



World Health
Organization

REGIONAL OFFICE FOR Europe

Regions for Health Network Twenty-third annual meeting report

Achieving a healthy, sustainable society: the
need for integration, inclusion and coherence at
international, subnational and regional levels

Kaunas, Lithuania, 22–23 September 2016





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Abstract

The 23rd annual meeting of the WHO Regions for Health Network took place in Kaunas Region, Lithuania, on 22–23 September 2016. The main theme was the integration of efforts at international, national and subnational levels to achieve the objectives of Health 2020 and the 2030 Agenda for Sustainable Development.

The meeting included sessions reviewing the relationship between Health 2020 and the 2030 Agenda; action at regional level within countries to address Health 2020; aspects of health and the environment; recent efforts to transform health care delivery; findings from recent studies on intersectoral collaboration; and the implications at regional level of the recently agreed Strategy on women's health and well-being in the WHO European Region.

The meeting also provided an opportunity for network members to hear about each other's recent experiences and progress with the agreed programme of publications, and to consider how better to work with other parts of the WHO family, and in particular the Healthy Cities Network.

Keywords: DELIVERY OF HEALTH CARE, HEALTH PLANNING, HEALTH PRIORITIES, HEALTH SERVICES, HEALTH STATUS INDICATORS, INTERNATIONAL COOPERATION

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Edited by Nicole Satterley

Book design by Marta Pasqualato

Printed in Italy by AREAGRAFICA SNC DI TREVISO GIANCARLO & FIGLI

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List of abbreviations

CAH	Community Action for Health
EHP	European Environment and Health Process
EU	European Union
EUPHA	European Public Health Association
FMC	Family Medicine Centre
GP	general practitioner
HPU	health promotion unit
NCDs	noncommunicable diseases
NGO	nongovernmental organization
NRW	North Rhine-Westphalia
PFA	perfluoroalkyl acid
PHC	primary health care
PSB	Public Services Board
RCHP	Republican Centre for Health Promotion
RHN	Regions for Health Network
SDG	Sustainable Development Goal
UNECE	United Nations Economic Commission for Europe
UNEP	United Nations Environmental Programme
VHC	village health committee
WFGA	Well-being of Future Generations Act



Preface: rationale for the meeting

The World Health Organization (WHO) Regions for Health Network (RHN) works to improve health and well-being through prioritizing equity, developing strategic alliances and fostering good governance. Its members represent 25 regions from 20 countries across the WHO European Region.

In 2012, the RHN committed itself through the Göteborg Manifesto (1) to implementing Health 2020 at the subnational level of governance. Recent activities in support of this include: a study visit on sustainable development and health; a summer school on advocacy and translation for different audiences of evidence on intersectoral action for health equity and well-being; the organization of workshops in the most relevant public health for a; and a number of publications in the successful RHN case study series.

Following the endorsement of the United Nations Sustainable Development Goals (SDGs) in September 2015, the RHN wants to position itself as the leading technical network advising technical actors and political decision-makers in the field on how to implement health aspects of the SDGs at the regional level of governance. This meeting therefore welcomed decision-makers, politicians and regional managers to join discussions on how to make progress on these issues.

The meeting's objectives included exploring how best to integrate actions in support of Health 2020 and the SDGs across government and society, as well as through different levels of administration. It included a presentation on the newly agreed Strategy on women's health and well-being in the WHO European Region (2), and discussion on how this might be implemented at the subnational level.

In addition, the meeting offered an opportunity for RHN members to: review progress within the network since the previous meeting; discuss the opportunity to conduct a mapping exercise on intersectoral action at subnational level; review options for improved collaboration with the Healthy Cities Network; and consider future activities.



Introduction

The 23rd annual meeting of the RHN was held in Kaunas Region, Lithuania, from 22 to 23 September 2016, with a range of participants from 30 regions and 23 countries taking part (see Annex 1).

Dr Francesco Zambon, Policy Development Officer at the WHO European Office for Investment for Health and Development (Venice, Italy) and RHN focal point for the Kaunas Region opened the meeting and welcomed all participants.

He also thanked the following bodies for hosting the meeting:

- Kaunas Region Development Council
- Kaunas Region Development Agency
- Kaunas Health Promoting Region Working Group
- Kaunas Health Promoting Region Advisory Group
- Kaunas District and Kaunas City Municipalities.

Professor Irena Misevičienė of the Lithuanian Sports University, member of the Health Advisory Board for Lithuania and RHN Focal Point for the Kaunas Region welcomed all present to the first RHN annual meeting to be held in Lithuania, noting the attendance of the WHO Regional Director for Europe Dr Zsuzsanna Jakab for the first time in recent years. Lithuania has been active since the 1980s in many WHO networks, and Professor Misevičienė specifically mentioned various participants by name, including WHO headquarters representatives, ministers and holders of political offices, thanking them for their attendance and support of the Kaunas Region's engagement in the RHN. She also thanked WHO for its support.

Dr Piroška Östlin, Director of the Division of Policy and Governance for Health and Well-being of the WHO Regional Office for Europe introduced the opening session, adding her welcome to the regional ministers, ranking officials, mayors and the Regional Director for Europe. She recalled the emphasis placed at the recent meeting of the WHO Regional Committee for Europe on the role of regions in implementing both Health 2020, the policy framework of the Region (3), and the United Nations SDGs. Vertical integration at national, regional and local levels would be vital in making progress and Dr Östlin noted that this Kaunas Region meeting would discuss specific collaboration between the RHN and the Healthy Cities Network.

Dr Juozas Olekas, Acting Minister of Health of Lithuania welcomed those present to Raudondvaris Castle, noting that the venue itself was an example of what can be achieved by acting together. It had been restored to new life after years of neglect, with help from European Union (EU) Structural Funds, which in a sense meant with the help of all the citizens of the EU.

The Göteborg Manifesto adopted by the RHN echoes this aim of joint endeavour, with members committing themselves to work together using new methods in order to increase equity and improve health governance in accordance with the values and principles of the Health 2020 strategy and across the whole health agenda, by paying more attention to “environmental, social and economic determinants which can foster or damage health” (1).

The 66th session of the WHO Regional Committee for Europe in September 2016 saw a similar commitment to the implementation of the SDGs. Inequalities in health are diminishing, but still exist within countries. Dr Olekas emphasized the role of the RHN in promoting working together, to ensure the focus of politicians, institutions, organizations, professionals and the whole of society, ready for action. The meeting would be a chance to assess progress, share experience and mark out the way ahead.

Dr Olekas warmly thanked the Regional Director Dr Zsuzsanna Jakab for her attendance and the Kaunas Region for organizing the event, mentioning in particular Mr Valerijus Makūnas, Mayor of Kaunas District Municipality, who instigated the region's members of the RHN, and expressed his hope for a very productive meeting.

Dr Jakab thanked the Kaunas Region and Lithuania for their welcome and for hosting the meeting. She commended Lithuania for its recent award for work to combat tobacco, as well as its progress in integrating health promotion into the health system and on tackling noncommunicable diseases (NCDs), and expressed gratitude for the country's support in hosting the 65th session of the Regional Committee for Europe in 2015. She recalled the contribution of Prof Grabauskas on the WHO Executive Board, reminding participants of when the then Regional Director for Europe Dr Asvall welcomed Dr Olekas as the first health minister of an independent Lithuania, in the early 1990s.

In Dr Jakab's view, the diversity of the European Region is a strength to be treasured and protected, as well as a platform for progress. Health inequality is subsiding but challenges continue to exist, and the need remains to work together. Regions have a special role to play through being able to be closer to their populations than national governments, as well as through their integrating role. They can also offer examples to national governments of how progress could be achieved. The aim is to engage more regions in this work and one mechanism would be through agreeing a Memorandum of Understanding with the EU's Committee of the Regions. Another method would be to engage politicians more. Dr Jakab invited participants to consider these suggestions, noting that the meeting would address many important issues, but would also include music, in the hope that some of the essential aspects of music – creativity, imagination, expressing a commitment to continual practice, to become better – would be reflected in the meeting's sessions. She recalled Hemingway's definition of courage – grace under pressure – and thanked the RHN for both its courage and grace.

Mayor Makūnas added his welcome, noting the important historic venue. The population of Kaunas Region is relatively young, and growing; the average age is 39, with a life expectancy of its inhabitants of 2 years above the national average. In 2013, Kaunas Region formally joined the RHN; since then, the work on subnational implementation of Health 2020 has been intensified and, more recently, has incorporated elements of the United Nations SDGs. Kaunas Region is aiming to mobilize all sectors of society in support of its public health agenda, with health now higher on the political agenda. New ideas are being taken up, including lessons learned from international experience.

Day 2 of the meeting was opened by the vice mayor of the Kaunas City, Mr Vasilijus Popovas, who welcomed the RHN to the Kaunas City Council Chambers.

Section 1. SDGs: implementing a universal agenda at national, regional and local levels

1.1 INTRODUCTION

Member States of the WHO European Region are actively implementing Health 2020, the European policy framework for health and well-being (3). Its key strategic objectives include improving health for all, particularly by reducing health inequities and strengthening governance for health using a health-in-all-policies approach and calling for intersectoral health action. In September 2015, the United Nations General Assembly agreed the 2030 Agenda for Sustainable Development and defining 17 SDGs.

The 2030 Agenda for Sustainable Development (4) is a universal plan of action for people, the planet, prosperity, peace and partnership, which all countries and stakeholders will implement, acting in collaboration with each other. Addressing inequalities (leaving no one behind) is at the core of the 2030 Agenda. The SDGs have been in force since 1 January 2016, and will guide policy development and implementation over the next 15 years, providing a stimulus to rethink approaches to health and development.

1.2 HEALTH 2020 AND THE 2030 AGENDA: REALIZING CO-BENEFITS FOR HEALTH AND DEVELOPMENT

WHO Regional Director for Europe Dr Zsuzsanna Jakab said that she had heard in the recent meeting of the WHO Regional Committee for Europe Health 2020 being described as “prophetic”, because when adopted in 2012 it was a visionary framework that in a way anticipated the 2030 Agenda. It already included a focus on equity and a whole-of-government and whole-of-society approach, highlighting the critical relevance of social, economic and environmental determinants of health and linking investment for health with sustainable development.

The centrality of health as outcome, determinant and enabler for sustainable development is widely acknowledged. Smart, well coordinated work in the implementation of Health 2020 and the 2030 Agenda, with partnering across all sectors and across society, offers mutual benefits from investments in health and sustainable development.

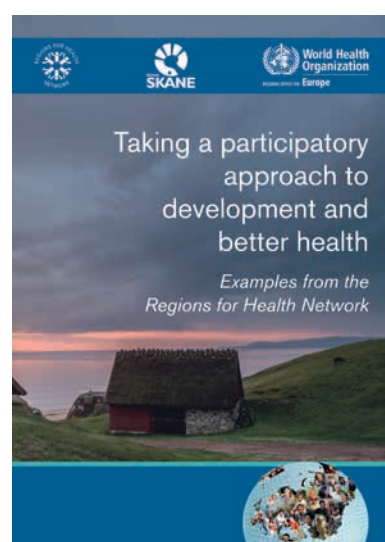
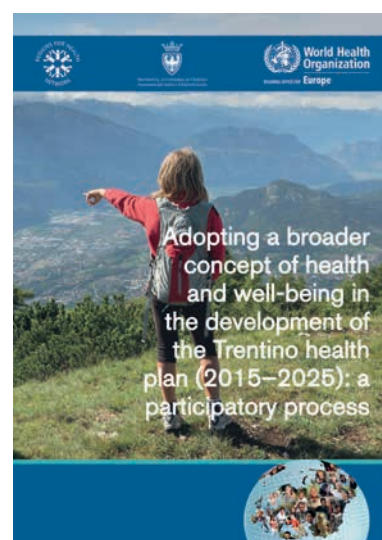
Comparing the language of Health 2020 and the 2030 Agenda shows how much they reflect similar values and objectives. Health equity and the whole-of-government approach in Health 2020 matches the idea of leaving no one behind and good governance in the 2030 Agenda. Social, economic and environmental factors are important in both bodies of work, as are resilience and empowerment. The rights- and gender-based approach exists in both frameworks, and Health 2020’s life-course approach is also implicitly present in the 2030 Agenda.

By addressing poverty (SDG 1) and hunger (goal 2); by improving quality education (goal 4) and decent working conditions (goal 8); by protecting the environment and changing production and consumption in a responsible way (altogether 9 out of the 17 SDGs); by acknowledging in all actions the principles of basic rights and equity, including gender equality (goals 5 and 10); by understanding the need for good governance and peaceful and secure environments (goal 16); and by allocating resources and investments in the private and public sectors, in line with the commitments made and targets set (goal 17), both the Health 2020 objectives and overarching SDG 3 – good health and well-being for all – can be achieved.

