WHO STRATEGIC OBJECTIVE 3: “To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.”
The epidemic of noncommunicable diseases (NCDs) is the epidemic of the 21st century. Within the WHO European Region, the impact of the major noncommunicable diseases (diabetes, cardiovascular disease, cancer, chronic respiratory diseases and mental disorders) is alarming. Taken together, these five conditions account for an estimated 86% of deaths and 77% of the disease burden in the European Region.

This broad group is linked by common risk factors, underlying determinants and opportunities for intervention. Lifestyle and demographic changes have led to huge increases in the common risk factors for NCDs: high blood pressure, tobacco use, harmful use of alcohol, high blood cholesterol, overweight, unhealthy diets and physical inactivity.

The noncommunicable disease epidemic affects all countries, but low- and middle-income countries have an additional burden as health systems usually have fewer resources for the prevention and early detection of diseases, as well as to provide comprehensive health care to those with diseases. Inequalities and the social determinants of health, including gender, play a role. Those in the most disadvantaged groups are at greater risk not only because of lower access to health services, but also because they have fewer resources in terms of education, employment, housing, participation in civic society and control over life, to make healthy lifestyle choices.

The WHO Regional Office for Europe promotes a comprehensive approach to tackling noncommunicable diseases which requires integrated action on health determinants and risk factors across sectors, combined with strengthening health systems to improve prevention at different levels and control of NCDs.

In the last 40 years, European countries have made striking progress in forestalling death and extending life, as evidenced by rising life expectancy and falling infant mortality rates. Yet health is by no means assured for all citizens in European countries. There is an increasing recognition of the burden and scope for prevention and control of NCDs, together with a growing understanding of the imperative to tackle them through intersectoral action. Addressing the social determinants of NCD demands a response which closely links efforts to achieve health in all policies, public health efforts to promote health and prevent disease, and individualized health care that unites prevention, control and management.

The following WHO/Europe programme areas address noncommunicable diseases:

- CARDIOVASCULAR DISEASES, CANCERS, CHRONIC RESPIRATORY DISEASES AND DIABETES
- MENTAL HEALTH AND MENTAL DISORDERS
- PATIENT EMPOWERMENT
- VIOLENCE AND INJURY PREVENTION
- PRISON HEALTH
“Today’s main burdens are chronic noncommunicable diseases, both physical and mental, injuries and violence, and disability.”
Zsuzsanna Jakab, WHO Regional Director for Europe

Executive Summary

Cardiovascular diseases, cancers, chronic respiratory diseases and diabetes
These diseases account for the majority of deaths in the WHO European Region and much of its disease burden. But cost-effective interventions for their prevention and control exist and with increased coverage could lead to significant health gains.

Mental health and mental disorders
Mental disorders are by far the largest contributor to the burden of disabilities and chronic conditions afflicting the population of Europe. Key challenges include the need to design and implement effective interventions to address the public mental health consequences of social determinants, inequalities and deprivation, and to establish effective community-based mental health services, continuing the closure of large asylums for persons with mental and intellectual disabilities.

Patient empowerment
Effective empowerment strategies that increase patients’ abilities to manage their disease, adopt healthier behaviours, and use health services more effectively form an essential part of the Regional Offices’ European Strategy for the Prevention, Control and Management of Noncommunicable Diseases.

Violence and injury prevention in the WHO European Region
As violence and unintentional injury is the leading cause of death among young people aged 5-44 years in the Region, WHO/Europe advocates for a public health approach to prevention based on evidence and multisectoral cooperation.

Prison health
The prison health programme works with Member States in improving public health by promoting health and health care in prisons, and facilitating the links between prison health and public health systems at both national and international levels.
Cardiovascular diseases, cancers, chronic respiratory diseases and diabetes

Cardiovascular diseases (CVDs), cancers, chronic respiratory diseases and diabetes accounted for 8.1 million deaths in 2004 (i.e. 86% of the total number of deaths in the Region), including 1.5 million deaths before the age of 60 years. Three out of four premature deaths from NCDs in the European Region occur in low- and middle-income countries (i.e. 1.1 million) although these account for only 54% of the population in the Region. If action is not scaled up, deaths from these NCDs1 will increase from 8.1 million in 2004 to an estimated 8.6 million by 2015.

These diseases are largely preventable by tackling four common modifiable risk factors, namely: tobacco use, unhealthy diet, physical inactivity and alcohol. Furthermore, effective measures are known that can significantly reduce premature death, long-term illness or disability. A comprehensive and integrated approach to addressing this disease burden needs to: facilitate population-level health promotion and disease prevention programmes; identify and target individuals and groups at high risk; and maximize access to effective treatment and care.

