

A DECADE

OF REGIONAL COOPERATION ON PUBLIC HEALTH
IN SOUTH-EASTERN EUROPE

A STORY OF SUCCESSFUL PARTNERSHIP



THIRD HEALTH MINISTERS' FORUM:
HEALTH IN ALL POLICIES IN SOUTH-EASTERN EUROPE – A SHARED GOAL AND RESPONSIBILITY
Banja Luka, Bosnia and Herzegovina, 13–14 October 2011



ABSTRACT

It has long been recognized that public health initiatives contribute to the reconciliation and stabilization of conflict-affected areas. Public health is increasingly regarded as a reliable predictor of economic growth. This report follows the South-eastern Europe Health Network (SEEHN), which for 10 years has provided a regional forum for cooperation among health ministries, international organizations (including the WHO Regional Office for Europe and the Council of Europe), nongovernmental organizations and health professionals. SEEHN operated first under the Stability Pact for South Eastern Europe and then, since 2008, the Regional Cooperation Council. Its contributions to health, reconciliation, stabilization, and social and economic development are examined in the context of three forums of health ministers from south-eastern Europe, forums that have been held in 2001, 2005 and 2011. The report publication coincides with the third forum, being held in Banja Luka in October 2011 to discuss the application of the “health in all policies” approach in the region.



Keywords

PUBLIC HEALTH

DELIVERY OF HEALTH CARE

HEALTH POLICY

REGIONAL HEALTH PLANNING

INTERNATIONAL COOPERATION

EUROPE, EASTERN

EUROPE, SOUTHERN





The purpose of this report is to:

- introduce the South-Eastern Europe Health Network (SEEHN), a unique, innovative partnership in public health, to south-eastern Europe (SEE), the European health community and the general public;
- describe the impact that SEEHN has had on public health through its regional projects and programmes;
- trace SEEHN's development over the past decade from a tool for promoting peace and stability to one for enhancing economic development and building an intersectoral approach to public health;
- utilize SEEHN's achievements to advocate public health as a viable instrument of health diplomacy;
- outline SEEHN's capacity as a major advocate of better public health in SEE and beyond;
- show how SEEHN provides a forum for its member countries to prepare for European integration through convergence with EU policies and legislation; and
- present SEEHN as an open initiative in public health that reaches beyond its initial historical and geographical boundaries to establish new partnerships and initiatives for better health.

The report also aims to show how, in today's interconnected and interdependent world, people cannot afford *not* to cooperate.

It calls on public health professionals and organizations to facilitate collaboration with SEEHN in the Network's continuing efforts to create a new role for public health as a tool for integration through cooperation.

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Abbreviations

RHDC	regional health development centre
SEE	south-eastern Europe
SEEHN	South-eastern Europe Health Network

SEEHN provides high-level representatives of SEE health ministries with a political, institutional forum to promote public health through regional initiatives. The Stability Pact for South Eastern Europe established SEEHN in 2001 as part of its mission to foster regional cooperation and stability and help SEE countries prepare for integration with the European Union. It is widely recognized as the most

successful initiative launched under the Stability Pact's Initiative for Social Cohesion and frequently cited as a model for regional cooperation.

The members of SEEHN are the governments of nine countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, the Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia.





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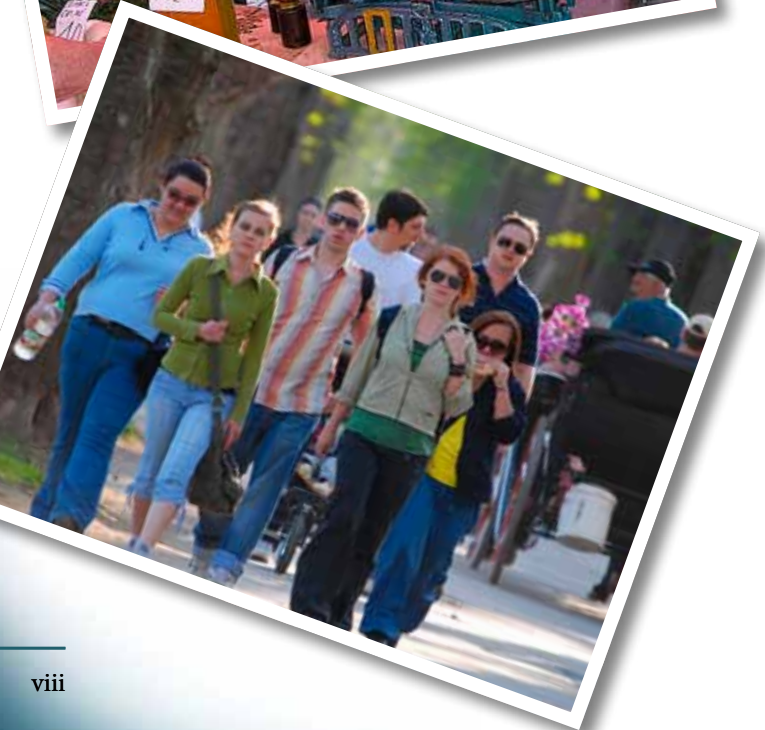
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Executive summary

A decade of regional cooperation on public health in south-eastern Europe tells the story of SEEHN from its founding in 2001 until today. It describes a unique process of regional cooperation in public health, involving the health ministries of the nine countries in the region, the Regional Office, the Council of Europe and the Council of Europe Development Bank, initially under the aegis of the Stability Pact for South Eastern Europe and then the Regional Cooperation Council.

The process started with the First Health Ministers' Forum, held in Dubrovnik, Croatia, in 2001, a breakthrough forum where the founding document of the cooperative enterprise, the Dubrovnik Pledge, was signed (Annex 1) (WHO Regional Office for Europe, 2001). This document set out a new, ambitious vision for regional partnership and cooperation on better health. What had been envisioned as a transitional mechanism to promote reconciliation and regional stability rapidly proved to be a model of regional cooperation. The Second Health Ministers' Forum, held in 2005 in Skopje, the former Yugoslav Republic of Macedonia, confirmed and expanded the vision, goals and aims of SEEHN in a new document, the Skopje Pledge (Annex 2)

(WHO Regional Office for Europe, 2005). Today, six years later, SEEHN is an established, highly valued actor in the promotion of public health in the region. It has a permanent seat in Skopje, and it is expanding by adding new Member States and partner states, as well as by steadily widening the scope of its activities. The current report is being published to coincide with the Third Health Ministers' Forum, which is being held in October 2011 in Banja Luka, Bosnia and Herzegovina.

The development of SEEHN has been shaped by the input and engagement of a wide variety of long-term partners, including different national government sectors, the Regional Cooperation Council, the Regional Office, the Council of Europe, the Council of Europe Development Bank and the Northern Dimension Partnership in Public Health and Social Well-being, as well as by newer, evolving partnerships with the International Organization for Migration, EuroHealthNet and the European Commission. In turn, SEEHN has helped shape the actions of these organizations in SEE while helping define core public health development functions in the region and beyond.

Foreword

Publication of this report, which coincides with the Third Health Ministers' Forum of SEEHN in Banja Luka in October 2011, is designed to serve a twofold purpose. First, it should help Forum participants look back at 10 years of regional cooperation in public health and forward to the challenges of the coming decade, particularly the growing burden of both communicable and noncommunicable diseases and their impact on the SEE region. Discussion at the Forum will be informed by new and developing perspectives that stress the importance of health to social inclusion, equity and sustainable economic development, as well as the responsibility of the every government sector to contribute to better health. A "virtuous" cycle of health, prosperity and social inclusion lies at the heart of modern democracy, and the ministers at the Banja Luka forum will look at what has been and can be done to promote such positive synergies in SEE, with particular reference to Health 2020, the new health policy being developed for the WHO European Region by the Regional Office, and to the European Union's "health in all policies" approach (WHO Regional Office for Europe, 2011; Council of the European Union, 2006).

The second purpose of this report is to celebrate 10 years of SEEHN, an initiative that the health ministers of the region established under the aegis of the Stability Pact for South Eastern Europe with the leadership and assis-

tance of WHO and the Council of Europe. The initial purpose of this initiative was ambitious enough – to use health issues, public health issues in particular, to promote reconciliation and stability in what was then a very troubled region. But SEEHN has long since outgrown those ambitions. So successful was the initiative in meeting its goals and in promoting improved public health through regional cooperation and synergy, that in 2005 the Second Health Ministers' Forum prolonged its existence, and then in 2008 it was made a permanent regional intergovernmental institution – the first of its type in SEE. That process is now complete, and the SEEHN Secretariat is settling into the home that the former Yugoslav Republic of Macedonia has provided in Skopje. Meanwhile, RHDCs continue to be established across the region to work on specific areas of public health that can benefit from regional cooperation and harmonization.

As readers of this report will see, SEEHN's achievements are considerable, and the Network has proved a model of success in regional cooperation. With the continued support and commitment of Member States, partner countries, and partner organizations both old and new, SEEHN will play a central role in tackling the health challenges facing SEE in the decade to come – just as it has in the decade whose achievements this report celebrates.



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Introduction

The story of the South-eastern Europe Health Network (SEEHN) is the story of regional cooperation in public health among the health ministries of the countries of south-eastern Europe (SEE) during the past 10 years. Those involved best know the challenges encountered along the way, from convincing sceptics that nine countries could be brought together into a single network and achieve meaningful results in an area as complex as public health, to persuading donors to fund ambitious projects whose very nature required intersectoral cooperation in several countries simultaneously. In the impressive results the Network has produced, everyone can now see how successfully those challenges have been overcome. SEEHN has become the primary vehicle for major regional public health initiatives in SEE. What it has achieved over the past 10 years will continue to bring better health and greater well-being to the region, as well as undeniable social and economic benefits. The presence of a regional institution that promotes public health – through the prevention and control of communicable and noncommunicable diseases and through the strengthening of health systems and public health services – is especially crucial for a crossroads of trade and migration like SEE.

Health is multidimensional, so any approach to securing the health of a population should be multidimensional too. A government that considers it in isolation, neglecting its essential social and economic dimensions and ignoring the public dimension of controlling and preventing diseases, risks not recognizing major challenges in time. In this age of globalization and mass consumption, many of the public health problems that SEE faces are common to countries and regions across the globe. Thanks to the increased movement of people and goods in today's integrated global economy, the spread of communicable diseases

is a growing health challenge for the region. Another is the emergence of new lifestyles and the preventable noncommunicable diseases they foster. Public health authorities are beginning to understand how public health is linked to social justice, equity and a strong economy. On the basis of this improved understanding of illnesses, their causes and the socioeconomic determinants of good and bad health (Box 1), SEE governments are better able to combat these new plagues, facilitate healthy development and replace unhealthy lifestyles with healthy ones – but only if they take seriously their responsibility for implementing the appropriate policies in all sectors and for educating the public effectively. That is the meaning of the motto “Health in all policies”. Since every area of public policy has the potential to affect people's health, the commitment to improve public health should be built into all policies.

Box 1 Key social and economic determinants of health

- Income and social status
- Education
- Employment
- Clean air, safe water and safe food
- Safe housing, communities, roads and working conditions
- Healthy workplaces
- Social support networks
- Culture
- Genetic inheritance
- Behaviours such as eating habits, exercise, smoking and drinking
- Coping skills, including stress management
- Access to health services
- Gender

Source: WHO, 2011.

Box 2 A two-way partnership

The Council of Europe is proud that together with the WHO and the Council of Europe Development Bank it has taken part since the inception of the Network in a true partnership spanning solidarity, equity and efficiency. Bringing people together from different regions was the first important step in the process. But today we can say that the Network has moved on: from commitment to cooperation, from declarations to deeds. Interim steps have all contributed to building up the Network: health and social cohesion were happily placed on the agenda of the Stability Pact, which resulted in the creation of the Social Cohesion Initiative of the Stability Pact. Lying at the roots of ensuing successes was the strong Secretariat support from donors who decided to invest in health and peace.

A vital factor in the growing strength of the Network came in the form of local expertise and continued political support, which allowed the Network to reach for sustainability and self-governance. These two elements figure at the core of the "Skopje Pledge". Clearly, the regional projects will allow the health systems to catch up with the current level of development in greater Europe. But this is ultimately only a part of the overall picture.

The 47 member states of the Council of Europe have benefited from a two-way Network traffic, one where at the outset partners provided support and expertise. This has now developed into a flow emanating from the Network, offering numerous resources to be shared with others. A precedent has been set: the Network is a model example for regional policy cooperation which should be made widely known and applied in other regions and sectors.

The regional notion of "balkanisation" is changing – from a synonym of fragmentation, partition and conflicts towards a model of cooperation. To build an enlarged, safer Europe we must use this language of health and peace, of social cohesion and human rights to overcome the difficult past and to build a better future for generations to come.

Network members: you may be proud of your achievements.

Mr Alexander Vladychenko
Director General of Social Cohesion
Council of Europe

Source: Vladychenko, 2010.

Much of the work WHO does is intended to help governments address the evolving policy landscape. Although communicable diseases represent a major threat to populations everywhere, public health officials are closer to controlling and managing them than ever before. The increasing global movement of people and goods means greater dispersion of diseases and contaminants. Borders melt before them. Yet humanity has always known epidemics that caused millions of deaths, the bubonic plague and Spanish influenza to name but two. The difference is that humans now know how to prevent or contain these epidemics. It requires preparation, of course, and having appropriate policies and programmes in place, coordinated not merely at the national but also at the regional level. When the authorities are properly prepared, however, people enjoy better protection from the ravages of disease than they ever have. It was precisely to provide such a common framework to anticipate and address acute border-crossing public health risks that WHO developed the International Health Regulations, which 194 governments have now signed, including all those in SEE.

In essence, SEEHN is the response of the countries of the region to these challenges. It has proven an excellent mechanism for bringing their policies and systems into line not merely with each other but with European and global health agendas (Box 2). In the past 10 years, the Network has developed and implemented a wide range of regional projects and programmes, addressing everything from blood transfusion services, maternal health and perinatal care to food safety, tobacco use, infectious disease control, mental health services and, most recently, community-based care for children with disabilities. Taken together, these projects represent a comprehensive effort to ensure health for all throughout the south-eastern European re-



gion. Their success has encouraged the Network to expand its membership, with the state of Israel scheduled to join SEEHN during the Banja Luka forum in October 2011.

The work that the Network has been doing will help ensure its members' readiness to meet the enormous health-related challenges entailed by integration with the European Union and the global economy. Its essential task has been to develop mechanisms that are appropriate to conditions in the region and the needs of the people living there, and that build on a strong national tradition of promoting public health by introducing meaningful international cooperation. The evidence clearly suggests that SEEHN has been accomplishing this task more than satisfactorily.

While the Network has produced impressive results through its individual projects and programmes, it has also evolved into something far greater: a model institution for regional cooperation. It provides a forum that allies not merely the health ministries and, as appropriate, the finance ministries of its 9 member countries, but also the Regional Office, the Council of Europe, the Council of Europe Development Bank, the Regional Cooperation Council, the health ministries of 12 partner countries, donors and a variety of other global and regional organizations to provide the people of SEE with better public health policies and programmes (Box 3). SEEHN offers the governments of the region a unique mechanism for meeting, consulting, seeking expert advice, coordinating, planning, shaping policies and implementing programmes across the full range of public health issues. This mediating function has not only facilitated the formulation of three major declarations by SEE health ministers – the 2001 Dubrovnik Pledge on meeting the health needs of vulnerable populations, the 2005 Skopje Pledge on health and economic

Box 3 A supportive neighbour

For the South-eastern Europe Health Network, its member states, and to some extent its partner organizations and partner countries, as well as all other friends and supporters of the Network's activities, this year is a special year, as we are celebrating the 10th anniversary of the Network's full operation. Anniversaries are traditionally a time to celebrate and to take stock, a time to look back and to analyse what has been done well or not so well, and what could have been done better. But it is usually also a time when our view into the future is even clearer, and when we make plans hoping that the future will be kind to us in terms of realising these plans and meeting our goals.

It is obviously the members of the South-eastern Europe Health Network that have demonstrated, through their activities to date, that this regional initiative is one of the most visible and successful linking elements in the field of health in the region. The network itself has been internationally recognised as one of the best examples of constructive regional integration and co-operation among initiatives within the Regional Cooperation Council.

Since 2002, as a partner country, Slovenia has supported the activities of the SEE Health Network, which in the first decade of its existence has managed to unite both political decision-makers and public-health professionals, with a view to agreeing on joint activities. Over the years, these have successfully given rise to projects that have evolved through long-term programmes of cooperation into what are called Regional Health Development Centres, covering particular public-health domains.

We are pleased with the success so far achieved by the Network. It is the result of the hard work of a large number of individuals and experts from the Network member states, in co-operation with numerous [international partner] organisations and partner countries. We are proud of Slovenia's participation in this process, and you may be assured that the South-eastern Europe Health Network and countries in the region can rely upon our country as a trustworthy collaboration partner in the future.

Dorijan Marušič,
Minister of Health, Republic of Slovenia
Second Preparatory Meeting for the Third Health Ministers' Forum
Bled, 14 April 2011

development in the 21st century and now the Banja Luka Pledge on health in all policies – but it has also ensured that Member States and partners provide the political and institutional support and introduce the policies and initiatives needed to implement these declarations. Through its success, SEEHN has clearly demonstrated the benefits of concerted, collective action in public health to members and partners alike.



To assist in these endeavours, SEEHN established 8 regional health development centres (RHDCs) and 13 areas of technical cooperation. The RHDCs play a major role in coordinating essential public health operations, standardizing protocols and procedures, exchanging data securely and reliably and establishing joint training programmes for specialists. They seek to align their efforts not merely throughout the region but also with European and global recommendations, standards and norms. Organizing such initiatives at the regional level not merely improves the quality of the processes, but involves a substantial rationalization of resources, in part by requiring only 8 regional centres instead of 72 national ones. Accordingly, SEEHN will call for resource mobilization and sustainability planning at the Banja Luka forum, giving Member States an opportunity to affirm their political and financial commitment to the Network, its activities and the regional promotion of public health.

After 10 years of evolution, the Network proudly stands an independent, seasoned intergovernmental institution. Today, the health ministries SEEHN was created to support regard its contribution to regional public health policy as indispensable to the services they provide local communities.



1 The what, who, why and how of SEEHN

What is SEEHN?

As its name suggests, the South-eastern Europe Health Network is a regional initiative to improve public health in SEE. It serves as a political forum where health ministers and other high-level health officials from nine Member States can meet and find ways to improve the health of their populations and the performance of their health systems, thereby contributing to economic and social development. SEEHN was founded in Sofia, Bulgaria, in April 2001, making it 10 years old at the time of this publication.

The Network acts as a regional resource, a knowledge base and a repository of expertise, with strong links to European and global organizations that can provide advice and support to its members (Box 4). It has an office in each Member State, together with a growing number of RHDCs and long-term joint projects and programmes throughout the region.

SEEHN operates at both a political and a technical level. Its highest-level political institution is the health ministers' forum that takes place every few years. The third such forum is taking place in October 2011. In addition, the SEEHN presidency rotates among the health ministers of Member States every six months, and each president organizes a meeting of Network members. These semi-annual meetings, which bring together representatives from the SEEHN health ministries and partners, are where most of the Network's policy is made. The SEEHN Executive Committee oversees the technical activities of the Network and the Secretariat manages them. These activities include the work of the country offices, the project offices and the RHDCs.

Box 4 Ends and means

What does SEEHN stand for?

- H** ealth for all
- E** qual and fair partnership
- A** ppropriate capacity-building and decentralization of resources
- L** ocal sustainability and ownership
- T** ransparency and accountability
- H** ealth in all policies

What does SEEHN want?

- Strong public health capacities to improve the health of all citizens

What is SEEHN doing to make that happen?

- S** ecuring implementation of the Dubrovnik and Skopje pledges
- I** dentifying key health issues for international cooperation
- M** aking regional health projects work
- P** romoting better policies, building partnerships and mobilizing resources
- L** inking sectors nationally and internationally
- E** xchanging information regionally

Who is SEEHN?

