World Health Organization
REGIONAL OFFICE FOR Europe

The WHO Global Monitoring Framework on noncommunicable diseases

Progress towards achieving the targets for the WHO European Region

Background paper for the WHO European Meeting of National NCD Directors and Programme Managers, Moscow, Russian Federation, 8–9 June 2017

Summary

In May 2013, the Sixty-sixth World Health Assembly adopted the comprehensive Global Monitoring Framework for the prevention and control of noncommunicable diseases (NCDs). The Framework comprises nine targets and 25 indicators across three areas, with a focus on key outcomes, risk factors and national system responses to the challenge of NCDs *(1)*. This report assesses the progress the WHO European Region as a whole is making towards achieving these targets (Table 1). Using the main indicators assigned for each target (1–3 indicators for each), it considers the data available, the trends and, where possible, projections to 2025.

This report was prepared for the WHO European Meeting of National NCD Directors and Programme Managers in Moscow, Russian Federation, on 8–9 June 2017. It is accompanied by a more detailed paper on premature mortality from NCDs and a report showing progress against the indicators of the United Nations time-bound commitments. These documents will be followed by a more substantial European NCD status report later in 2017. Together, they are intended as a contribution to the preparations for the WHO Global Conference on NCDs in October 2017 in Montevideo, Uruguay, and the third United Nations High-level Meeting on NCDs, scheduled to take place in 2018.

Table 1. Summary scorecard for the WHO European Region

Target	Progress/projections for the WHO European Region – "business as usual" scenario
1. A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory disease	If current trends continue, the Region is on course to exceed the target.
2. At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context	If trends continue, alcohol per capita consumption is expected to reduce by 9% by 2025.
3. A 10% relative reduction in prevalence of insufficient physical activity	It is not possible to make projections to 2025, but based on trends from surveys of adolescents and adults the Region is unlikely to achieve the target.
4. A 30% relative reduction in mean population intake of salt/sodium	It is not currently possible to make projections to 2025, but the Region is unlikely to achieve the target, given the current pace of change.
5. A 30% relative reduction in prevalence of current tobacco use	Projections are that the Region as a whole will not meet the target; nor will 36 of the 53 countries in the Region unless something more is done.
6. A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances	If current trends continue, the Region is on course to achieve the target, but widening of inequalities across Europe is likely.
7. Halt the rise in diabetes and obesity	The Region is well off track for reaching the 2025 target; prevalence of overweight/obesity is projected to rise and diabetes prevalence can be expected to do likewise.
8. At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	This is challenging to measure and projections to 2025 are not currently possible.
9. An 80% availability of the affordable basic technologies and essential medicines, including generics required to treat major NCDs in both public and private facilities	This is challenging to measure and projections to 2025 are not currently possible

Key to colour coding:

Red	Region is off course and unlikely to achieve the target
Amber	Region may or may not reach the target – progress/projections are difficult to measure
Green	Region is on course to achieve the target

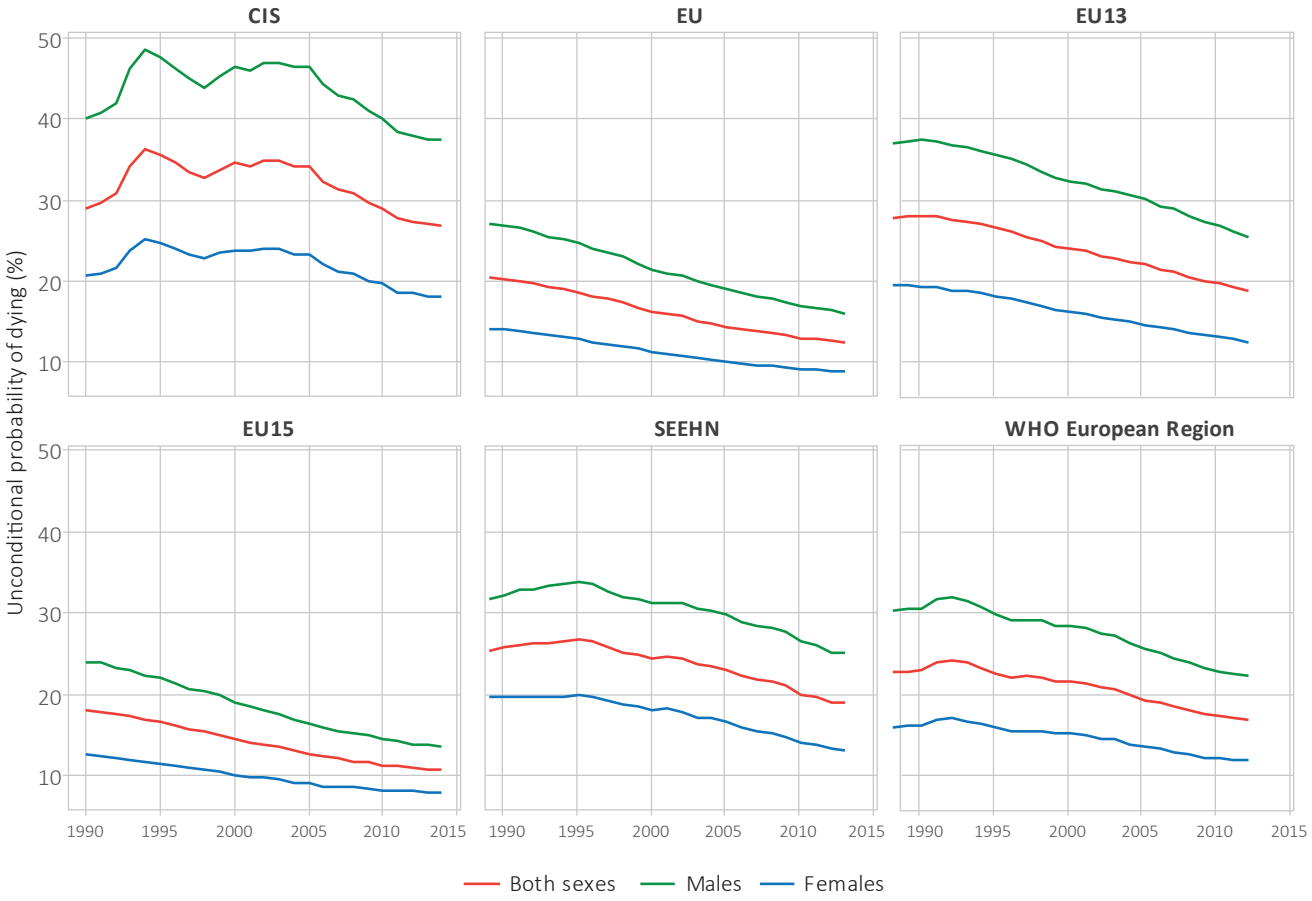
Premature mortality from NCDs

Target 1: At least 25% relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases

If current trends continue, the WHO European Region is on course to exceed the target.

Probability of premature death from the four major NCDs is given in Fig. 1.

Fig. 1. Unconditional probability of dying from the four major NCDs in the WHO European Region and selected subregions: trends, 1990–2014



Notes: CIS: Commonwealth of Independent States; EU: members of the European Union; EU15: members of the EU before May 2004; EU15: members of the EU before May 2004; SEEHN: South-eastern Europe Health Network (see the "Technical notes" section below for details of country groups).

