Use of behavioural and cultural insights in 2021–2022 in the WHO European Region: status report

World Health Organization
European Region

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ABSTRACT

In September 2022 Member States of the WHO European Region acknowledged the importance of behaviour and its cultural context for health in adopting a regional resolution on behavioural and cultural insights (BCI) for equitable health and an action framework, including five strategic commitments and related targets. They committed to reporting their BCI activities to the WHO Regional Office for Europe every 2 years from 2021–2022 (baseline) until 2025–2026. This first status report presents the activities for 2021–2022 of public health authorities (PHAs) in 48 countries, territories, areas and entities in the Region, representing 44 Member States. These data show that ambitious targets were set for 2026. Most of the PHAs had conducted BCI-related research and three quarters had used the insights gained to inform the development of health policies, services and communication. Examples of BCI work were provided, but were rarely done in a systematic or integrated way across health topics or target groups. Few PHAs reported a sufficient level of progress to ensure conditions conducive for BCI work. Approximately one third of PHAs had human and financial resources in place and were working with stakeholders to integrate BCI into their health strategies.

KEYWORDS

Behavior
Culture
Equity
Public Health
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Abbreviations

BCI	behavioural and cultural insights
BCI action framework	European regional action framework for behavioural and cultural insights for equitable health, 2022–2027
COVID-19	coronavirus disease
NGO	nongovernmental organization
PHA	public health authority
RCT	randomized controlled trial
SC	strategic commitment

1. Background

The vast majority of health challenges in the WHO European Region involve a behavioural component related to people's everyday and lifestyle behaviours (e.g. tobacco smoking, alcohol intake, physical exercise), as well as to their engagement with the health system and services (e.g. following a treatment plan, attending vaccination or cancer screening, using antibiotics appropriately). In recognition of the critical role of behaviours for health, well-being and equity and to promote a people-centred approach to health, Member States adopted the WHO *European programme of work, 2020–2025 – "united action for better health in Europe*" in September 2020. The programme endorses behavioural and cultural insights (BCI) as a flagship priority for the Region.

Following this, on 13 September 2022 Member States of the Region unanimously adopted resolution EUR/RC72/R1 and the accompanying European regional action framework for behavioural and cultural insights for equitable health, 2022–2027 (BCI action framework) (*1,2*). In so doing, they made five ambitious strategic commitments (SC1–SC5) to build understanding and support for BCI among key stakeholders; conduct BCI research; apply BCI to improve outcomes of health-related policies, services and communication; commit human and financial resources for BCI and ensure their sustainability; and implement strategic plan(s) to apply BCI for better health (Fig. 1).

Fig. 1. Strategic commitments made by the countries and territories and commitments of the WHO European Region through resolution EUR/RC72/R1. *Note:* **SC** – Strategic Commitment

In adopting resolution EUR/RC72/R1, public health authorities (PHAs)[1] in the Region have committed to reporting the monitoring indicators and progress measures of the BCI action framework to the WHO Regional Office for Europe every 2 years. The first reporting period covers the activities conducted in 2021 and 2022.

[1] In this report, PHAs encompass only those in the countries, territories, entities and areas in the Region that have reported their BCI-related activities.

1.1 Reporting framework

A reporting framework (*3*), adopted alongside resolution EUR/RC72/R1, was developed in consultation with BCI focal points who had been officially nominated to represent countries, territories, entities and areas of the Region. The framework is structured according to the five strategic commitments of the BCI action framework (Fig. 1), and includes both quantitative and qualitative assessments:

- PHAs use **qualitative self-assessment scales** to report their level of activities related to each strategic commitment on a scale of 1–5 – the scales enable a nuanced assessment that is not unnecessarily prescriptive; and
- PHAs report **three quantitative indicators** related to their implementation of the strategic commitments and two quantitative indicators for the outcomes of the qualitative self-assessments – these numerical indicators enable progress to be tracked over time across the Region.

Reporting includes the actions implemented by PHAs and institutions at all levels (i.e. national, subnational, local), including those implemented in collaboration with external stakeholders. Work conducted independently by external stakeholders (such as nongovernmental organizations (NGOs), academic institutions and private entities) in which PHAs or institutions have not been involved are not reported. Table 1 shows the timeline for reporting.

Table 1. Timeline for reporting

BCI WORK IN MEMBER STATES	REPORTING	PROGRESS REPORT
Activities in 2021–2022 (baseline)	March 2023	September 2023
Activities in 2023–2024	March 2025	September 2025
Review for adjustment of the action framework during 2025	-	-
Activities in 2025–2026	March 2027	September 2027
New action framework document developed in 2027–2028	-	-
Final report of current framework and new action framework presented for adoption at the 78th session of the Regional Committee for Europe in 2028	-	-

1.2 Reporting BCI activities for 2021–2022

PHAs conducted the first round of reporting on BCI activities in 2021–2022 during the first months of 2023. This was supported by WHO with the following activities.

- An official letter was sent to all PHAs on 17 January 2023 requesting them to submit their report before the deadline of 17 March 2023. Several PHAs requested an extension. The last report included here was submitted on 8 May 2023.
- User-friendly online reporting forms were established for reporting in English and Russian. An editable version was prepared to support in-country data collection.
- The reporting framework adopted by PHAs was distributed. It includes detailed guidance and definitions of all key concepts.
- An online regional meeting held on 18 January 2023 provided a detailed description of reporting and included a question and answer session.
- Two open clinics on 14 February and 7 March 2023 were organized to answer questions about reporting and share lessons learned.
- An animated video was developed and shared with PHAs to introduce resolution EUR/RC72/R1 and the reporting requirements.

By 8 May 2023 PHAs from 48 countries, territories, entities and areas, representing 44 of the 53 Member States in the Region[2], had submitted a report.

[2] The United Kingdom submitted separate reports from England, Northern Ireland, Scotland and Wales. Kosovo reported as a separate area. All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

2. Results[3]

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

SC1 relates to work by public health authorities and institutions to engage with key stakeholders and increase their awareness of and support to BCI for health. Stakeholders include policy- and decision-makers, public health managers, health workers, and members of academia, civil society organizations and local government. Activities may include developing coordination mechanisms; inviting stakeholders to collaborate on joint projects or add a BCI lens to their work; communicating BCI-related information and case stories, findings and tools; and using resolution EUR/RC72/R1 on BCI for equitable health to increase the visibility of BCI.

Both qualitative and quantitative data are reported for SC1.

