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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);
- D. final report on implementation of the International Health Regulations (2005) in the WHO European Region (resolution EUR/RC59/R5); and
- E. implementation of the European Vaccine Action Plan 2015–2020 (resolution EUR/RC64/R5).

Contents

	page
Progress reports.....	1
Category 2. Noncommunicable diseases.....	4
A. Progress report on implementation of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (resolution EUR/RC61/R4)	4
Background: the need for strengthened action in Europe	4
Alcohol policy developments: the 10 action areas.....	5
Leadership, awareness and commitment	5
Health services' response.....	5
Community and workplace action	5
Drink–driving policies and countermeasures.....	6
Availability of alcohol	6
Marketing of alcoholic beverages.....	6
Pricing policies	6
Reducing the negative consequences of drinking and alcohol intoxication	7
Reducing the public health impact of illicit alcohol and informally produced alcohol.....	7
Monitoring and surveillance	7
Key developments in alcohol policy.....	8
Role of the Regional Office	8
Governance.....	8
Strengthening surveillance, monitoring and evaluation, and research.....	10
Annex A.1. Total adult per capita consumption of alcohol by country in the WHO European Region.....	11
Annex A.2. Total adult per capita consumption of alcohol by country in the WHO European Region from 1990 to 2016 ^a	13
Part B. Progress report on implementation of the European Food and Nutrition Action Plan 2015–2020 (resolution EUR/RC64/R7)	18
Background.....	18
European Food and Nutrition Action Plan 2015–2020.....	18
Priority area 1: create healthy food and drink environments	19
Priority area 2: promote the health gains of a healthy diet throughout the life-course, especially for the most vulnerable groups	20
Priority area 3: reinforce health systems to promote healthy diets and p rovide diet-related services	21
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.....	22
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.....	24
Collaborating centres	24
Conclusions and future plans	24

C. Progress report on implementation of the European Mental Health Action Plan (resolution EUR/RC63/R7)	26
Introduction.....	26
Background.....	26
The European Mental Health Action Plan	27
Objective 1: everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk	28
Objective 2: people with mental health problems are citizens whose human rights are fully valued, protected and promoted	29
Objective 3: mental health services are accessible, competent and affordable, available in the community according to need	30
Objective 4: people are entitled to respectful, safe and effective treatment	30
Objective 5: health systems provide good physical and mental health care for all	32
Objective 6: mental health systems work in well-coordinated partnerships with other sectors.....	33
Objective 7: mental health governance and delivery are driven by good information and knowledge	33
Collaborating centres	34
Future plans.....	34
Category 5. Preparedness, surveillance and response	35
D. Final report on implementation of the International Health Regulations (2005) in the WHO European Region (resolution EUR/RC59/R5).....	35
Heading 2	35
Heading 2	35
Heading 3.....	35
Heading 3.....	35
Heading 2	35
E. Progress report on implementation of the European Vaccine Action Plan 2015–2020 (resolution EUR/RC64/R5).....	36
Heading 2	36
Heading 2	36
Heading 3.....	36
Heading 3.....	36
Heading 2	36
AnnexTitle. Test	37

Category 2. Noncommunicable diseases

A. Progress report on implementation of 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 Regional Committee for Europe called on Member States¹ 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 2014, the European average for alcohol consumption for adults (aged ≥ 15 years) was 10.7 L of pure alcohol, a decline from 11.9 L in 2007 and from 11.1 L in 2010. Country-specific trends can be seen in annexes 1 and 2. The average unrecorded consumption in 2014 was estimated to be 2.0 L of pure alcohol, which accounts for 18% of the total consumption in the European Region; the percentage has been stable during the past 10 years. The 12-month abstinence rate was on average 33.6%; the lowest abstinence 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 experienced an incident of heavy episodic drinking during the past month, with large differences among Member States.
3. It is estimated 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 areas²

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 Regional Office by December 2016, 39 had a written national policy on alcohol, and 20 of these were in the process of updating their policy. Of the 14 Member States without a national alcohol policy, nine were in the process of developing one. Since 2012, 10 Member States have adopted a new national alcohol policy, aligned with the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020.

5. Since 2011, the following countries have changed or adopted an alcohol policy: Albania, Belarus, Estonia, Finland, Germany, Iceland, Ireland, Israel, Latvia, Lithuania, Montenegro, Norway, Poland, the Republic of Moldova, San Marino, Sweden, Switzerland, Tajikistan, Turkey, Turkmenistan, the United Kingdom of Great Britain and Northern Ireland and Uzbekistan.

Health services' response

6. The health sector plays an important role in both identifying 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 States³ 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.³ The most commonly involved partners are nongovernmental organizations (41 Member States) and local government bodies (32 Member States).³ Involvement of economic operators, which in most cases means the alcoholic beverage industry, was reported by 20 Member States.³

8. Twenty Member States have national guidelines for the prevention of and counselling for alcohol problems in the workplace,³ and in 17 Member States testing for alcohol in the workplace is governed by legislation.³ In 19 Member States, social partners representing employers and employees are involved at the national level in action to prevent and address alcohol-related harm in the workplace.⁴

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 13 February 2017). Please note that the figures for 2016 will be updated in April 2017.

³ Data not available for two Member States.

⁴ Data not available for four Member States.

