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Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016

Investing in prevention and improved control of noncommunicable diseases (NCD) will reduce premature death and preventable morbidity and disability, and improve the quality of life and well-being of people and societies. No less than 86% of deaths and 77% of the disease burden in the WHO European Region are caused by this broad group of disorders, which show an epidemiological distribution with great inequalities reflecting a social gradient, while they are linked by common risk factors, underlying determinants and opportunities for intervention.

The attached document contains an action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases. Taking account of Members States' existing commitments, it focuses on priority action areas and interventions for the next five years (2012–2016) within a comprehensive and integrated framework.

It has been developed through a consultative process, guided by the Standing Committee of the Regional Committee, and including meetings of NCD focal points and of the European Health Policy Forum for High-Level Government Officials. Its formulation has taken place against a backdrop of development of the new European health policy (Health 2020) and the Public Health Framework for Action, as well as the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, April 2011) and the United Nations high-level Meeting on Noncommunicable Diseases (New York, September 2011) and takes account of these processes.

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE
Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark Telephone: +45 39 17 17 17 Fax: +45 39 17 18 18
E-mail: rc@euro.who.int Web: http://www.euro.who.int/en/who-we-are/governance

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Mandate

1. In 2006, the WHO Regional Committee for Europe at its fifty-sixth session adopted a comprehensive, action-oriented strategy for the prevention and control of noncommunicable diseases (NCDs) (resolution EUR/RC56/R2). This was a Europe-specific response to the Global Strategy for the Prevention and Control of Noncommunicable Diseases adopted by the World Health Assembly in 2000. A global action plan followed in 2008 *(1)*.

2. In September 2010, the Regional Committee at its sixtieth session called for the development of a new European policy for health, Health 2020, and for public health capacities and services in Europe to be strengthened. The WHO Regional Director for Europe was requested to maintain a commitment to strengthening health systems, to rejuvenate the commitment to public health capacity and to work hand in hand with Member States to support them in their development of comprehensive national health policies and plans (resolution EUR/RC60/R5).

3. Health 2020 responds to the changing context in Europe: the glaring health inequities within and between countries, the re-emergence of infectious disease threats, the impact of globalization and new technologies, the ageing population, concerns about the financial sustainability of health systems, the changing role of citizens, and the particularly alarming growth of NCDs.

4. With this in mind, WHO is committed to strengthening efforts for NCD prevention and control in the European Region. Within the overarching policy, this action plan derived from the European Strategy for the Prevention and Control of Noncommunicable Diseases identifies specific action areas and deliverables to which Member States, WHO and partners can commit themselves over the five years from 2012 to 2016, after its adoption in 2011.

5. While this action plan has been developed, the attention throughout the world paid to NCDs has reached unprecedented levels. The First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases Control took place in April 2011, and the active participation of WHO's European Regional Member States contributed to the strength of its Moscow Declaration *(2)*. The World Health Assembly, in its resolution WHA64.11, endorsed the Moscow Declaration. This action plan takes the implementation of that Declaration explicitly into account.

Epidemiological context

6. NCDs are the leading cause of death, disease and disability in the WHO European Region. The four major NCDs (cardiovascular disease, cancer, chronic obstructive pulmonary diseases and diabetes) together account for the vast majority of the disease burden and of premature mortality in the Region. In Europe, NCDs (more broadly defined) account for nearly 86% of deaths and 77% of the disease burden, putting increasing strain on health systems, economic development and the well-being of large parts of the population, in particular people aged 50 years and older.

7. At the same time, NCDs are responsible for many of the growing health inequalities that have been observed in many countries, showing a strong socioeconomic gradient and important gender differences. The same is true for the widening health gap between countries in Europe. However, the social gradient and/or distribution of risk vary for different risk factors and in

different Member States. In addition, there has recently been great concern that NCD risk factors increasingly affect younger age groups, with considerable consequences for public health trends in Europe in the future.

8. As individuals age, NCDs become the leading causes of morbidity, disability and mortality, and a great proportion of health care needs and costs are concentrated in the latter years of people's lives. European women live around eight years longer than men, with a greater share of their lives in poor health. An ageing population and the NCD disease burden risk imposing substantial costs on society. Dealing with chronic diseases and their risk factors comprises a significant proportion of a country's gross domestic product, while treatment costs, reduced income, early retirement and increased reliance on welfare support may be faced by the sufferer and/or their carer(s). Employers, and society as a whole, bear the burden of absenteeism, reduced productivity and increased employee turnover.

Why an action plan, and why now?

9. This action plan builds on developments during the past five years, takes account of new knowledge, takes stock of progress made to date and takes advantage of the new momentum for action on NCD and public health as a whole.

10. Globally, there has been a growing awareness of and mandate for action on NCDs in recent years. In 2008, the World Health Assembly endorsed the Action Plan for Implementation of the Global Strategy for the Prevention and Control of Noncommunicable Diseases (2008–2013), with its comprehensive plan for mapping emerging epidemics, reducing exposure to risk factors and strengthening health care for people with NCDs. A global strategy to reduce the harmful use of alcohol, endorsed in 2010, added to the existing tools on diet, physical activity and health, and to the Framework Convention on Tobacco Control. In September 2011, a high-level meeting of the United Nations General Assembly on the prevention and control of NCDs will take place in New York; it adds to the global attention being paid to this group of diseases.

11. Internationally, there has been growing awareness of the challenges posed by NCDs, the causes of their causes, and the evidence base for effective interventions. Alongside the establishment of alliances (including the involvement of international agencies, the scientific and public health communities and nongovernmental organizations (NGOs) in advocacy, research and collaboration), some important reports have been issued recommending strong action in relation to NCDs and, as in the Global status report on NCDs *(3)*, advocating "best buys" for NCD. The conclusions of the Commission on the Social Determinants of Health *(4)* have helped to view these priority public health conditions through the "lens" of equity *(5)* and have drawn further attention to the importance of investing in early child development so as to build a solid foundation for good health throughout life.