All European countries are now working on implementation of the 2030 Agenda, with many designing its goals into other plans and strategies, and setting up monitoring systems. This provides a strong basis for improving intersectoral action addressing social, economic and environmental determinants and health inequities. Dr Jakab welcomed submissions from WHO European Region Member States to the United Nations High-level Political Forum on Sustainable Development, the central body at which annual reporting of the 2030 Agenda takes place. At European Region level, a United Nations coalition on health is currently being developed, led by WHO Regional Office for Europe, to address all Health 2020-related issues in the context of the 2030 Agenda. Within countries, WHO Healthy Settings networks such as RHN, the Healthy Cities Network and others work with the Regional Office to share experiences and learning.

Dr Jakab outlined six RHN publications that reflect real practical experience and could help others.

1. The Autonomous Province of Trento has prepared a report on what a **participatory approach and governance for health** can mean when translated into action at regional level. It shows how participation of all sectors and stakeholders can be built in from the early planning stages, defining the vision and scope of a new regional health plan, and creating a strong focus on equity and empowerment, through improved health literacy (5).¹



2. Another publication shows how, recognizing that **health is central to development**, the two elements can be brought together in planning and implementation at regional level. The case reports from Skåne, Andalusia, Trento and Wales summarize important lessons learnt. The report concludes that the involvement of core social arenas is particularly important – such as the labour market, business, education and civil sectors – along with all groups and strata of the population(s). This approach will build social capital and the call is being made for a social investment paradigm, with health and well-being of the population are at the centre,

again with a particular focus on reducing inequities in exposure to risk, service provision and outcomes (6).

3. A report from another Swedish region, Västra Götaland, gives practical advice on how **health equity and “leaving no one behind”** can be mainstreamed into regional planning.

The region shows how identifying and exploiting so-called windows of opportunity can open the way to marry policy and political ambitions in framing problems and solutions. Clear mandates, goals and targets are seen as critical, together with institutional anchoring and legal and regulatory frameworks (7).



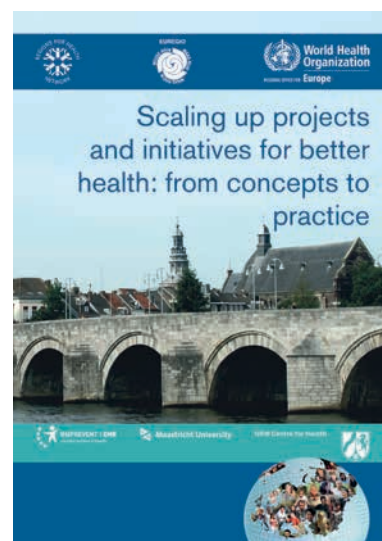
¹ See Subsection 2.2 of this report for more information on the participatory process.

4. A publication from Wales is in preparation, showcasing a groundbreaking piece of legislation called the Well-being of Future Generations (Wales) Act (WFGA), which aims to address the increasing health, social and economic challenges in a more effective and sustainable way. It highlights the important global, European, national and subnational windows of opportunity, combining the commitment to implement both Health 2020 and the 2030 Agenda, in order to ensure best attainable health and well-being for the present and future generations. It also highlights related case studies from other European regions and promotes the case for **investment for health and sustainable development**.²



5. A publication from the Veneto region sets out how to develop **an ambitious, flexible, integrated approach to improving health at regional level** (8). It draws on an international conference hosted by the region in December 2015. Since the 1990s the region has had a strong focus on an investment approach to health and development in its own policies and practices, along with a commitment to sharing regional experiences nationally and internationally. In 2003, together with the Government of Italy, the region supported the WHO Regional Office for Europe in opening the WHO European Office for Investment for Health and Development, which has since done much to contribute to European and global policy and strategy developments in the context of health and development.³

6. A document has been finalized by the Meuse-Rhine Euroregion in collaboration with North Rhine-Westphalia (NRW), Maastricht University and the RHN on **how to scale up projects**; that is, how to translate successful activities to reach the next level (9). It analyses and summarizes the experience of regions in 10 WHO Member States. Meeting the aims of Health 2020 and Agenda 2030 will require rapid transfer of interventions shown to be feasible and successful in pilot projects. The paper sets out systematically what needs to be done and will be very useful in regions and beyond.



To monitor the success of Health 2020, the WHO Regional Office for Europe has worked with Member States to develop indicators, improve data collection, and create a monitoring system, providing technical support and fostering collaboration where it can be helpful. The 2030 Agenda has created a new set of requirements and the Regional Office is considering further harmonization of indicators, reporting mechanisms and analysis across the Health 2020 and 2030 Agenda frameworks to assist Member States.

Regions have explicitly recognized the importance of windows of opportunity. When Health 2020 was adopted, it was not known that the 2030 Agenda would later exist. But the strategies, priorities, concepts and approaches underlying Health 2020 have provided excellent preparation for taking on the 2030 Agenda. The experience gained since Health 2020 was launched has put Europe in a good position to act quickly during the initial implementation stages of the 2030 Agenda – this is an historic opportunity that will not be repeated; as such, it is a time to share and use the lessons learned to date and to strengthen existing networks, using this opportunity to the fullest.

² See also Subsection 7.3 of this report. For more information on developments in Wales, see subsections 1.4 and 2.4 of this report.

³ For more information on developments in Veneto, see subsections 2.5 and 3.3 of this report.

The next stage is to develop a roadmap for the implementation of the 2030 Agenda, building on what already exists, to be presented to the WHO Regional Committee for Europe in 2017.

1.3 IMPLEMENTING A UNIVERSAL AGENDA AT NATIONAL LEVEL: THE CASE OF LITHUANIA

Acting Minister of Health of Lithuania Dr Olekas said that only a healthy society can create prosperity and develop successfully, and he too saw health and sustainable development as being intimately linked. Overall responsibility for meeting the SDGs lays with national governments, but these could not be met at the national level alone. The Constitution of Lithuania recognizes a national responsibility for health, but to meet these aims, effective governance and intersectoral working across society are essential.

Greater collaboration will be needed across different levels of government, civil society, the private sector and more widely, along with ownership and leadership at the country level, effective health governance, strengthened institutional and operational capacity and integration of the SDGs into national policies and priorities. To this end, Lithuania has established a National Commission for Sustainable Development, chaired by the Prime Minister and including representatives of all ministries, along with other relevant institutions. The Government has agreed four national priorities for sustainable development.

- Goal 1: end poverty in all its forms everywhere
- Goal 3: ensure healthy lives and promote well-being for all at all stages
- Goal 7: ensure access to affordable, reliable, sustainable and modern energy for all
- Goal 12: ensure sustainable consumption and production patterns

Dr Olekas noted in the present context the importance of Goal 3, within which three objectives were deemed to be of national priority.

3.4. Reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being.

3.5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

3.6. Halve the number of global deaths and injuries from road traffic accidents.

SDG 3 was already reflected in the Lithuanian Health Strategy (2014–2025), which had as a strategic goal the attainment by 2025 of the improved health of the Lithuanian population, as well as longer life and reduced health inequalities. There were four main goals – namely, to:

- build a safer social environment, reduce health inequalities and social exclusion;
- create a health-promoting physical environment for work and living;
- foster healthy lifestyles among the population and a culture of promoting them;
- guarantee provision of high-quality and effective health care focused on the needs of the population.

The strengths of the Lithuanian Health Strategy included the strong political commitment to action to improve the health of the Lithuanian population and to a whole-of-government and whole-of-society

approach and intersectoral actions; the fact that it was based on the provisions and values of Health 2020; and the commitment to principles such as universal coverage, social solidarity, social cohesion, equality of individual rights, participation of civil society in decision-making, continuity and sustainability of health care, responsible management, rational and effective use of resources, and accountability.

The Strategy is to be implemented through various specific programmes, including the Inter-institutional Action Plan under the horizontal priority “Health for All” within the National Progress Programme 2014–2020, and a number of high-level specialized programmes aimed at the improvement of population health.

The executive coordination function lies with the Ministry of Health, together with other ministries (Ministry of Social Security and Labour, Ministry of Education and Science, Ministry of the Interior and Ministry of Agriculture), within the limits of their competences and responsibilities. The implementation process also involves other ministries, different governmental institutions, academia, municipalities, business enterprises, nongovernmental organizations (NGOs) and communities and citizens. Additional financing and synergy in the implementation of the Strategy is assured by broad intersectoral collaboration through the State Health Affairs Commission.

The regional level is seen as playing a vital role. Kaunas Region became a Health Promoting Region in 2013 and in that year had joined the WHO RHN. The main goals of the region were better health for all, and implementation of the aims of Health 2020 and the SDGs. Initiatives supporting the implementation of the SDGs in the region included the municipal public health support programme, which aimed to promote healthy diets and physical activity, prevention of the use of addictive substances, promotion of mental health and prevention of disorders, initiatives on physical activity initiative, prevention of harmful behaviours and reducing the consumption of alcohol.

1.4 ALIGNING HEALTH AND SUSTAINABLE DEVELOPMENT AT REGIONAL LEVEL IN WALES

Ms Rebecca Evans, Minister for Social Services and Public Health of the Welsh Government, put the new (2015) Welsh legislation (the WFGA) into context, explaining that it was developed in parallel to the United Nations SDGs. It also followed a similar approach; using citizen participation both to create the new global development framework and to engage with the public through a two-year national conversation in Wales – asking people what mattered to them, their families and their communities, both now and in the future. Discussions took place in youth symposiums, classrooms, village halls, and at cultural and sporting events.

The WFGA focuses on improving the social, economic, environmental and cultural well-being of the Welsh population, and reflects the three interlinked dimensions of the SDGs: people, planet and prosperity. The WFGA and the SDGs can be used together to help Wales create a vibrant, healthy and sustainable society and global community over the coming years. The WFGA creates a legally binding common purpose, set out in seven ambitious well-being goals that public services must strive to achieve. These are for a prosperous, resilient, healthier, more equal and globally responsible Wales, with a vibrant culture, thriving Welsh language and coherent communities. These cross-cutting goals provide a clear steer for national and local government, local health boards and other specified public bodies in how to work together to improve well-being. The WFGA requires collective action through Public Services Boards (PSBs). These include local government, the local health board, the fire and rescue and natural resources authorities, and representatives from local NGOs and communities. The PSBs will develop well-being plans, reflecting an agreed agenda and agreed priorities and actions.

A real strength of Welsh legislation, reflecting an approach long recognized in public health, is the ambition to achieve a wide, shared understanding of the problems faced by populations and communities (such as issues relating to climate change, food, transport, green space and the built environment), their interconnections and how common solutions might be achieved.

To secure the benefits that will result from reducing dependence on motorized transport, for example, legislation developed in Wales in 2013 (the Active Travel (Wales) Act) seeks to encourage and increase levels of walking and cycling. The Environment (Wales) Act (2016) also reinforces this aspiration as it aims to increase the benefits of time spent in the natural environment, by managing Wales's natural resources in a more proactive, sustainable and joined-up way. In support of tackling climate change, it provides Welsh ministers with powers to put in place statutory emissions reduction targets, including at least an 80% reduction in emissions by 2050 and carbon budgeting to support their delivery.

To measure progress against the seven well-being goals and help set national well-being objectives, the WFGA requires the Welsh Government to publish and report against 46 national Indicators. It must also publish a report on future trends 12 months after each election to the Welsh Assembly. The report must take account of the United Nations SDGs and the impact of climate change in Wales. To improve accountability, new responsibilities have been placed on the Auditor General for Wales and a Future Generations Commissioner will act as a guardian for the interests of future generations in Wales and support the public bodies in implementing the legislation.

Reflecting public health principles, the WFGA recognizes that good health depends on concerted, collective action by government, local communities, public services, and private and voluntary sectors, as well as by individuals and their families. It requires the public services in Wales systematically to take into account the health implications of decisions, seek synergies, and avoid harmful health impacts in order to improve population health and health equity. It takes Wales a step closer to achieving the goal of health in all policies.

Sustainability and collaboration are central to Wales's approach to health and care. Its "prudent healthcare" philosophy encourages use of resources with careful attention to what is appropriate to the precise needs of each individual. The aim is to introduce new discoveries quickly, as appropriate, while recognizing that for many patients, simpler treatments can be just as good or better. This should improve health outcomes, quality and value. Together with the WFGA, it will help Wales to make progress towards a sustainable health and well-being system, shifting towards a more holistic, prevention-based approach to health.