Drink-driving policies and countermeasures

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

10. All but one Member State reported breath-testing as the usual method for measuring blood alcohol concentration. Blood or urine analysis is also commonly used (44 Member States). 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 44 Member States. Sobriety check-points or roadblocks established by the police on public roadways to control for drink-driving are used by 29 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, but eight countries still have a limit of 16 years for off-premise sales of beer and wine. For off-premise sales, 21 countries have restrictions on hours of sale, 35 countries have restrictions during specific events, and 20 countries have restrictions on sales at petrol stations. Twenty-five countries reported that they had banned alcohol consumption in health-care establishments, 27 in educational buildings, 22 in government buildings and 17 on public transport.

12. Thirty-six Member States (68%) have reported restrictions on on-premise sales of alcohol to intoxicated persons. The majority of Member States also restrict on- and off-premise sales at specific events. Between 43% and 58% of Member States have reported restrictions on locations of sales, depending on beverage type, and very few Member States reported restrictions on days of sale or on density of outlets.

Marketing of alcoholic beverages

13. In 47 Member States, there are legally binding regulations on alcohol advertising, and 36 countries have restrictions on alcohol product placement. Ten Member States have reported a total ban on national television advertising of beer, and 14 and 23 Member States have a total ban on national television advertising of wine and spirits, respectively. Twelve Member States reported no restrictions on national television advertising of beer, and nine and six 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 two Member States, alcoholic beverages are subject to value-added tax of above 0%, the rate varying from 8% to 30%;³ most countries levy taxes of 15–20%. All Member States reported that excise duty is levied on spirits, and all but one Member

State reported that it is levied on beer;⁵ 12 Member States do not have an excise duty on wine.⁵ Thirteen Member States reported that the level of excise duty is regularly adjusted for inflation.

15. A few countries (Belarus, Kyrgyzstan, Republic of Moldova, Russian Federation, 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. Poland recently decided to introduce minimum pricing.

Reducing the negative consequences of drinking and alcohol intoxication

16. Approximately 32% of 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 serve alcoholic beverages.

17. Ten Member States legally require the presence of safety messages or health warnings on bottles, cans or other packaging containing alcoholic beverages to inform or remind consumers of the risks associated with alcohol use.⁶

18. Nine 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 17 Member States for beer, by 24 Member States for wine and by 34 Member States for spirits.⁵

Monitoring and surveillance

21. Thirty-one 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.⁵

22. Twenty-six Member States reported regular publication of comprehensive reports on the national alcohol situation.⁷ The most commonly covered topics include drinking by adults (17 Member States), drink-driving and alcohol-related traffic accidents (17 Member States) and underage drinking (16 Member States). Regular reporting on

⁵ Data not available for one Member State.

⁶ Reflects changes in legislation in Turkey in 2013.

⁷ Data not available for five Member States.

the retail availability and affordability of alcohol, identified by the Regional Office as areas in which control measures on alcoholic beverages could contribute most to reducing the burden of noncommunicable diseases, is less common.

Key developments in alcohol policy

23. There have been a number of developments in the European Region since the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 was adopted. 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,⁸ 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 51.
- (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 46 Member States, compared to 27 in 2010.
- (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 47.
- (f) The number of Member States with legally binding restrictions on alcohol product placement increased from 31 to 36.
- (g) The number of Member States that require health warnings on alcohol advertising increased from 12 to 15.
- (h) The number of Member States in which the level of taxation for alcoholic beverages is adjusted for inflation increased from 7 to 13.
- (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 49.

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

⁸ Based on data provided by 45 Member States.

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 in 2016 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 in 2016, 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 that includes the text of resolution EUR/RC61/R4 and definitions of the indicators for the 10 action areas in English and Russian. 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 of 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 promote multisectoral action, build national capacity, identify new partnership opportunities, 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 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,⁹ 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 for all Member States. This can provide guidance in implementing new policies to decrease the harmful use of alcohol. A report on this topic will be published in 2017.

⁹ Data not available for five Member States.

Annex A.1. Total adult per capita consumption of alcohol by country in the WHO European Region¹

Table A.1. Comparison of total adult per capita consumption of alcohol in litres by country in the WHO European Region in 2014 and 2016

Country	Total adult consumption L			% difference
	2012	2014	2016	
Albania	6.6	6.0	TBP	-9.09
Andorra	NA	NA	TBP	NA
Armenia	5.0	5.2	TBP	4.00
Austria	10.2	9.9	TBP	-2.94
Azerbaijan	3.0	3.2	TBP	6.67
Belarus	19.4	17.8	TBP	-8.25
Belgium	11.2	13.2	TBP	17.86
Bosnia and Herzegovina	6.9	6.3	TBP	-8.70
Bulgaria	12.4	13.2	TBP	6.45
Croatia	13.2	12.2	TBP	-7.58
Cyprus	11.1	11.6	TBP	4.50
Czech Republic	13.7	13.9	TBP	1.46
Denmark	10.7	10.6	TBP	-0.93
Estonia	14.5	15.6	TBP	7.59
Finland	11.5	10.9	TBP	-5.22
France	12.0	12.0	TBP	0.00
Georgia	9.3	7.8	TBP	-16.13
Germany	11.7	11.6	TBP	-0.85
Greece	9.7	9.2	TBP	-5.15
Hungary	13.2	12.9	TBP	-2.27
Iceland	7.7	7.0	TBP	-9.09
Ireland	11.3	10.2	TBP	-9.73
Israel	3.0	3.4	TBP	13.33
Italy	7.7	7.6	TBP	-1.30
Kazakhstan	9.4	8.9	TBP	-5.32
Kyrgyzstan	5.0	5.0	TBP	0.00
Latvia	12.1	12.6	TBP	4.13
Lithuania	17.0	17.8	TBP	4.71
Luxembourg	NA	NA	TBP	NA
Malta	6.8	7.5	TBP	10.29
Monaco	NA	NA	TBP	NA
Montenegro	10.3	10.7	TBP	3.88
Netherlands	9.4	9.6	TBP	2.13
Norway	8.2	7.9	TBP	-3.66

¹ When the 2016 data are available, the 2012 data will be removed from the table and the % difference will show the change in consumption between 2014 and 2016.

