

Public Health Guidelines

REPORT

safe
Safe Food Advocacy Europe

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List of acronyms

BMI	Body Mass Index
CVDs	Cardiovascular Diseases
EU	European Union
HFSS	High in Fat, Sugar, and Salt
NCDs	Non-Communicable Diseases
PE	Physical Education
PNRR Salute	Italy's National Recovery and Resilience Plan
UPFs	Ultra-Processed Foods

Executive summary

Non-communicable diseases (NCDs) are a major public health challenge across Europe, driven by modifiable risk factors, including tobacco and alcohol use, physical inactivity and unhealthy diets. The analysis of four European countries (i.e., Croatia, Greece, Italy and Lithuania) shows that they have established policy frameworks to address these risk factors, however, gaps remain in implementation, access to preventive services and the reduction of health inequalities.

This report identifies shared challenges and opportunities across the four EU countries and presents eight practical public health guidelines to strengthen NCD prevention, tailored to national priorities and potentially adaptable by other EU Member States. These guidelines address the key NCDs risk factors, and advocate for policy measures that establish clear obligations for companies regarding the marketing, formulation and availability of food products, supporting healthier food environments and contributing to NCD prevention.

In Croatia, the guidelines focus on expanding community-based prevention and physical activity in rural areas and modernising school physical education. In Greece, they aim to strengthen the accessibility and inclusiveness of the "Sport for All" programme and improve access to and follow-up from smoking cessation clinics. In Italy, key priorities include strengthening prevention from an early age through schools and family engagement, while holding companies accountable for creating healthier food environments. In Lithuania, the recommendations seek to increase participation and continuity in cardiovascular disease prevention and strengthen coordinated tobacco and alcohol prevention and early intervention.

The cross-country analysis highlights shared barriers, including insufficient and unstable funding, workforce shortages, fragmented coordination and limited monitoring of policy implementation and outcomes. Rural communities and socioeconomically disadvantaged groups face particular challenges in accessing preventive services. At the same time, existing initiatives in schools, communities and primary healthcare demonstrate the value of accessible, locally delivered and coordinated prevention.

The report emphasises the need to embed prevention in everyday settings, ensure equitable access, combine health education with practical support and sustained follow-up, and strengthen cooperation between health services, schools, municipalities and community organisations. It also highlights the importance of policy measures that promote healthier food environments by holding companies accountable for the marketing, formulation and availability of their products. Moreover, stable resources and systematic monitoring are essential to assess progress, identify inequalities and improve the effectiveness of interventions.

Overall, effective NCD prevention requires moving beyond policy commitments towards sustained, measurable and equitable implementation. By strengthening existing initiatives, addressing barriers to access, promoting healthier food environments and sharing good practices, the four countries analysed and other EU Member States can support healthier communities and more effective prevention.

1. Opportunities, best practices and challenges in NCD prevention

Non-communicable diseases represent the primary health burden in European countries, driven by modifiable risk factors such as tobacco use, alcohol consumption, physical inactivity, and poor diets. While countries such as Croatia, Greece, Italy, and Lithuania have established strategic frameworks to address these issues, they face significant systemic challenges, including ageing populations, fragmented policy implementation, and healthcare systems that remain heavily focused on hospital-based treatment rather than primary prevention. Despite these hurdles, upcoming opportunities, such as digital health innovation, decentralised community care models, and school-based health promotion, offer pathways to modernise prevention.

2.1 Common strengths and opportunities

All four countries assessed demonstrate a clear recognition of the growing burden of NCDs and have translated this awareness into strategic policy frameworks. Across Croatia, Greece, Italy, and Lithuania, national strategies intersect at similar core aims, including reducing behavioural risk factors such as poor diet, physical inactivity, tobacco use, and alcohol consumption; improving early detection through screening; and addressing health inequalities. Health promotion through education, awareness campaigns, and school-based interventions features prominently in all four national contexts, suggesting a shared understanding of where early, low-cost interventions can have the greatest impact.

Countries also identified concrete opportunities within their policy landscapes. Italy's National Recovery and Resilience Plan (PNRR Salute) offers a distinctive funding mechanism, channelling significant EU-backed investment into community health centres, digital health infrastructure, and a holistic approach to healthcare that incorporates physical, emotional, and social well-being[1]. Moreover, Italy's dedicated Obesity Fund and accompanying legislation, which positions the country as the first in the world to pass a law specifically for obesity prevention and treatment, signals a strong institutional commitment that could serve as a model for other Member States[2].

Lithuania stands out for its structured monitoring and data collection systems, and for embedding mental health and substance use prevention within its broader NCD strategy, reflecting a more integrated approach to public health. Its Health Promotion and Preservation Development Programme 2022-2030 is explicitly aligned with the National Progress Plan and UN Sustainable Development Goals, ensuring coherence across sectors[3].

Greece benefits from a generally high level of public acceptance and active participation in health-related policies, alongside promising community-based approaches, particularly initiatives that are

[1] Panunzio, M. F., et al. (2026). Reforming territorial care in Italy: Evidence and lessons from European experiences. Available at: Link

[2] EASO Secretariat. (2025). *Italy approves the first law recognizing obesity as a chronic disease*. Available at: Link

[3] National Health Insurance Fund under the Ministry of Health. (2022). *The health preservation and strengthening development program has been approved*. Valstybinė Ligonių Kasa. Available at: Link

inclusive and freely accessible to children, such as the National Action Plan to Combat Childhood Obesity[4].

Croatia's "Healthy Living" programme demonstrates that broad, continuously implemented public campaigns can achieve a meaningful reach when properly resourced and monitored[5].

1.2 Best Practices

Across the four countries assessed, a number of concrete initiatives stand out as best practices, namely interventions that not only reflect sound design but have demonstrated measurable, tangible engagement with target populations. Taken together, they illustrate that even within resource-constrained systems, well-targeted and community-anchored interventions can achieve meaningful impact, and they offer a set of transferable lessons for other EU Member States seeking to strengthen their own NCD prevention strategies.