Challenges

The capacity of countries to tackle noncommunicable diseases varies widely across the Region and the policy response can often be inadequate to the challenge, piecemeal or uncoordinated, insufficiently resourced, or not appropriately intersectoral.

Cost-effective interventions exist but are not being used to scale or are not equitably distributed:

- The majority of all heart disease, stroke and type 2 diabetes and over 40% of cancer could be prevented if action were taken to eliminate the main risk factors for these diseases.
- Premature mortality and morbidity can be reduced if cases are detected and treated early, through raising awareness of early signs and symptoms, risk assessment in primary care, and through organized cancer screening programmes.
- Around one-third of cancer can be cured. Effective and inexpensive medication is available to treat nearly all CVDs and can reduce the risk of recurrence or death in the survivor of a heart attack or stroke. However, too many people in Europe do not enjoy universal access to primary health care or face heavy cost-sharing for these prescription drugs, both of which can pose important barriers to access common treatment of NCDs.
- Most advanced cancer patients, and many others suffering from end-stage chronic disease, could benefit from palliative care but accessing symptom control, care close to home and effective pain relief can prove difficult for many.

1 In this section the term “NCDs” refers to the four major conditions that this programme addresses. Mental health, as well as injuries and violence prevention, are described under separate sections in this paper.

2 WHO (2005) Preventing chronic diseases: a vital investment, p18
Disease registries, risk factor survey instruments or surveillance systems may be lacking, or not fit for purpose, with only limited disaggregation of data by sex, age or social strata. Consequently the potential for comparative analysis and benchmarking between and within countries and for monitoring of trends or impact of interventions is limited.

Training of health professionals and ways services are delivered need to improve with greater adherence to evidence-based medicine, standards for primary health care, integrated care for chronic diseases, well-functioning referral mechanisms and intensification of public health activities.

Health financing arrangements need to be reviewed to ensure affordability for patients, in particular for vulnerable groups. Access to essential medicines for NCDs is significantly lower than access to drugs for acute conditions in some countries in the Region; the poorer the country, the wider this gap becomes.

Self-management skills among patients, families and the voluntary sector need fostering and supporting so patients are enabled to manage their own conditions. There are still important gaps in health literacy on NCDs, what can be done to prevent them, and how to comply with treatment, among many people in Europe.

What the WHO Regional Office for Europe is doing

A number of programmes within the WHO European Office collaborate in the field of cardiovascular diseases, cancer, chronic respiratory diseases and diabetes, in the following ways:

- Identifying the scale of the problem and the capacity of countries to respond, resulting in substantial sections within The European Health Report 2009 and the report Country capacity for NCD prevention and control in the WHO European Region on the European situation, and assisting individual countries with their own situation analyses

- Supporting countries in the development, implementation and evaluation of disease-specific control programmes, for example with national cancer control programmes, cardiovascular disease programmes and national action plans for chronic respiratory disease

- Supporting countries in the development of policies and strategies for integrated prevention of noncommunicable diseases and in support of community demonstration projects for NCD prevention

Mortality profile by broad groups of causes of death in the WHO European Region, 2008

Source: WHO Europe. European mortality database, 2011
working on early detection of NCD for example through the development of screening programmes for breast and cervical cancer and risk assessment and management in primary care

- strengthening health and social care systems for the management of chronic disease, for example through access to essential medicines, and reforms of primary care systems to make them more responsive

- building capacity for palliative care through national palliative care programmes, strengthening of primary care and health service delivery, training of health workers on palliative care principles and pain management and increasing access to oral morphine;

- assisting countries in surveillance of diseases and their risk factors including risk factor surveys, cancer registries, chronic disease registries;

- facilitating the exchange of good practice between countries through international meetings, subregional workshops, producing and disseminating information;

- building alliances with other agencies and nongovernmental organizations and collaborating to raise awareness of the impact of noncommunicable diseases and the need for an adequate response.

What additional progress can be achieved with more resources?

