Good health starts with healthy behaviour

WHO STRATEGIC OBJECTIVE 6: “To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.”
The dramatic increase in behaviour-linked risk factors is the epidemic of the 21st century. Within the WHO European Region, the impact of the major noncommunicable diseases (diabetes, cardiovascular disease, cancer and chronic respiratory diseases) is alarming. Almost 60% of the disease burden in Europe is attributable to seven leading risk factors: high blood pressure, tobacco use, harmful use of alcohol, high blood cholesterol, overweight, low fruit and vegetable intake and physical inactivity.

It is possible to significantly reduce the burden of premature death, disease and disability in Europe through comprehensive action on these leading causes and conditions – health-related behaviour determinants.

Within the global noncommunicable disease (NCD) epidemic, the WHO European Region is the most heavily affected. This has been associated with worrying levels of common risk factors. Tobacco use is the highest behaviour-related risk factor in the WHO European Region, responsible for approximately 1.6 million premature deaths yearly throughout the Region; however, it is closely followed by alcohol. The Region has the highest alcohol intake in the world with a per capita consumption twice as high as the world average. Furthermore, alcohol consumption is increasing in the countries where it used to be less significant. Overweight and obesity is affecting around one in every four children and overweight affects 25–70% of individuals in the WHO European Region depending on the country.

Healthy diets are crucial for well-being and a healthy life, therefore the reduction of harmful components of the diet such as trans fatty acids is crucial. Salt intake is estimated to be above the WHO-recommended limit in the vast majority of the countries in the Region, making it likely one of the biggest contributors to cardiovascular disease in the Region.

WHO/Europe supports Member States in developing and implementing strategies and policies to promote health and development by preventing or reducing the common risk factors for noncommunicable diseases (unhealthy diets, alcohol, tobacco, physical inactivity), and by providing guidance for health promotion and health service development for different age groups and in specific settings.

Introduction

The following WHO/Europe programmes address behaviour-linked health determinants:

- TOBACCO CONTROL
- ALCOHOL
- ILLICIT DRUGS
- NUTRITION, PHYSICAL ACTIVITY AND OBESITY
“The fight against noncommunicable diseases in Europe begins by acknowledging that they are linked by common determinants and opportunities for shared policy interventions.”

Zsuzsanna Jakab, WHO Regional Director for Europe

Executive Summary

The tobacco control programme supports countries in developing, implementing and strengthening tobacco control measures at all levels of government, through reinforcement of the WHO Framework Convention on Tobacco Control (WHO FCTC), which reaffirms the right of all people to the highest standard of health. WHO/Europe plays an important role in providing tools and evidence-based guidance to support and monitor implementation, offer advice and training and promote exchange and learning across the European Region.

The alcohol programme works closely with Member States to improve public health through guidance on legislation, health promotion, disease prevention, disease management research, and evaluation and surveillance activities related to alcohol consumption and harm. Data collection on alcohol consumption, harm and policy responses are a core activity in partnership with the European Commission and WHO headquarters.

The programme on illicit drugs supports development of national policies and action plans to reduce the demand for drugs. An important part of this support to Member States is assistance in developing national guidelines in opioid substitution therapy.

The nutrition, physical activity and obesity programme works towards the inclusion of health-enhancing physical activity promotion in health policy and in other relevant sectors in Europe and calls on all sectors including health, transport, housing and education to collaborate in developing effective policies and interventions. The programme also works with Member States in the development, implementation and evaluation of policies to promote healthy diets and prevent overweight and obesity.
Tobacco control

Governments in the WHO European Region have recognized the importance of tobacco control and many are now seriously addressing it through taxation and pricing, bans on advertising, regulations on packaging, required warnings, bans on smoking in public places and support for people who want to kick the habit.

These initiatives are strongly supported by the WHO Framework Convention on Tobacco Control (WHO FCTC), the first treaty negotiated under the auspices of the World Health Organization, which 46 countries in the WHO European Region have ratified so far. The WHO FCTC was adopted in 2003 in response to the globalization of the tobacco epidemic and is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. Governments are finding that the health gains hugely outweigh the perceived political costs of taking action, and one country after another is introducing tough legislation to combat smoking.