After increasing in the first half of the 1990s, when it reached 24.2% in 1994 (31.9% for males and 17.0% for females), the probability of dying from NCDs decreased steadily in the WHO European Region and reached 16.9% in 2014 (22.4% for males and 11.8% for females). The rate of change was similar for males and females, but the gap stayed the same – an average of 89% higher.

Nevertheless, levels and progress have been very uneven between subregions. In CIS countries, rates remained relatively static between the mid-1990s and 2000s, following a steep increase after the break-up of the former Soviet Union in 1989. During this time, almost every second male and every fourth female died prematurely from the four major NCDs between the ages of 30 and 69 years. Premature mortality started to decline rapidly in 2005 and a relative reduction of 21.3% (2.63% average annual reduction) was witnessed until 2014, when it reached 26.9% (37.3% for males and 18.1% for females). The rates of decline are faster among females than among males (2.80% vs 2.40% annually), leading to an excess male mortality of 107% by 2014.

If recent trends continue, it is projected that the probability of premature death from the four major NCDs in the WHO European Region will reach 12.1% in 2025, a relative reduction of 33.1% on observed levels in 2010, with similar reductions for both men and women. Projected reductions are similar for EU (34.5%), CIS (34.0%) and SEEHN countries (34.1%). Projected reductions by gender are higher for males than for females in EU15, but smaller in CIS and SEEHN subregions. This topic is discussed in more detail in an accompanying paper.

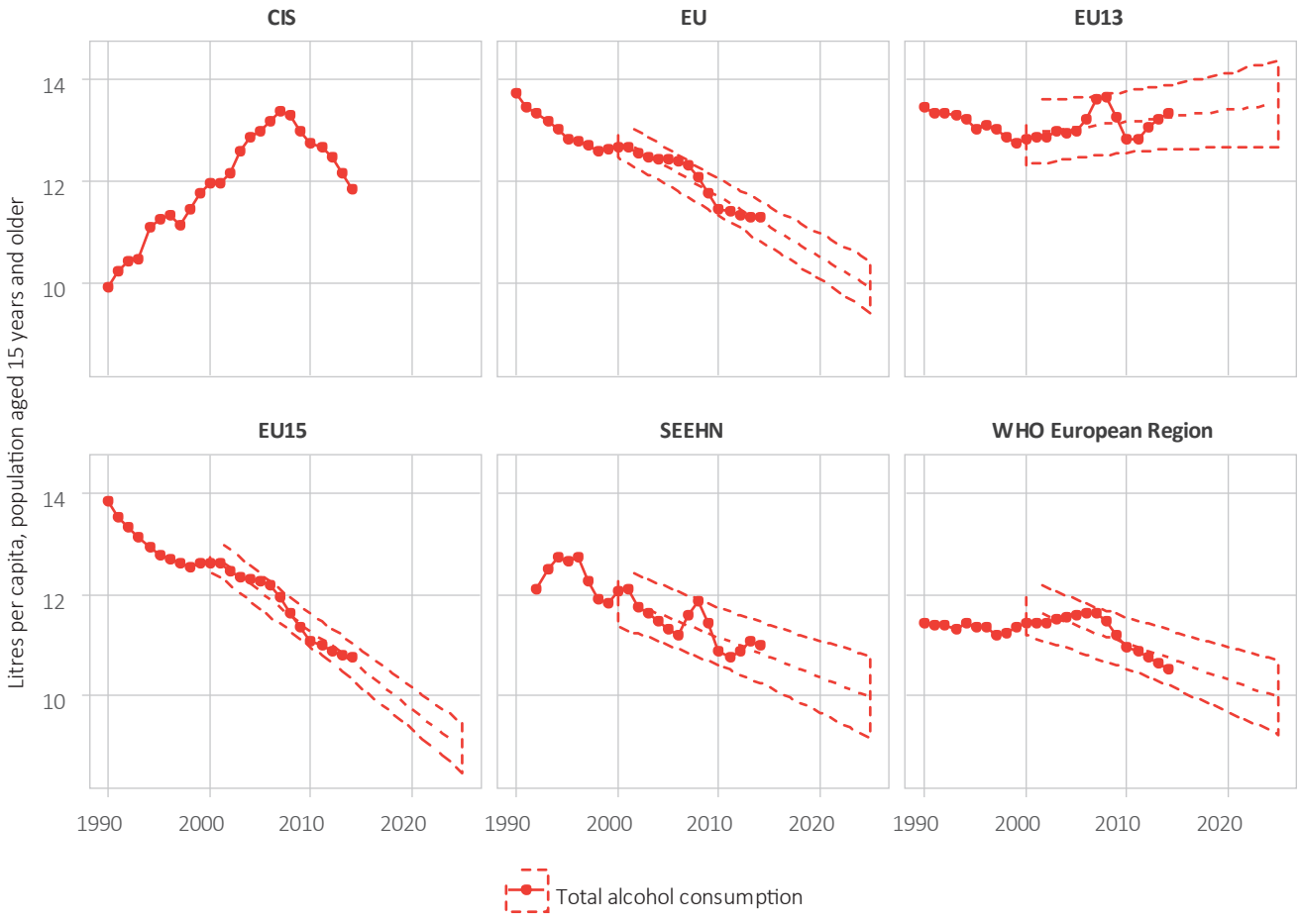
Harmful use of alcohol

Target 2: At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context

If trends continue, alcohol per capita consumption is expected to reduce by 9% by 2025.

The WHO European Region has the highest total (recorded and unrecorded) adult alcohol per capita consumption (APC) of all the WHO regions and almost double the world average.[1] Overall, the estimated APC for 51 of the 53 countries in the Region was 10.9 litres of pure alcohol in 2010, which decreased by 4% to 10.5 litres in 2014. If the trends observed since 2000 continue, the APC in the WHO European Region is likely to reduce by 9% by 2025, 1 percentage point below the global target (Fig. 2). Variability in the levels and projected reductions for subregions is wide, however, and the global target is likely to be achieved only in EU15 countries of those country groups analysed. It should be noted that APC in CIS countries spiked in 2007 and has been reducing fast since then. Variation was also considerable in the second half of 2000 for EU13 and SEEHN countries. Therefore, the projected reductions should be interpreted with caution.

Fig. 2. Total alcohol consumption by subregion 1990–2014 and projections to 2025, based on trends since 2000



Source: WHO Regional Office for Europe *(2)*.

[1] Alcohol consumption data referred to in this section have not yet been validated by countries, and small adjustments can be foreseen. Final data will be published in the global status report on alcohol and health in 2018.

Estimates of heavy episodic drinking, defined as the proportion of people drinking 60 g and more of pure alcohol on at least one occasion in the last 30 days, show that 16.3% of the total population of the WHO European Region were heavy drinkers in 2010, with more than three-fold differences between men (25.2%) and women (7.5%). The observed between country variation is considerable, ranging from 0.3% in Turkey to 38.5% in Austria.

According to the WHO estimates for 2012, the proportion of deaths attributable to alcohol consumption is 13.3% in the WHO European Region. Differences between countries are large, however, ranging from less than 2% to nearly 35% *(3)*. Recent data to estimate changes in alcohol-related mortality and morbidity are lacking. Nevertheless, using age-standardized premature death rates (before the age of 65 years) from chronic liver disease as a proxy measure, the data show a slight decrease from 12.27 to 11.02 deaths per 100 000 people between 2010 and 2014.

Physical inactivity

Target 3: A 10% relative reduction in prevalence of insufficient physical activity

It is not possible to make projections to 2025, but based on trends from surveys of adolescents and adults the Region is unlikely to achieve the target.