- The qualitative self-assessment scale ranges from little awareness (level 1) to wide recognition and collaboration (level 5). Annex 2 provides the full text used for the self-assessment.
- The quantitative indicator is the number of PHAs with a dedicated formal network of internal and external stakeholders whose terms of reference include applying BCI for better health.

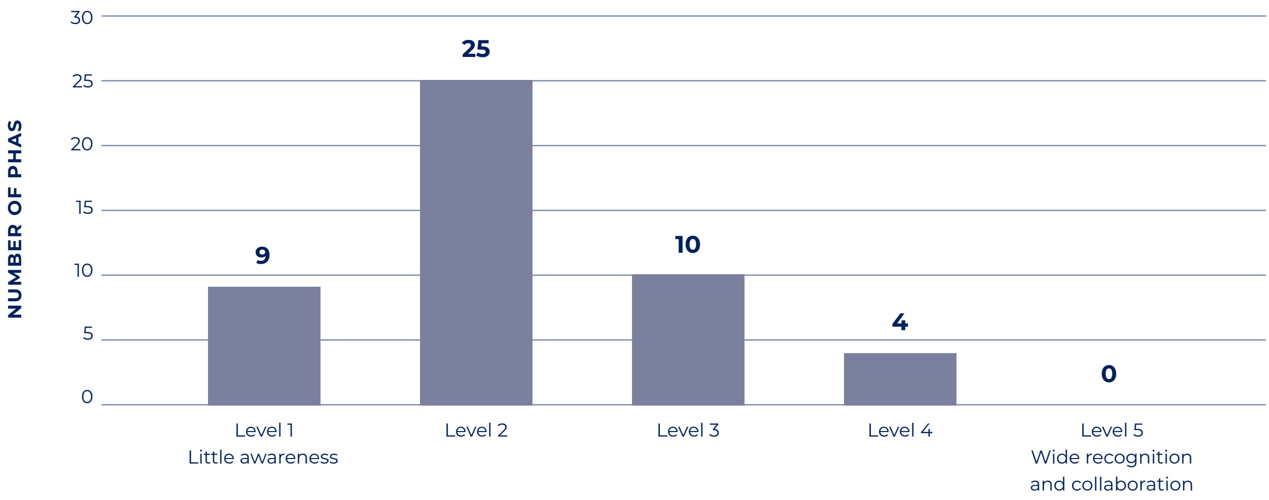
2.1.1 SC1 RESULTS FOR 2021–2022

2.1.1.1 Qualitative self-assessment

Most PHAs (34 out of 48) reported levels 1 or 2, indicating little or some degree of awareness and recognition of BCI for health among key stakeholders. Ten PHAs reported level 3, indicating widespread awareness and recognition and some collaboration initiated on BCI for health with key stakeholders. Four PHAs reported level 4, indicating that BCI for health is recognized and supported among many key internal and external stakeholders and across various health areas, academia and civil society organizations, with several collaborative projects. No PHA reported level 5 (Fig. 2).

[3] The targets set for 2026 are for Member States, whereas this status report for 2021–2022 is based on reporting by PHAs in 48 countries, territories, areas and entities of the Region, representing 44 Member States. The final report in 2027 will present the status of Member States in relation to the targets.

Fig. 2. Self-assessment for SC1: building understanding and support among stakeholders



For 2021–2022, 29% of PHAs reported level 3 or higher (Table 2). The target for 2026 is to increase this to at least 85% of Member States (45 out of 53).

Table 2. PHAs at level 3 or higher for SC1, 2021–2022 vs 2026 target

REPORTED FOR 2021–2022	TARGET FOR 2026
29%	85%

A subregional analysis[4] showed that PHAs in southern and western Europe scored their work with stakeholders at higher levels than those in other geographical regions, and that upper-middle-income PHAs reported the highest scores, followed by high-income PHAs. PHAs in the lower-middle-income range and in central Asia reported the lowest scores.

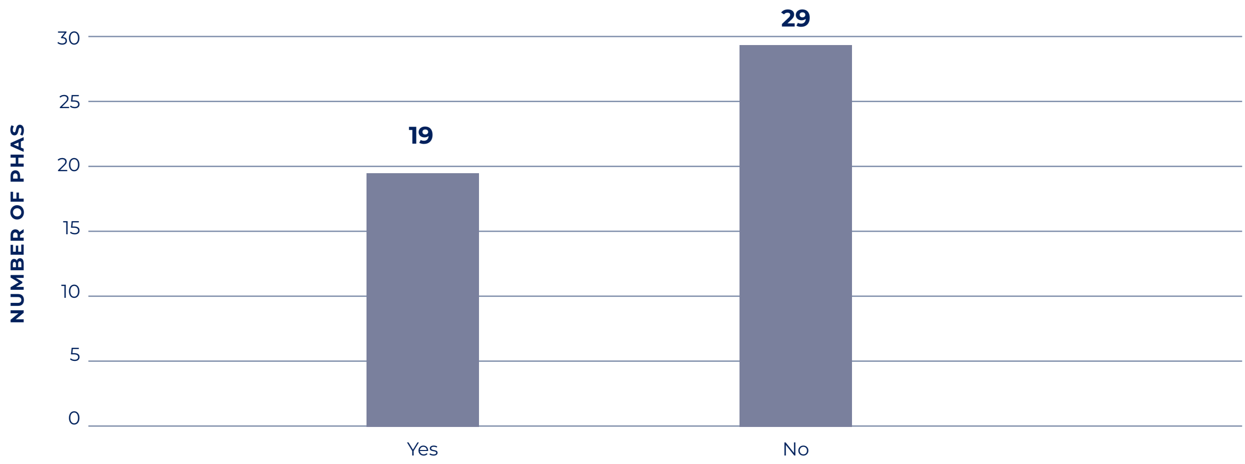
In total, 25 PHAs provided further detail on their self-assessment in a comments section, with some differences among countries. Some PHAs reported low interest levels among stakeholders, whereas others reported a growing stakeholder interest in BCI that offers a much-needed and innovative contribution to solving critical health issues. Yet others reported engagement with a wide range of stakeholders across ministries, public health institutions and, in some cases, civil society organizations and academia. Some PHAs had established formal networks to coordinate BCI-related work and/or policy dialogues, seminars and training. Several highlighted coronavirus disease (COVID-19) as an area for collaboration and for increasing interest in the value of BCI-related work. Even among those reporting a high level of stakeholder engagement, many highlighted that engagement was often irregular and not sustainable, with a lack of shared terminology and understanding of the added value of BCI-related work.