SEEHN is its Member States: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Montenegro, Romania, Serbia and the former Yugoslav Republic of Macedonia.

SEEHN was founded by the SEE health ministers within the framework of the Initiative for Social Cohesion, part of the Stability Pact for South Eastern Europe, and under the leadership of the Regional Office and the Council of Europe. In 2008, the Stability Pact was transformed into the



Regional Cooperation Council, based in Sarajevo, Bosnia and Herzegovina. Today, the Council provides the essential framework and leadership for all regional cooperation in SEE, including SEEHN.

Countries and international organizations can join the Network as members or partners, as long as they meet the conditions set out in the 2008 memorandum of understanding that serves as SEEHN's articles of incorporation (Annex 3). Israel will become its tenth Member State at the Third Health Ministers' Forum in October 2011.

The Network has a number of partner countries and international partner organizations. The 12 partner countries are Belgium, France, Greece, Hungary, Israel, Italy, Norway, the Netherlands, Slovenia, Sweden, Switzerland and the United Kingdom. The partner organizations are the Council of Europe, the Council of Europe Development Bank, EuroHealthNet, the International Organization for Migration, the Northern Dimension Partnership in Public

Health and Social Well-being, the Regional Coordination Council and the Regional Office. In addition, the European Commission follows the work of the Network closely as an observer.

What has SEEHN achieved?

SEEHN has directly contributed to regional cooperation, serving as a forum for identifying health issues of regional relevance and determining ways to respond to them through specific initiatives, programmes and projects.

Specifically, SEEHN has established:

- a region-wide network of more than 300 experts at all levels, including senior political representatives and civil servants;
- a region-wide network of more than 60 institutions working on public health issues;
- 8 RHDCs, dedicated respectively to public health services, blood safety, organ transplantation, communicable diseases, mental health, antibiotic resistance, human resources for health, and health care accreditation and quality improvement; and
- 10 pilot community mental health centres with a combined catchment area of more than 1 million inhabitants, centres that are being replicated to create an entirely new mental health system for SEE.
- SEEHN has focused its activities in 13 technical areas, in which it has:
 - built capacity through the exchange of experience and the training of experts;
 - organized international, regional and national meetings in all its areas of work,
 - conducted regional and national assessments and policy reviews, resulting in a thorough revision of relevant laws and regulations; and



- completed regional case studies and produced expert publications to provide a new knowledge base for work in these areas.
- As a result of the national policy reviews conducted in each country, SEEHN has assisted Member States in bringing their public health policies and laws into line with Council of Europe and WHO recommendations and standards and with European Union legislation. Specifically, the Network has helped members to:
 - develop and implement regional and national policies, strategies, reform processes and laws, resulting in more effective disease prevention and health promotion efforts and improved health;
 - support implementation of the International Health Regulations, surveillance of communicable diseases and preparedness for disease threats and pandemics;
 - ensure ratification of the WHO Framework Convention on Tobacco Control and approval of tobacco control laws;
 - reorient the provision of mental health services and the care of children with disabilities from institutions to local communities;
 - engineer the passage of food safety laws and regulations to protect consumers;
 - develop and update national strategies to improve maternal and neonatal health; and
 - update blood safety regulations and practices.

These efforts have engendered a strong feeling of ownership, trust and confidence on the part of the Member States, as well as a spirit of openness, transparency and accountability among them (Box 5). It is on the basis of these strong and enduring partnerships that the Member States look forward to the next decade of cooperation and regional coordination in public health.

Box 5 Principles of cooperation

Collaboration within SEEHN is guided by the following principles:

- regional ownership
- partnership
- transparency and accountability
- complementarity
- sustainability
- equal and active involvement of all Member States
- distribution of activities and resources based on country needs assessments
- decentralization of activities and resources and
- efficiency.

The Skopje Pledge
SEEHN memorandum of understanding
(see Annex 3)

Source: SEEHN, 2009.

What is the mission of SEEHN?

With a decade of experience in regional cooperation behind it, SEEHN has a strong understanding of its purpose and its mission, as distilled in its 2008 memorandum of understanding (Annex 3):

To promote the sustainable development of the SEEHN member countries by improving the health of their populations through better and more intense cooperation, collaboration, integration, capacity building, and coordination in public health at the regional level. This includes supporting reform of their national health systems and contributing to economic and social development.

SEEHN understands its mission as being to reduce real disparities and inequalities in health in SEE by improving health policy, public health and health systems in every Member State, with all the welcome knock-on effects such improvement entails for social well-being, economic development and overall quality of life. To pursue its mission and the goals endorsed by the SEE ministers of health, SEEHN will help build future institutional and organizational capacities on the basis of the existing institutional, human and knowledge resources in the region.

SEEHN believes that the best way to do that is by following a two-pronged approach:

1. a comprehensive governmental approach that integrates health into all policies on the basis of maximum intersectoral cooperation in each country; and
2. a process of increasingly close regional cooperation, coordination, integration and harmonization in health policy and public health.

Regional programmes represent the best approach for dealing with many of the major challenges affecting health in the 21st century. They permit the most efficient use of scarce resources, through the pooling of capacities and the concentration of expertise. Regional efforts also allow for the development of capacities that no one country could afford alone. And finally, they ensure harmonization and standardization on the basis of best practices and the continual exchange of knowledge and expertise, both inside and outside the region. In other words, regional cooperation makes all participants more efficient and more effective. These beliefs are strongly supported by SEEHN's partner countries and organizations (fig. 1).

How is SEEHN organized?

The structure of SEEHN has evolved over time, reaching its

mature form only in 2008, following the signing of a memorandum of understanding by Member States, who decided to ensure the Network's continued existence as a long-term institution. Its structure reflects its multiple roles. A political level provides leadership and vision, as well as a general policy direction, while a technical level works out policies in detail, develops regional and national projects and programmes and makes sure that policies become action.

The central, most political institution of SEEHN is the health ministers' forum, held every few years. The first forum took place in Dubrovnik in 2001, the second in Skopje in 2005 and the third is being held in Banja Luka in October 2011. It was in the forum that the Network was established, and it is there that its mandate to coordinate regional cooperation in public health is periodically renewed and updated.

The presidency of SEEHN rotates among the health ministers of the Member States. Each health minister holds the presidency personally for six months, in alphabetical rotation by country. Since 2005, an executive committee has implemented the decisions of the ministerial forums. The Executive Committee facilitates health action in the region and monitors progress. Its members cooperate closely and meet regularly.

During his or her term, each president hosts one meeting of the Executive Committee and one regional meeting of Network members, at which the Executive Committee presents a report. The regional meeting reports are available on the Regional Office web site (euro.who.int/en/what-we-do/health-topics/Health-systems/public-health-services/activities/south-eastern-europe-health-network-seehn/seehn-meeting-reports).

The regional meetings are where the Network makes policy, and all its decisions are made by consensus. Participants are the national health coordinators, who are



senior officials (in principle assistant or deputy health ministers) designated by the health ministers.

In 2008, it was decided to establish a secretariat for the Network in Skopje, the former Yugoslav Republic of Macedonia. The Secretariat role had previously been filled by the Regional Office in cooperation with the Council of Europe, as part of their function as leaders of the Network under the Stability Pact.

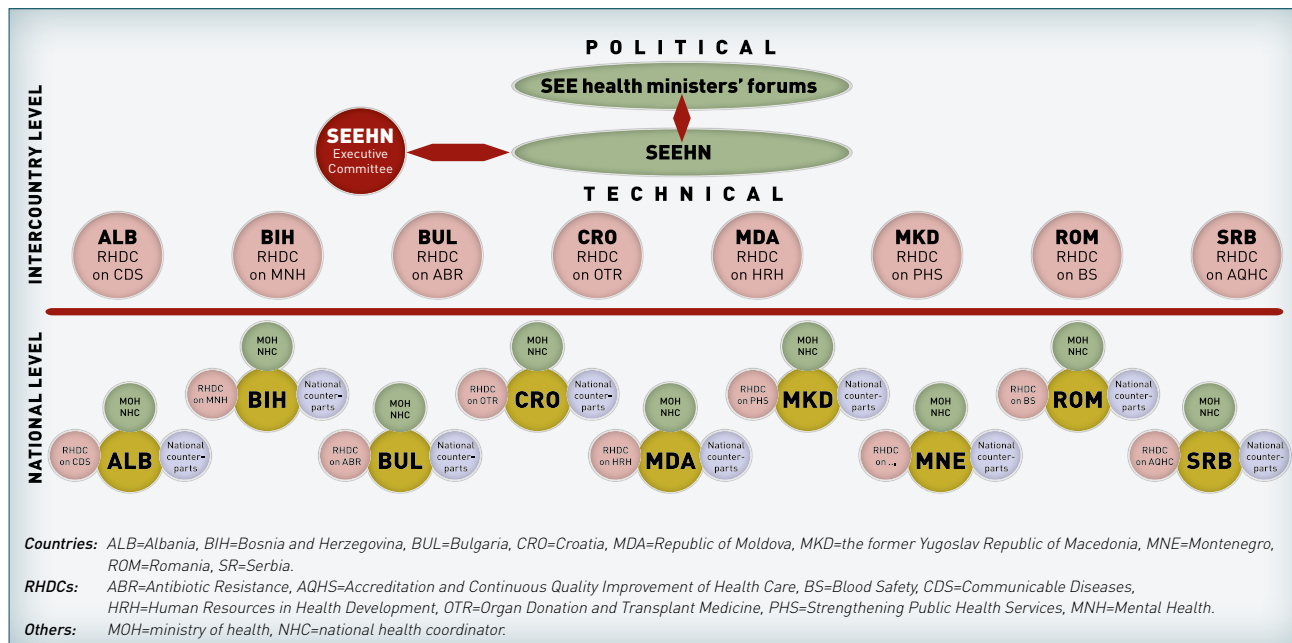
All the projects and programmes implemented by SEEHN are regional. The overall implementation, management and coordination of the activities are performed by a regional project office in the lead country for each technical area, with a country project office in each participat-

ing Member State. Together, these offices constitute a sub-network within SEEHN for each specific technical area. Completed projects, along with their experts and expertise, are integrated into long-term cooperation networks based in the RHDCs, which provide policy and technical support to continuing activities and address regional public health needs in their technical area. The eight RHDCs that have been established so far are:

1. Albania – the RHDC on Communicable Diseases;
2. Bosnia and Herzegovina – the RHDC on Mental Health;



Fig. 1 The structure of SEEHN, 2011



Box 6 Can we afford not to cooperate?

At a recent World Intellectual Property Organization conference on intellectual property and public policy issues, the Director-General of the World Trade Organization, Mr Pascal Lamy, forcefully articulated the imperative need for international cooperation on health in an increasingly globalized environment.

Effective partnership also means we have to recognize that we have complementary roles, different areas of expertise, and distinct mandates – we will make most progress if we each play to our strengths and reco,of WHO] just said, we see our work ... as a way to ensure that each agency contributes its core expertise to a collective effort, and respects the competences of others. ...

Infectious diseases certainly do not respect borders, and prey upon our common physiology, blind to political boundaries. Health represents the most compelling case for international cooperation. Interdependence is not a mere policy option; it is quite literally a matter of life and death.

Consider the international dimension of confronting the HIV-AIDS pandemic, the continuing devastation wrought by neglected diseases, suffered mostly by the world's poorest communities, the resurgence of resistant strains of TB [tuberculosis], and the current H1N1 flu pandemic. Climate change will likely have a severe impact on disease patterns and on agriculture: so health, food security and adaptation to climate change are fundamentally interlinked. To retreat behind borders – whether they are national borders, or formal boundaries between our institutions – is not an option.

.....

There will always be scope to improve how we work with our international partners. Partnership is hollow if we do not try to learn from each other; cooperation is wasteful of resources if we fail to coordinate on practical program delivery and the sharing of vital information; and coherence – which is probably the backbone of how we work with each other – is impossible if we do not respect and build on each other's distinct competences and policy settings. Above all, we must heed and respond to the concerns and practical needs of our Members and the communities they serve.

Source: Lamy, 2009.

3. Bulgaria – the RHDC on Antibiotic Resistance;
4. Croatia – the RHDC on Organ Donation and Transplant Medicine;
5. Republic of Moldova – the RHDC on Human Resources in Health Development;
6. Romania – the RHDC on Blood Safety;
7. Serbia - the RHDC for Accreditation and Continuous Quality Improvement of Health Care; and
8. the former Yugoslav Republic of Macedonia – the RHDC on Strengthening Public Health Services.

Every RHDC is by definition an example of cooperation among SEEHN Member States, partner states and partner organizations, particularly the Regional Office.

Networks revolve around connecting and working together: connecting people, connecting institutions and connecting countries to provide better practical solutions that all can use. In a word, networks are about partnership (Box 6). From 2001 to the present day, SEEHN has radically changed in character, starting as a joint endeavour intended to build peace and stability. Today, the Network has become a regional forum for the development of a modern approach to public health and a mechanism for participation in European health sector processes, intended to bridge the health inequalities present throughout the region and thereby improve health in Europe. Much of the credit for this successful transformation is due to the commitment of its partners. SEEHN's chief task continues to be connecting the countries of SEE with each other, in order to develop the policies and build the institutions needed to give the people of the region the best health care and public health systems possible. It also connects these countries with international institutions and partner countries that can help them achieve these goals, thanks to their technical expertise and willingness to provide assistance.



2 Looking back with pride: from regional stability to regional ownership

SEEHN was established under the aegis of the Stability Pact for South Eastern Europe. The Stability Pact was an international initiative to promote stability and reconciliation in the region. It was launched at a major international conference in Sarajevo in 1999, in response to a decade of war, humanitarian emergencies and economic crises throughout SEE.

The initial focus of the Stability Pact was to promote cooperation on reconstruction projects that went beyond the boundaries, and often the capacities, of the individual states. One long-term goal was also to help the countries of the region prepare for integration into wider European and northern Atlantic frameworks. As such, the Stability Pact brought together SEE countries and potential donors to identify common problems and generate coordinated solutions.

The Stability Pact had three areas of particular interest:

1. democratization and human rights
2. economic reconstruction, cooperation and development
3. security.

It organized its activities under three “working tables”, one for each of these areas. Each working table had several specific initiatives. In May 2001, health was added to the agenda of the Initiative for Social Cohesion, which was part of Working Table 2 (economic reconstruction, cooperation and development).

The Stability Pact asked the Regional Office and the Council of Europe to lead and facilitate a new forum that would approach public health from a regional perspective. This forum was established at the request of the SEE health ministers, who believed that public health was a

relatively uncontroversial area in which cooperative ventures might have a significant impact on social cohesion, prove fruitful in themselves and provide a positive example for other areas of cooperation. Over the following 10 years, that has proved to be the case (Box 7).

In cooperation with the Stability Pact, the Regional Office and the Council of Europe organized the first forum of SEE health ministers in Dubrovnik, in September 2001. The meeting’s main purpose, as requested by the ministers,

Box 7 The perspective from above

During the past decade, the countries of South East Europe (SEE) have made strides towards building peace and stability and creating better living conditions for their citizens. Many initiatives have emerged that promote and implement regional cooperation in different areas. While a positive trend has been witnessed across the board in terms of regional ownership and strengthened cooperation, the achievements of the SEE Health Network stand out and set a good example to be followed by other initiatives.

Regional cooperation in the health sector has produced important results. The network has successfully implemented regional action in several key fields, such as safe food products, mental health services, blood transfusion, tobacco control, maternal and neonatal health, communicable diseases and public health school[s]. They all aim at improving public health systems across SEE.

The Regional Cooperation Council (RCC) fully supports enhanced regional ownership and cooperation on health and health-related projects. In this respect, we commend the SEEHN members for their efforts towards establishing a regional secretariat and for transforming regional health projects into long-term regional programs for cooperation.

Mr Hido Bišćević
Secretary General
Regional Cooperation Council

Source: Biscevic, 2010.



was to address the pressing health needs of vulnerable populations throughout the region in light of WHO's strategic recommendations. In preparation for the meeting, the SEE countries carried out a joint assessment of the health situation of vulnerable groups for the first time.

The meeting resulted in the health ministers signing the Dubrovnik Pledge (Box 8; see Annex 1 for the full text of the Pledge). The ministers' priorities included ensuring access to appropriate, affordable, high-quality health care services; strengthening community mental health services; and establishing regional networks and systems for gathering and exchanging social and health information. They ended the Pledge with a call for international donors to provide financial assistance and a request for the Regional Office and the Council of Europe to provide technical and policy support.

They also created a new mechanism to ensure implementation of the Pledge and of regional projects within its framework: SEEHN. The ministers also took the first steps towards a regional health agenda. Within three months, SEEHN had secured initial funding for a number of regional projects. Over the years, nine such projects would be implemented, some lasting several years.

The Dubrovnik Pledge and the creation of SEEHN constituted the region's first cross-border political alliance in health, and they were recognized as a major political victory for peace and cooperation. As the intention of the Stability Pact was to promote reconciliation and stabilization in what had very recently been a region of armed conflict and humanitarian crisis, the ministers' decision to focus on public health was a recognition of health's contribution

to well-being and social and economic development, particularly by increasing social cohesion. Their hopes were not misplaced. SEEHN's record and its continuing potential as a vehicle for reconciliation and development have been recognized by many partner countries and international organizations. It is generally considered to be one of the most successful projects initiated under the Stability Pact and to provide a model for regional cooperation, not merely in public health, but in public policy more generally.

The aspirations and goals of the Dubrovnik Pledge were reaffirmed by the Second Health Ministers' Forum: Health and Economic Development in South-eastern Europe in the 21st century. Held in Skopje on 25–26 November 2005, the Forum culminated in the Skopje Pledge, which confirmed the commitment of SEE governments to continue regional cooperation on public health beyond 2005, with SEEHN as the main mechanism for doing so (Box 8; see Annex 2 for text). Specifically, the health ministers agreed to:

- take concerted action in the thematic areas identified in the Dubrovnik Pledge;
- improve their respective health systems to provide universal access to high-quality, sustainably financed public health services;
- demonstrate the economic potential of health to increase productivity and decrease public expenditure on illness;





Box 8 Three pledges for a new era in health

The SEEHN is the result of one pledge by SEE health ministers, and in turn the Network has facilitated two more pledges addressing the region's approach to public health.

The Dubrovnik Pledge (Annex 1)

The 2001 Dubrovnik Pledge is the founding document for regional cooperation in public health in SEE. It commits the governments of the region to work together to improve public health and meet the health needs of their vulnerable populations. The specific health priorities the Pledge identifies include:

- better access to appropriate, affordable, high-quality health care services
- greater social cohesion through the strengthening of community mental health services
- regional self-sufficiency in the provision of safe blood and blood products
- free integrated health care services
- improved surveillance and control of communicable diseases
- greater access to safe, affordable food
- regional collection and exchange of social and health information.

The ministers also created a new mechanism to ensure implementation of the Dubrovnik Pledge: SEEHN.

The Skopje Pledge (Annex 2)

The 2005 Skopje Pledge was promulgated at the Second Health Ministers' Forum. It reiterates and confirms the commitments of the Dubrovnik Pledge, expanding them and adding new elements of sustainability and local ownership. In particular, it consolidated SEEHN and assumed ownership of regional health projects. The Skopje Pledge responds in part to systemic problems identified in a study on health and economic development in SEE in the 21st century, a study conducted by the Council of Europe Development Bank and the Regional Office (2006). The most important of these problems include:

- the parlous state of public health systems in SEE due to systemic degradation, underinvestment, underfunding, low skill levels and the absence of serious reform, particularly with regard to funding mechanisms (such as compulsory social insurance);
- the decidedly underdeveloped nature of primary health care, and hence primary prevention; and
- a bureaucratic culture of formally agreeing to initiatives yet failing to follow through on them, particularly due to the absence of appropriate delivery mechanisms.

The Skopje Pledge expresses the SEE health ministers' determination to improve public health services, increase epidemic preparedness, implement the International Health Regulations, tackle mental health issues and demonstrate the economic potential of investing in health.