In Croatia, the standout example is the "Volunteers in the Park" initiative, launched under the National Programme "Healthy Living"[6]. This project created inclusive, accessible outdoor spaces where children, older adults, individuals with developmental difficulties, ethnic minorities, and other vulnerable groups could take part in enjoyable physical activity. Its success lies in its simplicity and inclusiveness: rather than requiring specialised infrastructure or significant financial outlay, it embedded health promotion directly into community life, demonstrating that low-cost, well-organised interventions can meaningfully improve engagement with physical activity across diverse population groups. More broadly, the "Healthy Living" programme itself – through its five components spanning health education, tourism, nutrition, workplace wellness, and environment – shows the value of a continuously implemented, publicly monitored programme with a transparent budget, in contrast to many other Croatian policies that remain in draft form or lack public reporting.

Greece offers several strong examples, most notably within its National Action Plan to Combat Childhood Obesity, developed in partnership with UNICEF. The "Food for Action" toolkits are a particularly instructive practice: developed by experts and integrated into the curricula of kindergartens, primary, and secondary schools, they provide age-appropriate educational materials that encourage healthy eating and physical activity through engaging, practical activities such as promoting nutritious breakfasts and increased fruit and vegetable consumption, while also equipping parents with resources to reinforce these habits at home[7]. This is complemented by a programme of free clinical assessments and counselling for children aged 0–17 and their families, ensuring that children identified as overweight or obese receive tailored support from doctors and dietitians rather than being left without follow-up. Greece has further strengthened this approach through community-based physical activity initiatives, including free nationwide sports events such as basketball tournaments, and by aligning its programming with the country's evidence-based National Dietary Guidelines, which are disseminated in public schools and endorsed by national

[4] UNICEF. (2023). *Launch of the National Action against Childhood Obesity in Greece 2023-2025* [Press release]. Available at: Link
[5] Stimac, D., et al. (2016). Croatian National Health Promotion Program– Living Healthy. Available at: Link
[6] World Health Organization. (2021). *Physical activity factsheet: Croatia 2021*. Available at: Link
[7] UNICEF. (2025). *Young people in Greece take action!* [Press release]. Available at: Link

health authorities. More recently, Greece has reinforced the regulatory foundations of healthy school environments through a 2026 ministerial decision on school canteens[8], which establishes hygiene rules for school canteens, food-service areas, and vending machines in primary and secondary schools, aiming to create a school environment that promotes healthier dietary choices from an early age. In the area of nutrition and eating disorders more broadly, Greece's approach to embedding structured programmes within the school environment, including age-appropriate nutrition education that promotes self-esteem and body acceptance, alongside early identification and intervention strategies, as well as public awareness campaigns to reduce stigma, illustrates a model of prevention that is both educational and psychologically sensitive.

Italy contributes some of the most structurally ambitious best practices in the assessment. The "Case della Comunità" (Community Homes Initiative), financed through the National Recovery and Resilience Plan (PNRR Salute), establish a network of community health centres where multidisciplinary teams, including general practitioners, specialists, nurses, and social workers, collaborate to deliver comprehensive, ongoing care to patients with chronic conditions[1]. This model is significant not only for improving access to primary care and prevention services closer to where people live, but also for reducing the fragmentation that often characterises chronic disease management, ensuring that a patient's physical, emotional, and social needs are addressed within a single, coordinated framework. Equally significant is Italy's Obesity Fund, which represents a best practice in policy design itself. By formally recognising obesity as a chronic disease and moving toward its inclusion in the Essential Levels of Care and the National Plan for Chronic Diseases, Italy has taken a step that few other countries have matched, sending a strong institutional signal that obesity should be treated with the same seriousness as other chronic conditions. This has been reinforced on the ground through a wide range of implemented initiatives, including "Guadagnare Salute" (Gain Health) campaigns, "Frutta nelle Scuole" (Fruit in Schools), the "OKkio alla SALUTE" childhood obesity surveillance system, and "Sport di Tutti" (Sport for All), all of which combine national coordination with practical, everyday engagement at the school and community level.

Lithuania's best practices are distinguished by their emphasis on structured, data-driven implementation. The Cardiovascular Disease Prevention and Early Diagnosis Programme, in continuous operation since 2005, employs a systematic, risk-based approach to screening: individuals undergo clinical evaluation and laboratory testing, are classified by risk level, and are scheduled for follow-up at defined intervals, with high-risk individuals receiving personalised prevention plans[9]. This programme is fully integrated into primary healthcare services, with family doctors playing a central coordinating role, and its outcomes have directly informed national policy, including alcohol control measures associated with reductions in cardiovascular mortality. Lithuania has also made notable progress in the area of substance use prevention through its National Agenda on Drug, Tobacco, and Alcohol Control, which has successfully introduced a national early intervention programme, mandatory school-based prevention activities, and a naloxone distribution initiative aimed at reducing overdose deaths – an approach that reflects growing alignment with EU and WHO harm-reduction guidance and demonstrates the value of

[8] e-Nomothesia (2026). Ministerial Decision D1b/G.P.oik. 21739/2026 – School Canteens. Available at: Link
[9] National Health Insurance Fund under the Ministry of Health. (2023). *Cardiovascular disease prevention programme is changed*. Available at: Link

combining education, treatment expansion, and targeted public health tools within a single coordinated agenda[10].

Viewed collectively, these best practices share several defining characteristics that may be instructive for future policy design across the EU: they are embedded within accessible, everyday settings such as schools, primary care centres, and community spaces rather than requiring people to seek out specialised services; they combine education with tangible follow-up support, whether through free health assessments, individualised prevention plans, or trained multidisciplinary teams; and they are, to varying degrees, supported by dedicated and identifiable funding streams that lend them a degree of stability and continuity often lacking in more fragmented or ambitiously scoped policies. Their consistent limitation, however, is one of scale: each represents a strong pocket of good practice rather than a fully nationalised system, underscoring the broader challenge identified throughout the assessment: translating promising, localised interventions into equitably distributed, adequately resourced national programmes.

