Status report: public health authorities' implementation of behavioural and cultural insights, WHO European Region 2021-2022

RESULTS OF REPORTING TO WHO

Draft report for consultation at the WHO regional meeting on behavioural and cultural insights for health

Copenhagen, Denmark, 12-14 September 2023

World Health Organization
European Region

Abstract

Acknowledging the importance of behaviours for health and well-being, and the cultural contexts they take place in, the Member States of the WHO European Region in September 2020 adopted the European Programme of Work (EPW) highlighting behavioural and cultural insights (BCI) as a flagship priority, and in September 2022 followed by adopting a regional resolution on BCI for health (EUR/RC72/R1) and an accompanying regional action framework with five strategic commitments and related targets. In doing so, the member States of the Region committed to reporting to WHO every other year on their BCI activities, and WHO Regional Office for Europe committed to preparing status reports every two years on regional progress in the application of BCI. The current report serves as the first such status report and baseline. It draws on reporting for activities during 2021-2022 by public health authorities in 48 countries, territories, areas and entities in the Region, representing 44 Member States. The analysis shows that the targets set for 2026 are ambitious. For the strategic commitments that relate to *conducting* BCI-related research and *using* the insights gained to inform the development of health policies, services and communication, the public health authorities (PHAs) report being on track, with up to three out of four PHAs reporting this has been done over the two years. This work, however, is rarely done in a systematic or integrated way across all health topics or target groups. For the strategic commitments that relate to ensuring *conducive conditions* for this work, very few PHAs report being on track towards the targets set. Approximately one in three PHAs report investing human and financial resources for BCI for health, working with stakeholders in a systematic way and integrating BCI into health strategies and plans. Lower income and Central Asian PHAs tend to report the lowest levels, while higher income and northern/southern European PHAs tend to report the highest levels.

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Contents

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Abbreviations

BCI	Behavioural and cultural insights
EPW	European Programme of Work, 2020–2025 – “United Action for Better Health in Europe”
NGO	nongovernmental organization
PHA	Public Health Authority
RCT	Randomized Controlled Study
SC	Strategic commitment

1. Background

The vast majority of health challenges in the WHO European Region involve a behavioural component, related to people's everyday and lifestyle behaviours (for example, related to tobacco, alcohol, physical exercise) as well as to their engagement with the health system and services (for example, related to following a treatment plan, attending vaccination or cancer screening, using antibiotics appropriately). Recognizing this critical role of behaviours for health, well-being and equity, and promoting a people-centred approach to health, the European Programme of Work (EPW) adopted by Member States in September 2020 endorsed behavioral and cultural insights (BCI) as a flagship priority for the Region.

Following up on this commitment of the EPW, on 13 September 2022, the Member States of the WHO European Region unanimously adopted resolution EUR/RC72/R1 (BCI resolution)[1] and the accompanying European regional action framework for behavioural and cultural insights for equitable health, 2022–2027 (BCI action framework)[2]. In doing so, they agreed to five ambitious strategic commitments related to building understanding and support of BCI among key stakeholders; conducting BCI research; applying BCI to improve outcomes of health-related policies, services and communication; committing human and financial resources for BCI and ensure their sustainability; and implementing strategic plan(s) for the application of BCI for better health (Fig. 1).

With the BCI resolution, public health authorities (PHAs)[3] of the Region have committed to report to WHO every other year on the monitoring indicators and progress measures of the BCI action framework, with the first reporting covering activities in 2021 and 2022.

Fig. 1. Strategic commitments made by the countries, territories and commitments of the Region, resolution EUR/RC72/R1

[1] The BCI resolution is available online: https://www.who.int/europe/publications/i/item/EUR-RC72-R1.
[2] The BCI action framework is available online: https://www.who.int/europe/publications/i/item/EUR-RC72-6-Rev-1.
[3] Public health authorities (PHAs) in this report refer to public health authorities in the countries, territories, entities and areas in the Region that have reported on their BCI-related activities.

1.1 Reporting framework

A reporting framework[4], adopted alongside the BCI resolution, was developed in consultation with BCI focal points that have been officially nominated to represent the countries, territories, entities and areas of the Region. This framework is structured according to the strategic commitments (Fig. 1) of the BCI action framework. It includes both quantitative and qualitative assessments.

- **Qualitative self-assessment scales:** PHAs use these to report their level of activities related to each strategic commitment on a scale from 1 to 5. The scales support PHAs in assessing their level in a nuanced way, without being unnecessarily prescriptive.
- **Quantitative indicators:** PHAs report on three quantitative indicators related to their implementation of the strategic commitments. In addition, two quantitative indicators have been set for the outcomes of the qualitative self-assessments. These numeric indicators allow for easier tracking of progress across over time across the Region.

The reporting framework includes extensive guidance on reporting as well as definitions of key concepts.

PHAs report on actions implemented by public health authorities and institutions at all levels (e.g. national, sub-national, local), including actions implemented in collaboration with external stakeholders. Work conducted *independently* by external stakeholders such as nongovernmental organizations (NGOs), academic institutions or private entities in which public health authorities or institutions have not been involved are not reported on.

Reporting is conducted every other year (Table 1).

Activities in 2021-22 (baseline)	Reported in March 2023	Shared in progress report in June 2023
Activities in 2023-24	Reported in March 2025	Shared in progress report in June 2025
Review for adjustment of the action framework during 2025		
Activities in 2025-26	Reported in March 2027	Shared in progress report in June 2027
New action framework document developed during 2027–2028		
Final report of current framework and new action framework presented for adoption at the 78th session of the WHO Regional Committee for Europe (RC78) in 2028		

Table 1. Overview of reporting over time

[4] The reporting framework is available online: https://apps.who.int/iris/handle/10665/361651.