The Banja Luka Pledge

A new pledge is scheduled to be discussed and agreed to at the Third Health Ministers' Forum, which is being held in Banja Luka, Bosnia and Herzegovina, on 13–14 October 2011, on the theme of health in all policies. The Banja Luka Pledge is expected to focus on:

- strengthening regional cooperation in public health, furthering health system reform and contributing to economic and social development through better health;
- advancing the goal of health in all policies in Member States throughout SEE, and ensuring that health and health equity are considered in all policy and investment decisions, with the capacity-building and technical cooperation such consideration entails;
- strengthening health systems and human resources for health in the countries of the region;
- addressing the social determinants of health by implementing the "health in all policies" approach in all Member States.

With the Forum's adoption of the Banja Luka Pledge, the ministers will bring SEE health policy – specifically public health policy – into line with all major European legislation, resolutions, charters, communications, treaties, frameworks and action plans.

- strengthen regional collaboration and coordination on preparedness planning for emerging priorities;
- advocate for national governments putting health higher on the political agenda and ensuring its inclusion in the policies and strategies of other sectors; and
- empower health professionals to ensure sustainable long-term improvement in public health.

The ministerial commitment to long-term collaboration in public health – specifically, in tackling epidemic preparedness, implementing the International Health Regulations and addressing the problem of mental health – has since been reiterated in two instruments signed by the SEE health ministers:

1. Declaration on a Long-term Programme for Regional Collaboration and Development on Mental Health; and
2. Declaration on Strengthening National and Regional Capacities for Epidemic Preparedness and Response to Implement the International Health Regulations (SEEHN, 2007a, 2007b).

The process of establishing regional ownership was confirmed in 2008, with the Memorandum of Understanding on the Future of the South-eastern Europe Health Network in the Framework of the South East European Co-operation Process (Annex 3). The Memorandum of Understanding set out new terms of operation for SEEHN, establishing its structure, responsibilities and funding mechanisms. In particular, it stipulated the establishment of a regional secretariat and outlined the steps for establishing RHDCs.

The Secretariat was subsequently established with its seat in Skopje. The official ceremony of signing the host agreement took place during the SEEHN's 24th regional meeting, in Albania in November 2010 (Annex 4). In January 2011, WHO and the Council of Europe ceased providing Secretariat support.

Box 9 A force for peace, wealth and health

Since its founding in 2001, SEEHN has been a flagship initiative under the umbrella of first the Stability Pact and later the Regional Cooperation Council. Today it is playing an exemplary role in the WHO European Region, proving that cooperation in public health can be a driving force for peace, economic development and health improvement.

The Network has now entered a second, more advanced phase of development, with the aim of achieving sustainability and full ownership of the regional cooperation process. The establishment of the Network's own institutions and cooperation mechanisms, which will secure its independence and leadership, is coming to an end. The Regional Office highly commends these developments.

Ms Zsuzsanna Jakab

WHO Regional Director for Europe

Source: Jakab, 2010.

The RHDCs are a permanent legacy of SEEHN's work during the past 10 years, and they represent the transformation of technical projects into long-term programmes of regional cooperation. As noted above, eight have been established to date.





3 Between past and future: SEEHN stakeholders assess the Network’s performance and prospects

In reviewing a decade of regional cooperation in public health in SEE, it was logical to conduct a survey to see what the people involved with SEEHN think of the Network’s activities and programmes during the past 10 years. Accordingly, a survey evaluating SEE cooperation in public health was conducted in early 2011. The survey consisted of a questionnaire sent to people working (1) at the political level (ministers, national health coordinators, alternates, et al.), (2) at the technical level (regional and country project managers, experts, et al.), (3) in SEEHN structures (the presidency, Executive Committee and Secretariat) and (4) for partner countries and organizations. These four groups comprise the major stakeholders working in processes initiated and coordinated by SEEHN.

The results indicate strong agreement on the Network’s positive effect, with 78% of those surveyed characterizing its impact as fair or great (Fig. 2). Political respondents were inclined to rate it more highly than technical respondents, suggesting their greater appreciation for the importance and difficulty of the work involved in harmonizing policy, and in establishing coordination mechanisms in the first place.

It is also interesting that there was considerable consensus on where the impact was significant, with 77% naming health care and 40% education (Fig. 3).

There was considerable diversity in respondents’ identification of areas where SEEHN effort had the most impact in the past 10 years – whether health system analysis, multi-country cooperation, the regional projects, policy harmonization, the organization of international meetings, networking or preparation for European Union integration (Fig. 4). The variety of responses suggests that the Network has had a significant impact in a wide range of areas.

Fig. 2 Stakeholder assessment of SEEHN impact

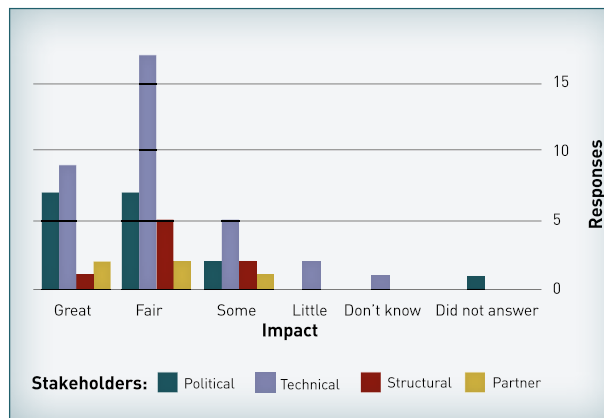
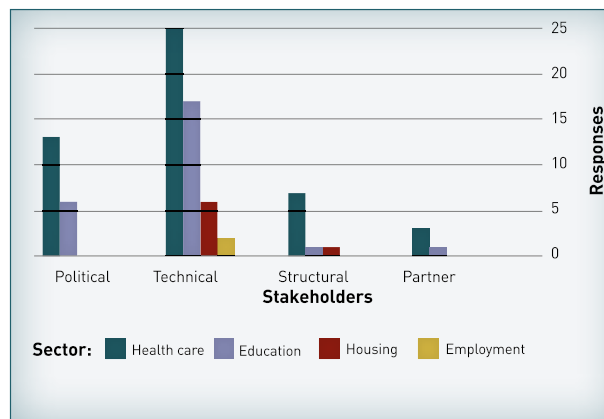


Fig. 3 Stakeholder identification of sectors where SEEHN has had major impact



It is noteworthy that 82% of the respondents said that participating in the Network had positively affected their country's health and public health systems, including 52% who characterized the changes as considerable or even great (Fig. 5). In addition, 78% found the technical cooperation at the regional level to be extremely or very important, while 73% of the respondents found the working contacts they had developed through the Network to be significant.

One of the most encouraging results from the survey was the fact that 89% of the participants expected future public health cooperation in SEEHN to be good or excellent (Fig. 6). When asked what health actions would be most important for SEEHN to concentrate on in future, respondents split fairly evenly among regional projects, multi-country cooperation, networking and European Union integration, confirming the desirability of the Network continuing its work on several fronts.

Encouragingly, 75% of the respondents expected the RHDCs to make a considerable contribution to regional coordination (Fig. 7), while 86% expected a fair amount or a great deal from the newly established Secretariat. These results indicate striking support for the strategy set out in the 2009 Memorandum of Understanding (Annex 3).

Fig. 4 Stakeholder assessment of which SEEHN actions have had the greatest impact, 2001–2011

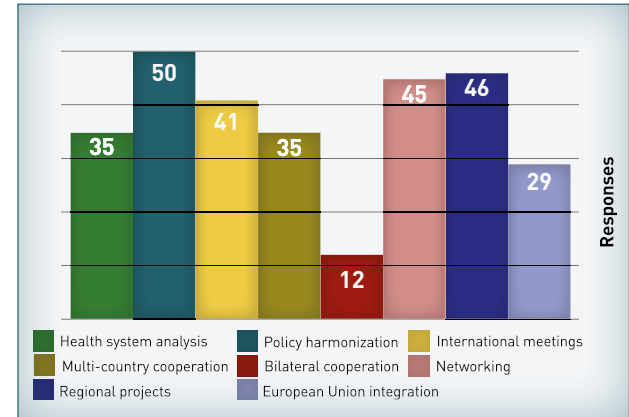


Fig. 5 Magnitude of change SEEHN has made to stakeholders' national health systems and public health systems

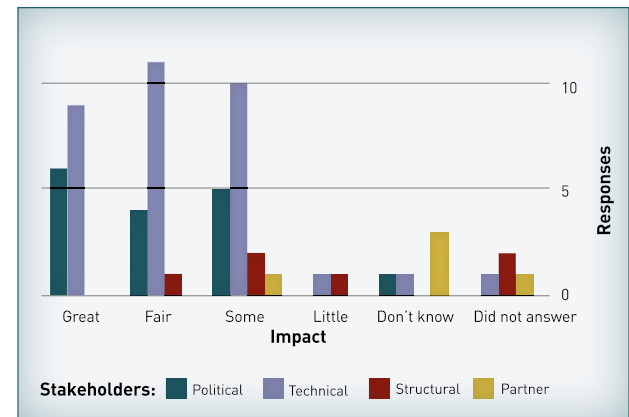




Fig. 6 Stakeholder estimates of the quality of future SEEHN cooperation in public health

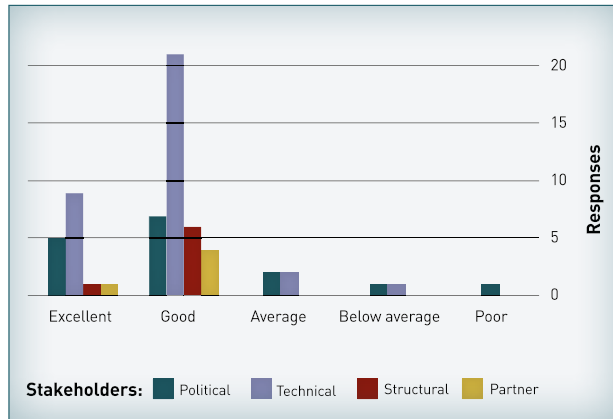
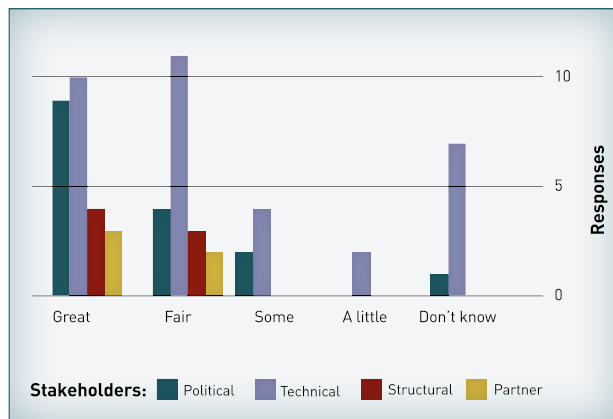


Fig. 7 Stakeholder estimates of future RHDC contribution to SEEHN cooperation



4 Regional cooperation at work: the SEEHN projects

Establishing a framework for regional cooperation in public health is a major achievement, but making such cooperation a reality requires practical implementation of specific projects. The original SEEHN concept included the development of such projects to introduce participants to the whys and wherefores of international cooperation and coordination, policy formulation, harmonization and legislative and regulatory follow-through; the projects also gave them a chance to try out some implementation modalities based on best practices. The plan was for each country to propose and lead a project in one public health area it found of particular concern.

The resulting projects allowed participants assess their national situation in the given area while learning from

their colleagues in other Member States (Table 1). The participants also consulted experts, who advised them and introduced them to tried and tested approaches. Then they could help their governments implement national policies and reforms under the aegis of a regional initiative.

The first regional project to be developed under the Stability Pact Initiative for Social Cohesion concerned mental health, a crucial but often neglected area in SEE public health. It became a paradigm for how to effectively go about regional reform. Guided by this experience, SEEHN soon developed another five projects, which addressed public health needs identified by SEE health ministries and health professionals in line with the priorities set out in the Dubrovnik Pledge. These projects were in the following areas:

- control and surveillance of infectious diseases
- food safety and nutrition
- blood safety
- tobacco control
- social and health information systems.

Thus they covered major issues in the control of communicable and noncommunicable diseases, as well as the integration of information technology in social welfare and health care systems. Additional projects were subsequently launched to address the following topics, for a total of nine:

- evaluation of public health services
- maternal and neonatal health
- community-based care for children with disabilities.



**Table 1 Overview of SEEHN projects**

Lead country	Project focus	Partners/donors
Albania	Communicable disease surveillance and control	Belgium, France, Greece, Netherlands, Regional Office
Bosnia and Herzegovina	Mental Health	Belgium, Greece, Hungary, Italy, Regional Office, Slovenia, Sweden, Switzerland
Bulgaria	Information systems for community health services	GI, Greece, OSI, Regional Office, Switzerland
Croatia	Tobacco control	Norway, Regional Office, Slovenia
Republic of Moldova	Maternal and neonatal health	Norway, Regional Office
Romania	Blood safety	CoE, Ireland, Regional Office, Slovenia, Switzerland
Serbia	Community-based care for children with disabilities	Belgium, Regional Office
Serbia	Food safety and nutrition	Belgium, Greece, Italy, Regional Office, Slovenia, Switzerland,
The former Yugoslav Republic of Macedonia	Public health services	CEB, Israel, Regional Office, Slovenia, United Kingdom
Croatia	Reconstruction and modernization of Andrija Stampar School of Public Health in Zagreb, Croatia	EB (loan)

CEB: Council of Europe Development Bank, GI: Geneva Initiative and OSI: Open Society Institute
Note: the Regional Office and the Council of Europe provided the projects with substantive health policy and technical advice.

Mental health

Project title	Enhancing Social Cohesion Through Strengthening Community Mental Health Services in South-eastern Europe
Initiating country	Bosnia and Herzegovina
Regional project office	Sarajevo
Duration	2002–2008
Number of components	Three
Donor	Contribution (€)
Greece	1 500 000
Belgium	530 000
Italy	366 000
Regional Office	274 500
Switzerland	200 000
Slovenia	132 000
Sweden	30 000
Hungary	8 700
TOTAL	3 041 200

Mental health gained prominence as a public health issue on the international agenda during the last decade of the 20th century. A growing consensus believed that major reforms were needed, including a shift to community-based care. WHO, led by its director-general at the time, Dr Gro Brundtland, strongly advocated this new approach, dedicating the 2001 World Health Report to mental health (Murthy et al., 2001).

The SEE mental health project was one of the first practical responses to the Report. The proposal was made by Bosnia and Herzegovina, and the first major donor was

Greece. The project was initially scheduled to continue for two years, but its success led to it being extended for another four.

A regional project office was established in Sarajevo, and national offices and national teams, which included leading mental health experts and government representatives, were set up in each country. Then the policy work began. A full assessment of mental health policy and legislation in each country was followed by the drafting of a common vision for mental health care. National mental health policies, strategies and legislation were then developed or revised in all the countries.

Drawing on the high capacity and level of expertise in the region, the project established pilot community mental health centres in every country, with two in Bosnia and Herzegovina. Standards and basic principles were drafted for the operation of these pilot centres. Leadership and management modules were also developed, and a case management system was introduced. The aim was to develop a model of service provision that could be rolled out as part of national reforms, which are now under way.

The final phase used the centres as bases for advocacy and training programmes to raise awareness of mental health issues and the need for reform. Special training and promotional materials were created for this purpose. The final phase also saw the regional project office in Sarajevo transformed into the RHDC on Mental Health.

The SEE mental health project initiated a comprehensive, coordinated process of mental health care reform in the region, in line with similar European and global processes. SEE health ministers signed a regional declaration on mental health (SEEHN, 2007a), and all Member States have drafted or revised their mental health laws and policies in accordance with its recommendations. The process



resulted in consistent national legal and political frameworks, coordinated in a regional framework, supported by a network of functioning institutions at all levels, and compatible with emerging European frameworks. It also established pilot community mental health centres in all the countries to serve as model institutions.

Finally, a special report on mental health reform in the SEE region was compiled as part of the project, and it is available on the Regional Office web site (Maurer & Murko, 2009).



Communicable disease surveillance and control

Project title	Strengthening Communicable Diseases Surveillance and Response in South-eastern Europe
Initiating country	Albania
Regional project office	Tirana
Duration	2002–2008
Number of components	Four
Donor	Contribution (US\$)
France	300 000
Regional Office	260 000
Belgium	200 000
Greece	200 000
Netherlands	100 000
TOTAL	1 060 000

Diseases can be categorized as communicable or noncommunicable. Communicable diseases represent a particular challenge, and due to the virulence of some pathogens, they have been responsible for the loss of millions of lives. Prevention and control of the infectious agents responsible for communicable diseases – whether transmitted by air, water, animals, food or people – require not just effective national programmes, but international cooperation. That has been shown decisively by the series of worldwide epidemics, ranging from HIV to avian influenza to *Escherichia coli*, that emerged in recent years, not to mention the resurgence of diseases once thought to be eradicated, such as tuberculosis and poliomyelitis. National and interna-

tional surveillance systems, early warning systems and early response systems for infectious diseases can provide some protection from what could otherwise be disasters on a massive scale.

It was for this reason that the SEE health ministers explicitly made strengthening the surveillance and control of communicable diseases one of their priorities in the Dubrovnik Pledge and later reiterated their commitment in the Skopje Pledge (Annexes 1 and 2). The communicable diseases project was one of the first to be set up, with a regional project office in Tirana. It ran from February 2002 to December 2008.

The first phase focused on strengthening national surveillance systems as well as coordination and integration mechanisms. That meant conducting a thorough assessment and analysis of the systems in place for monitoring infectious diseases and assessing potential threats, as well as the links between them. The next phase ensured that national policies and guidelines for communicable disease surveillance systems and response protocols for outbreaks were in place. It also developed a regional training package; strengthened regional capacity, particularly in applied and field epidemiology; and developed national influenza preparedness plans. While regional harmonization and integration were naturally one project goal, it was also important to ensure that systems were compatible with European Union approaches and procedures.

The third phase focused more specifically on strengthening integrated surveillance capacity, laboratories and information exchange mechanisms, again with special emphasis on national influenza preparedness plans. The final phase involved developing and deepening regional cooperation, with a focus on avian influenza and the technical capacity required to deal with potential outbreaks, and



ensuring proper implementation of the 2005 International Health Regulations. It culminated in the establishment of the RHDC on Communicable Diseases in Tirana in November 2010.



Food safety and nutrition

Project title	Strengthening Food Safety and Nutrition Services in South-eastern Europe
Initiating country	Serbia
Regional project office	Belgrade
Duration	2002–2008
Number of components	Two
Donor	Contribution (US\$)
Italy	300 000
Belgium	190 000
Greece	150 000
Regional Office	100 000
Slovenia	46 000
Switzerland	43 000
TOTAL	829 000

The quality of what people eat can affect them in several ways. Two of the most important factors are the safety of food (its freedom from contamination) and its nutritiousness (its ability to contribute to healthy functioning and growth). Poor nutrition can also result from poor eating and lifestyle choices. WHO has long recognized the role of safe food in preventing communicable diseases and of good nutrition in preventing noncommunicable diseases. In 2000, the Fifty-third World Health Assembly declared food safety an essential public health priority, leading to the development of a global food safety strategy to minimize foodborne risks by making sure the food chain is safe from chemical and microbial hazards. An effective food safety system is sustainable, integrated and responsive to risk. That in turn requires a proper legal framework based on the concepts of food safety.

While ensuring the safety of the food supply is vital to protecting public health of the general public, it must be part of a broader effort to achieve better nutrition, which is key to reducing the spread of both communicable and noncommunicable diseases.

As a consequence, the SEE health ministers singled out food safety and nutrition as key concerns at the first two health ministers' forums, explicitly mentioning them in the Dubrovnik and Skopje pledges (Annexes 1 and 2). The corresponding SEEHN project lasted from 2002 to 2008 and contained two main components. The first dealt with food and nutrition policies and laws, harmonizing them and bringing them into line with international and European Union standards. The second component established an integrated model for food safety systems, nutrition systems and a healthy food supply for the region, while national action plans for these issues were adapted to national needs.