[4] A subregional analysis was conducted using geographical regions as defined by the United Nations Statistics Division (4) and income levels for 2021 as defined by the World Bank (5).

2.1.1.2 Quantitative indicator

Overall, 19 PHAs had a dedicated formal network of internal and external stakeholders whose terms of reference include applying BCI for better health, and 29 PHAs did not (Fig. 3).

Fig. 3. Quantitative indicator for SC1: number of PHAs with a formal network of stakeholders



In 2021–2022 40% of PHAs had a dedicated formal network of internal and external stakeholders whose terms of reference include applying BCI for better health (Table 3). The target for 2026 is to increase this to at least 75% of Member States (40 out of 53).

Table 3. PHAs with a formal network of stakeholders, 2021–2022 vs 2026 target

REPORTED FOR 2021–2022	TARGET FOR 2026
40%	75%

A subregional analysis[5] showed that more southern European and western Asian PHAs had formal networks, and that most were in the upper-middle-income range, followed by the upper-income range. Formal networks were least often reported by eastern European PHAs and lower-middle-income PHAs.

PHAs that have a network of BCI stakeholders were asked for the name of the network. The names revealed that the networks range from being BCI specific (e.g. working group, advisory board, policy network, steering group, oversight group, task force) to topic or disease specific, including those with a BCI perspective (e.g. intersectoral working group, working group for emergencies or COVID-19, network of health promotion centres, health literacy alliance or network, NGO coordination group, HIV working group, childhood obesity working group, interdepartmental council on noncommunicable diseases).

[5] This was conducted using geographical regions as defined by the United Nations Statistics Division (4) and income levels for 2021 as defined by the World Bank (5).

2.2 Strategic commitment 2. Conduct BCI research

SC2 is to conduct research to explore the factors that prevent or drive health behaviours and evaluate which interventions have an impact on behaviours. This may involve synthesizing the existing evidence, conducting studies on the barriers and drivers to health behaviours in the general population or priority population groups, conducting experiments or action research to evaluate the impact of evidence-informed interventions, engaging with those whose voices are often not heard, and acquiring data from other sectors.

Both qualitative and quantitative data are reported for SC2.

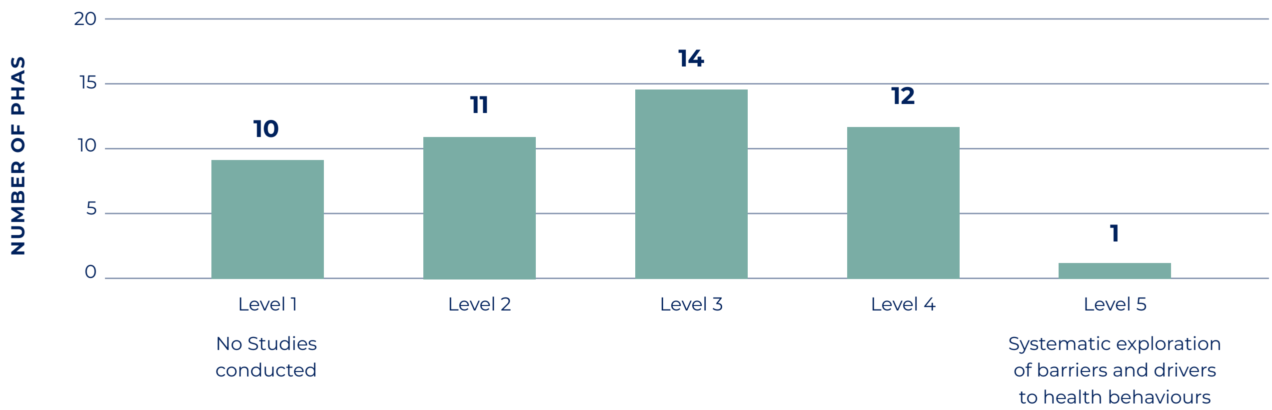
- The qualitative self-assessment scale ranges from no studies conducted (level 1) to a systematic exploration of the barriers and drivers to health behaviours (level 5). Annex 2 provides the full text used for the self-assessment.
- The quantitative indicator is the number of PHAs that have conducted at least one impact evaluation using randomized controlled trials (RCTs) or quasi-experimental methods to assess the impact of an activity intended to enhance positive health behaviours.

2.2.1 SC2 RESULTS FOR 2021–2022

2.2.1.1 Qualitative self-assessment

Over half of PHAs (27 out of 48) reported level 3 or above, indicating that they were conducting several BCI studies (level 3; 14 PHAs), BCI studies were being conducted across many health areas (level 4; 12 PHAs) or that BCI was being applied in a systematic manner across all relevant health areas (level 5; one PHA). In total, 21 PHAs reported that no studies (level 1) or one or very few studies (level 2) were being conducted to explore barriers to or drivers of health behaviours (Fig. 4).

Fig. 4. Self-assessment for SC2: conducting BCI research



In 2021–2022 56% of PHAs reported at level 3 or higher for conducting BCI research (Table 4). The target for 2026 is to increase this to at least 85% of Member States (45 out of 53).

Table 4. PHAs at level 3 or higher for conducting BCI research, 2021–2022 vs 2026 target

REPORTED FOR 2021–2022	TARGET FOR 2026
56%	85%

A subregional analysis[6] showed that northern and western European PHAs and high-income PHAs scored their research implementation at higher levels compared with those in other geographical regions. PHAs in the upper-middle-income range and in central Asia reported the lowest scores.

In total, 24 PHAs provided further detail on their self-assessment. Their comments highlighted a large degree of diversity between countries: some PHAs had engaged in several multicomponent, mixed-method studies on priority groups and priority health areas, whereas others had conducted a few smaller studies. In addition, some studies focused on monitoring a health behaviour rather than exploring the factors that influence the health behaviour. Some PHAs also noted that BCI-related studies were only conducted by academics or were initiated and supported by international partners such as WHO.