1.2 Reporting for 2021-2022

PHAs conducted their first reporting on BCI activities in 2021-2022 during the first months of 2023. The following was initiated to support PHAs in reporting:

- An **official letter** was sent to PHAs on 17 January 2023 requesting reporting before the deadline of 17 March 2023. Several PHAs requested an extension. The last report included here was submitted on 8 May 2023.
- A user-friendly **online reporting from** was established for reporting in English and Russian. A Word version was prepared to support in-country collection of information.
- The **reporting framework** adopted by PHAs was distributed. The framework includes detailed instructions as well as definitions of al key concepts.
- An online **regional meeting** was held on 18 January 2023 with detailed description of the reporting and Q&As.
- Two **'open clinics'** were organized on 14 February and 7 March 2023 to answer questions about reporting and share lessons learned.
- An **animated video** was developed and shared with PHAs to introduce the BCI resolution and reporting requirements.

By 8 May 2023, PHAs from 48 countries, territories, entities and areas in the Region had submitted a report. These represent 44 Member States out of the 53 Member States in the Region.[5]

[5] The United Kingdom submitted separate reports from England, Northern Ireland, Scotland and Wales. Kosovo[1] reported as a separate area.

[1] *All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).*

2. Results[6]

2.1 Strategic commitment 1: Build understanding and support of BCI among key stakeholders

Strategic commitment 1 (SC1) relates to the work conducted by health authorities and public health institutions to engage with key stakeholders and increase their awareness of and support to BCI for health. Stakeholders include policy- and decision-makers, public health managers, local governments, civil society, health workers, academia, and many more. Activities may include developing mechanisms for coordination; inviting stakeholders to collaborate on joint projects or helping to add a BCI lens to their work; communicating BCI-related information and case stories, findings and tools; using the resolution to increase the visibility of BCI; and more.

The reporting on SC1 is both qualitative and quantitative:

- Qualitative self-assessment scale ranging from little awareness (level 1) to wide recognition and collaboration (level 5);
- Quantitative indicator: Number of PHAs with a dedicated formal network of internal and external stakeholders that includes the application of BCI for better health in their terms of reference.

Results for SC1 in 2021-2022

Qualitative self-assessment

The majority of PHAs (34/48) report levels 1 or 2, meaning there was little or some degree of awareness and recognition of BCI for health among key stakeholders. 10 report level 3, indicating widespread awareness and recognition and some collaboration initiated on BCI for health with key stakeholders. 4 indicate level 4, meaning BCI for health was recognized and supported among many key internal and external stakeholders and across various health areas, academia and civil society, and several projects were done in collaboration. No PHA indicates level 5. (Table 2).

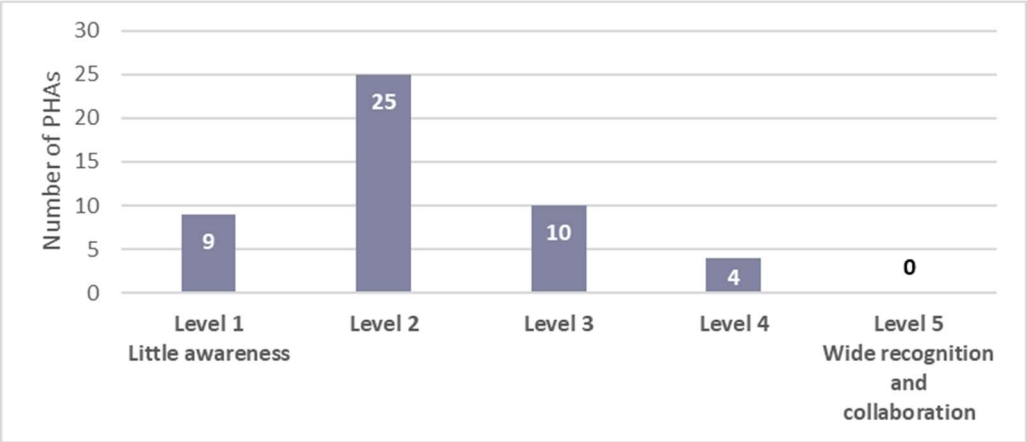

Table 2. Self-assessment for SC1 on level of building understanding and support among stakeholders

[6] Note that targets set for 2026 relate to Member States while this report is prepared based on reports by public health authorities (PHAs) in the countries, territories, areas and entities of the Region. For 2021-2022, reports were received from 48 PHAs, representing 44 Member States. For the final report in 2026, status vis-à-vis targets will also be shown by Member States.

The target for 2026 is that at least 85% of Member States (45 out of 53) report levels 3 or higher. In 2021-22, 29% of PHAs report level 3 or higher (Table 3).

Reported for 2021-22	Target (2026)
29%	85%

Table 3. Proportion reporting level 3 or higher on building understanding and support among stakeholders compared to target

Sub-regional analysis[7] shows that southern and western European PHAs assess their work with stakeholders higher than other geographical regions, and that upper middle income PHAs rate themselves higher, followed by high income. PHAs in the lower middle income range and in Central Asia score themselves lower compared to others.

25 PHAs elaborated on their self-assessment in a comments section that reflect diversity between countries. Some indicate low interest among stakeholders; others report growing stakeholder interest in BCI as an approach which offers a needed and innovative contribution to solving critical health issues; and others again report engagement with a wide range of stakeholders across ministries, public health institutions and in some cases civil society, academia and more. Some report having established formal networks to coordinate BCI-related work and/or policy dialogues, seminars, trainings. COVID-19 was highlighted by several as a field for collaboration and increasing interest on the value of BCI-related work. Even among those that report a high level of engagement, many highlight that engagement was often irregular, not sustainable and there is often a lack of shared terminology and understanding of how BCI-related work can add value.

Quantitative indicator

19 PHAs indicate having a dedicated formal network of internal and external stakeholders that includes the application of BCI for better health in their terms of reference; while 29 PHAs indicate not having such a network (Table 4).

