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Progress reports

This document contains progress reports on:

A. implementation of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (resolution EUR/RC61/R4);

B. implementation of the European Food and Nutrition Action Plan 2015–2020 (resolution EUR/RC64/R7);

C. implementation of the European Mental Health Action Plan (resolution EUR/RC63/R10); and

D. implementation of the International Health Regulations (2005) in the WHO European Region (resolution EUR/RC59/R5).

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Category 2. Noncommunicable diseases

A. Progress on implementation on the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (resolution EUR/RC61/R4)

Background: the need for strengthened action in Europe

1. In resolution EUR/RC61/R4, adopted in 2011, the 61st session of the WHO Regional Committee for Europe called on Member States[1] to use the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (document EUR/RC61/13) as a basis for formulating or, if appropriate, reformulating national alcohol policies and action plans. It also requested the Regional Director to assist Member States and organizations in preparing and implementing national policies to prevent or reduce the harm resulting from alcohol consumption; to monitor the progress, impact and implementation of the Action Plan; and to use the information collected to revise and update the European Information System on Alcohol and Health.

2. The WHO European Region has the highest adult alcohol consumption of the six WHO regions. In 2016, the European average for alcohol consumption for adults (aged $\geq$ 15 years) was 10.2 L of pure alcohol – a decline from 11.9 L in 2007 and 11.2 L in 2010. Country-specific trends for 51 Member States can be seen in Annexes A1 and A2. From 2012 to 2016, adult alcohol consumption decreased in 53% of Member States; increased in 37% of Member States, and remained constant in 10% of Member States. The average unrecorded consumption in 2016 was estimated to be 1.9 L of pure alcohol, which accounts for 18.6% of the total consumption in the European Region; the percentage has been stable during the past 10 years. In 2016, the 12-month abstention rate was on average 30%; the lowest abstention rates were in western Europe and the highest were in Member States with a large proportion of Muslims, such as Turkey and the central Asian countries. Men drink more than women: for drinkers only, the average per capita consumption in 2014 was 19.4 L of pure alcohol for men and 12.9 L for women. Heavy episodic drinking is defined as drinking at least 60 g of alcohol during one drinking event. On average and for drinkers only, 31.8% of men and 12.6% of women reported heavy episodic drinking during the past month, with large differences among Member States.

3. Estimates from 2010 indicate that 6.4% of adult men and 1.2% of adult women in the European Region are alcohol dependent, and 12.6% of adult men and 2.9% of adult women have an alcohol use disorder.

[1] And regional economic integration organizations, where applicable.

Alcohol policy developments: the 10 action areas[2]

Leadership, awareness and commitment

4. Since the endorsement of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 in 2011, countries are either developing or reformulating a national alcohol policy. Of the 53 Member States that had provided information to the WHO Regional Office for Europe by December 2016, 38 had a written national policy on alcohol, and 13 of these were in the process of updating their policy. Of the 15 Member States without a national alcohol policy, 10 were in the process of developing one.

5. Since 2011, the following countries have changed or adopted an alcohol policy: Albania, Austria, Azerbaijan, Belarus, Bulgaria, Cyprus, Czech Republic, Estonia, Finland, France, Georgia, Germany, Iceland, Ireland, Israel, Kazakhstan, Latvia, Lithuania, Montenegro, the Netherlands, Norway, Poland, Portugal, the Republic of Moldova, the Russian Federation, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Tajikistan, the United Kingdom of Great Britain and Northern Ireland and Uzbekistan.

Health services' response

6. The health sector plays an important role in identifying both people who drink at a harmful level and those who need treatment for an alcohol use disorder. A number of countries are working to conduct screening and to provide brief interventions in primary health care settings, and 30 Member States[3] have clinical guidelines for brief interventions that have been approved or endorsed by at least one professional health care body.

Community and workplace action

7. Community-based intervention projects involving stakeholders exist in 43 Member States.[4] The most commonly involved partners are nongovernmental organizations (41 Member States) and local government bodies (32 Member States).[4] Involvement of economic operators, which in most cases means the alcoholic beverage industry, was reported by 20 Member States.[4]

8. Twenty-two Member States have national guidelines for the prevention of and counselling for alcohol problems in the workplace,[5] and in 19 Member States, testing for alcohol in the workplace is governed by legislation.

Drink–driving policies and countermeasures

9. All but two countries have a maximum blood alcohol concentration of 0.5 g/L or less for drivers in the general population. Seven countries have adopted legislation on a zero-tolerance level.

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[2] For information on which Member States have adopted various measures, please refer to the European Information System on Alcohol and Health (http://who.int/gho/eisah, accessed 10 April 2017).
[3] Data not available for three Member States.
[4] Data not available for two Member States.
[5] Data not available for one Member State.

10. Random breath-testing, in which any driver can be stopped by the police at any time to test his or her breath for alcohol, is used by 47 Member States. Sobriety checkpoints or roadblocks established by the police on public roadways to control for drink–driving are used by 32 Member States as a means to enforce the maximum legal blood alcohol concentration.

Availability of alcohol

11. All Member States have regulated age limits for the sale of alcoholic beverages. The most frequently applied limit is 18 years for all beverage types; however, eight countries still have a limit of 16 years for off-premise sales of beer and wine. For off-premise sales, 24 countries have restrictions on hours of sale, 33 countries have restrictions during specific events, and 23 countries have restrictions on sales at petrol stations. Thirty-one countries reported that they had banned alcohol consumption in health care establishments,[5] 33 in educational buildings, 20 in government buildings[5] and 25 on public transport.

12. Thirty-four Member States have reported restrictions on on-premise sales of alcohol to intoxicated persons.[4] Between 30 and 32 Member States have reported restrictions on locations of sales, depending on beverage and sales outlet type, and very few Member States reported restrictions on days of sale or on density of outlets.

Marketing of alcoholic beverages

13. In 49 Member States, there are legally binding regulations on alcohol advertising, and 39 countries have restrictions on alcohol product placement. Thirteen Member States have reported a total ban on national television advertising of beer, and 13 and 20 Member States have a total ban on national television advertising of wine and spirits, respectively. Six Member States reported no restrictions on national television advertising of beer, and five and three Member States have no restrictions on national television advertising of wine and spirits, respectively. All other countries have either partial or voluntary regulations.

Pricing policies

14. Except in one Member State, alcoholic beverages are subject to value-added tax of above 0%, the rate varying from 4.5% to 27%;[5] most countries levy taxes of 15–20%. All but one Member State reported that excise duty is levied on spirits, and all but two Member States reported that it is levied on beer;[5] 15 Member States do not have excise duty on wine.[5] Sixteen Member States reported that the level of excise duty is regularly adjusted for inflation.

15. A few countries (Kazakhstan, Kyrgyzstan, the Russian Federation, Slovakia, Ukraine and Uzbekistan) have reported that they impose a minimum retail price on alcoholic beverages. Scotland has passed legislation for the introduction of a minimum pricing policy.

Reducing the negative consequences of drinking and alcohol intoxication

16. Nineteen Member States reported that systematic alcohol server training courses are organized regularly. Server training can be mandated by state or local laws, for example, as a prerequisite for obtaining a licence to sell or to serve alcoholic beverages.

17. Thirteen Member States legally require the presence of safety messages or health warnings on bottles, cans or other packaging containing alcoholic beverages to inform or to remind consumers of the risks associated with alcohol use.

18. Sixteen Member States have reported national legal requirements to display information for consumers on calories, additives and vitamins on the labels of alcohol containers.[5]

Reducing the public health impact of illicit alcohol and informally produced alcohol

19. At the time of data collection, all but two Member States reported that they had national legislation to prevent the illegal production or sale of informally or home-produced alcoholic beverages.

20. Applications of duty-paid, excise or tax stamps or labels on alcoholic beverage containers was reported by nine Member States for beer, by 22 Member States for wine and by 33 Member States for spirits.

Monitoring and surveillance

21. Thirty-seven Member States reported that they had national systems for monitoring alcohol consumption and its health and social consequences, consisting of a data repository containing a range of population-based and health facility data.

22. Forty-one Member States reported regular publication of comprehensive reports on the national alcohol situation. Thirty-five Member States reported publication of national reports with epidemiological data on the prevalence and patterns of alcohol use and alcohol use disorders.[5] Thirty-eight Member States reported publication of national reports with data from health services on alcohol use and alcohol use disorders.[5]

Key developments in alcohol policy

23. There have been a number of developments in the European Region since the adoption of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020. Clearly, it is not possible to attribute these changes directly to specific actions taken by Member States or to WHO interventions; however, since the *European Status Report on Alcohol and Health 2010* was published,[6] some countries have introduced stricter alcohol policies, as indicated below.

(a) The number of Member States with a written national or subnational policy increased from 30 to 38; 72% of all Member States in the European Region now have such a policy.

(b) The number of Member States that had conducted national awareness-raising activities increased from 39 to 49.

(c) The number of Member States with a blood alcohol concentration limit of 0.5 g/L or less for drivers in the general population increased from 42 to 51, and random breath-testing is now used by 47 Member States, compared to 27 in 2010.

[6] Based on data provided by 45 Member States.

(d) The number of Member States with a minimum age limit of 18 years for off-premise sales of alcoholic beverages increased from 31 to 43.

(e) The number of Member States with legally binding regulations on alcohol advertising increased from 42 to 49.

(f) The number of Member States with legally binding restrictions on alcohol product placement increased from 31 to 39.

(g) The number of Member States that require health warnings on alcohol advertising increased from 12 to 22.

(h) The number of Member States in which the level of taxation for alcoholic beverages is adjusted for inflation increased from 7 to 16.

(i) The number of Member States with legislation to prevent the illegal production or sale of informally or home-produced alcoholic beverages increased from 41 to 51.

Role of the Regional Office

Governance

24. Since 1992, when the first European Alcohol Action Plan (document EUR/RC42/8) was adopted by the 42nd session of the Regional Committee in resolution EUR/RC42/R8, the Regional Office has organized consultations with national representatives on alcohol policy. Following the adoption of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 in 2011, national representatives on alcohol policy have attended regional consultations in Warsaw, Poland (2012), Istanbul, Turkey (2013), Geneva, Switzerland (2014), and Ljubljana, Slovenia (2016). The most recent regional consultation was organized back to back with the 7th European Alcohol Policy Conference, hosted by the Slovenian Ministry of Health in November 2016. At a special workshop on the prevention of fetal alcohol spectrum disorders held during the regional consultation, the Regional Office launched the publication *Prevention of Harm Caused by Alcohol Exposure in Pregnancy: Rapid Review and Case Studies from Member States*. In 2016, the Regional Office also published the report *Public Health Successes and Missed Opportunities: Trends in Alcohol Consumption and Attributable Mortality in the WHO European Region, 1990–2014*. National focal points have supported the Regional Office by providing data on alcohol consumption, harm and policy developments, which were used for the European Information System on Alcohol and Health.

25. The Regional Office has published and distributed the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 as a stand-alone publication in English and Russian; the publication includes the text of resolution EUR/RC61/R4 and definitions of the indicators for the 10 action areas. The European Action Plan follows the five objectives and 10 action areas of the Global Strategy to Reduce the Harmful Use of Alcohol, endorsed by the Sixty-third World Health Assembly in resolution WHA63.13 in 2010. All the indicators defined in the Action Plan are included in the European Information System on Alcohol and Health.

26. The Regional Office has worked with Member States, intergovernmental organizations and major partners within the United Nations system to foster multisectoral action, build national capacity, identify new partnership opportunities and promote effective and cost-effective approaches to reduce the harmful use of alcohol for the prevention and control of

noncommunicable diseases. It has also undertaken such work to realize the commitments made under the United Nations 2030 Agenda for Sustainable Development, the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region and Health 2020 – the European policy framework for health and well-being.