Considerable progress can be made by strengthening implementation of policies addressing intersectoral actions, fiscal interventions, salt reduction, trans-fat elimination and means of transportation that facilitate physical activity:

- building partnerships to coordinate advocacy efforts, raising the priority of these conditions within development work and sharing good practice;
- improving surveillance of NCDs and risk factors, identifying common indicators and methodologies to allow comparative analysis and evaluation of impact;
- developing and disseminating policy issue briefings on the gender and other social determinants and equity dimensions of NCDs and their risk factors;
- increasing coverage of cost-effective interventions for prevention and control of these diseases, focusing on where the greatest health gains can be made;
- strengthening health systems through: training and capacity building of health workers, improvement in the ways services are delivered, review of health financing arrangements and increased access to essential medicines and technologies.
Mental health and mental disorders

The work of the mental health programme focuses on four key areas:

• service reform and deinstitutionalization
• stigma, empowerment and human rights in mental health
• mental health promotion and prevention of suicide
• health of children with intellectual disabilities and their families

The programme aims to keep these areas high on the health agenda of policy-makers and support them with evidence-based effective policies to address the significant treatment gap and the tremendous and inconsistent variation of services, treatment, numbers of staff and resources across the Region.

Challenges

Mental disorders are by far the largest contributor to chronic conditions afflicting the population of Europe. About a third of years lived with disability (YLD) is due to mental disorders such as depression (ranked first), dementia (seventh) and schizophrenia (eleventh). The growing aging population leads to an increase in the prevalence of dementia. Common mental disorders (depression, anxiety, somatic complaints) affect approximately 1 in 4 people in the Region every year. Depressive disorder is twice as common in women.

Due to the level of disability, mental health problems have become one of the leading causes for absenteeism from work and early retirement all over the European Region. The impact of mental health problems in the workplace has serious consequences not only for the individual but also for productivity and competitiveness of enterprises, thus the economy and society as a whole.

Although care based in the community has been shown to offer a better quality of life and satisfaction than traditional hospital care in most cases, institutional care still dominates in most parts of the WHO European Region.

Service reform and deinstitutionalization
Across Europe, countries develop strategies to support community-based services. In many countries, community health services have replaced the traditional models of care. Bed numbers have been reduced and institutions closed, but the pace of change varies. Since 2005, nearly all countries have mental health policies and legislation, but capacity and quality of services are uneven. Whereas some high-income countries have replaced institutions with a comprehensive range of community-based services, many other countries still rely on institutional care.

Stigma, empowerment and human rights in mental health
One of the main obstacles for equal opportunities for people with mental health problems is the stigma attached to mental illness. People with mental health problems face discrimination and exclusion in all facets of life, including health, housing, employment, in personal relationships, regarding personal respect and opportunities to contribute to their communities. The stigma attached to mental illness is also one of the major obstacles to help-seeking and treatment.
The WHO Regional Office for Europe supports Member States in developing policies to address stigma and discrimination and strategies and actions to inform the public about the nature and treatment options for mental health problems as well as raise public awareness for the importance of mental health for the well-being of all citizens in a society.

Since 2008, the WHO Regional Office for Europe has run a Partnership Project on Empowerment in Mental Health jointly with the European Commission aiming to support Member States in developing and implementing policies, strategies and actions to empower mental health service users and their families. A WHO Statement on Empowerment in Mental Health has been published, and about 100 examples of good practice in user and carer empowerment have been collected. Indicators for empowerment have been identified which address the promotion and protection of the human rights of people with mental disorders, the involvement of service users and their families as equal partners in decision-making processes at the policy level and in the development, implementation and monitoring of mental health services as well as the promotion of mental health and well-being of all population groups.

**Mental health promotion and prevention of suicide**

Suicide is one of the leading causes of death for young males, and a major cause of health inequality and geographical health disparities in Europe. In the European Region suicides alone account for 3.5% of life years lost. Completed suicides are just the top of the iceberg, as non-fatal self-harm is estimated to be 10-40 times more common than suicides. Major risk factors for suicide are poverty, poor education, unemployment, high debt, high level of alcohol use, social isolation, physical ill health and major negative life events.

Suicides have strong links to inequity. Within countries, there can be over six times as many suicide deaths in the most deprived fifth of areas compared with the least deprived fifth. The current economic crisis may increase suicide rates, unless adequate social protection, alcohol control and suicide prevention measures are undertaken.

Successful suicide reduction requires accessible mental health services with the capacity to identify and treat people at risk of suicide. The mental health programme has initiated preparations for a collaborative project to evaluate the impact of public policies on suicide rates in a range of European countries with high suicide levels.