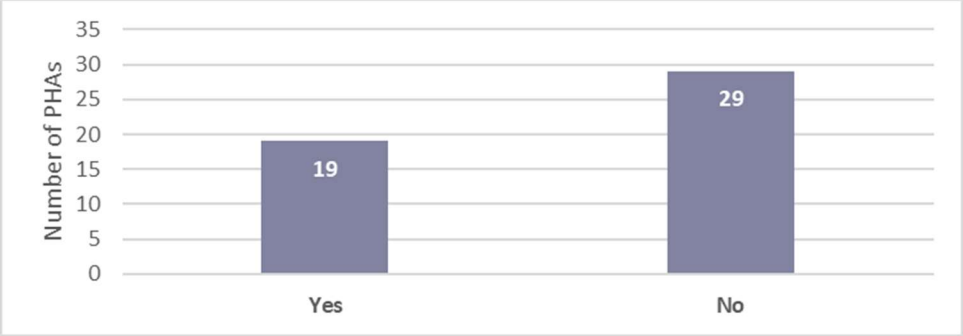

Table 4. Quantitative indicator for SC1: Number having a formal network of stakeholders

[7] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[7] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

The target for 2026 is that at least 75% of Member States (40 out of 53) have a dedicated formal network of internal and external stakeholders that includes the application of BCI for better health in their terms of reference. In 2021-22, 40% of PHAs report having such a network in place (Table 5).

Reported for 2021-22	Target (2026)
40%	75%

Table 5. Proportion reporting a formal network of stakeholders compared to target

Analysis by geography and income[8] shows that formal networks are reported more from southern Europe and western Asia and more often from upper middle income PHAs followed by upper income PHAs. Formal networks are seen least often in Eastern European PHAs and lower middle income PHAs.

Those reporting to have a network on BCI were asked to indicate the name of this network. The names indicate that they range from BCI-specific functions (with titles such as working group, advisory board, policy network, steering group, oversight group, task force) to topic or disease-specific functions which include a BCI perspective (such as, intersectoral working group, working group for emergencies or COVID-19, network of health promotion centres, health literacy alliance or network, NGO coordination group, HIV working group, childhood obesity working group, interdepartmental council on non-communicable diseases).

[8] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[8] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

2.2 Strategic commitment 2: Conduct BCI research

Strategic commitment 2 (SC2) relates to research that aims to explore the factors which prevent or drive health behaviours and to evaluate which interventions have an impact on behaviours. These efforts may involve synthesizing existing evidence; conducting studies on barriers and drivers to health behaviours in the general population or in priority population groups; conducting experiments or action research to evaluate the impact of evidence-informed interventions; engaging with those whose voices are often not heard; acquiring data from other sectors; and more.

The reporting on SC2 is both qualitative and quantitative:

- Qualitative self-assessment scale, ranging from no studies conducted (level 1) to systematic exploration of barriers and drivers to health behaviours (level 5);
- Quantitative indicator: Number of PHAs that have conducted at least one impact evaluation using randomized controlled trials (RCTs) or quasi-experimental methods to assess the impact of an activity that aimed to enhance positive health behaviours.

Results for SC2 in 2021-2022

Qualitative self-assessment

The majority of PHAs (27/48) report levels 3 and above, meaning several studies were conducted (level 3, 14 PHAs), across many health areas (level 4, 12 PHAs) or even applied in a systematic manner across all relevant health areas (level 5, 1 PHA). 21 PHAs report levels 1 or 2, indicating no, one or very few studies were conducted to explore barriers or driver to health behaviours (Table 6).

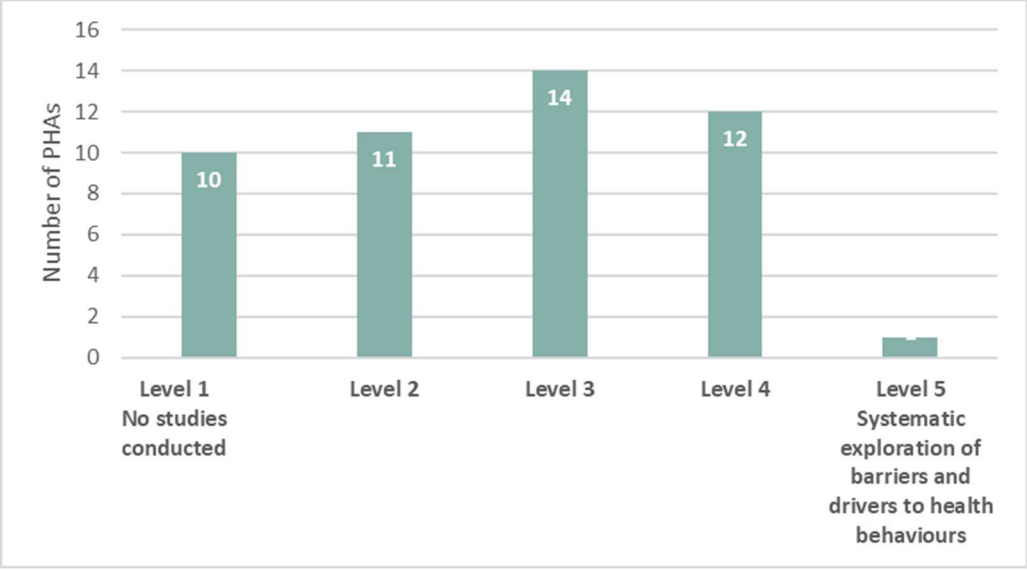

Table 6. Self-assessment for SC2 on level of conducting BCI research

The target for 2026 is that at least 85% of Member States (45 out of 53) report levels 3 or higher. In 2021-22, 56% of PHAs report level 3 or higher (Table 7).

Reported for 2021-22	Target (2026)
56%	85%

Table 7. Proportion reporting level 3 or higher on conducting BCI research compared to target

Analysis by geography and income[9] shows that northern and western European as well as high income PHAs assess their research implementation levels higher than other geographical regions. PHAs in the upper middle income range and in Central Asia score themselves lowest compared to others.