As a result, all the Member States now share a common legal and policy framework that will allow them to meet internationally recognized food safety standards and improve the nutritional status of their populations. Compatible food safety laws are in place in all nine countries, and many of them have food safety and nutrition action plans, strategies and policies in place. Seven of the nine have also established food safety agencies or committees. The food laws and regulations are in accordance with European Union regulations.

These reforms have had a major impact on the practical approach to food safety. Historically, food laws in the region have been fragmented and reactive, focused on defining unsafe food products and punishing transgressors. The new legislation applies a preventive, holistic approach to reduce the risk of food being unsafe to consume in the



first place. To implement this approach, all SEEHN members have revised their food standards to concentrate on safe production methods, and many of them are applying risk-prevention methods, such as good agricultural, hygienic and manufacturing practices as well as hazard analysis and critical control point principles.

While these efforts have laid the necessary groundwork for ensuring a secure food supply and improving nutrition, much remains to be done, particularly in establishing effective consumer organizations, raising public awareness of food safety and nutrition issues and implementing risk-assessment approaches that can serve as a basis for legislation. More work also needs to be done on food safety management, to enable authorities to better manage risks during outbreaks and emergencies.

Overall, the project has made people and governments in SEE far more aware of food safety and nutrition reforms and how critical they are to health, and it has increased country's capacities for addressing these issues. A special report on food safety and nutrition in the SEE region is available on the Regional Office web site (Kaluski, 2009).



Blood safety

Project title	Increasing Regional Self-sufficiency in Relation to Safer Blood and Blood Components
Initiating country	Romania
Regional project office	Constanța
Duration	2004–present
Number of components	Two
Donor	Contribution (€)
Switzerland	100 000
Regional Office	60 000
Slovenia	68 000
Ireland	10 000
CoE	30 000
TOTAL	268 000

It is no exaggeration to say that modern health services could not function without an adequate supply of safe blood and blood components. Blood safety is critical to a wide range of medical procedures, reflecting a widespread need for blood transfusions. Moreover, many of the most dangerous communicable diseases are transmitted by blood, such as hepatitis and HIV.

For a supply of safe blood, medicine relies on blood donors, who generally volunteer to donate for a noble reason – to help others – yet may unknowingly carry death and disease in their blood. They therefore need to be screened and their blood tested, so that it does not contaminate the blood supply and infect recipients.

That is why SEE health ministers emphasized the importance of blood safety at their first ministerial forum

in 2001, and why they mentioned it explicitly in both the Dubrovnik and the Skopje pledges (Annexes 1 and 2).

The first regional blood safety initiative was a seminar on governance principles for blood transfusion services, held in Bucharest in October 2004 with the support of the Irish Blood Transfusion Service. The idea behind the blood safety project arose from this seminar, with Romania taking the lead. The long-term aim of the project has been to increase the availability of safe blood for emergencies and special circumstances throughout the region, and to facilitate cross-border exchanges, which require a sufficiently large and dependably safe regional supply. Regional self-sufficiency, particularly for rare blood types, is crucial for SEE, given the modest size of most populations there. Such sharing depends on the existence of joint institutions and a common set of policies, regulations and procedures for the entire region – precisely what the new project was designed to establish.

The project had two components. The first developed national blood safety policies in line with relevant European Commission directives and international recommendations, based on a regional assessment of blood safety policies, services and the availability of blood and blood components, together with national and regional quality analyses of the blood transfusion services in each country and in the region as a whole. This component was completed, and a special report on blood safety in SEE was prepared (Hafner, 2007).

The second component is ongoing. Its focus is on rationalizing the various blood supply systems and restructuring them into nationally coordinated services, with integrated legislative and regulatory frameworks and adequate support from their respective governments. This effort should ensure blood quality and safety at both local and



national levels, allowing confidence to develop across borders and making safe blood and blood components available transnationally for emergencies. A critical aspect of this component has been the establishment of the RHDC for Blood Safety in July 2011, hosted by the regional blood transfusion centre in Oradea, Romania.



Tobacco control

Project title	Public Health Capacity Building for Strengthening Tobacco Control in South-eastern Europe
Initiating country	Croatia
Regional project office	Zagreb
Duration	2005–2007
Number of components	Three
Donor	Contribution (US\$)
Norway	616 000
Regional Office	100 000
Slovenia	17 000
TOTAL	733 000

Tobacco is the single most preventable cause of death in the world today. It is a major risk factor for six of the eight leading causes of death: ischaemic heart disease; cardiovascular disease; lower respiratory infections; chronic obstructive pulmonary disease; tuberculosis; and tracheal, bronchial and lung cancers. It is also a cause or complicating factor in many other cancers, heart conditions and fatal diseases. As the 2008 WHO Report on the Global Tobacco Epidemic observed, “Tobacco is the only legal consumer product that can harm everyone exposed to it – and it kills up to half of those who use it as intended” [emphasis added] (WHO, 2008).

Only a whole-of-government approach can tackle the tobacco epidemic effectively. For this reason, in 2003 the Fifty-sixth World Health Assembly adopted the WHO Framework Convention on Tobacco Control proposed by the WHO director-general, Dr Gro Brundtland. The keys to

the Framework are making tobacco cost more, making it more difficult and less acceptable to smoke, banning the positive presentation of tobacco, increasing anti-tobacco information, making it easier to quit smoking and making it much more difficult for children and young people to start smoking. Implementation requires using tax policy, banning smoking in public places and the workplace, banning tobacco advertising and sponsorship, organizing public information campaigns and promoting smoking cessation programmes, as well as enforcing laws that forbid tobacco sales to minors. It also means fighting tobacco smuggling, regulating the contents of cigarettes and similar activities. The Convention entered into force in 2005.

The First Health Ministers’ Forum in 2001 identified tobacco as a priority issue for SEE, which the Second Health Ministers’ Forum affirmed in 2005. SEEHN launched its tobacco control project in 2005, when seven of its nine Member States had already signed the Convention. The project was intended to be a framework, for the implementation of tobacco control in three logical steps or components.

1. The initial component was preparing the political ground for implementing the Convention in SEE. With assistance from the Government of Norway, a regional multisectoral conference was held in Sofia, Bulgaria, in September 2005, followed by national multisectoral meetings.
2. The second component focused on formulating policies concerning tobacco prices, taxes, advertising bans, smoking in public places, smoking in the workplace, health warnings and packaging, information and advocacy campaigns, and smoking cessation programmes. It prepared the groundwork for creating national anti-tobacco strategies, plans and programmes.
3. The last component prepared for public outreach, with



a regional workshop on designing and carrying out anti-smoking media campaigns. The workshop took place in December 2007 in Zagreb.

By the end of the project, participants could look back with satisfaction, noting that the Convention had been signed and ratified in every country of the region but one, that national tobacco strategies and plans were being developed, that legislation was being drafted and amended, and that the intersectoral links and mechanisms required for a comprehensive, effective anti-tobacco campaign were beginning to be built. Nearly all the countries of the region now ban smoking on all health, educational, governmental and cultural premises; restrict smoking in restaurants and bars; regulate tar, nicotine and carbon monoxide levels in cigarettes; and restrict tobacco advertising.

A special report on tobacco control in the south-eastern European region is available from the Regional Office web site (WHO Regional Office for Europe, 2008).



Information systems for community health services

Project title	SEE Mental Health Project: Establishing Regional Networks and Systems for the Collection and Exchange of Social and Health Information
Initiating country	Bulgaria
Regional project office	Sofia
Duration	2005–2008
Number of components	Two
Donor	Contribution (€)
Greece	150 000
Switzerland	75 000
Regional Office	40 000
Geneva Initiative	10 000
Open Society Institute	10 000
TOTAL	285 000

Good information systems are fundamental to the development of effective, efficient modern health services and the protection of people's health. Demographic characteristics, the prevalence and spread of disease, the success of vaccination drives, the volume of hazardous materials, the location and size of vulnerable groups – the list of things that public health authorities find useful to know but can only discover through reliable information gathering is endless. And such data are just so they can describe and analyse public health circumstances. How would modern

health and social welfare services function without the dedicated software that tracks patients, handles case files and permits treatment monitoring?

Recent decades have seen the increasing adoption of health information systems, coupled with major improvements to these systems. Yet such information systems need to be based on common standards and policies. If the countries of a region do not have compatible health information policies and standards, harmonization can be painstaking and pricey. Common processes bring greater efficiency, effectiveness and functionality.

The health ministers of SEE identified information systems for health and social welfare as a priority in the Dubrovnik Pledge and then affirmed its importance in the Skopje Pledge (Annexes 1 and 2). They decided that the best approach would be to target their efforts in an area where policy harmonization was already under way, and where the introduction of common standards, procedures and processes would permit the development of a single effective information system. The natural choice was the first of SEEHN's regional projects: the mental health project. Its initial component had addressed policy and standardization, while its second component was establishing pilot community mental health centres. In implementing the new common policies, standards and processes involved in the mental health reforms, the community centres would require information systems and software tailored to their shared needs. At the same time, they would provide a perfect region-wide opportunity to develop new systems for collecting and exchanging social and health information.

The resulting information system project also had two parts – a preparatory phase and then the implementation



of the information system in community mental health centres. The project ran from June 2005 to June 2008.

Bulgaria took the lead on this project, in close cooperation with Bosnia and Herzegovina, the lead country on the mental health project. The preparatory phase began with a thorough analysis of existing information systems for collecting and processing mental health information, combined with a full mapping of the new centres' information needs and the reporting needs of the administrative structures. A technical analysis followed, of the criteria used to identify vulnerable groups, the sorts of information to be collected and the functions it would serve. Then the software was developed in English and translated into the SEE national languages, and finally, user interfaces and functionality were tested. The project culminated in 2008, when the new information system was installed in the community mental health centres and when their staffs were trained to use it for all their patient management and reporting needs.



Public health services

Project title	Evaluation of Public Health Services in South-eastern Europe
Initiating country	The former Yugoslav Republic of Macedonia
Regional project office	Skopje
Duration	2007–2011
Number of components	Two
Donor	Contribution (€)
Council of Europe Development Bank	150 000
United Kingdom	100 000
Regional Office	50 000
Israel	30 000
Slovenia	17 000
TOTAL	347 000

Most SEEHN projects were created to harmonize and improve a particular area of public health policy, whether tobacco control, blood safety or mental health. Effective regional coordination and policy-making, however, require detailed knowledge of the overall public health situation in each Member State, including which areas require urgent remedial action or reform, and what type of processes will help each country on its path towards common goals.

At the Second Health Ministers' Forum in 2005, SEEHN recognized the need to undertake this critical preparatory work in a comprehensive fashion, rather than to do it piecemeal, starting again with each new project as had

been done up to that point. The ministers ordered a general review and evaluation of public health services in SEE, in order to assess the "level of resources allocated to public health services" and determine "whether the current arrangement for revenue collection is optimal" (WHO Regional Office for Europe, 2006).

It was on the basis of this decision that the project to evaluate SEE public health capacity and services was developed, with two main components. The first was the needed evaluation of existing public health services in the region (Box 10). The second component, which is still in progress, addresses the development of indicators for public health.

The project began by establishing national focal points in each country, with a regional project manager based in the former Yugoslav Republic of Macedonia, the lead country. Criteria were established, a self-assessment tool developed and then implemented in every country, review and monitoring bodies set up, seminars arranged and regional and international experts engaged.

A report was subsequently prepared to summarize the project findings (Sedgley & Gjorgiev, 2009). The process revealed that all the countries in the region still need to shift towards a "new" public health approach that focuses on disease prevention, noncommunicable diseases, mental health and health promotion, particularly by addressing the social determinants of health. This way of looking at things needs to be at the centre of government health agendas, which will require a major overhaul of strategic planning and public health capacities. Public health policy needs to reflect an integrated approach that makes health services part of public health and sees tackling poverty and other social determinants of health as a public health pri-



ority. Countries that have not done so already will have to invest in prevention and health promotion, which will mean adapting financing mechanisms that are currently oriented towards short-term reactions and interventions. Similar long-term investments also need to be made in human resources and the development of integrated information systems.

The project's second component, developing public health indicators, represents one step in the direction of this new policy framework. The overall process will be facilitated by the 2010 institutionalization of the regional programme for long-term cooperation as the RHDC on Strengthening Public Health Services, which was established in Skopje at the National Public Health Institute of the former Yugoslav Republic of Macedonia.

Box 10 Key operations evaluated

The evaluation project appraised provision of the following 10 essential public health operations in Member States:

1. surveillance and assessment of population health and well-being
2. identification of community health problems and hazards
3. public health emergency preparedness and planning
4. health protection (environmental, occupational, food-related, etc.)
5. disease prevention
6. health promotion
7. training of competent health care and public health workforces
8. public health system governance, financing and evaluation
9. public health communication
10. health-related research.



Maternal and neonatal health

Project title	Strengthening National Capacities for Improving Maternal and Neonatal Health in South-eastern Europe
Initiating country	Republic of Moldova
Regional project office	Chisinau
Duration	2007–2010
Number of components	Three
Donor	Contribution (US\$)
Norway	408 000
Regional Office	170 000
TOTAL	578 000

The 2005 World Health Report found that every minute, at least one woman in the world was dying from complications related to pregnancy or childbirth – some 530 000 women a year (Lerberghe et al., 2005). Nor is death the only common negative outcome; frequently, pregnancy also leads to great suffering and chronic ill health for mother or child. In fact, for every woman who dies in childbirth, about 20 more suffer injury, infection or disease – approximately 10 million women each year. In addition, more than 3 million newborn babies die every year, and another 3 million babies are stillborn. Yet given the right protocols and policies, many maternal and infant deaths can be avoided (WHO, 2005).

That is why improving maternal and child health was central to the Millennium Development Goals adopted by

world leaders at the Millennium Summit in 2000. The maternal health goal has two targets: providing universal access to reproductive health services, and reducing the 1990 maternal mortality ratio three-quarters by the end of 2015.

Though maternal mortality rates fell overall in SEE countries during the 1990s, they exhibited great volatility, as did infant mortality rates. Recognizing the importance of good maternal and perinatal health, the Second Health Ministers' Forum in 2005 prioritized their improvement throughout the region, as articulated in the text of the Skopje Pledge (Annex 2).

The Republic of Moldova took the lead role in the resulting project, which ran from 2007 to 2010 and had three components. The first component was devoted to developing and updating national standards, guidelines and protocols. The second involved a similar process with national laws, policies and strategies in order to ensure universal coverage with effective maternal and newborn public health interventions. And the last component set up models for the implementation of evidence-based practices and WHO recommendations on maternal and perinatal health.

In the course of these components, the project established a regional network of experts, from the Member States, the Government of Norway, the Regional Office and WHO headquarters. A necessary information-gathering and analysis process focused on obtaining baseline information and examining the problems faced by SEE health systems. It resulted in a regional report on maternal and newborn health and health systems (Leventhal, 2009). National guidelines and protocols were drafted, translated and discussed and finally endorsed. The project resulted in a complete overhaul of the entire regulatory and administrative framework, from national law down to the level of



guidelines and protocols, together with the establishment of best practice models. As a consequence, the attention of the national governments and medical establishment was directed to the needlessly high maternal and infant mortality rates in SEE, and they were encouraged to act.



Community-based care for children with disabilities

Project title	Achieving Social Cohesion by Shifting the Care for Children with Disabilities from Institutions to Community Care
Initiating country	Serbia
Regional project office	Belgrade
Duration	2009–present
Number of components	Two
Donor	Contribution (€)
Belgium	100 000
Regional Office	30 000
TOTAL	130 000

If there is one group for whom society has a special responsibility to provide care, it must surely be the most vulnerable of the vulnerable: children with disabilities. A consensus has emerged that says traditional systems of providing care to these children in long-stay residential institutions should be replaced by programmes offering care in community settings. However, for children with disabilities to thrive there, the state and the community must first ensure adequate, equitable access to all the services that developing and growing children need – including education, health care and social services – and that their families receive the support they require.

In SEE countries, the conversion to community-based

care is well under way, yet thousands of children with disabilities still remain in residential institutions where their basic needs are not being adequately met. To complete the process, public health authorities must plan access to community services and ensure that appropriate capacity is available, integrating all the forms of support that these children and their families have the right to. Linkages should be established among sectors and institutions, with information and monitoring and systems to make sure that no children with disabilities fall victim to systemic failure. Due to their age and disability, these children are especially liable to slip through the cracks.

Serbia has assumed the role of lead country, establishing the regional project office in Belgrade, with country project offices in the other Member States. As with other SEEHN projects, the first step in this initiative has been to assess the legal and policy situation in each country, as well as the care situation in residential institutions, community settings and family-based settings there. These assessments should provide the basis for developing national plans and guidelines, selecting models of care and establishing pilot institutions and community schemes.

Several elements of this first component have been implemented. A situational review examined the functions of stewardship, service delivery, resource generation and finance in each country, and several intrasectoral national committees were established. Two models already extant in the region were selected as examples of best practice in providing quality care for children with disabilities: the Croatian Down's Syndrome Centre in Pula and the Serbia Daycare Recreation Centre for Children with Disabilities in Belgrade. Drafting of action plans has begun in more than half the Member States, and the remainder are expected to



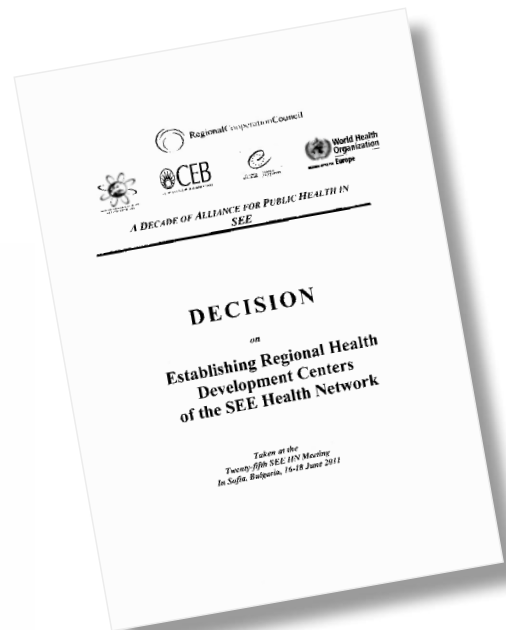
follow suit in the near future. In addition, workshops have been organized in six SEE countries so far, facilitating the provision of technical assistance and expert advice.

A second component will facilitate the development of a comprehensive new policy and legal framework and the rollout of best practice models throughout the region – and the closure of all residential long-stay institutions for children with disabilities.



5 From initiatives to institutions: the regional health development centres (RHDCs)

As individual SEEHN projects began to bear fruit, it became evident that their technical work should be continued and consolidated in some sort of permanent public health institutions that could provide continuing technical expertise and facilitation. Accordingly, the SEE health ministers decided to establish RHDCs in the most critical areas of collaboration. During 2010 and the first half of 2011, SEEHN established eight RHDCs in as many countries. Most of them are direct continuations of the regional projects, with the same country leadership. Together, these eight RHDCs represent a coherent, integrated, increasingly comprehensive response to the major public health challenges facing the SEE region in the 21st century. A brief description of each RHDC follows, presented in alphabetical order by host country.



In addition, the Network has also established 13 technical networks, many of them directly tied to RHDCs (Box 11).

The **RHDC on Communicable Diseases** was launched in November 2010, the culmination of 10 years of regional collaboration in the field. The Centre is based at the Institute of Public Health in Tirana, **Albania**. Its mission is to enhance regional cooperation in the management, control and prevention of public health threats.