12. Renewed emphasis has been placed on the need to strengthen health systems in recent years both in Europe, with the Tallinn Charter (adopted at the European Ministerial Conference in 2009), and its call to strengthen public health capacities and services, and globally with the world health reports on primary health care (2008) *(6)* and health systems financing for universal health coverage (2010) *(7)*, addressing the importance of access, availability and quality of services.

13. Within Europe, fresh attention has been focused on the main risk factors for NCDs. To date, 47 Member States in the European Region are parties to the WHO Framework Convention on Tobacco Control (FCTC). A Ministerial conference on counteracting obesity was held in 2006, leading to adoption of a charter, the second WHO European Action Plan for Food and Nutrition Policy 2007–2012, and a European framework to promote physical activity for health

(2007); a European action plan to reduce the harmful use of alcohol (2012–2020) is being presented to the Regional Committee for adoption this year (see document EUR/RC61/13). The Regional Office's broad focus on NCDs is continuing with work on mental health and disabilities; in that regard, the European Declaration on the Health of Children and Young People with Intellectual Disabilities (2010) is also being submitted to the Regional Committee for endorsement (see document EUR/RC61/Conf.Doc./5). In the Parma Declaration on Environment and Health (2010), European Member States have explicitly set themselves the goal of contributing to the prevention of NCDs through actions directed at reducing the relevant environmental exposures. In addition, the European Union (EU) is taking significant action on health determinants, in disease prevention, on healthy and active ageing, and against poverty and social exclusion.

14. Member States are showing a growing interest in and demand for implementation of the European NCD strategy, and progress has been made in many areas. Inventories of national policy documents and instruments relating to tobacco and alcohol control, nutrition, obesity and physical activity have been established and reviewed, and there is greater understanding of needs, capacities and gaps in implementation *(8,9)*. Seven countries are still not party to the FCTC, and even for some of the Parties, translation of commitment into action has been relatively weak. The coverage of cost-effective interventions for NCD prevention and care is still patchy. The overall picture of the disease burden and risk factors remains incomplete, with harmonization of data collection instruments and definitions still a challenge. While just over two-thirds of countries have a policy or strategy relating to NCDs, this is operational in only half of those countries and a specific budget for implementation in only one third. The extent to which health insurance covers NCDs varies across Europe, and lifestyle support services may be largely reliant on charitable, rather than state, funding. A large variety of different types of broad and issue-specific policies may be in place in a country but the coordination between them may be weak, and a more integrated approach to NCD prevention is often lacking.

15. As a new chapter opens for the WHO European Region with the development of the new European policy for health, Health 2020, and a renewed commitment to public health, the time is right to sharpen the focus on NCDs and for efforts to address this challenge to become an integral part of gaining health in Europe.

Rationale and guiding principles

16. The above global and regional documents, and more than two decades of work on health promotion, have resulted in a set of widely accepted principles, shared with Health 2020, that will guide all actions in this plan, from priority-setting through implementation to evaluation.

- **A focus on equity**. Specific attention must be paid to whether social determinants such as gender, socioeconomic status, ethnicity, migrant status and/or level of education, and their distribution, affect people's opportunities to make and sustain healthy choices.
- **Strengthening health systems**. Further development of primary health care services, together with public health services, is essential for improved health promotion, disease prevention, early detection and integrated care.
- **Health in All Policies**. The wider determinants of the NCD epidemic lie largely outside the control of the health sector. They range, for instance, from trade and fiscal policies, through access to education and health care, to urban planning and design.
- **A life course approach**. Exposure to the risk of NCDs accumulates throughout the life course, starting with influences that occur during pregnancy and continuing through early childhood, adolescence and adulthood. A healthy ageing experience consists of health

promotion throughout life, a health-supporting environment that promotes coping with disability, social protection, and appropriate and accessible social and health services.

- **Empowerment**. All activities, from planning preventive services to delivering individual patient care, should aim to strengthen not replace community action, promote health literacy and respect the expert status of the person receiving care.
- **Balance population-based and individual approaches**. Most cases of disease are found in those at low or moderate risk, and only a minority of cases are in those at high risk *(10)*. A comprehensive prevention strategy needs to balance an approach aimed at reducing risk factor levels in the population as a whole with one directed at high-risk individuals.
- **Integrated programmes**. All NCDs and their risk factors have technical particularities, need specific expertise and deserve focused, independent action if progress is to be made. Yet evidence suggests that a multiple-intervention strategy would achieve substantially greater health gains than individual interventions, often with an even more favourable cost–effectiveness profile.
- **'Whole-of-society' approach**. This is the "co-production" of health by state and society. The aim is to reinforce the integration between public health services and the health care system, to increase cooperation between state and non-state actors, and to ensure active involvement of civil society, businesses and individuals.

17. These principles are encapsulated in the key messages of the European Strategy for the Prevention and Control of Noncommunicable Diseases, as relevant now as when they were endorsed in 2006.

Key messages

Prevention throughout life is effective and must be regarded as an investment in health and development.

Society should create health-supporting environments, thereby also making healthy choices easier choices.

Health and medical services[1] should be fit for purpose, responding to the present disease burden and increasing opportunities for health promotion.

People should be empowered to promote their own health, interact effectively with health services and be active partners in managing disease.

Universal access to health promotion, disease prevention and health services is central to achieving equity in health.

Governments at all levels have the responsibility to build healthy public policies and ensure action across all the sectors concerned.

Scope

18. Although diverse chronic NCDs all deserve proper attention, a group of four diseases (cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases) and their shared risk

[1] The original terminology of the European Strategy for the Prevention and Control of NCDs (2006), refers to health care and public health services.

factors (tobacco use, harmful use of alcohol, physical inactivity and unhealthy diet) account for the majority of preventable disease and death in the WHO European Region. These four NCDs also share common determinants that are influenced by policies in a range of sectors, from agriculture and the food industry to education, the environment and urban planning. They share common pathways for interventions through public policy. Additionally, obesity merits specific attention, in that it is both a result of many of the same basic risk factors and a cause of other NCDs.