Challenges

The burden of tobacco across the WHO European Region is tremendous. It is the leading risk factor for premature mortality, responsible for approximately 1.6 million deaths a year. Tobacco is also a powerful factor in health disparities among socioeconomic groups and gender. Numerous studies have shown that tobacco usage and deaths follow a marked socioeconomic gradient. Smoking-related death rates are, on average, two to three times higher in low-income groups than in wealthier social groups.

The numbers of women and girl tobacco users in the WHO European Region are the highest in the world. The pattern of tobacco use between the sexes differs both within and between countries. The differences between male and female prevalence are small compared to those in other WHO regions, and as a worrying trend, the gap is closing rapidly, especially with increases in smoking among women in the eastern part of the Region and among girls in general.

Seven Member States in the Region have not yet ratified the WHO FCTC; and even among those that have ratified the treaty, implementation is uneven. For example, approximately 50% of Member States still do not have any smoke-free policies for public places.
What the WHO Regional Office for Europe is doing

The WHO Regional Office for Europe is committed to reducing the burden of disease and death caused by tobacco, and guides Member States in developing, implementing and strengthening tobacco control measures.

To reduce tobacco use, WHO supports countries in the Region in implementing the provisions of the WHO Framework Convention on Tobacco Control. In particular, the Convention promotes six cost-effective policy interventions (MPOWER):

- **monitor** tobacco use and tobacco-prevention policies
- **protect** people from tobacco smoke in public places and workplaces
- **offer** help to people who want to stop using tobacco
- **warn** people about the dangers of tobacco
- **enforce** bans on tobacco advertising, promotion and sponsorship and
- **raise** tobacco taxes and prices.

Taxes on tobacco are the single most effective intervention to reduce demand for tobacco. A price increase of 10% would reduce smoking by an estimated 4% in high-income countries and by about 8% in low- and middle-income countries.

In addition to working with the remaining seven Member States in the Region that have not yet ratified the WHO FCTC, the Regional Office has strong collaborations with those that have signed the WHO FCTC with the goal of providing reinforcement to the treaty as a powerful legal instrument.

What additional progress can be achieved with more resources?

Together with its partners, WHO/Europe aims to scale up efforts in the following areas:

- ratification of WHO FCTC by the remaining seven Member States in the Region;
- greater implementation of all articles and guidelines of the WHO FCTC;
- active use of economic arguments to support a high level of taxation on tobacco across the Region;
- increased action to counteract the tobacco industry through partnership with civil society, and other sectors;
- use of tobacco surveillance data to better understand and address the social determinants of health;
- introduction of tobacco control/cessation training module into the curriculum for health profession students to strengthen essential primary health care services.

Turkey

Turkey has implemented a “whole government” approach in its tobacco control efforts, leading to remarkable progress in recent years. Its tough anti-smoking policies have placed Turkey among the leaders in tobacco control not only in the WHO European Region but also globally.

Such measures have had great significance in reducing both sales/consumption and prevalence. Since 1988, there has been a steady decrease in prevalence of daily smoking among adult males. Since 2003 and the ratification of the WHO FCTC in 2004, there has also been a steady decrease in prevalence of daily smoking among adult females.

In a recent global assessment of the MPOWER measures, Turkey rated very high. Some key achievements:

- Turkey became the first of 14 countries globally to successfully complete the fieldwork of the Global Adult Tobacco Survey (GATS) in 2009. It has plans to repeat the survey in 2012.
- On the 19th of July 2010, “100% smoke-free” legislation came into force, making Turkey one of the few countries in the Region to have a comprehensive ban on smoking in public places.
- Since 2010, Turkey has also been one of the few countries in the Region to have pictorial warnings on tobacco packages.

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Alcohol

The WHO European Region is the heaviest drinking region in the world, with an average consumption of alcohol that is twice the world average. Consequently, the Region has the highest proportion of total ill health and premature death due to alcohol. There are huge variations among countries in Europe, including alcohol-related health inequalities between eastern and western Europe, particularly with regard to deaths from injuries.

