European regional action framework for behavioural and cultural insights for health, 2022–2027

World Health Organization
European Region

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Abstract

The European regional action framework for behavioural and cultural insights for health, 2022–2027 was adopted by the WHO Regional Committee for Europe at its 72nd session in September 2022. It was developed through a collaborative process between the Member States in the European Region and the WHO Regional Office for Europe. A range of partner organizations contributed technical input and advice. In setting a regional course of action in the field of behavioural and cultural insights (BCI) for better health in the Region, the framework will contribute to the implementation of the WHO European Programme of Work, 2020–2025 – "United action for better health". Through five strategic commitments, agreed by the Member States, and a progress model for regular country reporting on BCI activities, it offers pathways for advancing the BCI agenda for health towards more people-centred and effective health-related policy, service and communication at the country and regional levels. The framework is illustrated by country case examples.

Contents

Acknowledgments

The WHO Regional Office for Europe wishes to warmly thank the partners who provided financial support in the development process and in the implementation of BCI-related work in the countries, including the Belgian Federal Public Service (FPS) Public Health, Food Chain Safety and Environment, the German Federal Ministry of Health (BMG), the Robert Wood Johnson Foundation and the Nordic Culture Fund.

Foreword

Behaviour is at the heart of health. Our lifestyles and the way we interact with health systems have extensive implications for our own health and well-being, as well as for health system capacity and costs. It is, therefore, crucial that we explore the complex factors affecting health behaviour and use this insight to develop evidence-based interventions that improve health and well-being and reduce inequity. The WHO European Programme of Work 2020–2025 has taken up the tremendous challenge – and indeed opportunity – making behavioural and cultural insights a flagship priority.

This action framework, the first in any WHO region, sets the course to advance our ambitious efforts in the field of behavioural and cultural insights. It was unanimously adopted by the WHO Regional Committee for Europe at its 72nd session in September 2022, the culmination of a year-long collaborative process. I wish to express my profound thanks to Member States and partners for this milestone achievement.

The framework outlines the way forward for behavioural and cultural insights for health in the Region through applying joint targets and actions. It identifies opportunities to advance the behavioural-and-cultural-insights agenda, monitor progress, build knowledge and capacity, and ensure a peer-to-peer exchange of experience at the country level and regionally. By adopting this action framework, countries have committed to investing in behavioural and cultural insights (BCI) for health, conducting research, and implementing and evaluating people-centred evidence-based health policies, services and communications tailored to the needs and circumstances of individuals and communities.

As we work towards 2027, our joint ambition is to see a shift across the Region – going beyond an acknowledgement that behaviours are critical for health – to applying rigour and evidence in understanding and addressing them. I trust that the *European regional action framework for behavioural and cultural insights for health, 2022–2027* will serve as a strong foundation for this work, contributing to a culture of health in which people throughout the WHO European Region are supported, empowered and enabled to lead healthy lives.

I look forward to continuing our close collaboration with Member States, experts and partners in the months and years ahead. This action framework presents us with the opportunity to reach a critical mass, allowing countries to exchange research and experiences, and systematically incorporate evidence-informed behavioural and cultural insights for health. Such progress will pay enormous dividends for health, equity and people-centred policies and services in the Region.

Dr Hans Henri P. Kluge,
Director
WHO Regional Office for Europe

Joined in partnership

The action framework was developed in collaboration with the Member States in the European Region and in consultation with partner organizations.

Dr Andrea Ammon, Director of European Centre for Disease Prevention and Control (ECDC)

"Our experience from the COVID-19 pandemic has confirmed, once again, the importance of public health authorities understanding the needs, concerns and experiences of the communities we are serving. Without such an understanding, interventions aimed at the prevention and control of communicable diseases are unlikely to have an optimal effect. Behavioural and social sciences are uniquely placed to provide such understanding, and ECDC is therefore working hard to build capacity to support this essential pillar of public health throughout the EU/EEA."

Dr Raimund Jehle, Food and Agriculture Organization of the United Nations (FAO) Regional Programme Leader for Europe and Central Asia

"Agrifood systems are only as healthy as the people, animals and ecosystems upon which they rely. As the pandemic, antimicrobial resistance, climate change and other challenges have shown, promoting these interlinked, One Health dimensions depends on human behaviour. Therefore, leveraging behavioural science to better understand what drives behaviour is crucial. FAO looks forward to enhancing our work with WHO and partners through this framework. Generating behavioural and cultural insights together, we can better design and test new solutions that make pro-health behaviours easier and agrifood systems more sustainable."

Regina De Dominicis, Regional Director Europe and Central Asia. UNICEF, Representative to the UN in Geneva, Special Coordinator, Refugee and Migrant Response in Europe

"In UNICEF, social and behaviour insights are key to promote positive changes in support of children's rights. We rely on behavioural and social science to understand factors influencing people's choices and practices and we engage with decision-makers, civil society, community members to use these insights to inform policies and programmes, improve services and empower communities. We remain committed to work together with our partners to leverage the power of behavioral and social science for the development of more inclusive, culturally sensitive and sustainable programmes and services in the area of public health and beyond."

Dr Iveta Nagyova, President, European Public Health Association (EUPHA)

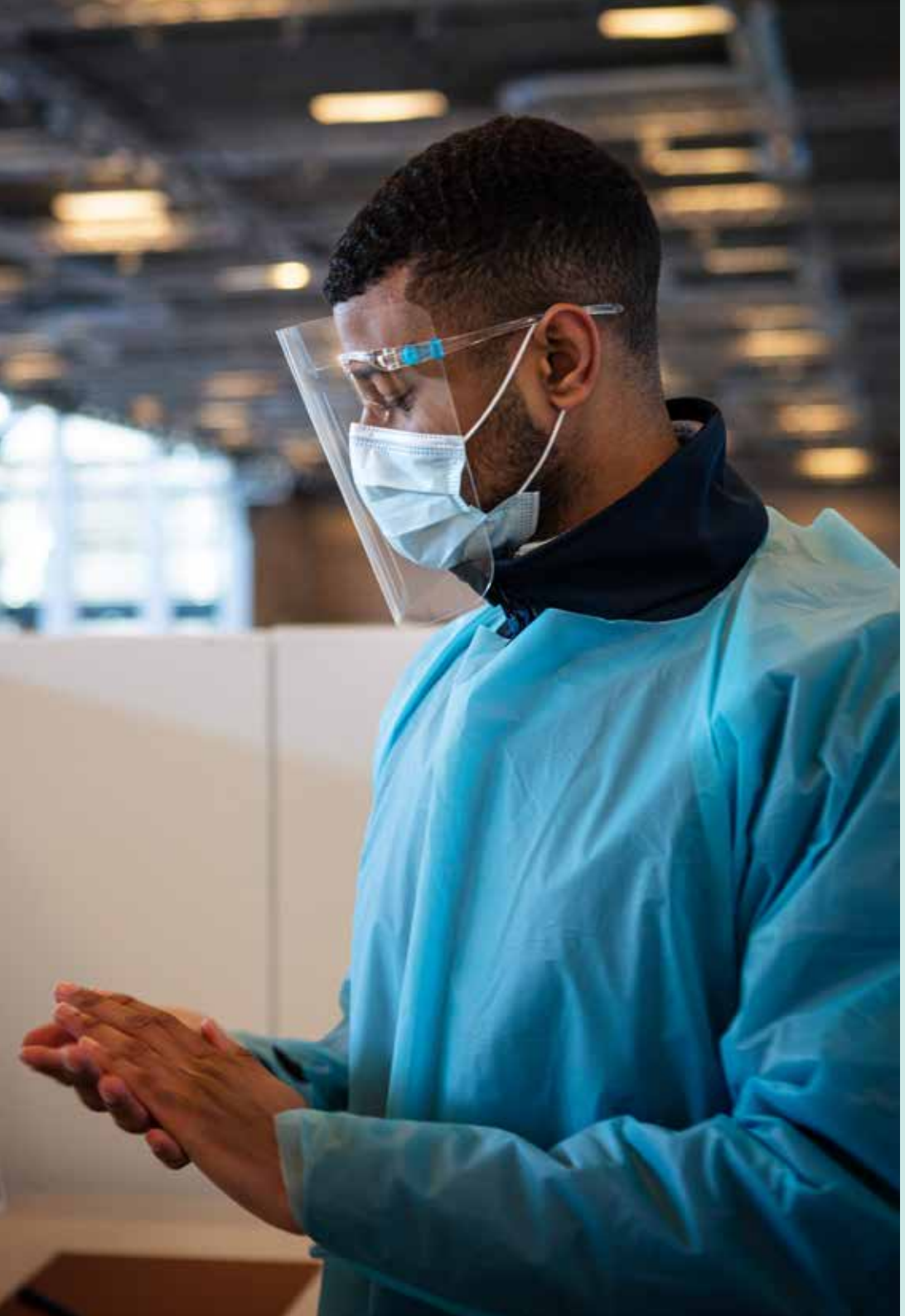
"Many of today's most pressing public health challenges have a strong behavioural component. Yet, how can we explain the chasm between knowledge about health determinants and action? Why are we not able to close the gap between what we know and what we put into practice to improve people's health? It is high time to break the silos between behavioural sciences and public health and, based on the synergistic use of knowledge from both disciplines, develop effective strategies to tackle the increasing disease burden in Europe and worldwide."

Professor Dr Martin Dietrich, President, EuroHealthNet, and Acting Director, Federal Centre for Health Education, Germany

"We need much better insights in behavioural and cultural factors in order to address health inequalities effectively. In addition, there are important connections that can be made as part of the green transition and efforts to achieve more sustainable lifestyles. The Euro-HealthNet partnership is keen to share information, tools and case studies. We are committed to working closely with WHO on new and tailored activities, like country-exchange visits to share good practice, and to advocate for the European Union institutions and Member States to include BCI elements as appropriate. We therefore welcome this important WHO Action Framework."

Stephen Quest, Director-General of the European Commission's Joint Research Centre

"The European Commission recognises the critical role that behavioural insights play in policymaking innovation. Understanding how people think, feel, and behave is essential to designing effective policies that address the complex challenges facing our society today. When it comes to public health, by incorporating these insights into our policymaking process, we can create more targeted and impactful initiatives that improve the health and well-being of our citizens. The European Commission will continue to collaborate with the WHO and other partners to advance the use of behavioural insights in policymaking and create a healthier and more prosperous future for all Europeans."



I

The potential

Applying behavioural and cultural insights for better health

Member States in the WHO European Region are joined in ambitious priorities to improve the health and well-being of their citizens. Succeeding in this requires health-related policies, services and communication based on medical and epidemiological considerations, as well as on an in-depth understanding of the barriers and drivers which people experience in leading healthy lives, in the context in which they take place.

Individual behaviour and social circumstances, together account for 60% of factors determining people's health *(1,2)*. Yet behavioural and cultural insights (BCI) in health remain underexplored and underutilized, and subject to modest investment in many places in the Region.

BCI work is defined here as the systematic exploration of individual and contextual factors affecting health behaviours, and the use of these insights to improve the outcomes of health-related policies, services and communication, delivering better health and reducing inequity. The use of BCI for health is evidence-based and builds on existing approaches from the fields of behavioural insights science, cultural science, social science and health humanities *(3-7)*. It acknowledges that tailoring interventions to local conditions is often needed, taking into account cultural diversity. BCI is an enabling approach and one which is relevant to all areas of health, health services and quality of health care, every setting that determines health behaviours, and everyone whose behaviours influence health outcomes, including the environment, climate, and animal health. BCI work adds value across the entire health-related policy, service and communication planning cycle, ranging from defining problems and conducting research into root causes, barriers to and drivers of health behaviours, to programme planning and implementation, monitoring and evaluation and scaling up or replicating effective interventions and policies. Early application of BCI helps ensure that such processes are based on an accurate understanding of human behaviour, taking into account factors such as age, gender, health literacy and disability, as well as contextual factors, such as those related to cultural diversity, socioeconomic factors, political and media environments, health systems and more, which can increase effectiveness.