19. This action plan adopts the all-encompassing vision of the global and European strategies for NCD prevention and control. There is a strong demand from Member States for support with taking effective action, yet the Action Plan needs to be realistic given that it is being implemented at a time of great need and scarce resources. However, the costs of inaction are potentially greater, owing to escalating costs to health and social care systems from the increasing burden of NCD. There is clear evidence of the need for a concerted societal response to this burden with tools that are effective and adaptable for use in countries at all levels of development. An effort has been made, therefore, to prioritize and select the actions that are achievable in the European Region within a limited timescale and within existing resources, thereby keeping the Plan realistic while achieving maximum impact.

Linkages

20. While this Action Plan has a deliberately narrow focus in the interests of feasibility, it recognizes that a number of other, related conditions stand to benefit from the approach outlined through exploiting the linkages that exist.

Capitalizing on common features

21. Chronic diseases (whether the four listed above or others, infectious or noncommunicable) share a number of common features: a similar aetiology and shared causative agents such as behavioural and environmental risk factors; a co-existence in some individuals; a requirement for similar models of care that integrate a social dimension, empower patients to live with different diseases, and which foster patient- rather than disease-centred programmes. Given this, promotion of chronic care models and control of obesity and tobacco use will benefit not just the four diseases listed above but also a range of other conditions, including musculoskeletal disorders. Attention to the socioeconomic environments and settings in which people grow, play, live and age, such as schools and workplaces, could contribute further to such common approaches.

Mental disorders

22. There is a strong connection between mental and physical health: for instance, harmful stress is associated with cardiovascular diseases, and cerebrovascular disease is a cause of dementia. Although “neuropsychiatric disorders” are the second leading cause of NCD burden in the European Region, it would be erroneous to subordinate a mental health strategy within an NCD action plan. Mental health and NCDs require distinct strategies and action plans arising out of a specific evidence base and unique technical requirements. The Regional Office is currently revisiting the Mental Health Action Plan in consultation with Member States and stakeholders, with a view to proposing a new mental health strategy to the Regional Committee in 2012.

Violence and injury

23. Violence and injuries have much in common with NCDs. Real or perceived risks of injuries are cited as the greatest barrier to cycling and walking. Furthermore, over-reliance on car transportation causes physical inactivity, noise and air pollution, which are also linked to NCDs. Violence and injuries have some risk factors in common with NCDs, such as deprivation and socioeconomic inequality, and are often mediated through harmful use of alcohol. Adverse childhood experiences are not only linked to an increased propensity towards violent behaviour in later life, but are also related to high-risk behaviours such as harmful alcohol use.

Infectious diseases

24. Despite the label “noncommunicable”, many NCDs have a strong link with infectious diseases. For example, cervical and liver cancers are linked with the human papilloma and hepatitis viruses, respectively, with unsafe sex and needle-sharing by intravenous drug users increasing risk; the chronic and palliative care of people living with HIV is often integrated with services for other chronic diseases. NCD risk factors (such as tobacco smoking, or the harmful use of alcohol) are associated with the majority of new cases of tuberculosis (TB) in the world’s highest TB burden countries; an effective TB programme in Europe must address these common risk factors. the links between NCDs, and with HIV/AIDS and TB, as well as with maternal and child health, have implications for attainment of the Millennium Development Goals (MDGs): promoting synergies between programmes could be an efficient and effective way of using limited resources.

Environment and health

25. Environmental and occupational exposures account for a significant part of the NCD burden. Physical activity is influenced by urban environments and transport policies, which can promote cycling and walking for transport by developing safe infrastructure, as well as fostering the establishment of accessible green spaces for leisure-time physical activity and encourageing behaviour modification. Occupational health and safety programmes can also be advocates for workplace wellness interventions. On a larger scale, lessons learned from the climate change and sustainable development movements serve as a model for developing advocacy for NCDs and development. There are deep connections with the causes of air and noise pollution and with efforts to control them. Sound and sustainable policies relating to the environment and health will contribute directly to reducing the burden of NCDs: from agricultural practices and policies, to protection of children from adverse environmental exposures.

Vision, goal and objectives

26. The vision, goal and objectives for this Action Plan were proposed and endorsed by Member States in the European Strategy for the Prevention and Control of Noncommunicable Diseases (2006). They are consistent with the new European health policy and the new framework for action to strengthen public health capacities and services in Europe.

Vision

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

Goal

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 NCD.

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.

Organizing principles for the Action Plan

27. In line with the European Strategy for the Prevention and Control of NCDs, the Action Plan takes a comprehensive and integrated approach to tackling NCDs: it simultaneously promotes population-level health promotion and disease prevention programmes, actively targets groups and individuals at high risk, and maximizes population coverage with effective treatment and care, while systematically integrating policy and action to reduce inequalities in health. At the same time, during the period 2012–2016, the action plan focuses on a selected number of evidence-based interventions for maximum health gain. The progress achieved with these interventions will be monitored and evaluated.

28. The Action Plan is organized into four priority action areas, five priority interventions and two supporting interventions. Priority interventions are concrete, evidence-based and in line with Member States' existing commitments. The focus is on deliverables, within the timeframe of 2012–2016, which can support countries in achieving the vision, goals and objectives of the European Strategy for the Prevention and control of NCDs. Addressing the social determinants of health and reducing inequalities in health are considered to be such core elements that they do not appear in a separate section but are integral to each of the main sections.

29. The four priority action areas are "mapped" to the European Regional Strategy for the Prevention and Control of NCDs as outlined below:

i. governance for NCD, including building alliances and networks, and fostering citizen empowerment (an action area relevant to the whole of the European Strategy);

ii. strengthening surveillance, monitoring and evaluation, and research (an action area relevant to the whole of the European Strategy);

iii. promoting health and preventing disease (an action area relevant to the population-level interventions of the European Strategy);

iv. reorienting health services further towards prevention and care of chronic diseases (an action area relevant to the person-centred elements of the European Strategy, and the sections within it that target high-risk groups and individuals).