24 PHAs elaborated on their self-assessment. The comments highlight a large degree of diversity between countries where some report engaging in several, multi-component, mixed-method studies focusing on priority groups and priority health areas and others report having done a few smaller studies. In addition, in some cases, the studies reported relate to monitoring a health behaviour more than exploring the factors behind. It is also noted by some that BCI-related studies are conducted only by academics or upon initiation and support from international partners such as WHO.

Those reporting levels above level 1 were also asked to list examples of the studies conducted. Given the timing for this reporting it is not surprising that the vast majority of studies conducted related to COVID-19 (protection behaviours, vaccination, mental health and more). In addition to that, the examples reveal a large and rich collection of studies across many health areas and focusing on many different target groups such, including different age groups, gender, migrants, vulnerable groups, health workers, parents, patient groups and more. Health behaviours explored ranged across topics such as alcohol, antimicrobial resistance, breast cancer, cervical cancer, depression, diabetes, drug use, food marketing, food safety, gambling, HIV/AIDS, kidney disease, menopause, mental health, noise, nutrition, obesity, physical exercise, routine and flu vaccination, sex work, sexual and reproductive health, shiftworking, tobacco, tuberculosis, urinary tract infections and more.

Quantitative indicator

14 PHAs indicate having conducted at least one impact evaluation using randomized controlled trials (RCTs) or quasi-experimental methods to assess the impact of an activity that aimed to enhance positive health behaviours; while 34 PHAs indicate not having done such studies (Table 8).

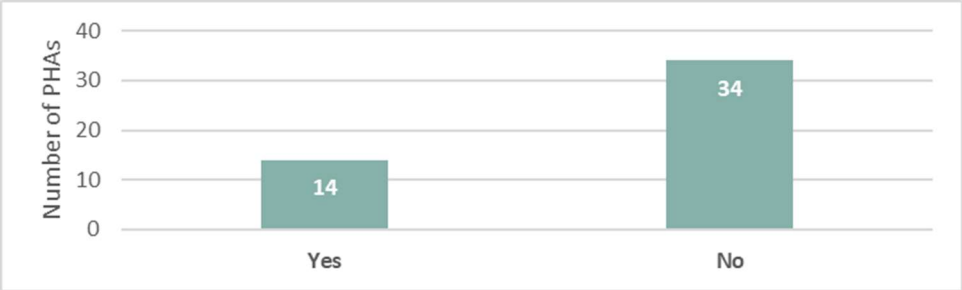

Table 8. Quantitative indicator for SC2: number having conducted impact evaluation

[9] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[9] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

The target for 2026 is that at least 75% of Member States (40 out of 53) have conducted at least one impact evaluation using RCTs or quasi-experimental methods to assess the impact of an activity that aimed to enhance positive health behaviours. In 2021-2022, 29% of PHAs report having conducted such an impact evaluation (Table 9).

Reported for 2021-22	Target (2026)
29%	75%

Table 9. Proportion reporting having conducted an impact evaluation compared to target

Analysis by geography and income[10] shows that impact evaluations are reported more from northern European and high income PHAs. Impact evaluations are seen least often in low income PHAs and Central Asia.

Those reporting to have conducted at least one impact evaluation using RCTs, were asked to list examples of the studies conducted. The examples indicate that a range of impact evaluations have been conducted across many different health topics and target groups. Examples include testing the effectiveness of a mental health literacy programme; assessing the impact of Nutri-Score labelling and product availability on consumer choices; testing the effectiveness of SMS reminders on HPV vaccination uptake; evaluating the impact of minimum unit pricing on alcohol consumption, crime and harmful drinking; comparing the effectiveness of community lifestyle interventions on diet and physical activity behaviours; testing the feasibility of HPV self-testing; testing redesigned breast cancer invitations; identifying the most effective and cost-effective intervention for self-managing of chronic condition; and more.

It should be noted that the actual number of impact evaluation studies is likely to be less than 14. Some of the examples noted appear to be formative research studies, and thus not all impact evaluation studies. However, the notes may be incomplete, and thus all 14 are included in this report.

[10] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[10] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

2.3 Strategic commitment 3: Apply BCI to improve outcomes of health-related policies, services and communication

Strategic commitment 3 (SC3) relates to how well the data derived from behavioural and cultural insights are used, alongside other data, to inform the development and improvement of health policies, services and communication, thereby making them more effective, equitable and acceptable. This may involve systematically applying a BCI lens to health-related policy, service and communication design processes; monitoring and evaluating interventions to understand their broader impact and gain feedback from those affected; scaling up proven effective interventions; and more.

The reporting on SC3 is qualitative:

- Qualitative self-assessment scale, ranging from no application of BCI (level 1) to systematic application across health areas (level 5);

Results for SC3 in 2021-2022

Qualitative self-assessment

The majority of PHAs (28/48) report level 3, indicating that BCI approaches were occasionally used to inform and improve health-related policies, services and communication processes. 8 report level 1, indicating no application of BCI in the development of health policies, services or communication; 5 report level 2, indicating appreciation but little application of BCI. 7 PHAs indicate level 4 meaning BCI was used widely and across many health areas to inform health policies, services and communication. No PHA report level 5, indicating systematic application of BCI to inform action (Table 10).