Applying BCI is critical for reaching the Sustainable Development Goals (SDG), tackling poverty and promoting economic equality *(8)*. Through systematic engagement, active listening, segmenting and tailoring interventions to the barriers experienced by specific population groups, BCI is an effective tool for reducing health inequities.

Member States can use BCI strategically to meet their health priorities. Global evidence shows that BCI have been used successfully to improve outcomes in areas such as antimicrobial resistance, immunization, health emergencies, mental health, uptake of preventative services and hospital appointments, health inequities, noncommunicable disease risk behaviours, and HIV/AIDS. These and other urgent health challenges require multifactorial and cross-sectoral action, including as informed by BCI.

In addition, the coronavirus disease (COVID-19) pandemic served as a stark reminder that understanding people's perceptions, social and physical circumstances and psychological state is critical for appropriate and effective health measures. Faced with an unprecedented global crisis, health authorities across the Region invested in efforts to understand population behaviours and their drivers and barriers, and used this evidence to guide action. This demonstrated commitment, while also identifying the need for further investment and capacity-building to fully leverage the value of these approaches.

Case examples illustrating the utility and value of applying BCI approaches to health are included in Annex 3.

Momentum of behavioural and cultural insights for better health

In September 2020, the 53 Member States in the WHO European Region adopted the European Programme of Work, 2020–2025 – "United action for better health" (EPW), which identifies BCI as a flagship initiative *(9)*. As a cross-cutting and enabling approach, incorporating BCI can help advance the three core priorities of the EPW, including implementation of its three other flagship initiatives: immunization, mental health and digital health.

In line with this, Member States across the Region are increasingly scaling up their application and integration of work on BCI to strengthen health-related policy, service and communication processes. Many national and local health-related strategies and action plans reference the use of BCI as part of an effective response to key health challenges.

The expanded application of BCI work, particularly during the COVID-19 pandemic, has offered a unique opportunity to advance this area of work. Advantage must be taken of the current global and regional momentum to expand approaches to tackling critical health challenges and increase proof of the utility and value of BCI application by publishing evidence and case examples from in-country contexts. Further progress in this field in the Region will require Member States to increasingly integrate BCI work into their health-related policy, service and communication processes; commit human and financial resources; develop institutional and system-wide capacity and capability to use BCI; translate BCI into policy and action; and evaluate and demonstrate impact, allowing effective actions to be scaled up, and contribute to the body of evidence across the Region. Skilled and experienced individuals delivering this work, and public health administrators and decision-makers supporting it and acknowledging its impact, can pave the road to success.

Vision, objectives and core principles

The **vision** for the proposed action framework is a WHO European Region where health-related policies, services and communication deliver better health and reduce health inequity owing to the systematic application of BCI approaches in their development, implementation and evaluation.

The overarching **objective** of the proposed action framework is to set the course for BCI work for better health in the Region, through joint commitment to actions and targets.

The specific objectives of the action framework are:

(a) to present a regional vision, targets and commitments, including through a progress model for biennial reporting and monitoring progress;

(b) to set the course for strengthened and more systematic integration of BCI approaches into health-related policy, service and communication processes;

(c) to provide a consolidated foundation on which to base support for Member States, through capacity-building, technical advice, collaboration platforms and evidence-based tools;

(d) to set a path for expanding the evidence on the transformative value and utility of BCI work for better health; and

(e) to strengthen coordination and exchange of promising practice and knowledge among Member States and partners in the Region.

Below are **eight core principles** for applying BCI in health-related policy, service and communication processes, which are critical to achieving better health and reducing inequity.

(a) People-centred: Health-related policies, services and communication should be shaped by and respond to the needs, perspectives and conditions of the citizens, patients, health workers, care-givers, relatives and others involved and affected.

(b) Equity-focused: BCI work should be designed to improve outcomes for everyone and all communities, with special concern for health inequalities and those experiencing disadvantage, applying approaches that protect and promote equity, ethics, gender equality and human rights.

(c) Participatory: BCI work should seek to empower and engage relevant people and communities, including through listening and co-design, thereby drawing on a range of experiences, expertise and perspectives and ensuring ownership and sustainability.

(d) Tailored: Acknowledging that the same measures will not be right for all, BCI work should support the tailoring of health-related policy, services and communication processes to different cultural, geographical, socioeconomic and health literacy-related needs and circumstances.

(e) Evidence-based: BCI work should be informed by evidence related to the psychological, cultural, social and structural influences on behaviour in any given context.

(f) Multisectoral: BCI should be integrated with bio-medical and health systems approaches and data, and should build on data from other sectors and work across sectors, such as those relating to social, cultural and educational matters, health literacy, employment, migration and housing.

(g) Action-focused: BCI work should be actionable, relevant and applicable, to inform and improve health-related policies, services and communication.

(h) Evaluation-informed: BCI work should be tested and evaluated to provide empirical evidence and inform improvements, scale-up and replication, using research-tested methods.

II

The commitment

It is a fundamental requirement for authorities at all levels to make positive health-related behaviours possible, accessible, convenient and attractive for people. Ensuring positive health behaviours is not just the responsibility of individual citizens, nor is it about placing blame, but rather about engaging, enabling and empowering people.

Acknowledging this responsibility, the proposed action framework has been developed in extensive consultation with Member States, represented by nationally nominated BCI focal points, and partner organizations. These stakeholders have contributed through several joint meetings and working group meetings and by reviewing multiple versions of the proposed action framework and related draft resolution.

Progress model

The proposed action framework is underpinned by a progress model that Member States can use to report their progress in applying BCI for better health. The progress model (Fig. 1) covers five strategic commitments (SC), with accompanying suggested pathways for implementation.

Please see progress model in Annex 1.

Fig. 1: Progress model

Note: SC – strategic commitment

SCs

Suggested pathways of action:

- Use the current action framework and related resolution and similar opportunities to increase the visibility and prioritization of BCI work and highlight commitment to applying BCI for better health.
- Communicate and disseminate information and case stories, findings, lessons, tools and other resources, for example through internal seminars, webinars, meetings, training, news pieces and intranet.
- Develop mechanisms for coordination, collaboration and support. This could include an advisory group, dedicated formal network for internal and external stakeholders, directory of BCI experts or intra-governmental, cross-party working groups.
- Invite relevant stakeholders to collaborate on joint projects or offer support in adding a BCI lens to their work.

Suggested pathways of action:

- Synthesize existing evidence to produce literature reviews or briefs on factors that prevent or drive health behaviours, and on the impact of interventions to improve health behaviours.
- Conduct national or local studies on factors that prevent or drive health behaviours in the general population or in priority population groups, using qualitative (observation, interviews, focus groups, engagement) and quantitative (surveys, social media monitoring) methods.
- Conduct experiments, trials or multicomponent action research projects to evaluate the impact of evidence-informed interventions in specific contexts and with specific population groups.
- Supplement the above by exploring innovative ways to engage with and listen to those whose voices are often not heard, and by acquiring data from other sectors that affect health-related behaviours, including those related to education, housing, social services, culture, employment, migration.

Suggested pathways of action:

- Systematically apply a BCI lens to health-related policy, service and communication design processes by using BCI approaches and guides to inform these processes, as well as involving BCI experts and engaging relevant population groups in scoping and design.
- Monitor and evaluate BCI-informed interventions to understand their broader impact through appropriate frameworks, such as collection of data and feedback from those involved and affected.
- Where findings from impact evaluations show that specific health-related policy, service or communication interventions positively affect health behaviours, scale these up to reach more people while tailoring to new contexts, or replicate them in other policy domains.

SC4:
Commit human and financial resources for BCI and ensure their sustainability

SC5:
Implement strategic plan(s) for the application of BCI for better health

Suggested pathways of action:

- As relevant to the context, establish a dedicated BCI team, embed BCI experts in technical units, or establish a cross-programmatic BCI coordination group.
- Ensure that expert staff with advanced skills, experience and expertise are available to apply BCI evidence to health and translate these insights into strengthened health policies, services and communication.
- Develop sustainable institutional capacity and capability to apply BCI for better health, including through upskilling of staff in different sectors, allowing non-BCI experts to apply basic BCI principles, engaging BCI experts to address complex issues, and increasing opportunities for collaboration with scientific institutions, fellowships or internships for BCI-focused roles.
- Allocate dedicated financial resources to allow sustainable delivery or commissioning of BCI work for better health.

Suggested pathways of action:

- Have a dedicated national strategy or plan for the application of BCI for better health, with a vision, targets and identification of priority actions and resources.
- Integrate BCI work into national, regional and local work programmes, into government, ministry or health agency plans, and national or local health plans, development plans and other key strategic documents. Include targets and identification of priority actions and resources for implementation.
- Include commitments to conduct BCI work in strategies and plans related to specific health topics (such as antimicrobial resistance, immunization, obesity, alcohol, nutrition, use of health services, quality of care, health inequalities, health emergencies, air pollution). Commitment in this regard includes identification of priority actions and resources for implementation.

Progress

Progress on each strategic commitment will be measured through **a combination of quantitative indicators and more flexible qualitative assessment scales.** Together, they allow for a nuanced measurement of progress that recognizes BCI work at different levels and in different country contexts.

The quantitative indicators are listed below.

(a) Number of Member States with a dedicated national strategy or plan for the application of BCI for better health.

(b) Number of Member States with an established and active network of stakeholders, which includes applying BCI for better health in their terms of reference.

(c) Number of Member States that have conducted at least one impact evaluation using randomized controlled trials or quasi-experimental methods to assess the impact of an activity that aimed to enhance positive health behaviours.

(d) Within each strategic commitment, number of Member States that have progressed to a higher self-assessment level by 2026, compared with 2022.

(e) Within each strategic commitment, number of Member States that self-assess at level 3 or higher by 2026.

Please refer to Annex 1 for more details.

Regional collaboration and support for implementation in Member States

BCI work for better health is a novel and still underexplored area of work in the Region. To achieve the vision of this proposed action framework and support Member States in its implementation, extensive support and collaboration from WHO, regional organizations and non-State actors will be required.

Guided by the vision set out in the EPW, in 2020 the WHO Regional Office for Europe established the flagship initiative, "Healthier behaviours: incorporating behavioural and cultural insights" (the BCI flagship initiative) to lead efforts, enhance evidence and provide technical guidance to countries in this field. The newly established Technical Advisory Group on Behavioural and Cultural Insights, with regional expert participation, is supporting this work.

Support for Member States to implement the proposed action framework arising from this flagship initiative includes: direct support for BCI work in countries, in collaboration with relevant health programmes under the aegis of WHO and external partners; capacity-building through online and face-to-face training; an online BCI knowledge hub for evidence and case examples; and guidance documents and tools. In addition, the WHO Regional Office for Europe will establish platforms and facilitate interaction between Member States, WHO and regional organizations and actors to enhance coordination and collaboration, and promote exchanges of promising practice and evidence.

Annex 4 offers an introduction to how a range of partners offer support to public health authorities in the Region related to BCI.

III

The way forward

Reporting mechanisms and timeline

The WHO Regional Office for Europe will convene a meeting for Member States and regional organizations and actors every two years to review and discuss progress, present examples of best practices, share evidence and promote peer exchange.

Member States will be asked to report to WHO every two years on their progress in implementing BCI work for better health, using the progress model.

The progress model will be reviewed for adjustment in 2025. A more comprehensive evaluation will be conducted in 2027, at the end of the five-year period covered by the action framework.

Please see the progress model in Annex 1.

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Annex 1

Progress model for the European regional action framework for behavioural and cultural insights for health, 2022–2027

Elements of the progress model

This progress model (**see Fig. 1 above**) will be used by WHO and Member States to measure and document progress in the application of behavioural and cultural insights (BCI) for better health in the WHO European Region.