30. The five priority interventions focus on:

i. promoting healthy consumption via fiscal and marketing policies;

ii. elimination of *trans* fats in food (and their replacement with polyunsaturated fats);

iii. salt reduction;

iv. cardio-metabolic risk assessment and management;

v. early detection of cancer.

31. Two other sets of supporting interventions are also included, as a means of promoting intrasectoral linkages with action on the environmental determinants of NCDs:

i. promoting active mobility;

ii. promoting health in settings.

Priority action areas

Governance for NCD, including building alliances and networks, and fostering citizen empowerment

32. Governance for health has been defined as "the attempts of governments or other actors to steer communities, whole countries, or even groups of countries in the pursuit of health and well-being as a collective goal" *(11)*; it is a key consideration in the development of Health 2020. Given that many of the influences on health lie outside the health sector and may operate across national boundaries, governance for NCD prevention and control requires mechanisms that are participatory, cross-sectoral and multilevel, and which extend from local to global arenas. Such mechanisms include action to define shared goals and resources, identify the co-benefits of NCD prevention, assess the health impact of policies, and implement intersectoral action accountably and sustainably. An NCD policy or strategy or plan can set the direction and targets for NCD prevention and control, as well as give policy coherence for a number of related issue-specific plans.

33. Governing for NCDs in ways that impact on the socioeconomic determinants of health and their distribution means providing leadership, mandate, incentives, budgets and mechanisms for collaborative working and problem-solving across government and sectors. Consideration of gender and other social determinants is essential to the design, development and implementation of public health programmes to tackle NCDs, firstly to enhance programme coverage and effectiveness, and secondly to lower the economic costs related to reduced productivity and increased demands on the health and social protection systems due to inequalities *(12)*. There is considerable scope for the health system to act to reduce inequalities, particularly given that the accessibility, appropriateness and acceptability of health services are socially determined *(13,14)*.

34. The most challenging health problems require engagement with stakeholders outside of government: international bodies, bilateral agencies, professional associations and NGOs, the private sector and academia. Alliances and networking are a fundamental mechanism for achieving results. Existing public health groups such as EuroHealthNet, the European Public Health Association (EUPHA), and the Association of Schools of Public Health in the European Region (ASPHER) have a particular interest in NCDs, as do existing networks of countries such as the South-Eastern Europe Health Network (SEEHN). The more general networks, such as Schools for Health in Europe or the WHO Healthy Cities movement, as well as those specific to NCDs such as WHO's Countrywide Integrated Noncommunicable Disease Intervention (CINDI) programme, the European network for the promotion of health-enhancing physical activity (HEPA), and the European Chronic Disease Alliance, among others, all have important contributions to make.

35. Empowerment is an essential part of the promotion of healthy lifestyles and the prevention and management of NCDs. The roles of patients and health care professionals are evolving to place patients at the centre of disease management. Patient and family empowerment strategies increase patients' abilities to manage their disease, adopt healthier behaviours and use health services more effectively, as well as increasing caregivers' coping skills and efficacy. Self-help groups, patient organizations and related advocacy groups support partnership relations between patients and caregivers by providing choice, information and capabilities. The role of the media in influencing norms and behaviours and in shaping the public debate must also be recognized. Nevertheless, action to strengthen empowerment will need to account for the fact that the most disadvantaged groups and individuals in society are potentially the least likely to benefit from participation initiatives, unless such initiatives are designed in ways that are appropriate, acceptable and sensitive to the need for equity.

Action by WHO

- Facilitate and support the development of national action plans for the prevention and control of NCDs, either as a stand-alone document or integrated with other public health policies and plans, and which include a focus on social determinants and their distribution.
- Build on existing policy mechanisms and platforms that offers synergy for primary prevention of NCDs, such as the European Environment and Health Process and relevant multilateral environment agreements
- Develop practical actions in order to convene a well-functioning and productive partnership of European networks of NCD focal points and stakeholders in the public sector, civil society, professional groups and academia for joint advocacy, resource generation and the exchange of experiences and to build capacity for NCD prevention and control. In connection with this partnership, forums for interaction with the private sector will be convened, with due attention to the appropriate policies to avoid conflicts of interest.
- Develop practical proposals for cooperation on NCD between international organizations such as WHO, the Organisation for Economic Co-operation and Development (OECD), the European Commission, the World Bank, the European Investment Bank and the International Atomic Energy Agency (IAEA), for advocacy for health, on specific topics such as standards and indicators, and on joint working in countries, with increased clarity on the value added by each partner.
- Provide technical support to assist Member States in implementing and strengthening patient and community empowerment in policies, strategies and programmes, including guidance on how to incorporate a focus on reaching those groups and individuals most likely to be disempowered and/or disadvantaged.

Action by Member States

- Increased number of NCD/NCD-relevant strategies and action plans at national level which address the social and environmental contexts for NCDs and healthy lifestyles, have dedicated budgets and capacity for implementation, and include a component for monitoring both overall health impact and its distribution.
- Increased number of countries that include NCDs in national and regional development agendas.
- Increased number of national NCD or chronic disease alliances with a focus on co-morbidities and common factors to coordinate advocacy efforts in an integrated way

Strengthening surveillance, monitoring and evaluation, and research

36. The WHO European Region is rich in data from surveys carried out at the subnational, national, regional and global levels (see Table, Annex 1). Yet data harmonization across the Region can be a challenge, owing to the use of different instruments and definitions by various agencies, and available country data may not always be nationally representative nor of sufficiently high quality.