WHO recommends that adults (including older people) engage in at least 150 minutes of moderate-intensity aerobic physical activity each week *(4)*. Figures from EU countries indicate that six in every 10 people above 15 years of age never or seldom exercise or play any sport, and more than half never or seldom engage in other kind of physical activity, such as cycling or walking, household chores or gardening. Another study confirms this trend, pointing out that one third of adults in Europe are insufficiently active, particularly people from low socioeconomic backgrounds and minority ethnic groups and people with disabilities *(5)*. Physical activity levels have also declined among adolescents aged 11–15 years; overall moderate-to-vigorous-intensity physical activity levels are low and decline with age during the adolescent years. Girls are consistently less active than boys.

In 2010, estimates of the prevalence of physical inactivity among adults – defined as less than 150 minutes of moderate-intensity or less than 75 minutes of vigorous-intensity physical activity per week – in the WHO European Region ranged between 10.1% and 38.6% in males and between 11.7% and 47.2% in females. Simultaneously, the Region observed a reduction in levels of physical activity across all age groups, with a steep decline among older children and adolescents, particularly among girls. Among older children and adolescents aged 11–17 years, estimates of the prevalence of physical inactivity – defined as less than 60 minutes of moderate-to-vigorous-intensity physical activity daily – ranged between 65.6% and 91.0% among boys and between 79.6% and 91.2% among girls.

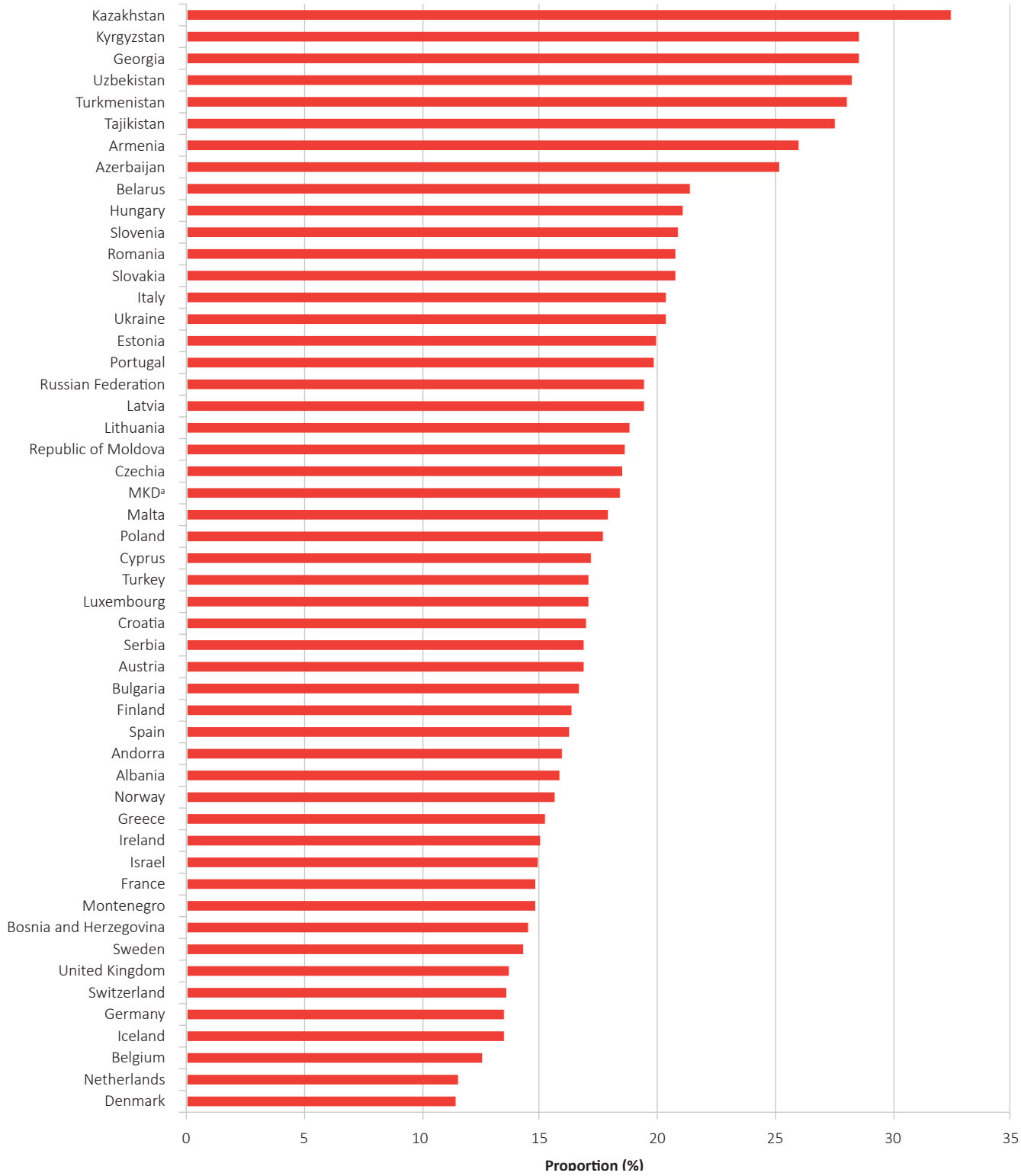
Salt/sodium intake

Target 4: A 30% relative reduction in mean population intake of salt/sodium

It is not currently possible to make projections to 2025, but the Region is unlikely to achieve the target given the current pace of change.

A high dietary intake of sodium is associated with elevated blood pressure – a major risk factor for cardiovascular disease. A recent meta-analysis found that across nine regions of the world, the absolute rate of sodium-associated deaths from cardiovascular causes was highest in central Asia and eastern and central Europe (13%) *(6)*. The proportion of cardiovascular deaths attributable to high sodium intake is particularly high for premature deaths among males (Fig. 3). In central Asia and eastern and central Europe, almost every third premature death from stroke and every fifth premature death from heart attack in males can be attributed to sodium intake of more than 2 g/day.

Fig. 3. Proportion of cardiovascular deaths among 20–69-year-old males attributed to sodium consumption of more than 2 g per day in 2010, by country



[a]MKD: the former Yugoslav Republic of Macedonia (abbreviation by the International Organization for Standardization (ISO)).
Source: Mozaffarian et al. *(6)*.

WHO does not have figures for mean population intake of sodium in the WHO European Region, but the availability of country-specific data is growing as more countries carry out surveys. Current daily salt consumption in most European countries is estimated via dietary surveys, and approximately one in every four countries already perform urine excretion surveys. Salt intake based on different methods is estimated to be 7–18 g/day, with no countries meeting WHO's

recommended level of 2 g sodium/day (equivalent to 5 g salt/day) *(7)*. Nevertheless, insufficient trend data are available to develop projections to 2025.

A relatively small number of countries in the Region have been able to show success in reducing salt intake at the population level. According to a recent systematic review of progress towards Target 4 *(8)*, nine countries reported a reduction in population salt intake. Despite the heterogeneity in the measurement tools to monitor changes in sodium intake, which may affect the magnitude of change over time, the reductions ranged from about 5% in France between 1999 and 2007 to 36% in Finland between 1979 and 2007. In any case, the pace of these reductions, if maintained, would not be enough to achieve the WHO salt reduction target by 2025.