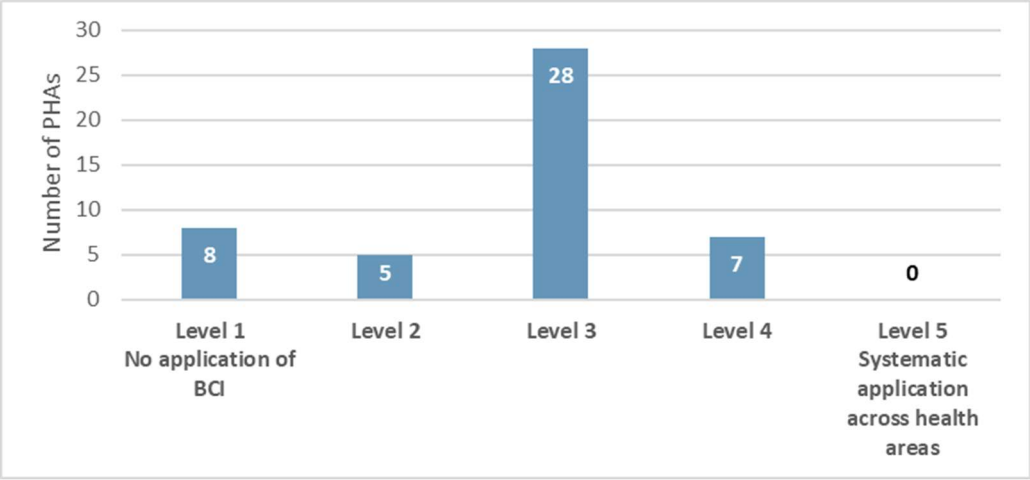

Table 10. Self-assessment for SC3 on level of applying BCI to improve policies, services and comunication

The target for 2026 is that at least 85% of Member States (45 out of 53) report levels 3 or higher. In 2021-22, 73% of PHAs report level 3 or higher (Table 11).

Reported for 2021-22	Target (2026)
73%	85%

Table 11. Proportion reporting level 3 or higher on conducting BCI research compared to target

Analysis by geography and income[11] shows that using BCI to inform policies, services and communities is reported more often from PHAs in western Asia followed by northern Europe. High income PHAs and Central Asian PHAs report the lowest levels.

14 PHAs elaborated on their self-assessment. For the most part, these comments highlight that translating insights and evidence of behaviours and the population perspective into evidence-informed practice is challenging. The notes say it is not being done at all, it is being done sporadically, or it is mainly done through "a bit of insights from the scientific literature". However, a small group of PHAs report that including population perspectives is increasingly valued, that BCI-related research serves as "the basis for many health programmes", or that it is even "mandatory to assess the public's ability to act as intended" for any new legislation.

Those reporting levels 3, 4 and 5 were also asked to list examples of how and where BCI approaches were used to inform and improve health-related policies, services and communication processes. These examples demonstrate a wide use of BCI-related evidence at A) policy level with new policies, strategies and plans in several health areas, more active engagement of civil society or a new strategic focus on socio-economic factors; B) health service delivery with new or redesigned patient tools, interventions and services; and C) communication with evidence-informed campaigns, letters, messages and guides. These interventions were informed by the studies mentioned above and range across the same health areas.

[11] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[11] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

2.4 Strategic commitment 4: Commit human and financial resources for BCI and ensure their sustainability

Strategic commitment 4 (SC4) relates to the level of institutionalization, commitment, capability, capacity and funding committed to BCI for health. This may involve allocating dedicated financial resources to allow sustainable delivery or commissioning of BCI work for health; ensuring expert staff are available; establishing a dedicated BCI team or coordination group; embedding BCI experts in technical units; upskilling of staff in different; increasing opportunities for collaboration with scientific institutions; and more.

The reporting on SC4 is qualitative:

- Qualitative self-assessment scale, ranging from no dedicated funding or people (level 1) to multiyear budgets and trained staff across health areas (level 5);

Results for SC4 in 2021-2022

Qualitative self-assessment

PHAs equally distribute themselves across levels 1, 2 and 3, meaning no dedicated funding or people were available (level 1, 15 PHAs); limited funding and people were available (level 2; 16 PHAs); or some dedicated funding and people were available, however, insufficient for systematic application across many health areas (level 3; 14 PHAs). A small minority of 3 PHAs selected level 4, meaning a larger amount of dedicated funding and appropriately trained people were available, however, still insufficient for a systematic application across all priority health areas. No PHAs selected level 5, indicating multiyear budgets available for a continued systematic application (Table 12).

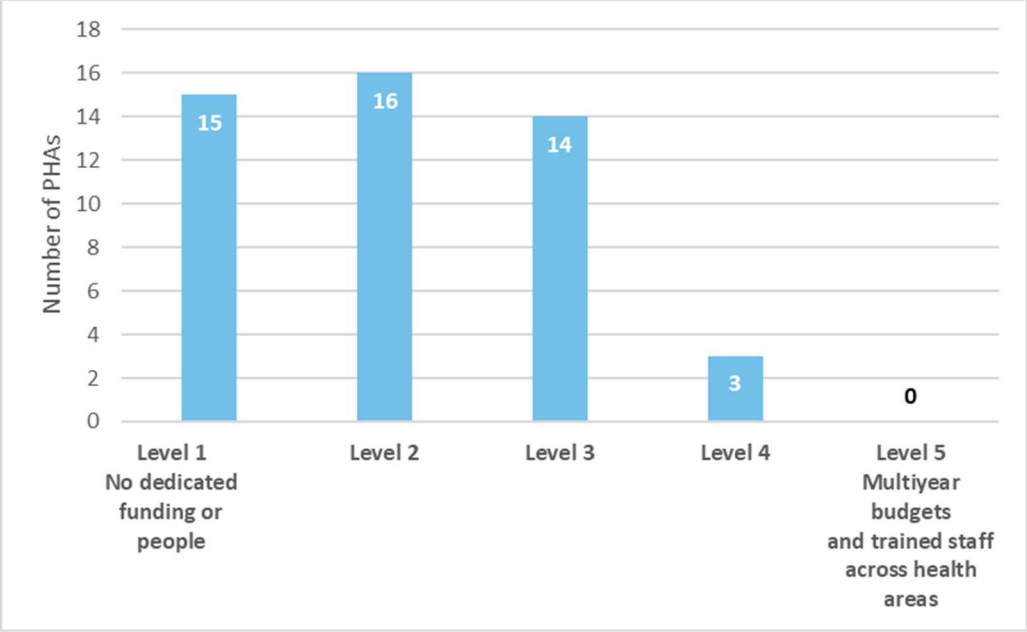

Table 12: Self-assessment for SC4 on level of human and financial resources for BCI

The target for 2026 is that at least 85% of Member States (45 out of 53) report levels 3 or higher. In 2021-22, 35% of PHAs report level 3 or higher (Table 13).