27. The Regional Office has supported capacity-building workshops on alcohol policy development and implementation, linked to the prevention and control of noncommunicable diseases, in selected countries in the European Region and, through these, facilitated the development of alcohol policies. Technical support was provided for meetings on alcohol policy held since 2012 in a number of Member States: Armenia, Belgium, Croatia, Denmark, Estonia, Finland, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Montenegro, Norway, Poland, Portugal, the Republic of Moldova, the Russian Federation, Slovakia, Turkey and the United Kingdom. The Regional Office has worked closely with some Member States to update or to draft new alcohol policies aligned with the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020. Dialogue is ongoing between the Regional Office and nongovernmental organizations and professional associations on ways in which they can contribute to reducing the harmful use of alcohol. The Regional Office has been represented at meetings organized by some nongovernmental organizations, a number of which were invited to participate in the meetings of national focal points for alcohol policy.

Strengthening surveillance, monitoring and evaluation, and research

28. The production and dissemination of knowledge on alcohol consumption, alcohol-attributable harm and policy responses in Member States have been improved by refining data collection and data analysis and through wider dissemination of findings. The Regional Office works with WHO headquarters and the European Commission on this task. A project was carried out with the European Commission during 2011–2013 to ensure the use of identical indicators and a unified system for data collection and analysis. A new project with the European Commission started in January 2016 and will end by 31 December 2018. The project focuses on alcohol monitoring, new publications on alcohol policy, regional consultations and reporting on the Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) (2014–2016), endorsed by the European Commission’s Committee on National Alcohol Policy and Action.

29. In 2016, the WHO Global Survey on Alcohol and Health was implemented in collaboration with Member States of the European Region. A number of specific regional indicators were included in the surveys, and the data will be used to compile a regional report with country profiles on alcohol consumption, harm and policies.

30. The Regional Office has developed and used new indicators on alcohol-attributable death rates based on data from the European Health for All database, and will continue to improve the quality of data on alcohol-attributable harm.

31. A new alcohol policy scoring system has been developed to evaluate effective alcohol policies in countries. A profile will be developed for each of the 10 action areas of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 by country. This can provide guidance in implementing new policies to decrease the harmful use of alcohol. A report on this topic was published in May 2017. A number of different evidence-based indicators for each of the 10 action areas are used to rate policy implementation.

Annex A1. Total adult per capita consumption of alcohol by country in the WHO European Region[1]

Table 1. Comparison of total adult per capita consumption of alcohol in litres by country in the WHO European Region in 2012 and 2016[1]

Country	Total adult consumption L		% difference
	2012	2016	
Albania	7.2	6.4	-11.1
Andorra	11.6	12.0	3.4
Armenia	5.4	5.4	0.0
Austria	10.3	10.8	4.9
Azerbaijan	3.1	3.1	0.0
Belarus	18.7	15.0	-19.8
Belgium	10.9	11.4	4.6
Bosnia and Herzegovina	6.8	6.2	-8.8
Bulgaria	12.2	12.5	2.5
Croatia	13.2	10.7	-18.9
Cyprus	10.8	10.8	0.0
Czech Republic	14.1	14.6	3.5
Denmark	10.6	10.6	0.0
Estonia	13.1	11.1	-15.3
Finland	11.6	10.5	-9.5
France	13.0	13.3	2.3
Georgia	10.2	9.8	-3.9
Germany	12.7	13.4	5.5
Greece	9.6	8.5	-11.5
Hungary	12.9	12.4	-3.9
Iceland	7.2	8.6	19.4
Ireland	12.6	13.4	6.3
Israel	3.3	3.9	18.2
Italy	7.7	7.9	2.6
Kazakhstan	8.8	7.8	-11.4
Kyrgyzstan	9.4	7.2	-23.4
Latvia	12.1	12.7	5.0
Lithuania	16.3	15.2	-6.7
Luxembourg	12.8	13.4	4.7
Malta	7.0	7.8	11.4
Monaco	NA	NA	NA
Montenegro	8.6	7.6	-11.6
Netherlands	9.6	8.7	-9.4
Norway	7.9	7.1	-10.1

[1] All data are three-year averages and include three components: recorded, unrecorded and tourist consumption. Data were validated, but most Member States are only able to validate recorded consumption.

Country	Total adult consumption L		% difference
	2012	2016	
Poland	12.0	12.2	1.7
Portugal	13.0	12.6	-3.1
Republic of Moldova	18.0	14.4	-20.0
Romania	12.1	11.5	-5.0
Russian Federation	15.2	12.2	-19.7
San Marino	NA	NA	NA
Serbia	11.3	10.8	-4.4
Slovakia	12.4	11.7	-5.6
Slovenia	11.6	13.3	14.7
Spain	10.2	10.8	5.9
Sweden	9.4	9.1	-3.2
Switzerland	10.6	10.8	1.9
Tajikistan	2.6	3.4	30.8
The former Yugoslav Republic of Macedonia	6.5	6.5	0.0
Turkey	2.3	2.1	-8.7
Turkmenistan	6.5	6.2	-4.6
Ukraine	12.7	9.8	-22.8
United Kingdom	11.8	11.6	-1.7
Uzbekistan	2.8	2.7	-3.6

NA: not available.

Annex A2. Total adult per capita consumption of alcohol by country in the WHO European Region from 1990 to 2016[a]

Fig. 1. Total adult per capita consumption of alcohol by country in group 1 (1990–2016)

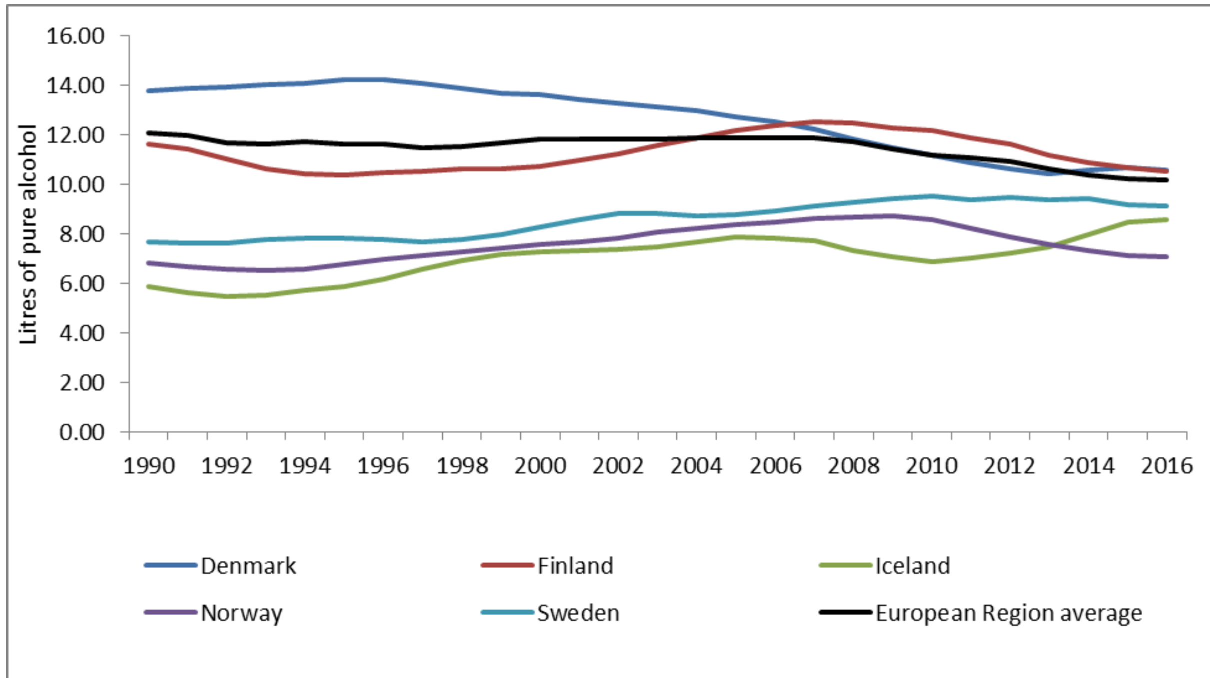


Fig. 2. Total adult per capita consumption of alcohol by country in group 2 (1990–2014)

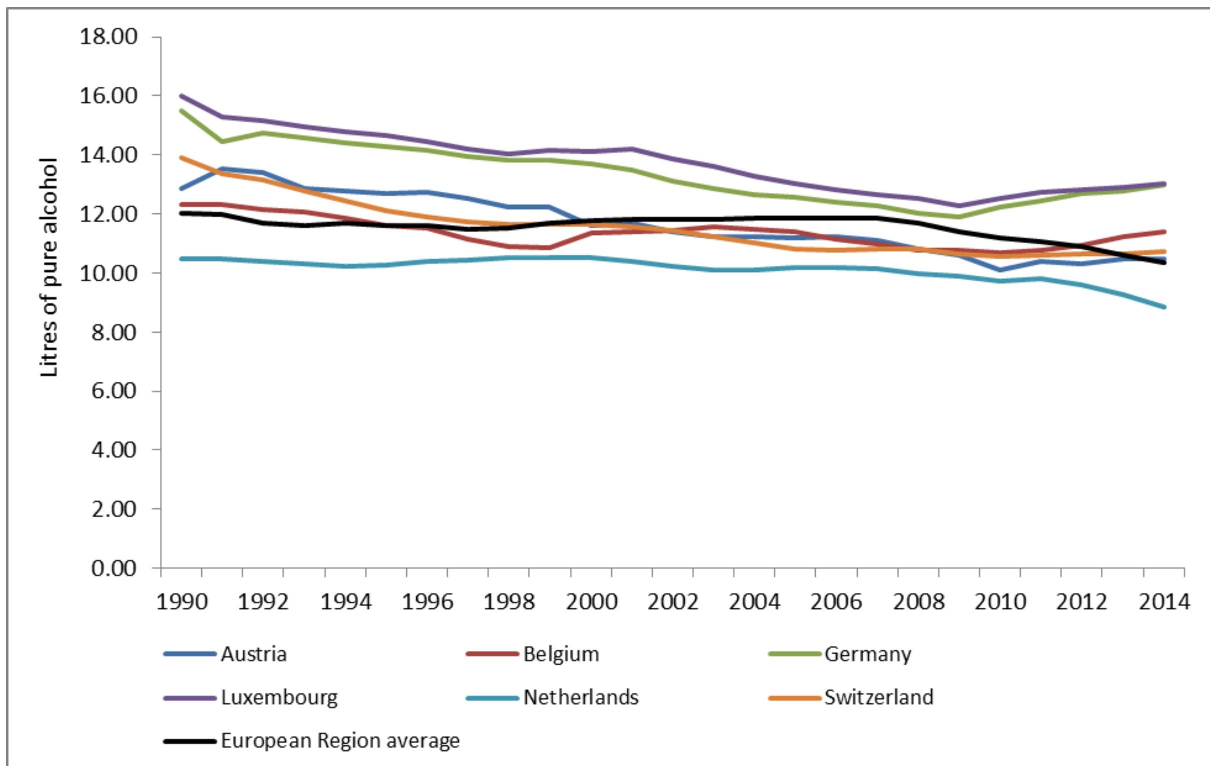


Fig. 3. Total adult per capita consumption of alcohol by country in group 3[1] (1990–2016)

