic infection with hepatitis B virus leads to cirrhosis and liver cancer. Vaccination is an effective public health intervention and, in recent years, significant progress has been achieved in protecting young children against hepatitis B through their life-course by implementing universal newborn or infant hepatitis B vaccination. Advances have also been made in developing and introducing new vaccines and in expanding the reach of existing immunization programmes. As part of a more comprehensive approach to cervical cancer prevention and control, HPV vaccination plays an important role in protecting adolescent girls and young women. There is also some evidence that influenza vaccine reduces exacerbations in COPD patients *(43)* and that pneumococcal vaccine for patients with some chronic lung conditions may be beneficial.

Actions

65. Proposed actions include:

- assess and maximize the opportunities for NCD prevention and control from communicable disease control programmes.

66. Actions in this area that cross-reference with existing action plans include:

- implement national immunization schedules, including for older people *(35,37)*;
- control hepatitis B infection *(43)*;
- make evidence-based decisions on the introduction of new vaccines: for example, when considering the introduction of HPV immunization programmes and immunization programmes for patients with chronic conditions *(44)*; and
- implement collaborative frameworks and mechanisms for the integrated management of NCDs and the most relevant communicable diseases, for example, the most frequently occurring conditions associated with tuberculosis, such as diabetes mellitus, alcohol and drug disorders, and smoking *(45)*.

Supporting interventions

Promoting oral health and musculoskeletal health

Goal

67. Promoting good oral and musculoskeletal health.

Rationale

68. Oral diseases are the most prevalent NCDs among children and adults in the European Region. Disease conditions such as dental caries, periodontal (gum) disease, tooth loss, oral cavity cancers and HIV/AIDS-related oral disease are major public health problems. Mouth pain and tooth-related problems with eating, chewing, smiling and communication have a major impact on people's health and well-being, restricting access to a healthy diet for example. Oral diseases are linked with other NCDs, such as CVDs and diabetes, and share common modifiable risk factors with them, for example, the consumption of sugary foods and drinks, and tobacco and alcohol use. Across Europe, a high relative risk of oral disease is related to socioeconomic determinants and gender. Control of oral disease depends on the availability and accessibility of oral health systems but services need to be financially fair and integrated with primary health care and prevention to reduce the risks of disease. The social inequities in use of oral health services by children, adults and older people are profound in all countries of the Region. Dental health practitioners can play a role in early detection of oral cancer and HIV/AIDS, advising on healthy diet, alcohol consumption and tobacco prevention *(46)*.

69. Musculoskeletal conditions are the greatest cause of disability in the European Region. They affect all ages. They are a major cause of worklessness and, in older ages, loss of independence. Good musculoskeletal health is a prerequisite for mobility, economic independence and active healthy ageing. It is an important contributor to the prevention of NCDs given the importance of physical activity. Musculoskeletal health is impaired by conditions such as arthritis, low back and neck pain, osteoporosis and fragility fractures, and injuries due to occupation and sports. Risk factors for musculoskeletal health are similar to other NCDs and musculoskeletal health can be promoted by their modification, in particular increased physical activity, ideal body weight, smoking cessation and moderate use of alcohol along with injury prevention. Control of musculoskeletal diseases and prevention of disability depends on availability and timely access to musculoskeletal health systems to enable early intervention and rehabilitation. Services need to be person-centred, integrated across the health community, and orientated towards enabling people to self-manage their musculoskeletal conditions and towards reducing the medicalization of common problems.

Actions

70. Actions in this area could support a number of current action plans but specific actions related to oral or musculoskeletal health are rarely mentioned. Given the importance of good oral or musculoskeletal health to achieving good overall health throughout the life-course or mitigating the negative impact of inadequate physical

activity, tobacco, alcohol, unhealthy diets and sugar-carbonated drinks on oral health, there is an opportunity to address this gap. Examples of relevant actions include:

- promote oral health by improving diet and reducing sugar intake; implementing automatic fluoridation (water, salt, milk) and optimizing use of fluoride-containing toothpaste; improving oral hygiene; tobacco and alcohol control; and preventing oral-facial injuries through safe environments and safe sport;
- promote musculoskeletal health at all ages to improve physical function by increasing physical activity, reducing obesity and avoiding injuries;
- improve oral and musculoskeletal health across the life-course by supporting children and adolescents through their families and peer groups and promoting oral and musculoskeletal health through preschool and school health programmes; integrating oral and musculoskeletal health with health promotion and occupational health in the workplace; introducing systematic oral and musculoskeletal health programmes for older people, including those living in residential care; protecting the oral health of vulnerable people such as those in poor and marginalized populations, for example, homeless people and refugee groups, people with disabilities, and populations at higher risk such as pregnant women and those living in long-term institutional care settings, for example, prisons and psychiatric hospitals;
- build oral health systems that are focused on disease prevention and health promotion; establish financially fair oral health care; and organize public health and primary care services to improve oral health outcomes equitably;
- build musculoskeletal health systems that allow timely access to person-centred care of musculoskeletal conditions, focusing on early intervention to restore and maintain function, and that enable people to self-manage their musculoskeletal conditions; and increase awareness of what can be achieved; and
- strengthen surveillance; and develop a skilled and diverse workforce relevant to oral and musculoskeletal health.

Promoting mental health

Goal

71. To promote mental health to reduce the onset or exacerbation of NCDs.

Rationale

72. Mental health is important for effective NCD prevention and management because it interacts with physical health in many ways and is a common comorbidity. It has a considerable impact on risk factors, particularly risk behaviours, and mortality from NCDs is two to three times higher in those people with mental health disorders than those without. Chronic stress, loneliness or social isolation increases the risk of a first coronary heart disease event. Short-term emotional stress can trigger cardiac events among individuals with advanced atherosclerosis and long-term stress can increase the risk of recurrent coronary heart disease events and mortality among those with existing disease. There is also evidence that psychological stress contributes to exacerbations of asthma and, in people with type 2 diabetes, often raises blood glucose levels.

73. Understanding stress as a risk factor and the use of stress management in clinical settings have been relatively limited. Management of psychosocial risk factors has been recommended as part of a multimodal and patient-centred approach to CVD prevention in clinical practice *(50)*. Given that half of mental health disorders start before the age of 14 years, their prevention must be targeted to include childhood. There are also potential health gains for emotional well-being from a common risk factor approach to NCD prevention, for example, in relation to dementia risk *(51)*.

Actions

74. Actions in this area are covered in-depth within the pre-existing European action plans on mental health *(34)* and child maltreatment *(21)*, and are highlighted within other sections of this Action plan, such as those on cardio-metabolic risk assessment and management, active living and mobility, and settings.

Promoting health in specific settings

Goal

75. To improve health and well-being by making specific settings more supportive of health.

Rationale

76. Cost-effective health promoting interventions can be delivered universally, as well as to target population groups, such as through schools and workplaces *(13)*. Interventions using a health-promoting school approach can produce improvements in certain areas of health, for example, physical activity and fitness levels, fruit and vegetable consumption, and tobacco use *(47)*. Some interventions may take a long time to be seen to be cost effective, such as those impacting on the risk of obesity; however, others are most cost effective in the short term, such as mental health protection in the workplace. Such interventions should be gender responsive. There are a range of settings in which health supportive interventions could be delivered, including dwellings, kindergartens, institutions such as social care homes or prisons, and universities.

77. People with a chronic disease or following an acute event, such as hospitalization for acute exacerbation of chronic respiratory disease, heart attack or stroke, may need support to remain in or return to school or work. Musculoskeletal disorders are the most common cause of sick leave and disability in many industrial countries, and workplace interventions can reduce the time away from work and improve pain and functional status *(48)*. Alcohol use has a significant negative effect on productivity, the working environment, and occupational health and safety. Multidisciplinary interventions involving physical, psychoeducational and vocational components lead to more cancer patients returning to work than those in typical care settings *(49)*.

Actions

78. Actions in this area that cross-reference with existing action plans include:

- support people affected by or living with NCDs with opportunities to learn and work despite these conditions, and to return to and remain in educational or workplace settings; and
- implement existing mandates and commitments to healthier environments to reduce exposure to agents that increase the risk of NCDs (such as radon, ultraviolet radiation, noise, asbestos and climate change) and act on identified risk of exposure *(36)*.