Reported for 2021-22	Target (2026)
35%	85%

Table 13. Proportion reporting level 3 or committing human and financial resources compared to target

Analysis by geography and income[12] shows that northern European followed by southern European PHAs as well as high income PHAs report the highest levels of investment in BCI. Lower middle income PHAs and those in Central Asia report the lowest investment.

13 PHAs elaborated on their self-assessment. With a few notable exceptions, the comments highlight that funding for BCI-related work is rarely sustainable, it is mostly ad hoc, relying on different types of agreements. One group of countries indicate relying heavily on donor funding and international partners for this area of work. Staff dedicated for this area of work is indicated only in very few responses. However, it is reported that BCI-related work in some places is conducted by different types of staff placed in different units and institutions. The exception to this norm is a handful of countries that have dedicated staff, often in a dedicated unit and with dedicated (in some cases even increasing) funding. It was however, also noted that funding is often linked with a health topic or programme, and BCI-related work is integrated into this.

Those reporting levels above level 1 were also asked to list examples of resources available. These examples include EU and EEA funding mechanisms and funding from international donors, research grants as well as budgets from various ministries (most ministry of health), public health institution or government/ state, from where funding is dedicated to specific projects (in most cases) or more sustainable programmes and staff.

[12] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[12] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

2.5 Strategic commitment 5: Implement strategic plan(s) for the application of BCI for better health

Strategic commitment 5 (SC5) relates to the level of strategic planning and prioritization of BCI for health, linked with opportunities to monitor progress, invest human and financial resources and using BCI to reach broader health targets. This may involve having a dedicated national strategy or plan for the application of BCI for better health; integrating BCI work into broader health work programmes, into government, ministry or health agency plans, and national or local health plans, development plans and/or other key strategic documents; or including commitments to conduct BCI work in strategies and plans related to specific health topics.

The reporting on SC5 is both qualitative and quantitative:

- Qualitative self-assessment scale, ranging from BCI not integrated in specific health-area plans (level 1) to BCI integrated in all specific health-area plans (level 5);
- Quantitative indicator: Number of PHAs with a dedicated national strategy or plan for the application of BCI for better health.

Results for SC5 in 2021-2022

Qualitative self-assessment

The majority of PHAs (34/48) report levels 1 and 2, meaning BCI work was not mentioned in any strategies/plans related to specific health topics (level 1; 20 PHAs); or that some strategies/plans referred to BCI work, but with no clear identification of how this work will be conducted, by whom or with which target (level 2; 14 PHAs). 12 PHAs report level 3, meaning that some strategies/plans made an explicit reference to BCI work and identified related actions and targets. 2 PHAs report level 4, meaning strategies/plans for several priority health areas made an explicit commitment to BCI work. No PHAs selected level 5, meaning BCI was included in strategies and plans across all health areas (Table 14).

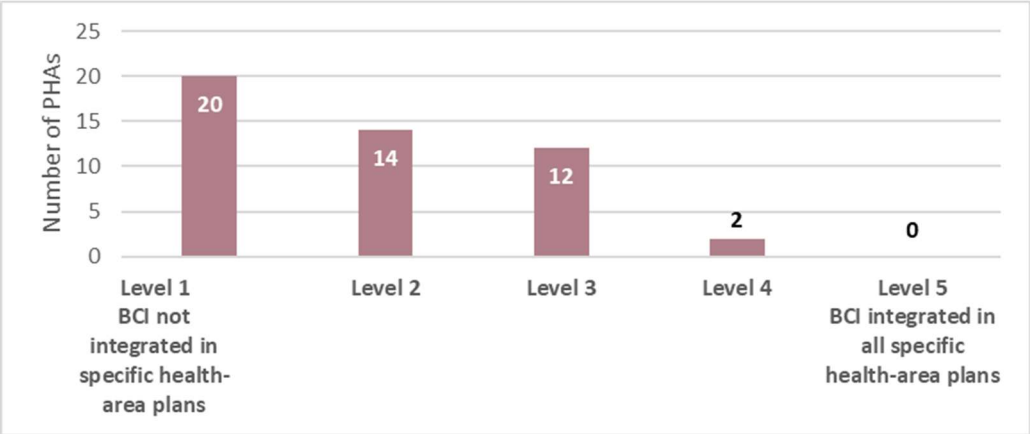

Table 14. Self-assessment for SC5 on level of integrating BCI into health plans and strategies

The target for 2026 is that at least 85% of Member States (45 out of 53) report levels 3 or higher. In 2021-22, 29% of PHAs report level 3 or higher (Table 15.

Reported for 2021-22	Target (2026)
29%	85%

Table 15. Proportion reporting level 3 or committing human and financial resources compared to target

Analysis by geography and income[13] shows that southern European followed by western Asian and western European PHAs as well as upper middle income PHAs assess their integration of BCI in health strategies higher compared to other regions. Low income PHAs, western Asian and central Asian PHAs report the lowest levels.

15 PHAs elaborated on their self-assessment and included the names of such strategies. Most of these comments express a desire and a need to integrate BCI-related work into health strategies; however noting that this is not yet the case. A handful of countries report including BCI-related work into national health strategies or annual reports, or to specific health areas such as those related to healthy lifestyles or to active ageing. Others report indirect inclusion but no specific mentioning, or specific reference to health literacy but not to broader BCI-related work.