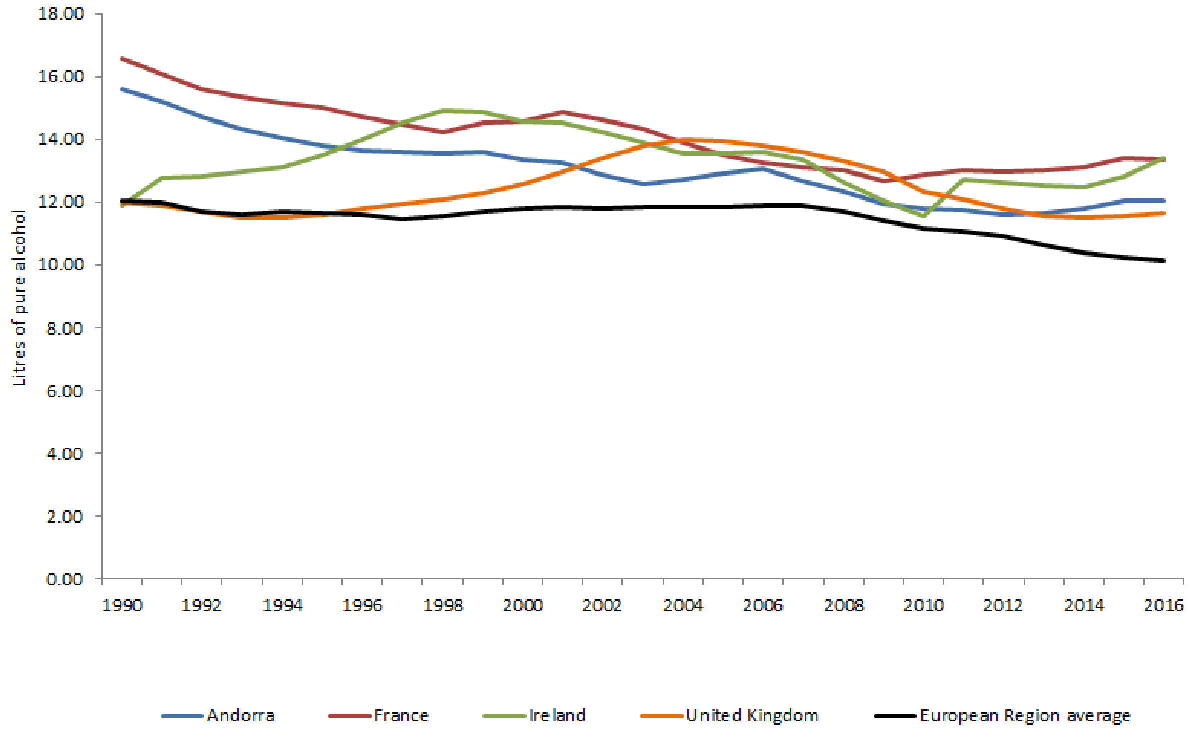
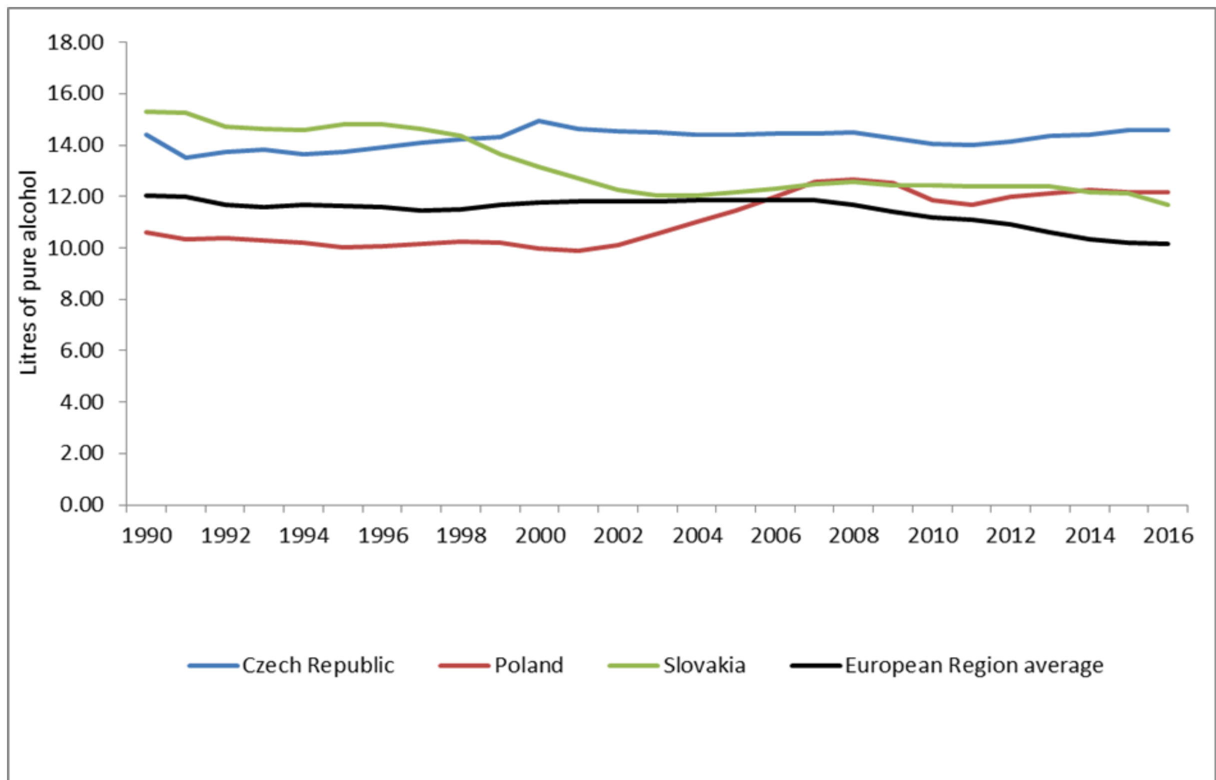


Fig. 4. Total adult per capita consumption of alcohol by country in group 4 (1990–2016)



[1] Data not available for Monaco or San Marino.

Fig. 5. Total adult per capita consumption of alcohol by country in group 5 (1990–2016)

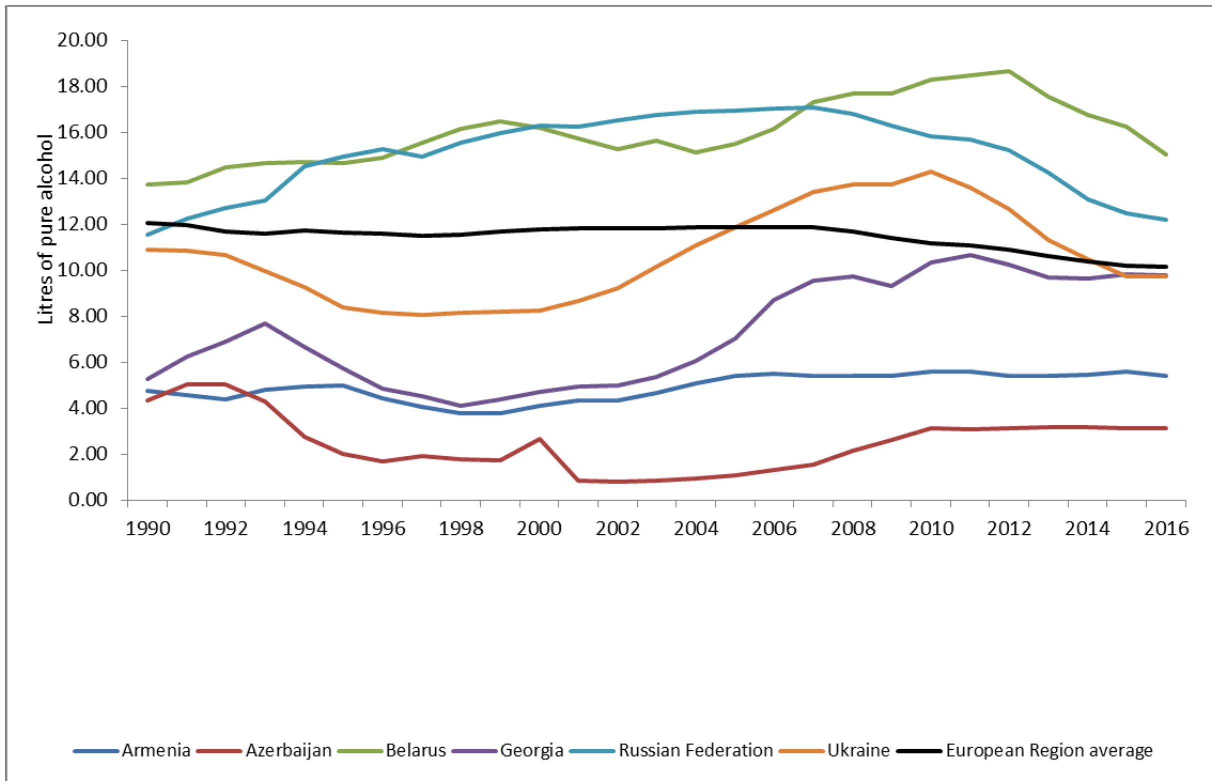


Fig. 6. Total adult per capita consumption of alcohol by country in group 6 (1990–2016)

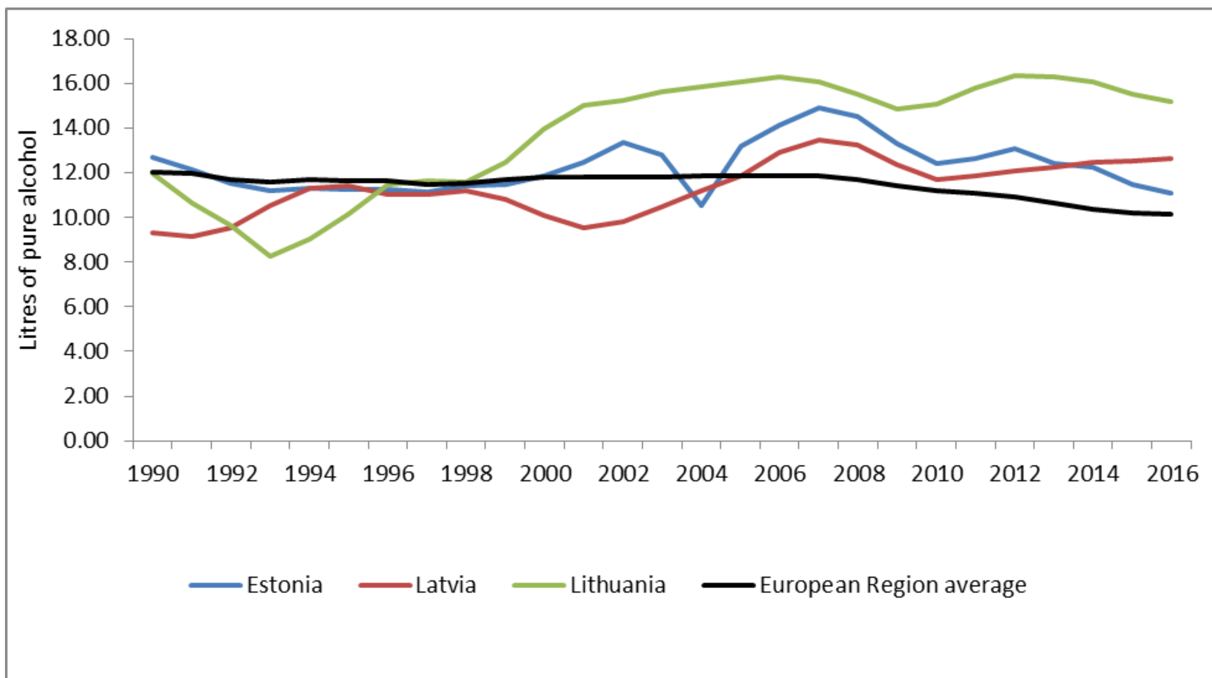


Fig. 7. Total adult per capita consumption of alcohol by country in group 7 (1990–2016)