Country	Total adult consumption			% difference
	2012	2014	2016	
Poland	12.8	13.0	TBP	1.56
Portugal	13.0	11.6	TBP	-10.77
Republic of Moldova	18.6	16.6	TBP	-10.75
Romania	13.6	14.1	TBP	3.68
Russian Federation	15.4	14.5	TBP	-5.84
San Marino	NA	NA	TBP	NA
Serbia	12.2	11.9	TBP	-2.46
Slovakia	11.8	12.3	TBP	4.24
Slovenia	11.4	11.3	TBP	-0.88
Spain	10.6	10.1	TBP	-4.72
Sweden	9.6	9.4	TBP	-2.08
Switzerland	10.3	10.1	TBP	-1.94
Tajikistan	2.5	2.1	TBP	-16.00
The former Yugoslav Republic of Macedonia	3.6	3.3	TBP	-8.33
Turkey	2.1	2.1	TBP	0.00
Turkmenistan	5.0	5.0	TBP	0.00
Ukraine	13.4	13.3	TBP	-0.75
United Kingdom	12.3	12.2	TBP	-0.81
Uzbekistan	5.0	5.1	TBP	2.00

NA: not available; TBP: to be provided in April 2017

Annex A.2. Total adult per capita consumption of alcohol by country in the WHO European Region from 1990 to 2016^{1,a}

Fig. A.2.1. Total adult per capita consumption of alcohol by country in group 1

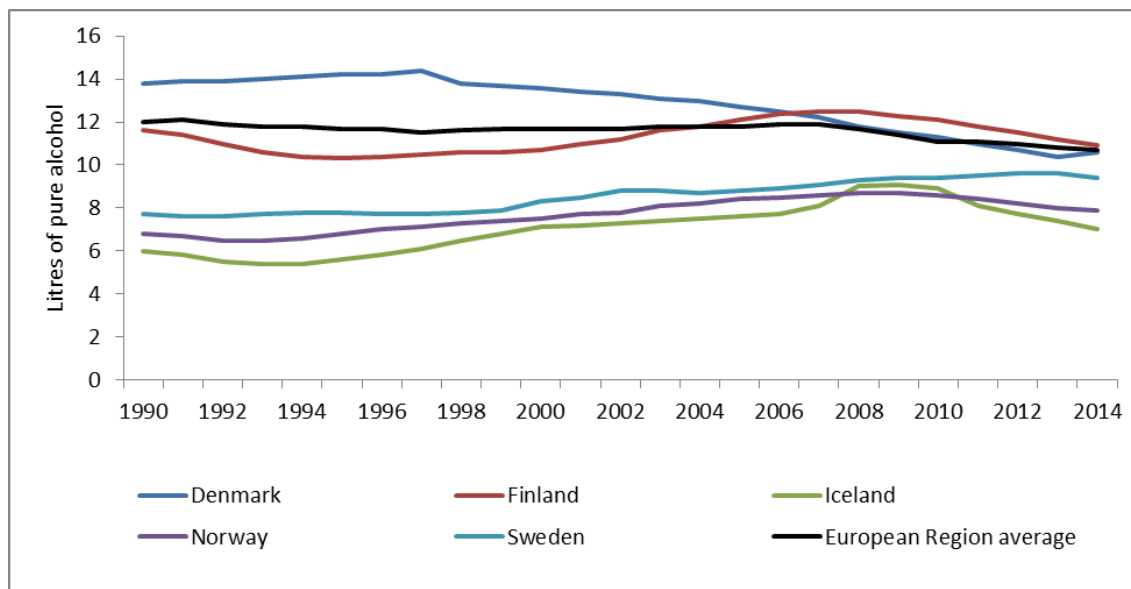
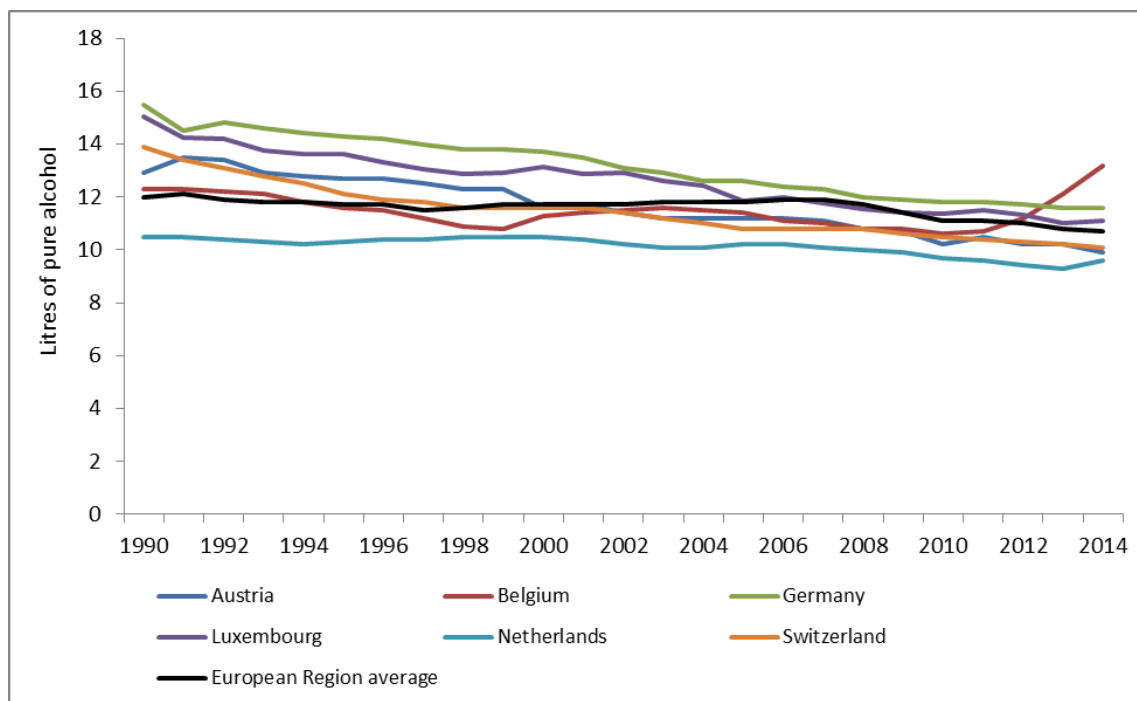