Quantitative indicator

5 PHAs indicate having an overall, national strategy or plan which defines BCI work for better health as a general public health priority; while 43 PHAs indicate not having such a strategy (Table 16).

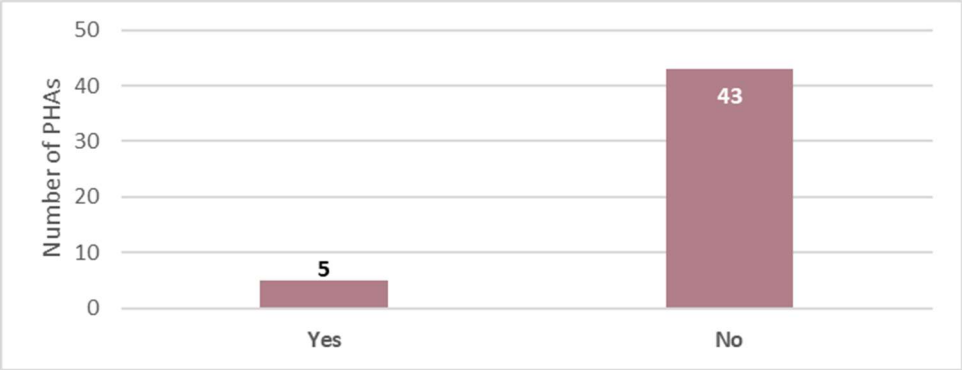

Table 16. Quantitative indicator for SC5: nUmber having a dedicated strategy or plan for BCI

[13] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[13] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

The target for 2026 is that at least 38% of Member States (20 out of 53) have a dedicated national strategy or plan across health areas for the application of BCI for better health. In 2021-2022, 10% of PHAs report having such a strategy or plan (Table 17).

Reported for 2021-22	Target (2026)
10%	38%

Table 17. Proportion reporting having a dedicated strategy or plan for BCI compared to target

Those reporting to have a national strategy on BCI were asked to include the title. The titles indicate that the number may be less than the 5 reported. Only one PHA refers specifically to a strategy for "Applying behavioural and social sciences to improve population health and wellbeing". Two PHAs refer to plans for health literacy, and one to a strategy for building a healthy lifestyle of the population, prevention and control of non-communicable diseases. The fifth PHA notes that a strategy is not yet in place but BCI will be critical for pandemics in the future. Even if the notes alone cannot establish that all 5PHAs indeed have a national strategy for BCI for health, this number is used for this report.

Analysis by geography and income[14] shows that national strategies are reported more often from northern and western European PHAs those that are high income. Lower income, western Asian and Centra Asian PHAs report having such strategy least often compared to other regions.

[14] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[14] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

2.6 Status vis-à-vis targets

The reporting framework sets two aggregated quantitative indicators related to the self-assessment; related to how many PHAs progress over time and how many PHAs self-assess at level 3 or higher within each strategic commitment. The following targets have been set:

- By 2026, 45 out of 53 (85% of) Member States have progressed to a higher self-assessment level within all SCs (compared with 2021-2022).
- By 2026, at least 45 out of 53 (85% of) Member States self-assess at Level 3 or higher within all SCs.

For the former, as this is the first reporting, no progress can yet be documented. For the latter, the below table shows an overview of level 3 or above reporting for each strategic commitment for 2021-2022 (Table 18).

Strategic commitment	**Percentage of PHAs reporting level 3 or above (target for all: 85%)***	**Status vis-avis target for 2026** Red: More than 1/2 to target Yellow: ½-1/3 to target Green: 1/3 or less to target
SC1: Build understanding and support of BCI among key stakeholders	29%	
SC2: Conduct BCI research	56%	
SC3: Apply BCI to improve outcomes of health-related policies, services and communication	73%	
SC4: Commit human and financial resources for BCI and ensure their sustainability	35%	
SC5: Implement strategic plan(s) for the application of BCI for better health	29%	

Table 18. Status in relation to targets for self-assessments

In addition, the reporting frameworks sets three quantitative indicators, related to three of the five strategic commitments. The results from the three quantitative indicators are summarized below (Table 19).

Strategic commitment	Percentage of PHAs saying yes*	Status vis-avis target for 2026 Red: More than 1/2 to target Yellow: 1/2-1/3 to target Green: 1/3 or less to target
SC1: Having a dedicated formal network of internal and external stakeholders that includes the application of BCI for better health in their terms of reference. Target: 75%	40%	
SC2: Having conducted at least one impact evaluation using RCTs or quasi-experimental methods to assess the impact of an activity that aimed to enhance positive health behaviours. Target: 75%	29%	
SC5: Having a dedicated national strategy or plan across health areas for the application of BCI for better health. Target 38%	10%	

Table 19. Status in relation to targets for quantitative indicators

**Note that targets set for 2026 relate to Member States while this report is prepared based on reports by public health authorities (PHAs) in the countries, territories, areas and entities of the Region. For 2021-2022, reports were received from 48 PHAs, representing 44 Member States. For the final report in 2026, status vis-à-vis targets will also be shown by Member States.*

Sub-regional analysis

As is reflected in the analysis for each strategic commitment above, there are some patterns related to geography and income (Table 20)[15]. Overall, low income and Central Asian PHAs tend to report lower self-assessments, and more often report a "No" for the quantitative indicators. At the same time, northern and southern European PHAs report higher self-assessments and more often report "Yes" on quantitative indicator. Western European, eastern European, western Asian PHAs often range in-between. High income and upper middle income PHAs generally self-assess higher than lower middle income PHAs. However, these geographical and income-related differences must not be over-interpreted. Due to the characteristics for the Region, the groupings are uneven in size, particularly the income groups. In the smaller groups, reporting from just one PHA can create a biased result.

The average differences between the sub-regions are clear but not large. Regardless of whether the group *on average* scores higher or lower, each group includes PHAs that score very high and PHAs that score very low.