In eastern Europe alcohol is the leading risk factor for life years lost. Looking at the European Region as a whole, alcohol is the second most important risk factor for years lost due to death and disability. For 2004, the number of disability-adjusted life years lost was estimated to be 17.3 million. The overall economic cost of alcohol to the EU alone is estimated to be €125 billion per year.

Both the volume of lifetime alcohol use and a combination of frequency of drinking and the amount drunk per occasion determine the risk of health-related and social harm, largely in a dose-dependent manner. Heavy episodic drinking is widespread across all ages and all of Europe.

Absolute annual risk of death from alcohol-related diseases

![Graph showing the absolute annual risk of death from alcohol-related diseases.](image-url)
Challenges

The disease burden attributable to harmful use of alcohol is significant and in many countries public health problems caused by it represent a substantial health, social and economic burden. Substantial evidence has shown that alcohol policies focusing on taxation, availability and promotion, as outlined in the European Alcohol Action Plan 2012-2020, achieve results and are cost-effective. The Action Plan covers ten important areas of prevention of the harmful use of alcohol and treatment of alcohol dependence. Each area has a number of options for actions that can be used for inclusion in national alcohol action plans.

What the WHO Regional Office for Europe is doing

WHO will use the European Alcohol Action Plan (2012-2020) to guide Member States in drafting or renewing their alcohol policy in order to reduce the harmful use of alcohol, decrease alcohol use among young people, eliminate alcohol and driving, reduce alcohol in the workplace, eliminate alcohol during pregnancy and improve the health system capacity for treatment of alcohol disorders.

The WHO alcohol programme is working closely with the European Commission on the European Information System on Alcohol and Health – which collects information on alcohol consumption, harm and policies from Member States at regular intervals to ensure comparability. Data are available online for public access. Furthermore, a number of guidance and policy instruments have been developed in recent years and more will follow. These all support national and community action to reduce the harmful use of alcohol, with young people as a special target group in most of the policy measures.

What additional progress can be achieved with more resources?

Although there is a large evidence base of what works in terms of policies, this data must be constantly updated and expanded. Greater efforts are also needed to increase implementation of effective policies as promoted in the European Action Plan and the Global Strategy to reduce the harmful use of alcohol. These include:

> further dissemination and promotion across the Region of effective alcohol policies – such as increased taxation and decreased access to alcohol products;
> strengthening of the evidence base on alcohol control through improved surveillance and the collection of best practices;
> development of guidelines on implementing alcohol policies and for direct technical support to Member States to fight alcohol-related harm and to improve treatment systems on alcohol prevention, treatment and care.
Drug abuse poses a global problem, which requires international cooperation and interdisciplinary and multisectoral action. In response to the rising drug problems in Europe, WHO devotes special attention to supporting the development of national policies and action plans to reduce the demand for drugs.

In Europe this work is done in close cooperation with a number of organizations working on prevention of illicit drug use, including the United Nations Office on Drugs and Crime (UNODC), the Pompidou Group of the Council of Europe and the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) of the European Union.

Prevention is the best means of fighting the problem, but the high number of drug-related deaths and infectious diseases related to drug injecting – especially HIV/AIDS and hepatitis B and C – point to the additional need for programmes to minimize harm. The WHO Regional Office for Europe therefore also focuses on developing programmes and giving guidance on treatment, including opioid substitution therapy and a number of harm reduction measures to decrease the spread of bloodborne diseases among injecting drug users.

The eastern part of the WHO European Region is the only part of the region where there still is an increase in HIV, and the main reason is injecting drug use. To achieve success in controlling the rapid spread of HIV among injecting drug users, it is imperative that countries pursue evidence-based strategies that are protective of human rights.

Challenges

It is estimated that 2.4 million years of life were lost in Europe in 2004 due to death or disability because of illicit drug use. In the same year, 45 000 deaths due to illicit drugs were recorded. In eastern Europe, 70–80% of all HIV infections occur among injecting drug users (IDUs) and in the whole Region the majority of new cases of hepatitis C is due to injecting drug use.