Strategic commitments (SC)
The model involves five strategic commitments. These are areas where Member States have committed to make progress over the six years of the action framework.

Pathways of action
Each SC is elaborated with a few suggested pathways of action which can be considered by national and local health authorities.

Definitions
Definitions of key concepts are included in the definitions section at the end of this annex to support Member States in their reporting.

Scope of reporting
Member States will be asked to report on actions implemented by national, sub-national and local authorities and public health institutions, including actions implemented in collaboration with external stakeholders. They will not report on work conducted independently by external stakeholders such as nongovernmental organizations (NGOs), academic institutions or private entities in their country.

Reporting timeline
The action framework covers the period of 2022 to 2027. Member States will be asked to report every other year, as indicated in Table 1.

Self-assessment scales
Member States will use self-assessment scales to report their activities regarding each SC on a scale from 1 to 5. The scales support Member States in assessing their level, without being unnecessarily prescriptive. Member States will be asked to include only actions in which national or local authorities or public health institutions were involved. The self-assessments will also be aggregated for regional-level indicators and targets.

Quantitative indicators
Quantitative indicators and corresponding regional targets have been agreed for three of the SCs. These indicators contribute a numeric measure of progress to supplement the self-assessment scales described above.

Table 1. Reporting timeline

BCI work in Member States	Reporting		Framework
Activities in 2021-2022 (baseline)	Reported in March 2023	Shared in progress report in September 2023	
Activities in 2023-2024	Reported in March 2025	Shared in progress report in September 2025	Review of the action framework for adjustment during 2025
Activities in 2025-2026	Reported in March 2027	Shared in progress report in September 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

SC1:
Build understanding and support of BCI among key stakeholders

SC1

Pathways of action

BCI can only be translated into policy and practice if understood and valued by the people who are intended to use them. Key stakeholders include policy- and decision-makers, public health managers, local governments, civil society, health workers, academia, and many more. It is important that stakeholders understand what is meant by the application of BCI for better health and how BCI add value regarding health outcomes and equity. This awareness should be generated and sustained through frequent interaction. How stakeholders are meaningfully engaged depends on the context.

The following are examples of pathways of actions for SC1.

Use the current action framework and related resolution and similar opportunities to increase the visibility and prioritization of BCI work and highlight commitment to applying BCI for better health.

- Communicate and disseminate information and case stories, findings, lessons, tools and other resources, for example, through internal seminars, webinars, meetings, training, news pieces and intranet.
- Develop mechanisms for coordination, collaboration and support. This could include an advisory group, dedicated formal network for internal and external stakeholders, directory of BCI experts or intra-governmental, cross-party working groups.
- Invite relevant stakeholders to collaborate on joint projects or offer support in adding a BCI lens to their work.

Self-assessment scale

Table 2. Self-assessment scale for SC1: Little awareness –> wide recognition and collaboration

1	During the year, there was little awareness of BCI for better health among key stakeholders.
2	There was some degree of awareness and recognition of BCI for better health among some key stakeholders.
3	There was widespread awareness and recognition of BCI for better health among key stakeholders, and some collaboration was initiated.
4	BCI for better 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.
5	BCI for better health was widely recognized and supported among key internal and external stakeholders and across various health areas, academia and civil society, and collaboration ensured the application of a BCI lens to all relevant projects.

SC2:
Conduct BCI research

SC2

Pathways of action

Understanding which factors prevent or drive health behaviours and testing which interventions have an impact is at the heart of applying BCI for better health. A deeper understanding of these factors can be achieved through existing evidence about the human mind, social and cultural influences, the structural environment, health literacy levels, and the health topic in question. It can also be achieved through new insights drawn from new and additional research studies and engagement with the affected people in the local context.

Testing which interventions have an impact may involve experiments, trials or multicomponent action research. Such research should consider potential issues related to health equity as well as factors such as age, gender, health literacy, disability, cultural diversity, sexual orientation or socioeconomic status.

The following are examples of pathways of action for SC2.

- Synthesize existing evidence to produce literature reviews or briefs on factors that prevent or drive health behaviours, and on the impact of interventions to improve health behaviours.
- Conduct national or local studies on factors that prevent or drive health behaviours in the general population or in priority population groups, using qualitative (for example, observation, interviews, focus groups, engagement) and quantitative (for example, surveys, social media monitoring) methods.
- Conduct experiments, trials or multicomponent action research projects to evaluate the impact of evidence-informed interventions, in specific contexts and with specific population groups.
- Supplement the above by exploring innovative ways to engage with and listen to those whose voices are often not heard, and by acquiring data from other sectors that affect health-related behaviours, including those related to education, housing, social services, culture, employment, migration and more.

Self-assessment scale

Table 3. Self-assessment scale for SC2: No studies conducted –> systematic exploration of barriers and drivers to health behaviours

1	During the year, no studies were conducted to explore barriers and drivers to health behaviours.
2	One or few single studies were conducted to explore barriers and drivers to health behaviours. Please list the studies conducted.
3	Several studies were conducted to explore barriers and drivers to health behaviours, but not for many relevant health areas. Please list the studies conducted.
4	Methodologically sound approaches to exploring barriers and drivers to health behaviours were applied and studies were undertaken across many relevant health areas. Please list examples of the studies conducted.
5	Methodologically sound approaches to exploring barriers and drivers to health behaviours were applied in a systematic manner and studies were undertaken across all relevant health areas. Please list examples of the studies conducted.

SC3:
Apply BCI to improve outcomes of health-related policies, services and communication

SC3

Pathways of action

By translating BCI into action, more effective, equitable and acceptable health-related policies, services and communication can be created and implemented. BCI can enhance established policy tools by improving their design, or by demonstrating a need to develop entirely new interventions. Such new interventions or changes to existing ones can be made based on new evidence or a review of existing evidence. They may also be explicitly tested through an initial experiment in the local context before adoption.

Upon implementation of such BCI-informed interventions, monitoring the process and the health outcomes allows Member States to document the impact of BCI approaches, to adapt the applications where appropriate, and to scale up and replicate successful interventions.

The following are examples of pathways of action for SC3.

- Systematically apply a BCI lens to health-related policy, service and communication design processes, by using BCI approaches and guides to inform these processes, as well as involving BCI experts and engaging relevant population groups in scoping and design.
- Monitor and evaluate BCI-informed interventions to understand their broader impact through appropriate frameworks, such as collection of data and feedback from those involved and affected.
- Where findings from impact evaluations show that specific health-related policy, service or communication interventions positively affect health behaviours, scale these up to reach more people while tailoring to new contexts, or replicate them in other policy domains.

Self-assessment scale

Table 4. Self-assessment scale for SC3: No application of BCI –> systematic application across health areas

1	During the year, no BCI approaches were used to inform and improve health-related policies, services and communication processes, and it was not generally encouraged.
2	Using BCI approaches to inform and improve health-related policies, services and communication processes was generally appreciated as important but was not implemented.
3	BCI approaches were occasionally used to inform and improve health-related policies, services and communication processes. Please briefly list how and where BCI approaches were used to inform and improve health-related policies, services and communication processes.
4	BCI approaches were widely used to inform and improve health-related policies, services and communication processes across many relevant health areas. Please briefly list examples of how and where BCI approaches were used to inform and improve health-related policies, services and communication processes.
5	BCI approaches were systematically used to inform and improve health-related policies, services and communication processes, and the process was formalized with applications across all relevant health areas. Please briefly list examples of how and where BCI approaches were used to inform and improve health-related policies, services and communication processes.

SC4:
Commit human and financial resources for BCI and ensure their sustainability

SC4

Pathways of action

While the situation differs between countries, systematically embedding BCI approaches across health areas requires a level of institutionalization, commitment, capability, capacity and funding. Ideally, dedicated multiyear budgets are available along with staff trained in relevant areas, such as psychology, behavioural economics, sociology, anthropology, political science, cultural studies or related fields.

The following are examples of pathways of action for SC4.

- As relevant to the context, establish a dedicated BCI team, embed BCI experts in technical units, or establish a cross-programmatic BCI coordination group.
- Ensure that expert staff with advanced skills, experience and expertise are available to apply BCI evidence to health and translate these insights into strengthened health policies, services and communication.
- Develop sustainable institutional capacity and capability to apply BCI for better health, including through upskilling of staff in different sectors, allowing non-BCI experts to apply basic BCI principles, and engaging BCI experts to address complex issues, and increasing opportunities for collaboration with scientific institutions, fellowships or internships for BCI-focused roles.
- Allocate dedicated financial resources to allow sustainable delivery or commissioning of BCI work for better health.

Self-assessment scale

Table 5. Self-assessment scale for SC4: No dedicated funding or people –> multiyear budgets and trained staff across health areas

1	During the year, no dedicated funding or people were available for BCI work for better health.
2	Limited funding and people were available for BCI work for better health, but only on an ad hoc basis and related to specific, one-time individual projects. Please list examples of resources and projects.
3	Some dedicated funding and people were available for the structured application of BCI work for some health areas; however, the level of resources was not sufficient for systematic application across many health areas. Please list examples of resources and projects.
4	A larger amount of dedicated funding and appropriately trained people were available for continued application of BCI work for more health areas; however, the level of resources was not sufficient for a systematic application across all priority health areas. Please describe the resources available in a short paragraph.
5	Substantial dedicated, multiyear budgets and appropriately trained people were available for a continued systematic application of BCI across all priority health areas. Please describe resources available in a short paragraph.

SC5:
Implement strategic plan(s) for the application of BCI for better health

SC5

Pathways of action

Implementing an overall strategic plan or plans for the application of BCI for better health may involve a dedicated national strategy or plan across health areas and/or integrating BCI work in a range of health-related documents at national, regional and local levels. These other documents may relate to public health broadly, to specific health areas or to health equity. Such documents can be useful to obtain commitment to BCI work, as tools to identify priority areas of health where BCI work can be applied to health, and to monitor progress. Plans should be tailored to the human and financial resources available and the institutional context, and should be aligned with overall health and equity targets and priorities.

The following are examples of pathways of action for SC5.

- Having a dedicated national strategy or plan for the application of BCI for better health, with a vision, targets and identification of priority actions and resources.
- Itegrate BCI work into national, regional and local work programmes, into government, ministry or health agency plans, and national or local health plans, development plans and/or other key strategic documents. Include targets and identification of priority actions and resources for implementation.
- Include commitments to conduct BCI work in strategies and plans related to specific health topics (such as antimicrobial resistance, immunization, obesity, alcohol, nutrition, use of health services, quality of care, health inequalities, health emergencies, air pollution). Commitment in this regard includes identification of priority actions and resources for implementation.

Self-assessment scale

Table 6. Self-assessment scale for SC5: BCI not integrated in specific health-area plans –> BCI integrated in all specific health-area plans

1	During the year, BCI work was not mentioned in any strategies/plans related to specific health topics.
2	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. Please attach strategies/plans in which BCI work was incorporated.
3	Some strategies/plans made an explicit reference to BCI work and identified related actions and targets. Please attach strategies/plans in which BCI work was incorporated.
4	Within several priority health areas, strategies/plans made an explicit commitment to BCI work and identified related actions and targets. Please attach examples of strategies/plans in which BCI work was incorporated.
5	Across all priority health areas, strategies/plans included a dedicated section on how BCI work should be used to reach health targets, and clearly identified actions, targets, roles and responsibilities, and resources for this work. Please attach examples of strategies/plans in which BCI work was incorporated.

Quantitative indicators and targets

Table 7. Aggregated indicators and targets for the self-assessment scales

Indicator	→	Target
• Within each SC, the number of Member States that have progressed to a higher self-assessment level by 2026 (compared with 2022). • Within each SC, the number of Member States that self-assess at Level 3 or higher by 2026.		• By 2026, 45 Member States have progressed to a higher self-assessment level within all SCs (compared with 2022). • By 2026, at least 45 Member States self-assess at Level 3 or higher within all SCs.