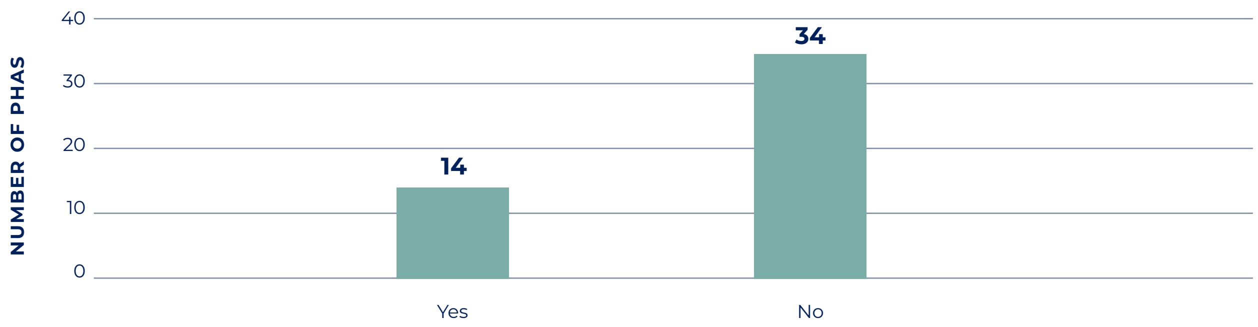
PHAs that reported level 2 and above were also asked to give examples of the studies they had conducted. Given the timing of the reporting, it is not surprising that the vast majority were related to COVID-19 (e.g. protection behaviours, vaccination, mental health). The examples also revealed a large variety of studies across many health areas and on many different target groups such, including different age groups and genders, migrants, vulnerable groups, health workers, parents, and patient groups. The studies explored health behaviours related to alcohol use, antimicrobial resistance, breast cancer, cervical cancer, depression, diabetes, drug use, food marketing, food safety, gambling, HIV/AIDS, kidney disease, menopause, mental health, noise, nutrition, obesity, physical exercise, routine and flu vaccination, sex work, sexual and reproductive health, shift-working, tobacco, tuberculosis, and urinary tract infections.

[6] This was conducted using geographical regions as defined by the United Nations Statistics Division (4) and income levels for 2021 as defined by the World Bank (5).

2.2.1.2 Quantitative indicator

Overall, 14 PHAs had conducted at least one impact evaluation using RCTs or quasi-experimental methods to assess the impact of an activity intended to enhance positive health behaviours and 34 PHAs had not (Fig. 5).

Fig. 5. Quantitative indicator for SC2: number of PHAs that have conducted an impact evaluation



In 2021–2022 29% of PHAs had 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 (Table 5). The target for 2026 is to increase this to at least 75% of Member States (40 out of 53).

Table 5. PHAs that have conducted an impact evaluation, 2021–2022 vs 2026 target

REPORTED FOR 2021–2022	TARGET FOR 2026
29%	75%

A subregional analysis[7] showed that impact evaluations were mostly reported by northern European and high-income PHAs and least often by low-income and central Asian PHAs.

PHAs that reported at least one impact evaluation using RCTs were asked to give examples of the studies they had conducted. The examples included a range of impact evaluations across many different health topics and target groups: testing the effectiveness of a mental health literacy programme; assessing the impact of nutrition-related food labelling and product availability on consumer choices; testing the effectiveness of text message reminders on human papillomavirus vaccination uptake; evaluating the impact of minimum unit pricing on alcohol consumption, crime and harmful drinking; comparing the effectiveness of community lifestyle interventions on diet and physical activity behaviours; testing the feasibility of human papillomavirus self-testing; testing redesigned breast cancer invitations; and identifying the most effective and cost-effective intervention for self-managing a chronic condition.

Although 14 PHAs reported that they had conducted at least one impact evaluation, the actual number of impact evaluation studies is likely to be less because not all of the examples appear to be impact evaluation studies – some are formative research studies. However, all 14 studies were included in this report.

[7] This was conducted using geographical regions as defined by the United Nations Statistics Division (4) and income levels for 2021 as defined by the World Bank (5).

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

SC3 relates to how well the data derived from BCI are used, alongside other data, to inform the development and improvement of health policies, services and communication in order to make them more effective, equitable and acceptable. This may involve systematically applying a BCI lens to designing health-related policy, service and communication; monitoring and evaluating interventions to understand their broader impact and gain feedback from those affected; and scaling up proven effective interventions.

Only qualitative data are reported for SC3.

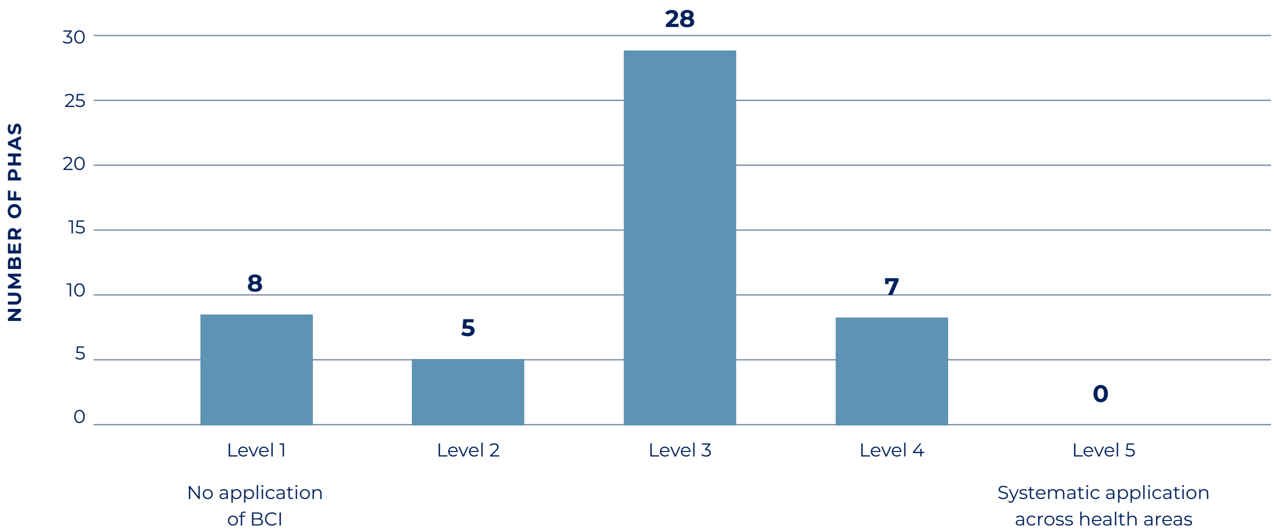
- The qualitative self-assessment scale ranges from no application of BCI (level 1) to a systematic application across health areas (level 5). Annex 2 provides the full text used for the self-assessment.