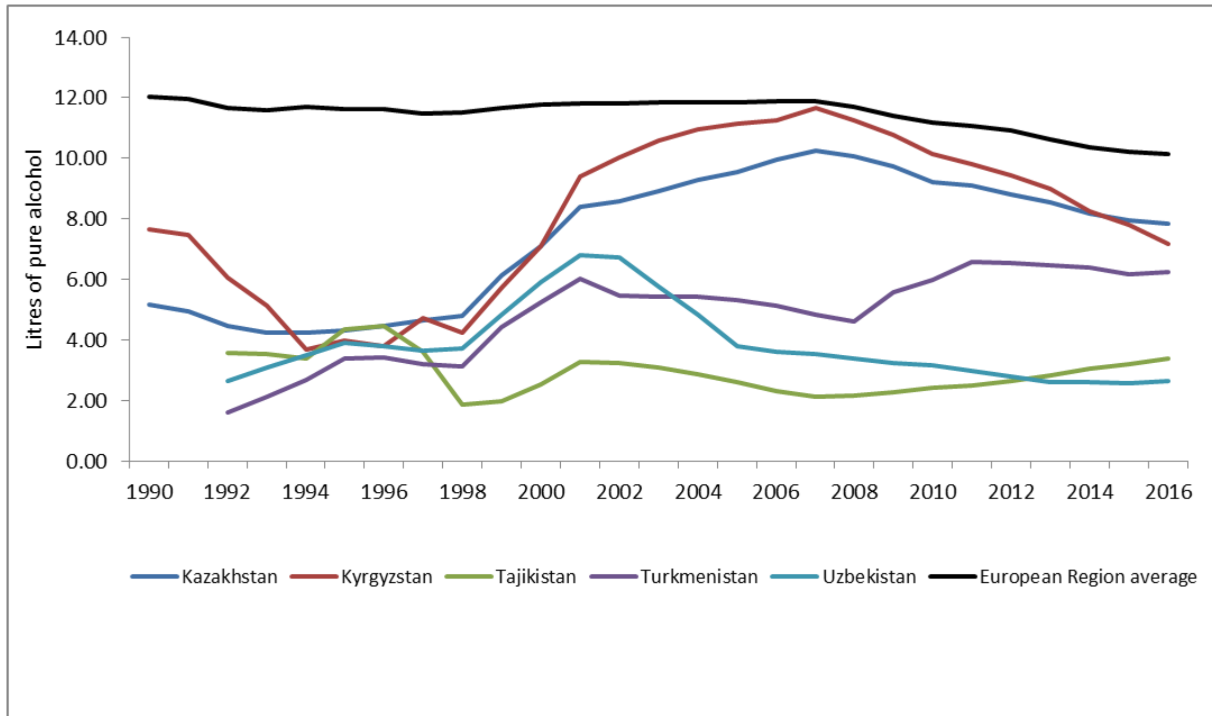


Fig. 8. Total adult per capita consumption of alcohol by country in group 8 (1990–2016)

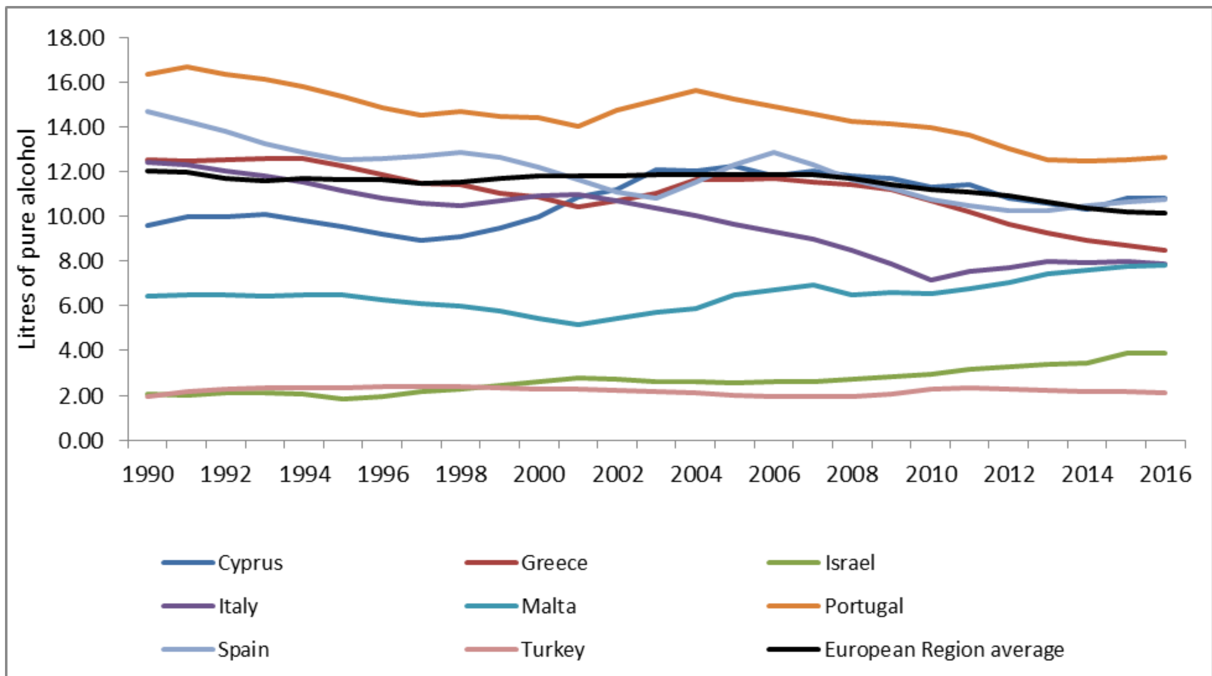
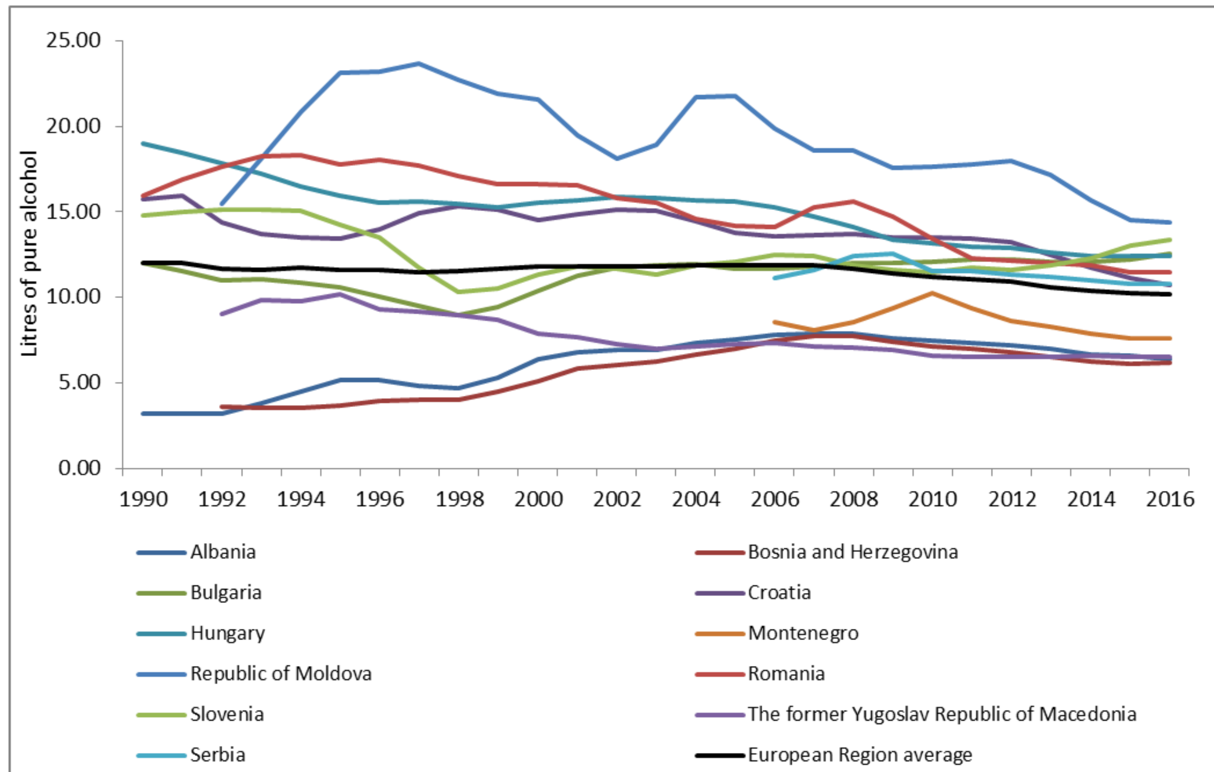


Fig. 9. Total adult per capita consumption of alcohol by country in group 9 (1990–2016)



[a] For the purpose of this Annex, Member States are categorized into nine subregional groups. The groups are defined partly by geographical area and partly by drinking patterns and traditions.

Group 1: Denmark, Finland, Iceland, Norway, Sweden.
Group 2: Austria, Belgium, Germany, Luxembourg, Netherlands, Switzerland.
Group 3: Andorra, France, Ireland, Monaco, San Marino, United Kingdom.
Group 4: Czech Republic, Poland, Slovakia.
Group 5: Armenia, Azerbaijan, Belarus, Georgia, Russian Federation, Ukraine.
Group 6: Estonia, Latvia, Lithuania.
Group 7: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan.
Group 8: Cyprus, Greece, Israel, Italy, Malta, Portugal, Spain, Turkey.
Group 9: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary, Montenegro, Republic of Moldova, Romania, Serbia, Slovenia, The former Yugoslav Republic of Macedonia.

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B. Progress on implementation of the European Food and Nutrition Action Plan 2015–2020 (resolution EUR/RC64/R7)

Introduction and background

1. This report provides information on progress made during the three years since the 64th session of the WHO Regional Committee for Europe adopted resolution EUR/RC64/R7 on the European Food and Nutrition Action Plan in Copenhagen, Denmark, in September 2014. The European Food and Nutrition Action Plan 2015–2020 (document EUR/RC64/14) contributes to the vision and mission of Health 2020, the European policy framework for health and well-being endorsed by the Regional Committee in 2012.

2. By adopting the European Food and Nutrition Action Plan 2015–2020, Member States have taken an important decisive step towards promoting healthy diets and addressing the high rates of obesity and diet-related noncommunicable diseases across the WHO European Region. The Action Plan calls for a wide range of policies to help people from all backgrounds to adopt a more balanced diet and to maintain a healthy body weight.

3. There is evidence that the burden of unhealthy diet, unhealthy weight and other forms of malnutrition remains very large in the European Region. In a significant number of Member States, energy-dense diets, high consumption of fat, *trans* fats, free sugars and salt, low consumption of fruit and vegetables, and high rates of overweight are impeding progress towards achieving the global noncommunicable disease targets.

4. The Action Plan is aligned with existing global policy frameworks for nutrition and for the prevention and control of noncommunicable diseases, notably the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and the WHO Comprehensive Implementation Plan on Maternal, Infant and Child Nutrition. Voluntary global targets emerging from these global processes have been incorporated in the Action Plan, including:

(a) to halt the increases in obesity and diabetes;

(b) to halt the increase in the prevalence of overweight among children aged under 5 years;

(c) to reduce mean population intake of salt and sodium by 30%;

(d) to increase the rate of exclusive breastfeeding in the first 6 months of life to at least 50%;

(e) to reduce the proportion of stunting in children aged under 5 years by 40%; and

(f) to reduce the prevalence of anaemia among non-pregnant women of reproductive age by 50%.

European Food and Nutrition Action Plan 2015–2020

5. This report marks the midway point for the implementation of the European Food and Nutrition Action Plan 2015–2020 in the WHO European Region. The goal of the Action Plan is to avoid premature deaths and significantly reduce the burden of preventable diet-related noncommunicable diseases, obesity and all other forms of malnutrition still prevalent in the Region.