Table 8. Quantitative indicators and targets for Strategic Commitments

Indicator	→	Target
SC1: Number of Member States with a dedicated formal network of internal and external stakeholders that includes the application of BCI for better health in their terms of reference.		By 2026, at least 40 Member States have a dedicated formal network of internal and external stakeholders that includes the application of BCI for better health in their terms of reference.
SC2: Number of Member States 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.		By 2026, at least 40 Member States 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.
SC5: Number of Member States with a dedicated national strategy or plan for the application of BCI for better health.		By 2026, at least 20 Member States have a dedicated national strategy or plan across health areas for the application of BCI for better health.

Definitions for use in reporting

"BCI for better health" or "BCI work"

Definition: Work that seeks to explore the individual and contextual factors that affect health behaviours and use these insights to develop and evaluate health-related policies, services and communication to deliver better health and reduce inequity.
For example:

- conducting or commissioning research to explore barriers and drivers to specific health behaviours;
- engaging affected individuals and communities to explore barriers and drivers to specific health behaviours;
- designing new, or improving existing, health-related policy, service or communication through systematically applying insights into people's motivations, abilities, and social and structural opportunities;
- evaluating insights-informed health-related policy, service or communication as part of a pilot before wider roll-out, using appropriate rigorous methods;
- longer-term, evaluating the outcomes and cost-effectiveness of interventions that sought to address health behaviours, using appropriate rigorous methods.

"Health-related policies, services and communication processes"

Definition: Planning, design, implementation, improvement, evaluation and scale-up processes that relate to improving existing or developing new actions in the health sector, or in other areas that affect health such as those related to climate, environment or animal health. This may include, for example:

- exploring the perspectives and conditions of affected citizens and health workers to help ensure more impactful policies that can effectively address relevant needs without a backfire effect, such as policies that affect citizens' health-related rights, access or opportunities, and other public health measures including standards, minimum requirements, regulations and officially recommended behaviours;
- exploring barriers and drivers faced by citizens, health workers and others involved, observing the use of current services, and piloting new services to help ensure they are more people-centred, accessible and convenient, including health services such as screening, vaccination, mental health, and other prevention, care and treatment services; or
- using evidence of psychological aspects in the design of messages and formats, testing communication measures with the intended target group, and exploring levels of health literacy to help ensure more effective communication with no backfire effect, including communication and broader efforts that seek to build health literacy, to ensure that citizens can access, understand and use health information, and to promote healthy behaviours in daily life and uptake of health services.

"Dedicated formal network for internal and external stakeholders"

Definition: An established and formal mechanism that communicates regularly, and which includes BCI for better health in its terms of reference.
This may take the form of, for example:

- a working group, steering committee or other function that meets regularly and is dedicated to BCI for better health;
- a working group, steering committee or other function that meets regularly and has BCI for better health as one key area of responsibility, among others; or
- ad hoc multidisciplinary project groups related to BCI projects that together ensure regular exchange among stakeholders.

"BCI lens"

Definition: A theory-based approach that uses insights gained about barriers and drivers to health behaviours (see the definition below) in order to inform and assess health-related policies, services or communication processes. This may involve, for example:

- using behavioural insights guides and theoretical frameworks;
- engaging relevant population groups in systematic processes for community-driven scoping and design;
- using knowledge of patient experiences to design new standards for specific health services, such as vaccination or cancer screening;
- using knowledge of patient health literacy to revise treatment guidance and information programmes;
- using knowledge of psychological mechanisms and cultural contexts to create messages or design front-of-package labelling for alcohol or food products; or
- using knowledge of barriers in daily life to design new programmes for increased physical exercise.

"Explore barriers and drivers to health behaviours"

Definition: To employ relevant methods to explore the individual and contextual factors that affect people in engaging, or not engaging, in a health-related behaviour in their daily lives or in their uptake of health services. Barriers can relate to motivation, ability, capability, and social, cultural and structural contexts. Appropriate methods may involve, for example:

- literature reviews and evidence syntheses
- focus group or in-depth interviews
- surveys
- data analysis using multiple data sources
- observation research
- participatory and listening approaches.

"Staff"

Definition: Staff in public health organizations who explore the contextual and individual factors that affect health behaviours and use this insight to inform and assess health-related policies, services and communication processes. Staff may be involved in, for example:

- commissioning or conducting research to explore barriers and drivers to specific health behaviours, such as studies to understand how health literacy affects uptake of cancer screening programmes or vaccination, or broader studies to understand the determinants of smoking or drinking alcohol, or factors affecting appropriate prescribing of antibiotics;
- designing a new health-related policy, service or communication process while systematically applying knowledge of people's motivations, abilities, and social and structural opportunities; or
- testing or evaluating BCI-informed interventions, including through RCTs.

"Strategies/plans related to specific health topics"

Definition: A strategy or plan related to a specific health area, for example, antimicrobial resistance, immunization, obesity, alcohol, nutrition, use of health services, quality of care, health inequalities or health emergencies. The strategies/plans can be national or subnational. Integration of BCI into such strategies/plans may involve specifically mentioning BCI, proposed activities, targets for this work, roles and responsibilities, and/or resources available.

"Dedicated national strategy or plan across health areas"

Definition: A document for the entire country or entity on BCI for better health, which identifies BCI as a public health priority; sets a vision, indicators, targets and actions for this work; has been made publicly available; and has high-level approval.

"Evaluation using RCTs or quasi-experimental methods"

Definition: An evaluation to quantitatively measure the impact of an intervention that aims to enhance positive health behaviours using either RCTs or quasi-experimental methods. The intervention can relate to any health-related behaviour, for example, smoking, physical activity, nutrition, the use of prevention services, appropriate prescriptions or treatment adherence.

Annex 2

Resolution (EUR/RC72/R1)

World Health Organization
European Region

Regional Committee for Europe
72nd session

Tel Aviv, Israel, 12–14 September 2022

EUR/RC72/R1 | 13 September 2022 | 220766 | ORIGINAL: ENGLISH

European regional action framework for behavioural and cultural insights for equitable health, 2022–2027

Resolution

The Regional Committee,

Recognizing that to reach the ambitious health goals set by Member States of the WHO European Region, health-related policies, services and communication need to be based on medical, epidemiological and health systems evidence, knowledge and data, and should take into account the social and economic determinants as well as psychological and cultural factors that affect people's health-related behaviours in their daily lives and in their use of health services;

Recalling that the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" identifies behavioural and cultural insights (BCI) as a priority flagship initiative that aims to promote the use of BCI and foster new scientific evidence on how BCI can improve the design and implementation of health communication and facilitate the development of effective health and health-equity-related public policies, as well as evidence on the way these policies respond to citizens' expectations for respectful and people-centred health services and reliable, evidence-based communication and information, in order to optimize uptake of services and adherence to treatment, self-care and individual lifestyles in contexts of people's (local) environments;

Understanding that making healthy choices and living healthy lives are shaped by individual, environmental and other factors, many of which are not amenable to change by individual action and, therefore, that improving the health and well-being of citizens is not the responsibility of individuals alone but also of the governments, relevant authorities, nongovernmental organizations, institutions, experts, civil society and health providers, and in relevant contexts, private-sector entities, who have a role in protecting and promoting the health of the population and preventing diseases;

Recognizing the value that the multidisciplinary and intersectoral nature of applying BCI — defined as systematically exploring factors that affect health-related behaviours, and making healthy behaviours possible, attractive and desirable — may have in improving the outcomes of health and health-equity-related public policies, services and communication, as well as building trust towards the authorities;

Noting the evidence demonstrating that BCI has been used to improve the outcomes of health and equity-related public policies, services and communication, including by making them more relevant, effective, equitable, sustainable, inclusive and people- and planet-centred, in protecting and improving health and well-being;[1]

Emphasizing the potential of BCI in increasing the awareness, attractiveness and cultural feasibility of available and economically possible healthy choices, as well as further discouraging unhealthy choices by making them unattractive, including through the use of fiscal measures;

Being aware of the potentially significant impact on health behaviours and use of health services, such as vaccinations, of communication by non-State actors, including commercial advertising, particularly if conflictual with public health objectives;

Concerned about the challenge created by health-related misinformation and disinformation, including during the COVID-19 pandemic;

Acknowledging the broad application of BCI during the COVID-19 pandemic and that BCI is becoming a strategic priority for health in many places and across many health areas;

Taking note of several regional resolutions and strategic plans across health areas that refer to the importance of BCI dimensions, including the European Immunization Agenda 2030, the WHO European Framework for Action on Mental Health 2021–2025, the Progress report on implementation of the European Strategic Action Plan on Antibiotic Resistance 2018, the Roadmap for Health in the Western Balkans 2021–2025, resolution EUR/RC69/R9, Towards the implementation of health literacy initiatives through the life course and resolution EUR/RC69/R5, Accelerating progress towards healthy, prosperous lives for all, increasing equity in health and leaving no one behind in the WHO European Region;

[1] Peer-reviewed case examples illustrating the utility and value of applying BCI approaches to health are included in the background document that accompanies this resolution.

Noting the report entitled Behavioural sciences for better health initiative,[2] which calls on all WHO regional offices to establish a behavioural insights function;

Being aware of the United Nations Secretary-General's Guidance note on behavioural science;

Recognizing that applying BCI for better health is, despite progress, currently underexplored and underutilized globally and in the Region, with low implementation capacities, including low multidisciplinary competences;

1. ADOPTS the European regional action framework for behavioural and cultural insights for health, 2022–2027[3] as the basis for intensified efforts across the Region to promote the multidisciplinary science and use of BCI for better implementation of measures related to Health in All Policies and of health, health-equity and well-being outcomes at intercountry, national and local levels;

2. EXPRESSES its commitment for the stated vision, objectives, principles and strategic commitments and implementation guidance of the action framework;

3. CONFIRMS the role of the action framework to ensure implementation of the flagship initiative of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe";

4. CALLS ON Member States:

(a) to implement the action framework in line with national needs and priorities, by applying BCI in health policy, together with other public health measures and actions, for the protection and promotion of health, prevention of diseases, and for the development and provision of health services;

(b) to consistently integrate BCI considerations into health and health-relevant policy planning and monitor, as appropriate, implementation and impact;

(c) to integrate BCI as a measure across plans for specific health areas, as appropriate;

(d) to build awareness of BCI to be used in the context of pursuing public health goals by key stakeholders, including governmental and nongovernmental organizations, academia, media, the private sector and others, with the aim that BCI is understood and implemented and multidisciplinary competences and mutual understanding are developed;

[2] Document WHA75/25.
[3] Document EUR/RC72/6 Rev.1.