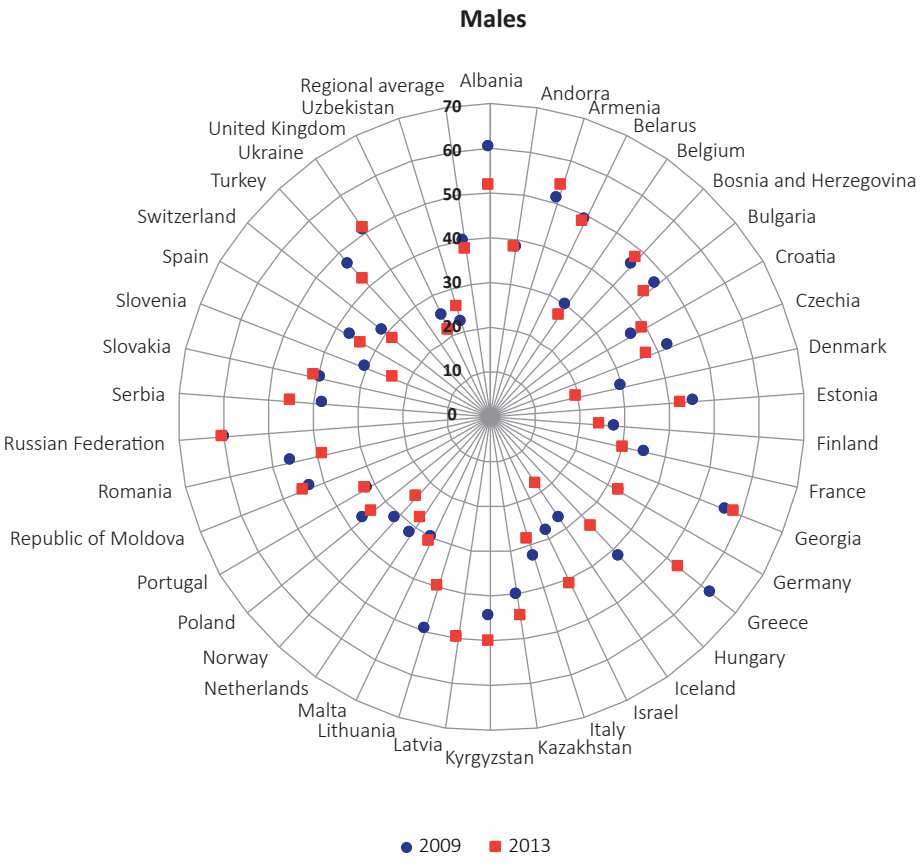
Tobacco use

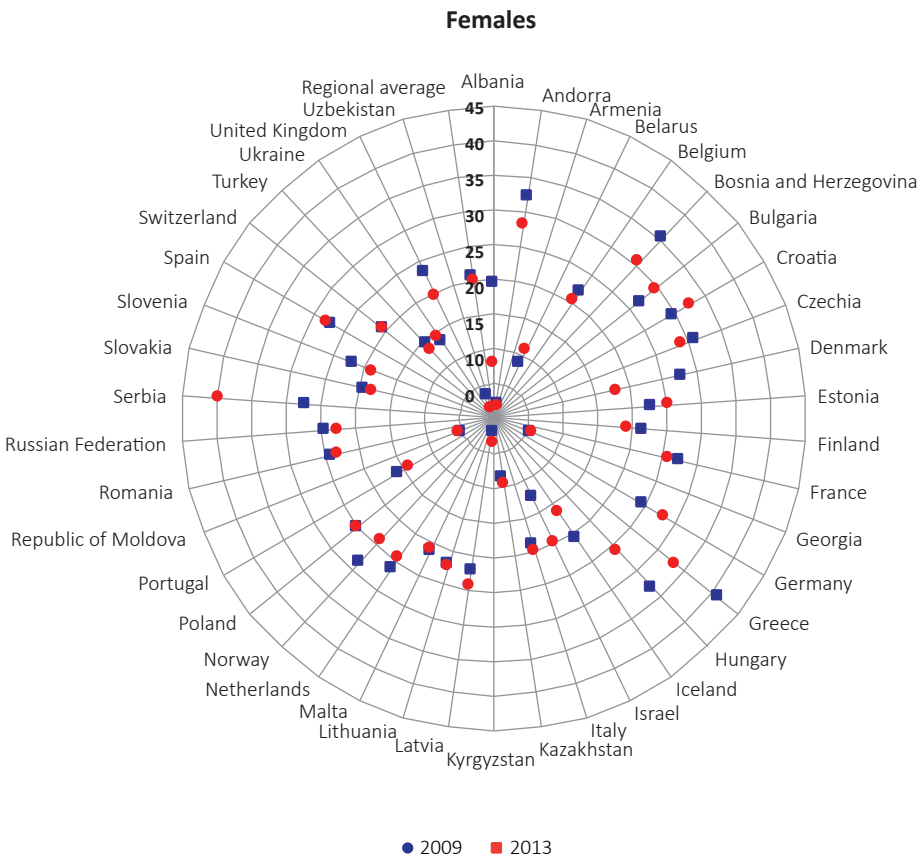
Target 5: A 30% relative reduction in prevalence of current tobacco use

Projections are that the Region as a whole will not meet the target; nor will 36 of the 53 countries in the Region unless something more is done.

The Region has one of the highest attributable mortality levels due to tobacco use (smoking and smokeless). Tobacco use accounts for 16% of all deaths in adults aged over 30 years, many of which occur prematurely (before 70 years).
Of the six WHO regions, the European Region has the highest prevalence of tobacco smoking among adults (29%) and some of the highest prevalence of tobacco use by adolescents. The gender difference in prevalence remains substantial in many countries, with 39% of men and 21% of women smoking tobacco in 2013 (Fig. 4). Nonetheless, the gap in prevalence between men and women is now very small (<5%) in some countries such as Denmark, Ireland, the Netherlands, Norway, Sweden and the United Kingdom. The prevalence is projected to be 31% for men and 16% for women by 2025, which corresponds to a projected relative reduction of 22% and 25% for male and female populations, respectively *(9)*.

Fig. 4. Tobacco smoking prevalence between 2009 and 2013 for males and females





Source: WHO *(10)*.

Raised blood pressure

Target 6: A 25% relative reduction in the prevalence of raised blood pressure, or contain the prevalence of raised blood pressure, according to national circumstances

If current trends continue, the Region is on course to achieve the target, but widening of inequalities across Europe is likely.

The main indicators for this target are age-standardized prevalence of raised blood pressure (BP) and mean systolic BP among adults (see the "Technical notes" section below for details). Prevalence of raised BP measures the number of high-risk people, irrespective of treatment status *(11)*. Trends in mean population BP measure how the BP distribution has shifted over time.