1.3 Common gaps and challenges

Despite the above-mentioned strengths, the four countries share a set of persistent structural weaknesses. The most pervasive is an implementation gap: even where strategic plans are well-designed on paper, execution frequently falls short due to limited funding, workforce shortages, and weak intersectoral coordination. This gap is compounded by a lack of transparency in many countries, where the public is informed of what is planned but rarely of what has actually been achieved or evaluated.

Rural and vulnerable populations remain consistently underserved across all four countries. Geographic disparities, particularly the urban-rural divide, combine with socio-economic inequalities to limit the reach and impact of otherwise sound policies. In Lithuania, for example, participation in the Cardiovascular Disease Prevention Programme remains especially low among men and rural residents. In Italy, Southern regions face a marked scarcity of tools and infrastructure compared to the North. In Greece, urban-focused interventions have left many rural and remote areas outside the practical scope of implementation.

A related and recurring theme is the underdevelopment of digital health infrastructure. Italy and Lithuania have made more progress integrating telemedicine, electronic health records, and digital monitoring tools, whereas Croatia continues to rely more heavily on centralised, hospital-focused models of care, limiting the reach of preventive services.

Workforce shortages are a near-universal constraint, with countries reporting insufficient numbers of doctors, nurses, dieticians, and community health professionals to implement detailed preventive programmes at scale. Financing also remains a critical weak point: many prevention programmes are inadequately funded or rely on non-governmental organisations and local authorities rather than sustained national investment, resulting in uneven and unpredictable coverage.

[10] Government of Lithuania. (2024). *2024–2026 action plan for the national agenda for drug, tobacco and alcohol control*. Available at: Link

Finally, some countries (particularly Croatia) face delays in the formal adoption of policy documents, some of which remain in "draft" status for years, alongside a general lack of publicly available results. These gaps make it difficult to determine whether policy objectives are being achieved, learn from past shortcomings, and reinforce the need for more systematic monitoring and evaluation of prevention policies.

2. Priority implementation guidelines for strengthening NCD prevention

This chapter presents eight priority implementation guidelines developed from the gaps and challenges identified in Croatia, Greece, Italy and Lithuania. Each country has selected two priority areas where targeted action could strengthen the prevention of NCDs and address existing gaps in policy implementation and access to preventive services. The guidelines outline practical recommendations, key stakeholders, potential barriers, success factors and suggested monitoring indicators to support effective, equitable and sustainable implementation. Although tailored to national contexts, they also offer approaches that may be adapted by other EU Member States to strengthen NCD prevention and reduce health inequalities.

2.1 Croatia

Guideline 1: Local Health, Local Heart

Why it matters (priority area):

Populations living in rural areas often have limited access to preventive health programmes, organised recreational physical activity and education on healthy lifestyle behaviours. Combined with demanding physical work, sedentary leisure-time habits and inadequate nutrition, this contributes to an increased risk of NCDs, particularly cardiovascular diseases (CVDs), type 2 diabetes, obesity and musculoskeletal disorders. As unhealthy lifestyles, including physical inactivity, are among the leading preventable risk factors for NCDs, improving access to prevention and health promotion is essential.

Health and sports infrastructure remains largely concentrated in urban areas, placing rural populations at a disadvantage and contributing to health inequalities. Greater efforts are therefore needed to bring preventive health services, health education and community-based physical activity programmes directly into rural communities by making use of existing local resources, such as community centres, fire stations and outdoor public spaces. This approach can improve access to prevention, strengthen health literacy and support healthier lifestyles among rural populations.

Objective:

Reduce health inequalities and the burden of NCDs among adults living in rural areas by improving access to preventive health services, strengthening health literacy and increasing participation in free, community-based physical activity programmes.

Recommended actions (concrete implementation steps):

- Establish a "Health in Your Community" programme involving regular visits by multidisciplinary mobile teams (e.g. physicians, nurses, physiotherapists or exercise professionals) to provide preventive health screenings, including blood pressure, blood glucose, body mass index (BMI) and functional mobility assessments, alongside personalised lifestyle counselling.
- Organise free weekly physical activity sessions tailored to adults and older people, including functional exercise, corrective exercise, walking groups and Nordic walking programmes, using existing community facilities such as cultural centres, local community halls and outdoor public spaces.
- Deliver practical workshops on healthy eating, including guidance on adapting traditional recipes to reduce salt, saturated fat and added sugar while promoting the use of locally available and affordable foods.
- Develop targeted communication campaigns through trusted local networks to raise awareness of available programmes and encourage participation.

Key stakeholders:

- Ministry of Health.
- Regional and local authorities.
- Primary healthcare providers.
- Municipalities.
- Community organisations.
- Local associations.
- Sports organisations.
- Public health institutions.

Potential barriers:

- Limited awareness of preventive health programmes.
- Resistance to behaviour change.
- Social stigma associated with participating in organised exercise in small communities.
- Inadequate indoor facilities during winter months.
- Insufficient communication regarding programme availability.
- Limited engagement or investment from local authorities.

Success factors:

- Strong community engagement through trusted local networks (e.g. community organisations, associations, religious organisations and local leaders).
- Programmes that are free of charge, easily accessible and adapted to local needs and working schedules.
- Effective use of existing community infrastructure.
- Sustained collaboration between health, sports and local government sectors.

Suggested monitoring indicators:

- Number and proportion of adults in rural municipalities participating in preventive health screening programmes.
- Percentage of programme participants demonstrating improvements in physical fitness and functional capacity after six months, measured using standardised assessments.
- Number of rural communities regularly delivering community-based physical activity and health promotion programmes.
- Participation and retention rates in community-based physical activity programmes.
- Changes in participants' health literacy and self-reported physical activity levels measured through pre- and post-programme surveys.