The same ideas are behind the concept social prescribing, or community referral, currently being developed in Wales. This is where primary care services refer patients with social, emotional or practical needs to a range of local, non-clinical services. Good examples already exist, even in the most deprived communities, and the work has been well received by general practitioners (GPs).

1.5 WHAT YOUNG PEOPLE WANT – AT ALL LEVELS

Luke Rees said he was 19 and from a small place in Wales called Blaenau Gwent. For the last four years he had been a young ambassador, involved in a programme that aims to empower and inspire young people to become leaders through sport, to help encourage their inactive peers to become more involved in sport. However, his life had not always been straightforward. At age 11 he started suffering with mental health issues, and often was unable to attend school, scared of social interaction and sometimes even too

scared to leave his house. He felt he had to change his life and did so through sport, which enabled him to take his mind off other issues. He had since realized that many others had mental health problems, as one in four people in Wales suffers with mental health difficulties at some point.

Having found that sport can change lives, he started volunteering and realized that by helping others he was actually helping himself. So what, he asked, do young people need? Two things: opportunity and engagement.

Everyone wants better opportunities for young people. What is vital is that people do something together to create opportunities for young people to have a wide range of experiences for the future. Luke referred to the report entitled *The Wales we want* (10), which captured the results from a two-year long engagement process with the public, finding that young people felt there were no longer opportunities in Wales, with one participant even stating “most of my family members are unemployed”. This was reflected in Luke’s own town, where he had seen over 8000 people job seeking, with only 300 vacancies, and most of them offering low wages and temporary positions. He recommended that a wider range of opportunities be made available, including in agriculture, for young people leaving education early, along with alternative educational opportunities, including life skills and practical training to cater for those who find concentrating in school lessons challenging. Luke felt he had been “saved” through the establishment of a new employment support centre in his local area.

He said if local communities failed to engage with young people they would go elsewhere to work and live. The report *The Wales we want* said that didn’t want services to be shaped around them, but with them (10). Young people must be given the opportunity to engage in their communities and develop self-confidence and self-worth.

Luke expressed his hope that the Welsh WFGA would improve the situation, as young people don’t have the confidence to go out and look for opportunities; they often sit on the sidelines and wait for opportunities to come to them. The Act could create more opportunities by bringing people together to help take responsibility for dealing with local issues, with the PSBs well positioned to take action. This could include developing a workforce of young people and volunteers and investing in their development, by, for example creating allotments and then selling the produce, or creating sporting opportunities in disadvantaged communities to develop confidence. The PSBs should enable young people from the community to experience being in a board environment and encourage local people to make their voices heard.

Luke concluded that there is no silver bullet that will be the answer to deep problems. Everyone needs to take responsibility and act together, working with others. Important messages are to pay close attention, to take action locally, and to hold on to the belief that “we can do something” to make a difference. He reminded the attendees that it was crucial to invest in young people and allow them to have opportunities to speak in public, so they become confident and grow into the future leaders and community champions. Because without young people, where is the future?

1.6 KEY MESSAGES AND ACTIONS

In discussion on how to take forward the 2030 Agenda, a number of challenges and opportunities were highlighted. These can largely be summarized as falling within three broad headings: process, policy and monitoring. Under process, the main point raised was the need to establish ways to build capacity and capability to support the goals. Independent scrutiny is vital in ensuring coherence and

purpose. In the past, Agenda 21 (11) helped mobilize and sustain support for the green agenda; the same imperative and urgency are needed to support the new emphasis on social aspects.

Key messages included that:

1. roles need to be clear, particularly in the way they interact, including coherence between different levels (local, regional, national and international), to support advocacy, ownership and accountability
2. good communication is essential to support wider engagement;
3. tracking and mapping indicators need to be harmonized, to help break down siloed behaviours and support collaboration.

Actions might include those outlined here.

1. The RHN could set up a technical group to work with WHO on issues around process, coherence, and monitoring and evaluation, helping to bring Health 2020 and the SDGs into a single, mutually reinforcing policy framework; this might include a handful of people representing those most advanced in thinking and action.
2. The RHN should collate what has already been learned about bringing Health 2020 and the SDGs together and make it easily available.



Section 2. The subnational level: strong progress on key elements of Health 2020

2.1 INTRODUCTION

Dr Zambon expressed that it was important to maintain links between the RHN and other health organizations, such as the European Public Health Association (EUPHA), noting that the RHN would be organizing two public sessions at the EUPHA conference in Vienna in November 2016.

2.2 BROADENING THE CONCEPT OF HEALTH THROUGH A PARTICIPATORY PROCESS IN THE DEVELOPMENT OF A STRATEGIC HEALTH PLAN IN TRENTO

Italy has a national health service organized into local health units, run by the regions. Trento is one of 21 regions in Italy, with 500 000 inhabitants. It is in the northeast and has special autonomous status. Its health service consists of a single Local Health Unit, with four health districts. The province has 16 valley communities. Priority-setting and political governance are provided by the Health Council of the provincial government, mainly through the annual assignment of specific objectives to the Local Health Unit and ad hoc resolutions.

Up to the start of the latest planning cycle, in November 2014, the planning process had not involved public participation and was based on short-term objectives and goal-setting, aimed almost exclusively at the health sector. The conceptual model had been pathogenic, dealing with the consequences of diseases, rather than salutogenic, aiming to promote and protect health, and health was rarely seen as an asset, but rather as something to be restored once damaged.

Annual reports were rich in data on services and activity but sparse in information on population health, social determinants and the distribution of risk factors/resources in the community. In terms of modernizing the process, the challenges are therefore to: broaden the concept of health; highlight health promotion and the determinants of health; make the case for a health-in-all-policies approach in planning; build capacity for linking epidemiological analysis, prioritization, community participation and public health planning; orientate the planning to Health 2020, the SDGs and health in all policies; and introduce a participatory approach.

Participation is highlighted because it enhances social cohesion and so improves health; it strengthens democracy, citizenship and civil society; it promotes health literacy and accountability for health; and it builds trust between the health system and other sectors. Crucially, it also improves the quality of the final product and makes implementation easier.

To this end, the framework of the annual report was radically changed; it is no longer a report on health services, but instead a population health profile. To support the changed approach, a training course on public health planning was organized in collaboration with the RHN and the WHO European Office for Investment for Health and Development (Venice). Politicians are involved throughout the process, including the president of each province and the assembly of local mayors.

In stage two (the second year), a working group was set up to develop the strategic health plan, including both the health and social sectors, together with a Health in All Policies Commission and involving all sectors of the regional government. The working group produced a first draft of the Strategic Health Plan 2015-2025.

In year three, comments and suggestions were collected through a web-based platform, initially from technical stakeholders, then from the general public, and face-to-face meetings were also arranged. This work fed into a second draft of the plan. Special arrangements were put in place to reach those less able to participate, such as older people with less access to web-based methods.

Data collected to check who had taken part in the process found that, while the educational level of participants was somewhat higher than average, there was good representation by age and gender, but nil involvement of immigrants, although they made up 10% of the population. After a first attempt to remedy this failed, a successful meeting to collect input, comments and proposals on the health plan was organized using open space technology and 20 health mediators as qualified interpreters.

Overall, 1200 comments and proposals were received on the internet platform, 35 meetings took place in local communities and 22 meetings were held with technical stakeholders, such as departments of the provincial government, the Local Health Unit and social services. Two thirds of the suggestions were integrated into the final draft of the document and all participants received detailed feedback.

The key messages on participation were that data are hugely helpful in making the case for broadening people's thinking about health and health policies; champions, political support and experts in participation are vital; and feedback to people on what is happening encourages participation and ownership. In addition, participation improves the quality of the product, ownership, and engagement with other agencies, but it is important to check continually that nobody is left behind.

2.3 MOBILIZING POLITICAL SUPPORT FOR HEALTH IN NORWAY

Mr Knut-Johan Rognlien of the Public Health Unit in Norway's Østfold County Council described how at the end of the 1990s pressure on financial budgets caused Norwegian local government bodies to neglect areas that were not required by law to be supported, and as a result public health activities came under threat. In autumn 2006, a government White Paper was launched looking at the future of the regional level, in terms of the number of regions and their responsibilities and governance. This offered a window of opportunity for public health, and consideration of whether it might be possible to create a new responsibility for public health at regional level.

Østfold County Council and the Norwegian Healthy Cities Network took part in an open hearing in the Norwegian Parliament and won its support for this idea. On the back of this in December 2008 a consultation document was distributed to all municipalities and regions, asking if they agreed that public health should be an obligation for the regions. After intensive lobbying, almost all the regions and around 150 municipalities supported a public health act for the regions. The regional politicians of Østfold had meetings with ministers, undersecretaries, members of parliament and key members of their own parties. The lobby mobilized all the regions, which in turn mobilized municipalities in their region. Text was composed that could be copied and used in the consultation, making it easier for the municipalities to respond.

However, when the proposed Public Health Act for Norwegian regions was launched in April 2009, it did not include what the lobby had been requesting. A new lobby was organized, and again secured the Parliament's support. In October 2010 the Government issued another consultation document, asking if public health also should be a mandatory task for the municipalities and the Government. It proposed that the Public Health Act be based upon four principles: health in all policies, sustainable development, the precautionary principle and health equity. However, it omitted empowerment and applied the health-in-all-policies element only to the central government health authorities.

A further lobby was organized, mobilizing over 100 municipalities and almost all the regions, arguing that empowerment must be included as a fifth principle and that the scope must include all central government authorities, not only the health ones, because lack of national coordination is a big challenge for local and regional government and many of the important means and instruments for strengthening public health are controlled by other ministries.

In June 2011 Parliament adopted the bill, with changes ensuring that the health-in-all-policies concept applies to the entire state administration and including participation (not empowerment) as a fifth principle. The Public Health Act came into force in 2012.

2.4 MAKING A DIFFERENCE: INVESTING IN SUSTAINABLE HEALTH AND WELL-BEING FOR WALES

While overall health in Wales has improved, a great deal more remains to be done. For example, only a third of adults eat the recommended five or more portions of fruit and vegetables a day and only a third of primary school children walk to school. There are already known interventions, approaches and tools available for improving this situation but there is a need to choose and combine these to the best effect.

Legislation can have a powerful impact, influencing behaviours and attitudes. The Social Services and Well-being (Wales) Act (2014) aims to make health and social services work better together, act early to prevent problems and stop existing problems from getting worse, as well as to see the individual receiving services as a key partner. The WFGA is another important example, calling for considering the sustainable development principles in all decisions and actions across all sectors.⁴

This also links to another key approach in Wales – the “prudent healthcare” principles, which focus on three areas of action:

1. reducing unnecessary and inappropriate tests, treatments and prescriptions and ensuring people are able to make informed decisions about the care they receive;
2. radically changing the outpatient model, making it easier to access specialist advice in primary care settings; and
3. developing strong public service partnerships and integration to provide the right care, in the right place, at the right time.

Growing emphasis is placed on co-production as a basis for designing services and on judging success in terms of relevant outcomes. This focus on the individual aims to exploit the fact that people are often the best experts in judging their own circumstances and conditions and is intended to help people move from a passive dependence on health services towards actively taking responsibility for their own health.

There is recognition that people’s chances of good health vary greatly. The next annual report of Wales’s Chief Medical Officer will focus on the social gradient in health, highlighting that outcomes depend not just on the clinical care and treatment offered to patients but on the wider aspects of a person’s life.

The report *Making a difference: investing in sustainable health and well-being for the people of Wales* (12) from Public Health Wales summarizes evidence and expertise to support relevant cost-effective interventions that prevent illness, promote, protect and improve health and reduce health inequalities. Its timing reflects the availability of evidence for action at a time at which challenges are increasing, and a sense that there is a willingness and capability to take action in Wales. The report draws on recent

⁴ See Subsection 1.4 of this report.

evidence, professional and expert opinion and is not intended to be exhaustive or comprehensive, but rather to focus on the most beneficial areas for intervention, in line with Welsh priorities for health and well-being. The publication consists of an executive summary, a supporting evidence report and a series of eight infographics setting out key health challenges for Wales and suggesting evidence-based solutions which are cost-effective or have return on investment. Its three priority themes and 10 action areas are set out in Box 2.1 and linked to the Welsh context (see Fig. 2.1).