37. Surveillance data are crucial for developing targeted action, monitoring the progress and success of counteracting NCDs, and informing and evaluating strategies and policies. Surveillance systems should be of good quality, reliable, standardized and sustainable. 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. For NCD, a surveillance system should generate and track information on: the burden of NCDs (morbidity, mortality, disability and economic costs); estimates of the prevalence and trends of their related risk factors; their social determinants; population groups at risk; and appropriate implementation of evidence-based policies. Sufficient attention must be paid to vulnerable groups, and to a disaggregated picture of the population, through cross-linking with sex, age group and social factors such as level of education, income and place of residence. Linkage with other relevant surveillance systems, such as those for environmental exposures and communicable diseases, should be explored.

38. 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 NCD. The WHO Regional Office for Europe works with Member States to monitor progress in countries' capacity for NCD prevention and control, including with regard to what can be learnt from good practice and how NCD policies are framed within wider public health and health reform agendas. The reports that are generated not only monitor the status of implementation of NCD policies in Member States, as part of the WHO mandate from the 2008–2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases; they also provide examples of good practice, and more in-depth analysis of selected country policies.

39. There is sufficient evidence to act on NCDs and the best available evidence should be used, monitoring continuously in order to learn and adjust. Nevertheless, there is still a need to develop evidence, for example that obtained from the evaluation of impact (both overall average population impact and its distribution) and on the cost–effectiveness of interventions. Better connections needs to be made between experts and policy-makers, and to ensure that data are accessible and communicated in different formats to different audiences through different media. Networks of public health institutes, WHO collaborating centres and the Health Evidence Network already exist as a rich resource for the Region.

Action by WHO

- Develop and implement a framework for evaluation of this NCD Action Plan, at WHO European Regional level and at country level, ensuring that actions, indicators, and monitoring and evaluation approaches are consistent with the other WHO risk factor-specific action plans.
- Establish an expert advisory group to help develop an approach on how and what elements of this Action Plan are to be monitored, in order to follow and report on progress using a combination of different data sources and methodologies (to be feasible in countries with different income-levels) and taking account of social determinants of health such as gender and socioeconomic status.
- Develop guidelines for an integrated NCD information system, including a regional list of NCD indicators (complementing the global initiatives) for national surveillance and inclusion in an integrated health information platform at the WHO Regional Office for Europe, harmonizing approaches of the Health for All database with existing NCD data collection and for disaggregation of data, and exploring synergies with related communicable disease and environmental surveillance systems in order to yield a comprehensive picture.
- Develop and disseminate policy briefings on integrating a focus on gender, other social determinants and equity into NCD policies and programmes, including a profile of the distribution of risk for specific NCDs and their risk factors.

Action by Member States

- Increased establishment of new, or strengthening of existing, integrated NCD national surveillance systems, including information on disease burden, risk factors, social determinants and populations at risk.
- Increased evidence of collaboration between researchers and policy-makers so that evidence on NCDs addresses policy needs in a coordinated way.
- Increased availability and use of NCD surveillance data disaggregated by sex, age and social strata, based on the global and regional reviews of social determinants, in order to monitor and analyse the distribution of impact.

Promoting health and preventing disease

40. The Ottawa Charter for Health Promotion *(15)*, adopted in 1986 and reconfirmed in the Bangkok Charter on Health Promotion *(16)*, put forward five main strategies for health promotion: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services. Recognition of the influence of contexts on life choices and behaviours has led to an emphasis on different settings, such as schools, prisons and workplaces, and on policies to create health-promoting environments so that healthier choices become easier choices *(17)*. For example, through healthy urban planning, physical environments can be designed that support safe and active commuting and create space for recreational activity.

41. Population-level approaches and those targeted at people at high-risk need to be balanced. Interventions directed towards whole populations can have the greatest benefits for the population. A small reduction in risk in a large number of people, for example in population cholesterol concentrations, blood pressure or smoking, may prevent many more cases, such as cardiovascular events and deaths, than treating a small number at higher risk *(18)*. National legislation and fiscal policies (for example banning industrial *trans* fats or halving dietary salt in processed foods) can be both effective and save costs. Individual approaches are more costly,

increase inequalities, and are dependent on well-resourced and effective health systems. Nevertheless, it is important to see which groups in the population have been the most able to respond to universal interventions, as there is usually a social gradient – with the most disadvantaged being the least likely to respond to such lifestyle measures.

42. At the same time as planning broad societal interventions on the determinants of NCDs, there are four behavioural risk factors that need to be addressed directly, taking gender and other social differences into consideration. As indicated in the global and regional reviews on social determinants, it is important to address the contexts for lifestyles – the "causes of the causes". In the last decade, global and regional strategies have been adopted to control tobacco use, the harmful use of alcohol, physical inactivity and unhealthy diets. In addition, the FCTC is the key international public health instrument for tobacco control. The MPOWER policy package is a set of evidence-based set of tools to assist in FCTC implementation. Interventions to control tobacco and to reduce salt have been assessed as among the most cost-effective globally. It is nevertheless recognized that multicomponent programmes are most effective as part of an integrated and comprehensive approach.

43. Disease prevention includes clinical preventive services such as vaccination programmes, population-based screening programmes and cardio-metabolic risk assessment in primary care services. These are further covered in the next section.

Action by WHO

- Develop policy toolkits ready for implementation by Member States in a small set of defined priority areas of intersectoral policy-making relevant to NCDs, starting from the extensive experience gained in the Region with tobacco control, transport and environment, and foreign policy (this work will be carried out in close coordination with action to follow up on Health 2020), and with attention paid to potential impacts on health and gender equity.
- Prepare and present an interim report on country progress on intersectoral action at the Eighth Global Conference on Health Promotion (Helsinki, Finland, 2013).
- Develop tools to promote health literacy and strengthen community action by using mechanisms to increase health literacy (such as patient decision support aids and self-management courses) and addressing illiteracy and language as a barrier to health literacy.
- Use the existing regional networks for health-promoting schools, workplaces, hospitals, prisons, universities and cities to develop tools and technical support that will promote the prevention and control of NCDs, and evaluation of the distribution of impact.