Guideline 2: Movement, health and inclusion: A new approach to school sports

Why it matters (priority area):

Physical education (PE) is a key component of a healthy education system and plays a crucial role in promoting the physical, mental and social wellbeing of children and young people. As childhood overweight and obesity rates continue to rise across Europe, schools have a unique opportunity and responsibility to promote healthy behaviours from an early age. High-quality PE provides all children, regardless of their background or ability, with regular opportunities to be physically active, develop movement competence, build confidence and establish lifelong healthy habits.

To maximise its impact, PE curricula should be modernised to better respond to current public health and educational needs. Traditional, rigid gymnastic activities that may discourage participation should be progressively replaced by inclusive, functional and enjoyable forms of movement, such as fitness, dance, functional training and team sports. Assessment should prioritise individual progress, participation and effort rather than fixed motor performance standards. In parallel, health education should be systematically integrated into PE to strengthen students' understanding of physical activity, nutrition, healthy lifestyles and disease prevention, thereby supporting the prevention of obesity and other NCDs across the life course.

Recommended actions (concrete implementation steps):

- Reform national PE curricula to incorporate inclusive, functional and health-oriented approaches to physical activity.
- Replace outdated compulsory gymnastic elements with a broader range of activities that promote enjoyment, participation and lifelong engagement in physical activity.
- Integrate health education topics, including nutrition, physical wellbeing, mental health and healthy lifestyle habits, into PE lessons.
- Develop assessment methods that recognise individual progress, participation and effort alongside physical competence.
- Provide continuous professional development opportunities for PE teachers to strengthen competencies in delivering modern, inclusive and health-focused physical education.

Key stakeholders:

- Ministry of Education.
- Ministry of Health.
- Schools.
- Higher education institutions (particularly faculties responsible for teacher education).

- PE teachers.
- Curriculum development experts.
- Public health organisations.

Potential barriers:

- Lengthy administrative procedures and slow policy implementation.
- Institutional resistance to change.
- Persistence of outdated educational practices.
- Limited availability of qualified professionals with expertise in modern physical and health education.
- Insufficient financial and organisational resources to support curriculum reform and teacher training.

Success factors:

- Establishment of a multidisciplinary working group to lead the revision of the physical and health education curriculum.
- Strong political commitment.
- Effective collaboration between the education and health sectors.
- Sustained investment in teacher training.
- Active engagement of schools and educators throughout the implementation process.

Suggested monitoring indicators:

- Percentage of schools implementing the revised functional and health-oriented PE curriculum.
- Percentage increase in student satisfaction with and active participation in PE classes, measured through annual surveys.
- Number and proportion of PE teachers completing accredited professional development programmes in functional training, inclusive teaching approaches and health education.
- Improvement in students' knowledge of lifelong physical activity, nutrition, health and wellbeing, measured through baseline and follow-up assessments.
- Percentage of students meeting recommended physical activity levels and reporting positive attitudes towards lifelong participation in physical activity.

2.2 Greece

Guideline 1: Active Communities for Health - Strengthening Greece's "Sport for All" Programme

Why it matters (priority area):

Physical inactivity is a major modifiable risk factor for NCDs. Greece's long-standing "Sport for All" Programmes (PAyO/EAyO) provide an established national framework for promoting lifelong physical activity through municipalities and other certified local organisations. In 2025–2026, 5,264 programme groups were implemented by 112 organisations across Greece, predominantly

municipalities, reaching approximately 150,000 participants of all ages[11].The framework also provides for programmes targeting different population groups, including older people, persons with disabilities, socially vulnerable groups and people with chronic conditions.

Objective:

Strengthen the reach, equity and preventive impact of the existing "Sport for All" model, ensuring broader access to regular physical activity regardless of age, socioeconomic status, health condition or place of residence.

Recommended actions (concrete implementation steps):

- Expand geographical coverage, particularly in rural, remote and underserved areas.
- Strengthen participation of groups facing greater barriers to physical activity through targeted outreach and adapted activities.
- Make greater use of existing municipal, school and other public sports facilities for accessible community-based activities.
- Strengthen links between programme providers, municipalities and primary healthcare/public health services to better integrate physical activity into NCD prevention.
- Introduce common monitoring tools covering participation, retention and, where feasible, changes in physical activity levels.

Key stakeholders:

- Ministry of Sports.
- Ministry of Health.
- Municipalities.
- Sports organisations.
- Schools.
- Physical education professionals.
- Primary healthcare services.
- Community organisations.

Potential barriers:

- Differences in local implementation capacity and available infrastructure.
- Geographical inequalities.
- Staffing constraints.
- Difficulties in reaching and retaining less active or vulnerable population groups.

Success factors:

- Stable institutional and financial support.
- Strong local partnerships.
- Accessible and affordable participation.

[11] Ministry of Sports, Greece. (2026). Press release 'This year's funding of PAgO and EAgO, which are already being implemented by 112 bodies – Municipalities throughout Greece, is €2.3 million'. Available at: Link

- Flexible delivery.
- Targeted outreach.
- Stronger links with prevention and primary healthcare services.

Suggested monitoring indicators:

- Geographical coverage.
- Number of participating organisations.
- Number and profile of participants.
- Participation of vulnerable groups.
- Retention rates.
- Changes in participants' physical activity levels.

Guideline 2: Supporting Tobacco-Free Lives: Strengthening Greece's Smoking Cessation Clinics

Why it matters (priority area):

Tobacco use remains a major preventable risk factor for NCDs, including cardiovascular and respiratory diseases and several types of cancer. Greece already has an established network of specialised Smoking Cessation Clinics. In May 2025, the Ministry of Health reported 52 specialised clinics operating across the country, providing services such as counselling, psychological support, pharmacotherapy and clinical assessment[12]. This existing network offers a strong basis for further integrating smoking cessation into routine prevention and healthcare.

Objective:

Increase the accessibility, uptake and effectiveness of existing smoking cessation services and strengthen their role within NCD prevention and routine healthcare.