Drug dependency is characterized as a chronic disease with many relapses; and opioid dependency is especially difficult to cure. Substitution maintenance therapy with methadone or buprenorphine improves the health and social performance of opioid-dependent patients and decreases the use of illicit drugs and the crime rate. Investment in methadone substitution therapy pays off well: for every dollar invested in drug treatment, an estimated seven dollars are saved in health and social costs. Although resources are well spent by addressing drug users with proven interventions, this population group is seldom a priority despite the fact that their behaviour impacts on a large part of society.
What WHO Regional Office for Europe is doing

There is overwhelming evidence that drug dependency can be treated as many other chronic diseases. The best approach for opioid dependence according to the evidence is opioid agonist maintenance treatment, combined with psychosocial assistance. WHO supports Member States in providing effective treatment programmes for drug users including harm reduction measures in order to avoid the spread of communicable diseases as HIV and hepatitis. Oral methadone liquid and sublingual buprenorphine tablets are the medications most widely used for opioid agonist maintenance treatment. Compared to detoxification or no treatment and in the context of high-quality, supervised and well-organized treatment services (using mostly supervised administration of the liquid methadone formulation), these medications interrupt the cycle of intoxication and withdrawal, greatly reducing heroin and other illicit opioid use, criminal activity, risk of HIV transmission, the risk of death due to overdose and overall mortality. It also helps to retain people in treatment.

The Regional Office gives technical advice to Member States on opioid substitution therapy and has initiated pilot studies in countries, including in the prison sector. Diseases spread rapidly among people in prison settings, and there is a need for a special focus on this particularly vulnerable population. Any treatment or measure to reduce the spread of diseases in the public health system should always be available in the prison system.

What additional progress can be achieved with more resources?

An important part of technical support to Member States consists of assistance in developing national guidelines in opioid substitution therapy and monitoring use, harm and responses regarding illicit drugs. Further progress could be made by establishing a system for illicit drugs monitoring with a focus on eastern Europe to complement the EU-based European Monitoring Centre for Drugs and Drug Addition (EMCDDA). In addition, there is a need for guidelines and technical support on drug treatment and care and on implementing national strategies and guidelines on drugs prevention, treatment and care.
Nutrition, physical activity and obesity

Obesity is one of the greatest public health challenges of the 21st century. Its prevalence has tripled in many countries of the WHO European Region since the 1980s, and the numbers of those affected, particularly children, continue to rise at an alarming rate. Obesity is already responsible for 2–8% of health costs and 10–13% of deaths in different parts of the Region. Both societies and governments need to act to curb the epidemic. National policies should encourage and provide opportunities for greater physical activity, and improve the availability and accessibility of healthy foods. They should also encourage the involvement of different government sectors, civil society, the private sector and other stakeholders. To facilitate action across the WHO European Region, WHO/Europe organized the WHO European Ministerial Conference on Counteracting Obesity in Istanbul, Turkey, on 15–17 November 2006. At the Conference, Member States adopted the European Charter on Counteracting Obesity.

Physical activity is a fundamental means of improving physical and mental health for population groups across all ages. It reduces the risks of many noncommunicable diseases and benefits society by increasing social interaction and community engagement. Physical activity is not just a public health issue; it also promotes the well-being of communities and the protection of the environment, and comprises an investment in future generations.

Engaging in physical activity prevents and controls risk behaviour such as tobacco use, alcohol and other substance use, unhealthy diet and violence – especially among children and adolescents. It is a crucial component in public health work and policy.

Challenges

Opting for a balanced, adequate and varied diet is an important step towards health and well-being. Proper nutrition and food habits that integrate culture and tradition can add years to life, but especially a better quality of life in later life through the reduction of risk of many chronic conditions related to poor nutrition. Healthy diets can also contribute to an adequate body weight.