The main functions of this RHDC are to:

- establish a regional inventory of cross-border collaboration on communicable disease surveillance and control;
- promote best practices in cross-border collaboration on infectious disease surveillance and control, public health threats and the International Health Regulations;
- evaluate the impact of such practices on security and development;
- coordinate relevant training and capacity development;
- develop, coordinate and implement regional initiatives on the International Health Regulations, vector-borne diseases, surveillance systems, risk assessment, early warning systems, epidemic preparedness and response, and vaccination;
- facilitate a SEE community of practice on infectious disease surveillance and control, and network with similar communities elsewhere in the world; and
- advocate collaborative research on communicable disease control and the impact of social, economic and environmental factors, using any results to promote equity and human rights in health in the region.



During European Immunization Week in April 2011, the Centre organized its first activity, on vaccination in vulnerable populations. It is currently working to evaluate the impact of influenza pandemic preparedness on public health, surveillance systems, early warning systems, policy development and the implementation of the International Health Regulations. It is also preparing a database of regional expertise in communicable disease surveillance, communicable disease policy and the International Health Regulations.

The **RHDC on Mental Health** was established in Sarajevo in 2010, at the Ministry of Civil Affairs in **Bosnia and Herzegovina**. A coordinator was appointed on 1 October 2010, and SEEHN approved a 2010–2011 action plan for the RHDC at its 24th regional meeting shortly afterwards. The Centre held an inauguration ceremony and its first workshop on 7 June 2011.

The mission of the RHDC on Mental Health is to support cooperation among SEE countries in order to improve mental health policy and practice. Its activities commenced with the appointment of national mental health coordinators and the preparation and completion of a questionnaire to quickly map out the current mental health situation in each Member State. The data collected served as the basis for the first workshop, which brought together experts; members of the SEEHN Executive Committee; and representatives of SEE countries, the Regional Office and other partners. The workshop assessed the progress that SEE had been made since the mental health project ended in December 2008, and participants discussed mental health priorities and the need for collaboration and support. A project proposal to strengthen the capacity of mental health professionals and of users' associations was presented at the workshop. The Swiss Agency for Develop-

Box 11 The SEEHN technical networks

SEEHN operates on two levels, the political and the technical. The technical work transforms the Network's political vision into practical results, regionally and nationally. These results are SEEHN's permanent legacy, proof of the value of regional cooperation in public health.

The 2011 survey found that 87% of the responding stakeholders consider the Network's work in these areas very or extremely important. While 40% of the respondents expect future cooperation to face obstacles, mainly financial, more than 90% said that the SEEHN model is the right way for SEE to approach further technical cooperation in public health.

Over the past decade, the SEEHN has brought together more than 300 technical experts from Member States, partner countries and partner organizations to form technical networks to collaborate on the 13 most critical regional issues in public health:

1. accreditation and quality of care
2. antibiotic resistance
3. blood and blood products
4. community mental health services
5. deinstitutionalization of children with disabilities
6. food safety and nutrition
7. human resources for health
8. information systems for community mental health services
9. maternal and neonatal health
10. organ donation and transplantation
11. public health services
12. surveillance and control of communicable diseases
13. tobacco control.

ment and Cooperation later approved it for funding, and implementation is scheduled to begin October 2011.



The **RHDC on Antibiotic Resistance** was established in **Bulgaria** in June 2011, hosted in Sofia by the National Centre of Infectious and Parasitic Diseases. It will be responsible for coordinating regional activities on management and stewardship of antibiotics in SEE, which will involve:

- promoting SEEHN policies on antibiotic stewardship and SEEHN priorities for decreasing antibiotic resistance in various technical areas;
- collecting and disseminating information on antibiotic use and resistance;
- participating in collaborative research under SEEHN leadership;
- training on European Union standards and guidelines in specific areas of antibiotic strategy, and harmonizing them with national standards and guidelines;
- developing regional policies and good practices;
- monitoring and evaluating existing practices, legislation, policies, strategies, etc.;
- facilitating networking among SEEHN members;
- collaborating with international organizations.

Among the Centre's most important roles will be the harmonization of procedures for collecting and processing data on antibiotic resistance, the training of public health professionals and the promotion of a coordinated regional response to antibiotic resistance.

The **RHDC on Organ Donation and Transplant Medicine** was established in 2010 and officially inaugurated on 22 February 2011 in Zagreb, **Croatia**.

Through close collaboration with national health authorities, this RHDC will coordinate and support long-term cooperation on organ donation and transplant medicine in SEEHN Member States. Transplantation medicine is presently underdeveloped in some countries of the region. While few data are available, it is apparent that fewer transplants are being performed in SEE than in other European countries. Many SEEHN members lack the organizational infrastructure needed for such advanced medical procedures.

The RHDC will facilitate dissemination within the Network of good practices, knowledge, expertise and experience relating to the subject in order to:

- increase professional and public awareness;
- exchange information, research and knowledge in the field;
- assist with training and educational programmes;
- help tailor policies to meet specific national needs;
- encourage networking to improve international collaboration in the field of organ donation and transplantation; and
- support SEE countries' efforts to become members of the Eurotransplant community.





The Centre's first meeting took place in Zagreb in February 2011. The role, objectives, functions and collaborative partners of the RHDC were presented, a network of national focal points established, and a questionnaire agreed upon for in-depth assessment of the current transplant situation in each Member State. The second meeting was held in Skopje on 27–28 May. Delegations committed to long-term cooperation in the field of organ donation and transplantation, in line with SEEHN's basic objectives. A third RHDC meeting is scheduled to take place in Bosnia and Herzegovina in October 2011.

The **RHDC on Human Resources in Health Development** was recently established in the **Republic of Moldova**, in June 2011. It is hosted in Chisinau by the National Centre for Health Management. The RHDC is a cooperative initiative to produce and exchange the information and knowledge needed to improve human resources for health in SEE, especially through the sharing of country experiences.

The main goals of the Centre are to:

- monitor and evaluate existing practices and legislation;
- research and exchange knowledge about policies addressing human resources for health, paying especial attention to regional characteristics;
- support the development of training programmes in human resource management, and of human resource standards and guidelines;
- support the implementation of global and European Union recommendations for health workforces in SEEHN Member States;
- act as a focal point for reliable data collection;
- develop common definitions and indicators for human resources for health; and
- collaborate with international organizations.

The **RHDC on Blood Safety** opened in 2010, and it is hosted by the Regional Blood Transfusion Centre in Oradea, **Romania**. Its overall goal is to help achieve regional self-sufficiency in the provision of safe blood and blood products while improving their quality. To do so, the RHDC is:

- establishing a network of experts throughout the region to exchange relevant knowledge and good practices; and
- building capacity in close cooperation with health authorities, to increase the safety and availability of blood supplies and help meet national and subregional clinical needs.

The blood safety centre opened its doors in June 2011, beginning with a multidisciplinary "train the trainers" programme on blood supply management in emergencies and special circumstances. This capacity-building exercise initiated a review of the emergency response abilities of the blood services in all nine Member States. The RHDC has also set up a dedicated electronic platform to enhance communication and the exchange of information within the professional blood safety network and beyond.

The **RHDC on Accreditation and Continuous Quality Improvement of Health Care** was established in **Serbia** in June 2011. The new centre is hosted in Belgrade by the Agency for the Accreditation of Health Care Institutions of Serbia. The ministry of health in each Member State will nominate a national coordinator for accreditation and quality improvement.



In line with its mandate and the guidance of SEEHN principles, the RHDC will perform several general functions:

- promote SEEHN policies and priorities in health care quality improvement and accreditation;
- collect, collate and disseminate information on accreditation and health care quality assurance, in part through the development of regional inventories and libraries;
- participate in collaborative research under SEEHN leadership;
- provide training in accreditation and health care quality improvement;
- harmonize standards and clinical practice guidelines in accreditation, quality and patient safety;
- develop regional policies and good practices in quality improvement and patient safety;
- develop and coordinate relevant programmes and activities;
- monitor and evaluate existing practices, legislation, policies, strategies, etc.;
- facilitate networking among SEEHN members; and
- cooperate with international and regional governmental and nongovernmental organizations.

The **RHDC on Strengthening Public Health Services** was established in **the former Yugoslav Republic of Macedonia** in 2010 and is hosted by the National Institute of Public Health in Skopje. The essential functions of the Centre include:

- promoting SEEHN policies and priorities in various technical areas;
- collecting, collating and disseminating information, in part through the development of regional inventories and libraries;

- participating in collaborative research under SEEHN leadership, including planning, conducting, monitoring, evaluating and promoting it;
- harmonizing standards and guidelines in specific areas of public health and public health training;
- developing regional policies and good practices;
- monitoring and evaluating existing practices, legislation, policies, strategies, etc.;
- facilitating networking; and
- cooperating with international and regional governmental and nongovernmental organizations.

One of the Centre's major roles will be to monitor the progress of selected public health projects and activities implemented in SEE. This task will be carried out by nine national coordinators for public health services, who will be appointed by the health ministries from their respective Member States.



6 Lessons learned

The publication of this report in connection with the Third Health Ministers' Forum in Banja Luka provides SEEHN an opportunity to take stock and draw lessons from its past decade of regional cooperation in public health. Only by analysing what was done right and what could have been done better can policy-makers learn from experience and rise to the challenges of a new decade. The particular task for SEEHN stakeholders is to connect their local experience of regional cooperation with the demanding processes associated with the enlargement of the European Union and the Euro-Atlantic community.

Given the social and economic diversity of Member States, it was always clear that cooperating on public health would be challenging, especially as it is traditionally viewed as a national policy realm. The rapidly changing global and European context has naturally magnified the challenge, yet it has also created new opportunities and the promise of new solutions. Two European policy documents – the Regional Director's vision for Health 2020 and the Council of the European Union's conclusions on the "health in all policies" approach (WHO Regional Office for Europe, 2011; Council of the European Union, 2006) – provide useful guidance, especially for the emphasis they place on:

- the importance of addressing health inequities within and among regions;
- the complex interaction between health and social and economic development; and
- the need for an integrated, multisectoral approach that places health at the heart of all government strategy and embeds it in all government policies, because of both the potential impact of policy on health, and the contribution of good health and general well-being to a well-functioning society and a productive economy.

Perhaps the most important lesson learned through the experience of regional cooperation in SEEHN is how much different stakeholders can learn from and offer to each other. By exchanging knowledge and expertise, by sharing best practices and successful models, by admitting failure frankly and by warning of potential pitfalls, they can help each other move forward together. Moreover, accepting regional cooperation as a fundamental principle has made room for unanticipated synergies. The RHDCs are becoming hubs of regional knowledge and facilitators of excellence, while resource pooling ensures better and better-coordinated processes, as well as more rational use of resources that are all too scarce. Indeed, it is worth stressing how positive the overall experience of regional cooperation has been for SEEHN Member States. Areas of particularly positive impact include:

- maintaining peace and stability in SEE while developing constructive cooperation;
- helping ensure the recognition of public health's central role in the sustainable development of Member States;
- increasing the visibility and influence of SEEHN members in European cooperation;
- developing and promoting common viewpoints in European Union policy consultations; and
- building capacity in specific technical areas of public health.

Challenges will always arise, but they must be met with determination and optimism. As Mr Ban Ki-moon, Secretary-General of the United Nations, said when addressing the Forum on Global Health in New York on 15 June 2009:

[W]e live in the midst of crisis and uncertainty. But this should only increase our resolve. Now, more than ever, it is critical

that we avoid any reversal or stagnation in the significant progress we have made in global health” (Ban, 2009).

In his speech, the secretary-general posed three questions that can help determine priorities for the global health agenda.

First, who do we need to reach and protect, as our first priority?

Second, how do we better define and build resilient, integrated systems to successfully deliver health services for all?

And finally, what are the opportunities and incentives we can build to enhance cooperation and foster partnerships that can deliver? (Ban, 2009)

Thanks to SEEHN and the health ministers of its Member States, these questions have been answered for SEE. More significantly, their work during the past decade of work has done a great deal to actually address these priorities. The key now is to “avoid ... reversal or stagnation” and tackle the tasks that remain in the region, for which the Banja Luka Pledge provides a strategic blueprint. In

adopting the Pledge, the SEE health ministers have renewed their commitments, extended their vision and set new goals. The central goals of the Pledge are to ensure that health is incorporated in all government policies and to prepare SEE to meet the national and regional targets being developed for Health 2020.

The RHDCs provide a good example of how to pursue both goals. By locating a technical centre in each Member State, the Network has created a truly regional structure in public health. Each country benefits from the concentration of expertise in each of the others. None of them could hope to maintain national centres in all the technical areas at anything close to the same level. By pooling resources, however, the Member States all have access to institutions with the potential to be as good as any in the world – to be leaders in their fields. It is up to SEEHN and its partners to ensure that the RHDCs realize as much of that potential as possible.



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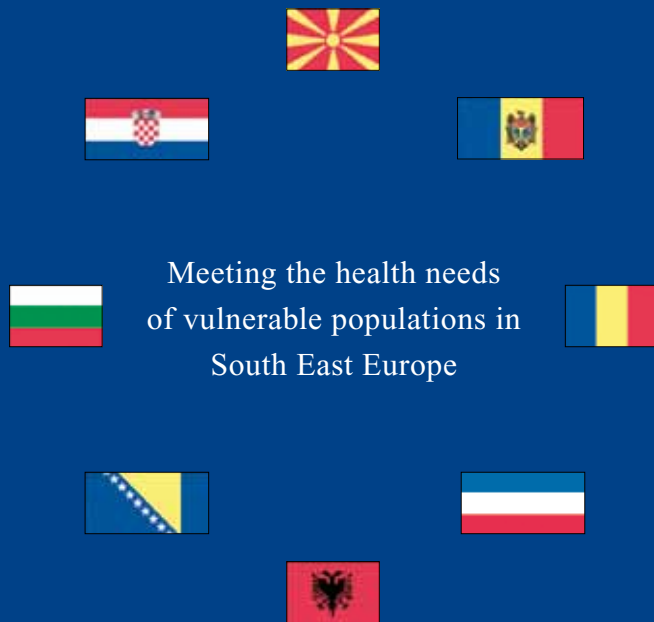


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Annex 1 – The Dubrovnik Pledge (2001)

Source: reproduced from WHO Regional Office for Europe, 2001.

The Dubrovnik Pledge



This Pledge was endorsed at the Health Ministers Forum on meeting health needs of vulnerable populations in South East Europe (Dubrovnik, 31 August – 2 September 2001) – an event which was co-sponsored by the Council of Europe and the World Health Organization, and hosted by the Ministry of Health of Croatia.

The Dubrovnik Pledge:

Meeting the Health Needs of Vulnerable Populations in South East Europe

We the Ministers of Health of South East Europe (SEE), gathered here today at the Health Ministers' Forum for Regional Health Development Action in South East Europe recognize the damaging effects on health of recent wars, continuing unrest and conflict, as well as the economic hardships faced by the populations of SEE during their countries' transition to market economies. We accept the challenge to play a key role in strengthening the fundamental human rights of our societies and of vulnerable populations and individuals within them to effective health care, social wellbeing and human development, in line with the principles of the World Health Organization and the Council of Europe.

Focus on specific strategies

We, the Ministers of Health of: Albania; Bosnia and Herzegovina; Bulgaria; Croatia; Romania and the former Yugoslav Republic of Macedonia; and the Federal Secretary for Labour, Health and Social Welfare of Yugoslavia commit ourselves through government action to the following goals.

WE WILL WORK IN PARTNERSHIP with relevant national and international bodies and organizations: to ensure equity, health gain and a better quality of life and health care (including reduced inequalities in its infrastructure and balanced primary and secondary services and public health interventions for the populations of SEE); and to collaborate on issues of common concern, including the harmonization of policies, legislation and information systems, institutional capacity building and networking to build an infrastructure to pursue regional goals and future European integration.

WE WILL MEET THE HEALTH NEEDS OF VULNERABLE POPULATIONS IN SEE, mobilizing human and financial resources to the extent possible to:

- increase citizens' access to appropriate, affordable and high-quality health care services;
- intensify social cohesion by strengthening community mental health services;
- increase the quality of and regional self-sufficiency in the provision of safe blood and blood products;
- develop integrated emergency health care services that are offered free of charge to the user;
- strengthen the surveillance and control of communicable diseases;
- strengthen institutional capacity and intersectoral collaboration for access to affordable and safe food products; and
- establish regional networks and systems for the collection and exchange of social and health information.

Plea to international stakeholders

The Health Ministers' Forum for Regional Health Development Action in South East Europe recognizes the need for assistance from international stakeholders to achieve the goals of this Pledge.


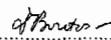
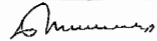
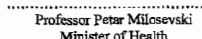
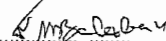
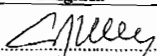



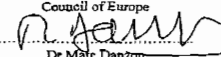
WE LOOK TO the Council of Europe and the World Health Organization for strategic guidance in developing mechanisms to coordinate partnership with national and international agencies in the fulfilment of this Pledge and request their support in organizing a first meeting to monitor and evaluate the progress achieved by such partnership.



WE ASK THAT the international community assist, within the framework of the Stability Pact for South East Europe, by providing resources to support the implementation of the above-mentioned urgent action areas for health reconstruction and development. In so doing, we commit ourselves to transparency and dedication in the implementation and reporting of all project activities and their results.

WE REQUEST that the World Health Organization Regional Office for Europe and the Council of Europe report to their governing bodies about this Pledge and the progress achieved towards its goals.

SIGNATORIES

Albania	Romania
 Ms Ruki Kondaj Secretary General of the Ministry of Health for The Minister of Health of Albania	 Dr Daniela Bartos Minister of Health of Romania
Bosnia and Herzegovina	The former Yugoslav Republic of Macedonia
 Dr Zelko Misanovic Minister of Health of the Federation of Bosnia and Herzegovina	 Professor Petar Milesevski Minister of Health of the former Yugoslav Republic of Macedonia
 Dr Milorad Balaban Minister of Health of the Republika Srpska	
Bulgaria	Yugoslavia
 Dr Bojidar Finkov Minister of Health of Bulgaria	 Dr Miodrag Kovac Federal Secretary for Labour, Health and Social Welfare of Yugoslavia
Croatia	For the Secretariat of the Meeting
 Dr Ana Stavijenic Rukavina Minister of Health of Croatia	 Mrs Gabriela Balfaini-Dragoni Director General for Social Cohesion Council of Europe  Dr Marc Danzon Regional Director for Europe World Health Organization

Dubrovnik, 2 September 2001

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Ref. No. 09-8858/1

Date: 18.10.2001



TO: Dr. Marc Danzon
 Regional Director
 World Health Organization
 Copenhagen, Denmark

Subject: Notification for the Dubrovnik Pledge

Dear Sir,

Ministry of Health of the Republic of Macedonia within the framework of the Stability Pact for South East Europe, supports the implementation of the Dubrovnik Pledge containing urgent action areas for health reconstruction and development. We commit ourselves to transparency and dedication in the implementation and reporting of all project activities and their results.

Yours truly,


 Professor Dr. Petar Milesevski
 M


Copy to:
 Cabinet of Minister, Ministry of Foreign Affairs, Skopje, Republic of Macedonia
 Dr. Marija Kisman, WHO Liaison Officer, WHO Liaison Office Skopje, R. Macedonia
 Ms. Raquel Ragnolo, UNDP Representative, UNDP Office, 3 Dimitrie Cupovski, 1000 Skopje, R. Macedonia



REPUBLIC OF SLOVENIA
MINISTRY OF HEALTH

Štefanova 5, 1000 Ljubljana, Slovenia
Tel.: (+386) 1-478 60 01
Fax: (+386) 1-478 60 58

Date: 13.11.2002

STATEMENT ON
CO-OPERATION OF THE REPUBLIC OF SLOVENIA
IN THE SOCIAL COHESION INITIATIVE OF THE STABILITY PACT
- SOUTH EAST EUROPE HEALTH NETWORK -
Health Development Action for south-eastern Europe
Belgrade, 14 -16 November 2002

Slovenia is aware of its responsibility for the stability and economic and social development of South Eastern Europe and has, since the very beginning, actively participated in the provision of assistance to the countries of that region, including activities under the auspices of the Stability Pact for South Eastern Europe. We attach special importance to co-operation in the field of health as one of the essential determinants of social and economic development.