Recommended actions (concrete implementation steps):

- Improve public awareness of available Smoking Cessation Clinics and how to access them.
- Strengthen systematic referral pathways from primary healthcare services and hospitals to specialised cessation support.
- Maintain multidisciplinary support combining medical assessment, counselling, psychological support and appropriate pharmacotherapy.
- Ensure equitable access for populations and areas with more limited access to specialised services.
- Introduce more systematic monitoring of service uptake, treatment completion and longer-term smoking cessation outcomes.

Key stakeholders:

- Ministry of Health.

[12] Greek Ministry of Health (2025). Μάριος Θεμιστοκλέους: Στηρίζουμε τη διακοπή καπνίσματος με 52 εξειδικευμένα ιατρεία σε όλη τη χώρα [We support smoking cessation with 52 specialised clinics throughout the country]. Available at: Link

- Health Regions.
- Public hospitals.
- Primary healthcare services.
- Smoking Cessation Clinics.
- Relevant healthcare professionals.

Potential barriers:

- Limited awareness of available services.
- Unequal access across areas.
- Differences in staffing and service capacity.
- Treatment dropout.
- Limited standardised monitoring of long-term outcomes.

Success factors:

- Easy referral and timely access.
- Trained multidisciplinary teams.
- Personalised support.
- Sustained follow-up.
- Effective communication to citizens.
- Stable institutional support.

Suggested monitoring indicators:

- Number and geographical distribution of active clinics.
- Annual service users.
- Intervention completion rates.
- Smoking cessation rates at defined follow-up points, such as 6 and 12 months.
- Referrals from primary healthcare services.

2.3 Italy

Guideline 1: Strengthening early-life NCD prevention through school and family-based health promotion in Italy

Why it matters (priority area):

Early childhood and school years represent key stages for educating children about healthy lifestyles and fostering healthy behaviours that can contribute to the prevention of NCDs. In Italy, strengthening systematic health promotion in schools and kindergartens could contribute to the prevention of obesity, diabetes and CVDs from an early age.

Particular attention should be given to the involvement of families, as children's dietary habits and lifestyle behaviours are strongly influenced by their home environment. Effective early-life prevention should therefore address children and parents together and promote stronger links between schools, families, healthcare professionals and public health services.

Objective:

Strengthen systematic and integrated NCD prevention from early childhood in Italy by promoting healthy lifestyles through schools and kindergartens, engaging families and strengthening collaboration between educational, healthcare and public health settings.

Recommended actions (concrete implementation steps):

- Integrate NCD prevention into school and kindergarten activities, with a focus on healthy diet, physical activity and other modifiable risk factors.
- Strengthen the involvement of healthcare and public health professionals in school-based health promotion.
- Engage parents and families alongside children to support healthy behaviours in the home environment.
- Promote continuous and systematic prevention activities, rather than isolated awareness-raising initiatives.
- Strengthen collaboration between schools, families, healthcare services and local public health authorities.
- Include NCD prevention and health promotion in relevant training for professionals working with children.

Key stakeholders:

- Ministries of Health and Education.
- Schools and kindergartens.
- Teachers and educational staff.
- Public health professionals and school health professionals.
- Paediatricians and general practitioners.
- Nutritionists/dietitians and psychologists.
- Local and regional health authorities.
- Parents and families.
- Children and adolescents.
- Universities and professional training institutions.
- Community and civil society organisations.

Potential barriers:

- Differences in the availability and organisation of health-promotion activities across schools and territories.
- Limited integration between the education system and health/public health services.
- Limited availability of dedicated health professionals in educational settings.
- Prevention activities that remain project-based or occasional rather than systematic and continuous.
- Limited parental participation in school-based health promotion.
- Competing priorities and limited time or resources within schools.
- Socio-economic inequalities that may affect children's opportunities to adopt healthy lifestyles.

Success factors:

- Strong and sustained collaboration between schools, families and health services.
- Integration of prevention into existing school and kindergarten activities and curricula.
- Involvement of qualified healthcare and public health professionals.
- Age-appropriate and evidence-informed health education.
- Active participation of parents and families.
- Continuity of prevention activities throughout childhood and adolescence.
- Adaptation of interventions to local needs while maintaining common prevention objectives.
- Attention to health inequalities and vulnerable children and families.

Suggested monitoring indicators:

- Number of schools and kindergartens implementing structured NCD prevention activities.
- Number of children and adolescents reached by school-based health-promotion programmes.
- Number of health/public health professionals involved in school-based prevention activities.
- Number of prevention programmes involving parents or families.
- Frequency and continuity of school-based prevention activities.
- Number of schools collaborating with local healthcare/public health services on NCD prevention.
- Participation rate of parents in health-promotion activities.
- Changes in children's knowledge and awareness of healthy lifestyles, where assessed.
- Changes in selected behavioural indicators (e.g. physical activity, dietary habits), where appropriate and feasible.

Guideline 2: Establishing corporate obligations for healthier food environments in Italy

Why it matters (priority area):

Unhealthy diets are among the leading modifiable risk factors for NCDs, including type 2 diabetes, CVDs, obesity and certain cancers. Despite Italy's strong cultural heritage linked to the Mediterranean diet, adherence to traditional dietary patterns has been declining, particularly among younger generations. At the same time, ultra-processed foods (UPFs) and products high in fat, sugar and salt (HFSS) play an increasingly prominent role in food environments.

Food choices are shaped not only by individual preferences and nutritional knowledge, but also by the availability, affordability, composition and marketing of food products. The widespread promotion of less healthy foods, alongside limited incentives for reformulation and uneven access to healthier alternatives, can make healthier choices more difficult. Vulnerable groups, such as children and adolescents, people with lower levels of education or income and older people are particularly vulnerable to persuasive marketing, including through digital media, social networks and influencer promotions.