**Health of children with intellectual disabilities and their families**

There are about 5 million children with intellectual disabilities in Europe, with the majority living in poorer countries. These children are often excluded from the community, from development activities, and ‘normal life’. In response to the emerging consensus that health is a key determinant of their development and social inclusion, the WHO Regional Office for Europe launched the Initiative on Health of Children and Young People with Intellectual Disabilities and their Families. This most vulnerable group in society has often been subjected to various forms of discrimination and neglect, as reflected in the high rates of institutionalization still prevalent across the European Region. The aim of the initiative is to ensure that all children and young people with intellectual disabilities are fully participating members of society, living with their families, integrated in the community and receiving care and support proportional to their needs within the scope of the Convention on the Rights of Persons with Disabilities. Good quality health care is essential to this by promoting good health and well-being and ensuring a successful transition to adulthood.
What the WHO Regional Office for Europe is doing

The mental health programme of the Regional Office has addressed the challenges by:

- identifying the scale of the problem by surveying the state of mental health activities and services in the Region, resulting in the report *Policies and Practices in Europe*;
- supporting about 20 countries in the Region with strategies towards the development of community-based mental health services, and assisting with their implementation, specifically reducing and closing institutions and establishing community mental health teams;
- strengthening the capacity of primary care to identify, diagnose, treat and refer appropriately people with mental health problems by increasing awareness and skills;
- initiating work to raise awareness of the impact of the economic downturn and supporting governments to prevent suicides through a policy brief, focusing on effective measures in all policies that have the potential to mitigate the effects of determinants of mental health and disorders (the Health Evidence Network has assessed effectiveness of a range of suicide prevention strategies);
- producing and disseminating information on mental health, resilience and inequalities, mental health promotion in young people as well as information on how to respond to the challenges that modern working life presents to mental health and well-being;
- collaborating with Member States and the European Commission to promote employability and inclusion of people with mental disorders in working life.

What additional progress can be achieved with more resources?

Further key challenges are:

- to design and implement effective interventions to address the mental health consequences of social determinants, inequalities and deprivation, and to establish the role of mental health services;
- to continue the development of community-based services and closure of large asylums for persons with mental and intellectual disabilities;
- to develop quality assurance systems that will identify strengths and weaknesses of mental health systems in hospitals as well as the community;
- to assist Member States in the implementation of the empowerment indicators at national level, in a joint effort with mental health counterparts and collaborating centres as well as the leading European service user and family associations.

![Geographical disparity of standardized suicide mortality rates in the WHO European Region](image)
What additional progress can be achieved with more resources?

The Regional Office is working towards establishment of a European Competence Centre for Patient Empowerment. The purpose of such a Centre would be to build and maintain leadership in patient empowerment across the European Region. This would be realized by developing and disseminating knowledge about patient empowerment and providing evidence of methods, processes and best practices. This information, backed up by a survey on health care system organization, chronic disease prevalence and patient empowerment initiatives in Member States, would provide the basis for the development of recommendations to assist Member States. The establishment of a European Competence Centre for Patient Empowerment is subject to adequate funding.
Violence and injury prevention in the WHO European Region

In the WHO European Region, injuries are the leading cause of death of children and young people aged 5-44 years. Whether unintentional or due to violence, injuries are no longer regarded as unavoidable ‘accidents’ and are now considered as preventable. This public health priority was addressed by the WHO Regional Committee for Europe resolution and European Council Recommendation on the prevention of injuries3 that call on greater commitment by countries to tackle injuries and violence in Europe.

Challenges
Every day 2,200 lives are lost due to violence and unintentional injuries in the European Region. Injuries and violence are one of the steepest causes of health inequality in the Region, with 3 out of 4 deaths occurring in low- and middle-income countries. Irrespective of country income, poorer people are disproportionately vulnerable to injuries and violence, as are children and older people. Males are at (up to 4 times) higher risk of all types of injuries and violence except for sexual and intimate partner violence, for which women or girls are more at risk.

The drain on societal income is enormous, and for road traffic injuries alone this is 2% of gross domestic product. In spite of this, the resources allocated to the prevention of injury and violence remain shockingly low and societal response needs to be scaled up to match the size of the problem. Almost half a million lives could be saved in the Region if all countries were as safe as the safest. The health sector has a key role to play in coordinating a multisectoral prevention effort.

What WHO Regional Office for Europe is doing

The violence and injury prevention programme works in partnership with health and other ministries, other European partners and experts to advocate for policy and programming to prevent premature death and disability. This advocacy work is supported by reviewing evidence on the scale, causes and consequences of injuries and violence and developing evidence-based guidance for policy-makers and practitioners. There is a focus on effective actions which address the needs of vulnerable populations. Such evidence-based guidance and dissemination of good practice helps countries to build capacity for prevention policies.