Fig. A.2.2. Total adult per capita consumption of alcohol by country in group 2



¹Data for 2016 to be provided in April 2017.

Fig. A.2.3. Total adult per capita consumption of alcohol by country in group 3

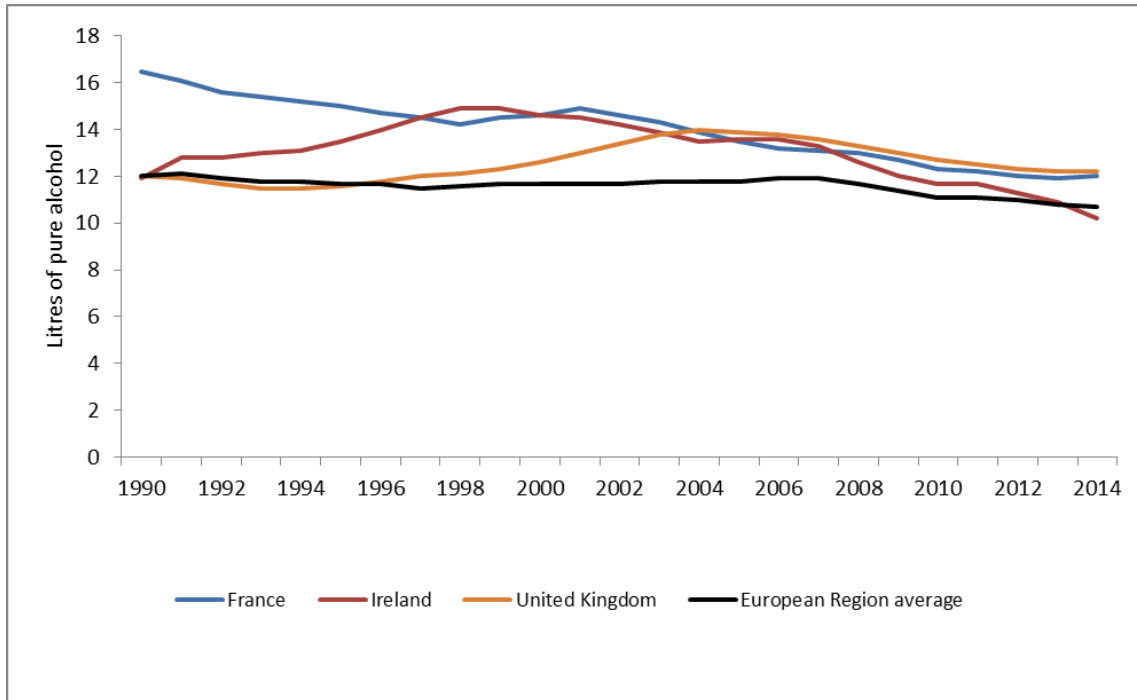


Fig. A.2.4. Total adult per capita consumption of alcohol by country in group 4

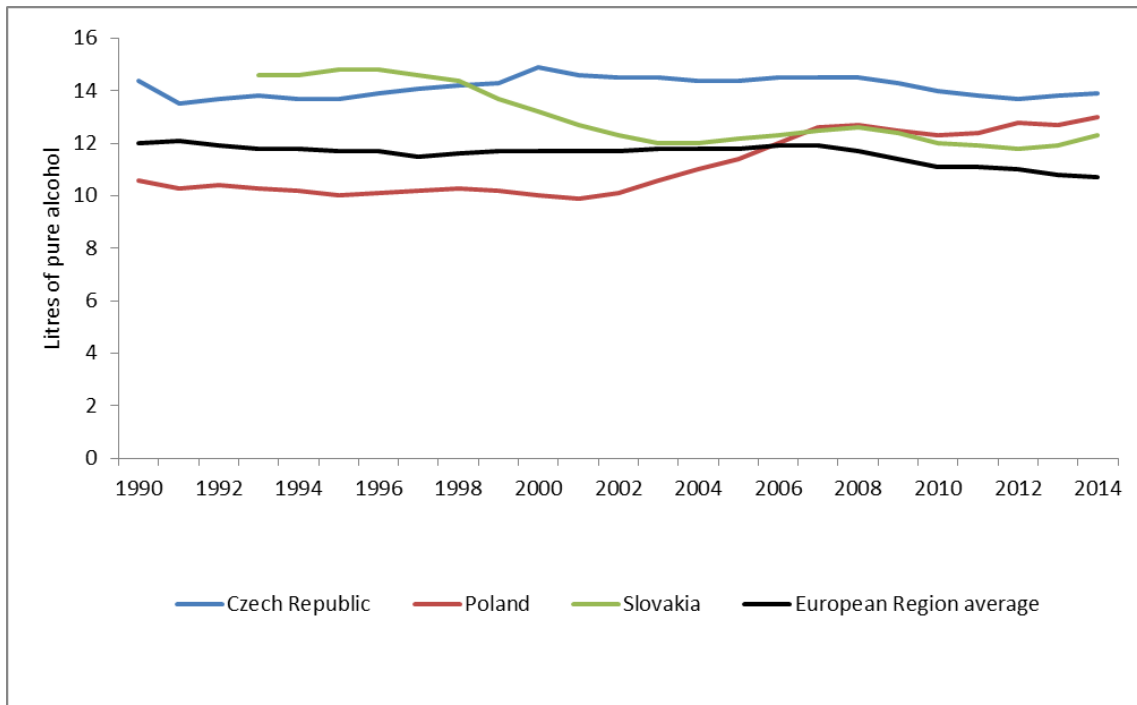


Fig. A.2.5. Total adult per capita consumption of alcohol by country in group 5

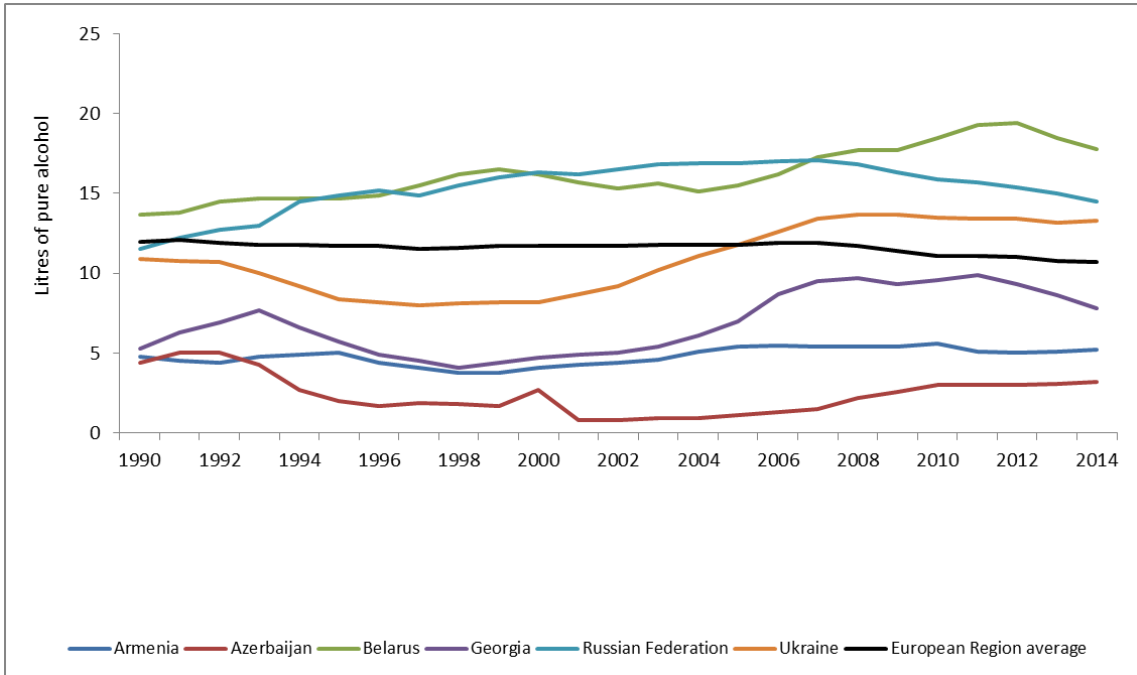


Fig. A.2.6. Total adult per capita consumption of alcohol by country in group 6

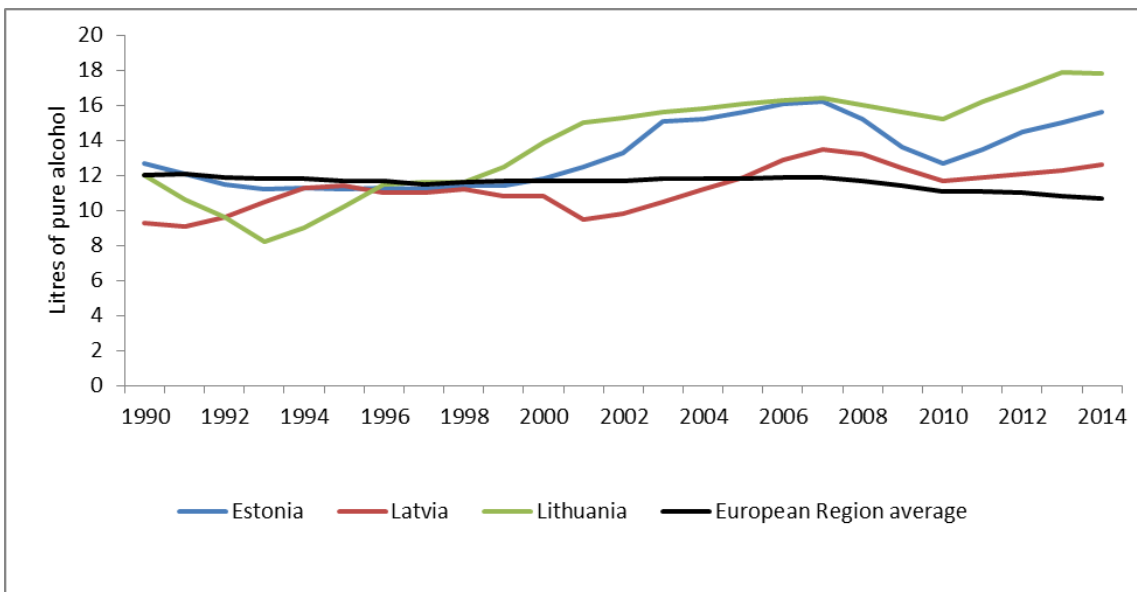


Fig. A.2.7. Total adult per capita consumption of alcohol by country in group 7

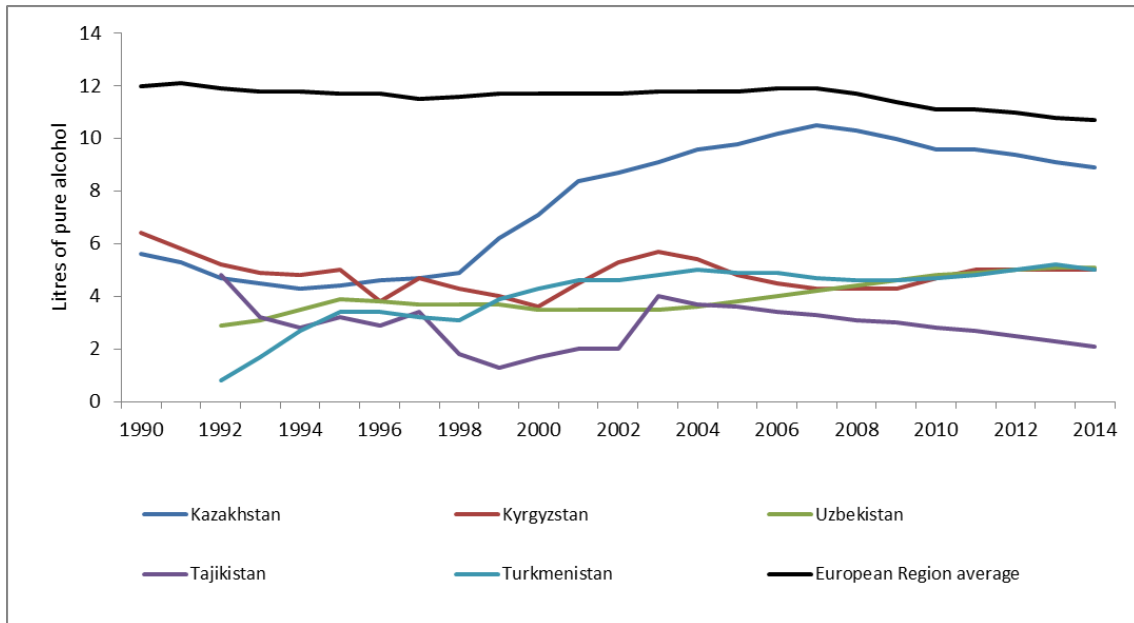


Fig. A.2.8. Total adult per capita consumption of alcohol by country in group 8

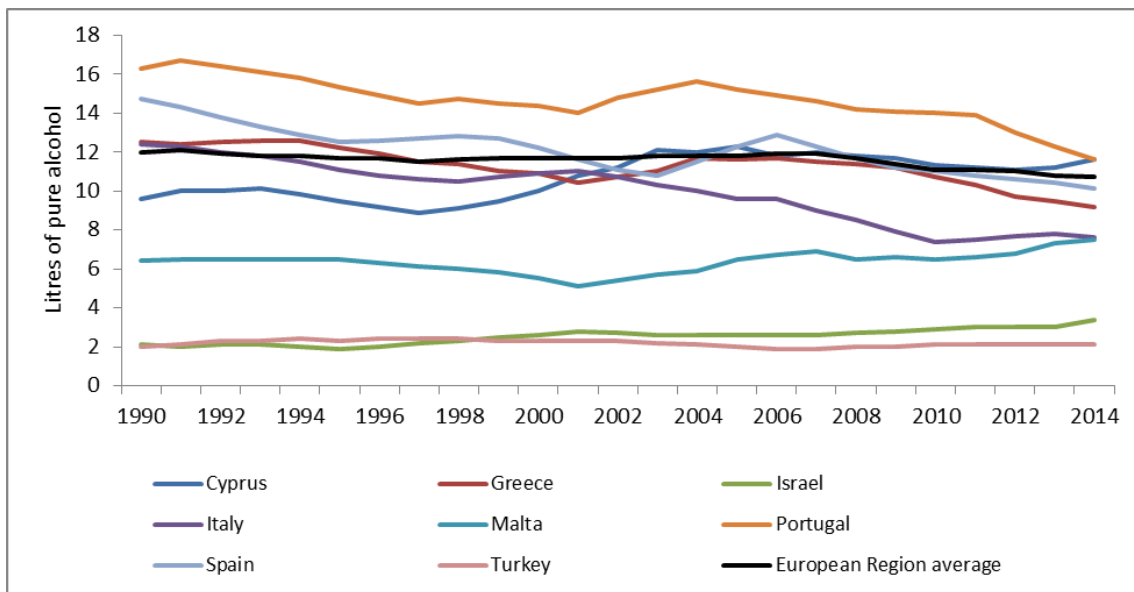
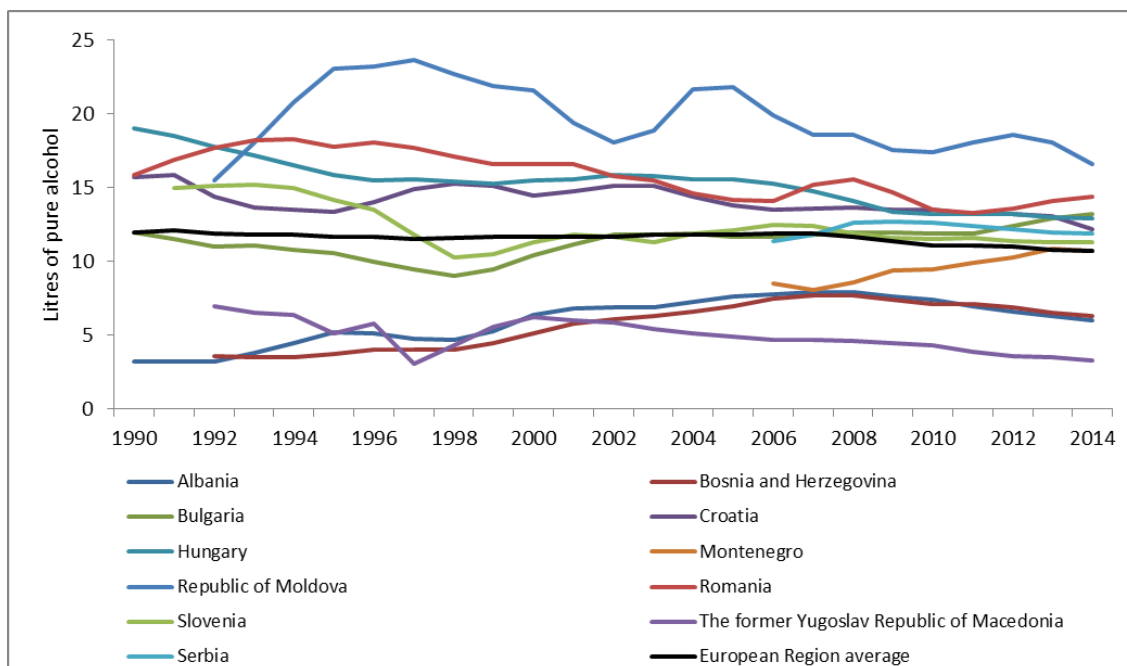


Fig. A.2.9. Total adult per capita consumption of alcohol by country in group 9^a



^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.

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