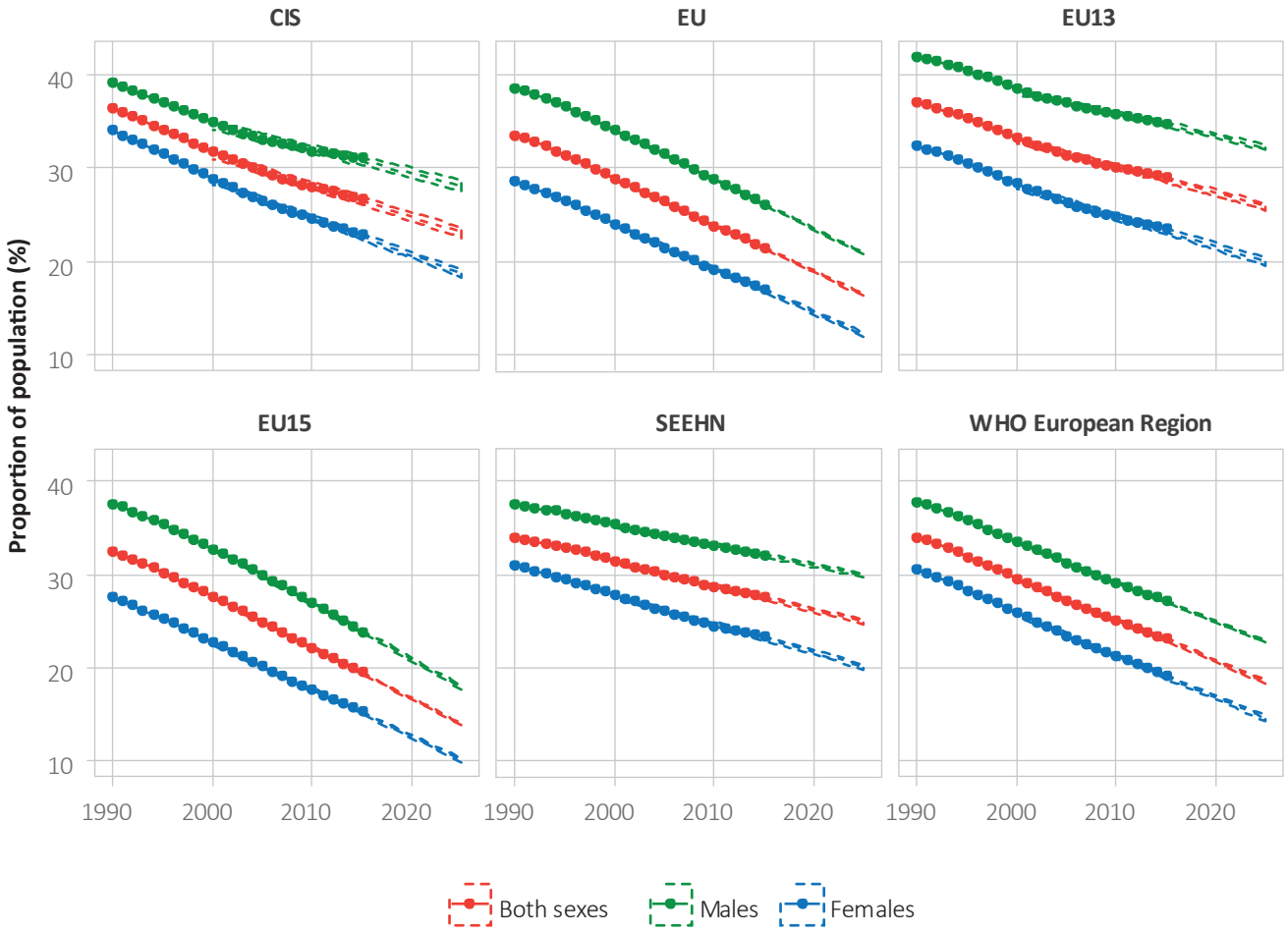
In the last 40 years (1975–2015), mean systolic BP decreased markedly in high-income countries while remaining persistently high in central and eastern Europe *(11)*. Whereas mean systolic BP seems to have decreased in women in central and eastern Europe, and more recently in central Asia, there has been little or no change in mean systolic BP in men in these subregions *(11)*. Men from some countries in central and eastern Europe have the highest mean systolic BPs in the world.

In general, male/female differences in age-standardized mean systolic BP and prevalence of raised BP are largely due to differences among people aged under 50 years; above 50 years, men and women have similar figures. Male/female differences in BP in 2015 were largest in central and eastern Europe and high-income countries and the male excess has increased since 1975. Males are on average 41% more likely to suffer from high BP than females, with substantial variance between genders by country.

Prevalence of raised BP in the WHO European Region was estimated to be 23.1% in 2015, a 7.9% reduction from 25.0% in 2010. There are two-fold differences between countries in prevalence figures, which range from 15.1% to 32.1%. Subregional prevalence ranges from 22.1% (EU15) to 30.1% (EU13). Prevalence is higher among males (29.1%) than females (21.2%) in the WHO European Region and all subregions, with the highest prevalence of 35.8% among males in EU13 countries.

If current trends for prevalence of raised BP continue, the Region is about to achieve the target of 25% relative reduction by 2025. Progress is uneven across the subgroups, however, and subregions with the highest burdens show the slowest progress. For example, the relative reduction is 37.1% for EU15 and 13.2% for EU13 countries. This will result in a further increase of inequalities between countries if current trends continue.

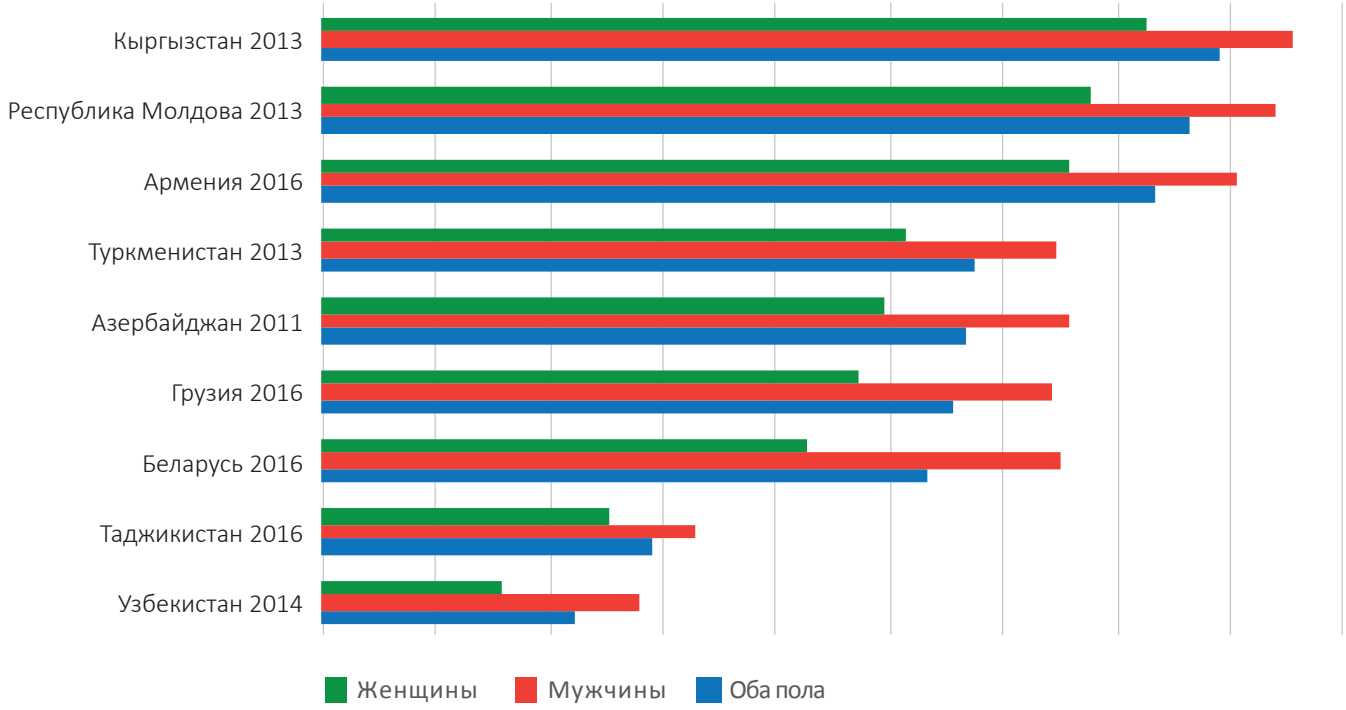
Fig. 5. Prevalence of raised BP by gender for sub-regions 1990–2015 and projections to 2025 based on trends since 2000



Source: WHO *(10)*.