(e) to provide necessary resources, as appropriate and according to national context, to increase the capacity for the research, development and use of BCI in public health and for collaboration across sectors;

(f) to develop and strengthen research and evidence for BCI to explore barriers to and drivers of, including the role of determinants of health in this regard, people's health-related behaviours in their daily lives and in their uptake of health services and uptake of health-related measures in other sectors, to protect and promote health and prevent disease;

(g) to use BCI to identify opportunities for effective, tailored, equitable, sustainable and people-centred health policies, services and communication that are more accessible, convenient, acceptable, functionally integrated, operational cross-sectorally, and fit for context, and that complement already established interventions by improving their design or developing entirely new interventions;

(h) to evaluate the impact and limits of applying BCI appropriately and expediently to health policies, services and communication, including when tailored for specific audiences such as policy-makers;

(i) to report to WHO on the monitoring indicators and progress measures of the action framework in line with the reporting timelines;

5. REQUESTS the Regional Director:

(a) to implement the action framework and provide support to Member States, on their request, in its implementation;

(b) to develop, monitor, compile and disseminate new evidence and best practice for implementable, relevant, effective and cost-effective applications of BCI for better health;

(c) to develop, publish and disseminate guidance documents and tools as well as policy considerations to support the implementation of the action framework;

(d) to provide support and guidance to Member States for the implementation and evaluation of BCI-informed health-related policies, services and communication in making them effective, tailored, inclusive, equitable and people- and planet-centred;

(e) to support capacity-building in Member States, including through face-to-face and online training opportunities and support for establishing sustainable institutional structures, capacity and capability, to apply BCI for better health and well-being, including in understanding preconditions and limits for its systematic use;

(f) to facilitate peer-to-peer and community-of-practice activities and dialogue for sharing and mutual support among Member States;

(g) to promote engagement, collaboration and coordination between regional and international organizations and non-State actors, including WHO collaborating centres if appropriate, to support and enhance BCI work for health in the Region, and facilitate the engagement of Member States;

(h) to develop guidance on how Member States can address, including by applying BCI, communication that is conflictual with evidence-based information, as well as misinformation and disinformation, in particular among vulnerable groups, including migrants;

(i) to make the case for investment in BCI for better health;

(j) to prepare status reports every two years on regional progress in the application of BCI in the context of health policy, health protection, health promotion, disease prevention and disease management to be shared and discussed with stakeholders as appropriate;

(k) to report to the Regional Committee every two years on progress made in implementing the action framework and submit a final report to the Regional Committee at its 78th session.

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Annex 3

Case examples illustrating
BCI approaches for better health

BCI work involves systematically exploring the structural, contextual and individual factors that affect health behaviours, and using these insights to strengthen health-related policies, services and communication to improve health and well-being and reduce inequity.

Health policy

It is challenging for individuals to change health-related behaviours when faced with unhealthy alternatives that are more attractive, convenient or cheap, and possibly even underpinned by social norms and expectations. In some cases, rather than increasing people's knowledge or changing their perceptions, it may be more effective to alter the environment around them. As such, at the policy level, BCI can be applied to the design of regulatory measures, the design of policies and interventions, and the functioning of health systems and communities.

Health services

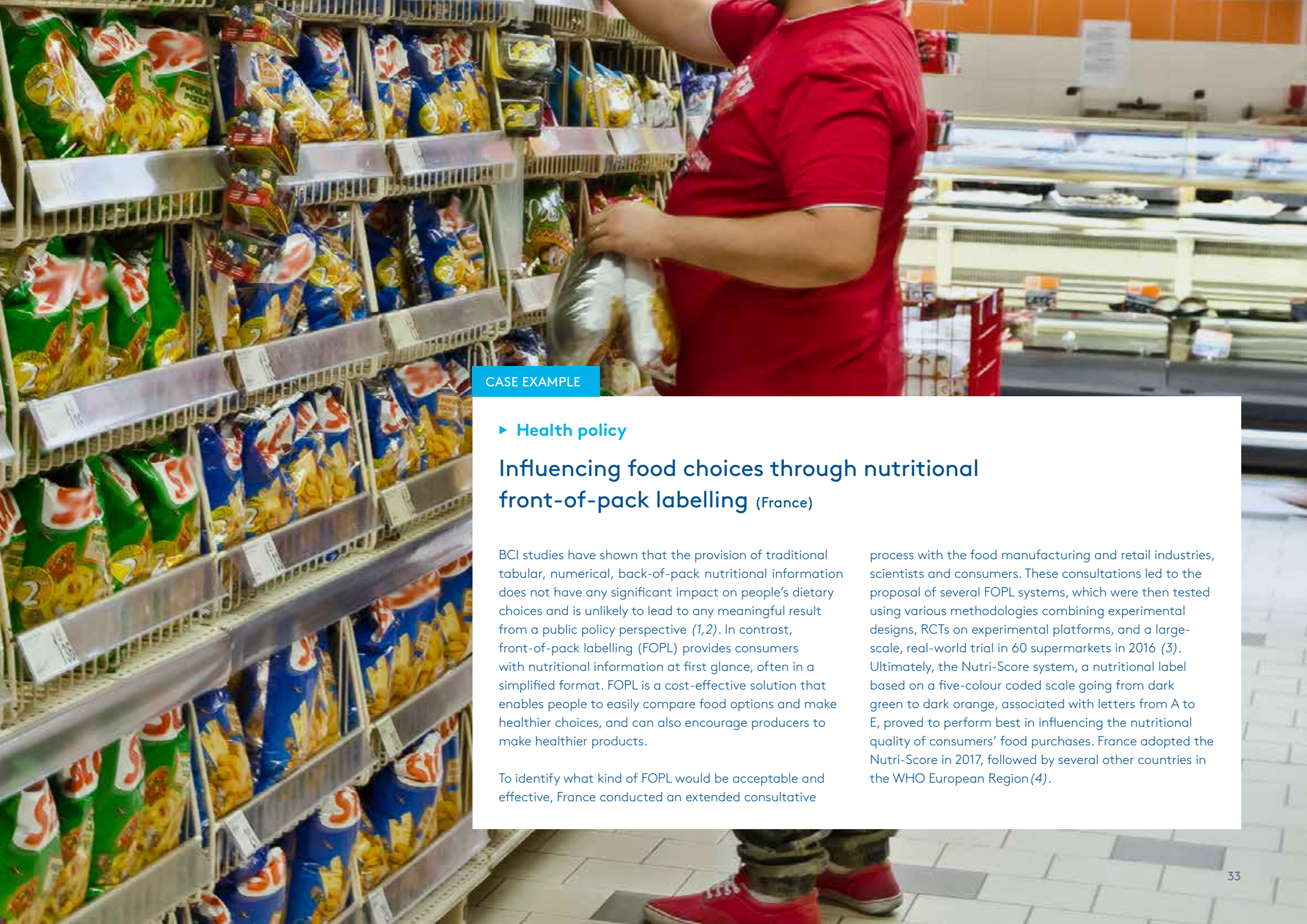
BCI can be used to strengthen health services by making them more convenient, accessible, acceptable and equitable, and to make sure they respond to the needs of patients, citizens and health providers. Such a people-centred approach in the health-care system can lead to better uptake of preventive measures, better adherence to treatment, more appropriate use of health services, and more appropriate procedures, treatment and prescribing among health personnel.

Health communication

Message framing as well as the language, visuals and channels used for engaging and communicating with people need to be tailored to the context to effectively influence health behaviours. To make sure messages and channels are effective, and that they do not have negative backfire effects, it can be useful to test them in an initial experiment. In some cases, it may be possible and effective to use channels that allow a wide number of people to be reached at a relatively low cost; in others, more intensive or direct approaches are needed.

CASE EXAMPLES

The case examples used in this publication demonstrate the range and diversity of applications of BCI to improve health-related policies, services and communication processes. Most of the examples have been evaluated and proven to have a positive impact on health and well-being. The list is not exhaustive and is meant to provide inspiration for those looking to apply BCI in their own contexts.



CASE EXAMPLE

▸ **Health policy**

Influencing food choices through nutritional front-of-pack labelling (France)

BCI studies have shown that the provision of traditional tabular, numerical, back-of-pack nutritional information does not have any significant impact on people's dietary choices and is unlikely to lead to any meaningful result from a public policy perspective *(1,2)*. In contrast, front-of-pack labelling (FOPL) provides consumers with nutritional information at first glance, often in a simplified format. FOPL is a cost-effective solution that enables people to easily compare food options and make healthier choices, and can also encourage producers to make healthier products.

To identify what kind of FOPL would be acceptable and effective, France conducted an extended consultative process with the food manufacturing and retail industries, scientists and consumers. These consultations led to the proposal of several FOPL systems, which were then tested using various methodologies combining experimental designs, RCTs on experimental platforms, and a large-scale, real-world trial in 60 supermarkets in 2016 *(3)*. Ultimately, the Nutri-Score system, a nutritional label based on a five-colour coded scale going from dark green to dark orange, associated with letters from A to E, proved to perform best in influencing the nutritional quality of consumers' food purchases. France adopted the Nutri-Score in 2017, followed by several other countries in the WHO European Region *(4)*.

CASE EXAMPLE

▸ **Health policy**

Decreasing consumption of high-sugar drinks through new tax design (United Kingdom)

In 2016, the Government of the United Kingdom announced that the Soft Drinks Industry Levy would come into effect in 2018. The design and implementation of the Levy were informed by a public consultation in 2016. Acknowledging that individual behaviour change is challenging, the tax targets producer behaviour by encouraging reformulation, as the tax escalates according to sugar levels in the drink. This has caused the soft drinks industry to significantly reduce the sugars in their products, leading to a 30% reduction of sugars sold per capita per day from soft drinks *(5)*.

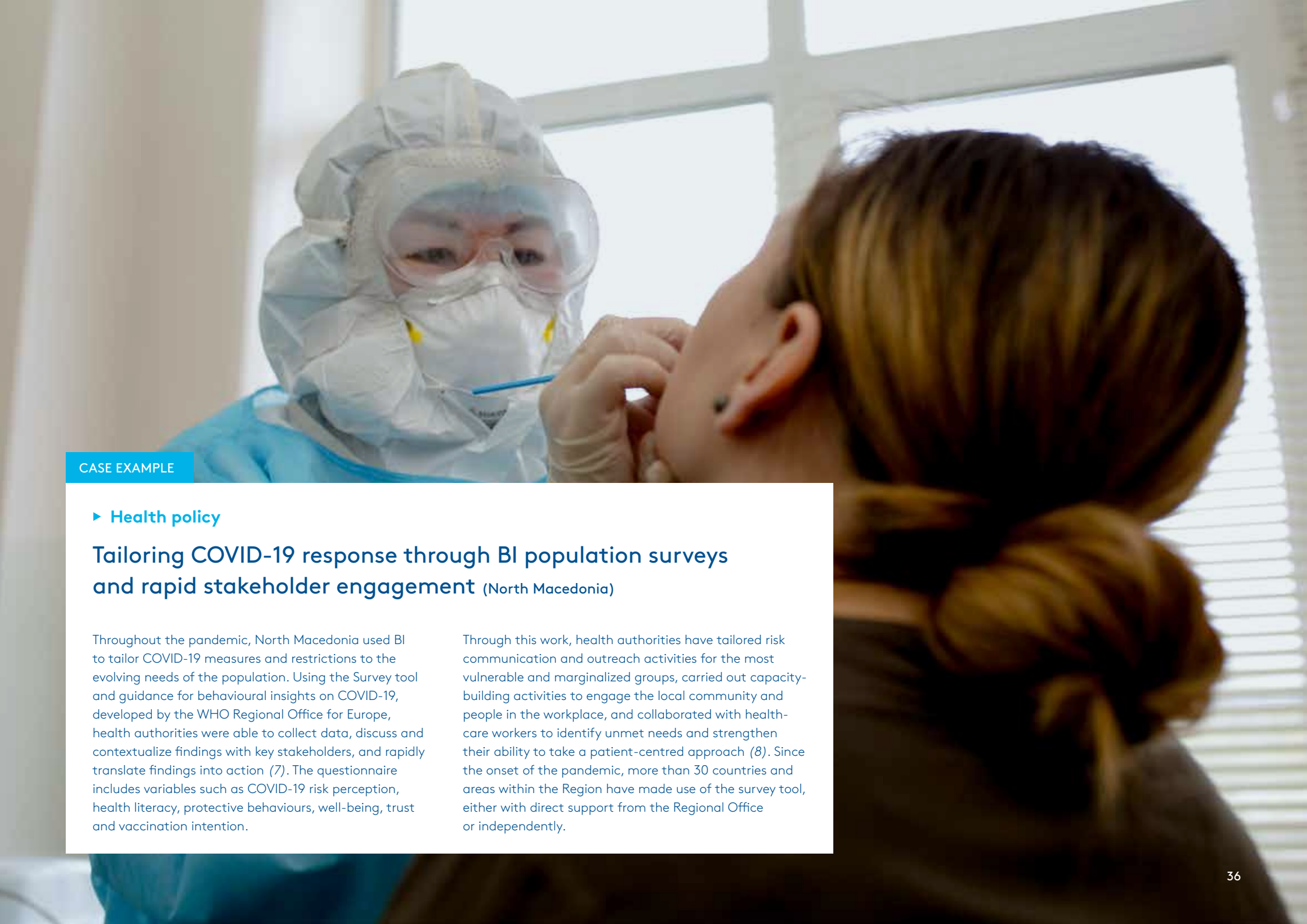
CASE EXAMPLE

▸ Health policy

Introducing vaccines for new age groups informed by behavioural insights (BI)

(Sweden)

In Sweden, BI survey data about attitudes, perceptions and behaviours related to the COVID-19 pandemic were used to inform the national policy and guidance for vaccination of younger age groups. The BI data showed that willingness to vaccinate decreased with decreasing age, from 80% among 16–17-year-olds down to as low as 52% among parents of 5–7-year-olds. The insights from the BI population survey were used to tailor national and local vaccination messages and promotion initiatives, and informed the decision to recommend COVID-19 vaccination for those aged 12–17 years, but not for those aged 5–11 years. The data showed that among those willing to vaccinate, younger age groups and their parents/guardians had different needs – a higher proportion had questions or concerns about safety and evidence and whether vaccination was in the interest of the child. The drivers of vaccination were also different, as younger groups primarily indicated that they accepted vaccination to protect others, not themselves *(6)*.