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. 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 2014, the Regional Committee requested the Regional Director to report on the implementation of the Action Plan in to the 67th session of the Regional Committee in 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 B.1. 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.

Box B.1. 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.

8. The present report describes and illustrates progress made by Member States, in partnership with the Regional Office, in each priority area from 2015 to 2017.

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 proposed 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 and 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 plans to continue 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 of 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 will 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 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 of 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 countries, 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, also remain 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 countries 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 countries 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 countries 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.

26. 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.

27. 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.

28. 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 of the Region.

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

30. A review by WHO of available dietary intake data shows that less than two thirds of countries of 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.

31. More countries, 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 of 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.

32. 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

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

34. 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.

35. 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

36. 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

37. 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 working.

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

39. 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).

40. 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 2021.

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C. Progress report on implementation of the European Mental Health Action Plan (resolution EUR/RC63/R7)

Introduction

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.

Background

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 disorders are 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 countries in the Region, mental disorders tend to be more prevalent among those who are the most deprived in society.

3. An important indicator of the disease burden on society and health systems is the contribution of specific groups to all chronic conditions (years lived with disability). Mental disorders are by far the most significant of the chronic conditions affecting the population of the European Region, accounting for up to 40% in some countries. A high percentage of people who receive social welfare benefits or pensions because of 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 between countries.

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 countries still rely on mental hospitals as the mainstay for mental health services. The commitment to deinstitutionalization and the development of community-based mental health services has continued, although progress is uneven across the Region. Thus, a focus on the expanding role of primary care, working in partnership with multidisciplinary mental health staff in community-based facilities, has become a principal focus.