The proportion of foods in the European diet which are rich in salt, added sugars and saturated and trans fatty acids is increasing. This creates an unbalanced intake of energy and combined with larger portion sizes, contributes to the burden of disease which is attributable to nutritional factors. Improving nutrition will help this situation and will result in a longer, happier and healthy life.
A large amount of evidence indicates that a healthy diet can protect the human body against certain types of diseases, in particular noncommunicable diseases. Maintaining the energy balance is crucial. In other words, people need to work off the energy they take in, especially through physical activity, and in order to not gain weight when it is not desirable.

Strong scientific evidence supports the need to eat fruit and vegetables and grains: foods high in complex carbohydrates, fibre, vitamins and minerals. Sources of trans and saturated fats should be limited and cholesterol should be kept within ideal limits. For environmental reasons, opting for fresh and local produce is best. Foods high in added sugars, salt and energy density and low in nutritional density should be reduced.

Unhealthy eating patterns in children and young people can have negative consequences for their health and education. Childhood obesity has reached epidemic proportions in Europe, even though some children do not get enough of the micronutrients iodine, iron, vitamins A and D and zinc.

Physical inactivity has been identified as the fourth leading risk factor for global mortality and accounts for around 1 million deaths in the European Region per year. Levels of physical inactivity are rising in many countries with major implications for the prevalence of noncommunicable diseases and the general health of the population. Decreasing levels of physical activity are clearly linked to the increasing rates of overweight and obesity. Physical inactivity is furthermore estimated to be linked with approximately 21–25% of the breast and colon cancer burden, 27% of diabetes and approximately 30% of the ischaemic heart disease burden. Physical activity has a positive influence on prevention of and recovery from depression.

There are inequalities in the levels of physical inactivity and dietary behaviours across countries, the countries in the eastern part of the Region being the most affected. Inequalities at population level are seen in relation to age, gender, ethnicity and disability. Furthermore, people living in deprived areas are least likely to meet current recommended levels of physical activity and less likely to have the opportunity to choose a healthier diet. Deprived geographical areas have higher risks of poor road safety, high-speed traffic and little green space, and they offer fewer opportunities for daily physical activity. At the same time restaurants and outlets that provide healthier dietary options at affordable prices are not prevalent in these areas.

Society has changed drastically over the last century, and this has had a direct influence on patterns of physical activity. Sedentary lifestyles are common, and physical activity is no longer a natural part of many people's everyday life. The conditions for transport-related physical activity such as cycling are not ideal in many circumstances. Technical developments such as elevators, escalators and devices for household chores...
What the WHO Regional Office for Europe is doing

The European Charter on Counteracting Obesity and the WHO European Action Plan for Food and Nutrition Policy 2007-2012 guide the action of the Regional Office in supporting countries in the field of physical activity and diet. WHO/Europe works with Member States to promote physical activity as a tool not only for disease prevention but also for improving health and well-being in the population.

In addition to developing tools and programmes with specific guidelines for physical activity promotion, WHO/Europe supports Member States in developing, implementing and evaluating policies for integrated obesity and noncommunicable disease prevention. It is essential that actions to promote healthy diets and physical activity are promoted across sectors in partnership with all relevant stakeholders at both national and local levels. Policy actions are monitored and reviewed and WHO facilitates knowledge exchange and networking between relevant actors. The Global Strategy on Diet, Physical Activity and Health serves as a worldwide framework to promote physical activity and healthier diets.

make routine physical activity less demanding and the inactive choice easier. Workplaces are also changing and many employees spend their whole day with little or no physical activity. Children are less active partly because they spend more time in institutions and are attracted to screen-based sedentary activities.

Physical inactivity and the related noncommunicable diseases impose substantial costs on health systems and society. Large savings could be gained if people were to become more physically active: through lower direct costs for health care and to an even greater extent through lower indirect costs such as disease-related work absence, disease-related work disabilities and premature death.

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What additional progress can be achieved with more resources?