CASE EXAMPLE

▸ **Health policy**

Tailoring COVID-19 response through BI population surveys and rapid stakeholder engagement (North Macedonia)

Throughout the pandemic, North Macedonia used BI to tailor COVID-19 measures and restrictions to the evolving needs of the population. Using the Survey tool and guidance for behavioural insights on COVID-19, developed by the WHO Regional Office for Europe, health authorities were able to collect data, discuss and contextualize findings with key stakeholders, and rapidly translate findings into action *(7)*. The questionnaire includes variables such as COVID-19 risk perception, health literacy, protective behaviours, well-being, trust and vaccination intention.

Through this work, health authorities have tailored risk communication and outreach activities for the most vulnerable and marginalized groups, carried out capacity-building activities to engage the local community and people in the workplace, and collaborated with health-care workers to identify unmet needs and strengthen their ability to take a patient-centred approach *(8)*. Since the onset of the pandemic, more than 30 countries and areas within the Region have made use of the survey tool, either with direct support from the Regional Office or independently.

CASE EXAMPLE

▸ **Health services**

Improving surgical safety through simple checklists (global)

Surgical complications are common and often preventable. Drawing on lessons learned from the aviation industry, the WHO Surgical Safety Checklist was developed as a simple tool to promote appropriate behaviours during surgery, thereby decreasing human errors and adverse events *(9)*. Beyond providing a gentle reminder of critical steps in the surgical process, the checklist also encourages changes in the culture and behaviour of the surgical team as a whole. Through the introduction of a formal pause during introductions and debriefings, all members of the surgical team are given the opportunity to speak up, irrespective of hierarchical rank or seniority.

Studies have found that this simple tool is effective in changing behaviours: complications were reduced by over one third and deaths cut by nearly 50% in eight pilot hospitals representing a variety of economic circumstances and diverse patient populations. The list is now used by most surgical providers around the world *(10)*.

CASE EXAMPLE

▸ **Health services**

Increasing patient treatment adherence through enhancing convenience with digital tools (Republic of Moldova)

Tuberculosis leads to 1.4 million deaths annually, and medical treatment is critical. Many countries use directly observed therapy (DOT) for medical treatment, where a health-care professional observes the patient take the treatment. This requires a high level of effort from both the patient and the health system, and can lead to low treatment adherence. BCI can shed light on barriers to optimal treatment adherence, such as the fact that even highly motivated patients can be deterred by the effort it takes to travel to a clinic every time they need to take the medication.

A potential solution that focuses on making medical treatment easier is video-observed treatment (VOT) where the patient films themselves taking the medication and sends it to their health-care professional. An RCT conducted in the Republic of Moldova found that VOT led to higher adherence (1.29 days missed per two-week period for VOT compared with 5.24 for DOT). The study demonstrates that increasing convenience, for example through VOT, offers a promising, time-saving alternative for increasing medical adherence *(11)*.

CASE EXAMPLE

▸ **Health services**

Increasing vaccination through identifying and addressing community-specific barriers (United Kingdom)

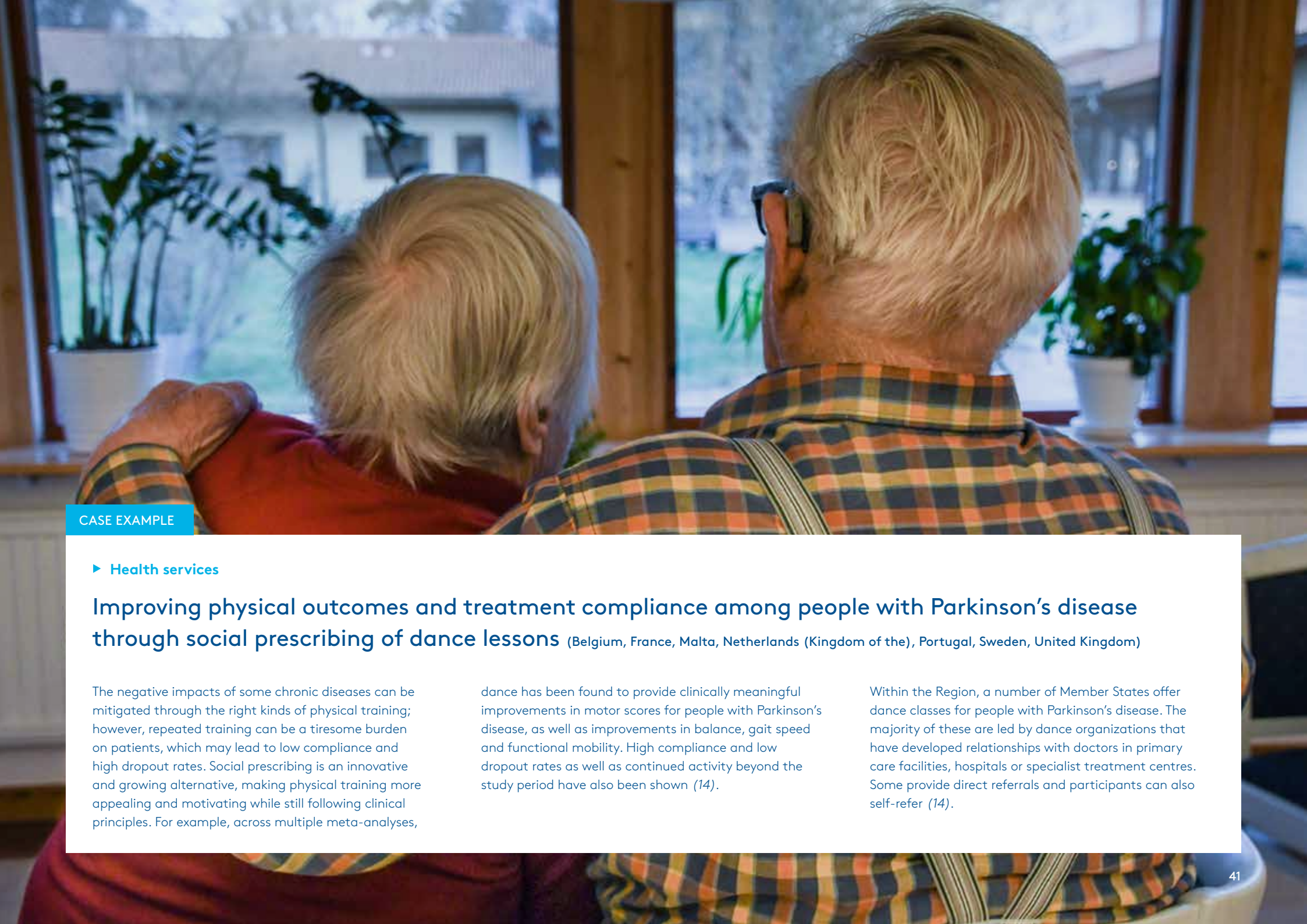
It is sometimes assumed that low vaccination uptake can be explained by vaccine scepticism alone. Yet the reasons behind low uptake may be complex and require careful consideration. The WHO Tailoring Immunization Programmes (TIP) approach combines multiple data, BCI research and stakeholder engagement to uncover the barriers to and drivers of vaccination in specific communities in order to tailor a response. Applying the TIP approach to the Charedi Orthodox Jewish community in London, United Kingdom, showed that the main barriers were associated with access to and convenience of immunization services, rather than cultural or religious anti-vaccination sentiment. The insights generated through the TIP approach allowed for the development of targeted interventions, including flexible appointments in family-friendly surroundings and robust call and recall systems *(12)*.

CASE EXAMPLE

▸ **Health services**

Improving health outcomes and equal access to care through intercultural mediation (Belgium)

Cultural differences between the patient and the health provider can lead to misunderstandings that can have negative impacts on the success of treatment or prevention measures, and may discourage patients from returning for care in time. An innovative approach, originating in Belgium, consists of training intercultural mediators who act as bridges between patients and health professionals. Intercultural mediators can help explain and contextualize messages and situations for both the patient and the health worker. Their role also involves interpretation, health education and advocacy. Over three decades, this approach was piloted and evaluated, and is now integrated within the health-care system in Belgium. Evaluation studies have found that cultural mediators can improve the quality of care, strengthen the doctor–patient relationship and lead to improved health outcomes *(13)*.



CASE EXAMPLE

▶ **Health services**

Improving physical outcomes and treatment compliance among people with Parkinson's disease through social prescribing of dance lessons (Belgium, France, Malta, Netherlands (Kingdom of the), Portugal, Sweden, United Kingdom)

The negative impacts of some chronic diseases can be mitigated through the right kinds of physical training; however, repeated training can be a tiresome burden on patients, which may lead to low compliance and high dropout rates. Social prescribing is an innovative and growing alternative, making physical training more appealing and motivating while still following clinical principles. For example, across multiple meta-analyses, dance has been found to provide clinically meaningful improvements in motor scores for people with Parkinson's disease, as well as improvements in balance, gait speed and functional mobility. High compliance and low dropout rates as well as continued activity beyond the study period have also been shown *(14)*.

Within the Region, a number of Member States offer dance classes for people with Parkinson's disease. The majority of these are led by dance organizations that have developed relationships with doctors in primary care facilities, hospitals or specialist treatment centres. Some provide direct referrals and participants can also self-refer *(14)*.

CASE EXAMPLE

▸ Health services

Increasing health effects and cost-effectiveness of physical therapy for children through making it fun and engaging (United Kingdom)

Children with hemiplegia (a weakness or paralysis affecting one side of the body resulting from brain injury or stroke) are recommended to undergo intensive programmes of physical therapy. Children can experience this therapy as repetitive and isolating, which may decrease the effectiveness of the treatment and negatively affect their well-being, in turn increasing their care needs. In response, Breathe Magic was designed to incorporate traditional hand therapy exercises into magic tricks to make the exercises more fun and engaging. By delivering the sessions in a group setting, they also meet some of the psychosocial needs of young people with hemiplegia *(14)*.

The programme was co-designed with input from artists, scientists, health-care staff and patients. Since its inception in 2008, the programme in Australia and the United Kingdom has been shown to result in clinically significant improvements in bimanual motor skills; improved well-being, communication skills, self-esteem and parent–child relationships; and a cost-saving reduction in the hours of care and support needed by each child. The programme has been shown to be comparable with other treatments such as botulinum toxin injections, both in terms of effectiveness and cost *(14)*.