79. Actions for schools and other educational settings include:

- link to the Schools for Health in Europe network as an opportunity to promote healthy behaviours and to create a healthy environment;
- set standards for food and drinks available in school settings, and ensure that schools and other settings in which children gather should be free from the availability and marketing of food and drinks high in energy, saturated fats, *trans* fats, sugar or salt *(16)*; and
- establish schools and other educational settings that are tobacco- and alcohol-free, where children enjoy smoke-free environments in childcare facilities, kindergartens, schools and public recreational settings, through implementation of WHO's indoor air quality guidelines *(14,17,36,37)*; and
- consider including physical activity in the core lessons of school curricula.

80. Actions for workplaces include:

- develop policy, legislation and governance tools targeting occupational and work-related NCDs, and which prevent discrimination against people with NCDs, and ensure employers' compliance with relevant rules and regulations;
- stimulate the development of comprehensive workplace health programmes by providing regulatory and financial incentives, social marketing, monitoring, dissemination of information and exchange of experience;
- create incentives for employers to reduce psychological and job-related stress, enhance stress management, and introduce easy-to-implement programmes to promote well-being in the workplace *(34)*;
- promote healthy food in workplace canteens, and implement strict alcohol and tobacco policies for the workplace with monitoring and evaluation; and
- provide opportunities and counselling for physical activity at the workplace, including considering appropriate measures to enable more physical activity during the working day and active transport to and from work *(15)*; and
- protect, promote and support breastfeeding in the workplace.

Role of the Regional Office for Europe

Leadership and advocacy

81. The Regional Office for Europe will continue to play a leading role in coordinating a regional response to the particular challenges of NCDs in the Region, both through this Action plan and related global and regional strategies and action plans, which together make up a coherent and robust approach. The Regional Office will work closely with WHO headquarters to support the regional implementation of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. The Regional Office will continue its close collaboration with the European Commission and will liaise with appropriate intergovernmental agencies, such as the United Nations Development Programme, United Nations Economic Commission for Europe, the United Nations Environment Programme and the World Bank, to seek inclusion of NCDs in relevant social, environmental and economic development agendas, and particularly within United Nations Development Assistance Frameworks.

Capacity-building

82. The Regional Office will support government bodies at the national and subnational levels to give high priority to NCD prevention and control, in particular those with the highest burden of NCD-related disability and death. The Regional Office will support countries in continuing to review the nature of NCDs in their populations and the resources and capabilities available for planning and mounting an effective response, and in assessing the potential health system barriers to and opportunities for improved NCD prevention and control. The Regional Office will work with Member States and relevant experts to promote networking and communities of practice; identify and share knowledge and information, experiences and good practices to support evidence-based policy measures, their implementation and evaluation; and develop relevant support materials. It will also support country efforts to formulate, develop and implement adequately financed national action plans on NCDs with clear objectives, strategies and targets, and to establish or strengthen mechanisms for intersectoral working and participatory governance for health.

Monitoring and surveillance

83. The Regional Office, together with WHO headquarters and other relevant partners, will continue to monitor and evaluate progress in NCD prevention and control, in particular through the periodic NCD capacities survey and by monitoring progress against agreed international and regional targets and indicators. The Regional Office will continue its efforts to push for improved quality, value and comparability of data on NCDs and risk factors. In 2015, the project on the prevention and control of noncommunicable diseases (NCD Project) of the WHO Regional Office for Europe, based in Moscow, Russian Federation, was launched. The NCD Project provides support to Member States, bringing together, analysing and sharing monitoring and surveillance information and facilitating country-level activities, for example on STEPS surveys and cancer registries, and through its integrated NCD surveillance project.

Working with others

84. The Regional Office will work in collaboration with other partners such as the European Union and its institutions and other United Nations organizations. Its work will be supported by WHO collaborating centres and existing health-promoting networks, such as the International Network of Health Promoting Hospitals and Health Services, the Schools for Health in Europe network, the Healthy Cities Network and the Regions for Health Network. Recognizing their expertise and potential contribution, the Regional Office will strengthen its processes of consultation and collaboration with civil society, nongovernmental organizations and relevant professional and patient associations that are free of conflict of interest with the public health interest. Coalitions of health organizations sharing the same interest in combating NCDs are important partners at the international and national levels.

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