6. In resolution EUR/RC64/R7, adopted in September 2014, the Regional Committee requested the Regional Director to report on the implementation of the Action Plan to the 67th session of the Regional Committee in September 2017. This report fulfils that commitment by:

- providing a picture of the state of play, reporting on progress and identifying areas for future efforts; and
- presenting an objective, data-driven picture of progress, derived from the latest analyses of epidemiological data, information on dietary intake and food composition and country responses to a standardized questionnaire on policy implementation.

7. Five priority areas based on the five objectives of the Action Plan (document EUR/RC64/14) are listed in Box B1. Each priority area prescribes a set of actions for Member States and for the Regional Office designed to yield measurable outcomes and to make progress towards achieving the global targets.

8. The present report describes and illustrates progress made by Member States, in partnership with the Regional Office, in each priority area since the Action Plan was adopted in 2014.

Box B1. Priority areas of the European Food and Nutrition Action Plan 2015–2020

Priority area 1	Create healthy food and drink environments.
Priority area 2	Promote the health gains of a healthy diet throughout the life-course, especially for the most vulnerable groups.
Priority area 3	Reinforce health systems to promote healthy diets and provide diet-related services.
Priority area 4	Support surveillance, monitoring, evaluation and research on the population's nutritional status and behaviours and the status and effectiveness of the policies implemented.
Priority area 5	Strengthen governance mechanisms, alliances and networks to ensure a health-in-all-policies approach, and empower communities to engage in health promotion and prevention.

Priority area 1 Create healthy food and drink environments.

9. The Regional Office collected information on the different types of policies (regulatory and non-regulatory) that Member States have adopted relating to the marketing of food to children, looking at the scope of the policies and the criteria adopted. It also prepared a report on digital marketing directed at children to alert policy-makers to the risks and challenges posed by this new reality. A report and video animation were launched at the High-level conference on working together for better health and well-being: promoting intersectoral and interagency action for health and well-being in the WHO European Region, held in Paris, France, on 7–8 December 2016.

10. The Regional Office, with a number of Member States, prepared a model nutrient profiling tool to be used to control the marketing of foods to children. The proposed tool was tested by over a dozen countries and was included in national policies and frameworks. Some Member States have used the model drawn up by the Regional Office to design food procurement guidelines and regulations for public institutions, in particular for schools. The proposed tool has been used as a model by other WHO regions, the private sector and other stakeholders to improve their own profiling systems.

11. Although the use of economic tools, notably taxes and incentives, to promote healthier diets remains a controversial area, significant progress can be observed. New measures have been adopted in some Member States, including Estonia, Hungary, Ireland, Portugal, Spain and the United Kingdom.

12. Significant progress can be seen in product reformulation and improvements in the nutritional quality of foods. WHO supported the initiatives and meetings of the European Salt Action Network (ESAN) and action on the marketing of foods to children. ESAN involves 28 Member States and is led by Switzerland, while the action on the marketing of foods to children is led by Portugal and involves 27 Member States. The Regional Office worked with the Netherlands and Slovakia during those countries' presidencies of the Council of the European Union, in particular, it collaborated in the Conference on Food Product Improvement held in Amsterdam, the Netherlands, on 22–23 February 2016, which focused on food reformulation and food product improvement. The Regional Office continued this work with Malta, the holder of the Presidency of the Council of the European Union from 1 January to 30 June 2017.

13. With regard to cross-government collaboration to facilitate healthier food choices, particularly in schools, it was possible to establish that almost all Member States in the Region have some form of school food policy in place. Further efforts are being made by the Regional Office to look at the different components of school food policies that might influence their impact. Examples of school food policies to be benchmarked include those of Latvia and Sweden.

14. Progress in front-of-pack labelling has been documented. Different approaches have been identified for conveying nutritional information to consumers in an easy-to-understand manner, with notable examples from Croatia, Finland, the Netherlands, the Nordic countries and the United Kingdom. The Regional Office organized an expert meeting in Portugal in late 2015 with the involvement of Member States. The report of that meeting and the background document on front-of-pack labelling is scheduled to be published in 2017.

Priority area 2 Promote the health gains of a healthy diet throughout the life-course, especially for the most vulnerable groups.

15. The European Food and Nutrition Action Plan calls for investment in nutrition beginning with the earliest stages of life, before and during pregnancy, by protecting, promoting and supporting adequate breastfeeding and addressing barriers, while also providing for appropriate complementary feeding. The Regional Office examined Member States' implementation of counselling and support for breastfeeding and complementary feeding. Data have also been collected on the implementation of the International Code of Marketing of Breast-Milk Substitutes and the Baby-Friendly Hospital Initiative in the

WHO European Region. The Regional Office worked with Member States in the promotion of the Baby-Friendly Hospital Initiative in the Russian Federation and elsewhere. The Regional Office prepared a report with a systematic review of the importance of nutrition during pregnancy. In addition, an analysis of guidance and nutrition advice during pregnancy was conducted, showing a wide variance between Member States and the need for more joint work on the issue. The Regional Office convened a group of nine Member States in Latvia to launch the above-mentioned report and to discuss possible policy developments in the participating countries. The Regional Office supported Latvia in the development of national recommendations on nutrition during pregnancy. Armenia, Georgia and Uzbekistan are working on developing their own national recommendations.

16. The Action Plan also underlined the importance of improving the ability of citizens to make healthy choices, taking into account the needs of different age groups. The Regional Office collected information, in collaboration with scientific stakeholders, on the existence, nature and characteristics of national guidelines for infant nutrition, particularly with respect to complementary foods. Discrepancies were found, and more work will be done during the implementation period of the Action Plan. The Regional Office also collected information on the amount of sugar in commercial baby foods and developed a methodology for further research.

17. The Action Plan also calls for the adoption of tools and strategies to address the special nutrition needs of vulnerable groups, including older age groups, both for those living in the community and for those in care institutions. The Regional Office is preparing a joint policy brief with its collaborating centres on nutrition and healthy ageing. A forthcoming report will highlight initiatives related to ageing and nutrition.

Priority area 3 Reinforce health systems to promote healthy diets and provide diet-related services.

18. The Action Plan urges Member States to ensure that nutrition and healthy eating are priorities for people-centred health-care systems and to include brief interventions and nutrition counselling in primary health-care settings. The Regional Office prepared a report on integrating diet, physical activity and weight management services into primary care, with country examples and further advice for Member States.

19. The Regional Office worked with Member States to educate health professionals with the aim of ensuring universal health coverage for preventable and treatable diet-related problems, with a continuum of high-quality nutrition services and appropriately qualified and resourced health professionals. A curriculum for health professionals in primary health care is available for dissemination. The training focuses on brief interventions and motivational techniques. Training programmes were initiated in Malta, the Republic of Moldova, Tajikistan and Uzbekistan.

20. The Regional Office is tracking the prevention and management of obesity and unhealthy diets in health-care settings, notably primary care. Data on this topic were less widely available from Member States; however, using information collected from a recent global nutrition survey, data on the following aspects will be compiled into a noncommunicable disease status report: existence of guidelines for management of obesity among children and adults in primary care; management of malnutrition in hospitals and

primary care; food service guidelines for hospitals; and ensuring better availability of data for benchmarking progress.

Priority area 4 Support surveillance, monitoring, evaluation and research on the population's nutritional status and behaviours and the status and effectiveness of the policies implemented.

21. The Regional Office and Member States have implemented the WHO European Childhood Obesity Surveillance Initiative (COSI), a unique initiative with repeated measurements looking at trends, a common protocol and highly comparable data. The comparative advantage for Member States is that there is an established network of experienced country experts; a tried and tested protocol; and support for analysis and data preparation, particularly in the eastern part of the Region.

22. The consolidation, fine-tuning and enlargement of existing national and international monitoring and surveillance systems, such as COSI and the Health Behaviour in School-aged Children study, have continued since the Action Plan's adoption. Some of the best epidemiological data available come from COSI. More than 300 000 children aged 6–9 years have been measured and 36 Member States in the European Region have joined the scheme. The prevalence of obesity increases with age and is higher among boys. Trend data are starting to emerge. There is potentially good news in some Member States, with a levelling-off or slight decrease in some age groups in Ireland, Italy, Portugal and Slovenia. Some significant declines have been observed. However, the overall picture indicates that rates remain very high and most of the decreases were observed in countries with the very highest levels. Severe obesity as well as levels of obesity in low-income countries continue to be major issues.

23. The Regional Office worked with 38 Member States in the implementation of COSI. Three meetings of the COSI Network have been held since the adoption of the Action Plan in 2014. The Regional Office organized a large series of training initiatives for the COSI roll-out, in collaboration with a large network of COSI principal investigators from Member States, including Austria, Kyrgyzstan, Montenegro, Poland, the Russian Federation, Tajikistan and Turkmenistan. New reports and scientific papers are in the pipeline, although more effort is needed and sustained monitoring is important.

24. The Action Plan's call for nutrition and anthropometric surveillance systems on nutritional risk factors that allow disaggregation by socioeconomic status and gender has been a major priority. Trend data in the Health Behaviour in School-aged Children study show progress for all indicators. It is, however, important to verify whether Member States are doing better overall, or only in certain areas. A trend analysis using data for children aged 11–15 years shows that obesity prevalence varies across countries, but is generally higher among boys, younger adolescents and low-affluence groups. While levels of obesity have stabilized in some countries, prevalence has increased in over half of all Member States since 2002. However, these increases are not consistent across age and gender groups. The most marked increases have been observed in eastern European countries where levels of obesity were relatively low in 2002. Only one country experienced a significant decrease in obesity prevalence. Social inequalities in obesity have persisted in most Member States over time.

25. The Action Plan also recommends monitoring and evaluation of diet-related activities, interventions and policies in different contexts in order to determine their effectiveness and to disseminate good practice. Data collected by the Regional Office show the following.

(a) There were slight increases in the daily consumption of fruit and vegetables between 2002 and 2014, but little evidence of a notable reduction in social inequalities over time. Daily consumption remains low.

(b) There may have been decreases in the daily consumption of soft drinks and sweets between 2002 and 2014, although the data are complex. This possible decrease is also driven by reduced intake among adolescents from affluent families.

(c) Adult obesity in the WHO European Region has more than tripled since 1980. Member States have pledged to halt the increase in obesity by 2025. To monitor the feasibility of achieving this goal, the Regional Office has projected future trends in obesity (defined as body mass index ≥ 30) to 2025 for each of the 53 Member States in the Region.

(d) By 2025, obesity is predicted to increase in 44 Member States. If present trends continue, 33 of the 53 Member States will have an obesity prevalence of 20% or higher by that date.

(e) A review by WHO of available dietary intake data shows that less than two thirds of Member States in the European Region conduct national diet surveys. However, for those that do have data, it is mostly recent. The WHO recommended dietary intake for saturated fatty acids is < 10% of total daily energy intake (%E); after intake was converted to %E, no male or female age group for any country met the target. The highest female added-sugar intake was 53 g/day and the highest male intake was 71 g/day. The WHO recommendation is 5%, which equates to roughly 25 g/day.

(f) More Member States, including some in the eastern part of the European Region (Greece, Kyrgyzstan, Montenegro, the Republic of Moldova, Uzbekistan) are conducting 24-hour surveys to measure sodium intake. The Regional Office calculates up-to-date figures and publicizes those countries which have recorded a decline in population salt intake. Data will be made available in collaboration with selected countries to indicate trends. So far, nine Member States in the European Region have documented significant reductions in salt intake. Two of them have achieved major global successes and impacts in terms of health outcomes from sodium reduction (Finland and the United Kingdom). However, achieving the global sodium reduction target will still be a challenge. WHO is modelling the achievement of the salt reduction target, specifying the required reductions in salt content, on the basis of case studies from Finland, the Russian Federation, Turkey and Uzbekistan.