While food and nutrition literacy remains important, awareness-raising alone cannot address the commercial and environmental factors that influence dietary behaviour. A more comprehensive

approach is needed to establish clear obligations for food manufacturers, retailers and other relevant economic operators regarding the marketing, formulation and availability of food products. Binding regulatory measures, supported by effective monitoring and enforcement, can help create healthier food environments, protect consumers and contribute to reducing diet-related health inequalities.

Objective:

Establish and strengthen policy measures in Italy that create clear, enforceable obligations for food manufacturers, retailers and other relevant economic operators to improve food marketing practices, encourage healthier product formulation and increase the availability of healthier food options, with particular attention to protecting vulnerable groups and reducing health inequalities.

Recommended actions (concrete implementation steps):

- Introduce comprehensive, binding restrictions on the marketing and promotion of HFSS foods and UPFs to children and adolescents. Establish a robust regulatory framework covering advertising across television, digital and social media, influencer marketing, online platforms, games and other channels used by young people. Restrictions should also address child-directed packaging and promotional techniques, including cartoon and licensed characters, toys, gifts and competitions, as well as the wider promotion of less healthy products in public spaces and retail environments. Rules should apply consistently across relevant media and settings to prevent marketing from shifting to less-regulated channels.
- Introduce clear reformulation targets for food manufacturers. Establish measurable targets for reducing salt, added sugars and saturated fats in relevant food categories, supported by transparent reporting requirements and appropriate compliance mechanisms. Build on existing voluntary initiatives while addressing their limitations through stronger accountability and, where appropriate, binding requirements.
- Improve the nutritional quality of food available in public settings. Establish nutrition standards for food and drink provided in public institutions, including schools, hospitals, public administration buildings and other publicly funded settings. Integrate these standards into public procurement requirements and catering contracts, with clear criteria and monitoring arrangements.
- Promote the availability and accessibility of healthier food products. Explore regulatory and procurement measures that encourage retailers and food service providers to make healthier options more widely available and accessible, including in disadvantaged and underserved areas. Consider measures to improve the placement and promotion of healthier products and limit the prominent positioning of HFSS products in settings frequented by children.
- Establish effective monitoring, reporting and enforcement mechanisms. Define responsibilities for the relevant public authorities, require transparent reporting by food businesses where appropriate, and introduce proportionate enforcement measures for non-compliance. Monitoring should assess changes in marketing practices, product composition and availability, as well as industry compliance with applicable requirements.
- Support implementation through consumer information and stakeholder engagement. Involve consumer associations, public health institutions, civil society organisations and relevant professional groups in raising awareness of new requirements and monitoring their implementation. Ensure that food literacy initiatives complement structural measures rather than placing the primary responsibility for healthier diets on consumers.

Key stakeholders:

- Ministry of Health.
- Ministry of Enterprises and Made in Italy (consumer protection).
- Ministry of Agriculture, Food Sovereignty and Forestry.
- Italian National Institute of Health (Istituto Superiore di Sanità).
- Regional health authorities and local health units (ASL).
- Consumer associations and civil society organisations.
- Food manufacturers, processors and industry associations.
- Retailers, supermarkets and food service providers.
- Public procurement authorities and municipalities managing public catering.
- Schools, hospitals and other public institutions.

Potential barriers:

- Resistance from food manufacturers, retailers and other economic operators to binding requirements, reformulation targets or marketing restrictions.
- Concerns about the costs of compliance and the potential impact of regulatory measures on businesses.
- Fragmented responsibilities across national, regional and local authorities.
- Difficulties in monitoring marketing practices across digital platforms and cross-border media.
- Limited enforcement capacity and resources among the relevant public authorities.
- Risk of continued reliance on voluntary industry commitments without measurable obligations or effective accountability.
- Challenges in ensuring consistent implementation across regions and different types of food businesses.
- Potential difficulties in improving the affordability and availability of healthier products in disadvantaged areas.

Success factors:

- A clear legal framework establishing measurable obligations for food businesses.
- Consistent rules across relevant marketing channels and food environments.
- Transparent, evidence-based criteria for identifying products subject to reformulation requirements.
- Clear allocation of responsibilities among regulatory authorities, with adequate resources for monitoring and enforcement.
- Regular reporting on industry compliance and progress towards defined targets.
- Meaningful involvement of public health experts, consumer organisations and civil society in policy development and oversight.
- Coordination between national and regional authorities to ensure consistent implementation.
- Integration of healthier food procurement and availability measures into public policies.
- Complementary consumer information initiatives that support, rather than substitute for, structural regulatory measures.

Suggested monitoring indicators:

- Adoption and implementation of binding measures regulating the marketing of HFSS foods and UPFs to children and adolescents.
- Compliance rates with applicable food marketing restrictions, including across digital and social media channels.
- Changes in children's and adolescents' exposure to HFSS food marketing, where data are available.
- Number and proportion of relevant food categories covered by measurable reformulation targets.
- Changes in the nutritional composition of products, including levels of salt, added sugars and saturated fats.
- Number and proportion of public institutions applying mandatory or established nutrition standards in food procurement and catering.
- Availability and placement of healthier and less healthy food products in selected retail and public settings, where assessed.
- Number of inspections, compliance assessments and enforcement actions undertaken by relevant authorities.
- Proportion of food businesses meeting applicable regulatory requirements and reporting obligations.
- Changes in selected dietary indicators, including fruit and vegetable consumption and adherence to the Mediterranean diet, using existing national surveillance systems such as PASSI, where feasible.
- Availability and affordability of healthier food options in disadvantaged and underserved areas, where data are available.

2.4 Lithuania

Guideline 1: Increasing participation and continuity of care in Lithuania's cardiovascular prevention programme

Why it matters (priority area):

Participation in Lithuania's Cardiovascular Disease Prevention and Early Diagnosis Programme remains uneven. Although the programme is established within primary healthcare and publicly funded, programme data reported by the State Health Insurance Fund indicate that only around 49.6% of the target population participated in 2022[13]. Engagement is particularly limited among men and rural residents. Limited awareness, workforce shortages and geographical barriers reduce its reach.