CASE EXAMPLE

▸ **Health communication**

Reducing antibiotic prescribing through social-norm feedback

(United Kingdom)

Many doctors continue to prescribe unnecessary antibiotics even though it contributes to antimicrobial resistance. The reasons vary across contexts, including time pressure during consultations, cultural expectations related to prescribing, perceived risk of reputational damage and legal reprisal, and so-called action bias – the desire to do something for the patient *(15)*.

A national-scale RCT run by the Behavioural Insights Team and Public Health England targeted general practitioner (GP) practices in England whose antibiotic prescribing rate was in the top 20% for the area. Half of the high-prescribing GP practices were randomly allocated to receive a letter from a high-profile messenger (the country's chief medical officer) providing social-norm feedback ("The great majority (80%) of practices in [local area] prescribe fewer antibiotics per head than yours"). The results showed a 3.3% relative reduction in antibiotic prescribing among the GP practices that received letters compared to those that did not. The research team calculated that, if the control group was also treated, the intervention would equate to a 0.85% reduction in antibiotic items nationally during the study period. For comparison, the National Health Service set aside significant funding to reward a 1% reduction in antibiotic items prescribed. The effect of the one-time letter was shown to last at least six months. This is a meaningful result for a low-cost intervention that is easy to scale up *(16)*.

CASE EXAMPLE

▸ **Health communication**

Increasing uptake of cervical cancer screening through letters and reminders (Armenia)

BCI evidence from high-income countries shows that invitation letters and reminders can substantially increase women's participation in cervical cancer screening programmes. A group of academics worked with the national screening programme of Armenia, the Armenia National SDG Innovation Lab and a range of other partners to design and run an RCT to test the impact of invitations and reminders in Shirak, the region with the lowest income levels in Armenia. The invitation letters enhanced screening participation, especially when followed by reminders: compared to the 2.1% probability of getting screened among those who did not receive a letter, those who received letters and reminders were three to four times more likely to get screened *(17)*.

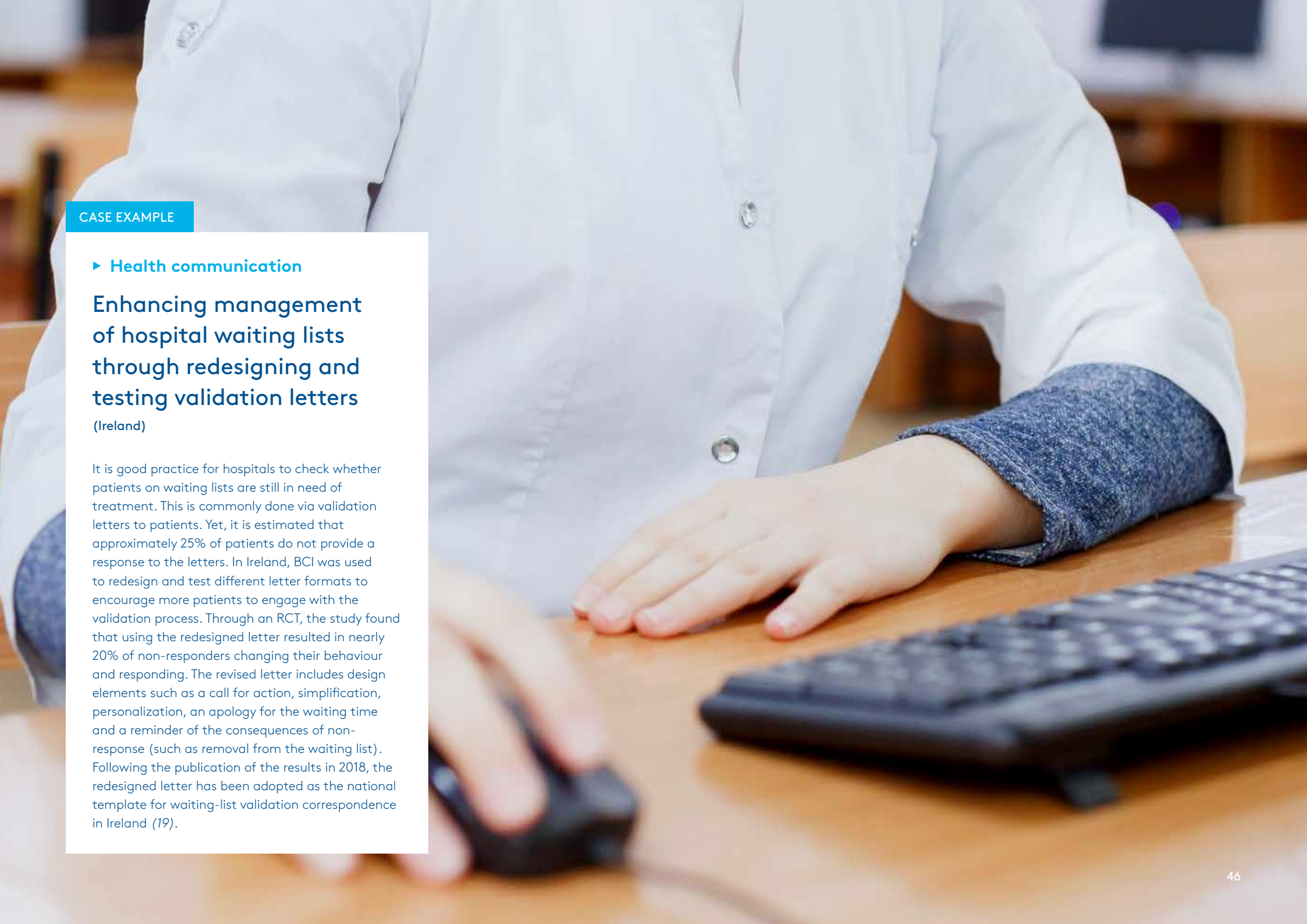
The RCT also tested differently framed messages in the letters (such as underlining the potential negative consequences of not attending a check-up) but these did not result in different rates of compliance, suggesting that the act of sending an invitation was more important than the specific wording of the letters *(17)*. The project showed that appropriately tested letters and reminders are a cost-effective intervention which can change health behaviours in both high- and low-income settings.

CASE EXAMPLE

▸ **Health communication**

Promoting health behaviours through trusted health information messengers (Kyrgyzstan)

A key issue in BCI and communication is the importance of selecting the right messenger. When information is delivered by trusted and respected members of the community, it is more likely to lead to change. In response to low levels of health literacy among the rural population in Kyrgyzstan, the Community Action for Health (CAH) programme was initiated in 2002 as a partnership for health promotion between the government health system and village health committees (VHCs). Members of each VHC are democratically elected by neighbourhoods and trained to implement health actions by visiting people in their homes and working with other organizations. The impacts of this innovative approach on behaviours among village populations are substantial. Outcomes that can be attributed to VHCs include the reversal of the brucellosis epidemic in Kyrgyzstan through the promotion of behaviours that protect people from infection during sheep lambing (with a total estimated cost savings of US$ 4 827 065 between 2007 and 2011), over 2 million people screened for hypertension, an increase in awareness of nutrition, and early detection of health problems in children and pregnant women. As of 2018, the CAH was a countrywide programme involving some 1700 VHCs that covered 84% of all villages *(18)*.



CASE EXAMPLE

▸ **Health communication**

Enhancing management of hospital waiting lists through redesigning and testing validation letters

(Ireland)

It is good practice for hospitals to check whether patients on waiting lists are still in need of treatment. This is commonly done via validation letters to patients. Yet, it is estimated that approximately 25% of patients do not provide a response to the letters. In Ireland, BCI was used to redesign and test different letter formats to encourage more patients to engage with the validation process. Through an RCT, the study found that using the redesigned letter resulted in nearly 20% of non-responders changing their behaviour and responding. The revised letter includes design elements such as a call for action, simplification, personalization, an apology for the waiting time and a reminder of the consequences of non-response (such as removal from the waiting list). Following the publication of the results in 2018, the redesigned letter has been adopted as the national template for waiting-list validation correspondence in Ireland *(19)*.

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Annex 4

The activities of international organizations and development partners in support of behavioural and cultural insights-related work in public health authorities

WHO Regional Office for Europe

The World Health Organization (WHO) provides technical support to Member Sates through its Headquarters, regional offices and country offices. The WHO Regional Office for Europe (the Regional Office) supports 53 Member States in Europe and Central Asia through: BCI research projects; capacity-building as part of online and summer-school initiatives; an online BCI knowledge hub with evidence and case examples; peer-to-peer and BCI community-of-practice activities; and guidance documents and tools.

The Regional Office established the Behavioural and Cultural Insights for Health (BCI) Unit as a flagship initiative to provide technical guidance and expertise on incorporating BCI approaches in health policy and programme planning. A technical advisory group of regional experts supports this work.

The BCI Unit works closely with technical experts in other WHO programmes. Together they seek to explore and address the barriers to and drivers of health behaviour across a wide range of health areas from mental health, cancer, diabetes and cardiovascular diseases, to vaccination, antimicrobial resistance, sexually transmitted diseases and environmental health, and to risk behaviour related to tobacco, alcohol, physical exercise and nutrition.

The BCI Unit works with the Member States in many ways, for example, by:

- providing direct support to national BCI research projects to explore the barriers to and drivers of health behaviour, and conducting evaluations of the impact of behavioural-change interventions;
- helping to build capacity among staff working for national health authorities through online training modules and summer schools;
- sharing evidence, best practice and case examples, also through the online BCI hub;
- creating platforms for the exchange of knowledge and experience and to enable peer-to-peer support across countries;
- developing new tools, guidance documents and policy considerations, where needed and on request.

World Health Organization
European Region

Contact:
→ euinsights@who.int

EuroHealthNet

EuroHealthNet, the European Partnership for Health, Equity and Wellbeing, is able to share BCI-related resources deriving from research projects in the field of health equity and environmental sustainability. These include policy guidance and tools, scientific evidence and case studies, as well as ideas for future research and transferable practice. EuroHealthNet is happy to explore possibilities for developing new resources and exchanges (webinars, workshops, visits) with Member States.

As a result of participation in Horizon 2020 and Horizon Europe projects, EuroHealthNet – through the lens of the **social, environmental and political determinants of health** – has developed expertise in behavioural and cultural insights, particularly regarding healthy behaviour related to environmental sustainability. EuroHealthNet can support the transfer of research and practice to policy, and is open to furthering collaboration, for instance, on linking Member States with ongoing research, as feasible.

Initiatives and relevant outputs include the following.

- INHERIT[1] (2016–2019) produced a useful model, policy briefs and database with practices that enable positive behaviour change to improve health, equity and sustainability;
- FEAST[2] (2022–2027) provides evidence and solutions to support transition to healthy and sustainable dietary behaviours and to ensure this transition is just and equitable;
- PSLifestyle[3] (2021–2025) co-develops an online (nudging) tool to help citizens adopt more sustainable and healthier lifestyles.

Alongside these research projects, the EuroHealthNets Strategic Development Plan and a memorandum of understanding with the WHO Regional Office for Europe will allow EuroHealthNet to develop policy briefings and conduct webinars, workshops and country-exchange visits with the aim of sharing good practice, advocacy and policy support. EuroHealthNet would be happy to explore the possibility of making BCI the focus of some of these activities.

EuroHealthNet
European partnership for health, equity & wellbeing

Contacts:
→ Alba Godfrey, Senior Project Coordinator
a.godfrey@eurohealthnet.eu

→ Ingrid Stegeman, Programme Manager
I.stegeman@eurohealthnet.eu

→ Caroline Costongs, Director
c.costongs@eurohealthnet.eu

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European Centre for Disease Prevention and Control (ECDC) Prevention and Behaviour Change team

The ECDC Prevention and Behaviour Change team offers European Union/European Economic Area (EU/EEA) Member States support in building behavioural and social capacity for the prevention and control of communicable diseases. This is provided, for example, through webinars, peer-to-peer exchange of experience and bilateral meetings with key actors. The development of a community of practice for the prevention of communicable diseases is currently underway.