(g) The FEEDCities project is an example of rapid assessment of nutritional composition of foods for low-resource countries. The Regional Office and experts in Member States have already produced a summary of the data on *trans* fatty acids and sodium from Kyrgyzstan, the Republic of Moldova and Tajikistan.

Priority area 5 Strengthen governance mechanisms, alliances and networks to ensure a health-in-all-policies approach, and empower communities to engage in health promotion and prevention.

26. A large number of Member States have recently prioritized nutrition and obesity in national and subnational strategies.

27. The Regional Office has been compiling an overview of progress in countries in adopting nutrition and obesity strategies, using various sources and with validation by Member States, determining which areas are covered by the policies.

28. Examples of social innovation in the area of nutrition are being fully documented as possible benchmarks for other Member States, depending on their national priorities and context:

- Estonia: policy options to reduce intake of sugar-sweetened beverages;
- Hungary: impact assessment of public health product tax; and
- Turkey: evaluation of healthy nutrition and active living programme.

Collaborating centres

29. WHO collaborating centres for nutrition and obesity prevention in Denmark, Germany, Kazakhstan, the Netherlands, Portugal and the United Kingdom have significantly contributed to the implementation of the Action Plan’s five priority areas.

Conclusions and future plans

30. The present progress report describes a challenging epidemiological situation, but simultaneously provides evidence for unprecedented emerging action by Member States to tackle obesity and promote healthy diets. Noteworthy examples and case studies from across the European Region have been identified to inform policy and practice, including possibilities for effective natural experiments. However, gaps and challenges remain if Member States are to meet global targets, address persistent inequalities and promote cross-sectoral action.

31. Since the adoption of the European Food and Nutrition Action Plan 2015–2020 in 2014, the Regional Office has been working in the area of nutrition and obesity with over 40 Member States, in 23 under bilateral country agreements. Interest by and requests from Member States have increased significantly and activities are expected to be scaled up with more Member States becoming involved from 2018 to 2020.

32. Notable examples of the Regional Office’s activities to support Member States in implementing the Action Plan include: developing tools (nutrient profile model; training in primary health care); showing the evidence (digital marketing; price policies; *trans* fats); looking at future scenarios (obesity and salt-modelling estimates; salt and sugar reduction); and thinking beyond health (legislation and food supply chain).

33. The Regional Office will continue to implement the European Food and Nutrition Action Plan 2015–2020 in collaboration with and under the guidance of Member States. The next progress report will be submitted to the 71st session of the Regional Committee in September 2021.

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C. Progress report on implementation of the European Mental Health Action Plan (resolution EUR/RC63/R10)

Introduction and background

1. This report provides information on progress made during the four years since the 63rd session of the WHO Regional Committee for Europe adopted resolution EUR/RC63/R10, endorsing the European Mental Health Action Plan (document EUR/RC63/11), in Izmir, Turkey, in September 2013. The European Mental Health Action Plan contributes to the delivery of Health 2020, the European policy framework for health and well-being, adopted by the 62nd session of the Regional Committee in resolution EUR/RC62/R4 in September 2012.

2. Mental disorders are one of the most significant public health challenges in the WHO European Region as measured by the burden of disease, prevalence or disability. Across the Region, neuropsychiatric disorders are the second largest contributor to the burden of disease (disability-adjusted life years), accounting for 19% of the total burden. It has been estimated that mental disorders affect more than one third of the population every year, the most common of these being depression and anxiety. Depressive disorder is twice as common among women as among men. About 1–2% of the population, men and women equally, are diagnosed with psychotic disorders and 5.6% of men and 1.3% of women have substance use disorder. Owing to the ageing of the European population, there is an increasing prevalence of dementia, typically 5% in people aged over 65 years and 20% among those aged over 80 years. In all Member States in the Region, mental disorders tend to be more prevalent among those who are the most deprived in society.

3. The contribution of specific groups to all chronic conditions (years lived with disability) is an important indicator of the disease burden on society and on health systems. Mental disorders are by far the most significant of the chronic conditions affecting the population of the European Region, accounting for up to 40% of such conditions in some Member States. A high percentage of people who receive social welfare benefits or pensions owing to disability have, as their primary condition, a mental disorder, mostly a depressive disorder.

4. Mental disorders are strongly related to suicide. Suicide rates in the European Region are high compared to other parts of the world. The average annual suicide rate in the Region is 11.2 per 100 000 (2013) but there is a wide variation among Member States.

5. The consensus is that care and treatment should be provided in local settings, since large mental hospitals often lead to neglect and institutionalization. However, many Member States still rely on mental hospitals as the mainstay for mental health services. The commitment to deinstitutionalization and to the development of community-based mental health services has continued, although progress is uneven across the Region. The emphasis on the expanding role of primary care, working in partnership with multidisciplinary mental health staff in community-based facilities, has therefore become a principal focus.

6. There is strong evidence of effective treatment and care for many mental disorders and their comorbidities. Through such treatment and care, mental health and well-being could be improved, productivity increased and many suicides prevented. However, a large proportion

of people with mental disorders either do not receive treatment, owing to poor accessibility (the so-called “treatment gap”), or experience long delays in receiving care.

7. Many people with mental health problems choose not to engage or to maintain contact with mental health services due to stigma and discrimination. Negative experiences with treatment and/or care are other factors contributing to the failure to engage. Reforms are required to achieve higher confidence in the safety and effectiveness of care. Mental health policies need to combine the structural reform of services with a focus on quality, ensuring the delivery of safe, effective and acceptable treatment by a competent workforce.

8. The awareness of the importance of mental health and well-being is increasing; for example, mental health is covered by target 3.4 of Sustainable Development Goal 3, which seeks to, by 2030, reduce by one third premature mortality from noncommunicable diseases (NCDs) through prevention and treatment and promote mental health and well-being. This awareness is also reflected in the many activities of the Regional Office’s mental health programme since the adoption of the Action Plan in 2013; the mental health programme currently collaborates with some 25 Member States in the European Region.

The European Mental Health Action Plan

9. Resolution EUR/RC63/R10, which endorses the European Mental Health Action Plan, [1] urges Member States:[2]

(a) to improve the mental health and well-being of the entire population and reduce the burden of mental disorders, ensuring actions for promotion and prevention, and intervention on the determinants of mental health, combining both universal and targeted measures, with a special focus on vulnerable groups;

(b) to respect the rights of people with mental health problems, promote their social inclusion and offer equitable opportunities to attain the highest quality of life, addressing stigma, discrimination and isolation;

(c) to strengthen or establish access to and appropriate use of safe, competent, affordable, effective and community-based mental health services.

10. The resolution also requests the Regional Director “to provide technical support for the implementation of the Action Plan” and “to report back on progress by 2017”.

11. The seven objectives of the European Mental Health Action Plan are listed in Box C1. Each objective proposes a set of actions for Member States and for the Regional Office that would support the achievement of measurable outcomes.

12. This report presents the progress made from 2013 to 2017 towards achieving the aims of the Action Plan by Member States in partnership with the Regional Office for each of the seven objectives.

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[1] Document EUR/RC63/11.
[2] And regional economic integration organizations, where applicable.

Box C1. Objectives of the European Mental Health Action Plan

Objective 1	Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk.
Objective 2	People with mental health problems are citizens whose human rights are fully valued, protected and promoted.
Objective 3	Mental health services are accessible, competent and affordable, available in the community according to need.
Objective 4	People are entitled to respectful, safe and effective treatment.
Objective 5	Health systems provide good physical and mental health care for all.
Objective 6	Mental health systems work in well-coordinated partnership with other sectors.
Objective 7	Mental health governance and delivery are driven by good information and knowledge.

Objective 1 Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk.

13. The equal opportunity to realize mental well-being throughout the lifespan is closely aligned with the priorities of Health 2020, and many WHO regional activities have contributed to this area. Primary examples are the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020, held in Minsk, Belarus, in October 2015, which addressed mental health throughout the life-course, and the High-level Conference on Working Together for Better Health and Well-being: Promoting Intersectoral and Interagency Action for Health and Well-being in the WHO European Region, held in Paris, France, in December 2016, which identified mental well-being as a key component of well-being.

14. The Regional Office’s mental health programme contributed to the work of other parts of the Organization relevant to objective 1, such as raising awareness of mental health across the Sustainable Development Goals and their targets, and supporting the preparation of the Health Behaviour of School-aged Children survey, which assesses health and well-being, bullying and family culture. WHO has been engaged in a one-year global campaign on depression – the leading cause of ill health and disability worldwide. More than 300 million people live with depression, an increase of more than 18% between 2005 and 2015. Depression was the theme of World Health Day on 7 April 2017, and regional and country offices actively collaborated with ministries of health and other partners in preparing a range of information materials and in organizing commemorative events.

15. The mental health programme collaborated with the European Commission on the Joint Action on Mental Health and Well-being (2013–2016), which focused on the well-being of young people, healthy schools and employment and the prevention of depression and suicide. WHO was represented at Commission meetings and co-organized several conferences on the promotion of mental health.

16. In order to raise awareness, the mental health programme worked with collaborating centres in Finland and the Netherlands to publish the policy brief "Preventing depression in the WHO European Region", which is accessible on the WHO Regional Office for Europe's website.

17. The mental health programme also addressed the specific needs of vulnerable populations, such as refugees. At a meeting at the Regional Health Development Centre on Mental Health in South-eastern Europe, located in Sarajevo, Bosnia and Herzegovina, the programme provided evidence on the prevalence of mental disorders among vulnerable groups, treatment and preventive actions. The programme also assisted in the production of the Health Evidence Network synthesis report *Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region* (2016).

18. Many Member States in the European Region are concerned about high suicide rates. The mental health programme worked with WHO headquarters on the first WHO world suicide report, *Preventing suicide: a global imperative,* and assisted countries, for example, Estonia and Kazakhstan, in developing actions and policies.

19. The programme also advised some Member States, including Bulgaria, Estonia, Montenegro, Norway and Portugal, on the drafting of mental health promotion plans.

Objective 2 People with mental health problems are citizens whose human rights are fully valued, protected and promoted.

20. The core aim of the European Mental Health Action Plan is to reduce stigma and discrimination and to support people-centred mental health care by involving people with mental health problems in their own care. Patient and family groups were actively engaged in the development of the Action Plan, as evidenced by several requests to the Regional Office to present the Action Plan at conferences organized by such groups.

21. In partnership with the mental health programme, the WHO Collaborating Centre on Research and Training in Mental Health (Lille, France) organized a meeting on indicators of empowerment of mental health patients and carers. The agreed indicators have since been disseminated and applied.

22. In recent years, the issue of human rights has received increased attention, as demonstrated, for example, by the adoption of the United Nations Convention on the Rights of Persons with Disabilities in 2006, which has subsequently been ratified by many Member States in the European Region. The Convention's implications for mental health have been actively discussed, and the mental health programme has represented the Regional Office at several meetings, including those convened by the European representative of the Office of the United Nations High Commissioner for Human Rights.

23. The mental health programme was represented at meetings of the Radicalisation Awareness Network, an organization set up by the European Commission to tackle terrorism and violent extremism, where it provided advice on the importance of safeguarding the rights of people with mental health problems and of protecting them against discrimination due to the mistaken association between violence and mental disorders. One of the main challenges

of the past few years has been to find a balance between individual rights and the protection of the public at a time of heightened fear and risk avoidance.

24. The mental health programme assisted Member States, including Lithuania, Turkey and Turkmenistan, in drafting mental health legislation that eliminates discrimination. A recurring challenge has been to prohibit legislation that excludes people with mental disorders from the labour market on the grounds of a medical diagnosis, as this is discriminatory.