2.3.1 SC3 RESULTS FOR 2021–2022

2.3.1.1 Qualitative self-assessment

More than half of PHAs (28 out of 48) reported level 3, indicating that they occasionally used a BCI approach to inform and improve health-related policies, services and communication processes. Of the other PHAs, eight reported level 1 (BCI is not applied in the development of health policies, services or communication), five reported level 2 (an appreciation of BCI, but little application); and seven reported level 4 (BCI is used widely across many health areas to inform health policies, services and communication). No PHA reported level 5, the systematic application of BCI to inform action (Fig. 6).

Fig. 6. Self-assessment for SC3: applying BCI to improve policies, services and communication



In 2021–2022 73% of PHAs reported applying BCI to improve policies, services and communication at level 3 or higher (Table 6). The target for 2026 is to increase this to at least 85% of Member States (45 out of 53).

Table 6. PHAs at level 3 or higher for conducting BCI research, 2021–2022 vs 2026 target

REPORTED FOR 2021–2022	TARGET FOR 2026
73%	85%

A subregional analysis[8] showed that most PHAs that use of BCI to inform policies, services and communities are in western Asia, followed by northern Europe. The lowest levels were reported by high-income PHAs and central Asian PHAs.

In total, 14 PHAs provided further detail on their self-assessment. Most highlighted the challenge of translating insights and evidence of behaviours and the population perspective into evidence-informed practice. Comments indicated that this is not being done at all, is being done sporadically or is mainly done through "a bit of insights from the scientific literature". However, a few PHAs reported that population perspectives are being increasingly valued and that BCI-related research serves as "the basis for many health programmes" or is even "mandatory to assess the public's ability to act as intended" for any new legislation.

PHAs that reported level 3 and above were also asked to give examples of how and where BCI approaches were being used to inform and improve health-related policies, services and communication. The examples demonstrated a wide use of BCI-related evidence (i) at policy level, with new policies, strategies and plans in several health areas, more active engagement of civil society organizations or a new strategic focus on socioeconomic factors; (ii) in health service delivery, with new or redesigned patient tools, interventions and services; and (iii) in communication, with evidence-informed campaigns, letters, messages and guides. These interventions were informed by the studies for SC2 and range across the same health areas.

[8] This was conducted using geographical regions as defined by the United Nations Statistics Division (*4*) and income levels for 2021 as defined by the World Bank (*5*).

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

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

Only qualitative data are reported for SC4.

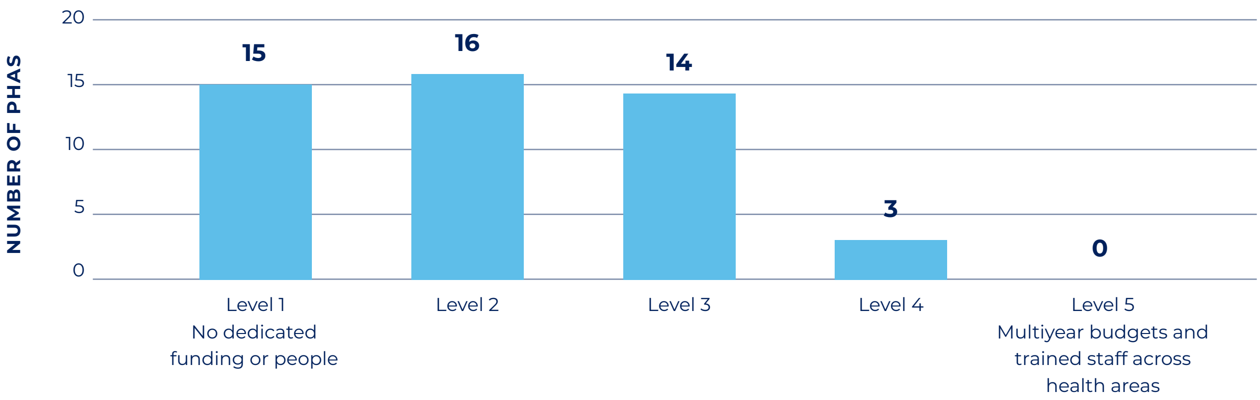
- The qualitative self-assessment scale ranges from no dedicated funding or people (level 1) to multiyear budgets and trained staff across health areas (level 5). Annex 2 provides the full text used for the self-assessment.

2.4.1 SC4 RESULTS FOR 2021–2022

2.4.1.1 Qualitative self-assessment

Similar numbers of PHAs reported levels 1–3, indicating no (level 1; 15 PHAs), limited (level 2; 16 PHAs) or some (level 3; 14 PHAs) dedicated funding and people were available but insufficient for systematic application across many health areas. Three PHAs reported level 4, indicating that a larger amount of dedicated funding and appropriately trained people was available but was still insufficient for a systematic application across all priority health areas. No PHAs reported level 5, indicating that a multiyear budget was available for continued systematic application (Fig. 7).

Fig. 7. Self-assessment for SC4: human and financial resources for BCI



In 2021–2022 35% of PHAs reported level 3 or higher for the availability of human and financial resources for BCI (Table 7). The target for 2026 is to increase this to at least 85% of Member States (45 out of 53).

Table 7. PHAs at level 3 for committing human and financial resources, 2021–2022 vs 2026 target

REPORTED FOR 2021–2022	TARGET FOR 2026
35%	85%

A subregional analysis[9] showed the highest levels of investment in BCI were made by PHAs in northern Europe, followed by those in southern Europe, and by high-income PHAs. Lower-middle-income PHAs and central Asian PHAs reported the lowest levels of investment.

In total, 13 PHAs provided further detail on their self-assessment. With a few notable exceptions, they highlighted that most funding for BCI-related work is ad hoc (relies on different types of agreements) and is rarely sustainable. Some low- and lower-middle-income PHAs reported that they rely heavily on donor funding and international partners for this area of work. Only a very few PHAs mentioned having dedicated staff for BCI work. However, some PHAs reported that BCI-related work is conducted by different types of staff in different units and institutions. Only a few PAHs reported having dedicated staff working in a dedicated unit and with dedicated (in some cases, even increasing) funding. However, they noted that funding is often linked to a health topic or programme, with BCI-related work integrated into this.

PHAs that reported level 2 and above were also asked for examples of the available resources. These included European Union and European Economic Area funding mechanisms; funding from international donors and research grants; and budgets from various ministries (mainly, the Ministry of Health), public health institutions, or government and/or the State, where funding is dedicated to specific projects (most cases) or more sustainable programmes and staff.

[9] This was conducted using geographical regions as defined by the United Nations Statistics Division (4) and income levels for 2021 as defined by the World Bank (5).