Evidence from recent WHO STEPwise approach to surveillance (STEPS) surveys *(12)* in eight countries (Fig. 6) indicates that between 22% and 79% of people with raised BP (systolic BP =>140 mmHg and/or diastolic BP =>90 mmHg) are currently not on hypertension medication to control it. Results also highlight gender differences in the BP control gap, with men generally showing significantly worse results than women.

Fig. 6. Percentage of adults with raised BP currently not on hypertension medication



Note: data for Turkmenistan and Uzbekistan cover 18–64 years; data for Kyrgyzstan cover 25–64 years; all other data cover 18–69 years.
Source: evidence from WHO STEPS surveys from eight countries.

Diabetes and obesity

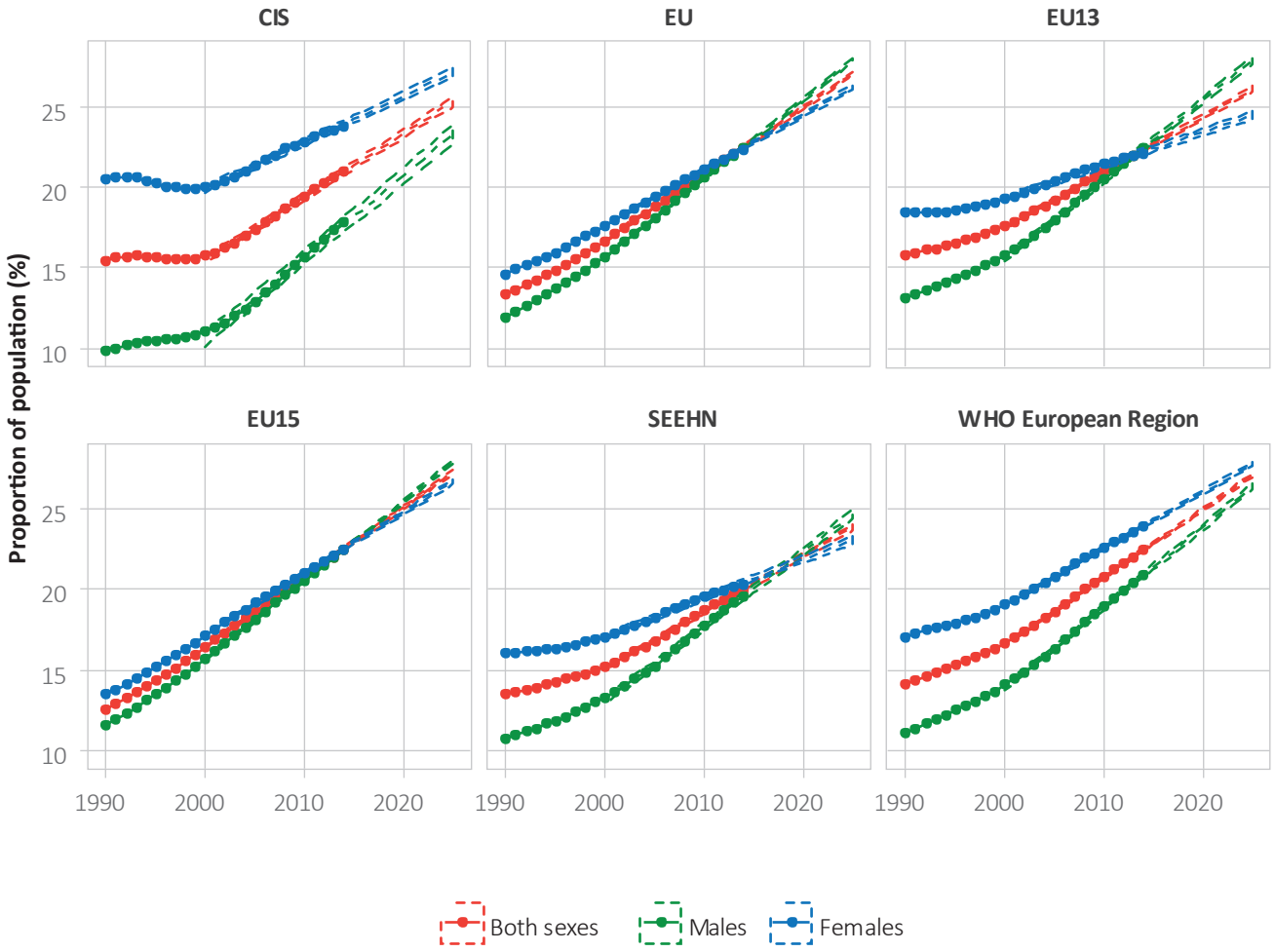
Target 7: Halt the rise in diabetes and obesity

The Region is well off track for reaching the 2025 target: prevalence of overweight/obesity is projected to rise and diabetes prevalence can be expected to do likewise.

The prevalence of overweight and obesity in the Region has been increasing steadily to alarming levels. In 2010 WHO estimated that 56.1% of the adult population was overweight (body mass index (BMI) ≥25 kg/m^2) *(10)*; by 2014 the prevalence increased to 58%. In general, more men are overweight than women (62.5% versus 53.7%) and prevalence is increasing faster for males, especially in CIS, SEEHN and EU13 countries; this will result in further increases of inequality between sexes. Prevalence below 50% was estimated in only five countries in the WHO European Region. The prevalence of obesity BMI ≥30 kg/m^2 increased from 20.8% in 2010 to 22.5% in 2014. Women were more likely to be obese than men (23.9% versus 20.9%), but male obesity prevalence is increasing nearly twice as fast. Differences between countries are more pronounced for obesity (range 13.6–29.5%) than for overweight (range 44.9–66.9%) but the projected increase of obesity to 2025 is twice as high as that of overweight (Fig. 7).

By 2025, in all countries in the WHO European Region except Tajikistan, more than half of the adult population will be overweight or obese, meaning that the majority of adults will be at an increased risk of disease and disability, placing an immense economic and social strain on health systems and wider society. It has been estimated that severe obesity (BMI 40 kg/m^2 and over) will affect 9% of women and that no country globally will achieve the WHO target by 2025 *(13)*. An estimated 64 million people are living with diabetes in the European Region, comprising 33 million women and 31 million men aged 18 years and over. Following the overweight and obesity trends, the age-standardized prevalence of diabetes rose from 7.6% to 8.1% for males and from 6.7% to 7.0% for females between 2010 and 2014. Increases were observed for all subregions, except for females in EU15 countries, where the rate remained constant. Between-country variation was more than two-fold for males, ranging from 5.2% to 13.3%. Differences were even higher for females, with prevalence ranging from 2.8% to 14.2%. WHO has not developed projections for diabetes prevalence to 2025, but based on overweight/obesity projections, it is likely that it will continue to rise.

Fig. 7. Prevalence of obesity by gender for subregions 1990–2014 and projections to 2025, based on trends since 2000



Source: WHO *(10)*.