Box 2.1 Priority themes and action areas in the Welsh Report *Making a difference: investing in sustainable health and well-being for the people of Wales* (12)

Building resilience across the life-course and settings

1. Ensuring a good start in life for all
2. Promoting mental well-being and preventing mental ill health
3. Preventing violence and abuse

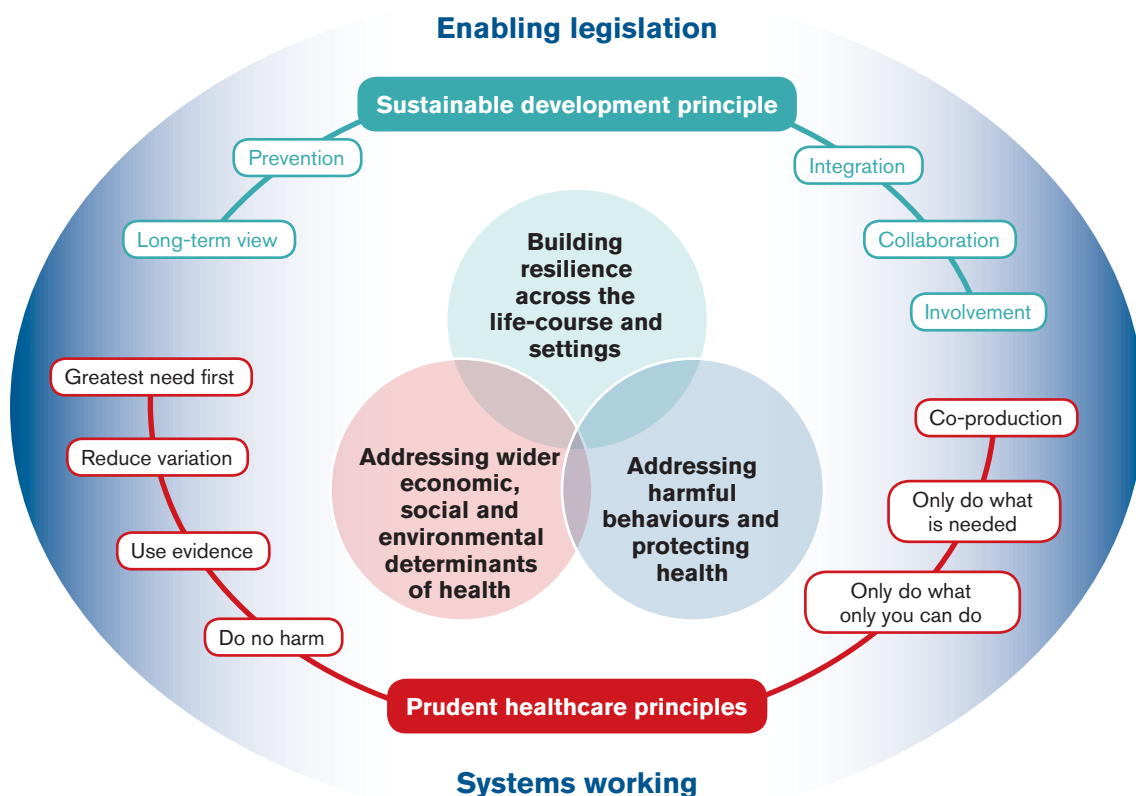
Addressing harmful behaviours and protecting health

4. Reducing the prevalence of smoking
5. Reducing the prevalence of alcohol and substance misuse
6. Promoting physical activity
7. Promoting healthy diet and preventing obesity
8. Protection from disease and early intervention

Addressing wider economic, social and environmental determinants of health

9. Reducing economic and social inequalities and mitigating austerity
10. Ensuring safe and health promoting natural and built environment

Fig. 2.1. Welsh priorities for public health within a favourable legislative and policy context



Source: Public Health Wales NHS Trust (12).

The target audience for the report includes decision-makers and policy-makers in national and local governmental roles, senior leaders and professionals with public health responsibilities or who can influence health and well-being across local communities, third sector and private organizations. It emphasizes the role of social and economic determinants of health, the strong evidence for a preventative approach in terms of value for money and wide-ranging long- and short-term benefits and the fact that Wales is in a unique position to seize the opportunity to take effective action. Another enabling development in Wales has been the effective cross-sector work, embedded through jointly funded posts between health and housing; health and criminal justice; health, physical activity and sport as well as a wide cross-organisational platform, focusing on the early years development and challenges.

The report has already been used to inform a workshop involving representatives from a range of government departments on how they can take action.

2.5 INTEGRATED HEALTH CARE: A PATIENT-CENTRED APPROACH IN VENETO⁵

The Italian national health service guarantees a basic basket of benefits through public funding, collected through taxation. This is the minimum level of public health services that must be delivered and is granted uniformly across the country. Each region has to provide the national minimum, using national resources. Additional services can be provided by each region but only by means of regional (not national) resources.

Veneto has about 5 million inhabitants, making up 10% of the Italian population, and 22% of the region's population are aged 65 years and older. Italy is an ageing country with one of the longest life expectancies in Europe (over 80 years for both men and women). The region has protected spending on health in recent years, spending rather less per capita than most of its European neighbours and less than the average spent in Italy as a whole. Around 20% of its population account for about 75% of the costs, due mainly to multi-morbidity.

A Regional Health Plan for 2012–2016 aimed to address the changing pattern of needs through reorganization of the hospitals and creation of a new intermediate level of care, followed by primary care reorganization. The region had a relatively low number of beds but a large number of hospitals (some quite old), which were reorganized into three levels. Clinical networks were strengthened, such as the oncological network and neurological networks for stroke and dementia. Primary care is being radically reformed, with the creation of medical hubs in teams integrating GPs with nurses and other professionals. Telemedicine and the electronic health records are other initiatives in the pipeline.

With needs increasing faster than resources, efficiency and effectiveness must improve through service transformation, developing integrated services with a people-centred approach. Patients report that care for people with NCDs is too often fragmented, hard to access, inefficient and unsafe, as well as very expensive. For example, one elderly lady with dementia might not only experience confusion resulting from the condition but also the confusing task of dealing with a system that in a year delivers 66 services from 52 different health professionals, and among them 37 nurses. The policy aim is therefore to develop integrated care based on the triple aim of improving population health, care experience and cost-efficiency. The care model needs to be population-focused but person-centred, targeting people who are at high risk or becoming so.

⁵ For more information on this topic and on the Veneto region, see WHO Regional Office for Europe's 2016 publication on the Veneto model (8).

To support this model, Veneto used a risk-adjustment tool to analyse the case mix in its population. It combines claims data provided by provider units, measures of disease prevalence and disease burden and estimates of future probabilities of adverse events to identify different levels of need in the population, from the lowest stratum comprising people in good health through to the highest containing those with the biggest prevalence of multi-morbidity and NCDs.

Another change has been the development of a new nursing role: the care manager nurse in primary care, who in charge of coordinating all providers and becoming the reference nurse for the patient, radically reducing the chances of 37 nurses being involved in the care of the one old lady in the example above.

These changes are being piloted before being phased in. Preliminary evaluation shows that satisfaction was higher among patients and nurses than among GPs, who may need more support. The region aims to present the results on hard outcomes, such as hospitalization and use of health services, at the next RHN meeting.

2.6 INCORPORATING EQUITY IN REGIONAL HEALTH PLANS IN VÄSTRA GÖTALAND

The main responsibilities of the Västra Götaland region are health care and regional development. Overall health is generally good, but the health gap is increasing. The region's Strategy for Growth and Development, VG2020, aims to create a region for everyone: "All inhabitants of Västra Götaland shall have good opportunities to develop through education, training, work and good communications. Exclusion must be combatted and social and economic differences reduced. Diversity among inhabitants is a resource that needs to be better utilized." (13:6)

In 2013 a regional paper entitled *Together towards social sustainability* identified issues and actions relevant to engaging stakeholders in improving health equity. Among many points, it noted that "Children and young people who have small socio-economic resources have a greater risk of leaving compulsory school without having achieved passing grades" (14:5) and "Persons who do not meet the entry requirements for upper secondary school have increasing difficulty in finding work in a labour market with increasing demands for formal qualifications" (14:6). This clearly marked out school failure as a factor that influenced individuals' social prospects and future life. In the region there is a 9-year difference in life expectancy between the best and worst, and a short education is associated with a short life. The region is not solely responsible for education, but can use regional influence, working in conjunction with others to help children where they need it, for example through regional psychiatric services.

Accordingly, the Public Health Committee sent a report to the Regional Executive Board in December 2015 showing the urgency of tackling school failure. The Board responded by charging the Committee to report back suggestions of broad regional actions entailing cooperation that could reduce school failures. In February 2016 an initial conference took place on the matter, with high-level participants from both regional and local levels.

A Commission for Region Västra Götaland was created to address the issue. Its steering group included the Healthcare Director, Regional Development Director and Communications and Public Affairs Director, and was tasked with producing a joint action plan for reducing school failures. That task is now in hand, with continued political support on different levels, working with the 49 municipalities. Västra Götaland is very interested in exchanging experiences with other regions that have a similar interest in the relationship between health and education.

2.7 KEY MESSAGES AND ACTIONS

In reviewing progress at regional level in responding to Health 2020 (and increasingly also to the SDGs), a number of points emerged. The European Region is extremely diverse and the regions it includes are very different in scale and competences. This diversity itself creates an opportunity, as every region will behave differently, resulting in a wealth of experimentation and experience on almost any topic. However, the RHN hears only sporadically about what is happening in member regions and so may not be capturing and sharing important learning in a systematic way.

Key messages included those listed here.

1. Don't always try to start from scratch. There is a great deal of experience from elsewhere and it is increasingly easy to find – communicating with the RHN itself and WHO can be a way to learn about what others are already trying.
2. Inequalities are difficult to tackle and systems often resistant to change, therefore every tool should be considered. Technical networks are important, but so are political channels and these should be used where possible. Government can be encouraged to work as an enabler, making it easier for people to achieve their own goals and become healthy. The public are a huge source of ideas and influence, and getting people involved can evoke changes in the system and improve policies and outcomes.
3. Problems change and evolve, and so must systems. Designing policy and services should be seen in terms of creating a continuous, virtuous cycle, with progress systematically assessed.

Actions might include those outlined here.

1. The RHN should establish a way of collecting continual updates from members on innovative processes.
2. RHN members should consciously create ways of monitoring systems to ensure no one is left behind and methods to compare their approaches.

Section 3. Creating resilient communities and sustainable environments in Europe

3.1 INTRODUCTION

Valuable discussions have taken place with the Steering Group of the RHN and the WHO European Centre for Environment and Health in Bonn about what the RHN might do in relation to the interface between environmental and health concerns, using the Centre's extensive experience of working at the subnational level.

3.2 ENVIRONMENT AND HEALTH IN EUROPE: STATUS AND PERSPECTIVES

The WHO European Centre for Environment and Health was established in 1991 as part of the WHO Regional Office for Europe and operates as a scientific centre of excellence, developing policy advice and international guidelines, and providing assistance to Member States.

It is estimated that environmental factors account for over 20% of total preventable deaths globally, and even in the European Region where conditions are better, it has been estimated that in 2012, 15% of deaths and 16% of healthy life years lost could have been prevented by environmental improvements, mainly in relation to NCDs. A 2014 study of six countries in western Europe found that the most significant risk factor was fine particles in the air (15).

There is now a deeper and more sophisticated understanding of how health and the environment interact, with growing attention to the urban environment (e.g. the role of green space and transport policies), as well as mixtures of exposures, well-being and quality of life (e.g. the impact of factors as diverse as odours and the property market), waste, industrially contaminated sites and so-called bad environments, where a multiplicity of factors together affect people's life and health. There is a better understanding of the economic dimension and the effectiveness of interventions.



The European Environment and Health Process (EHP) was initiated in the 1980s to eliminate the most significant environmental threats to human health. It is a partnership of the health and environment ministries of the 53 Member States of the WHO European Region, the United Nations Economic Commission for Europe (UNECE), the United Nations Environmental Programme (UNEP), the Youth Coalition and other NGOs and intergovernmental organizations. The WHO Regional Office for Europe provides the Secretariat for the EHP and the initiative has developed through a sequence of European ministerial conferences on environment and health, with the next due to take place in 2017 in Ostrava, Czech Republic. Over time new issues such as energy and waste have been introduced to the discussions, which now go beyond health to take into account well-being and sustainability.

Although there has been some slow progress in tackling environmental risks, they remain a major source of disease, and in some cases are worsening. There is a need to continue building a solid evidence base and improve work on communication, engaging with stakeholders and creating the economic case for action. Many environmental determinants can be addressed at regional and local levels and the WHO European Centre for Environment and Health in Bonn is willing to explore collaboration at those levels and the potential involvement of regions in the upcoming ministerial conference.

3.3 A CASE OF WATER CONTAMINATION IN VENETO⁶

Head of the Prevention Directorate in the Veneto region, Dr Francesca Russo presented a case study that remained the cause of controversy among politicians, the public and the press in Italy. The problem related to perfluoroalkyl acid (PFA) substances, which are human-made, mainly by factories producing materials such as Gore-Tex® and Teflon™. They were detected in surface- and groundwater in the Veneto region in 2013, although the contamination had been occurring for 30 years. Some 127 000 people had been exposed to the risk.