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

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

Both qualitative and quantitative data are reported for SC5.

- The qualitative self-assessment scale ranges from BCI is not integrated into specific health-area plans (level 1) to BCI is integrated into all specific health-area plans (level 5). Annex 2 provides the full text used for the self-assessment.
- The quantitative indicator is the number of PHAs with a dedicated national strategy or plan for applying BCI for better health.

2.5.1 SC5 RESULTS FOR 2021–2022

2.5.1.1 Qualitative self-assessment

Almost three quarters of PHAs (34 out of 48) reported levels 1 and 2, indicating BCI work is not included in any strategies or plans related to specific health topics (level 1; 20 PHAs) or that some strategies or plans referred to BCI work, but with no clear identification of how this work will be conducted, by whom or with which target (level 2; 14 PHAs). In total, 12 PHAs reported level 3, indicating that some strategies or plans explicitly include BCI work and related actions and targets. Two PHAs reported level 4, indicating that strategies or plans for several priority health areas make an explicit commitment to BCI work. No PHAs reported level 5, indicating that BCI is included in strategies and plans across all health areas (Fig. 8).

Fig. 8. Self-assessment for SC5: integrating BCI into health plans and strategies

In 2021–2022, 29% of PHAs reported level 3 or higher for integrating BCI into health plans and strategies (Table 8). The target for 2026 is to increase this to at least 85% of Member States (45 out of 53).

Table 8. PHAs at level 3 for committing human and financial resources, 2021–2022 vs 2026 target

REPORTED FOR 2021–2022	TARGET FOR 2026
29%	85%

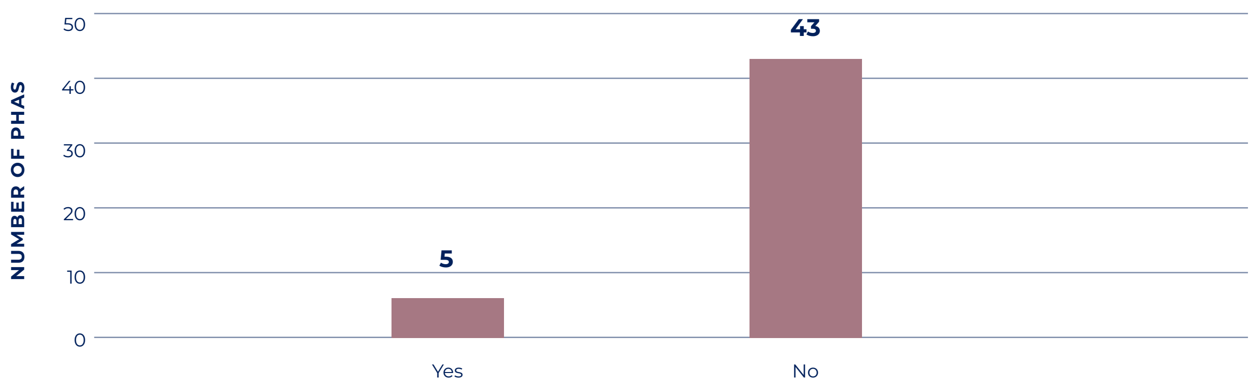
A subregional analysis[10] showed that PHAs in southern Europe (followed by those in western Asia and western Europe) and upper-middle-income PHAs reported the highest levels of integration of BCI in health strategies. Low-income PHAs and western and central Asian PHAs reported the lowest levels.

In total, 15 PHAs provided further detail on their self-assessment, including the names of relevant strategies. Most PHAs expressed a desire and need to integrate BCI-related work into health strategies, but noted that this is not yet the case. A few PAHs reported including BCI-related work into national health strategies or annual reports, or into specific health areas such as those related to healthy lifestyles or active ageing. Others reported including BCI work indirectly (not specifically mentioned) or that specifically referred to health literacy but not to broader BCI-related work.

2.5.1.2 Quantitative indicator

Overall, five PHAs had an overall national strategy or plan that defines BCI work for better health as a general public health priority and 43 PHAs did not (Fig. 9).

Fig. 9. Quantitative indicator for SC5: number of PHAs that have a dedicated strategy or plan for BCI



In 2021–2022, 10% of PHAs had a dedicated national strategy or plan across health areas for applying BCI for better health (Table 9). The target for 2026 is to increase this to at least 38% of Member States (20 out of 53).

[10] This was conducted using geographical regions as defined by the United Nations Statistics Division (4) and income levels for 2021 as defined by the World Bank (5).

Table 9. PHAs with a dedicated strategy or plan for BCI, 2021–2022 vs 2026 target

REPORTED FOR 2021–2022	TARGET FOR 2026
10%	38%

The five PHAs with a national strategy on BCI were asked to give the title of the strategy: the titles suggest that the actual number of strategies that include BCI may be less than the five reported. Only one PHA had a specific strategy for "applying behavioural and social sciences to improve population health and well-being". Two PHAs had plans for health literacy and one had a strategy for building a healthy lifestyle for the prevention and control of noncommunicable diseases. The fifth PHA noted that a strategy is not yet in place but that BCI will be critical for tackling pandemics in the future. Despite these inconsistencies, this report records that in 2021–2022 five strategies included BCI.

A subregional analysis[11] showed that national strategies were reported more often by northern and western European PHAs and high-income PHAs. Lower-income PAHs and western and central Asian PHAs reported having a national strategy least often.

[11]This was conducted using geographical regions as defined by the United Nations Statistics Division (4) and income levels for 2021 as defined by the World Bank (5).

2.6 Status regarding targets

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

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

As this is the first reporting period, no progress can yet be documented for the first target. For the second target, Table 10 gives an overview of the reporting of level 3 or above for each strategic commitment for 2021–2022 and the targets for 2026.

Table 10. Status in relation to targets for self-assessment

STRATEGIC COMMITMENT	PERCENTAGE OF PHAs REPORTING AT LEVEL 3 OR ABOVE	
	2021-2022	TARGET FOR 2026
SC1. Build understanding and support of BCI among key stakeholders	29%	85%
SC2. Conduct BCI research	56%	85%
SC3. Apply BCI to improve outcomes of health-related policies, services and communication	73%	85%
SC4. Commit human and financial resources for BCI and ensure their sustainability	35%	85%
SC5. Implement strategic plan(s) for the application of BCI for better health	29%	85%

Note: targets set for 2026 relate to Member States, whereas this report is based on reporting for 2021–2022 by PHAs in 48 countries, territories, areas and entities (representing 44 Member States) of the WHO European Region. The final report in 2026 will also show the status of Member States related to the targets.