Drug therapy to prevent heart attacks and strokes

Target 8: At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes

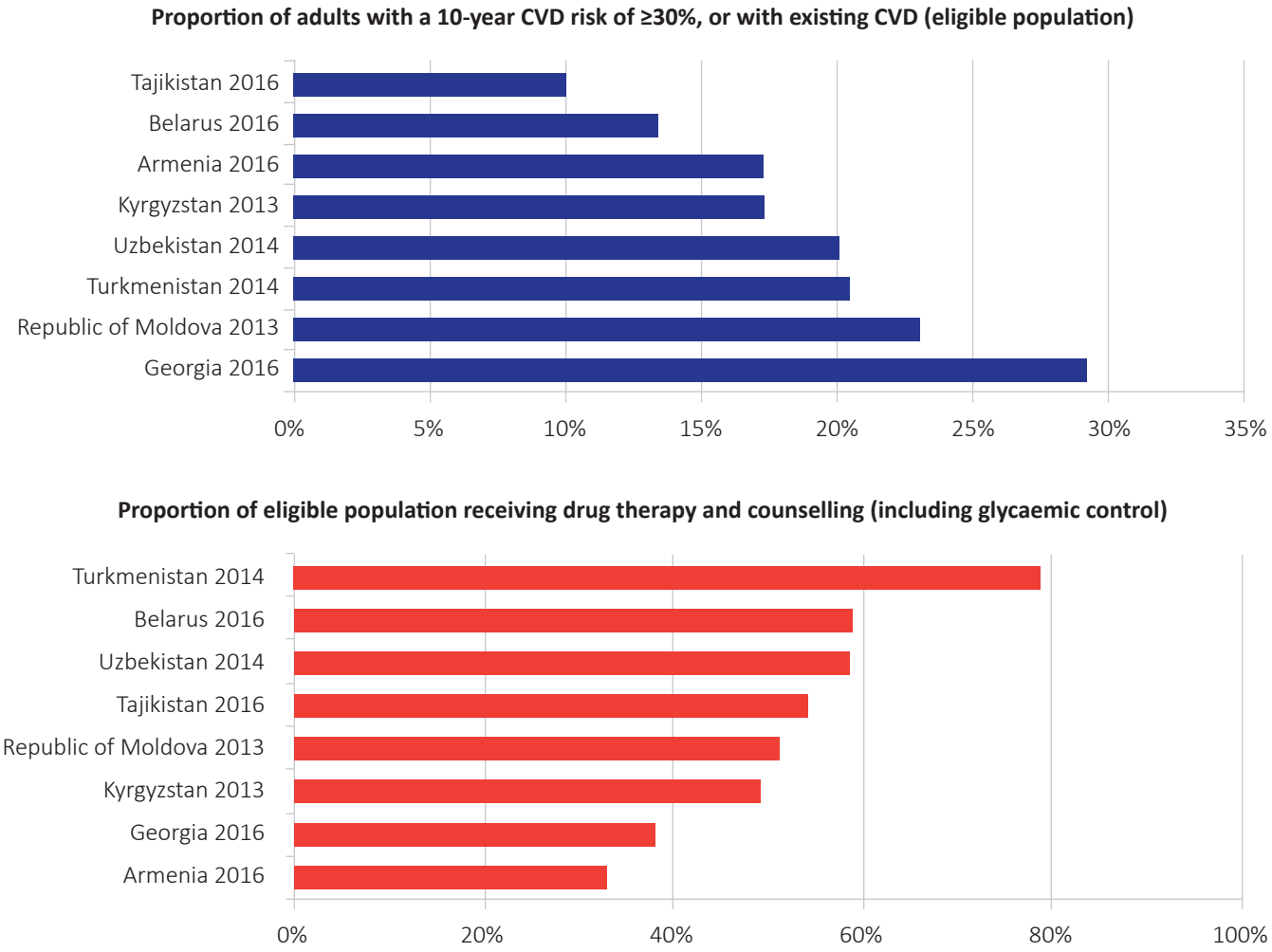
This is challenging to measure and projections to 2025 are not currently possible.

Among its menu of policy options and cost-effective interventions for prevention and control of cardiovascular diseases (CVD), WHO promotes drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke or with high risk of a fatal or nonfatal cardiovascular event in the next 10 years. High risk is quantified as a probability of ≥30% or ≥20% for such an event using the WHO risk prediction charts *(14)*, depending on the resource context: setting the threshold at ≥30% is considered feasible in all resource settings, whereas applying a lower risk threshold is likely to be feasible only in a more limited range of settings because it increases implementation cost.

Progress in implementing this "best buy" and achieving Target 8 for the WHO European Region is difficult to assess. The Global Monitoring Framework methodology proposes estimation using population-based nationally representative surveys, such as WHO STEPS, that ask specifically about relevant medication and counselling by health workers. Analysis of eight recent STEPS surveys found that the proportion of adults aged over 40 years (both sexes) in the population at high CVD risk varied three-fold from 9.5% in Tajikistan to 29.0% in Georgia, with a statistically significant difference between the sexes only for the Republic of Moldova (Fig. 8). For seven of these eight countries, the proportion of eligible people receiving drug

therapy and counselling was calculated and found to range from 33% to 79%, with five countries achieving the target of at least 50%.

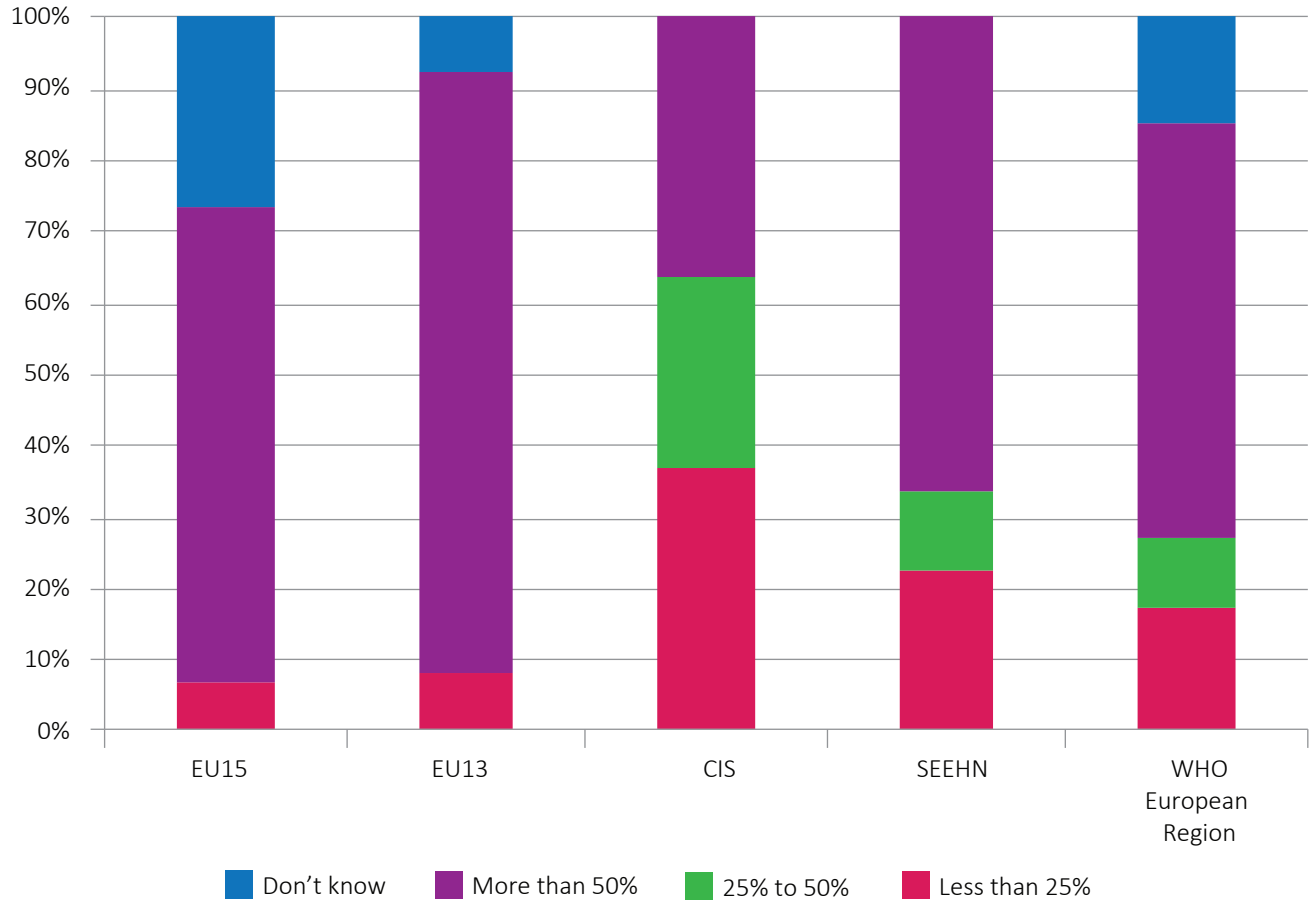
Fig. 8. Adults aged over 40 years with a 10-year CVD risk of ≥30%, or with existing CVD and proportion receiving drug therapy and counselling to prevent heart attacks and strokes