This was a potential environmental disaster, with drinking and irrigation water contaminated and humans exposed to harm as a result of raised cholesterol and blood pressure, increased cancer risk (kidney, testicle) and damage to the immune system, with effects on thyroid hormones and the metabolism of the liver and kidney.

The discovery presented a complex problem. Not only had it been going on for 30 years, there was also no agreed international threshold for what constituted a safe level of exposure. There was clearly a major problem but great uncertainty regarding the effect on humans. The response might entail enormous costs and there were issues around confidentiality of information, the factory's financial responsibility, and media reactions.

The Veneto region's response consisted of a mix of immediate actions and longer-term measures. The former included: setting up an ad hoc response committee; action by the relevant institutions aimed at risk management; informing the population; stopping the source of pollution; and making drinking water safe. Actions over the longer term included epidemiological studies, biological and serological studies, setting norms for the future and instigating legal action.

The Prevention Department put in place a process to create an integrated multisectoral response, involving the Veneto Regional Authority, the regional Technical Committee, the Regional Agency for Environmental Prevention and Protection, the Italian National Institute of Health, the agricultural

⁶ For further information on the Veneto region, see WHO Regional Office for Europe's 2016 publication on the Veneto model (8).

and legal sectors, the private sector water companies, the health services and GPs, as well as ad hoc task force groups and the WHO offices in Bonn and Venice.

Action focusing on protecting public health included: making drinking water safe by removing PFA substances, identifying contaminated areas, mapping contamination risk levels, carrying out biomonitoring surveillance, working to reduce PFAs in the environment, issuing guidelines for irrigation water and the food-chain industry, and taking care of the exposed population. Serological analysis showed the population concerned to have a far higher concentration of harmful substances. The introduction of carbon filters dramatically reduced drinking-water contamination.

Veneto noted that PFAs are the 5th risk factor for NCDs (alongside tobacco, alcohol abuse, unhealthy diet and physical inactivity) and reviewed around 80 000 people (aged 14–65 years) by means of an ad hoc questionnaire and biomonitoring surveillance, linking to existing screening for cardiovascular diseases (CVD) and running targeted population campaigns, trying to ensure no-one was overlooked. This offered an opportunity to improving health awareness, and to change attitudes and behaviour around health.

Assessing the lessons learned from this case study in terms of how best to establish capability for an emergency response, the region noted that the following factors supported rapid, effective action. Good intersectoral mechanisms were already in place. The mandate for action was clear, as were the priorities, and political commitment was readily available. The agencies worked in a cohesive way, with transparency in their actions, which was very important because of the legal aspects of the case. Difficulties experienced included a lack of relevant evidence, the highly politicized nature of the problem, and issues around legal responsibility, costs, risk communication and sensationalism.

3.4 SOME DECISION SUPPORT TOOLS – FOCUSING ON AIR QUALITY, PHYSICAL ACTIVITY AND CLIMATE CHANGE

The WHO European Centre for Environment and Health in Bonn has developed tools developed to assist in environmental management and health improvement by helping to prompt and inform discussions around health issues based on international evidence and data relevant to the local situation. They have been developed and tested using expert knowledge user feedback.

At one stage few resources were readily available for monitoring air pollution, but a number of tools have been developed, including AirQ, which is widely used in Europe and beyond. Analysis with AirQ has been applied to a single city in most cases, although it was also used at regional level.

In 2016 an enhanced version was launched, AirQ+ (16), intended to help quantify health impacts of air pollution and the benefits of better air quality. It is downloadable, user-friendly software, able to estimate the magnitude of the most important and recognized effects of air pollution in a given population. It can be used to produce estimates to help decision-makers develop appropriate actions to protect public health. It calculates long-term mortality and years of life lost, allowing assessment of the impact of different pollutants. A module currently being developed will also cover indoor pollution. Training will be available from 2017 on using the tool.

A second tool is a climate change health costing tool (17), which supports discussions on climate-related health impacts and adaptation. It can calculate the costs of health impacts and the costs and benefits of interventions. Costs can be expressed in terms of damage to people or health service expenditure.

It can illustrate cost per health case averted, the cost per premature death prevented and the cost per disability-adjusted life year averted. It uses simple, accessible formulas to explain impacts and will be further updated in future to reflect the agreement on the 2030 Agenda.

These tools can help to explain and illustrate the range of health, carbon and economic benefits from climate change mitigation. Using them would allow analysts and decision-makers to quantify costs and benefits, conduct better informed discussion with other relevant stakeholders and sectors, and promote wider education among communities and the public.



3.5 KEY MESSAGES AND ACTIONS

Issues addressed in discussions on health and the environment included: how to use the tools available from WHO in small regions and at local levels; possible engagement of the RHN in the Sixth Ministerial Conference on Environment and Health in Ostrava; how to establish thresholds for pollutants, using the Veneto example; tackling environmental risks generated by other countries (e.g. through visits from cruise ships); whether economic arguments are in practice effective in influencing other sectors; and whether it is acceptable for polluters to fund health promotion initiatives.

Key messages are that:

1. the tools developed by WHO on air pollution and climate change are well designed for local use and can be effective in arguing a case at that level;
2. the opportunity should be pursued for the RHN and Healthy Cities Networks to take part in the Ostrava conference in June 2017.

Actions might include those outlined here.

1. RHN members should consider how, drawing on the Veneto example, they might establish a way of alerting each other and others to hidden problems in the environment that are uncovered locally and might occur elsewhere.
2. RHN members should use the WHO tools available to them to establish the health impacts of air pollution and monitor climate change, as well as to communicate information about these tools and their benefits to others in the various regions.
3. RHN members should take part in the Sixth Ministerial Conference on Environment and Health in Ostrava in June 2017.



Section 4. Health services delivery transformation and the role of regions

4.1 INTRODUCTION

The WHO Regional Committee for Europe in 2016 formally adopted a framework for action on integrated health services delivery. While challenges remain, there are also significant opportunities to create smarter services, drawing on new technologies, processes and models of care, and working with the population, for example to provide more home-based services. A high percentage of disease is preventable, as are many hospital admissions. Much more can be done to involve and empower patients and improve their satisfaction with services, and reduce barriers between services, as well as between services and the public. Pathways for change have been identified, with a range of entry points allowing countries to choose how best to initiate transformation. Analysis must look at the interface between the service and the population, and between the service and the enablers. The regions which run the services are crucial to both interfaces, in terms of changing services to meet people's needs and expectations, and helping to mould the system as a whole to support action at regional level.

4.2 THE ROLE OF LOCAL VILLAGE HEALTH COMMITTEES (VHCs), ENGAGING PATIENTS AND EMPOWERING POPULATIONS IN SERVICE DELIVERY IN KYRGYZSTAN

The Community Action for Health (CAH) initiative in Kyrgyzstan is a partnership between VHCs and the governmental health system. With the aim of improving health, CAH initiative was designed to help both sides of the partnership, enabling rural communities to act independently for the improvement of their health and the governmental health care system to work better in partnership with communities.

Since 2002 the initiative has been extended to include around 1700 villages (84% of the total) and since 2010 it operates under the umbrella of the National Association of VHCs. The VHCs are independent community-based voluntary organizations that work on health issues in close collaboration with local primary health care (PHC) providers and local government bodies. They form 58 NGOs at the district (rayon) level. Under the CAH initiative they work with the local health promotion units (HPUs), which are part of the Family Medicine Centres (FMCs) (within the PHC system). These help establish the VHCs and offer them training and support, helping them to build organizational capacity. There are 210 HPU staff in the country, specifically introduced for the CAH programme, who operate under the guidance of the Republican Centre for Health Promotion (RCHP). The HPU staff also collect data and undertake monitoring, feeding back to the FMCs and the RCHP.

Examples of issues identified as priorities in addressing health determinants include clean water, roads, bath houses, ambulances, street lights, preschools, sports squares and PHC building repairs. Health issues presently addressed by the CAH are hypertension, alcohol, tobacco, tuberculosis, hygiene and sanitation, sexual/reproductive health, HIV/AIDS, mother and child health, iodine deficiency disorders and brucellosis. As an example of activities undertaken, for hypertension there is a nationwide annual health screening initiative for adults, with those registering hypertension above a given level being referred into the PHC system. At the same time, hypertension awareness is being supported through the school system. It is notable that cardiovascular mortality has diminished by 5% over a two-year period (18). To tackle the determinants of health, VHCs have been cooperating with different state organizations and local NGOs, for example on a small grants programme and in initiatives such as village cleaning and greening, providing sports activities for young people and minor repairs to public buildings.

Challenges remain, including general poverty, a need to improve the skills of VHCs in dealing with the local self-governing bodies, poor accessibility of high-quality health services, high staff turnover and a lack of qualified staff in the health system. Lessons learned from this initiative include: the importance of support from the Ministry of Health and other government agencies; the value of approaching the problem from the starting point of people's own priorities; and the benefits of having an independent community organization separate from government structures and the health system, both because it helps to develop local organizational capacity and because people feel a direct benefit from this. Donor flexibility has also been valuable.

4.3 THE ROLE OF THE REGIONAL HEALTH AUTHORITY AND LOCAL HEALTH UNITS IN STRENGTHENING THE INTEGRATION OF SERVICES THROUGH PRIMARY CARE IN MADEIRA

Madeira, with its population of a quarter of a million people, has political and administrative autonomy within Portugal and runs its own health system. It has eight public hospitals and 48 health centres. Life expectancy is 69 years for men and 78 for women.

The island's Regional Health Policy for 2015–2019 included the following objectives: improve access to and quality of services; promote hospital and health centre efficiency; strengthen clinical governance; motivate professionals; achieve financial sustainability; and encourage action by social support agencies, ensuring ensure good communication with citizens.

It set out six actions: reorganizing the health centres and hospitals; improving collaboration between public services and the private and social sectors; tackling waiting lists; introducing a human resources policy for health; implementing a strategic plan for a new hospital; promoting financial sustainability and synergies with the national level.

In 2004, PHC and hospitals were integrated into a single entity, as were the medical and nursing services, in 2007. However, this led to too much centralization (for example, only one director for 48 health centres), a very vertical organization, insufficient attention to public health programmes, a disconnect with local authorities and a feeling of neglect and lack of ownership by health professionals.



As a result a new reform was introduced in 2016, aiming to: restructure the health centres while continuing the improvement of primary care provision; strengthen health promotion and disease prevention programmes and activities; better respond to the needs of an ageing population (with special attention to chronic diseases); guarantee access, continuity and integration of care; and focus on individuals' needs and empower the population. This is to be achieved by decentralizing management, with a general coordinator, a Clinical and Health Council representing the professions, and seven regional units organized around multi-professional teams (medical, nursing, psychology, nutrition, dental care, etc.).

In order to make this happen, it will be important to align services with real needs, break away from established, possibly outdated institutional arrangements and avoid getting trapped in political arguments. To this end the regional government is purposefully aiming to ensure open engagement with politicians across the region as the policy develops.

4.4 STRENGTHENING COMMUNITY-BASED MENTAL HEALTH SERVICES IN FLANDERS

The Flemish mental health system has many psychiatric hospitals, with over 10 000 beds but poor outcomes, including many suicides. Reform was deemed necessary, to create a community-based service. The principles underlying the new model included that: the patient should be allowed to remain at home; therapists should take into account the broader social circumstances of the patient; the patient's family should be seen as part of the therapeutic network; and care should be evidence based and practised according to established guidelines.

The pattern of services envisaged was a regional model, including prevention, mobile outreach teams for those with acute and chronic conditions, psychiatric rehabilitation to help patients back to work, intensive hospital services where needed and an option for patients to live in the community with community support. Patients should have individual care plans and the aim was to empower them to take greater control over their own treatment and lives. The reforms were initiated in 2012 across Flanders, with 13 specific projects undertaken.

After some time was allowed for the reform to make progress, a university-led review was undertaken. It found that, while much effort had gone into creating the mobile teams, the other elements were relatively underdeveloped. There had been success in shifting the balance of care away from the hospitals, bringing together the relevant social and medical actors, improving working between the psychiatric and general hospitals and improving patient satisfaction. However, progress had not been as fast or extensive as had been hoped, seemingly as a result of fear of losing control and resistance to financial cuts, hindering the reform. The main reason for this is the difficulty experienced in freeing up and reallocating budgets. The hospitals have retained dominance in the system, there has been friction with GPs, and prevention and rehabilitation services have been slow to grow.