25. Objective 2 is also being addressed by supporting deinstitutionalization in Member States. The mental health programme is aware of the discrimination and neglect faced by adults with mental disabilities, particularly those living in institutions, sometimes for decades, without any opportunity to lead meaningful lives. At the request of Member States, the programme launched a project focusing on adults with long-term mental health problems and/or intellectual disabilities living in institutions, often under adverse conditions. The project analyses national policies, surveys the number and type of institutions, and assesses the quality of a sample of institutions in the 36 participating countries. A report on the project will be submitted for consideration by the 68th session of the Regional Committee in September 2018.

Objective 3 Mental health services are accessible, competent and affordable, available in the community according to need.

Objective 4 People are entitled to respectful, safe and effective treatment.

26. Objectives 3 and 4 are interconnected and indivisible, since the integration of structure and process is an essential requirement for the provision of good mental health services. These objectives will therefore be presented together.

27. The European Mental Health Action Plan proposes a model of community-based mental health care that involves family doctors in the identification, diagnosis and treatment of common mental health problems and the referral of complex and severe mental disorders to specialist community teams. Hospital beds are required as a last resort for people who pose a risk to themselves or others.

28. Since the endorsement of the Action Plan in 2013, the Regional Office has supported many Member States in drafting their own strategies and in transforming care from hospital-based models to community-based, low-stigma services that are accessible to patients and their families.

29. In Turkey, the mental health programme supported the Ministry of Health and the Ministry of Family and Social Policies in a comprehensive project to provide community-based care services for people with mental disorders and for those with intellectual disabilities. The project was co-funded by a grant from the European Commission. A Turkish model of care based on family-centred community services sought to prevent hospitalization and to provide family psychoeducation. Small residential homes, called Houses of Hope, were planned for people with long-term dependencies. Quality assessments of the institutions were performed, more than 100 community teams and about 50 Houses of Hope were established and some 350 staff were trained. The second phase of this project is now under way.

30. In Ukraine, the Regional Office helped to establish and to train four community teams for the care of people with mental health problems who were not in contact with mental health services, including internally displaced persons. This proved to be very popular and successful, and the mental health programme is now supporting the revision of legislation to integrate these teams into regular mental health services.

31. The mental health programme conducted missions to assess the status of national mental health services and to make recommendations for reform in Armenia, Bulgaria, the Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Slovenia, Tajikistan and Turkmenistan. Despite the diversity in terms of geography and available resources, the challenges were similar, namely:

(a) a high proportion of the budget allocated to hospitals in poor condition, serving a small number of patients;

(b) understaffed polyclinics struggling to cope with high demand;

(c) family doctors not engaged in mental health problems;

(d) insufficient staff numbers, often affected by migration;

(e) outdated legislation; and

(f) reluctance of patients and families to attend mental health services due to stigma and discrimination.

32. The mental health programme made several visits to Armenia, the Czech Republic, Hungary, Kyrgyzstan, the Republic of Moldova and Turkmenistan to support strategy development and to conduct seminars with opinion leaders and stakeholders. The content of these workshops covered strategy and legislation development, workforce competencies and change management techniques.

33. In Portugal, in partnership with the European Commission, the programme co-organized a meeting on the state of mental health care with the Ministry of Health.

34. On several occasions, the mental health programme convened meetings with groups of Member States at similar stages of mental health care development and with common languages or cultural backgrounds. Three meetings brought together eight Russian-speaking countries, including Armenia, Belarus, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, Turkmenistan and Uzbekistan. These meetings allowed the sharing of experience and good practice on a range of issues relevant to the countries, such as suicide, mental health in primary care, deinstitutionalization, community-based mental health service delivery and workforce development needs. Of particular interest was the suggestion to establish a joint workforce development centre for Central Asia; however, it was not possible to identify funding.

35. The Regional Office supported the Regional Health Development Centre on Mental Health in South-eastern Europe, based in Sarajevo, Bosnia and Herzegovina. It co-organized three meetings, covering the progress of previously established community centres, suicide prevention, quality assurance and mental health among refugees. The participating Member States were Albania, Bosnia and Herzegovina, Bulgaria, Israel, Montenegro, the Republic of Moldova, Romania and the former Yugoslav Republic of Macedonia. Turkey attended as an observer.

36. The mental health programme has worked closely with partner organizations such as the European Commission and the Organisation for Economic Co-operation and Development. The European Commission included community services as a component of its Joint Action on Mental Health and Well-being. Recommendations were in line with the objectives of the European Mental Health Action Plan. The Organisation for Economic Co-operation and Development conducted some country assessments in Member States in the Region.

37. Throughout this period, the mental health programme has worked closely with nongovernmental organizations, involving them in its work. These include the European Federation of Associations of Families of People with Mental Illness, the European Psychiatric Association, the Global Alliance of Mental Illness Advocacy Networks–Europe (the European mental health patient association) and many national associations active in mental health. The programme also presented the European Mental Health Action Plan at a large number of national and international meetings and conferences, such as in Albania, Armenia, Belgium, Bulgaria, the Czech Republic, Estonia, France, Germany, Hungary, Ireland, Italy, Kazakhstan, Lithuania, Montenegro, the Netherlands, Norway, Portugal, the Russian Federation, Serbia, Spain, Turkey, Turkmenistan and the United Kingdom.

Objective 5 Health systems provide good physical and mental health care for all.

38. This issue has gained interest due to the high morbidity among people with mental health problems caused by NCDs and the high prevalence of risk factors such as smoking, alcohol consumption and obesity among people in this group.

39. The mental health programme has worked closely with other programmes to incorporate activities relevant to mental health in their strategies and action plans. It has also contributed to cross-cutting conferences and meetings, such as the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020 (2015) and the High-level Conference on Working Together for Better Health and Well-being: Promoting Intersectoral and Interagency Action for Health and Well-being in the WHO European Region (2016).

40. The mental health programme is addressing the need for curriculum development for the medical and mental health workforce to improve competency in identifying and treating comorbidities. In particular, the roles of family doctors and polyclinic staff are receiving much attention in Member States where community-based services are being developed.

41. The mental health programme, supported by the NCD programme, has produced a report on addressing comorbidities, presenting evidence and case studies of comorbidity between psychiatric disorders and cardiovascular diseases, cancer, diabetes and asthma, and drawing conclusions for good practice.

Objective 6 Mental health systems work in well-coordinated partnerships with other sectors.

42. Since a great number of actions beneficial to well-being and the needs of people with mental health problems are the responsibility of sectors other than the health sector, the

Regional Office has sought to make links across government departments. The contribution of the mental health programme to the Minsk and Paris conferences has already been mentioned.

43. Suicide has many socioeconomic precipitants, and a number of agencies are involved in its prevention. The mental health programme's work has addressed such risk factors by engaging relevant agencies. Examples are activities in Estonia and Kyrgyzstan and a seminar with Russian-speaking countries.

44. In most Member States, long-term care for people with mental disabilities falls under the responsibility of the ministry of social affairs. The mental health programme has engaged these ministries in its work on the quality of care for adults with long-term care needs.

45. Although the European Mental Health Action Plan does not specifically cover dementia, the mental health programme has worked in close partnership with WHO headquarters and the European Commission to address this condition, which has become a public health priority. The programme has also discussed dementia with delegations during mission visits to WHO offices and with ministries of health in Member States.

46. The cross-cutting nature of mental health care is reflected in a multidisciplinary workforce employed by a range of agencies and sectors. This manifests different values and ways of working, which can hinder joint work. The Regional Office convened a group of associations representing the staff groups active in mental health care, including nurses, occupational therapists, physiotherapists, psychologists, psychiatrists and social workers. A consensus statement has been agreed, and the group will continue to explore how to improve mental health work by agreeing on joint positions.

Objective 7 Mental health governance and delivery are driven by good information and knowledge.

47. Information and knowledge of the evidence regarding issues such as the mental health status of the population, the prevalence of mental health problems, needs assessments of patients and the quality of services provided are required in order to develop responsible planning and implementation of services. A comparison with the mental health status in other countries can be useful as an indicator of service provision.

48. The mental health programme has been working with WHO headquarters on the collection, analysis and dissemination of European national mental health data, which is available in the WHO Mental Health Atlas series (2001, 2005, 2011 and 2014). The series provides detailed data on the mental health policies, services, workforce and financing in each country. Country profiles are available on the Mental Health Atlas website. The table in Annex C1 provides an overview of data for the European Region provided in the *Mental Health Atlas 2014*, revealing gaps in mental health system governance, service delivery and performance measurement. A new mental health atlas survey in 2017 will enable monitoring of how the situation has changed in Member States in the Region since 2014.

49. The mental health programme has supported the European Commission in the collection of national information and the identification of good practice within the scope of the Joint Action on Mental Health and Well-being and the European Union Compass for Action on Mental Health and Well-being mechanism.

Collaborating centres

50. WHO collaborating centres in the European Region have actively supported the Regional Office's mental health programme. Their contributions include activities in the following areas:

- patient empowerment and good mental health services (Centre Frontières in Lille, France);
- suicide prevention in Russian-speaking countries (V. Serbsky Federal Medical Research Centre for Psychiatry and Narcology in Moscow, Russian Federation);
- awareness-raising of good practices and support for services development (Azienda per i Servizi Sanitari N.1 Triestina in Trieste, Italy);
- evidence of prevention and good practices in e-health (Trimbos Institute in Utrecht, Netherlands);
- the mental health of refugees and quality assurance (Queen Mary University of London, United Kingdom); and
- evaluation of community-based mental health care and workforce development in that area (University of Verona, Italy).

Conclusions and future plans

51. The mental health programme of the Regional Office will continue to implement the European Mental Health Action Plan by supporting Member States. Between 2013 and 2017, some 25 Member States in the Region prioritized mental health in their biennial collaborative agreements. For the 2018–2019 biennium, a similar number of countries have identified mental health as a priority, particularly primary care development and community-based policies and services.

52. The mental health programme will continue its close partnerships with associations representing workforce groups, patients and families, academic bodies and nongovernmental organizations, focusing on special conditions such as autism and dementia.

53. The next progress report on the implementation of the European Mental Health Action Plan will be submitted to the 70th session of the Regional Committee in September 2020.

Annex C1. Overview of WHO Mental Health Atlas 2014 data for Member States in the WHO European Region

Table. Mental health data for Member States in the WHO European Region on specific domains and indicators by number of countries and regional percentage

Domain/indicator		Number	%
1	**Atlas questionnaire completed/submitted**	**48**	**91**
2	**Mental health data reporting**	**37**	**70**
	Specific report on mental health in past two years	*19*	*36*
	Data reported in general statistics	*18*	*34*
3	**Mental health expenditure reporting**	**25**	**47**
	Inpatient care only	*25*	*47*
	Inpatient and outpatient care	*20*	*38*
4	**Mental health workforce reporting**	**30**	**57**
	Partial breakdown	*30*	*57*
	Comprehensive breakdown	*18*	*34*
5	**Service availability reporting**	**41**	**77**
	Inpatient beds only	*41*	*77*
	Inpatient beds and outpatient visits	*24*	*45*
6	**Service utilization reporting** *(for persons with a range of severe mental disorders)*	**19**	**36**
7	**Involuntary admission reporting**	**23**	**43**
8	**Mental health policy implemented**	**41**	**77**
	Fully	*13*	*25*
	Partially	*28*	*53*
9	**Mental health law implemented**	**41**	**77**
	Fully	*25*	*47*
	Partially	*16*	*30*
10	**Service users and family involvement***	**36**	**68**
	Fully	*13*	*25*
	Partially	*23*	*43*
11	**Promotion and prevention programmes** *(country has two or more functioning programmes)*	**27**	**51**

* Participation of persons with mental disorders and family members in Ministry of Health planning, policy, service development and evaluation.

Source: Mental health atlas 2014. Geneva: World Health Organization; 2015.