Taking into consideration the priorities agreed in Dubrovnik in 2001 by the countries of South Eastern Europe within the framework of the South East European Health Network in the co-operation with the World Health Organisation and the Council of Europe, Slovenia is prepared to continue its active participation in the coming year, as a donor and partner country, primarily in the "Intensifying Social Cohesion by Strengthening Community Mental Health Services in South East Europe" project.

From 4 to 6 November 2002 Slovenia hosted the First Workshop on Mental Health Policies and Legislation, thus contributing USD 25,000 to the project. The same contribution is in 2003 earmarked for this project.

Since co-operation with individual countries within the SEE Health Network or the WHO Network is well underway under the "Strengthening Surveillance and Control of Communicable Diseases in SEE" and "Strengthening Food Safety and Nutrition Services in SEE" projects, we are willing to offer expert assistance and exchange professional experience as our in kind contribution within these two projects. Slovene experts could participate in these workshops with their knowledge and experience, as was the case with the harmonisation of legislation and institutional structure with the European Union and in setting up a system for monitoring communicable diseases and the required infrastructure.




Prof. Dr. Dušan Keber, M.D.

MINISTER

MINISTERUL
SĂNĂTĂȚII AL
REPUBLICII MOLDOVA



MINISTRY OF
HEALTH OF THE
REPUBLIC OF MOLDOVA

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d.7. XI. 02. Nr. 04-4/954

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

To: Dr. Marc Danzon, M.D.
Regional Director

Dear Dr. Danzon,

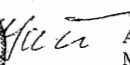
Herewith, the Ministry of Health of the Republic of Moldova expresses its sincere gratitude for the invitation to join the South East European Health Network established in the frame of the Stability Pact Initiative for Social Cohesion. We would like to inform you that our Ministry supports the implementation of the Dubrovnik Pledge containing urgent measures for health reconstruction and development and will promote the Stability Pact policy.

The Ministry of Health will highly appreciate the involving of the Republic of Moldova in all the activities of the SEE Health Network, including those we do not take part in.

In the light of the above, please give us the permission to thank you for your kind attention and to address you our highest consideration.

Yours sincerely,









Andrei GHERMAN
Minister



Annex 2 – The Skopje Pledge (2005)

Source: reproduced from WHO Regional Office for Europe, 2005.

			<p>The Skopje Pledge page 3</p>
<p>Second Health Ministers' Forum EUR/05/5056095 With the special participation of ministers of finance 15 November 2005 <i>Health and Economic Development in</i> 54634 <i>South-Eastern Europe in the 21st Century</i> Original English Skopje, The former Yugoslav Republic of Macedonia, 25–26 November 2005</p>			<p>We, the Ministers of Health of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Romania, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, have gathered for the Second Health Ministers' Forum for Health Development Action in South-eastern Europe in Skopje, The former Yugoslav Republic of Macedonia on 25 and 26 November 2005 with the purpose of discussing progress achieved towards the goals of the Dubrovnik Pledge.</p>
<h2>The Skopje Pledge</h2>			<p>Current situation</p>
			<p>We acknowledge the importance of the role of the South-eastern Europe (SEE) Health Network - in partnership with the World Health Organization (WHO) Regional Office for Europe and the Council of Europe, supported by the Council of Europe Development Bank and politically coordinated by the Social Cohesion Initiative of the Stability Pact – in meeting the challenges related to the health needs of vulnerable populations in the SEE region.</p>
			<p>We:</p> <ul style="list-style-type: none"> • recognize that health, as an integral determinant of social cohesion, and an investment and a major factor in development, is essential to lasting peace, stability and economic progress; • recognize that regional cooperation in the field of health is a vital part of the European Union (EU) integration process; • recognize that health and the health systems in the SEE region are facing important challenges; • recognize that there is a need to continue to develop, strengthen and support work being carried out in this area in general and, in particular, to improve the access of vulnerable populations in society to the health services of the region; • recognize that there is a need to promote the exchange of experiences within the area of health systems and health system reform, at international, regional and national levels; • express our gratitude for the support received from international and bilateral institutions and governments, and particularly the important analytical and policy development work of the Council of Europe, the Council of Europe Development Bank and the WHO Regional Office for Europe.
			<p>Looking forward</p>
			<p>Having reviewed the concerted action taken over the last five years in health development as a bridge to reconciliation, peace and development, we accept the challenge of reforming the health systems in the region and thus contributing to its economic development in the twenty-first century.</p>
			<p>WE UNANIMOUSLY AGREE:</p> <ul style="list-style-type: none"> • to continue to cooperate beyond 2005 on the initiative: "Health development action for south-eastern Europe: the South-Eastern Europe Health Network" (hereinafter referred to as the SEE Health Network); • to further consolidate the SEE Health Network alliance at regional level, according to its agreed Statutes, which form an integral part of this Pledge (Annex);



The Skopje Pledge
page 4

- to assume full responsibility for regional cooperation on health and health-related projects;
- to continue regional cooperation and concerted efforts to improve the health systems of the countries in the SEE region in order to secure universal access to high-quality public health services for the populations of the region, based on sustainable financing;
- to confirm our commitment to implement action in the thematic areas identified in the Dubrovnik Pledge and, in doing so, to develop and apply the common criteria and procedures outlined in the Statutes;
- to demonstrate the economic potential of health as a means to increase productivity and decrease public expenditure on illness: a healthy population works better and produces more;
- to strengthen regional collaboration and coordination on preparedness planning for emerging priorities and to put this forward as a priority for action within the SEE Health Network;
- to advocate that national governments should put health higher on the political agenda and ensure that health is reflected in the policies and strategies of other sectors;
- to empower health professionals to ensure a sustainable long-term improvement in public health.

WE COMMIT OURSELVES to transparency and dedication in the implementation and reporting of all project activities and their results.

Plea to international stakeholders

The Second Health Ministers' Forum on Health and Economic Development in South-Eastern Europe recognizes the need for assistance from international stakeholders to achieve the goals of this Pledge.

WE LOOK TO the Council of Europe and the WHO for strategic guidance in further consolidating regional cooperation through concerted action to improve the health systems in the region and provide its populations with universal access to high quality health services. We also request their support in the further implementation of action related to the thematic areas outlined in the Dubrovnik Pledge and in fulfilling the commitments of this Pledge.

WE ASK THAT the international community assist by providing resources to support the implementation of urgent action for health and economic development in the above-mentioned areas. In doing so, we commit ourselves to transparency and dedication in the implementation and reporting of all project activities and their results, in accordance with the Statutes of the SEE Health Network.

WE REQUEST THAT the WHO Regional Office for Europe and the Council of Europe report to their governing bodies on this Pledge and the progress achieved towards its goals.

SIGNATORIES

Ministers of Health of the SEE Member States

<p>ALBANIA Dr Maksim Cikuli Minister of Health</p> 	<p>BOSNIA AND HERZEGOVINA Mr Zlatko Hozjat Secretary of Ministry of Civil Affairs</p> 
<p>BULGARIA Professor Radoslav Gaydarski Minister of Health</p> 	<p>CROATIA Professor Neven Ljubicic Minister of Health and Social Welfare</p> 
<p>REPUBLIC OF MOLDOVA Professor Ion Ababil Minister of Health and Social Protection</p> 	<p>ROMANIA Mr Vasile Leca, Charge d'Affaires a.i., Embassy of Romania to The former Yugoslav Republic of Macedonia</p> 
<p>SERBIA and MONTENEGRO Professor Miodrag Pavlicic Minister of Health of the Republic of Montenegro</p> 	<p>THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA Professor Vladimir Dimov Minister of Health</p> 

**Witnessed in the presence of:
Partner States**

<p>BELGIUM Ms Leen Meulenbergs Advisor, Ministry of Health</p> 	<p>GREECE Dr Pavlos Theodorakis, SEE National Health Coordinator, Ministry of Health and Social Solidarity</p> 
<p>NORWAY Mr Wegard Harsvik State Secretary, Ministry of Health and Care Services</p> 	<p>SLOVENIA H.E. Mr Marjan Siftar, Ambassador of Slovenia to The former Yugoslav Republic of Macedonia</p> 
<p>SWITZERLAND Mr Romain Darbellay, Deputy Chief of Mission, Embassy of Switzerland to The former Yugoslav Republic of Macedonia</p> 	

Partner Organizations

<p>Council of Europe Mr Alexander Vladychenko Director General, Directorate General III-Social Cohesion</p> 	<p>Council of Europe Development Bank Mr Krzysztof Nemej Vice-Governor</p> 
<p>Social Cohesion Initiative of the Stability Pact for South Eastern Europe Mr Laurent Guye, Director of Working Table II-Economy</p> 	<p>WHO Regional Office for Europe Dr Marc Danzon Regional Director for Europe</p> 

Skopje, The former Yugoslav Republic of Macedonia, 26 November 2005



REPUBLIC OF MACEDONIA
MINISTRY OF HEALTH

No.07-12460
25.11.2005
Skopje

Skopje, 25 November 2005

Der Mr. Danzon,

I hereby acknowledge receipt of your letter from November, 2005 referring to the Skopje Pledge.

I have the honour to confirm that the above-mentioned Skopje Pledge is acceptable. Therefore, please consider this letter as equivalent to signature of the Skopje Pledge on the part of the Republic of Macedonia.

With regard to the provisional reference to my country as used in the Skopje Pledge I hereby reiterate that its constitutional name is the Republic of Macedonia.

Accept, Sir, the assurances of my highest consideration.

MINISTER OF HEALTH
Prof. Vladimir DIMOV, MD, PhD

TO: Mr. Marc Danzon, M.D.
Regional Director
Regional Office for Europe
Of the World Health Organisation

COPENHAGEN



Annex 3 – Memorandum of Understanding (2009)

Source: reproduced from SEEHN, 2009.

**South-eastern Europe Health Network
Health development action for South-eastern Europe**

Memorandum of
Understanding
on the
Future of the South-eastern Europe Health Network
in the Framework of the South East European
Co-operation Process
(2008 and beyond)

22 April 2009



Preamble

The ministries of health of the Republic of Albania, Bosnia and Herzegovina, the Republic of Bulgaria, the Republic of Croatia, the Republic of Moldova, the Republic of Montenegro, Romania, the Republic of Serbia, and The former Yugoslav Republic of Macedonia, hereinafter referred to as the members of the South-eastern Europe (SEE) Health Network,

Acknowledging that the positive developments in SEE in the past decade and the need to safeguard the significant achievements of the Stability Pact for South Eastern Europe necessitate the development of a more regionally owned and led framework for cooperation, with continued support from the international community,

Recognizing that regional cooperation remains of the highest priority in underpinning political stability and economic recovery in the region, facilitating confidence-building, and as a supporting instrument for European and Euro-Atlantic integration,

Agreeing that regional cooperation in health is important to the SEE members' aspirations for integration into and accession to the European Union, and is also an important contribution to their economic development,

Recalling that the SEE Health Network has been operational for the past six years, overseeing the implementation of regional technical projects in the field of public health, and that this regional cooperation in health was formalized with the agreement and the commitment of the ministers of health of the SEE member countries to the provisions of the Dubrovnik and Skopje pledges, endorsed at the First Health Ministers' Forum in 2001 and the Second Health Ministers' Forum in 2005, respectively,

Recalling that the Statutes of the SEE Health Network were adopted in Skopje during the Second Health Ministers' Forum in 2005,

Acknowledging the political, technical and financial support and substantial human resources provided to ensure the functioning of the SEE Health Network since its inception following the Dubrovnik Pledge by the World Health Organization Regional Office for Europe, the Council of Europe, the Council of Europe Development Bank and the Stability Pact for South Eastern Europe,

Acknowledging the close collaboration and involvement in and contributions provided to the SEE Health Network and its projects by a number of European countries, namely Belgium, France, Greece, Hungary, Italy, Norway, Slovenia, Sweden, Switzerland and the United Kingdom.

Acknowledging that regional cooperation in SEE in the field of public health is entering a very important phase, with changes in the political set-up and emerging new entities, in particular the newly established Regional Co-operation Council, and with

two of the SEE Health Network members (Bulgaria and Romania) having become members of the European Union, requiring the SEE Health Network to adapt to the new realities,

Have agreed as follows:

Title I – Vision, goal and principles of the SEE Health Network

Article I – Vision

1. The SEE Health Network shall continue to coordinate and maintain regional cooperation in public health in order to further the reforms of the health systems in the SEE member countries, and thus contribute to economic and social development in the twenty-first century.
2. The future institutional and organizational capacities shall be built on the existing institutional, human and knowledge resources in the SEE region, gradually transforming the SEE Health Network into a viable, self-reliant mechanism, capable of serving the goal endorsed by the SEE ministers of health in the Dubrovnik Pledge of 2001 and the Skopje Pledge of 2005.

Article II – Goal

1. The goal of the SEE Health Network is to improve the health of the people in the SEE region, providing and sustaining the ownership and leadership of the countries in the region in implementing concerted action in the priority areas for health defined by the ministers of health of the SEE member countries.

Article III – Principles

1. Collaboration within the SEE Health Network shall continue to be guided by the following principles:
 - 1.1 regional ownership
 - 1.2 partnership
 - 1.3 transparency and accountability
 - 1.4 complementarity
 - 1.5 sustainability
 - 1.6 equal and active involvement of all SEE member states
 - 1.7 distribution of activities and resources based on a country needs assessment
 - 1.8 decentralization of activities and resources
 - 1.9 efficiency.



Title II – Members and partners

Article IV – Members and partners

1. The SEE Health Network is a joint initiative of the ministries of health of the Republic of Albania, Bosnia and Herzegovina, the Republic of Bulgaria, the Republic of Croatia, the Republic of Moldova, the Republic of Montenegro, Romania, the Republic of Serbia, and The former Yugoslav Republic of Macedonia (hereinafter referred to as the SEE member states).
2. The SEE Health Network will seek collaboration with other countries and integrational organizations, as well as with international and regional governmental and nongovernmental organizations, hereinafter collectively referred to as the partners. They may become partner states or organizations upon accepting the relevant decisions and Statutes of the SEE Health Network, and after approval by the SEE Health Network.
3. The SEE Health Network shall seek expert advice and support from a multiplicity of institutions such as the World Health Organization, the Council of Europe, the Council of Europe Development Bank, the Regional Co-operation Council, the European Commission, the European Investment Bank and the International Organization for Migration, with which it has a history of successful collaboration and a real prospect of joint activities.
4. The SEE member countries agree to commit themselves politically and financially for a minimum period of 5 years at a time.

Title III – Organizational structure

Article V – General provisions

1. The organizational structure of the SEE Health Network, as stipulated in its Statutes, consists of the governance and leadership (Presidency, Executive Committee, regional meetings), the administration (Secretariat) and the technical structures (steering committees of the regional projects in areas of public health, regional management offices and managers, country project offices and managers).
2. The roles and responsibilities of the Presidency, the Executive Committee, the regional meetings, the Secretariat, the regional project offices and the country project offices are based on the Skopje Pledge 2005 and the SEE Health Network Statutes.
3. The working language of the SEE Health Network, Secretariat and other bodies is English.

Article VI – Governance and leadership: Presidency, Executive Committee and regional meetings

1. The Presidency shall be held by the ministry of health of one of the SEE members. It shall rotate once every six months following the alphabetical order of the countries and operate on the “troika” principle (past, current and future presidents forming a team). The SEE member country that holds the Presidency of the SEE Health Network shall host one regional meeting of the Network, together with one meeting of its Executive Committee.
2. The regional meetings of the SEE Health Network shall comprise one high-level representative, hereinafter referred to as

the National Health Coordinator, and one alternate nominated by the ministry of health of each country, whether an SEE member state or a partner country, and shall be open to one representative from each partner organization. The national health coordinators and alternates shall be decision-making and/or decision-influencing professionals at the level of deputy minister and/or as designated by the respective minister of health.

3. The Executive Committee shall be composed of five members: three representing the SEE member states, one representing the partner states and one member jointly nominated by interested integrational organizations and international and regional governmental and nongovernmental organizations. The members of the Executive Committee shall be elected by the SEE Health Network from among its members on personal merit for a period of two years. Should a member withdraw or be withdrawn before completing the Committee's term of office, the SEE Health Network shall be responsible for appointing a replacement at its following regional meeting. Representatives of integrational organizations and of international and regional governmental and nongovernmental organizations are entitled to participate in the meetings as observers with the right to contribute to the discussions.
4. The SEE Health Network may elect advisers to the Executive Committee on their personal merit with a mandate to strengthen and enhance the work of the Executive Committee and the SEE Health Network.
5. The Executive Committee shall appoint a chairperson, an alternate and a rapporteur for its term of two years. The rapporteur shall also act as rapporteur of the semi-annual regional meetings of the SEE Health Network.
6. The roles and responsibilities of the Presidency and the Executive Committee are contained in the Statutes of SEE Health Network.

Article VII – Administration: Secretariat

1. The Secretariat shall provide administrative support to the SEE Health Network, its Presidency and the Executive Committee.
2. The roles and responsibilities of the Secretariat are reflected in Annex 1 of this document in accordance with the current Statutes of the SEE Health Network. It should be noted that one additional item (Point 8) has been added.
3. The permanent seat of the Secretariat shall be in one of the SEE Health Network member states.
4. The location of the permanent seat of the Secretariat shall be established through an open selection process based on proposals submitted by interested SEE member states, considering all the necessary arrangements, including logistics, human resources and other technical and leadership aspects. The SEE Health Network shall adopt selection procedures, indicators and criteria on the basis of proposals submitted by the Executive Committee. The proposals shall be assessed by a committee elected by the SEE Health Network, comprising three representatives of SEE member countries and two independent evaluators (from outside the SEE region), using the above-mentioned procedures, indicators and criteria, in an open and transparent way.
5. Any proposal by a prospective host country for the SEE Health Network Secretariat must fulfil the following basic requirements:
 - a) legal status for the Secretariat, so that it may exercise its functions and operate without hindrance;



- b) exemption of the Secretariat from local taxes and duties for purchases and services;
 - c) exemptions for officials of the Secretariat who are not citizens of the host country (or permanent residents in the host country immediately prior to their employment by the Secretariat) from immigration restrictions and from income tax and general social security contributions on salaries;
 - d) provision of suitable office premises free of charge, including necessary up-to-date infrastructure and communications, as well as administrative and logistical support and maintenance.
6. The Secretariat shall be staffed by four personnel from the SEE region selected by the Executive Committee on the basis of their professional merit. The staff shall be recruited by the SEE Health Network according to the competences required, without any discrimination, and taking into account gender and geographical balance as appropriate, through an open selection process, with applications invited from all member countries in the SEE region. In addition, the SEE Health Network may accept staff secondments to the Secretariat for specific assignments.

Article VIII – Technical structures and networks: regional health development centres

1. The implementation of programmes, projects and activities in the technical areas agreed by the ministers of health shall be organized and performed through the appropriate technical structures and networks, including the regional health development centres, national institutions, national project offices, and regional and national counterparts. The regional health development centres shall act as coordinators of the respective networks.
2. The SEE Health Network may designate as a regional health development centre either an existing institution or one especially established in a member state that is carrying out activities in support of the SEE Health Network programme in a specific technical area designated by the ministers of health.
3. Regional health development centres shall seek expert advice for their overall scientific and technical guidance, as well as to provide direct support for the regional cooperation programmes for health development.
4. The functions of the regional health development centres are specified in Annex 2 of this document.
5. A regional health development centre shall carry out activities according to its annual plan of work, prepared by the regional health development centre and approved by the SEE Health Network in line with SEE Health Network procedures, taking into consideration the needs of the SEE members and the recommendations of the international partners, as well as the activities taking place at country and regional levels.
6. The criteria to be applied in the establishment/designation of regional health development centres are detailed in Annex 3 of this document.
7. The SEE Health Network is responsible for establishing/designating regional health development centres in the SEE region. The initiative for proposals may come only from the SEE member states. Proposals for establishment/designation are reviewed by the SEE Health Network according to the criteria laid out in Annex 3 of this document. As a first step in the designation process, the member states of the SEE Health Network shall, in consultation with the SEE Health Network, draft a plan of work identifying products and activities in one of the SEE Health Network-approved technical areas of work

in which the regional health development centre would be able and willing to collaborate. The SEE Health Network shall approve the establishment/designation of a regional health development centre at its regional meeting, provided that the criteria laid out in this document are met, and shall inform the member state submitting the proposal of the outcome.