The programme provides structured risk assessment and individual prevention plans, but lifestyle changes remain inconsistent and digital tools are used only to a limited extent for follow-up. Improving participation therefore needs to be accompanied by practical support after assessment, linking primary healthcare with municipal health-promotion services. This approach also supports

[13] Institute of Hygiene (2023). Lithuanian Health Statistics 2022. Available at: Link

the objectives of the Health Promotion and Preservation Development Programme 2022–2030 concerning regional and social health inequalities.

Objective:

Improve equitable participation in cardiovascular prevention by addressing lower engagement among eligible men, rural residents and people facing socioeconomic barriers, while strengthening follow-up and support to sustain long-term lifestyle changes.

Recommended actions (concrete implementation steps):

- Strengthen existing patient invitation and recall procedures in institutions delivering the cardiovascular prevention programme, with particular attention to eligible people who have not participated.
- Provide clear information about the programme through municipal public health bureaus, community organisations and employers, particularly to men and residents of underserved areas.
- Improve access through flexible appointment times and transport support where needed, taking account of local staffing capacity.
- Strengthen cooperation between primary healthcare institutions and municipal public health bureaus so that participants can access available support for healthy eating, physical activity and smoking cessation.
- Use appointment reminders and follow-up records where available. Offer telephone or face-to-face contact for patients who cannot use digital services.

Key stakeholders:

- Public authorities: Ministry of Health and State Health Insurance Fund — programme oversight and financing.
- Healthcare providers: primary healthcare institutions, family doctors and nurses — risk assessment, individual prevention plans and follow-up.
- Local authorities and public health services: municipalities and municipal public health bureaus — local health promotion and access to preventive activities.

Potential barriers:

- Low awareness of cardiovascular risk and limited motivation to attend preventive assessments.
- Workforce shortages, travel distances and limited appointment availability in smaller municipalities.
- Insufficient capacity to provide ongoing support for lifestyle changes.
- Limited digital skills or internet access among some patients.

Success factors:

- Clear responsibility for patient invitations and follow-up in programme providers.
- Accessible services and communication adapted to groups with low participation.
- Sustained cooperation between primary healthcare and municipal public health services.
- Adequate staffing and funding for outreach and continued prevention support.

- Routine use of local participation data and participant feedback to adjust delivery.

Suggested monitoring indicators:

- Annual number of programme participants, by sex, age group and municipality, where these breakdowns are available in existing programme data.
- Number of follow-up assessments completed, using existing programme records.

Guideline 2: Strengthening coordinated tobacco and alcohol prevention and early support in Lithuania

Why it matters (priority area):

Tobacco use and alcohol consumption are important modifiable risk factors in Lithuania. The National Agenda on Drug, Tobacco, and Alcohol Control provides a basis for coordinated prevention, including early intervention and school-based activities. Implementation challenges include uneven coverage, insufficient sustainable funding, weak intersectoral cooperation and limited access to services in rural areas.

Stigma and fragmented addiction care create barriers to seeking and receiving help. For NCD prevention, tobacco and alcohol interventions should be linked to routine healthcare, schools, workplaces and community services, with clear information about confidential support. Stronger links with mental health services are consistent with the integrated approach set out in the Health Promotion and Preservation Development Programme 2022–2030.

Objective:

Reduce tobacco use and harmful alcohol consumption by improving equitable access to prevention, early intervention and continued support, with particular attention to young people, working adults and underserved communities.

Recommended actions (concrete implementation steps):

- Strengthen cooperation between municipal public health bureaus, healthcare providers and schools to identify local gaps in prevention and early support.
- Train healthcare professionals to identify tobacco and harmful alcohol use, provide brief, non-judgemental advice and explain where further help is available.
- Expand access to existing early intervention activities for young people and provide clear information through schools about local support services.
- Adapt workplace and community prevention activities to adults who are less likely to use preventive services, combining practical information with guidance on accessing help.
- Improve rural access through available local services and telephone or remote support where appropriate, while maintaining in-person options.
- Ensure sustained funding and staff training for existing prevention and early intervention activities.

Key stakeholders:

- Public authorities: Ministry of Health and Drug, Tobacco and Alcohol Control Department — national policy and prevention coordination.
- Local authorities and public health services: municipalities and municipal public health bureaus — local prevention and early intervention activities.
- Healthcare providers: primary healthcare institutions, mental health centres and addiction treatment services — advice, assessment and support.
- Education sector: schools and education authorities — school-based prevention and information about early support.

Potential barriers:

- Unstable funding, specialist shortages and unequal service coverage between municipalities.
- Weak cooperation between health, education and social services.
- Stigma, concerns about confidentiality and reluctance to seek support.
- Limited workplace engagement and difficulty reaching rural or socially excluded groups.

Success factors:

- Sustained financing and clear responsibility for delivering prevention and early support services.
- Trained professionals applying evidence-informed prevention and early intervention approaches.
- Confidential, non-stigmatising support accessible through everyday settings.
- Strong links between prevention, primary healthcare, mental health and addiction services.
- Adapted outreach and a combination of remote and in-person delivery.
- Regular monitoring using existing programme and service reports.

Suggested monitoring indicators:

- Number of municipalities providing early intervention activities, using existing programme reports.
- Number of people receiving early intervention or smoking cessation support, reported separately by service type from existing service records.
- Numbers starting and completing early intervention programmes, using existing programme reports.

3. Conclusions and key messages

Non-communicable diseases remain a major public health challenge across Europe, placing a substantial burden on individuals, communities and healthcare systems. The assessment carried out in four EU countries (i.e., Croatia, Greece, Italy and Lithuania) highlights a common conclusion: while national strategies and prevention initiatives are in place, further efforts are needed to translate policy commitments into sustained, accessible and equitable action. Strengthening NCD

prevention requires not only effective policies, but also the capacity, resources and cooperation necessary to implement them consistently and reach the populations most in need.