Further support is being provided to about 20 countries in the areas of policy development and capacity building using the WHO TEACH-VIP curriculum available in different European languages. To match country needs and requests, the programme responds to priorities such as road safety and the prevention of childhood injuries and maltreatment, youth violence, intimate partner violence and elder maltreatment. The policy response in the 53 countries of the Region is closely monitored, and there is a strong emphasis on advocating that injury and violence prevention be mainstreamed into other areas of health and public policy. The programme has also written and disseminated reports and guidance in the Region to promote good preventive practice.

Leading causes of death due to injuries and violence in the European Region

![Pie chart showing leading causes of death due to injuries and violence in the European Region](chart)

What additional progress can be achieved with more resources?

Investment in core products aimed at policy-makers would enable more sharing of good practice in developing national policies. The following activities are envisioned:

- development of a syllabus to build European capacity to prevent alcohol-related injuries and violence;
- subregional exchange of good practice – child survival could be improved by exchanging best practice subregionally to prevent maltreatment and injuries;
- production of a good practice guide to show how governments and practitioners can engage with young people to prevent violence;
- production of guides and policy briefings for the prevention of violence and maltreatment in order to protect vulnerable populations such as children, women and older people;
- capacity building of health ministries and practitioners through workshops and the exchange of expertise at subregional level;
- provision of support to countries in monitoring implementation of the Regional Committee resolution and Council Recommendation on the prevention of injuries.
The WHO programme on prison and health works with countries to improve public health by addressing health and health care in prison settings, and to facilitate links between prison health and public health systems.

By collecting evidence and experience, the Regional Office improves understanding about the health of prisoners and the health care which should be available to them, so as to contribute to narrowing health inequalities. The Regional Office demonstrates an international commitment to health and human rights through collaborative partnerships between Member States and international partners.

The prison health programme provides guidance to European Member States in developing or updating their policies and strategies regarding prison health.

It promotes a ‘whole prison approach’ instead of just focussing on the health care staff working in prison settings. Numerous WHO/Europe publications detail the generally accepted rules, guidelines, principles and standards related to prison conditions, prison health care and/or prevention and treatment in prison settings.

In short, the strategic objectives of the programme are:

- to encourage cooperation and establish integrated work between public health systems, nongovernmental organizations and prison health systems to promote public health and reduce health inequalities;
- to encourage prisons to operate within the widely recognized international codes of human rights and medical ethics in their provision of services for prisoners;
- to assist the reduction of reoffending by encouraging prison health services to contribute fully to each prisoner’s rehabilitation, especially, but not exclusively, in relation to drug addiction and mental health problems;
- to reduce the exposure of prisoners to communicable diseases, thereby preventing prisons becoming focal points of infection; and
- to promote all prison health services, including health promotion services, to reach standards equivalent to those in the wider community.

Challenges

Worldwide, over 9 million people are held in custody – of these, 2 million are held in the European Region. They often come from deprived backgrounds and a high number of prisoners have drug-related problems, mental health problems, infectious diseases like HIV/AIDS, Hepatitis C and tuberculosis, and poor general health:

- A disproportionate number of prisoners in Europe have personal histories of drug use and many of the people entering prison have a severe drug problem (percentages up to 70% reported).
- About 40% of all prisoners have some form of mental health problem and prisoners are up to 7 times more likely to commit suicide compared to people living in the community. These rates are found to be even higher among female prisoners especially with regard to post-traumatic stress and substance use disorders.
- Rates of HIV and Hepatitis C infection are found to be much higher among prisoners than among people living in the community.
- Tuberculosis in prisons is reported to be up to 50 times more common than in the general population.
What additional progress can be achieved with more resources?

Although there is a better understanding of effective practices in the Region, there is still much to be done. One of the pressing challenges is the dissemination of evidence-based guidance on the stewardship role for prison health. During the last years, a few Member States in the Region have shifted the responsibility for prison health from their Ministry of Justice to their Ministry of Health. More and more countries in the Region are considering this transfer and have requested practical guidance from WHO on the issue.

There is a strong need for establishing a data monitoring system, involving the collection of data on key prison health indicators from all Member States in the Region. Furthermore, the attention for continuity of care needs to be increased, as it is vital that persons entering and leaving the prison system have access to continuous care of equal standards, especially regarding treatment of infectious diseases and drug dependencies. All national strategies addressing health issues must have a prison health component in order to be effective.