Action by Member States

- Accelerated ratification and implementation of the FCTC to achieve a world essentially free from tobacco.
- Implementation of commitments made under the European Charter to Counteract Obesity, the European Action Plan for Food and Nutrition Policy for 2007–2012, the Global Strategy on Diet, Physical Activity and Health, and the Global Strategy to Reduce the Harmful use of Alcohol.
- Alignment of national policies on agriculture, trade, industry, and transport to promote improved diets, increase physical activity and reduce harmful alcohol use.

Reorienting health services further towards prevention and care of chronic diseases

44. Health systems are faced with the challenge of providing comprehensive approaches to reducing the NCD burden by integrating health promotion, disease prevention and chronic care management, responding to acute episodes of illness and providing rehabilitation and palliative care when needed. Although effective, and even cost-effective, interventions are well known for the majority of these conditions, many are not used at scale.

45. Furthermore, for many patients who suffer from chronic NCDs, there are severe barriers to access to good quality, continuous care. Public coverage with chronic care services is far from universal in many countries, and there are wide differences in the cost-sharing requirements that NCD patients must meet for access to health services and drugs. In particular, financial barriers may be an obstacle to the management of common risk factors that can be effectively controlled through medication, such as high blood pressure. And even when good universal access exists, poorer people still have poorer management of chronic conditions.

46. Moreover, there is evidence of untapped efficiency gains in the management of chronic diseases that could be achieved by better coordination or integration of services across institutional boundaries. This is particularly important in a resource-constrained environment, when it is even more necessary to get better value for money and to redistribute resources from tertiary to preventive care. Removing these obstacles and making patient pathways more rational and patient-centred are now high on the reform agenda of a growing number of health care systems in Europe. The ageing of the population and the escalation of health care costs increase the urgency of this task.

47. Stronger health systems providing effective and affordable care in a timely manner can contribute greatly to the reduction of premature morbidity and mortality from NCDs. To achieve this, service delivery modalities need to improve, with greater adherence to evidence-based medicine by medical practitioners and intensification of public health activities. Health financing arrangements need to be reviewed to ensure affordability, in particular, by vulnerable groups. Health system approaches to generating human resources, medicines and technologies need to be reassessed, to ensure appropriate quantities and quality of health system inputs. Stewardship arrangements need to be strengthened, notably by improving governance, securing the necessary human and financial resources, and empowering patients. And finally, public health capacities and services need to be strengthened, particular in the relevant areas of surveillance, needs assessment, disease prevention and health promotion, public health leadership and workforce development.

Action by WHO

- Research, document, disseminate and promote best practice in using a patient-centred model to coordinate management of chronic diseases from prevention to palliative care, at all levels of the health system, across institutional boundaries (primary health care, social care in the community, hospital services, emergency care), including across noncommunicable and communicable diseases, and with attention to assessing the distribution of impact across the population.
- Build regional capacity through models of good practice in improving the competencies of health professionals to provide advice on and support for self-management, and in mechanisms to foster self-management skills among patients, families and the voluntary sector.
- Disseminate and advocate for improved universal access to more comprehensive and equity-sensitive packages of NCD interventions and continuity of services through appropriate health financing models, adapted to the specific context of each country.

- Further develop strategies to ensure access to cost-effective medicines and their enhanced rational use by health professionals and patients, as well as identifying models of good practice that have contributed to this end in Member States.
- Develop internationally comparable indicators to monitor trends in access to effective interventions to tackle NCDs (such as on essential medicines, out-of-pocket spending and slower uptake by more disadvantaged groups in the population) and promote efficiency in the delivery of health care through independent and evidence-based health technology assessment processes.
- Develop operational guidance to promote integrated case-finding and management, emphasizing the links between vaccination, sexual and reproductive health and NCDs; HIV/AIDS, cardiovascular disease and cancer; TB and tobacco control; and control of the harmful use of alcohol, management of diabetes, and nutrition.

Action by Member States

- Strengthened role of primary health care in NCD prevention and control, particularly in relation to risk factor assessment and management and to brief interventions (for smoking cessation and reduction of the harmful use of alcohol), and with attention paid to population groups and individuals most likely to be vulnerable owing to their social and economic circumstances.
- Increased adoption, implementation and monitoring of the use of evidence-based guidelines and standards established for the integrated management of NCDs in primary health care, including a focus on social determinants and equity.
- Increased health care surveillance, with measurement of the impact of health interventions, including how satisfied patients/families are and what patients feel about their health.
- Aspects of health promotion and disease prevention included in the curricula of health professionals and primary care providers, in particular, empowered to become agents of change in “advertising” NCD risk reduction strategies to their target population and more aware of how people’s social and economic circumstances affect their opportunities to make healthy choices, while the content of public health operations in countries is harmonized with the scope and content of individual health promotion and disease prevention.
- Public health capacities and services strengthened at all levels and close links with health care ensured in implementing the framework for action on strengthening public health capacities and services in Europe.

Priority interventions

48. The priority interventions for the next five years have been selected because they are evidence-based, cost-effective measures that are feasible, financially and politically, for implementation and scale-up in a range of country contexts. The evidence base behind these priority interventions has been summarized and many of them are included as “best buys” in the WHO Global status report on NCDs (2010), which characterizes them as “actions that should be undertaken immediately to produce accelerated results in terms of lives saved, diseases prevented and heavy costs avoided”. These actions are also consistent with a consensus listing of priority actions on the prevention and control of NCDs *(19).*

49. The intention is that these priority interventions take place within the framework of a more comprehensive and integrated approach, and against a backdrop of efforts outlined in the

preceding section of this document on priority action areas. It is *not* the intention that only these interventions and nothing else are achieved in the next five years. But it is the intention that at least the results listed here are achieved.

50. By the end of 2012, a detailed project plan will have been developed for each priority intervention, and there will be a monitoring and evaluation framework in place that will report in 2017 not only on impact but also on the distribution of that impact across the population.