4.5 A NATIONAL STRATEGY FOR INTEGRATED HEALTH SERVICES DELIVERY IN SLOVAKIA

Slovakia needed to reform its primary care system, which was stagnating and under pressure as a result of ageing of both the population and the primary care workforce. Many practitioners were working single-handed, and the system urgently needed updating. The health service was privately run, financed through a variety of health insurance companies, with no regulation or support and almost no national funding. Slovak regions had no responsibility for health and central Government felt little responsibility for the private system.

In the absence of regular national funding for reform or modernization, the opportunity to do so came through the availability of European Union Structural Funds, outside of the usual budgeting system. The approach that was adopted draws on work led by John Cole in Northern Ireland and developments in Karelia in Finland. The vision is for 140 integrated care centres across Slovakia, to bring PHC, social care and health promotion together under one management umbrella. The initiative is still in its early stages.

4.6 KEY MESSAGES AND ACTIONS

Discussions on health system transformation touched on many issues, including the need for regions to take full responsibility for creating high-quality systems in their countries and to use their competencies effectively, reflecting their own cultural identity. The implications of the fact that regions vary greatly in size were also discussed, along with: the challenge of matching services to needs when there are different models and options available; philosophical tensions in designing new systems; the need to develop person-centred thinking and care at all levels (from national to local); the need for regions and municipalities to feed into central Government, helping to mould policies and services; and the difficulty of dealing with interest groups that may not represent the best interests of the community overall.

Key messages included those listed here.

1. The subnational level is very important, but size matters; in some smaller countries, no regional level exists or is needed, but in larger ones such a need can be key. Ultimately it is important to address effectively the real needs of local communities.
2. National governments have a duty to ensure policies enable the regions to act effectively. Regions can have a closer relationship with their people and territory, and have a duty both to provide good (continually updated) services and to feed back to the centre about changing and emerging needs.
3. Regions can be thought of as the middle management in a big company that is working on building and maintaining health in populations; this means they are at the heart of the business of health care. The middle management is the engine of every system and the regions are the engine of the health care system.

Actions might include those outlined here.

1. Regions with experience in integrated care should contribute to create a community of practice designed to help others in their (and other) countries to better tailor reform to match regional needs and circumstances.
2. Regions should recognize and promote the fact that they have a number of roles, including listening to and representing the local communities (including culturally), developing and providing services, feeding back to the national level, and contributing to the national health policy strategic planning.

Section 5. Mapping intersectoral action for health in the WHO Regional Office for Europe: where do regions stand?

5.1 INTRODUCTION

WHO is committed to documenting and sharing the lessons of successful intersectoral working in different contexts. Dr Christoph Hamelmann, Head of the WHO European Office for Investment for Health and Development (Venice, Italy) expressed his great respect for the achievement of the RHN and his eagerness to visit the member regions and engage with their work.

5.2 INTERSECTORAL ACTION FOR HEALTH: EXAMPLES FROM SMALL COUNTRIES IN EUROPE

Intersectoral action is needed because health and well-being are affected by social, economic and environmental determinants, and these need to be addressed with an intersectoral and multidisciplinary approach. Its importance was recognized in the 1978 Alma-Ata Declaration (19), which spoke of the need to “involve, in addition to the health sector, all related sectors and aspects of national and community development” to promote health. It was further reinforced by the 1986 Ottawa Charter for Health Promotion and in repeated declarations and policy documents up to and including Health 2020 and the 2030 Agenda for Sustainable Development.

A WHO Regional Office for Europe mapping exercise is under way, aiming to identify intersectoral initiatives that can strengthen regional implementation of these agendas, through collecting case stories and narratives of successful intersectoral initiatives and mechanisms at local, regional and national levels, based on specified criteria. The work is being undertaken on a systematic basis, drawing on a standardized interview guide and case-collection approach, grouping countries into six clusters. Of the 53 Member States of the Region, 36 have participated.



A further mapping exercise is being undertaken as part of the WHO European small countries initiative's efforts to share knowledge on how to implement Health 2020. The initiative involves eight countries with a population of under 1 million: Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro and San Marino. In 2015 a panel convened to consider the issue agreed that small countries have an advantage when building intersectoral collaboration and setting up new initiatives, owing to their existing mechanisms of collaboration and proximity of working relations, but that the process needed to be properly managed and documented. The countries chose topics to explore further (see Box 5.1); these are presented more fully in the report on the mapping exercise (20).

General lessons from combining the learning across the case studies include the fact that a trigger for action stem from awareness raised through national data, political or media concerns, or external reports. In initiating work, attention should be paid early on to bringing different agencies together and creating shared goals and clear roles and responsibilities, and a focus should be placed on realistic expectations, maintaining involvement and longer term sustainability.

Box 5.1 Intersectoral topics selected in the small countries study

- Childhood obesity and sedentary lifestyle in the school setting
- A whole-of-school approach to healthy eating and physical activity
- Nutrition and sustainable agriculture in the school setting
- Population-wide obesity reduction
- Sexual abuse, exploitation of children and child pornography
- Establishment of a ministerial council on public health
- An alert system to signal the arrival of highly infectious diseases
- Reduction of salt intake

Sources: WHO Regional Office for Europe (20, 21).

It is useful to consider and “hook into” existing or forthcoming legislation, existing policies or programmes, and other significant events. A dedicated working group and staff can help, along with clear governance arrangements and, if possible, high-level government support, but this should avoid bureaucratic rigidity. Useful communication tools include web-based platforms, parliamentary hearings, one-on-one engagement, consultations, and participatory mechanisms.

Other facilitating factors include committed champions in key positions; support from nongovernmental actors, the private sector and the media in promoting initiatives; the existence of international commitments and agreed global or regional policy frameworks; and technical networks to share knowledge, lessons and experiences.

Challenges include a lack of dedicated funding; pressure on staff time; existing silo working; political change; and a lack of tools, experience and convincing evidence to prove the case for action, including financial and non-tangible benefits such as gender, equity and human rights considerations.

The main message to emerge, therefore, was to use the above-mentioned “hooks” and explicitly design into the process to be adopted as many strengths as possible in order to support continued engagement and a shared sense of purpose.

5.3 INTERSECTORAL STRATEGIES AND IMPLEMENTATION: EXPERIENCE FROM POMURJE REGION

Slovenia's Pomurje region, with a population of 120 000, has relatively poor health and social circumstances. It has the highest unemployment in the country, low income levels, low life expectancy at birth (especially for men), and well documented health inequalities.

Accession to the EU offered an opportunity to target social and economic development in the region and to link that to improving health outcomes. A new Regional Council compensated to some extent for the absence of an elected regional government and supported a focus on the socioeconomic determinants of health, including education, employment and social cohesion. These were brought together in the Regional Development Plan on Investment for Health and Development for the period 2001–2006. A wide-ranging regional partnership brought many agencies together to support this work.

Four priority areas were identified, which located health improvement in a larger context. These were:

- reducing health inequalities (including their social roots) and capacity-building;
- healthy food, cooking and development of the countryside, including countering pollution;
- healthy tourism, using the region's existing attractions;
- nature, the environment and health, including encouragement for walking.

Efforts were also made to introduce health improvement into lower-level planning in the region by promoting a health-in-all-policies approach.

Challenges included sustaining the commitment of all sectors in the face of austerity, integrating good practices into the system, finding tools and models to monitor inequalities and support action, and evaluation.

Factors that helped to achieve success included: finding a common language that could move discussion from sectoral to broader society objectives; good use of evidence; purposefully building partnerships and alliances with others (including internationally); and creating institutional capacity to support sustainability. It is useful to forge links with established practices and infrastructure and essential to plan for continuity, to evaluate and document progress and failures and to allow time and resources for capacity-building. The existence of durable structures and relationships enabled the process to continue, even after the funding fell away.

5.4 EMPOWERING LOCAL HEALTH AUTHORITIES AS DRIVERS OF HEALTH-ORIENTED, INTERSECTORAL URBAN PLANNING IN NRW

NRW, one of the 16 German regions (*Länder*), has a population of 17.6 million people and includes 53 local (district-level) public health authorities. The NRW Public Health Services Act of 1997 gave them a responsibility to comment on planning proposals with regard to potential health impacts.

The NRW Centre for Health offers the public health authorities support in relation to their health-oriented planning responsibilities. It uses an ecological model, recognizing many levels and types of health determinants and the feedback loops linking the natural, technical and built environment to individual and societal actions, operating in both directions, from local to global levels. Most of these determinants are of significant relevance in urban planning.

The planning requirement offered the basis for neighbourhood-specific long-term, integrated and sustainable policy development and action, based on intersectoral and political consensus. It could build on pre-existing arrangements for local health reporting and local health conferences, supporting a continuous needs-assessment planning/ implementation/evaluation cycle.

The introduction of the planning process was carefully managed: it was initially piloted in 2010 in three municipalities, followed by a publication in 2011 drawing out the lessons. Model local public health action plans at city and district levels were issued in 2012, with a second exploratory phase in 2013–2014 in two municipalities. These took very different approaches – one using public health reporting as the starting point, the other using participation in planning.

This work has helped exemplify the range of freedom available to municipalities; the value of integration in planning and administration; ways of identifying specific groups needing support; and how to encourage a health-in-all-policies approach. Problem areas have included resource and data availability, and techniques for engaging other sectors.

Healthy Urban Development guidelines have been developed for NRW, available since October 2016, drawing on the Healthy Urban Development Checklist from New South Wales, Australia to support cooperation with stakeholders from spatial planning and health sectors in assessing urban planning and development approvals.

5.5 KEY MESSAGES AND ACTIONS

Discussion on intersectoral working noted that there was a striking degree of congruence across the case story reports, in terms of what helped or hindered intersectoral working. A number of important issues were identified, including the importance of governance, capacity-building, adapting language to the audience, and developing data sets and targets that had a common value across different sectors.

Key messages included that:

1. success in improving health and reducing inequities will not happen by accident – it requires action across many dimensions;
2. funding appears to be a consistent problem, thwarting effective intersectoral working; pooling funds may be a solution and good practices need to be identified.

Actions might include those outlined here.

1. It would be useful to undertake a mapping study at regional level. This would ascertain what helps and hinders intersectoral working and identify useful examples of good practice.
2. This exercise might in turn be useful as the basis for developing a toolkit to help regions better tackle intersectoral issues.

Section 6. Subnational perspectives on the implementation of the European women's health strategy

6.1 THE STRATEGY ON WOMEN'S HEALTH AND WELL-BEING IN THE WHO EUROPEAN REGION

The Strategy on women's health and well-being in the WHO European Region (2) was approved at the recent meeting of the WHO Regional Committee for Europe, and regions had contributed suggestions during the drafting process. It remains the case that few women hold senior positions in health systems and the focus tends therefore by default to be on men's health. Those attending the RHN meeting were invited to consider how best to influence this imbalance in their own regions and at the regional level more generally.

The Strategy was the product of many years of work and it was significant that this was the first occasion that the Regional Committee had discussed the issue, together with a complementary action plan for sexual and reproductive health. The Strategy strengthens global and regional agendas such as Health 2020 and the 2030 Agenda and supports implementation in Member States. The status and well-being of women is a major theme in the 2030 Agenda and equity and human rights are fundamental to Health 2020, with gender recognized as an important determinant of health. The Strategy shows the links between SDG 5 on gender equality and women's empowerment and Goal 3 on health and well-being. Health sector action is crucial in achieving the targets under Goal 5, to:

- end all forms of discrimination against all women and girls everywhere;
- eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation;
- eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation;
- recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family, as nationally appropriate.

The Strategy also supports the implementation of the Global Strategy for Women's, Children and Adolescents' Health, 2016–2030, and its operational framework adopted by the Sixty-ninth World Health Assembly in May 2016. The European version of the strategy strengthens the areas which are less developed by the global version, which has a strong focus on maternal and child health.

The Strategy explicitly aims to go beyond issues around maternal health and sexual and reproductive issues to examine the wider aspects of women's health throughout the life-course. Evidence was carefully assembled and analysed in order to clarify the issues and put in place the tools to promote the use of sex-disaggregated data and gender-sensitive analysis and action, and to build capacity and accountability.

The vision in the Strategy is that (2:6):

[a]ll girls and women are enabled, supported and empowered in achieving their full health potential and well-being, with their human rights respected, protected and fulfilled, and in which countries, both individually and together, work towards reducing gender and socioeconomic inequities in health within the Region and beyond.

The Strategy represents a transformative agenda in that it aims to change social norms and roles deeply rooted in societies and in health systems in the WHO European Region that may currently have a

negative impact on the health of women. A more rigorous focus on gender would also be likely to clarify issues relating to men's health and so be applicable to a future men's health strategy, as gender equality is understood to be beneficial for both women and men, both now and for future generations.