In addition, the reporting framework set three quantitative indicators related to three of the five strategic commitments. Table 11 summarizes the data from the three quantitative indicators.

Table 11. Status in relation to targets for quantitative indicators

STRATEGIC COMMITMENT	PERCENTAGE OF PHAs WITH A POSITIVE RESPONSE	
	2021-2022	TARGET FOR 2026
SC1. Having a dedicated formal network of internal and external stakeholders whose terms of reference include applying BCI for better health	40%	75%
SC2. Having conducted at least one impact evaluation using RCTs or quasi-experimental methods to assess the impact of an activity that aimed to enhance positive health behaviours	29%	75%
SC5. Having a dedicated national strategy or plan across health areas for the application of BCI for better health	10%	38%

Note: targets set for 2026 relate to Member States, whereas this report is based on reporting for 2021–2022 by PHAs in 48 countries, territories, areas and entities (representing 44 Member States) of the WHO European Region. The final report in 2026 will also show the status of Member States related to the targets.

2.6.1 SUBREGIONAL ANALYSIS

Subregional analysis of the scores for each strategic commitment revealed patterns related to geographical region and income level (Table 12).[12] Overall, low-income and central Asian PHAs tended to report lower scores for qualitative indicators and a “no” response for the quantitative indicators. In contrast, more PHAs in northern and southern Europe reported higher scores for qualitative indicators and a “yes” response for quantitative indicators. Overall, self-assessed scores and responses for PHAs in western Europe, eastern Europe and western Asia were intermediate. In general, self-assessed scores were higher for high- and upper-middle-income PHAs than for lower-middle-income PHAs. However, these differences should not be overinterpreted. In the WHO European Region, country groupings are uneven in size, particularly for income groups. Therefore, reporting from one PHA can bias the result for smaller groups.

There are clear, but not large, average differences between subregions. However, groups with higher and groups with lower average scores both included PHAs with very high and very low scores.

[12]This was conducted using geographical regions as defined by the United Nations Statistics Division (4) and income levels for 2021 as defined by the World Bank (5).

Table 12. Data analysis by geographical region and income level

REGION (No PHAs Reporting)	SC1		SC2		SC3	SC4	SC5	
	Self Assessment: Stake-holders Scale: 1-5	**Quantitative indicator:** formal network Scale: -1 to +1	**Self Assessment:** BCI research Scale: 1-5	**Quantitative indicator:** impact evaluation Scale: -1 to +1	**Self Assessment:** Translating BCI into practice Scale: 1-5	**Self Assessment:** resource investment in BCI Scale: 1-5	**Self Assessment:** BCI in health plans Scale: 1-5	**Quantitative indicator:** national BCI plan Scale: -1 to +1
GEOGRAPHICAL REGION[a]								
CENTRAL ASIA (4)	1.25	-0.5	1.25	-1	2	1.25	1.25	-1
EASTERN EUROPE (9)	1.78	-0.56	2.44	-0.56	2.33	1.78	1.89	-0.78
WESTERN ASIA (6)	2.5	0	2.33	-0.67	3.33	2	2.17	-1
NORTHERN EUROPE (13)	2.31	-0.23	3.15	-0.08	2.85	2.54	1.69	-0.69
SOUTHERN EUROPE (10)	2.6	0.2	2.7	-0.4	3	2.1	2.2	-0.8
WESTERN EUROPE (6)	2.17	-0.33	3	-0.33	2.33	2.33	2.17	-0.67
INCOME LEVEL[b]								
HIGH (32)	2.23	-0.23	2.84	-0.23	2.68	2.26	1.87	-0.74
UPPER-MIDDLE (14)	2.29	0	2.29	-0.71	2.71	1.86	2.07	-0.86
LOWER-MIDDLE (3)	1.33	-1	2.33	-1	3	1.67	1.67	-1
WHOLE REGION (48)	2.19	-0.21	2.65	-0.42	2.71	2.1	1.92	-0.79

[a] Geographical regions are as defined by the United Nations Statistics Division (*4*).

[b] Income levels relate to 2021 and are as defined by the World Bank (*5*).

Notes: For each strategic commitment, the highest scores by geographical region and income level are shown in green and the lowest in red. The average scores for quantitative indicators were calculated by assigning the value of 1 to "yes" and the value of -1 to "no". An average of 1 means that all PHAs report "yes" and a value of -1 means that all PHAs reported "no".

3. Member State consultation

On 12–14 September 2023, the WHO Regional Office for Europe held a meeting at United Nations City in Copenhagen, Denmark to discuss the way forward to advance the implementation of the BCI action framework and its five strategic commitments. The participants comprised 112 representatives of PHAs in 48 Member States (most of which had been conducting BCI reporting for their country), nine international partner organizations and WHO. A preliminary version of the current report had been shared in advance, and key data and the analysis were presented, followed by a discussion. The feedback is summarized below.

The participants noted that reporting had been initiated just a few months after the official adoption of the action framework and before the adoption of a new global resolution on behavioural science for health (6). They agreed on the ambitious targets set for 2026, but maintained that these should be paired with realistic expectations.

The strengths of the reporting were considered to be the opportunities to monitor BCI implementation and progress over time, compare with other countries, use the reporting requirement as an advocacy tool with decision-makers, and engage with stakeholders across many institutions to complete the reporting for each PHA. For this first reporting period, some focal points had successfully engaged a wide range of colleagues and stakeholders across ministries and institutions, whereas others had based their report on their knowledge of the ongoing work. Focal points now have 2 years to prepare for the next report and will be able to engage with stakeholders to ensure a more complete overview of BCI-related work for health within the country.

The key limitation was the subjective nature of self-assessment. In interpreting the reported data, participants highlighted a paradox in that those at more advanced levels may be more self-critical (the Dunning–Kruger effect) and, therefore, may have reported more conservatively than those at less advanced levels. Participants also said that difficulties in translating BCI into national languages hamper internal coordination.

In moving forward to reach the targets, participants highlighted the gap between evidence making and policy-making as a critical issue that must be addressed, alongside challenges related to funding for long-term work and the strategic application of BCI. Other critical issues were related to education and training in BCI across various sectors, from PHAs to academic societies, medical schools and public health institutions. A need for impactful and illustrative case examples and collaboration between countries and strategic stakeholders was also highlighted.