Promoting healthy consumption via fiscal and marketing policies

Goal

51. 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.

Outcome measures

- Reduction of tobacco prevalence – both in terms of the population average and at a faster rate among groups in the population with the highest levels;
- reduction of harmful use of alcohol – both in terms of the population average and at a faster rate among groups in the population with the highest levels;
- reduced obesity.

Process measures

- Restrictions of exposure to direct and second-hand smoking via increases in tobacco prices, health warnings, smoke-free environments, and a complete ban on all forms of tobacco promotion;
- reduction in the harmful use of alcohol via increases in alcohol taxes, enforcing advertising bans and restricted access to retailed alcohol;
- promotion of healthier diets via food pricing, labelling and marketing controls.

Rationale

52. Marketing of processed food, with its “hidden” sugars, salt and excessive saturated fats, especially to children, and their increased availability are contributing to the alarming increase in the prevalence of overweight and obesity among children and adults reported in Europe, particularly for those with a lower socioeconomic status. Alcohol is a risk factor for NCDs, but it is also an important, independent cause of mortality and morbidity through alcohol dependence, violence and injury, and other alcohol-related disorders. Too high a proportion of the population is not yet covered by the cost-effective interventions outlined in the FCTC, either because their country has not ratified it or because the translation of commitment to action (for example in legislating for smoke-free environments) has been weak. A package of interventions on the pricing and marketing of tobacco and alcohol and the control of marketing of foods to children are both mandated by global and regional strategies and resolutions, as well as being part of the package of ‘best buys’ identified.

Actions

- Build the case for fiscal mechanisms to support healthy choices and explore the use of revenues from these taxes to funding sustainable structures for health promotion;
- ban the marketing of tobacco products (not limited to cigarettes), progressively reduce children’s and young people’s exposure to the full range of alcohol marketing, and limit

their exposure to the marketing of foods high in salt, fat and sugar, and sugar-sweetened beverages.

Replacement of *trans* fats in food with polyunsaturated fats

Goal

53. To eliminate *trans* fatty acids from processed foods and replace them with polyunsaturated fats.

Outcome measures

- *Trans* fats eliminated in processed foods in the majority of Member States.

Process measures

- National and international agreements reached and implemented on the elimination and appropriate replacement of *trans* fats in processed foods intended for the European market.

Rationale

54. *Trans* fatty acids contribute to heart disease by raising levels of so-called "bad cholesterol" (low-density lipoprotein, or LDL), lowering levels of "good cholesterol" (high-density lipoprotein, or HDL) and damaging the cells in the linings of blood vessels, contributing to inflammation and blockage and leading to heart attacks. *Trans* fats are found primarily in products that contain partially hydrogenated oils, whose longer shelf life and texture make them attractive for restaurants and food processors. This partial hydrogenation process not only creates *trans* fats but also destroys the healthy omega-3 fats that are naturally found in vegetable oils. Phasing *trans* fat out of food supplies is feasible; it could be done by major food producers in a relative short time and has already been achieved by some major food companies.

Actions

- Work alongside industry to develop a timetable for removing *trans* fats from foods intended for the European market and to ensure that they are not replaced by saturated fats (thus exacerbating another problem), but to favour polyunsaturated fats or overall fat reduction.

Salt reduction

Goal

55. To reduce salt intake in the diet to less than 5 g (2000mg sodium) per person per day.

Outcome measures

- Reduction of salt intake to recommended levels in majority of Member States.

Process measures:

- National salt reduction strategic plans in place;
- population salt intake measured;
- multistakeholder bodies convened.

Rationale

56. Daily salt intake in most countries exceeds the WHO recommendation, and salt in processed foods is a major source. There is a direct dose-response relationship between salt and blood pressure. Decreasing salt intake reduces the long-term risk of cardiovascular events and stroke. It is estimated that decreasing dietary intake from 10 grams to 5 grams per day would reduce the overall stroke rate by 23% and cardiovascular disease rates by 17%. Reducing salt intake in communities is possible and is one of the most cost-effective and affordable public health interventions. While there are clear differences between countries in relation to sources of salt intake, behaviours and dietary patterns, several common principles and general guidelines can be identified and shared to ensure the successful implementation of a salt reduction strategy *(20)*.

Actions

- Develop and implement salt reduction strategies with core elements in line with WHO recommendations.

Cardio-metabolic risk assessment and management

Goal

57. To assess and lower absolute cardio-metabolic risk scores as a core function of primary health care services in Europe.

Outcome measures

- Increase in the proportion of patients for whom recommended behavioural and treatment goals are met.

Process measures

- Production of evidence-based guidelines for the assessment of risk and for behavioural and pharmacological interventions;
- increase in utilization measures (i.e. training of health care providers, numbers of prescriptions of various drugs);
- increase in the proportion of patients for whom cardiovascular risk (CVR) is estimated, with evidence of equitable distribution of services.

Rationale

58. Diabetes significantly increases the risk of cardiovascular disease (CVD), and the combination of risk factors associated with CVD is greater than the sum of the individual factors. There is a growing consensus that a multidisciplinary approach is needed to adequately address cardio-metabolic risk (CMR) factors. Evidence shows that early identification and modification of CMR factors is an effective intervention to prevent the development of hyperglycemia, type 2 diabetes mellitus, hypertension and hyperlipidemia. Emphasis should be placed on overall assessment of a number of risk factors, rather than on a strategy aimed at a single disease or single risk factor. Early and effective management can thus be initiated, including a combination of interventions on health behaviours (weight management, physical activity, diet, smoking cessation) and of pharmacological vascular protective measures in people identified at high CMR. Such a strategy can be largely based in primary care.

Actions

- Generate evidence and provide guidance on what organizational and resource changes are required within primary care to deliver a comprehensive service for CMR assessment, modification and follow-up;
- generate evidence on successful multidisciplinary CMR assessment and management programmes;
- strengthen the capacity of primary care to assess and manage CMR, including clinical guidelines, capacity-building, monitoring and evaluation.