Source: evidence from WHO STEPS surveys from eight countries.

For other countries that have not carried out such surveys, estimation of progress may be challenging. Preliminary data for the WHO European Region from the WHO Country Capacity Survey (CCS) in 2017 *(15)* indicate that CVD risk stratification for the management of patients at high risk of heart attack and stroke is provided in more than 50% of primary care facilities in 26 (49%) countries (see Fig. 9), but there is substantial variability between the subregions in the availability of these services.

Fig. 9. Proportion of countries offering cardiovascular risk stratification for the management of patients at high risk of heart attack and stroke in primary care by country group, 2017



Implementation of CVD risk assessment and management programmes can be challenging; national programmes can struggle to achieve high coverage and control of risk factors among the eligible population during implementation *(16)*. One study of clinical practice in 12 European (largely EU) countries found that only two thirds (68.5%) of physicians reported using global risk calculation tools, citing time constraints, lack of perceived usefulness and inadequate knowledge as common reasons for not using them *(17)*.

Essential medicines and technologies

Target 9: An 80% availability of the affordable basic technologies and essential medicines, including generics required to treat major NCDs in both public and private facilities

This is challenging to measure and projections to 2025 are not currently possible.

The minimum list of essential medicines referred to for this target are at least these nine: aspirin, a statin, an angiotensin-converting enzyme inhibitor, thiazide diuretic, a long-acting calcium-channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant. The minimum basic technologies referred to are at least these six: a BP measurement device, a weighing scale, height measuring equipment, blood sugar and blood cholesterol measurement devices, with strips and urine strips for albumin assay.

Analysis of the data from the WHO CCS for the WHO European Region in 2015 shows that the minimum nine medicines and six technologies were "generally available" (that is, available in 50% or more of public and private facilities) in 63.5% of countries *(18)*. This had dropped to 56.6% in 2017 according to the preliminary analysis of the WHO CCS data for 2017 *(15)*. Nevertheless, a perception of general availability of medicines does not necessarily mean that they are easily accessible to patients or affordable – a factor particularly important when patients at high risk for CVD, for example, require long-term treatment with multiple medicines. A recent WHO report highlighted the substantial out-of-pocket costs incurred by

patients for medicines *(19)*. The introduction and expansion of health insurance programmes are important opportunities to try to ensure inclusion of the key NCD medicines in the basic health care package in order to promote affordable access. Monitoring progress against this target in the WHO European Region is challenging. The data should be monitored through nationally representative health facility assessments – for example, using the WHO service availability and readiness assessment (SARA) tool *(20)* – but very few countries within the Region have done this. It may be that this indicator is less meaningful in the European context, given that most of the medicines are prescription medicines dispensed through pharmacies rather than available in public health care facilities.

Technical notes

The WHO Global Monitoring Framework on NCDs includes nine voluntary targets for prevention and control by 2025 and 25 indicators used to monitor progress *(1)*. The following indicators and sources of data were used in this report.

- Probability of dying (Target 1) shows the percentage of 30-year-old people who would die before their 70th birthday from CVD, cancer, diabetes or chronic respiratory disease; it was calculated using cause-specific mortality rates in standard life table methods.
- For Target 2, three indicators are referred to. Recorded APC is defined as the recorded amount of alcohol consumed per capita (15+ years) over a calendar year in a country, in litres of pure alcohol. Heavy episodic drinking is defined as the proportion of adults (15+ years) who have had at least 60 g or more of pure alcohol on at least one occasion in the past 30 days.
- Prevalence of insufficient physical activity (Target 3) is defined as less than 60 minutes of daily vigorous-to-moderate-intensity physical activity among adolescents and 150 minutes of moderate activity per week (or equivalent) among adults.
- For Target 4, age-standardized mean population of salt (sodium chloride) per day in persons aged 18 years or older is considered.
- Age-standardized prevalence of current smoking of any tobacco product (Target 5) by persons aged 15 years and above is calculated from analysis of the full set of adult tobacco-use surveys.
- Age-standardized proportion of population with systolic BP ≥140 mmHg or diastolic BP ≥90 mmHg is used as prevalence of raised BP (Target 6).
- For target 7, two indicators are referred to: age-standardized prevalence of raised fasting blood glucose (≥126 mg/dl/7.0 mmol/l) or use of glucose-lowering medication; and age-standardized prevalence of overweight, defined as body mass index (BMI) ≥25 kg/m^2.
- Target 8 refers to the percentage of eligible persons (defined as those aged 40 years and older with a 10-year CVD risk ≥30%, including those with existing CVD) receiving drug therapy and counselling to prevent heart attacks and strokes. Drug therapy is defined as taking medication for raised blood glucose/diabetes, raised total cholesterol or raised BP, or taking aspirin or statins to prevent or treat heart disease. Counselling is defined as receiving advice from a doctor or other health worker to quit using tobacco or not start, reduce salt in diet, eat at least five servings of fruit and/or vegetables per day, reduce fat in the diet, start or do more physical activity and maintain a healthy body weight or lose weight.
- Target 9 refers to the percentage of public and private primary health care facilities that have all the following available: medicines – at least aspirin, a statin, an angiotensin converting enzyme inhibitor, thiazide diuretic, a long-acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant; technologies – at least a BP measurement device, a weighing scale, blood sugar and blood cholesterol measurement devices, with strips and urine strips for albumin assay.

All age-standardized rates are standardized to the WHO standard world population.
Projections are based on linear least squares model fitted to existing data since 2000.

Country groups

EU15 Members of the EU before May 2004 (15 countries): Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom

EU13 Members of the EU from May 2004 (13 countries): Bulgaria, Croatia, Cyprus, Czechia, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia

CIS Commonwealth of Independent States (11 countries): Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan

SEEHN South-eastern Europe Health Network (nine countries): Albania, Bosnia and Herzegovina, Bulgaria, Israel, Montenegro, the Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia

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