Lastly, there was a call for more guidance and clarity on the cultural context element of BCI, which is often overshadowed by behavioural insights evidence and science.

Based on this feedback, the report was updated and finalized in its current form.

References[13]

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4. Methodology: standard country or area codes for statistical use (M49) [website]. In: United Nations Statistics Division. New York: United Nations Statistics Division; 2023 (https://unstats.un.org/unsd/methodology/m49/).

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[13]All references accessed 27 October 2023.

ANNEX 1. COMPLETE REPORTING FROM 48 PHAs, EXCLUDING NOTES

Table A1. Complete self-assessed reporting for SC1–SC5, 48 PHAs

PUBLIC HEALTH AUTHORITY	SC1		SC2		SC3	SC4	SC5	
	Self Assessment: Stake-holders	**Quantitative indicator:** formal network	**Self Assessment:** BCI research	**Quantitative indicator:** impact evaluation	**Self Assessment:** Translating BCI into practice	**Self Assessment:** resource investment in BCI	**Self Assessment:** BCI in health plans	**Quantitative indicator:** national BCI plan
Armenia	4	Yes	1	No	3	1	3	No
Austria	2	Yes	3	No	3	3	3	Yes
Azerbaijan	3	No	4	No	4	3	3	No
Belarus	2	Yes	2	No	2	2	1	No
Belgium	2	No	3	No	3	2	3	No
Bulgaria	1	No	2	No	1	2	2	No
Croatia	2	Yes	2	No	3	2	1	No
Cyprus	2	Yes	4	No	3	3	3	No
Czechia	2	No	3	Yes	3	2	3	No
Denmark	3	No	3	No	3	3	2	No
Estonia	2	No	3	Yes	3	2	1	No
Finland	3	Yes	4	No	3	3	3	No
France	1	No	1	No	1	1	1	No
Georgia	2	Yes	3	Yes	3	2	2	No
Germany	3	No	5	Yes	3	4	2	No
Greece	3	No	2	No	3	2	2	No
Hungary	1	No	1	No	1	1	1	No
Iceland	2	No	1	No	2	1	1	No

Table A1. Contd.

PUBLIC HEALTH AUTHORITY	SC1		SC2		SC3	SC4	SC5	
	Self Assessment: Stake-holders	**Quantitative indicator:** formal network	**Self Assessment:** BCI research	**Quantitative indicator:** impact evaluation	**Self Assessment:** Translating BCI into practice	**Self Assessment:** resource investment in BCI	**Self Assessment:** BCI in health plans	**Quantitative indicator:** national BCI plan
Ireland	3	Yes	4	Yes	3	3	3	No
Israel	2	No	1	No	4	2	1	No
Kazakhstan	1	Yes	1	No	1	1	1	No
Kyrgyzstan	1	No	2	No	2	1	1	No
Latvia	2	No	2	No	3	1	1	No
Lithuania	1	No	2	No	1	1	1	No
Luxembourg	1	No	2	No	1	1	1	No
Malta	2	No	1	No	1	1	1	No
Montenegro	2	No	3	No	3	1	1	No
Netherlands (Kingdom of the)	4	Yes	4	Yes	3	3	3	No
North Macedonia	3	No	2	No	3	2	3	No
Norway	2	No	4	Yes	4	4	1	No
Portugal	4	Yes	3	Yes	4	3	3	Yes
Republic of Moldova	2	No	3	No	3	2	2	No
Romania	2	No	2	No	2	1	1	No
Russian Federation	3	Yes	3	Yes	4	3	4	Yes

Table A1. Contd.

PUBLIC HEALTH AUTHORITY	SC1		SC2		SC3	SC4	SC5	
	Self Assessment: Stake-holders	**Quantitative indicator**: formal network	**Self Assessment**: BCI research	**Quantitative indicator**: impact evaluation	**Self Assessment**: Translating BCI into practice	**Self Assessment:** resource investment in BCI	**Self Assessment:** BCI in health plans	**Quantitative indicator:** national BCI plan
Serbia	3	Yes	3	No	3	3	3	No
Slovakia	1	No	2	No	1	1	1	No
Slovenia	3	Yes	4	Yes	4	3	4	No
Spain	2	Yes	4	Yes	3	2	2	No
Sweden	2	Yes	3	No	3	2	2	No
Tajikistan	1	No	1	No	3	2	2	No
Turkmenistan	2	No	1	No	2	1	1	No
Türkiye	2	No	1	No	3	1	1	No
Ukraine	2	No	4	No	4	2	2	No
England[a]	4	Yes	4	Yes	3	4	2	Yes
Northern Ireland[a]	2	No	4	Yes	3	3	1	No
Scotland[a]	2	No	4	Yes	3	3	2	Yes
Wales[a]	2	Yes	3	No	3	3	2	No
Kosovo[1]	2	Yes	3	No	3	2	2	No

[a] The United Kingdom of Great Britain and Northern Ireland reports from four entities.

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

ANNEX 2. COMPLETE TEXT USED FOR SELF-ASSESSMENT

SC1: Build understanding and support of BCI among key stakeholders

Please self-assess your country/area's level in 2021-2022, related to this Strategic Commitment. Use the below scales to guide you and select your level:

1	During 2021-2022, 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

Please self-assess your country/area's level in 2021-2022, related to this Strategic Commitment. Use the below scales to guide you and select your level:

1	During 2021-2022, 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.
3	Several studies were conducted to explore barriers and drivers to health behaviours, but not for many relevant health areas.
4	Methodologically sound approaches to exploring barriers and drivers to health behaviours were applied and studies were undertaken across many relevant health areas.
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.

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

Please self-assess your country/area's level in 2021-2022, related to this Strategic Commitment.
Use the below scales to guide you and select your level:

1	During 2021-2022, 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.
4	BCI approaches were widely used to inform and improve health-related policies, services and communication processes across many relevant health areas.
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.

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

Please self-assess your country/area's level in 2021-2022, related to this Strategic Commitment.
Use the below scales to guide you and select your level:

1	During 2021-2022, 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.
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.
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.
5	Substantial dedicated, multiyear budgets and appropriately trained people were available for a continued systematic application of BCI across all priority health areas.

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

Please self-assess your country/area's level in 2021-2022, related to this Strategic Commitment. Use the below scales to guide you and select your level:

1	During 2021-2022, 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.
3	Some strategies/plans made an explicit reference to BCI work and identified related actions and targets.
4	Within several priority health areas, strategies/plans made an explicit commitment to BCI work and identified related actions and targets.
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.

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.

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