6. There is strong evidence of effective treatments and care for many mental disorders and their comorbidities. Well-being could be improved, productivity increased and many suicides prevented. However, a large proportion of people with mental disorders either do not receive any 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 treatment and care experiences are other factors contributing to the failure to engage. Reforms are needed to achieve higher confidence in the safety and effectiveness of care. Mental health policies need to combine 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 mental well-being is increasing, and mental health is covered by Sustainable Development Goal 3.4, which aims 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, which has increased since 2013, and which currently includes collaboration 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, urges Member States¹:

- (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 (document EUR/RC63/11) are listed in Box C.1. Each objective proposes a set of actions for Member States and for the Regional Office that would achieve measurable outcomes.

¹ And regional economic integration organisations, where applicable

Box C.1. 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.

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

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

14. Mental well-being throughout the lifespan and equity are 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.

15. 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.

16. 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 prevention of depression and suicide. WHO was represented at Commission meetings and co-organized several conferences on the promotion of mental health.

17. In order to raise awareness, the mental health programme worked with Dutch and Finnish collaborating centres to publish the policy brief “Preventing depression in the WHO European Region” which is accessible on the WHO Regional Office for Europe website.

18. The mental health programme also addressed the specific needs of vulnerable populations, such as refugees. At a meeting at the Regional Health Development Centre for Mental Health in South-eastern Europe, located in Sarajevo, Bosnia and Herzegovina, the programme provided evidence on the prevalence, treatment and preventative actions of mental disorders of vulnerable groups. The programme also assisted in the production of a 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)*.

19. Many countries 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, to develop actions and policies.

20. 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

21. At the core of the European Mental Health Action Plan is the aim 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 patient and family groups.

22. 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.

23. In recent years, the issue of human rights has received increased attention, as indicated, for example, by the ratification of the United Nations Convention on the Rights of Persons with Disabilities in 2006, which has been subsequently ratified by many Member States of the European Region. The Convention’s implications for mental health has been 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.

24. 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 protecting them against discrimination due to the wrongful association between violence and mental disorders. One of the main challenges of the past few years has been to find a balance between the protection of individual rights and those of the public at a time of heightened fear and risk avoidance.

25. The mental health programme assisted countries, including Lithuania, Turkey and Turkmenistan, in drafting mental health legislation to eliminate 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.

26. Objective 2 is also addressed by supporting deinstitutionalization. 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 live 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 in very 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 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

27. 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.

28. 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 the last resort for people who pose a risk to themselves or others.

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

30. In Turkey, co-funded by a grant from the European Commission, 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 those with intellectual disabilities. A Turkish model of care designed around family-centred community services sought to prevent hospitalization and 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; with more than 100 community teams and about 50 Houses of Hope established and some 350 staff trained. The second phase of this project is now under way.

31. In Ukraine, the Regional Office assisted in forming and training four community teams, targeting 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.

32. The mental health programme conducted missions to assess the status of national mental health services and to make recommendations for reform in Armenia, Bulgaria, 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 very 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.

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

34. 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.

35. On several occasions, the mental health programme convened meetings with groups of countries at similar stages of development and with common languages or cultural backgrounds. Three meetings brought together Russian-speaking countries, namely, 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.

36. 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 countries 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.

37. 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 also conducted some country assessments.

38. Throughout this period, the mental health programme has worked closely with nongovernmental organizations, involving them in its work. These included 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 (Albania, Armenia, Belgium, Bulgaria, 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

39. 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 in this group.

40. 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).

41. 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 countries where community-based services are under development.

42. 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

43. Since a high number of the actions beneficial to well-being and many of the needs of people with mental health problems are the responsibility of sectors other than health, the Regional Office for Europe has tried to make links across government departments. The contribution of the mental health programme to the Minsk and Paris conferences has already been mentioned.

44. 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.

45. In most countries, 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.

46. Although dementia was not specifically covered by the European Mental Health Action Plan, the mental health programme has worked in close partnership with WHO headquarters and the European Commission to address this condition, which has become a high priority for several Member States. The programme has also discussed dementia with delegations during visits to WHO offices and with ministries of health in countries during missions.

47. 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 upon joint positions.

Objective 7: mental health governance and delivery are driven by good information and knowledge

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

49. 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. The series provides detailed data on policy, services, workforce and financing in each country.

50. The 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 EU-Compass for Action on Mental Health and Well-being mechanism.

Collaborating centres

51. WHO collaborating centres in the European Region have actively supported the Regional Office's mental health programme. This includes input from the Centre Frontières in Lille, France, on patient empowerment and good mental health services; the V. Serbsky Federal Medical Research Centre of Psychiatry and Narcology in Moscow, the Russian Federation, on suicide prevention in Russian-speaking countries; the Azienda per i Servizi Sanitari N.1 Triestina in Trieste, Italy, on awareness-raising of good practice and support to service development; and the Trimbos Institute in Utrecht, the Netherlands, on evidence of prevention and good practice in e-health; the Queen Mary University of London, United Kingdom, on the mental health of refugees and quality assurance; and the University of Verona, Italy, on evaluation of and workforce development in community services.

Future plans

52. The mental health programme of the Regional Office will continue to implement the European Mental Health Action Plan with 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.

53. In the immediate future, the mental health programme will continue to develop its close partnerships with associations representing workforce groups, patient and families groups, and academic and nongovernmental organizations focusing on special conditions such as autism and dementia.

54. 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 2020.

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Category 5. Preparedness, surveillance and response

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

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E. Progress report on implementation of the European Vaccine Action Plan 2015–2020 (resolution EUR/RC64/R5)

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