Over the course of the COVID-19 pandemic, the ECDC Prevention and Behaviour Change team worked to support EU/EEA Member States in two broad areas: implementation of non-pharmaceutical interventions aimed at reducing infection rates, and promotion of COVID-19 vaccination. This work was based on the importance of understanding the needs, concerns and experiences of communities to ensure that interventions were both relevant and actionable. Training in behavioural and social sciences and community engagement formed a key part of the approach. Special support was provided to countries with lower-than-average vaccination rates through webinars, peer-to-peer exchanges of experience and bilateral meetings. Extensive guidance on working with socially vulnerable populations was also provided.

With ECDC's recently extended mandate, the work of the Prevention and Behaviour Change team has now turned to the development of a comprehensive framework for the prevention of communicable diseases. Based around a community of practice that will include actors from all EU/EEA Member States, this work will focus primarily on vaccine-preventable diseases and antimicrobial resistance, through health promotion, health education, health literacy, and behavioural change, all based on an understanding of socioeconomic risk factor.[4]

In the meantime, the Prevention and Behaviour Change team is continuing to provide health professionals throughout EU/EEA with training and support in behavioural and social sciences relevant to the prevention and control of communicable diseases.

ecdc
EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

Contact:
→ prevention@ecdc.europa.eu

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European Commission Joint Research Centre
Competence Centre on Behavioural Insights (CCBI)

The CCBI is part of the Joint Research Centre's EU Policy Lab:[5] a collaborative and experimental space which uses foresight, behavioural insights and design to drive innovative policymaking in the European Commission and beyond.

The mission of the Centre is to support EU policy-making by providing evidence on human behaviour. To do so, CCBI brings together expertise from different areas of behavioural science, including behavioural and experimental economics and social psychology. CCBI also supports individual EU Member States when needed and feasible.

CCBI's objectives are to:

- conduct behavioural research;
- provide expert assistance to other departments of the European Commission with the aim of embedding behavioural evidence in policy-making;
- build capacity for behavioural insights.

The Centre focuses mainly on three areas of work: research, expert assistance, and capacity-building.

Research
CCBI conducts in-house behavioural research in various policy areas for other departments of the European Commission, mainly on-demand, as well as anticipatory research into future policy needs related to behavioural evidence. When possible, the Centre involves the EU Member States as research partners and hosts of the behavioural interventions being tested.

Expert assistance
CCBI helps other departments of the Commission to embed behavioural evidence in policy-making. This is done by: identifying the behavioural elements of policy issues and possible policy options; gaining an understanding of the existing behavioural evidence; and defining and overseeing the methodological aspects of behavioural studies commissioned to external contractors.

Capacity-building
CCBI delivers periodic training modules, including a 90-minute crash course for managers and an eight-hour introductory course on behavioural insights for policy-makers. The Centre also organises workshops to promote and enable the use of behavioural insights throughout the EU policy cycle and in national policy-making and builds and manages communities of practitioners applying behavioural insights in key policy areas.

This initiative has been supported by the

Contact:
→ JRC-CCBI@ec.europa.eu

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European Public Health Association (EUPHA)

EUPHA provides a platform for:

- exchange of knowledge, information, experience, and expertise (for example, through annual conferences, scientific journals, newsletters and webinars);
- dissemination of knowledge about and information on projects, activities and training related to BCI to EUPHA member associations and organizations.

EUPHA's triple-A approach (Analysis-Advocacy-Action) delineates the main focal points of its work.

EUPHA is an umbrella organization for public health associations and institutes in Europe. Founded in 1992, it currently has 85 members from 47 countries, including 46 national associations of public health and 28 institutional members. It is an international, scientific organization, bringing together around 39 000 public health experts for professional exchange and collaboration throughout Europe.

EUPHA encourages a multidisciplinary approach to public health in the belief that sustainable advancements in public health and health services can only be achieved through collaboration. Therefore, EUPHA has formal collaborative agreements with 13 partner organizations, including the Association of Schools of Public Health in the European Region, the European Public Health Alliance and EuroHealthNet.

With 30 years' experience, EUPHA has a strong basis for contributing to the implementation and mainstreaming of the BCI agenda in the European public health arena.

Main activities include:

- the European Journal of Public Health (Open Access);
- annual scientific European Public Health conferences;
- European Public Health Week.

Besides, **EUPHA advocates public health in Europe** by producing a wide range of materials for national public health associations, public health professionals and other stakeholders, and through active participation in key advisory groups and events to influence public health policy and practice in Europe.

Contact:
→ Iveta Nagyova, EUPHA President
president@eupha.org

→ office@eupha.org

Save the Children
Center for Utilizing Behavioral Insights for Children (CUBIC)

Launched by Save the Children in 2020, the CUBIC provides practitioners with technical advice on and supports capacity building for behavioural science, with a focus on child-centred programmes. CUBIC supports programme design, behavioural diagnosis, solution ideation and testing, and provides guidance, expert analysis and training. It is the aim of the Center to increase the application of behavioural insights within programming, focusing on the world's most marginalized children.

Currently, CUBIC[6] is working with partners throughout the Save the Children network, and to date has collaborated on 25 projects with more than 20 country teams around the world. These projects include research into health behaviour, mainly in connection with COVID-19 prevention and vaccination. CUBIC led the development of the "Little Jab Book" series, which has informed policy and practice in tackling vaccination hesitancy in Africa, Asia and the United States. In Europe, CUBIC is supporting work around adolescent online gender-based violence and sexual abuse in Spain.

As CUBIC continues to grow, it is the intention to increase collaboration with other actors, also in the WHO Member States.

In offering a child-focused lens on behavioural science, CUBIC:

- supports analysis of the behaviours in families, communities and institutions that affect children's rights and their ability to thrive and grow to their fullest potential;
- provides direct programme support, working with Save-the-Children country teams (or other organizations) to design and deliver programmes that use behavioural insight for the benefit of children;
- offers coaching, guidance, and training on how to apply behavioural insights within a programme cycle;
- shares evidence and case studies, publishes a regular case-study newsletter and provides programme resources through the CUBIC Resource Centre.[7]

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Contacts:
→ Allison Zelkowitz, Director, CUBIC
Allison.Zelkowitz@savethechildren.org

→ Jimena Llopis, Head of Behavioral Science, CUBIC
Jimena.Llopis@savethechildren.org

United Nations Children's Fund (UNICEF) Regional Office for Europe and Central Asia
Social and Behaviour Change (SBC) Section

The SBC Section of the UNICEF Regional Office for Europe and Central Asia supports the Europe and Central Asia (ECA) countries in application of social and behavioural science through a comprehensive approach that spans from understanding the drivers and barriers influencing the adoption of positive behaviours, developing and evaluating evidence-based solutions, ensuring the rollout of effective, sustainable and scalable interventions. Together with partners, we develop research tools and solutions tailored to ECA's unique context. We consider individual, community, institutional and systemic levels to identify and propose effective policies/programmes/solutions that will move individuals and societies, including the most marginalized ones, towards the adoption of positive behaviours.

In the area of health, we support initiatives regarding immunization, nutrition, and mental health, with focus on strengthening national systems and capacities to generate behavioural evidence and develop relevant, inclusive and equity-focused programmes. We also support countries in setting up and strengthening social listening mechanisms, track and address misinformation.

To improve quality of service delivery and improve demand for immunization, we engage with and support national stakeholders to:

- conduct behavioural insights research with focus on families and service providers,
- generate, test, evaluate and scale behaviour insight solutions,
- adjust national training curricula of health workers and strengthen their interpersonal communication and community engagement capacities through training, development of job aids and guidance;
- develop national demand promotion strategies and action plans, demand promotion plans during outbreaks,
- develop information and communication materials and assets for national immunization campaigns
- strengthen social listening mechanisms.

Contacts:
→ Mario Mosquera, Regional SBC Adviser
mmosquera@unicef.org

→ Sergiu Tomsa, Regional SBC Specialist
stomsa@unicef.org

The Food and Agriculture Organization (FAO) of the United Nations Office of Innovation (OIN)

The OIN provides technical support to the FAO of the United Nations and partner teams by injecting behavioural thinking into projects and programmes and connecting needs for behavioural change with tools and expertise related to behavioural science.

In addressing behavioural science, OIN helps FAO and partners understand the limits of knowledge and information on driving behaviour, and that social, psychological and physical contexts are often the key determinants of people's actions. Therefore, to leverage the power of innovation to deliver more effectively and work more efficiently, OIN uses behavioural science to build evidence on how to encourage behaviour that underpins innovation and leads to the transformation of agrifood systems. This includes, but is not restricted to, One Health. Translating this evidence into concrete interventions that promote innovative actions and eventually mindsets, OIN supports teams in their application of behavioural science to projects, programmes and policies.

OIN supports FAO teams and Member States by:

- introducing behavioural science as an innovative approach to problem solving via information sessions, webinars and ad-hoc introductory training sessions;
- kick-starting applied behavioural science via experiential learning through the first phases of behavioural-science research projects (for example, problem scoping, co-design via sprints);
- providing advice on how to integrate behavioural science in existing and new projects in terms of both delivery and change management;
- connecting interested teams with behavioural-science experts for rigorous trials;
- maintaining a network of behavioural-science service providers, consultants and partners;
- coordinating with the Executive Office of the UN Secretary-General on mainstreaming behavioural science across UN entities as one of the aims of the Quintet of Change included in the Secretary-General's Common Agenda.

Food and Agriculture Organization of the United Nations

Contact:
→ Behavioural-Science@fao.org

UN Innovation Network and Executive Office of the UN Secretary-General
UN Behavioural Science Group

The UN Behavioural Science Group brings together over 1000 UN colleagues from 60+ UN entities and 110+ countries interested in the application of behavioural science, as well as several thousand non-UN observers, including those in Member States. Along with its members (from within UN and beyond), the Group has hosted practical discussions at the working and senior levels and collaborated on developing guidance documents and conducting research projects.

Behavioural science is part of the UN Secretary-General's "Quintet of Change,[8] which highlights key capabilities for UN 2.0.

This commitment is reaffirmed in the Secretary-General's 2021 Guidance Note on Behavioural Science,[9] published during UN Behavioural Science Week, and in the UN Behavioural Science Report,[10] which describes the experiences of 25 UN entities and key enablers in applying behavioural science.

These efforts were led by the UN Behavioural Science Group, an initiative of the UN Innovation Network,[11] supported by the Executive Office of the Secretary-General. This Network brings together over 1000 UN colleagues from 60+ UN entities and 110+ countries interested in applying behavioural science, as well as several thousand non-UN observers, including those in Member States.

The UN Behavioural Science Group supports the application of behavioural science across the UN, including in areas such as health, climate, gender, peace and security, and on reducing administrative burden.

The Group hosts practical discussions at the working and senior levels, including knowledge-sharing webinars and discussions with behavioural-science practitioners from the UN, academia and the Member States.

The Group also works with Member States to produce knowledge products (e.g., Covid-19 Global Lessons from the Field Using Behavioural Science, the UN Practitioner's Guide to Getting Started with Behavioural Science[12]) and conduct research projects through the UN Behavioural Science Fellowship Programme (e.g., to support UN entities and Resident Coordinator Offices in their work with governments on challenges they have identified, such as, reducing friction in registering for social security).

To join the UN Behavioural Science Group see UN Behavioural Science Group website.[13]

[8] UN 2.0 Quintet of Change. New York, NY: United Nations; 2021 (https://www.un.org/sites/un2.un.org/files/2021/09/un_2.0_-_quintet_of_change.pdf, accessed 30 August).
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UN INNOVATION NETWORK

Contact:
→ behavioural-science@uninnovation.network

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

World Health Organization
Regional Office for Europe

UN City, Marmorvej 51,
DK-2100 Copenhagen Ø, Denmark

Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int

Member States

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Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
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