Early detection of cancer

Goal

59. To reduce mortality from cervical, breast and colorectal cancers.

Outcome measures

- Reduction of the stage at which breast, cervical and colorectal cancers are diagnosed;
- improvement in survival from breast, cervical and colorectal cancers.

Process measures

- Coverage with organized screening programmes;
- assessment of cancer awareness in key population subgroups.

Rationale

60. Interventions are available that permit the early detection and effective treatment of around one-third of cancers. There are two strategies for early detection: early diagnosis, through raising awareness of the early signs and symptoms of disease, so that prompt referral for confirmation of diagnosis and treatment can take place; and screening of asymptomatic and apparently healthy individuals to detect pre-cancerous lesions or an early stage of cancer and referral for diagnosis and treatment. To be effective, and to avoid causing more harm than benefit, screening should take place within population-based, organized screening programmes with quality assurance. Where resources and health systems are limited, and where the majority of the cancers amenable to early detection are diagnosed in late stages, the establishment of an early diagnosis programme may be the most feasible strategy to reduce the proportion of patients presenting with late stage cancer (“downstaging”) and to improve survival rates. In all countries, there should be a national cancer control plan with a range of provisions, from surveillance with a population-based cancer registry through to access to palliative care.

Actions

- Assess the incidence of and mortality from major avoidable, early detectable and treatable types of cancer, including the proportion of cancers diagnosed at advanced stages and the prevalence of cancer survivors, where information systems allow;
- raise awareness of the early signs and symptoms of cancer among health professionals and public and, where appropriate, implement population-based, organized screening programmes according to country context;
- assess the quality, safety and effectiveness of existing early detection programmes.

Supporting interventions

61. These supporting interventions are included in this Action Plan as a means of promoting intra-sectoral linkages between actions on NCDs and actions within the broader environmental and educational agenda.

Promoting active mobility

Goal

62. To promote increased physical activity through modifications of the urban environment.

Outcome measures

- Number of kilometers travelled on foot and by bicycle per person per year;
- proportion of children going to and from school by different modes of transportation (walking, bicycling, public transport, private car).

Process measures

- Number of countries that have national policies for the promotion of cycling and walking;
- number of countries that have developed national transport, health and environment action plans, either as self-standing plans or integrated in other plans.

Rationale

63. Transport and urban planning policies play a paramount role in determining environmental exposures to transport-related air pollution and noise, as well as in providing conditions that can enable or suppress daily physical activity, particularly through cycling and walking for transport or leisure. There is growing evidence that interventions which provide urban environment settings that facilitate active transport, in combination with public transport, can influence people's choices of their mode of transportation and thereby facilitate the choice of healthier behaviour – as well as contributing to the climate change agenda. In the European urban context, where more than 50% of trips done by car are shorter than 5 km and more than 30% are shorter than 3 km, the substitution of short car trips by walking and cycling is largely feasible and broadly coincides with the recommended levels of daily physical activity of moderate intensity.

Actions

- Develop and implement national transport, health and environment action plans;
- participate in regional networks, share experience, identify and transfer evidence on the effectiveness of transport and urban planning intervention in reducing the risk of NCDs;
- develop and apply databases, guidance and tools for estimating transport-related health effects, including in economic terms;
- develop and implement tools to integrate health into transport decisions.

Promoting health in settings

Goal

64. To improve health and well-being by making school and workplace settings more supportive of health.

Process measures

- Number of countries that have occupational health and safety legislation with clauses for protection of workers against occupational cancers and occupational lung disease, including occupational asthma;
- number of countries that have national programmes supporting comprehensive initiatives for healthy schools and workplaces according the WHO framework.

Rationale

65. Health and education are inextricably linked: education has a powerful effect on health outcomes; students learn more effectively if they are healthy; and they have better learning outcomes and less risk-taking behaviour if they feel good about their school and are connected to significant adults. Health promotion in a school setting aims to improve the health of all school users, staff and students, through holistic and participatory approaches, and it includes healthy school policies, the school's physical and social environment, the curriculum, community links and health services.

66. Annually more than 300 000 lives are lost in the Region from various work-related diseases (not including deaths from injury), the majority of which are NCDs. The risk factors for these diseases are involuntary and can be mitigated by the organized efforts of society and enterprises. Workplaces also provide an important entry point for NCD prevention and health promotion programmes. Workplace health promotion (WHP), when designed and executed as a comprehensive initiative for healthy workplaces, is effective in reducing NCD risk factors by tackling physical inactivity, unhealthy dietary habits, smoke- and alcohol-free work environments, and psychosocial risk factors, with the participation of workers and managers.

Actions

- Implement existing mandates and commitments to healthier environments in a manner that reduces exposure to risk of noncommunicable diseases;
- develop policy, legislation and governance tools targeting occupational and work-related NCDs at the national, local, and workplace settings in line with WHO guidance, and ensure employers' compliance with relevant rules and regulations;
- engage with relevant networks such as Schools for Health in Europe and the European Network for Workers' Health in strengthening countries' capacity, health-promoting settings and primary prevention of NCDs.

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Annex 1. Examples of existing NCD surveillance systems

Country level	Regional level	Global level
• Nationally representative surveys • School health check-up systems • Cancer registration • Health services utilization	• WHO European Health for All (HfA) Database • WHO European Information System on Alcohol and Health • WHO European Tobacco Control Database • WHO European Database on Nutrition, Obesity and Physical Activity • WHO European Childhood Obesity Surveillance Initiative • Eurostat • Health Behaviour in School-aged Children Survey	• WHO Global Infobase • WHO Global School-based Student Health Survey • WHO Global Tobacco Surveillance System (including Global Youth Tobacco Survey, Global School Personnel Survey, Global Health Professions Student Survey and Global Adult Tobacco Survey) • WHO-CDC Global Tobacco Surveillance System • WHO STEPS surveillance systems • WHO Global Health Observatory