The Strategy identifies four priority areas, delineated here.

1. Strengthening governance with women at the centre requires action going beyond a traditional focus on women as mothers or as potential mothers to recognize that, for example, mental health and CVD are major health issues for women; to strengthen education to eliminate gender stereotypes that have negative health outcomes; to tackle eating disorders, sexual violence, high risk behaviours, job segregation, and so on; and to introduce approaches such as gender budgeting to break the tyranny of rigid thinking and systems.
2. Eliminating discriminatory values norms and practices requires action, despite the WHO European Region's relatively good record, to reduce further inequalities within and between countries; to begin to understand and deal with practices that demonstrate how girls are given less value; to acknowledge and remedy discrimination against specific groups, such as migrants, Roma women, lesbian, gay, bisexual and transgender (LGBT) women, older women, and so on; and to eliminate violence against women – in all this acknowledging that health systems do not have total control, but that they are in a crucial position to do much more than is currently being achieved.
3. Tackling the impact of gender and other social economic, cultural and environmental determinants requires action to improve understanding of how gender interacts with other determinants, including behaviours, as well as the operation of the labour market and the creation and experience of poverty.
4. Improving health systems responses to women's health and well-being requires action to develop a comprehensive life-course approach to women's health, rather than only considering childbearing; unravel issues around unpaid carer roles; and tackle biases in research and care.

A wide variety of actions can be undertaken in response to these challenges. What is appropriate will depend on local circumstances. One women's strategy may not be the best answer, as the issues are so wide-ranging and pervasive. It is likely that the best results will involve reviewing with different eyes all existing and future strategies and policies.

6.2 KEY MESSAGES AND ACTIONS

In discussion the new Strategy was warmly welcomed and it was agreed that there are many different ways of using it to reform and improve local services and attitudes. The need to be sensitive to different cultures was acknowledged, in terms of how best to manage implementation. Any response needs to be smart, with arguments based on ways of improving outcomes that may best support progress. Those seeking change need to operate within and beyond the boundaries of the health system and take a tactical approach to identifying the best entry points. Progress may also require a self-critical appreciation within health and social systems as to how existing messages and behaviours may inadvertently have harmful impacts, for example in framing dietary advice, and how services may undermine independence and choices.

Key messages included those listed here.

1. Women's health issues are moving up the political agenda, and they have been given a new emphasis through Health 2020 and associated work, as well as the SDGs.

2. This is probably not a matter best addressed by creating a new separate strategy. It is a transformational agenda, and its effects could be similar to the way in which the recent understanding of how social and economic determinants create health inequalities has radically shifted understanding of how to improve health. It will require action across all sectors and could possibly influence attitudes to and outcomes in men's health as much as women's.
3. Regions are starting from very different places. Where they are and how much progress they can make, and how quickly, will be affected by their culture, public expectations, existing service arrangements and data availability.
4. Because this is a new development, to support and track future progress, changes in information systems and how research is planned, undertaken and used will be an essential early step.

Actions might include those outlined here.

1. Individual regions will review how they might respond best to the Strategy and report back in a year's time on specific initiatives and how this approach has been built into everyday working.
2. The RHN will set up (in association with WHO) a small group of RHN regions, ready to implement or explore the new Strategy.
3. Consideration should also be given to how to place greater emphasis on the importance of medical/health research with a gender view.



Section 7. Reviewing progress in the RHN

7.1 A STUDY VISIT TO WALES: SUSTAINABLE DEVELOPMENT APPROACHES TO HEALTH AND EQUITY

A visit to Wales was organized in June 2016 to examine ways of linking the health and sustainable development agendas. The objectives included examining Wales' policies, programmes and legislative approaches, demonstrating policy implementation in action, discussing and sharing examples of good practice, and helping EuroHealthNet and WHO to gain detailed insights into their members' policies, initiatives, programmes, projects and approaches. Attendees included 22 participants from 16 countries. The group heard about the development of the sustainable development legislation in Wales, including: practical visits to charities that enables disadvantaged children to learn skills and confidence; a restaurant where people in prison learn catering skills; and groups organizing timebanking schemes. These are schemes which shift the focus from the usual method of organization through the money (surface) economy towards a more human-centric model, based on the core economy, with reciprocal relationships and practices underlying how families and communities really work (Table 7.1).

Table 7.1 Characteristics of the surface versus core economy

	Surface economy	Core economy
Currency used	Money	Time
Methods through which goods are exchanged	Through markets	Through reciprocation and negotiation
Characteristics of resources	Tangible; easy to account for	Often invisible
Value/characteristics of a good	Easily abstracted as a price	Variable and hard to abstract
Examples of goods and resources	Clothes, building materials, food and fuel, savings and loans, shops, farms, data, tax	Identity, homes, family, trust and confidence, communities, culture, country, wisdom, duty

Learning outcomes from the visit included an understanding of the Welsh legislative and policy context; insight into how schemes can be designed around viewing people as assets rather than service users; and how, in practice, sustainable development can be tied into action-orientated approaches to reduce inequalities, promote social inclusion, reduce unemployment and avoid exclusion. It is clear that challenges still remain, such as overcoming silo-based thinking and behaviours and developing small projects which require scaling up in order to effect major social and cultural change.

7.2 THE LJUBLJANA SUMMER SCHOOL ON INTERSECTORAL ACTION, 2016

The Centre for Health and Development Murska Sobota, along with WHO, EuroHealthNet and other Slovenian organizations organized the 5th Summer School on advocacy and translation of evidence for different audiences on intersectoral action for health equity and well-being in Ljubljana in July 2016. There were three main objectives to be discussed: how to argue effectively for intersectoral action for health equity and well-being; the role of different stakeholders and organizations in this process; and developing and translating evidence for different audiences.

Key themes in the programme were translating evidence to support evidence-informed policy-making; data profiling and social marketing campaigns supporting health equity and poverty reduction strategies; and the communication of health information and of risks. A wide range of international speakers were present, and examples of good practice were presented.

It is clear that the principles of the Ottawa Charter are as relevant today as in 1986, although the context is very different. A great deal is already being done by WHO European Region Member States on the issue of advocacy and the 2030 Agenda, and the SDGs offer a valuable opportunity to broaden and accelerate progress. In terms of techniques, it was concluded that ensuring policy is evidence-informed is crucial, as is matching the data and communication methods to the context and target audience.

7.3 RHN PUBLICATIONS⁷

There have been three new RHN publications:

1. *Scaling up projects and initiatives for better health: from concepts to practice* (9);
2. *Adopting a broader concept of health and well-being in the development of the Trentino health plan (2015–2025): a participatory process* (5);
3. *The Veneto model – a regional approach to tackling global and European health challenges* (8).

A fourth publication is currently being developed on sustainable development in Europe and achieving health and equity for the present and future generations. The rationale for this publication is to identify the implications for regions of implementing the SDGs and Health 2020 and to explore the role of subnational governments, using the example of developments in European regions. Its purpose is to help ensure that national and subnational implementation of the SDGs and Health 2020 has the biggest possible impact, especially on health and well-being. The publication is to focus on the interrelationships between sustainable development, health, well-being and equity; it is to promote sharing and common learning, highlight the role of regional governments and provide examples of useful practices. The examples are to be drawn from Wales, NRW, Pomurje, Lithuania and Västra Götaland, finishing by identifying lessons useful to others. The aim is to launch the publication by spring 2017.

7.4 THE UNIVERSITIES PARTNERSHIP PROJECT

The project aimed to address the issue that too little is known about what we can do in practice to apply knowledge on reducing social inequalities in health in different local contexts across Europe. More insight is needed into how to adjust the intensity and scale of action to local circumstances, and many initiatives are not rigorously and independently evaluated with regard to experience and outcomes. Because much of the effort to reduce social inequalities in health must happen locally, local capacity-building is essential, and so it is important to understand the local contextual factors as much as possible, such as culture and organizational aspects.

In response to these concerns, at the 2016 RHN meeting the idea was put forward to establish a network of European universities producing high-quality work focused on social inequalities in health. The idea was that RHN members could cooperate with and support regional academic institutions in reducing such inequalities.

After discussion with the RHN Steering Group, a working group was set up, which decided that the first step should be a mapping exercise to examine the needs and strengths of the RHN member regions, including if and how they already cooperate with regional academic institutions. What makes the RHN (and the Healthy Cities Network) interesting for researchers is that they represent very different local contexts.

⁷ For more on these, see Subsection 1.2 of this report.

A key focus is partnership; namely, looking to develop existing partnerships between regions and local or regional academic institutions, and to create new ones. The network will aim to bring together the experiences and knowledge of practitioners with academic and research-based knowledge and approaches relevant to practice. Exchange of experiences, research results and evaluation reports will be of use to all involved and will shed new light on local results and experiences.

The project aim is therefore to recognize the importance to regions and cities of using evidence to help in reducing health inequalities. Equally, it is important to recognize the importance to the national and European levels of a fuller understanding of the impact of contextual factors; to develop local and regional partnerships in which local/regional universities take part; and to compile knowledge from different contexts at a European level, assisting in capacity-building and over time. Possible deliverables include the mapping exercise itself; collecting case studies from the regions and creating new ones; establishing a network of partnerships (not regions or cities); developing a joint strategy between the Healthy Cities Network, RHN and collaborative projects; and supporting research, following through into implementation.

7.5 COMMUNICATIONS ISSUES

The RHN website was redesigned in 2016 to be more flexible and responsive. In addition, the online RHN newsletter has been expanded to include eight or more items per issue, instead of four. The weekly update includes two news items each concerning RHN topics, from WHO websites, scientific journals and the broader media. Social media activity has grown to the extent that in September 2016 the RHN had over 1800 followers on Twitter (@WHO_Europe_RHN; with the official hashtag #RHN), including *Lancet*, *BMJ* and prominent researchers, epidemiologists and activists. Another development is that it is now possible to follow Dr Christoph Hamelmann, the Head of the WHO European Office for Investment for Health and Development (Venice Office) on Twitter.

The most important resource must be the RHN members and it is crucial that they continue to provide material for these various channels and pass on information they receive to others who might be interested. Ideas and suggestions for further improving communication would be very welcome.

7.6 REPORTING BACK FROM THE 66TH SESSION OF THE WHO REGIONAL COMMITTEE FOR EUROPE

As is now usual, a representative of the RHN attended the 66th session of the Regional Committee in Copenhagen. The Regional Committee is the formal annual meeting of the governing body of the WHO European Region, bringing together representatives of all 53 Member States. Reference had already been made to business undertaken in the meeting.⁸

The meeting highlighted a growing acceptance that health and well-being need to be routinely considered together; that it is better to speak of evidence-informed than evidence-based policy; and that economic evidence needs to be better disseminated. The potential importance of networks such as the RHN, the Healthy Cities Network and the small countries initiative were repeatedly mentioned. The strong commitment of WHO professionals to meeting responsibilities and targets and to supporting other agencies was particularly evident.

⁸ See the Introduction and subsections 1.2, 4.1 and 6.1 of this report.

RHN and the Healthy Cities movement have the same objectives, but different rules and governance systems. Most cities have political leadership of some sort, whereas some regions do not. Several regions were already represented in both networks, and representatives of the two networks had produced an initial position paper on bringing them closer together, underlining the benefits of achieving greater solidarity, learning together and from each other, and improving health for local people. They proposed that the RHN should agree to support further efforts to improve collaboration, that WHO should agree to help develop a more coherent approach, and that the Healthy Cities movement should also work to take the matter forward.

Joan Devlin of the WHO European Healthy Cities Secretariat (Belfast) described the work of that network. The Healthy Cities movement was established to support achievement of the 1988 “health for all” objectives, putting health high on the agenda of decision-makers in the cities of Europe. Its aims included institutional change and innovative action for health, and its structure comprised various networks in individual countries.

A number of phases have been passed through, each with clear goals and priorities. The current period, Phase VI (2014–2018), sees the European Healthy Cities Network positioned as a strategic vehicle for implementing Health 2020 at the local level. The overall Phase VI goals include tackling health inequalities and promoting city leadership and participatory governance for health. It also has six strategic goals: to promote health and sustainable development locally and collectively; to strengthen the national standing of Healthy Cities, with an emphasis on national–local cooperation; to generate relevant expertise, evidence, knowledge and methods; to promote common working; to work with others; and to increase the Network’s accessibility across the WHO European Region.

The current phase is particularly concerned with demonstrating the tangible value of action by cities. It is still evolving, with new leadership in the WHO Regional Office for Europe, a number of scientific specialist groups in place and a strong commitment to developing a durable political leadership group.