8. A regional health development centre has the responsibility to monitor and evaluate its work, according to the developed indicators. Activities shall be monitored throughout the whole process of their implementation. The regional health development centre shall provide regular six-monthly reports to the SEE Health Network on programme progress and financing.
9. Reviews and evaluations shall be designed for each programme in order to collect information on the process and outcome of the activities/programmes, i.e. to assess to what extent the programme objectives have been achieved, and to make suggestions for further development of the programme in its subsequent stages. The regional health development centre shall be responsible for programme reviews and internal evaluations, including designing the internal evaluation tools, and scheduling and carrying out the evaluation process.

Title IV – Financial provisions

Article IX – Secretariat

1. The annual budget of the SEE Health Network Secretariat shall cover the costs of its activities (including the meetings of the Executive Committee but not the regional meetings) and its staff of four (two technical public health professionals, one financial officer and one administrative assistant). The size of the SEE Health Network Secretariat might increase, depending on the workload and future developments.
2. The SEE Health Network Secretariat shall receive contributions from the member countries in the SEE region.
3. The minimum annual estimated amount for the operation of the SEE Health Network Secretariat and the Executive Committee meetings is euros 202, 000. This amount shall be covered by annual contributions from all SEE members.
4. The amount to be contributed by each SEE member country shall be calculated on the basis of the methodology developed for contributions to the Regional Co-operation Council, whereby SEE members are categorized in four groups according to their level of gross domestic product. The contributions to be made by each country are specified in Annex 4 of this Memorandum of Understanding.
5. Financial contributions to the SEE Health Network Secretariat shall be made by all the SEE member countries at the beginning of each year, and no later than 1 April.
6. The local costs for organizing and holding the regional meetings shall be borne by the country holding the Presidency during which the meeting takes place. The local costs shall include: logistics of the meeting (transportation to and from airports, local transportation, provision of meeting venue and necessary equipment), and reproduction of meeting materials, including the meeting report.
7. All costs related to participation in the regional meetings, including airfare, accommodation and per diems, shall be borne by the participant's Ministry of Health.



Article X – Regional health development centres

1. During the inception phase, the regional health development centres shall be funded by host country resources. The term of the inception phase will be decided by the SEE Health Network at one of its regular meetings.
2. During the operational phase, the regional health development centres shall be funded jointly by the host country and other SEE members, through financial contributions and contributions in kind, as appropriate.
3. Donors, including integrational organizations, international and regional governmental and nongovernmental organizations, and partner countries, may make financial contributions and contributions in kind to the regional health development centres.

Article XI – Contributions

1. In addition to annual contributions by the Member States, as set out in Annex 4, additional contributions by members or partners may take the form of in kind and/or direct financial contributions to the SEE Health Network through the Secretariat and/or the regional health development centres.
2. The contributions shall be used exclusively for carrying out the activities of the SEE Health Network, as established by the annual work plan.

Title V – Final provisions

Article XII – Amendments

1. Amendments to this Memorandum of Understanding shall be effected only in writing, by mutual agreement between the signatories.

Article XIII - Disputes

1. Any dispute arising between the signatories concerning the interpretation and implementation of the Memorandum of Understanding shall be settled amicably either by negotiation or by other judicial means as agreed by the signatories.

Article XIV – Annexes

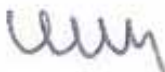
1. All four annexes attached are integral parts of this Memorandum of Understanding.

Article XV – Entry into Force and Duration of this Memorandum of Understanding

1. This Memorandum of Understanding shall enter into force upon signature of all signatories.
2. Without prejudice to any right of withdrawal, the SEE Health Network and its structures shall have an unlimited duration.
3. In the absence of a decision to terminate contributions to them by the members, the SEE Health Network and its structures shall be renewed for subsequent periods of five years.
4. This Memorandum of Understanding may be terminated by agreement of all signatories.

IN WITNESS WHEREOF, the undersigned, being duly authorized by their respective Governments, have signed this Memorandum of Understanding:

Finalized on 22 April 2009 in a single copy, in the English language.

Nard Ndolka


For the Republic of Albania



For the Republic of Moldova



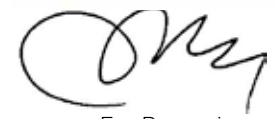
For Bosnia and Herzegovina



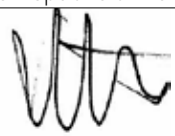
For the Republic of Montenegro



For the Republic of Bulgaria



For Romania



For the Republic of Croatia



For the Republic of Serbia

For The former Yugoslav Republic of Macedonia



REPUBLIC OF MACEDONIA
MINISTRY OF HEALTH

Ref No 12-15069/1
Date 13-10-2008

TO:

Ministry of Health, Labour and Social Welfare of Montenegro
- Doc. dr Miodrag Radunović – Minister
Montenegro - (Country at presidency with SEE Health Network)

Mr. Marc Danzon, M.D
Regional Director of WHO Europe

Mr. Alexandra Vladichenko, Director General a.i. of the Social Cohesion,
Council of Europe

I inform that the Memorandum of Understanding on the future of the South Eastern Europe Health Network in the framework of the South East European Co-operation Process (2008 and beyond) has been approved by the Government of Republic of Macedonia.

Please consider this letter as equivalent of the signature of the Memorandum of Understanding on the part of Republic of Macedonia.

With regard to the provisional reference to my country as used in the Memorandum of Understanding I hereby reiterate that its constitutional name is Republic of Macedonia.

MINISTER OF HEALTH
D-r. Bujar OSMANI

Copies to:

- Ministry of Foreign Affairs, Cabinet of the Minister, Skopje, Republic of Macedonia
- Dr. Maria Ivancheva, Regional Advisor, SEE Health Network Coordinator
- Division of Country Health Systems, Public Health Services, WHO Europe
- Dr. Peko Mircetković, Head of the Health Division, Department of Health and Bioethics
- Directorate General II – SOCIAL COHESION, Council of Europe
- Ms Snezana Coviceljeva, Chair, SEE Health Network Executive Committee, Ministry of Health, Republic of Macedonia

Annex 3.1

Roles and responsibilities of the SEE Health Network Secretariat

1. To assist the Executive Committee to prepare a proposal for a two-year strategic plan.
2. To assist the Executive Committee to prepare a proposal for the annual work plan and the budget.
3. To support the implementation of the work plan and to manage the activities of the SEE Health Network.
4. To support the fundraising efforts of the SEE Health Network.
5. To assist the Executive Committee to prepare annual technical and financial progress reports for the regular meeting of the SEE Health Network.
6. To assist the Executive Committee to prepare a short interim progress report half-way through each budget year.
7. To assist the Executive Committee to ensure the appropriate utilization of resources.
8. To assist the Executive Committee and the Presidency of the SEE Health Network to prepare the semi-annual regional meetings of the SEE Health Network.

Annex 3.2

Functions of the regional health development centres

1. Promotion of SEE Health Network policies and priorities in the different technical areas.
2. Collection, collation, and dissemination of information, including through the development of regional inventories and libraries.
3. Participation in collaborative research under the SEE Health Network's leadership, including the planning, conducting, monitoring and evaluation of research, as well as promotion of the application of the research results.
4. Training.
5. Harmonization of standards and guidelines in specific areas.
6. Development of regional policies and good practices.
7. Development and coordination of implementation of programmes and activities.
8. Monitoring and evaluation of existing practices, legislation, policies, strategies, etc.
9. Facilitation of networking among SEE members.
10. Cooperation with integrational organizations, as well as international and regional governmental and nongovernmental organizations in the area of technical work.
11. Fundraising.
12. Establishment and maintenance of a reporting system.
13. Administration of projects, programmes and activities.

In fulfilling the above functions, the regional health development centres will also promote human rights and interdisciplinary and intersectoral approaches.



Annex 3.3

Criteria for the designation of regional health development centres

1. Scientific, technical, administrative, financing and human resource capacities, with particular reference to the technical area of work.
2. Ability to contribute to the regional health development programmes.
3. Sustainability for long term duration.
4. Communication capacity.
5. Capacity to perform monitoring and evaluation of activities.
6. Capacity to carry out activities in support of the SEE Health Network programme.
7. Administrative and financial management capacity in multicountry settings.

Annex 3.4

Contributions to SEE Health Network Secretariat by SEE members

Group	GDP at PPP,* Billion \$	Countries	Country % (Group %) of costs	Share € per country	Share € per group
I	<10.0	Moldova Montenegro	5% (10%)	10 000	20 000
II	<50.0	Albania Bosnia and Herzegovina The former Yugoslav Republic of Macedonia Serbia	10% (40%)	20 000	80 000
III	>50.0	Croatia	15% (15%)	30 000	30 000
IV	>70.0	Bulgaria Romania	18% (36%)	36 000	72 000

*Gross domestic product at purchasing power parity

Total (in €): 202,000

SEE Health Network Secretariat annual budget

Annual Budget -- SEE Health Network Secretariat					
	Unit	Number	Cost/unit (€)	Amount (€)	Total
Personnel					108 000
Technical officer	person	2	36 000	72 000	
Financial officer	person	1	24 000	24 000	
Admin assistant	person	1	12 000	12 000	
Office					
Office rent	space	1	in kind from local ministry of health		
Office equipment	equipment	1	in kind from local ministry of health		
Running costs					25 000
Telephone	cost	5	4 000	20 000	
Stationery	cost	1	5 000	5 000	
Website					9 600
Setting up	cost	1	4 800	4 800	
Maintenance	cost	1	4 800	4 800	
Travel					40 000
Technical officer	cost	2	20 000	40 000	
Executive Committee meetings					19 440
Air travel	cost	16	1 000	16 000	
Hotel	cost	16	80	1 280	
Local travel	cost	16	65	1 040	
Per diems	cost	16	70	1 120	
				Total (in €)	202 040

Note: Net salaries of national and international staff will be adjusted accordingly, taking into account the tax status of the individual.



Annex 4 – Multicountry legal agreement on the seat of the SEEHN Secretariat (2010)

Source: reproduced from SEEHN, 2010

AGREEMENT AMONG THE MEMBER STATES OF THE SOUTH- EASTERN EUROPEAN HEALTH NETWORK ON THE HOST COUNTRY ARRANGEMENTS ON THE SEAT OF THE SECRETARIAT OF SOUTH- EASTERN EUROPEAN HEALTH NETWORK

Member States of the South-Eastern European Health Network (hereinafter "SEE Health Network") being Parties to the present Agreement (hereinafter referred to as the „Parties”);

Building upon the commitments of the Memorandum of Understanding on the Future of the South-eastern Europe Health Network in the Framework of the South East European Co-operation Process signed by the Ministers of Health of the Member States of SEE Health Network, on 22 April 2009 ;

Noting also that the Memorandum of Understanding, outlines the future of the regional cooperation in public health, under the auspices of the Regional Cooperation Council, and determines the establishment of the SEE Health Network Secretariat with the Seat in the South East Europe;

Recalling the unanimous decision of the SEE Health Network members during the 21st SEE Health Network meeting in Bucharest, Romania, 25-27 June 2009, to select Skopje, as the new location of the SEE Health Network Secretariat seat;

Recognizing the expressed commitments of the SEE countries to embrace full regional ownership which would further encourage existing and new partners to be involved in the regional political and technical cooperation in the field of Public Health;

Have agreed as follows:

Article I

Definitions

For the purposes of the present Agreement :

- a) "Host Country" means the Republic of Macedonia;
- b) "the Government" means the Government of the Republic of Macedonia;
- c) "Secretariat " means the SEE Health Network Secretariat in Skopje;
- d) "Head of Secretariat " means a person appointed as the Head of the SEE Health Network Secretariat in Skopje;
- e) "Official " means staff member of the Secretariat, notified to the Ministry of Foreign Affairs of the Host Country performing duties to the Secretariat on a full time basis other than under "h" of this Article;
- f) "Representative" means entitled representative of the SEE Health Network Members or other SEE Health Network partners;
- g) "Expert" means a person performing temporary mission for the Secretariat other than under "e" and "h" of this Article;



- h) "Administrative and Technical Staff " means employees engaged in technical and administrative service of the Secretariat;
- i) "Service Staff" means employees providing domestic services for the Secretariat; j) "Memorandum of Understanding" means Memorandum of Understanding on the Future of the South-eastern Europe Health Network in the Framework of the South East European Co-operation Process signed by the Ministers of Health of the Members of SEE Health Network on 22 April 2009;
- k) "Vienna Convention on Diplomatic Relations" means Vienna Convention on Diplomatic Relations dated 18 April 1961;
- l) "Premises of the Secretariat" means the building including the land ancillary thereto, occupied by the Secretariat and used only for the purposes of the Secretariat of, irrespective of ownership as specified in the Annex 1.

Article 2

Objective and Seat

The objective of this Agreement is to enable the Secretariat to discharge its duties and functions efficiently through the fully operational Seat of the Secretariat. The Secretariat is hereby established. The Seat of the Secretariat is in Skopje.

Article 3

Legal Status

1. The Secretariat shall have legal personality and the legal capacity necessary for carrying out its functions as to conclude contracts, to acquire and dispose movable and immovable property and to establish legal proceedings in accordance with the legislation of the Host Country.
2. The Secretariat shall be entitled to the same privileges and immunities as the ones accorded to the diplomatic missions in the Host Country, in line with the Vienna Convention on Diplomatic Relations.
3. The Host Country shall assist in the procedure of obtaining relevant documents for regulating legal status of the Secretariat, in order this status to be achieved within 60 days from signing of this Agreement.

Article 4

Financial contributions and other office related contributions by Host Country

1. The Government shall provide to the Secretariat for duration of this Agreement, at no fee, the necessary facilities, including convenient and appropriate premises for effective performance of its functions, equipment and furniture as set out in this Agreement and further specified in Annex 1 of this Agreement.
2. The premises including equipment, furniture and services as specified in Annex 1 shall be made available upon signature of this Agreement.
3. The Host Country shall provide to the Secretariat a financial support as provided in Annex 1 of this Agreement which is different from the annual financial contribution of the country stipulated in the Memorandum of Understanding.
4. The Host Country will give monthly office supply contributions and provide the Secretariat with a vehicle as specified in Annex 1 of this Agreement.

Article 5

Internal regulations of the Secretariat

1. The Secretariat may issue the necessary internal regulations concerning the implementation and organization of its functions, in line with the Statute of the SEE Health Network.
2. The Secretariat will inform the competent authorities of the Host Country on the relevant regulations.

Article 6

Visual identity

1. The Secretariat may display the SEE Health Network items of visual identity (e.g. flag and logo) as adopted by the SEE Health Network, on its premises and on motor vehicles used for official purposes.
2. Motor vehicles that belong to the Secretariat shall be entitled to diplomatic registration plates and to appropriate status.

Article 7

The Freedom of Secretariat's Operations

The Host Country shall guarantee the Secretariat a freedom of operations.

Article 8

Inviolability

1. The premises of the Secretariat shall be inviolable. Competent authorities of the Host Country shall have the right to enter the premises of the Secretariat in order to perform their duties, only with consent of the Head of the Secretariat or duly authorized Officials of the Secretariat, under conditions agreed by them.
2. The Government shall take all measures in order to protect the Secretariat's premises against any intrusions or damages, and to prevent damaging of its dignity.
3. Records and archive of the Secretariat as well as all documentation including compute programs and photographs belonging to it or being in its possession shall be inviolable.
4. The Secretariat shall ensure that its premises do not become a shelter for persons trying to avoid arrest at command issued by the authorities of the Host Country, or for persons who are trying to avoid the execution of legal procedure or for persons for whom extradition or deportation order was issued.

Article 9

Exception from court proceedings and executions

1. SEEHN Secretariat shall enjoy an exemption from court proceedings and executions in the host country, except in cases:
 - a) when SEE Health Network competent body has authorized waiver of immunity from court proceedings. Waiver of immunity from court proceedings shall not be held to imply in respect to any measures of execution or detention of property ;



- b) counter-claims in direct connection to procedure initiated by the SEEHN Secretariat.
2. SEEHN Secretariat shall endeavor to resolve through negotiation or if such negotiations fail by means of alternative dispute resolution all disputes arising from:
 - a) any agreement on purchase of goods and services, any loan or other transaction to provide financing, as well as any guarantee relationship or indemnification related to any such transaction or any other financial obligation;
 - b) lawsuits under Labor Law.
3. The SEEHN Secretariat, in terms of its movable and immovable property, wherever located and by whomsoever held in the Host Country shall be exempted from any measure of execution, including confiscation, deprivation, freezing or any other form of execution or sequestration or any other deprivation of property provided for by the laws of the Host Country.

Article 10

Communication

1. The Secretariat shall, in terms of its official communication, be provided with the same treatment which is accorded to diplomatic missions in the Host Country.
2. The Secretariat may use all appropriate communication tools and shall have the right to use codes in its official communication. It shall also have the right to send and receive correspondence via properly identified couriers or in packages that shall be given the same privileges and enjoy exemptions as diplomatic couriers or diplomatic packages.
3. Official correspondence and other official communication of the Secretariat, when properly identified shall not be censored.

Article 11

Publications

Import and export of publications for the needs of the Secretariat as well as of other information material that the Secretariat imports or exports within its official activities, shall not be the subject to restrictions of any kind.

Article 12

Utility Services

1. Competent authorities of the Host Country shall be obligated to, at request of the Secretariat and under the just conditions, provide utility services to Secretariat, which it needs in order to perform its functions, including, but not being limited to, post services, phone, electricity, water, sewerage, gas, garbage pick-up services and fire fighting protection.
2. Prices for utility services under the previous paragraph, shall not exceed the lowest comparable prices approved to diplomatic missions.
3. In case of termination or indication of termination of the aforementioned utility services, the Secretariat shall be given the same priority as to diplomatic missions, for the requirements of its official functions.
4. At request of competent authorities of the Host Country, the Head of Secretariat shall be responsible to ensure to appro-

privately authorized representatives of utility service companies, to check, repair, maintain and relocate installations in the Secretariat's premises, at appropriate time, under conditions that will not effect the functioning of the Secretariat.

Article 13

Exemption From Duties and Taxes

1. The Secretariat, its funds, income and other property shall be exempted from direct duties and taxes. This exemption shall not be applied to taxes and appropriations considered utility services taxes offered at fixed prices, in line with the quantity of provided services, which can be identified, described and divided.
2. In terms of value added tax included in prices or separately calculated, exemption shall be applied only on items acquired for official usage of the Secretariat, whereas goods purchased for its usage, for which exemptions apply in line with this provision, must not be sold, given as a gift or in any other way deprived, except in line with conditions agreed with the Government.
3. The Secretariat shall be exempted from all state and local rates or fees, except rates or fees calculated as the price of actually rendered services.
4. The Secretariat will not, as general rule, claim exemption from excise duties and from taxes on the sale of movable and immovable property which form part of the price to be paid.

Article 14

Exemption From Customs and Treatment

1. Customs treatment of items for the Secretariat shall be equally favorable as the ones accorded to diplomatic missions in the Host Country.
2. Goods imported or exported for the purpose of official use by the Secretariat shall be exempted from payment of customs, taxes and fees.

Article 15

Free disposal of funds and freedom of business

1. The Secretariat, for the purpose of executing its functions, shall have the right to receive, keep, convert and transfer all funds, currencies, cash and other transferable values, and freely dispose with them, perform business without restrictions, in line with the legislation of the Host Country.