What WHO Regional Office for Europe is doing

The WHO European Office supports Member States in developing and updating national policies, laws, regulations and guidelines for improved prison health and links to public health, as well as through capacity building activities. Since 1995, a network for prison and health has been established, including senior level representatives from the majority of European Member States and several international partner organizations. Experience gained over the years shows which interventions work and provides best practice examples of successful implementation.

The prison health programme organizes an annual meeting for its Member States and international partners to share experiences and discuss best practices. Over the last years the programme has produced several publications and declarations with evidence-based recommendations on how to improve the current situation in prisons regarding infectious diseases including HIV/AIDS and TB, mental health problems, drug problems and women prisoners’ specific health needs.

Spread of the disease is made worse by late diagnosis and treatment, poor prison conditions, poor nutrition and overcrowding.

Prisons are a serious source for the spread of diseases, within prisons but also into the community. The prison environment is often not conducive to good health. Prisons can act as breeding grounds for communicable diseases, can introduce prisoners to new, unhealthy practices (drug use, unsafe sex) and can seriously worsen a prisoner’s mental health. There is an intensive interaction between prisons and the society and prison health is a concern for the whole society as such.

Prison health is a unique part of the health system because it is usually under the responsibility of a ministry separate from that responsible for health care, often the Ministry of Justice. It is important to break down the isolation of the prison health services from public health services, so that equivalent standards of care can be provided and to ensure follow-up of released prisoners.
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 and the European Alcohol Action Plan. The European Charter on Counteracting Obesity and the WHO European Action Plan for Food and Nutrition Policy 2007 – 2012, guides the WHO Regional Office for Europe and its activities in the Region.

The Global mhGAP is also an important objective for mental health, targeting the ability of non-specialists, particularly in primary care settings, to provide a range of evidence-based mental health interventions. In 2006, the WHO Regional Committee for Europe adopted the European Strategy for the Prevention and Control of Noncommunicable Diseases, establishing a framework for action. A draft Action Plan for 2011 – 2016 responds to a demand by Member States for implementation by identifying specific action areas and deliverables.

Recent publications

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

- Better health, better lives, Declaration of the Conference on children and young people with intellectual disabilities
- Country capacity for the prevention and control of noncommunicable diseases in the WHO European Region
- European report on child injury prevention
- European report on preventing violence and knife crime among young people
- European status report on road safety
- Gaining health. The European strategy for the prevention and control of noncommunicable diseases
- Health in Prisons. A WHO guide to the essentials in prison health
- Impact of economic crises on mental health
- Preventing injuries in Europe: from international collaboration to local implementation
- Prevention of acute drug-related mortality in prison population during the immediate post-release period

To date, key partnerships include:

Chronic Disease Alliance and its members
Collaboration for Integrated Noncommunicable Disease Intervention (CINDI)
Global Alliance against Chronic Respiratory Diseases (GARD)
International Agency for Research on Cancer (IARC)
International Atomic Energy Agency
Union for International Cancer Control
Mental Health Europe and mental health patient and family groups
Bloomberg Philanthropies
Centers for Disease Control
European Association for Injury Prevention and Safety Promotion (EuroSafe)
European Commission
  - DG SANCO
  - DG JUSTICE
  - DG Mobility and Transport
European Monitoring Centre for Drugs and Drug Addiction
UNICEF
United Nations Development Programme (UNDP)
United Nations Office on Drugs and Crime (UNODC)
AIDS Foundation East-West
KNCV Tuberculosis Foundation
United Nations Office on Drugs and Crime (UNODC)
USAID
World Bank

Contact information

Cardiovascular diseases, cancers, chronic respiratory diseases and diabetes
Gauden Galea
Tel.: +45 39 17 13 42
E-mail: gga@euro.who.int
www.euro.who.int/ncd

Mental health and mental disorders
Matt Muijen
Tel.: +45 39 17 13 91
E-mail: mfm@euro.who.int
www.euro.who.int/mental-health

Patient empowerment
Anja Baumann
Tel.: +45 39 17 13 41
E-mail: anj@euro.who.int

Violence and injury prevention
Dinesh Sethi
Tel.: +39 06 48 77 526
E-mail: dins@euro.who.int
www.euro.who.int/violence-and-injuries

Prison health
Lars Møller
Tel.: +45 39 17 12 14
E-mail: lmo@euro.who.int
www.euro.who.int/prisons-and-health
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.