Dr Zambon noted that the new RHN terms of reference, which clearly identify a commitment to Health 2020 and the SDGs – shared also by Healthy Cities – offer a strong basis for closer collaboration. The complementarity of purpose needs to be matched by effective vertical coherence between the regional and municipal levels. Potential benefits include better sharing of experience and learning, improved collaboration and working to develop joint products. These matters would be taken forward with WHO colleagues.

It was agreed that it was important that the RHN and Healthy Cities Networks continue to explore options for how to work together effectively. The steering bodies of both networks should consider how best to work together and support each other and the populations they serve.

Closure

Dr Zambon brought the meeting to a close by inviting participants to give thought to what they wanted from the RHN in future, and how they could best work with it and each other. He noted the variety of presentations and issues considered at the conference and the strong sense that these represented some of the best thinking in the health field in Europe. He urged members to think about how to ensure the RHN could survive and grow, and above all how it could remain at the cutting edge of thinking on health and sustainable development.

Dr Zambon thanked the Steering Group for its organizational help, along with the many agencies and individuals in Lithuania, including the WHO Country Office, who had given such strong support to the meeting. He thanked again all who had attended, his colleagues in Copenhagen and especially those who worked with him in the Venice Office, wishing all attendees a safe journey.



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Annex 1. Programme

WHO REGIONS FOR HEALTH NETWORK (RHN)

23RD ANNUAL MEETING

REGIONS: ACHIEVING A HEALTHY SUSTAINABLE SOCIETY.

THE NEED FOR INTEGRATION, INCLUSION AND COHERENCE AT INTERNATIONAL, SUBNATIONAL AND REGIONAL LEVELS

Programme

Day 1

22 September 2016 (Thursday)

Venue: *Raudondvaris Castle*

Masters of ceremonies: Dr Irena Miseviciene, Health Advisory Board, Lithuania

Dr Francesco Zambon, RHN Focal Point, WHO Regional Office for Europe

Time	Title/Activity
08:00 sharp	Bus leaves from the Hotel to Raudondvaris
08:30-09:00	Registration <i>Welcome coffee</i>
09:00–09:30	Opening Moderator: Dr Piroška Östlin, Director, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe Welcome remarks by: - Dr Juozas Olekas, acting Minister of Health, Lithuania - Dr Zsuzsanna Jakab, WHO Regional Director for Europe - Mr Valerijus Makūnas, Kaunas District Municipality Mayor, Lithuania
09:30–11:00	Session 1. Moderators: Dr Bettina Menne, Coordinator, Health and Development (SDG), WHO Regional Office for Europe Ms Solvejg Wallyn, Flemish Ministry of Welfare, Flanders, Belgium Sustainable Development Goals: implementing a universal agenda at national, regional and local levels - Introduction by moderators (5 minutes) - Dr Zsuzsanna Jakab, WHO Regional Director for Europe (20 minutes) - Dr Juozas Olekas, acting Minister of Health, Lithuania (20 minutes) - Rebecca Evans AM, Welsh Government Minister for Social Services and Public Health, Wales, United Kingdom - Mr Luke Rees, civil society representative, Wales, United Kingdom (Minister + civil-society representative: 25 minutes) - Structured discussion (20 minutes)
11:00–11.10	Family picture
11:10–11:30	Coffee break

11:30–13:00	Session 2. Moderators: <i>Dr Natasha Azzopardi Muscat</i>, President-Elect of European Public Health Association <i>Dr Francesco Zambon</i>, RHN Focal Point, WHO Regional Office for Europe The subnational level: an existing repository of knowledge, know-how and practices on key elements of Health 2020 - Introduction by moderators (5 minutes) - <i>Broadening the concept of health and well-being through participatory processes. Examples from the Autonomous Province of Trento and Østfold (20 Minutes)</i> <i>Mr Luca Zeni</i>, Regional Health Minister and <i>Dr Pirous Fateh Moghadam</i>, Department of Health and Social Solidarity, Autonomous Province of Trento, Italy <i>Mr Knut-Johan Rognlien</i>, Public Health Unit, Østfold, Norway - <i>Making a difference: investing in sustainable health and well-being. Example from Wales (15 minutes)</i> <i>Mrs Cathy Weatherup</i>, Inequalities and International Health, Welsh Government, United Kingdom <i>Dr Mariana Dyakova</i>, Policy, Research and International Development, Public Health Wales, United Kingdom - <i>Integrated health care: a patient-centred approach. Example from Veneto (15 minutes)</i> <i>Dr Domenico Mantoan</i>, General Director for Health and <i>Dr Maria Chiara Corti</i>, Integrated and Intermediate Health Care, Veneto Region, Italy - <i>Incorporating equity in regional health plans. Example from Västra Götaland (15 minutes)</i> <i>Mr Håkan Linnarsson</i>, Vice Chairman, Public Health Committee and <i>Ms Elisabeth Rahmberg</i>, Director of Public Health, Västra Götaland, Sweden - Structured discussion (20 minutes)
13:00–14:30	Lunch
14:30–15:30	Session 3. Moderators: <i>Dr Marco Martuzzi</i>, Programme Manager WHO European Centre for Environment and Health, Bonn, Germany <i>Dr Pirous Fateh Moghadam</i>, Department of Health and Social Solidarity, Autonomous Province of Trento, Italy Creating resilient communities and sustainable environments within WHO RHN - Introduction by moderators (5 minutes) - <i>Dr Marco Martuzzi</i> Presentation on Environment and Health: current WHO approach and relevance for regions (10 minutes)

	- <i>Dr Francesca Russo</i>, Regional Director for Prevention, Veneto Region, Italy Water contamination in Veneto (10 Minutes) - <i>Dr Pierpaolo Mudu</i>, Dr Gerardo Sanchez, Technical Officers WHO European Centre for Environment and Health, Bonn, Germany Presentation of tools for quantitative estimations of impacts and costs (air quality, climate-related effects) (15 minutes) - Discussion and wrap-up (20 minutes)
15:30–16:30	Session 4. Moderator: <i>Dr Juan Tello</i>, Head of office, acting, WHO European Centre for Primary Health Care Health services delivery transformations and the role of regions - <i>Dr Juan Tello</i>, Head of office, acting, WHO European Centre for Primary Health Care Setting the context: health services delivery transformations and the role of regions (10 minutes) - Illustrative country cases panel discussion (40 minutes): <i>Kyrgyzstan: the role of local Village Health Committees (VHCs) and engaging patients and empowering populations in services delivery in Kyrgyzstan</i> Mr Rakhat Mamytkojoev, VHCs Ms Tolkun Djamangulova, Deputy Director of the Project on Community Action for Health (CAH) <i>Madeira: the role of regional health authorities and local health units in strengthening the integration of services through primary care in Portugal's region of Madeira</i> Dr Miguel Pestana, Chief of Cabinet, Madeira Regional Secretariat, Madeira, Portugal <i>Flanders: strengthening community-based mental health services in Belgium – the experience of North West Flanders</i> Dr Dirk Dewolf, General Administrator, Flanders Agency for Health and Care, Flanders, Belgium - Interventions by plenary (10 minutes)
16:30–17:00	Coffee break
17:00–18:00	Session 5. Discussion groups Themes for discussion: Sustainable Development Goals implementation Group leads: Dr Bettina Menne and Mrs Cathy Weatherup Environment Group leads: Dr Marco Martuzzi and Dr Pirous Fateh Moghadam Integrated care Group leads: Dr Juan Tello and Dr Chiara Corti <i>There will be three discussion groups.</i> <i>Each group will discuss one theme.</i> <i>Each participant will be allocated to one discussion group.</i>

18:00	Transfers back to hotel in Kaunas
19:30	<u>Bus leaves the hotel at 19:30</u>
20:00	Dinner hosted by Kaunas Region, restaurant “Monte Pacis”, Pazaislis Monastery

Day 2

23 September 2016 (Friday)

Venue: *Kaunas City Hall*

Time	Title/Activity
08:30	On foot to Kaunas City Hall. Meeting point: Lobby of the Hotel
09:00–09:30	Session 6. Reports from discussion groups of Day 1 Rapporteurs: RHN representative of each discussion group
09:30–10:30	Session 7. Moderators: <i>Ms Isabel Yordi</i> , Technical Officer, Equity, Social Determinants, Gender and Rights, WHO Regional Office for Europe <i>Ms Solvejg Wallyn</i> , Flemish Ministry of Welfare, Flanders, Belgium Subnational perspectives on the implementation of the European strategy for women’s health and well-being - Introduction by moderator (5 minutes) - <i>Ms Isabel Yordi</i> (15 minutes) - Discussion (35 minutes) - Wrap up (5 minutes)
10:30–11:30	Session 8. Moderators: <i>Dr Francesco Zambon</i> , RHN Focal Point, WHO Regional Office for Europe <i>Dr Irena Miseviciene</i> , Health Advisory Board, Lithuania RHN progress report: - Wales study visit Dr Mariana Dyakova and Mrs Cathy Weatherup - Ljubljana summer school Mr Peter Beznec - RHN publications Ms Brigitte van der Zanden, Dr Pirous Fateh Moghadam and Dr Marian Dyakova - Partnership of universities Mr Knut-Johan Ronglien - RHN communication Ms Cristina Da Rold - Report from the WHO Regional Committee Ms Solvejg Wallyn
11:30–12:00	Coffee break

12:00–13:00	Session 9. Moderators: <i>Dr Christoph Hamelmann</i>, Head of the WHO European Office for Investment for Health and Development, Venice, Italy <i>Mr Peter Beznec</i>, Centre for Health and Development in Murska Sobota, Slovenia Mapping intersectoral action for health in WHO Europe: where do regions stand? - Introduction by moderator (<i>5 minutes</i>) - Presentation on the Regional Office mapping exercise on intersectoral action, with key examples from the small countries <i>Ms Leda Nemer</i>, WHO Consultant (<i>15 minutes</i>) - Presentations on the topic from RHN members (<i>10 minutes each</i>): <i>Mr Peter Beznec</i>, Centre for Health and Development in Murska Sobota, Slovenia <i>Dr Odile Mekel</i>, Institute of Public Health, North Rhine-Westphalia, Germany - Structured discussion (<i>15 minutes</i>) - Wrap up (<i>5 minutes</i>)
13:00–14:30	Lunch
14:30–15:30	Session 10. Moderators: <i>Ms Elisabeth Bengtsson</i>, Regional Development Officer, Västra Götaland, Sweden <i>Ms Joan Devlin</i>, Chief Executive, Belfast Healthy Cities <i>Francesco Zambon</i>, RHN Focal Point, WHO Regional Office for Europe The 4Cs of RHN and Healthy Cities: complementarity, coherence, collaboration and coordination. - Introduction by moderator (<i>5 minutes</i>) - <i>Ms Joan Devlin</i>, Healthy Cities Network (<i>10 minutes</i>) - <i>Dr Francesco Zambon</i>, RHN (<i>5 minutes</i>) - Discussion in smaller groups (<i>30 minutes</i>) - Wrap up, feedback and next step (<i>10 minutes</i>)
15:30–16:30	Session 11. Discussion groups Themes for discussion: Women's health Group leads: Ms Isabel Yordi and Ms Solvejg Wallyn Intersectoral action for health and well-being Group leads: Dr Christoph Hamelmann, Mr Peter Beznec and Dr Mariana Dyakova RHN and Healthy Cities Group leads: Ms Elisabeth Bengtsson, Ms Joan Devlin <i>There will be three discussion groups.</i> <i>Each group will discuss one theme.</i> <i>Each participant will be allocated to one of the discussion groups.</i>

16:30–17:00	<i>Coffee break</i>
17:00–17:30	Session 12. Reports from discussion groups of Day 2 Rapporteurs: RHN representative of each discussion group.
17:30–17:45	<i>Closing</i>
19:00	Cultural Event: Ciurlionis National Museum of Art, short piano recital, tour of museum followed by dinner, hosted by WHO RHN

See you at the 24th RHN Annual Meeting!



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The 23rd annual meeting of the WHO Regions for Health Network took place in Kaunas Region, Lithuania, on 22–23 September 2016. The main theme was the integration of efforts at international, national and subnational levels to achieve the objectives of Health 2020 and the 2030 Agenda for Sustainable Development.

The meeting included sessions reviewing the relationship between Health 2020 and the 2030 Agenda; action at regional level within countries to address Health 2020; aspects of health and the environment; recent efforts to transform health care delivery; findings from recent studies on intersectoral collaboration; and the implications at regional level of the recently agreed Strategy on women's health and well-being in the WHO European Region.

The meeting also provided an opportunity for network members to hear about each other's recent experiences and progress with the agreed programme of publications, and to consider how better to work with other parts of the WHO family, and in particular the Healthy Cities Network.

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