Sub-region (no of PHAs that reported)	SC1 self-assess-ment Stakeholders (scale 1-5)	SC1 Quanti-tative indicator* Formal network (scale -1 to +1)	SC2 self-assess-ment BCI research (scale 1-5)	SC2 Quanti-tative indicator* Impact evaluation (scale -1 to +1)	SC3 self-assess-ment Translating BCI into practice (scale 1-5)	SC4 self-assess-ment Resource investment in BCI (scale 1-5)	SC5 self-assess-ment BCI in health plans (scale 1-5)	SC5 Quanti-tative indicator* National BCI plan (scale -1 to +1)
Geographic subregions[16]								
Central Asia (4)	1.25	-0.5	1.25	-1	2	1.25	1.25	-1
Eastern Europe (9)	1.78	-0.56	2.44	-0.56	2.33	1.78	1.89	-0.78
Western Asia (6)	2.5	0	2.33	-0.67	3.33	2	2.17	-1
Northern Europe (13)	2.31	-0.23	3.15	-0.08	2.85	2.54	1.69	-0.69
Southern Europe (10)	2.6	0.2	2.7	-0.4	3	2.1	2.2	-0.8
Western Europe (6)	2.17	-0.33	3	-0.33	2.33	2.33	2.17	-0.67
Income levels[17]								
High income (32)	2.23	-0.23	2.84	-0.23	2.68	2.26	1.87	-0.74
Upper middle income (14)	2.29	0	2.29	-0.71	2.71	1.86	2.07	-0.86
Lower middle income (3)	1.33	-1	2.33	-1	3	1.67	1.67	-1
All Region (48)	2.19	-0.21	2.65	-0.42	2.71	2.1	1.92	-0.79

Table 20. Data analysis by income and geography. Highest and lowest score for each SC highlighted.

[15] Sub-regional analysis was conducted using the geographic regions defined by the UN Statistical Commission[15] and income levels as defined by the World Bank. World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

[16] UN Statistical Commission geographical regions can be accessed via https://unstats.un.org/unsd/methodology/m49/

[17] World Bank classifications by income level can be accessed here: https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023. Income levels for 2021 were used for the analysis.

**Note: The average for quantitative indicators were calculated by assigning the value 1 to "Yes" and the value -1 to "No". An average of 1 means all PHAs report "Yes". A value of -1 means all PHA report "No".*

Annex 1. Complete reporting from 48 public health authorities, excluding notes

Public Health Authority (PHA)	SC1 self-assess-ment Stake-holders	SC1 Quanti-tative indi-cator Formal network	SC2 self-assess-ment BCI research	SC2 Quanti-tative indi-cator Impact evalua-tion	SC3 self-assess-ment Transla-ting BCI into practice	SC4 self-assess-ment Resource invest-ment in BCI	SC5 self-assess-ment BCI in health plans	SC5 Quanti-tative indi-cator National BCI plan
Armenia	4	Yes	1	No	3	1	3	No
Austria	2	Yes	3	No	3	3	3	Yes
Azerbaijan	3	No	4	No	4	3	3	No
Belarus	2	Yes	2	No	2	2	1	No
Belgium	2	No	3	No	3	2	3	No
Bulgaria	1	No	2	No	1	2	2	No
Croatia	2	Yes	2	No	3	2	1	No
Cyprus	2	Yes	4	No	3	3	3	No
Czech Republic	2	No	3	Yes	3	2	3	No
Denmark	3	No	3	No	3	3	2	No
Estonia	2	No	3	Yes	3	2	1	No
Finland	3	Yes	4	No	3	3	3	No
France	1	No	1	No	1	1	1	No
Georgia	2	Yes	3	Yes	3	2	2	No
Germany	3	No	5	Yes	3	4	2	No
Greece	3	No	2	No	3	2	2	No
Hungary	1	No	1	No	1	1	1	No
Iceland	2	No	1	No	2	1	1	No
Ireland	3	Yes	4	Yes	3	3	3	No
Israel	2	No	1	No	4	2	1	No
Kazakhstan	1	Yes	1	No	1	1	1	No
Kyrgyzstan	1	No	2	No	2	1	1	No
Latvia	2	No	2	No	3	1	1	No
Lithuania	1	No	2	No	1	1	1	No
Luxembourg	1	No	2	No	1	1	1	No
Malta	2	No	1	No	1	1	1	No
Montenegro	2	No	3	No	3	1	1	No
North Macedonia	3	No	2	No	3	2	3	No
Norway	2	No	4	Yes	4	4	1	No

Portugal	4	Yes	3	Yes	4	3	3	Yes
Republic of Moldova	2	No	3	No	3	2	2	No
Serbia	3	Yes	3	No	3	3	3	No
Romania	2	No	2	No	2	1	1	No
Russian Federation	3	Yes	3	Yes	4	3	4	Yes
Slovakia	1	No	2	No	1	1	1	No
Slovenia	3	Yes	4	Yes	4	3	4	No
Spain	2	Yes	4	Yes	3	2	2	No
Sweden	2	Yes	3	No	3	2	2	No
Tajikistan	1	No	1	No	3	2	2	No
The Netherlands	4	Yes	4	Yes	3	3	3	No
Turkmenistan	2	No	1	No	2	1	1	No
Türkiye	2	No	1	No	3	1	1	No
UK – England*	4	Yes	4	Yes	3	4	2	Yes
UK – Northern Ireland*	2	No	4	Yes	3	3	1	No
UK – Wales*	2	Yes	3	No	3	3	2	No
UK – Scotland*	2	No	4	Yes	3	3	2	Yes
Ukraine	2	No	4	No	4	2	2	No
Kosovo[1]	2	Yes	3	No	3	2	2	No

[1] *All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).*

**United Kingdom of Great Britain and Northern Ireland (UNK) reports from four entities.*