The findings show that the four countries have established important foundations for prevention, including national health strategies, screening programmes, health promotion campaigns and initiatives addressing behavioural risk factors. Promising practices demonstrate the value of delivering prevention through everyday settings, such as schools, primary healthcare services and community facilities. Examples include Croatia's community-based physical activity initiatives, Greece's Sport for All programmes and smoking cessation services, Italy's school-based health promotion and community healthcare models, and Lithuania's structured cardiovascular risk assessment programme. These experiences offer practical lessons for other Member States seeking to strengthen their own prevention systems.

However, the existence of policies and programmes does not automatically ensure their effective implementation or equitable reach. Across the countries assessed, persistent challenges include insufficient and unstable funding, workforce shortages, fragmented cooperation between sectors, uneven geographical coverage and limited monitoring of implementation and outcomes. Rural residents, socioeconomically disadvantaged populations and other underserved groups may face additional barriers to accessing preventive services. These inequalities highlight the need to move beyond general awareness-raising towards targeted interventions that address the practical and structural factors influencing participation in prevention.

The eight public health guidelines suggested in this document respond to these challenges by identifying two priority areas for each country analysed. In Croatia, the focus is on bringing preventive services and inclusive physical activity opportunities closer to rural communities and modernising school physical education. In Greece, the priorities are to strengthen community-based physical activity and improve access to smoking cessation support. In Italy, the guidelines emphasise systematic NCD prevention in schools and kindergartens, alongside corporate obligations to foster healthier food environments. In Lithuania, the priorities are to increase participation and continuity of care in cardiovascular prevention and strengthen coordinated tobacco and alcohol prevention and early support.

Despite their different national contexts, these recommendations share several overarching principles. First, prevention should be integrated into existing health, education and community structures rather than delivered primarily through isolated or short-term initiatives. Second, interventions should be inclusive and adapted to local needs, with particular attention to vulnerable populations facing geographical, socioeconomic, informational or other barriers. Third, prevention should combine awareness and education with practical opportunities for behaviour change, early identification of health risks, appropriate referral and continued support. Fourth, cooperation between health services, education providers, local authorities, civil society organisations, the private sector and other relevant stakeholders should be strengthened to improve coordination and extend the reach of interventions. This should be accompanied by clear accountability mechanisms for relevant actors, including food businesses, to ensure that their practices support public health objectives. In particular, companies should be subject to appropriate obligations regarding the marketing, formulation and availability of food products, helping to create healthier food environments and reduce exposure to unhealthy food marketing.

Sustained implementation also requires adequate funding, a skilled workforce, clear institutional responsibilities and systematic monitoring. Establishing measurable indicators for programme coverage, participation, retention and relevant health behaviours can help authorities assess progress, identify gaps and adjust interventions in response to local needs. Monitoring should, where feasible, include disaggregation by sex, age, geographical area and socioeconomic circumstances to determine whether prevention programmes are reaching different population groups equitably. Sharing implementation experiences and lessons learned between Member States can further support policy development and encourage the adaptation of promising practices to different national settings. Accountability should also extend to the implementation of policies and the responsibilities of relevant actors. Clear requirements, transparent reporting and effective monitoring and enforcement mechanisms are needed to assess compliance and ensure that public health commitments translate into measurable action. Where relevant, this includes monitoring food businesses' compliance with requirements concerning food marketing, product formulation and the availability of healthier options.

Overall, effective NCD prevention requires a shift from fragmented and predominantly reactive approaches towards coordinated, continuous and people-centred prevention throughout the life course. By combining strong policy frameworks with accessible community-based action, intersectoral cooperation and a sustained commitment to reducing health inequalities, Member States can strengthen their capacity to prevent NCDs and promote healthier lives. The Preventia guidelines provide a practical basis for translating these principles into context-specific action while supporting wider European cooperation and mutual learning.

Key messages:

- **Bridge the gap between policy and implementation.** Established strategies and prevention programmes need sustained investment, adequate staffing, clear responsibilities and effective implementation mechanisms to achieve their intended impact.
- **Make prevention accessible and equitable.** Particular attention should be given to rural and underserved communities and populations facing socioeconomic barriers, ensuring that access to preventive services and health promotion does not depend on where people live or their personal circumstances.
- **Embed prevention in everyday settings.** Schools, kindergartens, primary healthcare services, workplaces and community facilities provide important opportunities to promote healthy behaviours, identify risks early and reach people throughout the life course.
- **Turn awareness into sustained behaviour change.** Health education and communication should be complemented by practical support, accessible services, personalised guidance and appropriate follow-up.
- **Address key modifiable risk factors.** Policies should support healthier diets, regular physical activity, tobacco prevention and cessation, and the prevention of harmful alcohol consumption through coordinated and context-appropriate interventions.
- **Strengthen accountability for healthier food environments.** Establish clear obligations for food businesses regarding the marketing, formulation and availability of food products, supported by transparent reporting, effective monitoring and enforcement. Corporate

accountability should complement individual-level prevention efforts and help ensure that commercial practices support, rather than undermine, public health objectives.

- **Strengthen intersectoral cooperation.** Health authorities, healthcare providers, schools, municipalities, civil society organisations and other stakeholders should work together to coordinate prevention activities and improve their reach and continuity.
- **Monitor participation, equity and outcomes.** Routine data collection and evaluation should assess programme coverage, participation, retention and relevant behavioural outcomes, helping policymakers identify underserved groups and improve implementation.
- **Promote European cooperation and knowledge exchange.** The experiences of Croatia, Greece, Italy and Lithuania demonstrate that promising practices can inform prevention efforts across Member States when adapted to national priorities, local capacities and population needs.

Ultimately, strengthening NCD prevention depends on making effective preventive action a sustained and integral part of public health systems and community life, with equity, continuity and measurable impact at the centre of implementation. It also requires clear accountability for all relevant actors, including businesses whose practices influence health-related behaviours and food environments, to ensure that public health objectives are reflected in both policy implementation and commercial practices.



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