The WHO Regional Office for Europe will work towards an increase in health-enhancing physical activity and the promotion of healthy diets to prevent obesity and noncommunicable diseases across the European Region with an approach consisting of the following activities:

> Coordinated regional and national action to support the implementation of effective policies to address the burden of noncommunicable diseases linked with diet and physical activity, using evidence-based approaches. These policies include:
  - adoption of population-based salt reduction strategies (WHO will help Member States and stakeholders set up appropriate reformulation strategies to reduce salt in processed foods);
  - elimination of trans fat from the diet keeping appropriate balance in fat sources (WHO will work with Member States and other stakeholders on strategies to improve the fat profile in foods through reformulation);
  - promotion of active transport (WHO will identify and disseminate cost-effective local initiatives to promote active transport).

> Monitoring of progress on improving physical activity and prevention of obesity in the WHO European Region through refinement and expansion of the existing information system. This will make it possible to evaluate progress in policy development, the actions carried out to implement existing policies, and the implementation status of key commitments contained in the European Charter on Counteracting Obesity and the WHO European Action Plan for Food and Nutrition Policy. WHO will provide Member States with information on the progress of the obesity epidemic, especially among children in the Region.

> Support to Member States in addressing obesity, diet and physical activity by assisting in the development, implementation and evaluation of national intersectoral plans with a focus on health inequalities and the social determinants of health (i.e. gender and poverty policies will include actions in the area of obesity prevention).

> Support in capacity building to address obesity in the health system, namely through workforce development interventions in particular within primary health care (i.e. provision of guidance for workforce development in the area of obesity).
Global strategies tailored for the WHO European Region

The WHO European Region has adapted global strategies to the needs and challenges specific to the European Member States. The Region has recently developed an NCD Action Plan, a European Alcohol Action Plan, the European Charter on Counteracting Obesity and the WHO European Action Plan for Food and Nutrition Policy 2007 – 2012, which guide the activities of the WHO Regional Office for Europe.

Recent publications

The following recent publications are available on the respective programme web sites

Global Adult Tobacco Survey (GATS) 2010 – Reports from the four Bloomberg Initiative countries – Poland, Russian Federation, Turkey and Ukraine – first in the WHO European Region to conduct GATS. The reports detail the prevalence of tobacco use, as well as attitudes and behaviours of adults in the four countries.

Empower Women: Combating Tobacco Industry Marketing in the WHO European Region, 2010. Examples of actions to tackle the alarming increase of tobacco use among women and girls, in the context of the WHO FCTC and guidelines.

The challenge of obesity in the WHO European Region and the strategies for response, 2007. Evidence enabling policy-makers to work to stop and reverse the obesity epidemic in Europe.

European Status Report on Alcohol and Health, 2010. Latest data from the WHO European Region on alcohol consumption and harm and the responses made in countries. It summarizes the situation in the Region as a whole and gives profiles of its 53 countries.

Prevention of acute drug-related mortality in prison population during the immediate post-release period, 2010. This includes recommendations for Member States to prevent a huge risk of overdose deaths during the first two weeks after release from prison.


To date, key partnerships include:

Bloomberg Initiative
Framework Convention Alliance (FCA)
International Network of Women Against Tobacco (INWAT)
AIDS Foundation East-West
Pompidou Group of the Council of Europe
European Monitoring Centre for Drugs and Drug Addiction
United Nations Office on Drugs and Crime (UNODC)

International Obesity Task Force (OTF)
European Association for the Study of Obesity (EASO)
World Public Health Nutrition Association
European Commission’s Directorate General for Health and Consumer Policy (DG SANCO)
Centers for Disease Control and CDC Foundation
WHO’s Strategic objectives

With a specific focus on inequalities, social determinants of health and health in all policies, 2020 provides a European platform for achieving the 11 Strategic Objectives which frame the work of WHO in the European Region.

Briefings are available in each of the Strategic Objective areas:

1. Reduce the health, social and economic burden of communicable diseases.
2. Combat HIV/AIDS, tuberculosis and malaria.
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.
4. Reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.

6. Promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.

7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

9. Improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.

10. Improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.

11. Ensure improved access, quality and use of medical products and technologies.