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Category 5. Preparedness, surveillance and response

D. Final progress report on implementation of the International Health Regulations (2005) in the WHO European Region (resolution EUR/RC59/R5)

Introduction and background

1. As requested in resolution EUR/RC59/R5 on implementation of the International Health Regulations (IHR) (2005), adopted by the 59th session of the WHO Regional Committee for Europe in September 2009, this progress report provides an overview on the implementation of IHR (2005) in the European Region. In line with resolution EUR/RC63/R8 on review of the status of resolutions adopted by the Regional Committee at previous sessions and recommendations for sunsetting and reporting requirements, this is the final report on progress under resolution EUR/RC59/R5.

2. Recent disease outbreaks, such as Ebola virus disease in West Africa in 2014 and the Zika virus outbreak in 2015–2016, have underlined the importance for Member States in the European Region to have strong national and international mechanisms and capacities in place to rapidly detect, respond to and take preventive measures to contain serious public health threats. There is also overwhelming evidence that strong and resilient health systems are an underlying factor for well-functioning core capacities of IHR (2005).

3. Although the Ebola and Zika outbreaks occurred outside the European Region, they demonstrated the need for strong and coordinated preparedness systems in the Region to combat threats and also to prevent secondary events from escalating into emergencies. Emergency preparedness and response also requires coordinated risk communication.

4. The Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response indicated that implementation of IHR (2005) and core capacity strengthening, in particular, should be seen as a continuous process, which includes preparedness, detection, risk assessment and response to all health emergencies.

5. The Review Committee recommended that a key element of improving strategic action plans would involve a continual cycle of assessment, action and re-assessment. It also noted that there are no processes or systems currently in place to institutionalize the collection and dissemination of event-related observations and lessons learned. The report of the Review Committee paved the way for the revised IHR (2005) Monitoring and Evaluation framework, which complements the self-assessments of States Parties on their progress on IHR (2005) implementation, with voluntary simulation exercises, after-action reviews and external evaluations that can provide a more accurate overview of existing operational capacities in countries. As part of its function and mandate under Article 44.2 of IHR (2005), the WHO Secretariat has developed technical tools for each of these three voluntary components.

6. The global momentum and various ongoing processes related to IHR (2005) and health security require strong European leadership to ensure input to the global debate on emergency preparedness and response. In order to enable the Standing Committee of the Regional Committee for Europe to effectively inform the Regional Committee and to contribute to the

global discussions on accelerated use of the IHR (2005) in the European Region, a Standing Committee subgroup on implementation of the International Health Regulations (2005) was established in 2015. Since then, the subgroup has played a crucial role in guiding the Secretariat to shape and prioritize the IHR activities of the Regional Office, as well as to adapt global approaches to the regional context.

IHR (2005) application in the European Region

7. The network of National IHR Focal Points (NFPs) remained a key success factor in the European Region throughout the reporting period. During this time, NFPs have been active in the notification and verification of potential public health events of international concern and the timeliness of sharing information has improved in all States Parties of the Region. There has also been visible progress in the reporting of different types of public health hazards – in addition to infectious disease hazards – including chemical, radio-nuclear, food-related and human-made threats.

8. The States Parties and the Regional Office have been involved in responses to major public health events at both regional and global levels. The WHO Health Emergency Information and Risk Assessment team for detection, verification and risk assessment maintains a 24/7 duty officer system and functions as the WHO IHR Contact Point. The team conducts continuous monitoring activities on signals of public health events from a variety of sources, in collaboration with Member States and partners, as appropriate. From September 2016 to June 2017, an estimated 15 000 signals from various sources were screened. About 1500 signals were analysed in greater detail, resulting in the detection of 32 serious public health events. In order to detect potential events, WHO regularly collaborates with partners, particularly the European Commission and the European Centre for Disease Prevention and Control (ECDC). The affected Member State is always involved in the assessment, as is the WHO country office, when one exists. The new internal rapid risk assessment template, adapted by the WHO Health Emergencies Programme in February 2017, was applied to four events in the European Region in 2017. Iterative in-depth risk assessments were conducted on 29 events with relevant WHO technical units. While three of the 32 events mentioned above did not require further verification by the relevant NFP, 29 verification requests were submitted between 1 September 2016 and 10 July 2017. Almost all verification requests were responded to and available public health information was provided by the NFP in a timely manner, in accordance with IHR (2005). WHO supported the Member State response to six of these events, which included outbreaks of botulism, poliomyelitis, Zika virus, Legionnaires' disease and Crimean-Congo haemorrhagic fever.

IHR (2005) implementation in the European Region

9. IHR (2005) implementation and emergency preparedness, in general, should follow a cyclical approach with tailored capacity-building activities in countries addressing the needs identified through monitoring and evaluation and the lessons learned from previous responses to public health events. Gaps should be alleviated through the development of costed and funded national action plans aimed at developing capacities, structures and operational plans and/or procedures of the health system and of related sectors.

10. As of July 2017, 50 external evaluations had been completed globally, with 27 additional evaluations planned for 2017–2018. To date, the Regional Office has facilitated eight voluntary external evaluations in Albania, Armenia, Belgium, Finland, Kyrgyzstan, Latvia, Slovenia and Turkmenistan. Preparations are under way for Lichtenstein and Switzerland; several Member States have expressed interest in undergoing an external evaluation in the coming year. The external evaluation has proved to be an effective tool for bringing together various sectors involved in IHR implementation at the country level, as they allow peer-to-peer discussions between external and national experts in relevant IHR areas. External evaluations have also proved successful in raising health security and IHR obligations to the attention of national decision-makers.

11. Similarly, simulation exercises and after-action reviews benefit from the participation of external peers, for example, in facilitating technical discussions and strengthening regional and global expert networks. As of July 2017, 34 simulation exercises have been completed globally and 25 are planned for 2017–2018. The Regional Office supported the planning and implementation of five simulation exercises to test various functional capacities in preparedness, detection and response, including for mass gatherings. Two examples are an exercise to test the management of a case of Middle East respiratory syndrome coronavirus in conjunction with the upcoming 5th Asian Indoor and Martial Arts Games to be hosted in Turkmenistan in September 2017 and a four-day table-top exercise on the coordination of response and the use of IHR mechanisms during a public health emergency in Bosnia and Herzegovina.

12. The Regional Office also participated in the G20 simulation exercise and in the ConvEx exercise led by the International Atomic Energy Agency with the European Union, several United Nations organizations and more than 80 countries. It simulated a radio-nuclear incident in Hungary, and tested its interagency and intercountry cooperation, including with NFPs.

13. The Regional Office developed an after-action review handbook, in close collaboration with ECDC. The handbook, which will be used to develop a global tool, underwent a consultation process involving European experts and NFPs.

14. In close collaboration with the European Commission and its institutions, the Regional Office supports Member States to achieve full implementation of IHR (2005). For example, the Regional Office was invited to provide input on preparedness monitoring under Article 4 of EU Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health. The Regional Office plans to collaborate with the European Commission on several areas of action in 2017–2018, including simulation exercises, after-action reviews and risk communication.

15. Important progress has been made by Member States in the European Region, in particular with regard to capacity development of laboratories, surveillance, legislation and policy, preparedness and human resources, as confirmed by the relatively high scores for all capacities on self-assessment questionnaires completed by States Parties. Areas restricting operational functionality of IHR (2005) implementation include, but are not limited to, a lack of awareness of and the ability to manage capacities, training gaps, engagement of all relevant national sectors in utilizing all-hazards and whole-of-government approaches and the development of mechanisms and processes for multisectoral and cross-border collaboration. There is some confusion in certain countries on the minimum requirements stipulated in

Annex 1 of the IHR (2005) and core capacities, based on the assumption that IHR compliance can only be achieved when all core capacities are functioning at a maximum level.

16. The Regional Office conducted different activities to address gaps and to further support countries to strengthen and maintain their capacities. A National IHR Focal Point meeting was held in Saint Petersburg, Russian Federation, in February 2017. The meeting provided an opportunity to discuss progress made and the process going forward, to share experiences and to address specific gaps and challenges in complying, implementing and applying the IHR (2005). In particular, the meeting provided a platform for focused discussions and the exchange of best practices and to enhance intercountry and interregional partnerships.

17. Recent activities involving points of entry, an issue of interest for many European States Parties, include:

- the Sixth meeting of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA-EUR/06) in Minsk, Belarus, on 12–14 July 2017; and
- expert visits to international airports to review compliance with IHR requirements for points of entry in Kazakhstan, Tajikistan and Turkmenistan. Additional expert visits are planned for Armenia and Bosnia and Herzegovina.

18. The Regional Office supported countries in developing national action plans, reviewing lessons learned and addressing recommendations from evaluations and assessments. In June 2017, WHO facilitated a three-day national consultation in Kyrgyzstan aimed at developing a costed national action plan to address identified priority areas based on the recommendations provided by the external evaluation. Technical areas prioritized by the Ministry of Health included: IHR coordination, intersectoral communication and advocacy, preparedness, points of entry, antimicrobial resistance and risk communication. Experts from the sectors involved in IHR implementation at the country level (public health, veterinary, emergency response, border control, transport, customs, among others) have identified actions that would effectively address existing gaps. The activity was supported by the Office of the Prime Minister and the Minister of Health. At the end of the consultation, a partner meeting with embassies, development agencies and other United Nations organizations was organized to debrief participants and to discuss opportunities for collaboration.

IHR (2005) compliance in the European Region

19. Interest from NFPs in the European Region, according to information provided on the Event Information Site (EIS) as measured by the number of logons by States Parties, has been consistently high and has increased since 2007. On average, States Parties of the Region log on to EIS 198 times per year (approximately four times per week). However, when considering EIS logons by country, there is a big difference among countries of the Region, with some States Parties logging on less than once a month.

20. In general, responses to verification requests of WHO on individual events meet the 24-hour requirement, as per Article 10 of IHR (2005), with only some States Parties failing to meet this requirement. In such cases, WHO country offices provide critical support in facilitating the verification process. Bilateral communication between individual NFPs has improved. Informal consultation with WHO in line with Article 8 of IHR (2005) on technical matters is currently underutilized.

21. In reviewing measures going beyond WHO's Temporary Recommendations at the end of the Ebola outbreak, it was noted that all European States Parties provided a justification based on Article 43 of IHR (2005); globally, 23 States Parties did not do so.

22. To date, 42 States Parties have nominated at least one expert to the IHR Roster of Experts in accordance with Article 47 of IHR (2005). Thirteen Member States in the European Region have not yet nominated experts to the Roster.

23. States Parties in the Region have increasingly implemented Article 44.1 of IHR (2005), and provided support and offered to collaborate with other States Parties, mainly to develop, strengthen and maintain public health capacities. Several States Parties supported activities of the Regional Office by releasing staff for expert exchanges and by offering technical and financial support for the facilitation of workshops, trainings, exercises and after-action reviews.

Conclusions

24. States Parties in the European Region take full ownership of IHR (2005) implementation and recognize the added value of gathering epidemic intelligence through the mutual and timely sharing of information, and the reporting and notification of events.

25. The Regional Office has expanded its services as the WHO IHR Contact Point and has provided support to States Parties on risk assessment and response.

26. In following up monitoring and evaluation activities, the Regional Office has continued to support the development of national action plans and their implementation. Other useful interventions in the European Region have included national and regional trainings for NFPs, both through e-learning and in face-to-face sessions; advocacy with other sectors; legislative reviews; risk communication trainings; and bilateral workshops. IHR support from the Regional Office is coordinated closely in conjunction with the strengthening of health systems at the country level.

27. States Parties with higher vulnerability and lower capacities require special focus by the Regional Office. Bilateral and multilateral collaboration under Article 44 of IHR (2005) are important elements for routine preparedness, as well as during the response to public health events.

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