Article 16

Privileges and Immunities of the Members of the Secretariat

1. During the time of performance of duty in the Host Country, the Head of the Secretariat, provided that he, she is not a national of the Host Country shall be entitled to the same privileges and immunities as the ones accorded to the head of diplomatic missions in the Host Country, in line with the Vienna Convention on Diplomatic Relations.
2. During the time of performance of duty in the Host Country, the Officials of the Secretariat, provided that they are not nationals of the Host Country shall be entitled to the same privileges and immunities as the ones accorded to the diplomatic agents in the Host Country, in line with the Vienna Convention on Diplomatic Relations
3. Members of the Administrative and Technical Staff, provided that they are not nationals of the Host Country shall be entitled to the same privileges and immunities as the ones accorded to the administrative and technical personnel in the Host Country in line with the Vienna Convention on Diplomatic Relations.
4. The Government shall take all the necessary measures to facilitate the entry, into, departure from and residence in the Host Country of the Head of Secretariat, Officials, Representatives, Experts and Administrative and Technical staff and their family members.
5. The family members of the Secretariat personnel living in the same household shall be entitled to the same privileges and immunities as the ones accorded to the family members of diplomatic agents of comparable rank in the Host Country, in line with the Vienna Convention on Diplomatic Relations.
6. Secretariat personnel and members of their family, Representatives and Experts, which may require visa for performing professional activity in duration proportional to the duration of their mission, as well as permission for temporary residence shall be granted visa free of charge.

Article 17

Access to the Labor Market

Under special conditions and within the limits of the relevant Host Country Legislation, the spouses and children forming part of household of the members of the Secretariat shall enjoy access to the labor market provided they reside in the Host Country as the principal holder of the identity card, as long as they are not citizens of the Host Country.

Article 18

Social Security

1. The Secretariat and Officials, Experts and Technical and Administrative Staff, provided that they are not nationals of the Host Country shall be exempted from paying obligatory contributions, in connection to any type of social security in the Host Country.
2. Officials, Experts and Technical and Administrative Staff shall have the right to participate in a health insurance system, and to be insured against accident and have pension insurance in the Host Country, in line with the legislation of the Host Country.

Article 19

Officials

1. Without prejudice to privileges and immunities provided in Article 16, Officials in the Host Country shall enjoy the right to import for personal use, free from customs and other taxes or duties, under condition those are not taxes for rendered utility services, as well as exemption from import restrictions and limitations of import and export of:
 - (i) their furniture and personal belongings at the moment when they first take their duty, in one or more separate shipments, and
 - (ii) one motor vehicle every four years.
2. The way in which imported goods will be disposed with, with exemption from payment of import duties, shall be applied in line with regulations on duty, tax and other facilities to which foreign diplomatic and consular representative office in the Host Country are entitled.

Article 20

Experts

Experts shall enjoy shall enjoy the following privileges and exemptions in the Host Country :

- a) exemption from court proceedings in respect of words spoken or written as well as all acts carried out by them in the performance of their official functions, even after they cease to be the Officials of the Secretariat;
- b) exemption from check and seizure of personal and official luggage;
- c) inviolability of official documentation, data and other material;
- d) exemption from taxes, including from VAT, contributions on salaries, additional benefits and indemnities, paid to them by the Secretariat for their service.
- e) exemption from immigration restrictions, and obligation to register themselves, their members of their families living in the same household;
- f) equal protection and facilities in repatriation, for them, their members of their families living in the same household, accorded to the members of comparable rank in diplomatic missions.

Article 21

Representatives

Representatives shall enjoy the following exemptions, during the period of execution of their responsibilities in the Host Country as well as during their trip on the territory of the Host Country:

- a) exemption from court proceedings, in respect of words spoken or written as well as all acts carried out by them in the performance of their official functions, even after they cease to be the representatives;
- b) exemption from check and seizure of personal luggage;
- c) inviolability of official documentation, data and other material;
- d) exemption from immigration restrictions.

**Article 22****Citizens of the host country and persons with Permanent residence permit**

Officials, Experts, and Administrative and Technical Staff who are citizens of the Host Country or persons with permanent residence permit in the Host Country, or personnel seconded by the Ministry of Health of the Host Country shall be entitled only to privileges and immunities stated under Article 20, Paragraph 1, items a, b and c.

Article 23**Administrative, Technical and Service Staff**

The Secretariat shall have the right to engage Administrative Technical and Service Staff, who are citizens of the Host Country and persons with permanent residence permit in the Host Country in line with the laws of the Host Country.

Article 24**Exception to Immunity From Legal Proceedings and Execution**

Officials, Experts and Representatives shall not enjoy immunity in terms of civil action by third party for damages arising from a road traffic accident caused by motor vehicle operated by Secretariat where these damages are not recoverable from insurance.

Article 25**The Purpose of Privileges and Exemptions**

1. Privileges and immunities under this Agreement are granted in the interests of the Secretariat and not for-the personal benefits of the individuals themselves.
2. Their purpose is solely to provide freedom of actions of the Secretariat under all circumstances as well as full independence of mentioned persons in performing their duties for the Secretariat.
3. The SEE Health Network competent body shall have a right and duty to waive immunity of any Member of the Secretariat in any case where in its opinion, the immunity would impede the course of justice and can be waived without prejudice to the interest of the SEE Health Network. Waiver of immunity from jurisdiction in respect of administrative proceeding shall not be held to imply waiver of immunity in respect of the executing of the judgment, for which a separate waiver of immunity shall be necessary.

Article 26**Notification**

1. The Secretariat shall notify to the Ministry of Foreign Affairs of the Host Country the names of Head of Secretariat, Officials, Experts, Administrative and Technical Staff, as well as of the members of their families immediately or, at latest,

within three days as of the date of their arrival. The Secretariat shall also notify the termination of the mandate of Head of Secretariat or any Official, Expert or Administrative and Technical Staff as well as, where appropriate, the fact that a person ceases to be a member of their family.

2. The Ministry of Foreign Affairs of the Host Country shall issue to Head of Secretariat, Officials, Experts, Administrative and Technical Staff and to members of their families appropriate identity cards.

Article 27

Not Assuming Responsibility by the Host Country

The Host Country shall not assume any international responsibilities for actions or omissions made by the Secretariat at its territory.

Article 28

Security Issues

1. Nothing in this Agreement shall preclude the right of the Government of the Host Country to apply all appropriate measures of protection in the interest of public security. Nothing in this Agreement shall prevent implementation of the laws of the Host Country, necessary for perseverance of health or public order.
2. Should the Government of the Host Country consider necessary to apply provisions of the Paragraph 1 of this Article, as soon as circumstances allow, it shall establish the connection with the Secretariat in order to make a joint decision on measures that might be necessary to protect the interest of the Secretariat.
3. The Secretariat shall be obligated to cooperate with authorities of the Host Country in order to prevent any impediment of public security due to any activity carried out by the Secretariat.

FINAL PROVISIONS

Article 29

Settlement of Disputes

All disputes concerning the interpretation and implementation of this Agreement shall be settled through negotiations between the Parties.

Article 30

Amendments

This Agreement may be amended by mutual consent of the Parties to this Agreement. Amendments shall enter into force in accordance with Article 31 of this Agreement.



Article 31

Entry Into Force

1. This Agreement shall enter into force on the date of the receipt of the fifth notification of the Parties, including the Host Country, by the Ministry of Foreign Affairs of the Host Country about the completion of their internal requirements for its entry into force.
2. For every Party which, after the deposit of the fifth notification in accordance with paragraph 1, notifies the Ministry of Foreign Affairs of the Host Country about the completion of its internal requirements for the entry into force of this Agreement, it shall enter into force on the date of the notification to the Ministry of Foreign Affairs of the Host Country.
3. After signing the Agreement the original will be deposited with the Government of the Host Country which shall serve as the Depository. The Depository shall provide the Parties to the Agreement and the Secretariat with duly certified copies thereof.
4. This Agreement will apply provisionally as of the day of its signing. Any Party may, at the moment of signing of the Agreement, declare that the Agreement shall apply in its regard as from the date of completion of its relevant internal requirements for its entry into force.
5. The Annex 1 is considered to be an integral part of this Agreement.

Article 32

Duration, Denunciation, Withdrawal and Termination

1. This Agreement shall remain in force for an unlimited period as long as the Memorandum of Understanding is in force.
2. The Government of the Host Country shall be entitled to denounce this Agreement, notifying the Parties in written form. In that case, this Agreement shall be terminated six (6) months as of the receipt of this notification.
3. Each Party may withdraw from this Agreement notifying the Depository and the other Parties in written form. In that case, this Agreement shall cease be in force for that Party six (6) months as of the receipt of the notice by the depository.

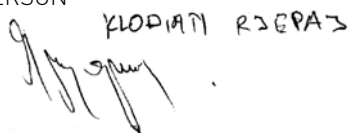
IN WITNESS WHEREOF, the undersigned being duly authorized by their respective Governments, have signed this Agreement,

Done at _____, on this _____ 2010, in one original in English language.

THE REPUBLIC OF ALBANIA

AUTHORIZED PERSON

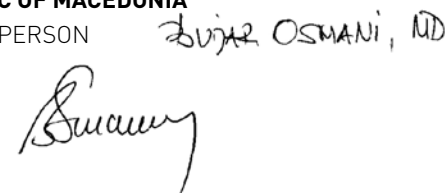
SIGNATURE

KLODIAN RZEPAS


THE REPUBLIC OF MACEDONIA

AUTHORIZED PERSON

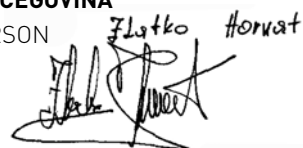
SIGNATURE

ZIJAR OSMANI, MD


BOSNIA AND HERCEGOVINA

AUTHORIZED PERSON

SIGNATURE

Željko Horvat


THE REPUBLIC OF MOLDOVA

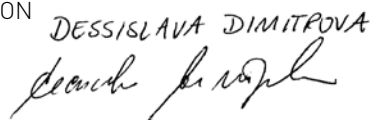
AUTHORIZED PERSON

SIGNATURE

THE REPUBLIC OF BULGARIA

AUTHORIZED PERSON

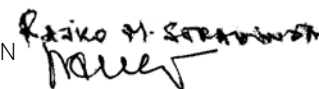
SIGNATURE

DESSISLAVA DIMITROVA


MONTENEGRO

AUTHORIZED PERSON

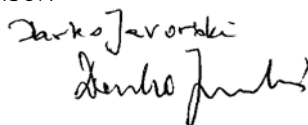
SIGNATURE

Rajko M. Stanić


THE REPUBLIC OF CROATIA

AUTHORIZED PERSON

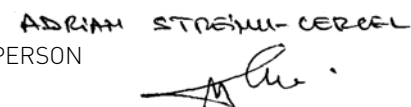
SIGNATURE

Zarko Javoracki


ROMANIA

AUTHORIZED PERSON

SIGNATURE

ADRIAN STREINU-CERCEL


THE REPUBLIC OF SERBIA

AUTHORIZED PERSON

SIGNATURE



Republic of Serbia

MINISTRY OF HEALTH

No: official

Date: 9th November 2010.
Belgrade

Sector for Health Care, Department for EU Integration and
International Projects Preparation, Implementation and
Monitoring
Nemancina 22-26, Belgrade
Phone.: +381 11 3614-890
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Fax: +381 11 3614-890
E-mail: bestovic.nemad@gadm/jc.gov.rs

MINISTRY OF FOREIGN AFFAIRS OF THE REPUBLIC OF MACEDONIA

Your Excellency,

Hereby, I declare that the Government of the Republic of Serbia agrees with the provisions of the Agreement among the Member States of the South-eastern Europe Health Network on the Host Country Arrangements on the seat of the Secretariat of South-eastern Europe Health Network.

It is considered that with this Letter concerning signature the Republic of Serbia becomes a signatory State to the Agreement among the Member States of the South-eastern Europe Health Network on the Host Country Arrangements on the seat of the Secretariat of South-eastern Europe Health Network

I avail myself of this opportunity Your Excellency, to extend the assurances of my highest consideration.

ANNEX 4.1

PREMISES, EQUIPMENT, SERVICES FINANCIAL AND OTHER OFFICE RELATED CONTRIBUTIONS BY THE HOST COUNTRY

Article 1

Premises and equipment

The Host Country shall transfer and make available to the Secretariat in accordance with this Agreement:

- a) the premises of the Seat of the Secretariat, property of the Republic of Macedonia, with total area of 100 m², allocated in Skopje, 1 km from the center of the city. Premises include two offices and meeting room, The Government of the Host Country shall undertake all necessary activities which might be needed for adaptation and refurbishment in accordance with needs of the SEEHN Secretariat.
- b) office equipment and furniture shall include 4 computers, 2 printers, 1 copier, 1 scanner, 1 fax machine, 4 tables with drawers, 4 chairs and 4 book/file shelves, and two tables and 10 additional chairs in the meeting room, for all the duration of this Agreement, without interruption.
- c) the Host Country shall provide all necessary utility services for functioning of the SEEHN Secretariat including, but not limited to telephone lines and internet access.

Article 2

Financial support

The Host Country shall, in addition to annual contribution, provide amount of 60.000 EUR, as a one-time only contribution.

Article 3

Other office-related contributions

1. The Host Country shall provide the following:

- a) office supplies contributions at a minimum of the equivalent of 500 Euros per month. This contribution will be on a monthly basis and will be repeated continuously for the whole duration of this Agreement.
- b) shall cover the costs of running and maintenance for the premises one telephone line and internet connection, but not the mobile phones.
- c) One vehicle for the needs of the personnel of the Seat of the Secretariat and will cover the expenses for the maintenance of the vehicle, except for the spare part, lubricants, tires and supplies.



Three fundamental aspects of better health

1. The right to health

The right to health is the right to the highest attainable level of health. It is not an abstract ideal, though it contains freedoms and entitlements that are universal, and to which there must be equitable access without discrimination. It underpins the duty of the state and society to care for those who are most vulnerable and most easily excluded. Importantly, the right to health recognizes that there are underlying social and economic determinants of health, and that the government is obligated to tackle their impact. For while the state cannot guarantee good health, which is influenced by factors outside its direct control, it can help secure an environment that promotes rather than damages health.

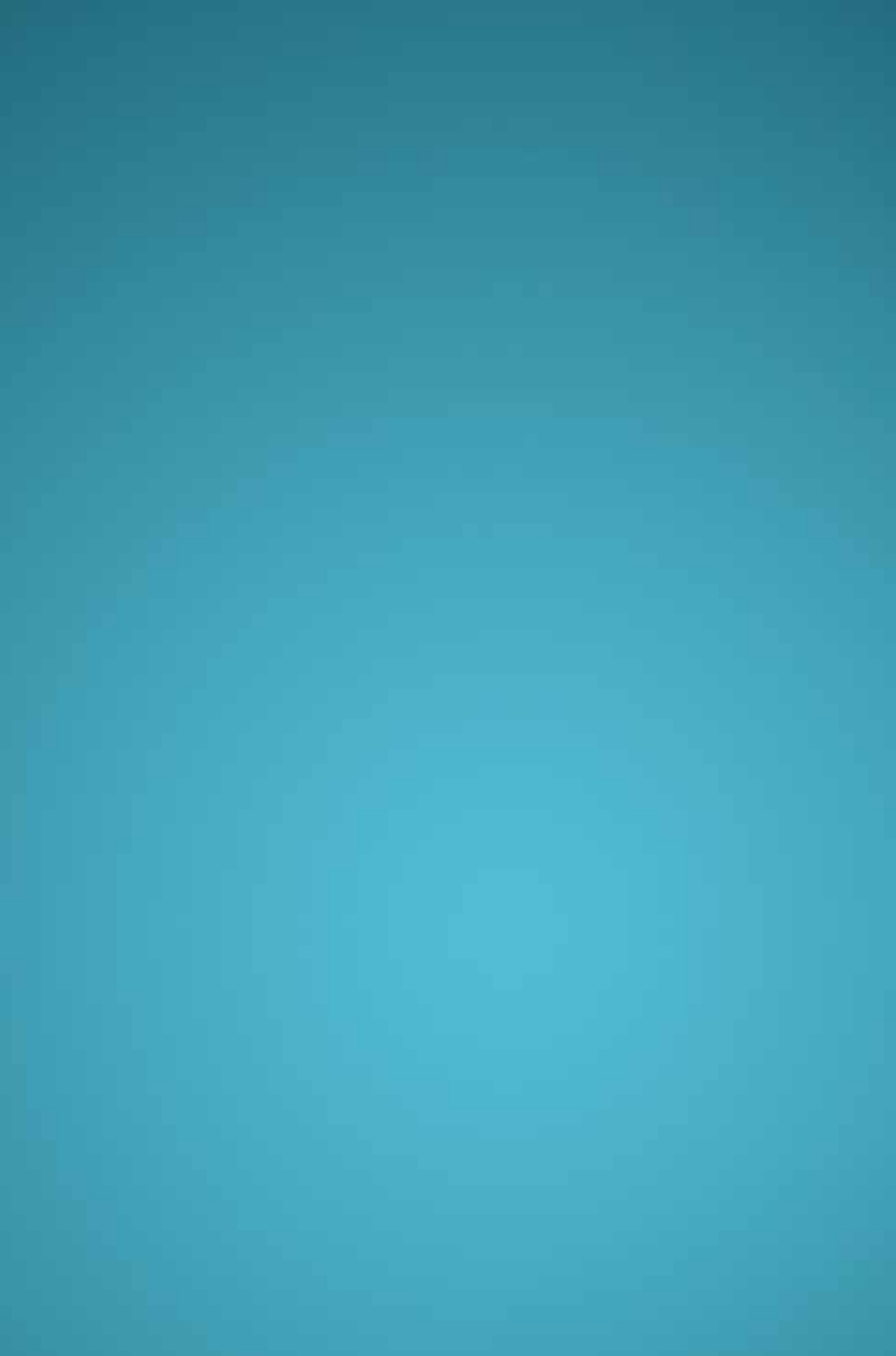
2. Public health

Public health is, to quote an often-cited definition, “the science and the art of preventing disease, prolonging life and promoting health through the organized efforts of society” (Acheson, 1988). Essentially, public health is how the government, the health sector and society as a whole approach their duty to secure the right to health of the populations for which they are responsible. It covers all policies and programmes to prevent communicable and noncommunicable diseases and minimize their impact, to promote good health and well-being through good lifestyle practices or to otherwise address health determinants and inequalities.

3. Health in all policies

A particularly important development in public health in recent years has been the focus on health in all policies. Essentially, it reflects the need to consider health consequences whenever government policy is being made, particularly when it concerns major social or economic issues. The fact that many of the social and economic determinants of health have been identified means that the government can address them by incorporating awareness of their impact on health into social and economic policy. It also means ensuring that all policies be formulated with sensitivity to their potential impact on the health of both sexes, all age groups and people living with disabilities. This broader understanding of health and of its implication in all other aspects of society and economy has been developing simultaneously in different parts of the world, giving rise to a variety of new approaches that share a common core – the recognition that an adequate approach to public health must be a “whole government” approach that integrates the public health dimension into all policies, duly considering both the impact of health on policy and vice versa.

In European Region strategy, this understanding has recently crystallized around two complementary approaches: Health 2020, the new European policy for health, and the approach simply known as “health in all policies” (WHO Regional Office for Europe, 2011; Council of the European Union, 2006).





SOUTH EASTERN EUROPE HEALTH NETWORK (SEEHN)

*“Health Development Action for
South-eastern Europe”*

Members

Albania
Bosnia and Herzegovina
Bulgaria
Croatia
Montenegro
Republic of Moldova
Romania
Serbia
The former Yugoslav
Republic of Macedonia

Donors and neighbours

Belgium
France
Greece
Hungary
Italy
Israel
Netherlands
Norway
Slovenia
Switzerland
Sweden
United Kingdom

Partner organizations

Council of Europe
Council of Europe Development Bank
Regional Cooperation Council
WHO Regional Office for Europe

SEEHN Executive Committee
Mrs Snezhana Chichevalieva, Chair
Head, Department for European Integration
Ministry of Health
The former Yugoslav Republic of Macedonia

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